BRK Global Healthcare Journal, 978-1-5323-4858-7

Volume 2, Issue 1, 2018

Women and HIV: Gender Inequalities of Women Contributing to HIV Pandemic around the Globe

Bernice Roberts Kennedy, PhD, APRN, PMN-CNS, BC
Research Consultant

Chalice C. Jenkins, PhD, LPC, NCC
Assistant Clinical Professor in the Department of Counseling & Family Therapy.
College of Nursing and Health Professionals, Drexel University

BRK Global Healthcare Consulting Firm, LLC
Correspondences Address:
Bernice Roberts Kennedy, Ph. D, APRN, PMN-CNS, BC
Research Consultant
BRK Global Healthcare Consulting Firm, LLC
P.O 90899
Columbia, South Carolina, 29209
e-mail brkhealthcare@gmail.com

Abstract

HIV/AIDS is a global health problem affecting women around the globe. The term global health refers to the goal of improving health and achieving equity in health for all people worldwide. HIV is a virus that destroys the immune system. AIDS is the last stage of the virus. During this stage there is little to no immune system left to fight off other infections or cancers. This virus can be acquired by men, women, and children of any age. HIV is the leading cause of death among women of reproductive age. This paper is an analytical review of research and literature related to the contributing factors to the rise of HIV in women, treatment and policy development. The model*: Global Model: Gender Inequalities of Women Contributing to HIV Pandemic around the Globe* was used in conceptualizing gender inequality and power imbalances between men and women contributing to the incidence and prevalence of HIV of women around the globe. Global health problems such as HIV/AIDs are best addressed by collaborate efforts and solutions that involve more than one country. More research is needed collaboratively on for the treatment of women around the globe. Collaborative efforts are needed for empowerment, improving treatment and educating women on HIV/AIDS Policy development is needed in changing laws to promote gender equality for women around the globe.

Key Words: Women, females; global; HIV/AIDS; inequalities; health promotion; health disparities; treatment; policy development

President Barack Obama, 44th President of the United States' Administration Goal:
"A woman-centered approach is particularly critical in creating an AIDS-free generation. Women now account for more than half of the world's population living with HIV. We have to address their specific needs if we are going to make any progress against the HIV pandemic."

Introduction

HIV/AIDS is a global health problem that was first recognized in 1981 (The Kaiser Family Foundation [KFF], 2016). It is a virus that destroys the immune system. AIDS is the last stage of the virus. During this stage, there is little to no immune system left to fight off other infections or cancers. This virus can be acquired by men, women, and children of any age.

Health is an international health concern and considered a global goods therefore collective efforts must be made in preventing the spread of this HIV pandemic (Barnett & Whiteside, 2000). Also, the increase of international travel contributes to the spread of sexual transmitted diseases (STDs). Women are gradually increasing in the incident of HIV/AIDs over the last 25 years.

The term global health refers to the goal of improving health and achieving equity in health for all people worldwide (Koplan et al., 2009). However, global health is not limited to health-related issues that cross international borders but health issue that concerns many countries such as HIV/AIDS (Koplan et al., 2009). Global health refers to any health issue that concerns with many countries affected by transnational determinants such as climate change or urbanization or solutions (Koplan et al., 2009). According to Koplan et al. (2009), global health has areas of overlap with the more established disciplines of public health and international health. Global health, public health and international health share three characteristics (a) priority on a population-based and preventive focus; (b) concentration on poorer, vulnerable, and underserved populations; and (c) multidisciplinary and interdisciplinary approaches with an emphasis on health as a public good ;(d) the importance of systems and structure, and (e) the participation of several stakeholder.

Definition

According to the Center for Disease Control [CDC, 2018a], HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with an uninfected person's broken skin or mucous membranes. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection (CDC, 2018b) Some of these people will develop AIDS as a result of their HIV infection. Once it infects one person, it can be passed along to another, and along a continuum. HIV is spread through unprotected contact with HIV contaminated blood and bodily fluids in semen, vaginal secretions, breast milk, or sharing of contaminated needles.

According to the CDC (2018a), AIDS stands for **A**cquired **I**mmuno**d**eficiency **S**yndrome. Acquired means that the disease is not hereditary but develops after birth from contact with a disease-causing agent (in this case, HIV). Immunodeficiency–means that the disease is characterized by a weakening of the immune system. Syndrome refers to a group of symptoms that collectively indicate or characterize a disease. AIDS can include the development of certain infections and/or cancers, as well as a decrease in the number of certain cells in a person's immune system. A diagnosis of AIDS is made by health providers using specific clinical or laboratory standards.

Overview of HIV in Women

HIV/AIDS is a global health issue that has crossed ethnic, racial, gender, economic and geographical boundaries (Collazos, Asensi, & Carton, 2010). Approximately, 36.7 million people globally were living with HIV and 35 million people have died of AIDS related causes since the beginning of the epidemic (UNAIDS, 2016a). HIV is the leading cause of death among women

of reproductive age (The Kaiser Family Foundation [KFF], 2014). Women and children die each year for the lack of preventable health services.

On a global level, woman have been disproportionally affected by HIV (Avert, 2017a, b). Today, women constitute more than half of the people living with HIV (Avert, 2017b). Also, AIDs related illnesses remain the leading cause of death for women of reproductive age (e.g., 15-44). The persons more affected by HIV are women who are primary in their productive years consisting of about 35% of new infections are among young people in the ages of 15 to 24 (UNAIDS, 2016a).

HIV is growing in region of the world such as sub-Saharan Africa, Eastern Europe, and Central Asia consisting of 79% between the year of 1998 to 2003 (Avert, 2017b). New cases have been reported around the globe, two thirds are reported in sub-Saharan Africa, with 46% of new cases in Eastern and Southern Africa (UNAIDS, 2016a). In some countries, the prevalence of HIV is equally high among women compared to men. In Eastern Europe and Central Asia, women who inject drugs also engage in sex work placing them at risk for HIV transmission (Avert, 2017a). Countries with high prevalence of HIV in women who inject drugs and participate in sex work include 62% of women in Kyrgyzstan and 84% of women in Azerbaijan. Conversely, in Central Asia, HIV is estimated to be 20 times higher among female sex workers (Avert, 2017a)

