**SUPPLEMENT**
**to the Blue Book Report: *A Working Paper***

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## WOMEN, HIV AND AIDS in the United States and Globally

### *SUMMARY*

*"Although physiology affects women's greater risk of HIV transmission, it is women and girls' lack of power over their bodies and their sexual lives, supported and reinforced by their social and economic inequality, that makes them such a vulnerable group in contracting and living with HIV/AIDS. … The stereotypical gender roles that underpin sexual inequality and sexual violence are confirmed and reproduced by social, cultural and religious norms. This lends an aura of 'naturalness' and inevitability to these roles and can make them particularly difficult to contest and change." (1)*

Any report on the status of women has to include coverage of women, HIV and AIDS. The number of women around the world living with HIV and AIDS has increased significantly over the last several years. The impact of the disease on women, its impact on children, families and entire communities is momentous. For women, the intersecting social, cultural, economic, racial and ethnic factors result in increased vulnerability and decreased power and authority over their own health and lives. The single greatest overarching factors for women and HIV infection worldwide are the inequality between men and women, institutionally and in relationships, and the prevalence of a variety of forms of violence in their lives.

Worldwide, to change the current picture and trends of HIV and AIDS for women, we need action that provides for women and children:

- increased knowledge about HIV disease;
- greater access to sexual health, reproductive and prevention educational services, equal quality health care to men, and economic autonomy;
- increased empowerment and authority to negotiate safer sex and more equal gender relations;
- support and means for decreasing gender discrimination in women's lives;
- the elimination of violence in all of women's environments.

"The HIV pandemic is increasingly viewed as a strongly gendered health, development and human rights issue". (2)

Evidence has been accumulating over the last decade that the HIV/AIDS pandemic affects males and females in different ways. Women now account for the majority of new aids cases and recent data indicates that about 90% of HIV infection occurs during heterosexual sex. All studies have shown that women of color are disproportionately affected. The HIV virus is transmitted eight times more efficiently from men to women than by the reverse path and this fact, combined with gender-based sociological and cultural factors, has served to promote the rapid spread of the HIV virus among women and girls

For women, the struggle to overcome the threat of HIV/AIDS is two-fold: the virus itself and systemic gender discrimination. Globally, gender-specific circumstances increase women's risk of HIV infection. Sexual violence, coercive sex, both in and out of marriage, traditional, discriminatory, cultural practices such as early marriage and genital mutilation, inequality in privilege and rights between genders, are the real experience of many women, as are lack of HIV and sexual education, choice, access to health care, prevention options and treatment. Poverty, limited or non-existent property and inheritance rights, education, employment and economic independence often make them dependent on men. In many cases, women, and medical professionals, do not know of their partners' risk for HIV infection. Women are frequently denied power and input in decision and policy-making and their execution in the areas that most affect them.

Worldwide about half of persons living with HIV/AIDS are women. The percentage of infected women is rising dramatically and has increased by 7% in the last 7 years. If this trend continues HIV/AIDS will become a mostly female concern in the next 20 years. African American and Latina women together represented 25% of all U.S. women, yet they accounted for 84% of AIDS diagnoses reported in 2003. An astounding 67% of new HIV/AIDS cases among women are African American women who constitute only about 7% of the general population; similarly, Latina women account for about 16% of new HIV infections.

