Fact Sheet No. 2
March 2008

amfAR AIDS RESEARCH

fact sheet

Women and HIV/AIDS

Historically, women have been neglected in HIV/AIDS research, treatment, care, and prevention efforts in the U.S. and around the world. This lack of attention to women's health issues, combined with biological differences in the ways HIV affects men and women, social and economic inequities, and environmental factors, has led to a dramatic rise in the number of women living with HIV, as well as an increase in AIDS-related deaths among women. These factors, along with research and prevention efforts that focused on men only, have left many women unaware that they are vulnerable to the disease. As a result, the proportion of women in the U.S. living with HIV/AIDS has more than tripled since the beginning of the epidemic. In 2005, women represented 26 percent of HIV/AIDS diagnoses, compared with 8 percent in 1985.[1]

> Globally, more than four-fifths of new HIV infections in women result from sex with a husband or primary partner.

At the beginning of the epidemic in the 1980s, HIV/AIDS was first viewed as a disease of men who have sex with men (MSM). Although the illness was soon identified in women, the scientific community failed to address women as a target population and instead quickly grouped them with other risk groups, such as partners of drug users. Additionally, when perinatal transmission of the virus from mother to child was identified in the 1980s, efforts focused on testing and treatment to prevent transmission to children, rather than on reducing women's risk factors for acquiring HIV.

The rising rates of HIV/AIDS among women are not limited to the U.S. Worldwide, 46 percent of people living with HIV/AIDS in 2007—about 15.4 million total—were women.[2] In some locations and within certain age groups, the percentage of females with HIV/AIDS has already surpassed that of males, and recent studies suggest that rates of HIV infection in women continue to rise.

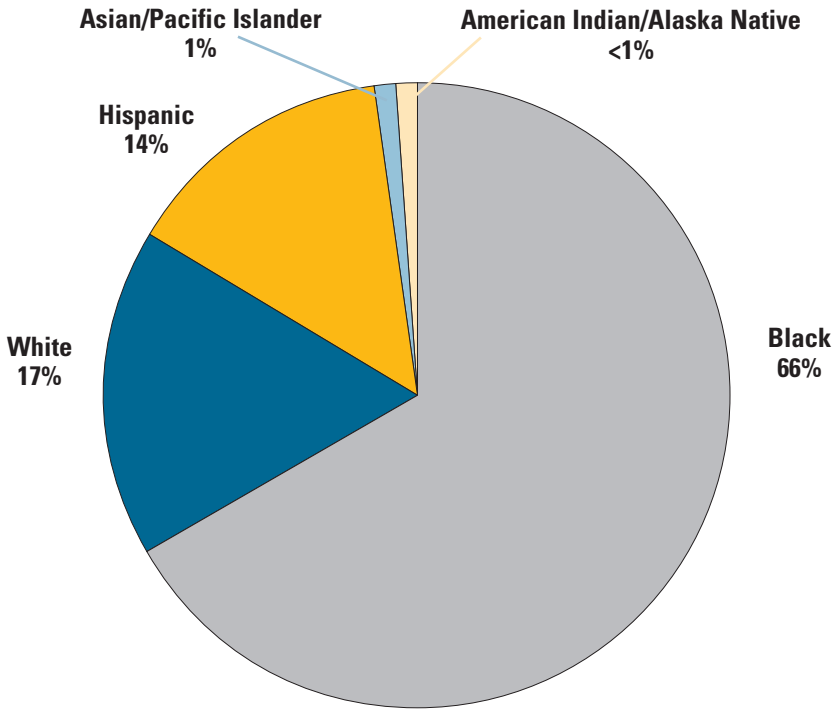
There are multiple biological, social, economic, and environmental risk factors that increase women's likelihood of contracting HIV. The physiology of the female genital tract makes women inherently more vulnerable to HIV than men. In addition, social and gender inequalities, such as poverty and unequal educational opportunities, force women to rely on male partners for financial support, making it more difficult for them to insist on interventions that reduce their risk of acquiring HIV.

The changing face of the AIDS epidemic requires urgent efforts to address this public health threat to women and girls worldwide. There is a critical need for increased research, service delivery, and prevention programs that address the HIV/AIDS epidemic among women, and for intensified efforts to reduce the inequities that women face in societies around the world.

Women and HIV in the U.S.