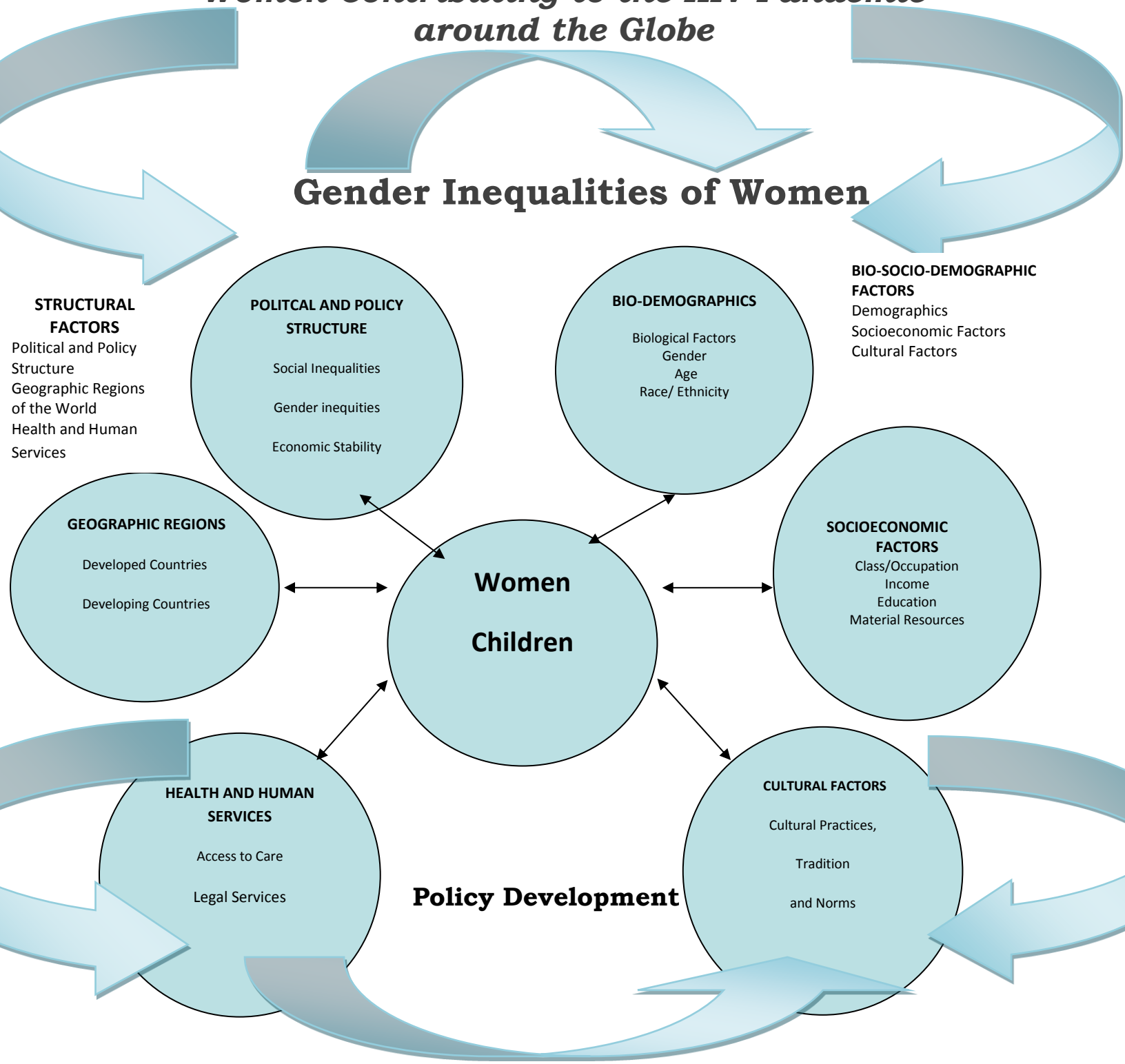
Gender Inequalities of Women Contributing to HIV Pandemic around the Globe

In our society, there is unequal distribution of power among women and men (Kennedy, 2015). When there is imbalance of power, women are not empowered to protect themselves from HIV/AIDS and other infections. Women who lack sexual assertiveness often are powerless to refuse unwanted sex, require their sexual partner to use contraception's, or ask information about their partner histories which can lead to a greater risk of unwanted pregnancies, STDs and HIV (Jenkins & Kennedy, 2013; Kennedy & Jenkins, 2011). As a result, the AIDS pandemic is expanding and intensifying globally.

Because of social inequalities of women worldwide factors such as gender inequalities, differential access to services, and sexual violence increase women's vulnerability to HIV (Avert, 2017b). Especially young women who are more biologically susceptible to HIV. Gender inequalities, referring to difference in unequal socio-cultural expectations and treatment of women as compared to men lead to many health disparities experienced by women and their children (Kennedy, 2017).

This paper is an analytical review of research and literature related to the contributing factors in the rise of HIV in women, treatment issues, and the needed policy development. The author has developed a holistic model: *Global Model: Gender Inequalities of Women Contributing to HIV Pandemic around the Globe.* This model is useful in guiding this paper focusing on gender inequality based on power imbalances between men and women contributing to the incidence and prevalence of HIV around the globe. First, *Structural Factors* will be discussed focusing on the social inequalities contributing to the prevalence of HIV. Second, the *Bio-sociodemographic Factors* related to the women population affected with HIV will be discussed. Third, the needed for policy changes related to treatment and recommendations for *Policy Development* with the emphasis on changing laws for the empowerment of women for the future will be evaluated.

Figure 1: Global Model: Gender Inequalities of Women Contributing to the HIV Pandemic around the Globe



In the model, *Structural Factors* include: (a) political and policy structure of countries; (b) geographic regions of the world; and (c) health and human services. These factors will be discussed individually

Structural Factors

Political and Policy Structural

Current political and policy structures create unequal distribution of wealth (Kennedy, 2017). This unequal distribution of wealth leads to similar unequal distribution in the equality, living and health condition (Kennedy, 2017). Women and children are often in lower status in numerous countries contributing to inequalities. However, in most cases, the inequalities are more prevalent in the poorest living conditions, poorest countries and population groups (Kennedy, 2017). Social, cultural, and economic factors cause substantial inequality in access to resources and services (Kennedy, 2017). Because of the status of women and children in our society, they often are not in a position to protect themselves from HIV and other infections, in addition to access to health and human services. For example, economic factors within countries, however, resulting in gender inequalities contributed to a growing demand for sex work (Kennedy, 2017).

New advances in treatment have occurred in most developed countries (Parker, 2002). However, globally, the HIV/AIDS pandemic continues to spread in developing countries. Structural inequalities continue to contribute to this epidemic in developed and developing countries especially the poorest and marginalized sectors of all countries.