***The Impact of the HIV/AIDS Pandemic on Women – Globally and in the U.S.***

- Of the 40 million people living with this preventable virus, the proportion of infected and affected women is increasing - 47% globally, while in Sub-Saharan 57% of the adults living with HIV disease are women; 67% of infected young people are women and girls.
- UNAIDS/WHO AIDS epidemic update of 2004 shows that the number of women living with HIV has risen in each region of the world over the past two years, with the steepest increases in East Asia, followed by Eastern Europe and Central Asia. I East Asia, there was a 56% increase over the past two years.
- Worldwide, an even larger percentage of women are affected by the epidemic – either through their own infection or HIV positive status of those who depend on them or are related to them.
- The World Health Organization reports that the disproportionate infection rates suffered by females are a worldwide phenomena. The number of women living with HIV has increased both in industrialized nations and all other regions of the world. The steepest reported increase is in East Asia (where a 56% increase has been observed) followed by Eastern Europe and Central Asia.
- In 2004, nearly five million people became infected with HIV (UNAIDS); record numbers of women, particularly young women, are now included in the high-risk category.
- Because women are usually the caregivers for children, the high infection rates among women can manifest themselves as increased infection rates among the children of the world. While there are medical treatments that help to prevent the transmission of the HIV virus from mother to child during pregnancy, these treatments are often not available even if the HIV status of the woman is known.
- In addition to their risk, women and children living with HIV or AIDS disproportionately experience stigma, discrimination, violence and unequal access to treatment.
- Women account for 65% of the AIDS-related deaths between 1993 – 2003
- The proportion of new AIDS cases attributed to women in the U. S. has more than tripled from 7% in 1993 to 27% in 2004.
- AIDS cases in adolescent and adult women have declined by 17% and have remained stable since 2000 – reflecting the success of antiretroviral therapies in preventing the development of AIDS..
- AIDS is the leading cause of death for African American women in US between the ages of 25 to 34.
- 66% of all AIDS cases reported in women in the U.S. were among ages 30 to 49.

***Human Rights: Gender Inequality, Discrimination, Inaccessibility***

Female partners may not be aware of the high-risk behaviors of their male partners -- multiple sexual partners, sex with men or injected drug use (and shared syringes). Additionally, nine-tenths of STDs go unrecognized by women because there are no immediate symptoms and many women do not recognize that they are at risk because they perceive themselves to be in a monogamous relationship.

In the US, at least 25% of individuals who are HIV positive are unaware of it. This observation

has serious consequences when it is combined with recent statistical data indicating that most people acquire the virus from newly infected individuals who are the mostly likely to be unaware of their status. Because, as mentioned, there is an eightfold magnification rate in male to female HIV transmission, any alteration in men's sexual behavior can be expected to have an even greater consequence to women.

Women are often diagnosed at a later disease stage because they and their medical professionals do not suspect their exposure and test for the virus. 25% of women postpone treatment because of limited access to health care services or insurance status, responsibilities as primary caregivers and stigma. According to a government audit, health care systems do not always provide equitable care and treatment for women as compared to men. While the number of AIDS-related deaths for men has shown a decrease since 2002, later detection in women may account for the lack of a decrease in women's AIDS-related deaths.

Men on the "down-low" is contributing to rising female infection rates, although the extent to which this behavior affects women has yet to be determined. Men on the "down-low', sexual behavior which occurs worldwide, are males who have sex with both men and women but who are not classified as bisexual. Typically such men have infrequent sexual relations with other males and more persistent relationships with females. Anal sex, the most frequent form of male to male unprotected sex, has the highest risk of transmission probability. All of this results in a new channel of HIV transmission: male to male relations at high risk followed by male to female relations also at relatively high risk.

Equality between men and women in sexual decision-making continues to be largely absent in relationships. In many areas of the world, males can successfully demand that their wives continue to have unprotected sex even when risk factors are present and known. Condoms, for example, can reduce the chance of infection by a factor of about 100, but condoms are not available to many women and even when some sort of prophylactic method is available males often object to its use and women's preferences and needs cannot prevail and women are not empowered and cannot exercise authority over decisions directly affecting them. It is clear that the roots of this problem are strongly related to inequities in female-male relationships and that continued medical advances may be of minimal advantage as long as this gender inequality shapes and controls sexual behavior.

It should be noted that health organizations often make policy decisions based on mathematical projections and models. For instance, the Center of Disease Control routinely predicts infection rates, the likely consequences of varying methods of disease treatment. Funds are allocated and treatments applied according to the best estimates of the mathematical models. If a simulation or model fails to take into consideration gender or other similar factors in making its projections, then, those factors often become secondary treatment concerns and their true impact may go unrecognized. Gender awareness needs to be an intentional concern in formulating HIV models and steps need to be taken to make sure this happens now that the evidence is at hand.