In the minds of many people, AIDS is no longer a crisis in the U.S., and the decline in deaths from the disease has created a sense of complacency. However, the changing picture of the domestic epidemic is cause for deep concern:

Figure 1: Race/Ethnicity of U.S. Women Diagnosed with HIV/AIDS in 2005



Source: Centers for Disease Control and Prevention. *HIV/AIDS Among Women*. Revised June 2007

- In 2005, women accounted for 26 percent of the estimated 37,163 new diagnoses of HIV/AIDS in adults and adolescents, up from 8 percent in 1985.[3]
- 70 percent of American women with HIV were infected with the virus through sexual contact with men, and another 27 percent became infected through injection drug use.[1]
- In 2005, HIV was the fifth leading cause of death among all U.S. women aged 34–44, and the sixth leading cause of death among all U.S. women aged 25–34.[3]
- Women of color are disproportionately affected by HIV/AIDS: In 2005, African-American and Latina women represented 24 percent of all U.S. women, but accounted for 82 percent of the total AIDS diagnoses that year.[3]
- In 2004, HIV infection was the leading cause of death for African-American women aged 25–34.[3]
- African-American women are 23 times more likely than Caucasian women to be diagnosed with AIDS. The AIDS diagnosis rate for Latinas is four times that of Caucasian women.[3]
- Many HIV-positive women report no risk factors for HIV infection. It is likely that these women were infected through sexual contact with a partner they did not know to be HIV positive.[1,4]

Women and HIV: The Global Epidemic

Since 2001, the proportion of women living with HIV/AIDS has increased in every region of the world.

- In 2007, 46 percent of people living with HIV/AIDS (15.4 million) were women. [2]

- In 2007, 1.6 million more women were living with HIV/AIDS (15.7 million) than in 2001 (13.8 million), an 11.6 percent increase.[2]
- The majority of new HIV infections occur among women of child-bearing age.[5]
- In many regions, women represent a large percentage of people 15 years and older living with HIV/AIDS: 61 percent in sub-Saharan Africa; 43 percent in the Caribbean; 29 percent in Asia; and 26 percent in Eastern Europe and Central Asia.[2]
- Globally, more than four-fifths of new HIV infections in women result from sex with a husband or primary partner.[6] In Ghana, for example, married women are almost three times more likely to be HIV-positive than women who have never been married.[7]
- Many women worldwide indicate that their first sexual experience was forced. Women who experience physical or sexual violence are at greater risk of acquiring HIV, and women living with HIV have experienced more violence during their lifetimes than HIV-negative women.

Factors That Increase Women's Vulnerability

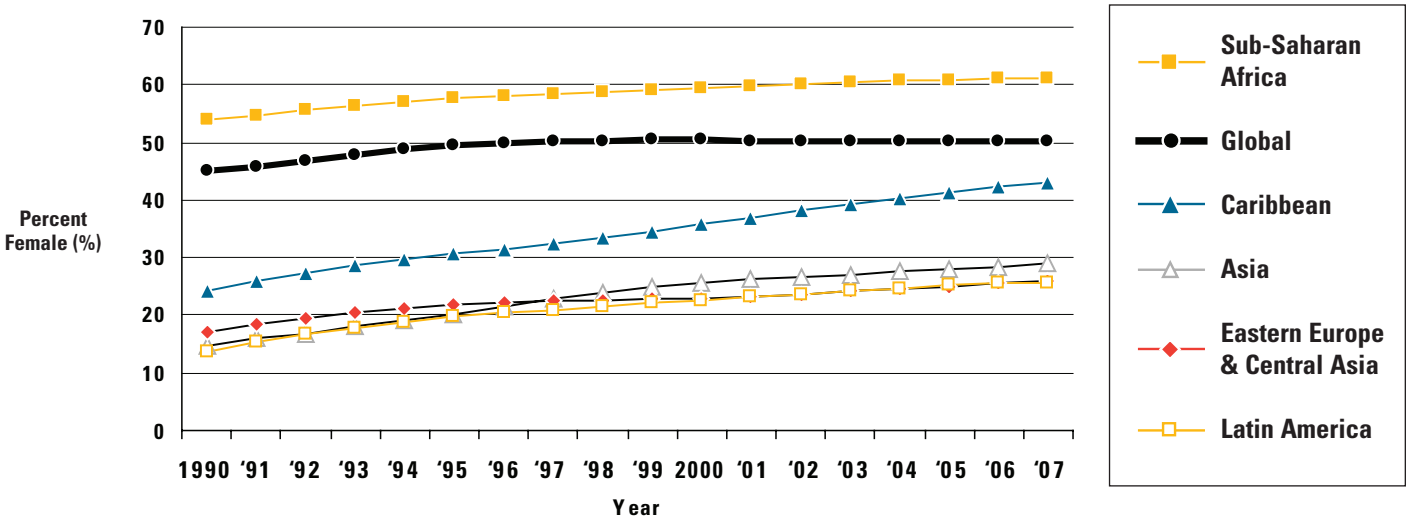
Despite the differences between the lives of women in resource-limited settings and those in developed countries, certain risk factors apply to women worldwide.