Geographic Regions of the World

In developing countries improving the health status of women remain an unmet challenge with great disparities existing between low and high-income countries resulting in deaths due to HIV/AIDS, pregnancy, and tuberculosis which primary affect poor women (Carr, 2004). The worst affected are undoubtedly the poorer regions of the world as combinations of poverty, disease, famine, political and economic instability and weak health infrastructure exacerbate the severe and far-reaching impacts of the epidemic. In developing countries, gender inequities, sexual coercion, and violence by intimate partners undermine women's sexual and reproductive autonomy and jeopardize their health and well-being (Carr, 2004). However, Gender disparities and gender-violence extend to rich and poor women and between developed and developing countries.

In some countries, girls are given in matrimony before the age of puberty or under the age of 18. In most cases, the female is a virgin (Kennedy, 2017). In developing countries, females may have fewer resources for support. These girls often contract HIV/AIDs by their older husband. (Kennedy, 2017). In many countries, the dowry decreases as the girl get older, therefore their families encourage them to get married earlier (Kennedy, 2015; Nour, 2006). Typically, girls who marry early are from poor families. In some cases, child marriage is protection for young girls preventing premarital sex, unintended pregnancy and sexual transmitted diseases. However, when their husbands are having sex with other partners, these young girls are more at risk for sexual transmitted diseases (United Nation, 2017). For example, in sub-Saharan Africa, girls' ages 15–19 years are (2–8 times) more likely than boys of the same age to become infected with HIV.

Some critical concerns of girls marrying at a young age are health problems (United Nation, 2017). Their children are more likely to be premature, have a low birth weight, and are more at risk for contracting HIV/AIDS. In addition, these children brides are isolated from peers. They are often embedded in large families of their new husband.

Research reported a link between HIV and sex trafficking and the lack of knowledge regarding prevention in victims of trafficking in India (Wirth, Tchetgen Tchetgen, Silverman & Murray,

2013). Genital mutilation AKA female circumcision is the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons (Kennedy, 2017). Typically, female genital mutilation or circumcise is performed under unsanitary or unsterile conditions using an unclean sharp instrument such as a piece of glass, knives or razor blades. In most cases, the same instrument is used over on more than one girl. This unsterile procedure may lead to the transmission of HIV and other infectious diseases.

In the United States, health disparities exist related to HIV/AIDS among African American females in comparison to other ethnic groups (Arya, Behforoz, & Viswanath, 2009; Jenkins & Kennedy, 2013; Kennedy, 2013; Kennedy & Jenkins, 2011). HIV/AIDS is rising among African American women (Kennedy, 2013). Research reported that African American women and women of color are at a high risk of contracting HIV/AIDS as a result of domestic violence (Stockman et al., 2013).

Women with HIV/AIDs with a history of physical abuse are increased risk for HIV/AIDS (Josephs & Abel, 2009). Research literature reported that African American women involved in physical abuse relationship were less likely to use condoms and victimized by partners as a result of requesting to use a condom (Josephs & Abel, 2009; Wingood & DiClemente, 1997). Women who have limited voice in their intimate partner relationship are at increased risk for HIV infection (Josephs & Abel, 2009; Lane et al., 2004; Wingwood & DiClemente, 1997). In some cases, culture barriers of African American women, often prevent her from protecting themselves and babies from HIV. Women who reported being physically or sexual assaulted by intimate partner were more likely to be infected (Lane et al., 2004). Women who are in a high degree of control relationship are often associated with HIV infection (Kennedy, 2017). Researcher reported that gender inequalities are significantly associated with discussion of HIV and condom use (Jewkes, Levin, & Penn-Kekana, 2003).

Health Services and Human Services

Health and human services are needed for women and girls with HIV around the globe (Kennedy, 2017). Disparities exist based on gender inequality in comparison to women and men.

Access to Care. Women and children in developed and developing countries have lack of access to health care (Kennedy, 2017). Gender inequalities of women have an impact on certain factors such as access to care and utilization of health services for this group. In many countries, lack of empowerment prevents women and children from receiving basic health care. Women compose half of the world population consisting of 70% of the people in the world living in poverty (OECD, 2008). The healthcare system is often unresponsive to the women living in poverty and increasing their vulnerability to impoverishment. Around the globe, health services to poverty-stricken woman are often poor in quality. People living with HIV do not have access to health care, prevention care, and treatment. Also, there is still no cure for HIV. In many countries, women lack access to health services. These barriers have numerous negative effects on women's health outcomes occurring on an individual, interpersonal, community and society Level (WHO, 2015). Racial and ethnic minorities who have HIV infection have poor access to care and unequal treatment once enrolled in health contributing to their negative health outcomes (Cargill & Stone, 2005). Minorities health status are complicated with lack of insurance, lack of concordance between the race of patient and provider and satisfaction of their health care. Often women experience barriers resulting from (a) denial of access to services that only women require; (b) discrimination from many services because of views around women female sexuality; and (c) poor-quality services. In some cases, health providers may lack knowledge in laws related to childbirth

and HIV contributing to women abortion (ICW, 2008). This knowledge deficit can result in women not knowing their health options.

Presently, in 29 countries women are required to receive consent from husband or spouse to receive sexual and reproductive services (UNAIDS, 2017). Therefore, these women are less likely to access health services for HIV and reproductive services contributing to their risk for HIV Infection.

In 2016, around the globe, 46% of people living with HIV had access to antiretroviral therapy (UNAIDS, 2016a, b). Also, in 2015 46% of all people living with HIV had access to treatment. In addition, in 2015, 77% of all pregnant women living with HIV had access to antiretroviral medicines to prevent the transmission to their babies (UNAIDS, 2016a, b).

Legal Services. Some countries have laws that discriminate against women and girls in such cases as property and inheritance, age of marriage and ability to enter and leave marriage (Garcia-Moreno et al. 2014a, b). Also, in some countries, state laws operate with traditional religious, customary or indigenous laws that promote male pre-eminence to include penalties for female victim violence (Garcia-Moreno et al. 2014a, b). Some countries don't recognize marital rape (WHO, 2013). In approximately 53 countries; marital rape is not recognized as a crime (WHO, 2013). The government in many countries plays a vital role in eliminating violence. They are vital in developing laws promoting equality and eliminating gender inequality.

Bio-sociodemographic Factors

In this model, *Bio-sociodemographic Factors* include: (a) Bio-demographics (i.e. biological factors, gender/sex, age and race/ethnicity, (b) socioeconomic factors (i.e., class/occupation, income, education, material resources and (c) cultural factors (i.e., cultural, practices, tradition and norms). These factors will be discussed individually.

