ISSUES RELATING TO WOMEN’S VULNERABILITY TO HIV/AIDS IN NIGERIA

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ABSTRACT

This article examines the issues relating to high vulnerability of women to HIV infection and the challenges posed by these issues with particular reference to Nigeria. The paper notes that women are particularly vulnerable to HIV infection for biological, social, cultural and economic reasons. Globally, evidence has shown that the number of women infected with HIV/AIDS has increased tremendously - indicating a corresponding increase in the number of infants acquiring HIV infection through mother to child transmission. Most of the AIDS prevention strategies are focused on men therefore there is an urgent need for transformation of these strategies to meet women’s needs.

1.0 Introduction

HIV/AIDS now presents another formidable challenge to the survival of women that may become greater than the already tragic loss of life related to pregnancy and childbirth. Joint United Nations on HIV/AIDS (UNAIDS) estimates in 1998 show that at least 33 million people had HIV/AIDS and another 14 million people had died as a result of HIV/AIDS. About 95% of HIV infected people are in the less developed world where healthcare systems and economic resources are unable to keep pace with the spread of the disease and most of them do not know that they are infected (United Nations, 2000:67).

The overall life expectancy in sub-Saharan Africa has dropped precipitously over the past 10 years, mostly because of the AIDS epidemic (WHO, 2000). For example, life expectancy dropped for female babies from 51.1 years to 46.3 years. For males, the level dropped from 47.3 years to 44.8 years. Countries like Sierra Leone had 25.9 years of healthy life for babies born in 1999; Niger, 29.1; Malawi, 29.4; Zambia, 30.3; Botswana, 32.3; Uganda, 32.7; Rwanda, 32.8; Zimbabwe, 32.9; Mali, 33.1; and Nigeria, 38.3 (WHO, 2000). On the contrary more developed countries have higher life expectancies such as Australia, 73.2 years; France, 73.1; Sweden, 73.0; Spain, 72.8; Italy, 72.7; Greece, 72.5; Switzerland, 72.5; Monaco, 72.4; and Andorra, 72.3 (WHO, 2000).

The early and persistent stereotype of AIDS as a gay disease has perpetuated the notion that women are not at risk for HIV infection. The reality is that in sub-Saharan Africa and other...
regions of the world where HIV is predominantly transmitted through heterosexual intercourse, there are as many infected women as there are men. Globally, evidence has shown that the number of women infected with HIV/AIDS has increased tremendously. The percentage of HIV-positive adults who are women has risen from 25% estimated in 1990 to 43% in late 1997 and appears to be still rising (Gardener et al., 1999:6; NIMR, 2000A: 30). Women account for almost half (49%) of the 12.7 million adults who have died since the epidemic began. In 1999, out of 5 million adults newly infected, 2.3 million were women and out of 2.1 million that died in the same year, 1.1 million (52%) were women (WHO, 2000; United Nations, 2000:67). These suggest that women are bearing an increasingly large burden of the disease. Currently, there are 12 million women of childbearing age who are HIV positive (UNICEF, 2001:10). The prevalence rate varies from one region to another. In Africa, more women than ever before are getting new infections than men and there are 12 to 13 African women currently infected for every 10 African men (United Nations, 2000:67; WHO, 2000; UNICEF, 2001:10). WHO Fact Sheet (2000) and United Nations, (2000:67) report that 55% of adult infections in sub-Saharan Africa are women, 30% in South East Asia and 20% in Europe and USA. A large percentage of the infected women are married or in committed monogamous relationships. These high rates of HIV infection among women indicate a corresponding increase in the number of infants acquiring HIV infection through mother to child transmission. Mother to child transmission is the main source of HIV infection in children under 15 years.

This article examines the issues relating to high vulnerability of women to HIV infection and the challenges posed by them, with particular reference to Nigeria. In the next section, HIV/AIDS situation in Nigeria is examined.

2.0 Literature review

2.1 HIV/AIDS situation in Nigeria

In Nigeria, the first AIDS case was identified in 1986 in a sexually active girl of 13 years old. Ever since then the infection has continued to spread at an alarming rate affecting all strata of the society. This rapid spread is due primarily to long delay between infection of HIV and ultimate development of AIDS, ignorance, misinformation, religious and cultural barriers, denial, poverty, male promiscuity etc. Data from National HIV Sentinel Surveys indicated a rapid transition from the near zero prevalence in 1990 to 1.4% in 1992, 3.8% in 1994, 4.5% in 1996 and to 5.4% in 1999 (NASCP, 1999; NIMR, 2000a: 4). This trend supported by clinical data indicates that the pandemic has spread beyond the high-risk groups (commercial sex workers, truck drivers etc.).

