# The Circumstances Of Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome

## Introduction

This essay will examine the circumstances of Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) in Swaziland and Australia and contrast the influence of education, discrimination and stigma on women using the example of HIV/AIDS in these two countries. Swaziland is a middle-income southern African country with a population of about 1.2 million people (CSO,2007). It has the highest HIV prevalence in the world, 27% for the population group aged above 15 years (Ministry of Health, 2016). The outbreak had an extreme effect on the socio-economics of the state, leading to high death rates. Life expectancy decreased from 60 years to 48.6 years for females in 2015 ( NERCHA,2017). Australia is a middle to high-income country with a population of about 24.6 million (ABS,2017) In 2015 an estimated 25 313 people were living with HIV in Australia. Of these, approximately 2,906 were women, 11.48%(Positive women Victoria,2019).HIV incidence remains extremely low among female sex workers at 0.13 per 100 person-years in 2017 (Kirby Institute, UNSW Sydney; 2018). In Australia HIV/AIDS doesn't cause much death because 95% of individuals diagnosed receive treatment or therapy for the disease (Kirby Institute, UNSW Sydney; 2017). This is due to Australia's increasing public awareness of HIV/AIDS severity to act fast to prevent progression further leading to death.

### Key terms

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), heterosexual, epidemic, incidence, prevalence, virus, internal and external stigmatization.

## Incidence and prevalence of HIV/AIDS in Australia and Swaziland

In Swaziland, more than 200,000 people are living with HIV out of the country's population of 1.2 million, and are faced with a high HIV prevalence of 39.2 per cent among pregnant women (UNICEF). The gender discrepancy starts at a young age, with 15 to 24 years old women in SSA being more than twice as likely as men to become newly infected with HIV( Sia et al. BMC Public Health, 2016). These figures could be because 1 in 3 women or 35% experience some form of genital or physical abuse making them susceptible to contracting diseases like HIV/AIDS (UNICEF,2007). There is an absence experienced health care staff in Swaziland with working numbers inadequate to meet the request in a notable number of health providing establishments. There is also an acute requirement to enlarge the amount of community-orientated workers who have specifications that can target the requirements of specific communities. In contrast in 2015, a calculated 25 313 individuals were coexisting with HIV in Australia. Of these, approximately 2,906 are women which are significantly lower then men with a staggering 22,407(Positive women Victoria,2019). In 2017 HIV prevalence (the proportion of all people in Australia who are living with HIV), was estimated to be 0.14%, which is low compared to other high?income countries (Kirby Institute, UNSW Sydney; 2018) The major most common risk factors for females is heterosexual contact and injecting drugs. Stigma and

Discrimination’s effect on HIV transmission Stigma is an attitude or belief and discrimination is behavioural because of those attitudes or beliefs (Definitions of Stigma and Discrimination, 2019) Increased elevation of HIV stigma and discrimination in Swaziland continue to be a crucial obstacle to individuals acquiring HIV prevention services. Women’s heightened vulnerability to HIV arises from gender discrepancy within the community. Women are often inferior to males and the number of men involved in multi-partner relationships is comparatively prominent as is violence against women. For instance, in 2010, the most recent data available, 2.7% of women had more than one sexual partner in the last year, while for men this figure stood at 16%. In addition, around 12% of women aged 15-49 years are in a polygamous marriage.('HIV and AIDS in eSwatini', 2019) Traditionalist Swaziland culture is exceedingly orthodox and taboos such as HIV is viewed to correlate with sexual exploitation, polygamy and licentiousness.As shown in the study ‘Men’s and Women’s experiences with HIV and Stigma in Swaziland ‘(2009) women often experienced more enacted and perceived stigmatisation than those of male gender. This is because in Swaziland women are often held accountable for HIV transference. In addition due to their spiritual practices and beliefs, HIV is seen as an unethical condition caused by dark magic and dejected descendants. Sexually acquired conditions are frequently contemplated to be representative of infection or adulteration. As a result, likening HIV to pollution and fear is interpreted into condemning behaviour such as segregation. In contrast stigma and discrimination face individuals with HIV in Australia but at a lesser force than that of Swaziland due to the increased level of education provided to Australians and the advancement of technology available. As shown in the study done by the Australian Federation Of Aids Organisation approximately 10% of women who have HIV/AIDS experienced some form of discrimination compared to a staggering 90 % in Swaziland. (Australian Federation Of Aids Organisations, 2019) In both Australia and Swaziland and individual who is HIV/AIDS positive may be subject to two types of stigmatisation; internal and external. Internal stigmatisation alludes to ways that people stigmatise one's self. For example, an individual may feel they are obliged to remove themselves from communal gatherings to preserve themselves due to ultimate sensations of culpability, humiliation and valuelessness. In addition, external stigmatisation denotes to the stigmatisation of others by others. This can occur when an individual rejects and oppresses an individual who is HIV positive to depart a social setting. Both internal and external stigmatisation can prevent an individual from seeking aid from health care services.