Bio-sociodemographic Factors

Biological Factors. Research reported that women are at greater risk for contracting HIV than men because women have greater mucosal surface area exposed to pathogens and infection fluid for longer periods during sexual intercourse (Ramjee & Daniels, 2013). During the sexual intercourse women are more likely to experience more increase injury of tissue. In addition, young women are more expose to HIV due to cervical ectopy which facilitates greater exposure of target cells to trauma and pathogen in the vagina. In addition, research reported progesterone play a role in women's biological vulnerability to HIV infection to include progesterone injectable contraception depot medroxyprogesterone (Ramjee & Daniels, 2013).

Differences exist in viral load and CD4(+) T lymphocytes cell counts related to gender Cabrera- Muñoz, Hernández-Hernández, & Carmacho-Arroyo, 2012). Women have more favorable clinical and viro-immunological patterns than men in the early stage of HIV infection. However, once the infection has established these patterns are reversed. Clinical evidence shows that estradiol (E) and progesterone (P) participate in the regulation of HIV and other infections. Effects of E and P depend on their concentration or the phase of HIV infection, however, they could exert a protective role against HIV infection. Ragupathy et al. 2016 reported that in human immunodeficiency virus type 1 (HIV-1) infected women, oral or injectable progesterone containing contraceptive pills may enhance HIV-1 acquisition in vivo. However, the mechanism of occurrence is not fully understood. Results of the finding indicated that progesterone treatment enhances HIV-1 replication in infected cells and co-infection with HSV-2 may further fuel this process.

Gender/Sex. Gender inequalities contribute to HIV/AIDS in underserved, vulnerable, women in childbearing age. These women are at increased risk for HIV infection because of heterosexual contact related to the lack of social and economic power to control sexual relationships with their partners (Avert, 2017b). In many regions of the world, culture expectation promotes men to have multiple sex partners while women are expected to be abstinent or monogamous. This practice will place women at risk for HIV. Therefore, being female places a person more at risk of contracting HIV than being male.

Often, women who participate in sex work enter into illicit use drugs (UNAIDS, 2006). In some cases, these women will use substance to decrease inhibition to perform in the sex work. The addiction will cause them to use sex work to buy drugs or alcohol. However, sex workers who use drugs are at increased risk for HIV and other Sexual Transmitted infections in countries with large population of injecting drug users (UNAIDS, 2006).

In 1997, females accounted for 41% of people living with HIV worldwide (UNAIDS, 2017). This figure had risen to almost 50% by 2002. This gender-bias is especially apparent in sub-Saharan Africa, where the majority of those infected are women and girls. Widespread wars and regional conflicts in Africa escalate, by orders of magnitude, the risk of rape of women and girls.

Age. Age is factors in contracting HIV (Kennedy, 2015; Kennedy, 2017). Victims of human trafficking are usually young females or innocent girls who are seduced or kidnapped from their home countries and forced into sex industry (Bruckert & Parent, 2002). In addition, females especially girls get involved with trafficking for the purpose of sex or labor. Victims may have trafficked from countries to countries legally or illegally. Young or minor females are sold for sex or sex slavery for the financial support for their family (Kennedy, 2015; Kennedy, 2017).

Race/Ethnicity. Racial/ethnic minorities are disproportionately affected by the HIV/AIDS epidemic in the United States (Stone, 2012). Minorities in the United States are less likely to receive the treatment. These disparities result in poor outcomes especially for black women with HIV/AIDS. Disparities of treatment for HIV/AIDS differ for women and men. In the United States, 80 % of women with HIV/AIDS are black or Hispanics (Stone, 2012).

In the United States, HIV affects African Americans disproportionately regardless of this group representing less than 13% of the U.S. population. African American women, including adolescents and adults, are disproportionately affected by the transmission of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (Kennedy, 2013). Currently, HIV/AIDS is the leading cause of death for black women (including African American women) in the 25–34 years age group (The Kaiser Foundation, 2018). It is the third leading cause of death for Blacks women aged 35–44 years and the fourth leading cause of death for black women aged 45–54 years (The Kaiser Foundation, 2018).

Sociodemographic Factors

Sociodemographic factors such as socioeconomic status, income, education, and material resources contribute to the inequalities of women placing them in a vulnerable position of contracting HIV. These factors will be discussed individually.

Socioeconomic status (SES). Socioeconomic status (SES), also called socioeconomic position, is a core concept of sociology (Kennedy, 2013). It represents a form of an individual's place in a society's status hierarchy (Kennedy, 2013). Where SES is taken as a single concept, it is not directly observed, but instead a statistical measurement. In most countries, women are more poverty stricken than men (Kennedy, 2017). Women in lower socioeconomic status are often poverty-stricken (AVERT, 2018). Poverty increases vulnerability to HIV contributing to gender inequalities. Often, women in lower SES are often dependent on men. Because of the need for

economic support, females are often married early and gender inequalities make them less empowered to make decisions about safe sexual practices. Therefore, they are put at risk for HIV and other STDs.

Income. Income is a factor predisposing women to HIV (Kennedy, 2015; Kennedy, 2017). Women who earn less or no income places her in a position of contracting HIV/AIDS. Young women and girls may seek enter into prostitution for survival. All over the globe women have issues of income, poverty, unemployment, hunger, disease, and illiteracy (Getu, 2006; Kennedy, 2017). In addition, employment, education, vocational training, and economic opportunities are limited in poverty-stricken vulnerable groups such as women and children especially minor females (Getu, 2006; Kennedy, 2017). For example, unemployed and dropout's youth are more prone to human traffickers. Because of young people and girls' vulnerability, they are more prone to human traders with the promise of marriage, employment, education opportunities, and a better life. Especially, young girls fall in the hands of perpetrators (Getu, 2006; Kennedy. 2017). These circumstances place these vulnerable groups in exposure to HIV and other infectious diseases. Because of poverty-stricken status, women lack the resources to be treated for HIV. These women may lack decision-making concerning their basic life needs, in addition, to protection from HIV.

Education. Research has shown education achievement among women and girls is contributing to positive outcomes such as sexual and reproductive health and rights (SRH), delaying childbearing, safer abortion, reduce the risk of partner violence and less vulnerability to HIV (Avert, 2017b). However, research has reported a need for more education on HIV for women in many countries. Sexual assertiveness has been reported in young college women (Jenkins & Kennedy, 2013). However, women who are poorer and less educated may have less knowledge and unable to adopt to HIV risk-reducing behavior. Also, they may not be able to afford HIV prevention material increasing their exposure to HIV (Wingood & DiClemente, 2000).