Economic and Social Factors

Economic and social factors place women around the world at increased risk for HIV. The decreased economic power of women, compounded by reduced social and legal rights, has a number of consequences in the context of HIV/AIDS. Women and girls may be forced to marry or are coerced into unequal relationships as a means of economic support. Young women may enter into sexual relationships with older men who are able to provide basic necessities for them and their families.

Because of economic dependency on husbands or partners and, in many cases, culturally prescribed gender roles that perpetuate men's unequal share of power within marriage or a relationship, women are unable to insist that their partners remain monogamous or use condoms.[8] Additionally, for women of child-bearing age trying to conceive, condom use is not an option.

Figure 2: Percentage of Adults (15+) Worldwide Living with HIV Who Are Females (1990–2007)



Source: UNAIDS. *AIDS Epidemic Update*. December 2007

Moreover, many women are unaware of their male partners' risk behaviors—such as multiple sexual partners or injection drug use—and thus may not realize that they are being put at risk of infection. The result is that, in some parts of the world, a woman's greatest risk of acquiring HIV occurs when she is married and monogamous, but her husband is unfaithful.[9] Economic pressures sometimes force families to make difficult choices, sacrificing a daughter's education for her contributions as a wage earner. This leaves girls and women not only less informed about health issues but also less able to obtain information that might help protect them from HIV infection. In the long term, educational and economic disadvantages for women perpetuate poverty and a reliance on men for economic support, decreasing their ability to take the necessary steps to protect their health.

> Violence against women is both a cause and a consequence of HIV infection.

Such economic disparities are not limited to the developing world. In the U.S., for example, low-income women are particularly vulnerable and are disproportionately affected by HIV/AIDS. In the only nationally representative study of people with HIV/AIDS receiving regular or ongoing medical care, nearly 64 percent of women had annual incomes below $10,000, compared to 41 percent of men.[10] Men with HIV are also more likely than women to have private health insurance (36 percent of men compared to 14 percent of women),[10] while women constitute 61 percent of adult Medicaid beneficiaries, compared to 39 percent of men.[9] The disparities are not just limited to healthcare coverage. Studies reveal that women's lack of access to basic necessities, such as transportation, can be significant barriers to receiving HIV/AIDS treatment and care.[11]

The HIV/AIDS epidemic places an additional burden on women, many of whom are already expected to care for sick family members, serve as primary caregivers of children, and play a central role in keeping families and communities together. In some societies, women may lose property if they become widowed, and suffer stigma and blame for the illnesses and deaths of husbands and children from HIV/AIDS.[12] Older women may also face additional stigma if they are suspected of caring for HIV-positive persons, grandchildren, or orphans.[13]

Gender-Based Violence

Violence against women is both a cause and a consequence of HIV infection. Emerging evidence connects the rapidly expanding HIV epidemic with gender-based violence, particularly among young women.[14] A recent review of evidence suggests that as many as one in five young women worldwide has experienced non-consensual sex.[15] Furthermore, studies have shown that many women choose not to disclose their HIV status for fear of abandonment, rejection, discrimination, violence, and accusations of infidelity from their partners, families, and communities.[16]

Biology

A number of biological factors may contribute to women's increased vulnerability to HIV/AIDS. Transmission of HIV from a man to a woman is two to eight times more efficient than from a woman to a man.[17] Physiologically, women are more susceptible to HIV than men because of greater mucous membrane exposure during sex, a larger amount of fluid exchange from male to female, and higher viral content in male sexual fluids. Young women may be especially vulnerable because of the developmental changes occurring in their reproductive anatomy during adolescence.[18] A woman's susceptibility to HIV infection is further increased if she or her partner has a sexually transmitted infection, if she has experienced genital trauma, or if her partner is HIV positive and has a high viral load.[19] Several HIV-related conditions occur solely or more frequently in women than in men. Most significant are gynecological complications of HIV disease, including invasive cervical cancer, pelvic inflammatory disease, and, more frequently, recurrent and persistent vaginal yeast infections.