About 10% of African adults infected with HIV live in Nigeria, the region’s most populous country (UNAIDS, 1998:75). Based on the blood tests conducted in pregnant women in 1999, it was estimated that 2.6 million people aged 15-45 years were living with the HIV infection in Nigeria (NIMR, 2000a: 28; and 2000b: 1). This figure placed Nigeria as the country with the highest number of infected adults in West Africa and second in Africa (NIMR, 2000a: 28). Also in 1999, about 250,000 people died of AIDS. The major mode of transmission in Nigeria is by heterosexual contact. Due to this mode of transmission women and children are more affected than in any country where HIV initially spread through homosexuals or sharing of intravenous drug infecting equipment (UNAIDS 1998:75). HIV/AIDS spreads first among people in urban centres and strikes more men than women (62% against 38%, NIMR, 2000a: 23) but new infections in women are rising fast just like in any other nation. Between 1986-1995 women constituted 43.26% of HIV infected people. By October 1996 women in Nigeria
represented 55% of all positive cases in one cohort i.e. semi urban population against 25% in 1991 (FMOH, n/d).

One out of 20 pregnant women is HIV infected (FMOH et al n/d). According to NASCP (1999), the prevalence rate among pregnant women varies from one region of Nigeria to the other. For instance, the prevalence rates in "Hot Spot" areas such as Benue state in North Central zone are 21%; 15% in Kaduna state in North West zone; and 13.3% in Akwa Ibom in South South zone. Others are 11.1% in Ebonyi state in South East zone and 7% in Lagos and Taraba states in South West and North East zones respectively. The most affected are pregnant women under 20 years. The rates range from 2.8% in the North East zone to 8.4% in North Central zone (UNIFEM, 2000:18). About 30%-40% of babies of HIV positive mothers are infected and the remaining 60% are at risk of becoming orphans as their parents die of AIDS (NIMR, 2000:5). Infection to children born to infected mothers may erode the previous gains in child survival as it is estimated that AIDS deaths may increase the infant mortality by 75% and mortality of children under 5 years by more than 100% (FMOH, n/d). 1999 Sentinel Sero-prevalence Survey findings show that 44% of the 4180 cases of AIDS-related deaths were among women.

As at now there is no known cure for HIV/AIDS but recently antiviral drugs have been developed to reduce the amount of HIV in the body, delay the onset of symptoms of AIDS, improve the quality of life for HIV-infected people, and reduce the likelihood that HIV-infected mothers will pass HIV to their children. These drugs are expensive and most of the infected people in developing countries including Nigeria cannot afford them even if subsidized. Prevention is the best cure for now. It then becomes necessary to examine the issues that make women vulnerable to HIV infection and suggest possible ways of limiting their risks to the pandemic.

2.2 Issues relating to women's vulnerability to HIV/AIDS

Women are particularly vulnerable to HIV infection for biological, social, cultural, and economic reasons. For biological reasons, a woman is more likely to contract HIV/AIDS sexually from an infected man than a woman is to infect a man (Population Reference Bureau (PRB), 1998). First, all women having unprotected sex are exposed to high concentration of HIV in the semen, have longer contact with the infected semen than males with the infected vaginal fluid. Second, a woman's anatomical feature exposes a larger part of her body surface thus enhancing the transmission of the infection. Therefore, women's risk of being infected is two to four times higher than that of men (United Nations, 2000). The risk is higher for younger women because they have fewer protective antibodies and immature cervixes than do older women (United Nations, 2000:68; and AGI, 1998:34) They often have multiple, short-term sexual relationships, do not consistently use condoms and lack sufficient information on how to protect themselves from HIV/AIDS. Likewise they stand a higher risk of sexually transmitted infections (STIs) that enhance the HIV infection. Prevalence and incidence of curable STIs are particularly high in developing countries when they are the second most frequent causes of sickness and death among women of reproductive age (Gardener et al, 1999:6).