Material Resources

Material resources are clearly linked to both individual income and distribution of income. Income has a significant relationship on material resources in our society (Kennedy, 2013). Typically, income determines accessibility to resources such as housing, food, clothing, health care, and recreation opportunities (Kennedy, 2013). HIV-infected women especially those in marginalized groups may have different needs which may be barriers to healthcare utilization, financial assistance, housing, transportation, food, and substance abuse treatment (Luseno, Wechsberg, Kline, & Ellerson, 2010).

Women have lack of material resources because in many countries, they may not own property or have financial resources and dependent on men for support. Because of poverty, no education and job skills, many of these women may enter sex work for survival of themselves and families (UNAIDS, 2006). Africa and Asia, sex workers have a higher HIV prevalence than the general population because engagement of sex behavior placing them at risks (UNAIDS, 2006). This group is the most marginized and discriminated in their country because of these sexual practices.

Cultural Factors

Cultural factors contribute to a great risk of women contracting HIV (Kennedy, 2015). There are negative and sexual reproductive sexual outcomes in countries where cultural factors such as gender inequities, sexual coercion, and violence by intimate partners exist.

HIV/AIDS, gender inequity, and gender violence is based on a patriarchy society with men having control of women (Jewkes, Dunkle, Nduna, & Shai, 2010). These society norms are translated into risky sexual behavior to include predatory sexual practices and sexual acts of violence again women. For example, in some countries, it is acceptable for men to have multiple

partners and control their encounters placing these females at risk for HIV. In some cases, women may resist the power of men, however women in developing countries acquiesce to these norms and practices. Research and scholarly literature reported that gender-based violence on the controlling behavior of a partner is associated with high risk sexual behaviors (Jewkes et al., 2010). These high-risk sexual behaviors consist of multiple and concurrent sexual partners, substance use, transaction sex and prostitution, and less condom use contributing to HIV. Fear of violence toward their partner prevent women from asserting herself resulting in increased sex and less condom use. In many regions around the world, women lack the ability to discuss safe sex practices with partner to include the use of a condom placing them at an increased risk for HIV infection. Many women will abide by the norms, practices, and roles of their culture (AVERT, 2017b).

In some cultures, women who lack sexual assertiveness versus autonomy often are powerless to make decisions about unwanted sex and use conception predisposing them to HIV/AIDs and other infectious diseases (Jenkins & Kennedy, 2013; Kennedy & Jenkins, 2011). For example, child brides in certain cultures are given in marriage for a dowry before the age of 18. These girls are at risk for contracting HIV/AIDS and STDs by their older husband and they have other reproductive health problem because of being physical undeveloped (Kennedy, 2015).

Policy Development

Globalization affects all facets of human life, including health and well-being (Koplan et al., 2009). The HIV/AIDS pandemic highlighted the global nature of human health and welfare finding common solutions to global health challenges. Recognition of the severity of the disease spurred national and international policy action and scientific study to bring global surveillance and awareness which included recognizing risk factors and prevention efforts that have helped reduce the death rate of HIV/AIDS internationally between the years of 2002 to 2007 (World Health Organization, 2011). As mentioned, the imbalance of power results in inequalities of women, children, and minorities other vulnerable groups around the globe. When there is an imbalance of power, women are not empowered to protect themselves from HIV/AIDS and other infections.

This model focuses on the imbalance of power between men and women in our society (Davies, DiClemente, Wingood, Harrington, Crosby, & Sionean, 2003; Wingood & DiClemente, 1997; Wingood & DiClemente, 1998; Wingood & DiClemente, 2000). When developing policy changes gender-based inequities and disparities in the expectations of women generate the exposures, or acquired risks, and the risk factors that adversely influence women's health especially HIV/AIDS.

Prevention

HIV/AIDs pandemic is one of the greatest challenges for the healthcare system for the 21st century (Fauci, 2001; Parker, 2002). Globally, 40% of people with HIV are receiving treatment (The Kaiser Family foundation, 2015). Although, there are an increased report in access to antiretroviral treatments (ART) for over 45 million people worldwide, the number of AIDs-related deaths have declined over the years (UNAIDS, 2018).

Access to prevention remains limited, however, the treatment of choice for HIV includes a combination of ART to attack the virus and other medication to prevent the opportunistic infections that occur when the immune system is compromise with HIV. Combining ART was first introduced in 1996 which led to dramatic reductions in morbidity and mortality (The Kaiser Family foundation, 2015). In 2015, WHO released guidelines for the treatment of HIV related to starting the treatment early (World Health Organization, 2015). Since this time, access to care in 2015 increased to 17 million people. Therefore, 46 million of people living with HIV are receiving treatment and approximately 38 of people living with HIV are virally suppressed meaning they are less likely to transmit the virus.

Preventing HIV transmission from mother to child from pregnancy, birth or breasting feeding is needed because 20 to 45 % of infants may become infected (Cavarelli, & Scarlatti, 2011). In 2014, approximately, 73% of pregnant women were receiving ART for prevention in comparison to 36 % in 2009 (The Kaiser Family foundation, [KFF] 2015).

Even though there have been improvements in health care for HIV patients over the years, more strategies are needed on a global level (KFF, 2015). Stuckler, Basu, and McKee (2010) suggested that countries with high rates of HIV are often unable to address other significant health issues such as tuberculosis rates and other health disparities that are prevalent comorbidities along with HIV and AIDS. HIV not only affects the health of the individual but impacts on their household, communities, and the development and economic grow of nations around the globe (KFF, 2015). These countries also suffer from other infection diseases, lack of foods, and other serious problems. Despite these challenges, new global efforts have been mounted to address the pandemic and there has been significant progress.

Health Promotion

Health promotion strategies are needed to include education and treatment to decrease the spread of HIV in women (UNAIDS, 2010). Recent data has showed a decline in new infection among adults (UNAIDS (2016c). However, incidence is now rising in some areas of the world.

WHO also estimated that AIDS remains the leading cause of mortality among women of reproductive age globally. Antiretroviral therapy is the treatment of choice for persons with HIV (WHO, 2010). More persons with HIV in developing countries have more accessibility to antiretroviral therapy in comparison to developed countries. Antiretroviral therapy is becoming increasingly available to people in developing countries. When this treatment is available the mortality rates will decrease. Although, HIV is declining but not at a rapid rate because more people are becoming infected than those dying from the disease.

More than 100 countries have established PMTCT programs but most of these have not been scaled up to meet the need for services (WHO, 2007). Data from 2005 show that only 7 countries provide antiretroviral prophylaxis to 40% or more of HIV-infected pregnant women (WHO, 2007). HIV testing and counseling are essential for identifying women who can benefit from treatment either immediately or later, or from interventions to prevent HIV in their infants (Center for Disease Control and Prevention [CDC, 2010]. Entry to such programs is initially determined by the proportion of HIV-infected pregnant women identified, often through an HIV test in antenatal care settings.