Sex Differences in HIV Treatment

Although many women respond just as well as men to antiretroviral therapy, there are many unanswered questions pertaining to gender-specific manifestations of HIV disease and responses to treatment.[20] In the past, women were omitted from clinical trials of HIV/AIDS medications and data were often not analyzed for sex differences in dosage, outcomes, and side effects. In 1993, legislation was passed to ensure that women and minorities were included in all clinical trials (where appropriate) and that findings were analyzed for sex and racial/ethnic differences. Knowledge about variability in treatment outcomes and side effects for women remains limited, however, and women have not benefited from HIV/AIDS treatment as much as men. The U.S. mortality rate for HIV-positive women remains 20 percent higher than for men.[21]

Policy Recommendations

The following ten recommendations for action will create positive change in the lives of women and girls in the U.S. and around the world, contributing to the prevention of HIV infection among women as well as improved treatment and care for those already living with HIV/AIDS.

1. Make Women a Priority in National HIV/AIDS Strategies

A national HIV/AIDS strategy should guide and drive each country's response to the vulnerabilities and special needs of women in the context of HIV/AIDS. Countries with national strategies must ensure that policies are in place across all sectors to empower women, reduce their vulnerability to infection, and improve access to treatment and care. Moreover, national HIV/AIDS strategies must set clear targets for improving prevention and treatment outcomes through reliance on evidence-based programming. National strategies must also identify clear priorities for action across governmental agencies, including setting realistic and sustainable goals and requiring annual reporting on progress towards those goals. Such plans must promote gender equality and the human rights of women and girls, including ensuring education, economic security, and access to resources such as healthcare.

> Current HIV/AIDS programs often ignore the biological differences and the social, economic, and cultural inequities that make women more vulnerable to HIV/AIDS.

2. Increase Public Knowledge and Decrease Stigma and Discrimination

Governments and communities must take concrete steps to increase public knowledge about HIV/AIDS and to eradicate stigma and discrimination against HIV-positive women. Greater investment is needed in educational campaigns that not only provide the public with accurate information about the transmission and prevention of HIV, but that also address all aspects of HIV stigma. These awareness campaigns should promote a more supportive and empowering environment for women living with HIV/AIDS by countering negative stereotypes and discriminatory attitudes. In addition, governments and communities must also work toward eliminating the cultural, institutional, and structural conditions that fuel stigma and discrimination. The enactment, strengthening, and enforcement of legislation, regulations, and other measures to eliminate discrimination against people living with HIV/AIDS should be a top priority.

3. Increase Funding and Resources for Female-Focused HIV/AIDS Programs

Current HIV/AIDS programs often ignore the biological differences and the social, economic, and cultural inequities that make women more vulnerable to HIV/AIDS. Sex differences must be examined in the design, implementation, and evaluation of biomedical and behavioral research. Existing HIV/AIDS prevention, care, and treatment programs should be re-evaluated to ensure that they address the needs of women and include outcome measures that can accurately capture female-specific data. Additionally, all HIV/AIDS prevention initiatives should include components focusing on women's educational and economic empowerment, as well as increase access to health services and comprehensive, evidence-based HIV information.

4. Reduce Barriers Faced by Women in Disadvantaged Populations

Current HIV/AIDS programs and research not only ignore the needs of women in general but also fail to take into account the fact that the rise of HIV/AIDS among women has primarily affected those in disadvantaged populations. In the U.S., this trend has occurred primarily among women of color, while internationally women from ethnic minorities and other socially and economically disenfranchised groups have been affected. Whether in the U.S. or abroad, these women may face additional barriers to accessing HIV prevention, care, and treatment services. Existing HIV/AIDS programs and research should be re-evaluated to ensure that they address the social, economic, cultural, and linguistic needs of women from disadvantaged populations. Additionally, emphasis should be placed on involving disadvantaged women in the planning, design, and implementation of HIV prevention programs, as well as involving more women of color in research studies. Recent studies demonstrate that investing in women and girls has a multiplier effect on productivity, efficiency, and sustained economic growth in communities and countries.

5. Increase Women's Access to HIV Testing and Counseling Services

HIV testing and knowledge of HIV status are important for both treatment and prevention efforts. Additionally, making HIV testing a routine part of healthcare could help reduce the stigma associated with both HIV testing and HIV infection. Routine HIV testing and counseling services should be made available whenever possible, while recognizing that these services need to be adapted to account for barriers particular to women, especially gender-based violence. For many women, the fear or experience of violence influences the use of HIV testing services. It is important that this and other potential issues, such as limitations on women's autonomy and decision-making authority about healthcare, be addressed by HIV counseling and testing providers. Providers should train staff to assess female clients' risk of violence and link them with appropriate post-test support services. Expanded access to HIV testing and counseling must be accompanied by a simultaneous expansion of HIV prevention, treatment, and care services focused on women.