Coerced sex increases the risk of HIV infection. Some young girls are exposed to sexual abuse. There is evidence that sexual abuse is an underestimated mode of HIV transmission in children (WHO, 2000). Sexual abuses of young girls occur all over the world. Heise et al.
Report that between one-third and two-thirds of known sexual assault victims are age 15 or younger. In other parts of the world, people talk about them and efforts are made to legislate against them. The victims are educated to report such acts that are visited with harsh punitive measures, coupled with monitored sexual-education programs. But in Nigeria or Africa, women are so much afraid to talk about sexual abuses just to avoid stigmatization and scandal. People pretend such acts do not exist and hence are not seen as health, moral or social problems that need to be addressed either through effective sex education or legislation. Adult men seek younger girls in order to avoid HIV infection. The vulnerability of girls is exacerbated by denial or neglect of their recognized human rights including gender discrimination, resulting in inadequate control over their exposure to sexual HIV transmission and poor access to socio-economic opportunities.

Other factors are social and cultural which reflect different roles, norms, and expectations. Norms encourage men to take sexual risks and discourage women from questioning their partner’s sexual activity (Francoeur 1998:1737). Women have little or no powers to control the risky sexual behaviours of their partners or take action to limit their sexual exposure. They are not expected to discuss or make decisions about sexuality while men can make such decisions. According to Gupta (2000) men have greater control than women over when, where and how sex takes place. Harmful traditional practices predispose African women and Nigerian women in particular to HIV and other STIs. Female genital mutilation (FGM) that young girls or adolescents have to go through in the name of culture may result into complications such as genitourinary infections that can act as contributory factor to HIV infection. The objects used in this mutilation are most often not sterile. In most cases the same objects are used for several patients without proper sterile procedure.

The traditional norm of virginity for unmarried girls increases young women’s risk of infection because it restricts their ability to ask for information about sex for fear of being thought to be sexually active (Gupta 2000). Gender norms often discourage people from using condoms even when they risk contracting an STI including HIV/AIDS. Data have documented that fear of abuse and retaliation may make women reluctant to discuss possible partner infidelity or unwilling to ask their partners to use condoms. Pivnick (1993) and Sobo (1995) found that the negative implications of condom use conflicted with values surrounding relationships, womanhood and family. Fulfillment of family and gender roles through pregnancy and childbearing was significant. Some religious laws continue to confer privileges on males. for example, polygamy which may make women more vulnerable to HIV/AIDS/STIs (Solomon, 1996:1) If the woman is economically dependent on a man she and her children can end up on the street. Worth (1989) in his study found that condom use carried a stigma of infidelity and lack of trust. Studies on every continent demonstrate that both men and women perceive condoms as for having sex with 'others' not stable partners or for women ‘of the street’ not the home’. Condom use therefore becomes a negative sign of the level of trust in a relationship rather than simply a sensible means of protection. Women who carry condoms are labeled sex workers (Foster, 1995 cited in Hockey 1997:301). Gender inequality predisposes women to HIV risk as they cannot use or discuss the use of condoms. Doing that requires the woman to play a more assertive role that is not the norm.

Economically, women, who represent half of the population, control only 20% of the world’s resources (Population Reference Bureau, 1998) and depend on their men for financial and material resources. This dependence on men means that they cannot control when, with whom
and in what circumstances they have sex. More women are becoming heads of households (from 15% in 1991 census to 17% NDHS in 1999) and most of these female-headed households are poor. With the current world economic crisis, economic opportunities for women are becoming more and more scarce. Increasing number of women exchange sex for money, goods and services to support themselves, their children and families. Most often they do this without adequate control over the conditions or terms of the transactions involved. Sex work places women at greater risk of HIV infection and also places them at increased risk of blame for HIV transmission whereas in-fact they are themselves a particularly vulnerable group (Heise and Elias, 1995). The risk of HIV infection is particularly high among women who have multiple sexual partners and who often have sex in exchange for money or commodities. These women are generally poor and live in highly organized communities supervised by chairladies and managers. Their clients include businessmen, office workers, military, police and students. For fear of violence at worst and economic loss at best commercial sex workers find themselves quite unable to insist on condom use. They are often highlighted in a literature that either implicitly or explicitly portrays the women as deviant.