Despite the large amount of aid being made available in addressing the AIDS epidemic, shortfalls in both money and numbers of people being reached are apparent. Most of the program developed for this group focus more on treatment than prevention. Future initiatives need to focus more on health promotion and disease prevention.

The World Health Organization [WHO, 2011] is important in the global effort to prevent HIV/AIDS, because it works with countries and other organizations such as UNICEF and the United Nations to collect statistical information, communicate the latest scientific evidence and educating healthcare professionals. Effective prevention strategies are needed to include behavior change programs, condoms, HIV testing, blood supply safety, harm reduction efforts for injecting drugs and male circumcision (The Kaiser Family foundation, 2015). Globally information can be provided on the available programs. Also, resources such as the Centers for Disease Control and Prevention and the World Health Organization can be useful for current health information. Countries now have more access to knowledge about HIV/AIDS. These databases can assist health professionals around the global in knowing the Information such as (a) to HIV/AIDS prevalence;

(b) transmission locations; (c) current treatment, interventions, prevention strategies;(c) populations and countries most affected; and (d) current research. The progress of women can be communicated to others in the various countries.

Numerous international funds have established to address global health challenges of HIV (Coovadia & Hadingham, 2005). However, despite increasingly large amounts of funding for health initiatives being made available to poorer regions of the world, HIV infection rates and prevalence continue to increase worldwide. Gaining the support of charitable organizations and governments in countries is vital in paying for the needed treatment and client education. Progress is being made in decreasing the number of new cases of HIV/AIDS. When all recommendations of the CDC for pregnant women with HIV/AIDS are followed, the maternal-to-child transmission rate can be reduced to less than 2% (National Institute of Health, [NIH] 2018). Programs have been effective in enhancing women's practice of safe sex, however, the limitation will be social norm or culture practices promoting male dominate regulating females' ability to change.

Collaboration on a Global Level

Global health problems such as HIV/AIDs are best addressed by a collaborate effort and solutions that involve more than one country (Kennedy, 2017). Because global health problems can move across national borders, countries can learn from one another's experiences related to the spread of diseases, treatments, prevention and control of these diseases (Kennedy, 2015). This collaborate effort can be attained by combining population-based health promotion and disease prevention measures.

In 1987, The first international efforts to combat HIV was the creation of the WHO's Global Programmes on AIDS. In 1996, UNAIDS was originated to serve as the UN system's coordinating body to help galvanize world attention to AIDS (The Kaiser Family foundation, 2015). Gradually, funding was provided by donors and several initiatives was launched. In addition, overtime numerous initiatives around the global were launched to eradicate the spread of AIDS.

In 2009, President Barack Obama, the 44 President in the United States introduced the U.S Global Health Initiative (GHI) (The Kaiser Family Foundation, [KFF, 2011]. The GHI contributed 63 billion dollars as an effort to develop a comprehensive U.S government strategy for global health. This initiative is an overarching approach to U.S global health policy guided by seven core principles that seeks to strengthen, streamline, and increase the efficient of existing U.S. programs. These programs include HIV/AIDS, maternal and child health, family planning, neglected tropical diseases.

An important health agenda of GHI was the first principle focusing on women, girls, and gender equality (KFF, 2011). Eight GHI countries to include Bangladesh, Ethiopia, Guatemale, Kenya, Mali, Malawi, Nepal, and Rwanda were required to submit strategies. Presently, the extent of the focus on women, girls, and gender equality varied by countries based on the different country context and the ability to address gender while developing strategies. Only one country addressed all 7 country strategies. Importantly some countries address integrating of services to include HIV. For example, Malawi, plan to integrate HIV, antenatal care (ANC), family planning, reproductive health, and to conduct screening for GBV in HIV test and counseling. A second example, Ethiopia plans to integrate prevention to mother-to-child transmission (PMTCT) of HIV, ANC, and maternal care services.

HIV/AIDS continues to pose a threat in human lives throughout the world (Fauci, 1999). The CDC (2011) teamed with other global leaders to control and prevent HIV/AIDS in more than 70 countries located in Africa, Asia, America, and the Caribbean. These organizations work together to educate healthcare professionals and the population across the world. Thereby, breaking down

transcultural barriers to promote changes in behavior that will prevent further transmission of the disease.

CDC and WHO have worked on a global level for prevention. Presently, the Centers for Disease Control and Prevention [CDC] 2010) provided assistance to over 37 additional countries in areas of surveillance, laboratory, and epidemiology. As mentioned, WHO focuses on an effort to prevent HIV/AIDS with other countries and organizations to collect statistical information, communicate the lasted research, and education healthcare workers (World Health Organization, 2011).

Advances in science and technology have enabled the treatment, cure, and potential eradication of many of the world's illnesses, yet HIV/AIDS continue to claim lives prematurely and to undermine health on a large scale (World Health Organization [WHO], 2016). A critical step to address this issue has been the identification of major causes of HIV/AIDS, effective prevention and treatment interventions, as well as research efforts to develop new approaches to treatment. The approach must be comprehensive, yet appropriate to local country and community level needs. The WHO and UNAIDS led efforts to find a cheaper, more practical treatment to help the women and children in this devastated country. The U.S. sponsored many of these trials through the CDC and National Institute of Health (NIH).

Health professionals have a responsibility for health promotion and disease prevention (Kennedy, 2017). HIV is pandemic; therefore, health professionals need to be aware of the threats in order to prevent the spread on a global level. More health promotion and disease prevention strategies are needed in addressing this disease on a global level. Efforts are needed to develop new approaches, medications and treatment. However, global funding has increased but the needs of this population are growing faster and widening. The needs for treatment and funding are especially a concern in developing countries because of availability.

Global Advocacy Groups for Diminishing Social Inequalities of Women

Global effort has been made in decreasing the incident of HIV in females around the globe (KFF, 2011). Limited initiatives and programs have addressed the specific issue of "gender inequalities" (KFF, 2011). These initiatives and programs mostly focused on various health needs for this group. Therefore, advocacy groups in diverse countries need to address the gender inequalities of women contributing HIV and other infection diseases around the globe. Prevention of increase incidence and mortality of HIV/AIDs in women and girls first need to start with addressing the gender inequality of women around the globe. In order to address "gender inequality" social and economic development of women need to be addressed on a global level. Globally, a collaborative effort is needed for the empowerment of women.