> Women may be more comfortable seeking services at a family planning clinic because of the stigma surrounding visits to HIV-only service providers.

6. Increase Women's Access to Healthcare

Despite targeted programs and policies in the U.S. and abroad that have helped women lead healthier lives, significant gender-based health disparities remain. Globally, a lack of education, employment opportunities, and economic stability are significant barriers preventing women from accessing quality basic healthcare. In the U.S., lack of adequate insurance and inability to pay for medical care impede women's access to health services. National, state, and local governments must implement policies to increase women's access to healthcare. These policies need to take into account women's disproportionately lower incomes, as well as their unique health needs and their role in negotiating not only their own care but also that of family members.

Policies are also needed to promote the sexual and reproductive health and rights of women and girls. For many women, reproductive health services—which traditionally include family planning, maternal health and nutrition, and prevention and treatment of sexually transmitted infections (STIs)—are the access point to the broader healthcare system. Women may also be more comfortable seeking services at a family planning clinic because of the stigma surrounding visits to HIV-only service providers. Integrating reproductive health and HIV services presents an opportunity to move HIV prevention forward by providing women with "one-stop shopping" for healthcare and comprehensive resources to prevent HIV/AIDS. Such facilities should also provide testing and treatment for STIs—a known risk factor for HIV infection. Integrated services may also help improve care for HIV-positive women who are seeking family planning or maternal and child health services.

7. Invest in the Development of Female-Controlled Prevention Methods

Currently, the only available female-initiated HIV prevention method is the female condom. However, female condoms are often underutilized by women who lack the ability to negotiate safe-sex practices with a partner. Promoting the acceptability and use of the female condom should be a component of HIV prevention strategies, but other, more "user-friendly" female-controlled methods of HIV prevention are urgently needed. The development of a prevention method that women could use discreetly to prevent sexual transmission of HIV (such as a topical microbicide or oral prophylaxis) would represent one of the most important advances in preventing HIV infection among women. Different formulations of microbicides will be necessary to prevent HIV and STIs, while accommodating women's preferences to prevent or permit conception. Additionally, more research is needed on other prevention technologies including vaccines and behavior change strategies.

8. Scale Up Prevention of Mother-to-Child-Transmission (PMTCT) Programs

In the U.S. and abroad, expanded availability of HIV screening programs and treatment to prevent perinatal transmission of HIV from mother to child has led to a steady decrease in the number of children living with HIV. However, despite these advances, less than 9 percent of HIV-positive women worldwide have access to these services. In addition to preventing new infections in infants, PMTCT programs can provide other important services to women, including HIV testing and counseling, psychosocial support, and family planning services. Operations research is needed on how to optimally increase access to and uptake of PMTCT services.

More research is also needed on other prevention technologies, including a vaccine.

9. Ensure Women's Sexual, Psychological, and Physical Safety

Violence continues to be a common, often ignored problem that increases a woman's risk for HIV and may prevent her from seeking the prevention, treatment, and care services she needs. National, state, and local governments must enact and enforce laws that protect women from violence. Implementation of these laws should be reinforced through training and education of civil servants, police, judiciary, healthcare workers, and clergy to assure that the links between HIV risk and violence against women are clearly understood. Increasing the number of violence prevention and intervention programs is another important measure. There is also a need for community-based programs that challenge traditional notions of masculinity and educate men, boys, and community leaders about the rights of women. All of these components should be integrated into countries' national HIV/AIDS strategies, as should an increased focus on expanding economic and support systems for women seeing to leave abusive situations. Furthermore, enhanced funding is urgently needed for violence prevention and intervention programs.

10. Increase Women's Rights and Involvement in Leadership

Ensuring women's and girls' rights and empowerment at all levels of society is crucial to eradicating HIV/AIDS and should be a top priority for governments and international donor agencies. National HIV/AIDS strategies should include components that seek to enhance women's economic status, secure women's property and inheritance rights, promote gender equality and the human rights of women, ensure education and economic security, and increase women's meaningful participation in civil society and governmental decision making. All of these factors are essential to ending the HIV/AIDS pandemic.

Summary

HIV/AIDS among women is an epidemic with multiple biological, social, and environmental risk factors in the U.S. and around the world. Stemming the tide of infection among women and girls is dependent on the combined efforts of political leaders, researchers, businesses, philanthropists, and civil society to promote the empowerment of women worldwide.

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