Studies have shown that majority of HIV-infected women live with husbands or steady partners therefore their steady male partners are the sources of their HIV risk. For instance, a study in India found out that 91% of the women attending a sexually transmitted infection (STI) clinic reported having sex exclusively with their husbands yet were infected with at least one STI and 14% were infected with HIV (United Nations, 2000:68). In addition to all these factors the Nigerian women have to contend with poverty, illiteracy, ethnic conflicts political unrest etc. For instance, majority of the women live in the rural areas and Nigeria being a poor nation where majority of the population lack basic education is beset with unstable government, uncaring and selfish leaders. The nation is bedeviled by unrest. It lacks sustainable economy, health and social policy and therefore qualifies through poverty, neglect, greed and lack of good leadership for the spread of HIV. Only a tiny fraction of those with HIV know they have it. This disguises the extent of the epidemic and invites denial by some national leaders. The erstwhile conspiracy of silence surrounding the disease is gradually breaking down among African leaders. The first policy on HIV/AIDS was released in December 1997, eleven years after the first AIDS case was discovered. The national government had been paying lip service to the problem of HIV/AIDS not until recently Obasanjo administration shows commitment to fight the spread of HIV/AIDS. This is commendable but much more needs to be done in terms of openness about the disease, the mode of transmission and the need for behaviour change among men.

The precarious state of women’s reproductive health in poorer nations places them at an augmented risk. Chronic iron deficiency, malaria, complicated pregnancies and lack of access to safe and legal abortion predispose women to the need of blood transfusion which is another major way of HIV transmission. Most of the screening centres are concentrated in capital cities. Adequate quality assurance procedures are still evolving. The equipment necessary to screen blood is often non functional.

In addition to being more susceptible to HIV infection, HIV/AIDS carries gendered implications in that women’s reproductive rights, their sexuality and their role as informal care providers are affected. They are primary care providers for dependent relatives throughout their lives e.g. children under five receive 87% of the care from their mothers (Kiernan and Wicks, cited in Oakley, 1995). Women, in their traditional role as care
providers in the family and community, are affected by AIDS pandemic. Several studies have noted that the burden of AIDS care falls disproportionately on the women whether infected or not. In addition to other demanding tasks in and outside the home, women are expected to take care of husbands, children and other family members infected with HIV/AIDS. Those women who have not been the main bread winners are increasingly being forced to assume such further responsibility as their partners sicken and die of AIDS. Women with HIV infection often lack social support and face other challenges that interfere with their ability to adhere to treatment regimens. Many women live in isolation and fear rejection because of their HIV status. In addition, the infected women will have to deal with their own illness, continue to take care of family members who are ill, and also see their children die. They will have to plan for the well being of the orphaned children that will be left behind and face the additional stigmatization related to the disease. Indeed stigma impacts strongly on women who are infected or who care for someone living with AIDS. The incidence of AIDS reflects the diverse forms of women’s oppression. Therefore, whether as someone who has AIDS or as the care provider of people with AIDS, women’s experience not only differs from that of men and reflects the diversity of women’s social position, it also reflects their vulnerability within patriarchal and capitalist systems of power.

Trends which show that HIV infection is often diagnosed at a later stage in women than in men may be due in part, to poor access to health care by women, especially those in minority populations. Reduced access to health care is associated with disadvantaged socio-economic status cultural and language barriers that limit access to prevention information and other services.

Fertility rate is still high in Nigeria as in any other developing country therefore HIV-infected women will increase the absolute number of mother-child transmission. Consequently there will be more infected infants and more orphans when the women die. The family will become unstable and may be wiped out if the rate of the infection continues to rise.

Other effects include childlessness if the infected women are not yet mothers and the women will become destitute. Whichever way we look at it women tend to be at least slightly worse off than men. The women’s lower social and economic status, their disadvantaged, legal situation, their low educational and literacy levels and the cultural norms and expectations placed on women lead to a greater dependency on men e.g. fathers, husbands, other male relatives, for their status and survival. This leads to imbalances of power in the relationships between women and their male partners and a decreased level of control by women over their sexual relationships, including a decreased ability to demand safer sex.

Health risks faced by women with poor housing, diet, environment and social support can be exacerbated by domestic violence from male partners (Hanmer and Maynard, 1987; Yllo and Bograd, 1988; Hanmer et al, 1989; Dobash and Dobsh, 1992 cited in Robinson and Robinson, 1997). Women’s risks in the face of HIV/AIDS are a final area of neglect with existing services.