## Education’s effect on HIV transmission

Education is an essential social determinant of health which is an upstream source of health. Education directly impacts elements in life that are conducive to health including being able to obtain a dependable occupation, retrieving secure shelter and having the ability to make choices that are good for your health. In 2016, 40% of women and 31% of men aged 25-29 had attained a Bachelor Degree in Australia (ABS, 2016) In comparison by age 20, 15 per cent of Swazi women compared to 45 per cent of Swazi men were enrolled in school (ABS,2018). This exhibits that in a country like Swaziland, women are more probable to be jobless, not educated and poverty-stricken than men, which makes them susceptible to sexual disease transmission. These sexual transmissions are often made with impromptu sexual partners and are often unaccompanied by condoms. In contrast, Australia’s population of women were more likely to be present at school expanding their knowledge which ultimately guides them into good healthy decision making. Authorising them to be conscious of the modes of HIV/AIDS transmission. Ultimately leading to a reduction in the amount of women contracting HIV/AIDS and further

transmission to offspring. Furthermore, in Swaziland, a reduction in knowledge is a significant issue facing Swazi women. Self- diagnosis and self-treatment continue to be a major problem facing the advancement of HIV to AIDS. Swaziland contains a rich history of natural medicine, witches and witchcraft which encourage self-diagnosis of illnesses as well as rituals performed by healers. Frequently, individuals in Swaziland believe that HIV/AIDS is the cause of dark magic and witchcraft since it is more culturally acceptable. The Swazi people would much rather claim that they are enchanted by witchcraft or have a form of tuberculosis than accept that they are HIV/AIDS positive. To conclude education is a major factor that can influence an individuals life through health literacy, employment and overall knowledge. By providing every woman culturally appropriate ways where they can expand their knowledge could mean that rates of diseases like HIV could depreciate. As women are an integral part of the economy and bearers of offspring which aid in the growth of the population.

## Recommendations

Education. To fight the battle of HIV/AIDS, initiatives like Comprehensive Lifeskills Education(CLSE) Programme should be adopted in secondary schools, in both Swaziland and Australia. This initiative focuses on the education of students about safe sex practices and protection processes. In addition, CLSE aids in changing the attitudes and conduct of the community combating the spread of HIV/AIDS. The Swaziland National AIDS Programme can be used in conjunction with CLSE to prevent and control HIV/AIDS in Swaziland by providing guidance, knowledge, encouraging and dispensing condoms, controlling sexually transferred infections and ensuring protected blood transfusion. Ultimately it aims to maximise prevention and healthcare of the community. Moreover, teachers, health practitioners and departments of health can band together to put in place educational programs and strategies which increase culturally appropriate community health access.

## Stigma and discrimination

In addition, educating the public about mindful word selection and detesting stereotypes can enhance the affirmative integration of HIV positive individuals. Also providing support groups for individuals where they can participate by sharing their story, informing others that they are not alone further comforting the stigmatised. Furthermore by integrating anti-discrimination regulations can help reduce stigma and discrimination to encourage equality. Furthermore by suppling training and seminars for health professionals teaching respect, maintenance of confidentiality and alternative terms that are not derogatory to prevent external stigmatization.

## Conclusion

Ultimately education plays a major role in the prevention and reduction of HIV/AIDS. It does so by providing knowledge about safe sex measures as well as empowering individuals. In contrast stigma and discrimination is a major part of a person’s life living with HIV /AIDS as they experience a combination of both internal and external stigmatisation which has a great impact on the individuals social life, participation in activities, mental health and overall fulfilment in life.