### *Detection, Prevention and Control*

One encouraging development for all persons infected with HIV is the new rapid test procedure. Previously one week or longer was necessary to HIV test results to be returned. Rapid testing allows results to be obtained in as little as 20 minutes. Timely test results are important because a sizable proportion of people who are tested for HIV never return to learn the results of the test. If results can be obtained before the individual leaves the testing site, then, a treatment protocol can be begun immediately.

Data obtained in Northern New Jersey counties indicates that rapid testing does result in a **10-30% increase** in persons receiving treatment. In rural areas and countries where travel to medical facilities is time consuming or difficult, rapid test can be expected to be a valuable asset when it becomes available. In particular, the early identification and treatment of HIV+

pregnant women can be expected to reduce the number of newborns who are HIV+.

Unfortunately again, where women's access to health care options, sexual health and prevention education exist, new technologies and treatment plans cannot be effectual.

### *Human Rights: Gender Inequality, Discrimination, Inaccessibility*

Multiple gender-based factors increase women's risk of HIV infection. Violence is at epidemic levels for women. Other factors are related to women's insubordinate position such as illiteracy, poverty, conflict situation (war, etc.), lack of sexual autonomy, trafficking for sexual exploitation, survival sex, prostitution, injection drug use, rape, partner risk, non-monogamous partners and multiple sexual partners. Myths and superstition further endanger women and increase their risks.

Violence occurs in many settings. It is experienced in the home, battering by family members and intimate partners, sexual abuse of female children and marital rape and includes abuse of domestic workers, who may experience involuntary confinement, physical brutality, enslavement and sexual assault. Women also experience gender-based violence in the community – rape, sexual harassment and assault at work, trafficking and forced prostitution, forced labor. Further violence includes that condoned by "state actors": police, prison and border guards, soldiers, immigration officials and rape by government forces during armed conflict.

### *To effect change*

To change the impact of HIV infection and AIDS, women must be able to exercise power over their own lives without risking them. Treatment is reaching more people worldwide, including Sub-Saharan Africa, and making a difference in the number of new infections and death from AIDS-related disease. Unfortunately, treatment alone is not sufficient to save women's lives.

What will make a significant difference over the next 10 years is to strengthen women's human rights and opportunities for equality, equity and justice. We must support major expansion of the campaigns to provide access to treatment, hand-in-hand with sexual, reproductive health and prevention education and psychosocial counseling. We must reach health care professionals to ensure that women's risk and infection is recognized as early as possible.

We must also advocate for inclusion of the gender dimension in all HIV policy and clinical trials, financial support for HIV and AIDS research and treatment and increased funding for the research and development of methods of female-controlled preventive methods, such as microbiocides, which could be in the form of topical creams or gels, suppositories, rings, films or sponges, which would kill the HIV virus, while working to reduce poverty and women's forced reliance on sexual exploitation, survival sex and the high risk of being trafficked, and secure economic independence for women globally.

This means that we must also find effective means to address and lessen violence, promote a culture of non-violence and provide protections for women, in all their environments, including access to post-exposure prophylactics for women who have been raped. **One of the most important efforts must be to commit to effecting long-range changes in societal norms that perpetuate gender roles, discrimination and gender-based power dynamics that reinforce women's powerlessness over their own lives and systematize and institutionalize inequality between men and women.**


1. **UNAIDS, UNFPA, UNIFWM, Women and HIV/AIDS: Confronting the Crisis, New York, 2004. Available at http://www.unfpa.org/hiv/women/**
2. **http://www.amestyusa.org/news/document.do**
3. **http://www.cdc.gov/hiv/pubs/facts/women.htm**
4. **http://gbgm-umc.org/health/wad04/factsheet.cfm**
5. **http://www.blackwomenshealth.com/HIV_AIDS.htm**
6. **http://web.amesty.org/library/Index/ENGACT770842004**
7. **CDC,HIV/AIDS Surveillance by Race/Ethnicity, L238 Slide Series & Surveillance in Women, L264 slice Series (through 2003**
8. **NIAID, HIV INFECTION IN WOMEN, 2004**



**Working Paper: Ms. Lyn Headley-Deavours, for the Committee on the Status of Women 1/2006**