Most of television public service announcements emphasize the risks that men, not women run and do not give women messages on how to protect themselves from HIV infection. These
undercut women's rights in relationships by positioning men as sole sexual decision-makers. This has led to infection of women who thought they were safe.

3.0 Conclusion and recommendations.
At the beginning of the HIV epidemics, AIDS was primarily a disease of white homosexual men. Fewer women were affected than men. Consequently, most of the epidemiological investigations and preventive strategies were focused on men on how HIV caused disease. Except for studies designed to prevent HIV transmission from infected mothers to their infants there was no exclusive research focused on women and women were not included in most clinical trials. Even when it became clear that the epidemic was attaining almost the same proportion in females as in males especially in the developing countries and particularly in sub-Saharan Africa nothing was done to address the women’s needs. Instead of focusing on how to combat AIDS, the disease was seen as sexual or social aberration or sexual promiscuity. This resulted in limited knowledge of the action, safety, and efficacy of drug therapy for women with HIV-infection. The few trials carried out appear to show that there are differences in the safety and efficacy of the drugs between men and women (United States Public Health Services 1998:8)

With the increase of new cases in women it is obvious that past approaches to HIV prevention have not worked. Therefore, we need to rethink how to portray women, how to deal with gender-related power imbalances and how to avoid the simplistic logic that if women only knew how to protect themselves, they would. We can start by acknowledging and accepting that there are special individual needs of women in the family, community and the nation that have been neglected and which have made women more vulnerable.

From the foregoing, what are the challenges for Nigeria in the 21st Century? I will like to start by asking these questions. How do we identify HIV-positive women and those living with AIDS? How do we know the number infected? How do we change the power imbalance between men and women and ensure that a male partner uses a condom even if there is a legislation for it? How do we increase the level of literacy among women and subsequently their knowledge about HIV/AIDS? How do we improve the socio-economic status of women?

- First and foremost the identities of HIV/AIDS infected women will be revealed only when denial, rejection and stigmatization surrounding the infection are removed. Denial, fear of rejection and stigmatization make revelation difficult. Until these problems are solved the HIV-infected women will remain unidentified. They should stop feeling silenced or powerless to change what happens to them. Their speaking out will prevent further infections. Parents, communities and the nation must also speak out and should realize that if this issue is not addressed urgently many more people will be infected.

- We should be involved in operational research which will focus at both micro and macro levels to identify HIV-positive women and those living with AIDS, take stock of the current scientific knowledge on HIV/AIDS and women and pave way forward for tackling the problem. In order to increase our understanding of the clinical course, treatment and prevention of HIV/AIDS in women, it is critical that women be included in research including clinical trials. The recent figures reeled out to us by UNAIDS were based on the findings of sentinel surveillance systems which were established to collect HIV prevalence data from women attending antenatal care facilities. It is
assumed that most Nigerian or African women bear children and most pregnant women receive some form of antenatal care. The truth is that only 53% of pregnant women in developing countries have the assistance of skilled health personnel and only 40% give birth in a hospital or health center (WHO 1999:15-16). Therefore it is imperative that researches are conducted to know the actual figures. There is still much that is still unknown about levels and trends of HIV infection among women. The mere possibility of a physiological vulnerability of infection calls for an urgent and significant research effort. Therefore a policy-oriented and multidisciplinary research is required to provide more detailed analysis and better understanding of the natural history of HIV infection and its impact on fertility and mortality in Nigeria. Epidemic patterns will also change over time due to natural epidemic processes and the effect of HIV prevention efforts. Future descriptions of HIV/AIDS situation in Nigeria will continue to be revised to reflect our improved understanding. Findings and recommendations must be accessible to the public and therefore dissemination of research findings is being emphasized so that they will be translated into actions.

• Currently in Nigeria condom is the only known barrier against HIV and other STIs. Reliance on the male condom is unrealistic as cooperation of male partners is a far-fetched dream in Nigerian context. Hence, female condom and non-irritating virucides and spermicides should be provided at affordable prices. They have been used successfully in some Africa countries. This will empower women to protect themselves from HIV infection because it will give them more latitude to negotiate safer sex and can be used with or without knowledge of partner. Enlightenment campaigns should be carried out to raise awareness about female condom. Also information and education programs should be developed for men to reduce the risks of their behaviour for as long as they do not adopt responsible sexual behaviour, efforts targeted at women will remain largely pointless. Communication between men and women about sex can be fostered via small group discussions to correct misperceptions. Ultimately a technology that allows women to circumvent their lack of power in sexual relationships in patriarchal society like Nigeria is no answer, but merely a band-aid for deeper problems (Heise and Elias, 1995:931-943). Therefore men will be targeted to enhance dialogue on the issues of sexuality and reproduction and enable them to fully assume their role and responsibility within the household in absolute respect of equality and equity among the sexes. Based on research findings specific sensitization and advocacy programmes should be developed involving men to fight against all types of violence on women including female genital mutilation (FGM).