Conclusion

More collaborative research is needed on a global level for the treatment of women around the globe. However, the needs of countries in the diverse regions differ in health promotion and disease prevention strategies. Current research has shown that providing treatment to people with HIV decreases the risk of transmission to their negative partners. More evidence-based research is needed to support policy changes to improve health care for this group. Collaborative efforts are needed to educate women and girls on HIV/AIDS and empower them on special skills such as sexual assertiveness and condom use. Policy development needs to promote changes in laws to eliminate inequalities of women around the globe.

References

Arya, M., Behorouz, H.L., & Viswanath, K. (2009). African American women and HIV? AIDS:

A national call for targeted health communication strategies to address disparities, *AIDS Research*, 19 (2), 79-84.

Avert (2017a). HIV and AIDS in Eastern Europe & Central Asia, retrieved from https://www . avert.org/professionals/hiv-around-world/eastern-europe-central-asia

Avert (2017b) Women and Girls, HIV and AIDS, retrieved from /hiv- https://www.avert.org /professionals social-issues/key-affected-populations/women

Avert (2018). Gender Inequalities and HIV, retrieved from https://www.avert.org/professionals/social-issues/gender-inequality

Barnett, T., & Whiteside, A. (2002). *AIDS in the twenty-first century: Disease and globalization. Basingstok*e: Palgrave McMillan.

Bruckert, C. & Parent, C. (2002). Trafficking in Human Beings and Organized Crime: A Literature Review. Ottawa: Research and Evaluation Branch, Community, Contract and Aboriginal Policing Services Directorate, Royal Canadian Mounted Police (RCMP

Cargill, V.A. & Stone, V.E. (2005). HIV/AIDS: A minority health issue, *Medical Clinics of North American*, 89 (9), 895-912.

Carr, D. (2004). Improving the health of the world's poorest people, population, retrieved from http://www.prb.org/pdf04/ImprovingtheHealthbrief_Eng.pdf.

Cavarelli, M. & Scarlatti, G., (2014) HIV-1Infection: The role of the gastrointestinal tract, *American Journal of Reproductive Immunology*. 71. 537-542.

Center for Disease Control and Prevention (CDC, 2010). HIV Infection: Detection, Counseling and Referral, retrieved from https://www.cdc.gov/std/treatment/2010/hiv.htm.

Center for Disease Control and Prevention (2011). *What CDC Is Doing in South Africa? http://www.cdc.gov/globalhealth/countries/southafrica/what/*.

Center for Disease Control and Prevention (CDC, 2018a). About HIV/AIDS, retrieved from https://www.cdc.gov/hiv/basics/whatishiv.html

Center for Disease Control and Prevention (CDC, 2018b). HIV among Pregnant women, infants, and children, retrieved from https://www.cdc.gov/hiv/group/gender/pregnantwomen

Collazos, J., Asensi, V., & Carton, J.A. (2010). Association of HIV transmission categories with sociodemographic, vironimmunological and clinical parameter of HIV-infected patients. *Epidemiological infection*, 138 (7) 1016-1024.

Coovadia, H. & Hadingham, J. (2005). HIV/AIDS: Global trends, global funds and delivery bottlenecks. *Global Health*, 1-13.

Davies, S.L., DiClemente, R.J., Wingood, G.M., Harrington, K.F., Crosby, R.A., Sionean, C. (2003). Pregnancy desire among disadvantaged African American adolescent females. *American Journal of Health Behavio*r, 27 (1), 55-62.

DiClemente, R. J., Crosby, R. A., & Kegler, M.C. (2002). *Emerging theories in health promotion practice and research: Strategies for Public Health*, Jossey Bass, A Wiley Publisher.

Fauci, A.S. (1999). The AIDS Epidemic: Considerations for the 21st century. *The New England Journal of Medicine*, 341 (14), 1046-1050.

Fauci, A.S. (2001). Infectious diseases: Considerations for the 21st century. *Clinical Infectious Diseases*, 32 (1). 675-678.

Garcia-Moreno C., Hegarty, K., Lucas d'Oliveia, A. F., Koziol-Maclain, J., K., Colombini, M. & Felder, G. (2014a). Violence against women and girls 2. *Lancet*, 385 (9977), 1567-1579.

Garcia-Moreno C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Naeemah, A., Monotoya, O., Bhate- Deosthali, P., Kilozno, N., & Watts, C. (2014b). Violence against women and girls: Addressing violence against women: A call to action. *Lancet*, 385 (9978),

1685-1695.
Getu, M. (2006). Human trafficking and development: The role of microfinance *Transformation*, 23 (3) 142-148.
International Community of Women Living with HIV/AIDS (ICW, 2008) Addressing the needs of HIV-positive women for safe abortion care, retrieved from http://www.icwglobal.org/
Jenkins, C.C. & Kennedy, B.R. (2013). An exploratory study of sexual assertiveness and characteristics of African American women in negotiating condom. *Journal of Cultural diversity: An Interdisciplinary Journal,* 20 (2) 139-145.
Jewkes, R.K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequality, and incidence of HIV infection in young women in South Africa: A cohort study. 376(9734):41-8. doi: 10.1016/S0140-6736(10)60548-X.
Jewkes, R.K., Levin, J.B., & Penn-Kekana, L.A. (2003). Gender inequalities, intimate partner Violence and HIV preventive practices: Findings of a South African cross-sectional study. *Social Science & Medicine,* 56 (1), 125-134.
Josephs, L. L., & Abel, E. M. (2009). Investigating the relationship between intimate partner violence and HIV risk-Propensity in Black/African-American women. *Journal of Family Violence*, 24 (4), 221-229. doi: 10.1007/s10896-009-9223
The Kaiser Family Foundation (KFF, 2011). The women, girls, and gender equality principle of The U.S. Global Health Initial (GHI): Assessment of the GHI plus country strategies, The Henry J. Kaiser Foundation
The Kaiser Family Foundation (KFF, 2014). The HIV/AIDS epidemic in the United States. Retrieved from http://kff.org/hivaids/fact-sheet/the- hivaids-epidemic-in-the-united-states/
The Kaiser Family Foundation (2015). The Global HIV/AIDS Epidemic Fact Sheet, retrieved from http://www.kff.org/global-health-policy/fact-sheet/the-global-hivaids-epidemic/
The Kaiser Family Foundation (KFF, 2016). Global HIV Timeline, Global Health Policy, retrieved from http://www.kff.org/global-health-policy/timeline/global-hivaids-timeline/
The Kaiser Family Foundation (2018). Black Americans and HIV/AIDs: The Basics, retrieved from https://www.kff.org/hivaids/fact-sheet/black-americans-and-hivaids-the-basics/
Kennedy, B. R. (2013). Health inequalities: Promoting policy changes in utilizing transformation development by empowering African Americans' communities in reducing health disparities, *Journal of Cultural Diversity: An Interdisciplinary Journal,* 20 (4) 155- 161.
Kennedy, B. K. (2015). *Global structural violence, social injustice, and inequality of women and children: Confronting 21 century slavery*, *BRK Healthcare Publications,* ISBN-13:978-0-9897244-5-6.
Kennedy, B. R. (2017). Global perspective on violence of women and children: Advocacy on preventing 12 century slavery. *BRK Global Healthcare Journal*, 1(1) retrieved from http://brkhealthcare.com/BRK_GLOBAL_HEALTHCARE_JO.html
Kennedy, B.R. & Jenkins, C.C. (2011, December) (Promoting African American Women and sexual assertiveness in reducing HIV/AIDS: An analytical review of the research literature. *Journal of Cultural Diversity, An Interdisciplinary Journal, 18 (4), 1-17.*
Koplan, J.P., Bond, T. C., Merson, M.H., Reedy, L.S., Rodriquez, M.H., Sewankambo, N.K., & Wasserheit, J.N. (2009). Toward a common definition of global health. *Lancet,* 373, 1993-1995.
Lane, S.D., Rubinstein, R.A., Keefe, R. H., Webster, N. Cibula, D.A., Rosenthal, A., &Dowdell, J. (2004). Structural violence and racial disparities in HIV transmission. *Journal of Health*

Care for the Poor and Underserved, 51 (3) 319-335.
Luseno, W.K., Wechsberg, W. M., Kline, T.L., & Ellerson, R.M. (2010). Health services utilization among South African women livig with HIV and reporting sexual and substance-use risks behaviors, AIDS *Patient Care STDS*, 24 (4), 257-267.
National Institute of Health [NIH] 2018). Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States, retrieved from https://aidsinfo.nih.gov/guidelines.
Nour, N.M. (2006). Emerging Infectious Diseases • www.cdc.gov/eid • 12 (11), 1644 -1669.
OECD (2008). OECD Database on family outcomes and family policies, retrieved http://www.oecd.org/els/family/database.htm
Parker, R. (2002). The Global HIV/AIDS pandemic, structural inequalities, and the politics of international health. *American Journal of Public Health*, 92 (3) PMC1447073
Ramjee, G. & Daniels, B. (2013). Women and HIV in sub-Saharan Africa. *AIDS Research and Therapy*, 10 (30), https://doi.org/10.1186/1742-6405-10-30.
Stockman, J.K., Lucea, M.B. & Campbell, J.C. (2013). Force sexual initiation, sexual intimate partner violence and HIV risk in women. A global review literature and AIDS and Behavior, *AIDS and Behavior*, 17 (3) (2013), pp. 832-847, 10.1007/s10461-012-0361-4.
Stone, V.E. (2012). HIV/AIDS in women and racial/minorities in the U.S. *Current Infectious Disease Report*. 14 (1), 53-60.
Stuckler, D., Basu, S., McKee, M. (2010). Budget crises, health, and social welfare programmes. *BMJ* (Clinical research ed), 340. c3311. ISSN 0959-8138 DOI: https://doi.org/10.1136/ 10.1136/bmj.c3311
UNAIDS (2006). *2006 report on the global AIDS epidemic: A UNAIDS 10th anniversary special edition*. Geneva, Switzerland: UNAIDS.).
UNAIDS (2010). Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioral and Structural Strategies to Reduce New HIV Infections10 A UNAIDS, Discussion Paper, Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010, retrieved from file:///C:/Users/Bernice/AppData/Local/Temp/JC2007_Combination _Prevention_paper_en.pdf
UNAIDS (*2016a). Core Epidemiology Slides*; 2016. UNAIDS. AIDS info website; accessed June 2016, available at: http://aidsinfo.unaids.org/.
UNAIDS (2016b). *Global AIDS Update 2016;* 2016, retrieved from http://www.unaids.org/sites /default/files/media_asset/global-AIDS-update-2016_en.pdf
(UNAIDS (2016c). *Prevention Gap Report*; 2016, http://www.unaids.org/enresources/ / documents/2016/prevention-gap
UNAIDS (2017). When women lead change happens: Women advancing the end of AIDS, retrieved from http://www.unaids.org/en/resources/documents/2017/when-women-lead-
UNAIDS (2018). Global HIV & AIDS statistics — 2018 fact sheet, retrieved from http://www.unaids.org/en/resources/fact-sheet
United Nation (2017). Sexual and reproductive health and rights, Human Rights, Office of Higher Commission, retrieved from http://www.ohchr.org/EN/Issues/Women/
Wingood, G.M. & DiClemente, R.J. (1997). The effects of an abusive primary partner on condom use and sexual negotiation practices of African American women. *American Journal of Public Health*, 87 (6), 1016-1018.WRGS/Pages/HealthRights.aspx
Wingood, G. M., & DiClemente, R. J. (1998). Partner influences and gender-related factors

associated with non-condom use among young adult African American women. *American Journal of Community Psychology, 26*(1), 29-51 http://dx.doi.org/10.1023/ A:102183
. 0023545

Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Educational & Behavior*, 27(5), 539-565.

Wirth, K. E., Tchetgen Tchetgen, E. J., Silverman & Murray, M. (2013). How does sex trafficking increases the risk of HIV infection? An observational study in from Southern India, *American Journal of Epidemiology*. Published online doi 10.1093/aje/kws338

World Health Organization (WHO, 2007). Towards universal access scaling up priority HIV/AIDS interventions in the health sector Progress Report, (NLM classification: WC 503.6)

World Health Organization. (WHO, 2010). *Priority interventions: HIV/AIDS prevention, treatment and care in the health sector*. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241500234_eng.pdf

World Health Organization (2011). Global HIV/AIDS Response: Epidemic update and health Sector progress towards Universal Access, progress 2011, retrieved http://www.who.int/hiv/pub/progress_report2011/hiv_full_report_2011.pdf

World Health Organization (2013). *Global update on HIV treatment 2013*; June 2013.

World Health Organization (2015). Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV, retrieved from http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/

World Health Organization (2016). HIV/AIDS Fact Sheet, retrieved from http://www. who.int/mediacentre/factsheets/fs360/en/

Bernice Roberts Kennedy, PhD, APRN, PMH-CNS, BC, *is a research consultant at BRK Global Healthcare Consulting Firm, LLC, P.O. 90899, Columbia, South Carolina, 29290. Dr. Kennedy may be reached at: brkhealthcare@gmail.com*