• Enlightenment campaigns, against the disease particularly as it affects women can be organized to educate and inform women about the dangers of HIV/AIDS and encourage them to seek care. Handbooks in different languages and or in pictorial forms that will contain the women’s risks to HIV/AIDS, modes of transmission and prevention should be developed. Newsletters are published by some women NGOs which address feminist health matters giving women access to current medical research in issues devoted to women’s health particularly HIV/AIDS but they are few.

• There should be advocacy for equal opportunities to education, employment and economic upliftment for both males and females. Economic and educational empowerment, family support and community organizing which can enable women to protect themselves should be encouraged. This can be done by expanding female
education, educating women about their rights, fighting the cultural beliefs and biases that denigrate women and value boy children over girls. We can advocate for a policy of providing scholarships for girls and young women which will obviate the need for young girls to find older men to finance their schooling, land and property inheritance and access to micro credit facilities. Health education programme can be developed to reach young women early in their lives. They can also be helped to organize and create social support networks where they can seek counsel and be given support to change their behaviour and to create change in their communities. These will also provide the women with communication skills and negotiation skills. Some Yoruba women have been able to refuse sexual relations without violent reprimaisl if their partners were known to be infected with STIs because they are financially independent and they can return to their families if they quarrel with their husbands (Lande, 1993; Orubuloye et al, 1992). Formation of women groups particularly HIV positive women and women living with AIDS should be encouraged. Women throughout the world have a history of rallying together to solve common problems - a strength that has yet to be widely utilized by AIDS prevention programmes. Ulin (1992) observes that women's collective perception of their ability to act on AIDS prevention messages can be a critical determinant of both male and female behaviour change. Organizing as opposed to information and counseling helps build group consensus and imparts a unified sense of purpose and possibility.

- Also traditional harmful practices particularly female genital mutilation should be discouraged through enlightenment campaigns, education and legislation.
- Comprehensive community-based system of care for HIV-infected women, including childcare should be provided. HIV/AIDS related educational messages specifically for women should be created. The messages will build on the premise that women are individuals and not appendages of men and children and can also demonstrate how to use humour to bring up sensitive subjects such as condom use.
- While there may be no immediate cure, the spread of HIV can be halted with strong political commitment for public education. In several countries the spread of the disease has been attributed to the lack of serious government policy attention. Recently President Olusegun Obasanjo inaugurated the National Action Programme Committee on HIV/AIDS promising not to allow our country become overwhelmed by HIV/AIDS (UNAIDS 2000:39). This is not enough. Nigeria’s response to HIV/AIDS is still at a fraction of what it should be. Therefore, there is need to increase, massely, resources, systems and social commitment needed to turn the tide of the epidemic. It must be followed up with budgets and action.
- Another challenge is making clinics hospitable and available to women. Women feel most comfortable being treated by a woman. Feminists have shown women’s reproductive health to be one of the areas where medicine’s ideological frameworks contribute most to the subordination of women. The medicalization of HIV/AIDS has allowed the male medical profession to consolidate its knowledge and status while feminist issues such as the hierarchy of the medical profession and the relative powerlessness of women have become a focus for resistance (Wilton, 1994). Therefore, more female medical practitioners, sociologists and women academics in health-related fields are urged to specialize in this area particularly in the area of counselling, testing and care. We should ensure that health care facilities are decentralized to be accessible to most women especially rural and urban poor women.
We should endeavour to document and theorize women’s health. This is very important in terms of responses not only to HIV/AIDS but also to a range of threats to women’s well being.

In summary several factors are identified as risk variables to HIV infection such as physiological, economical etc. In order to address the issues gender, sexuality and stigma are considered in terms of research, programme planning, and advocacy, legislative and policy advocacy, and care for people living with HIV/AIDS.

REFERENCES


