Women and HIV

(updated June 2021)

AETC AIDS Education & Training Center Program New England

Women and HIV

This educational packet is a curated compilation of resources on women and HIV.

The contents of this packet are listed below:

- Diagnoses of HIV Infection in the United States and Dependent Areas, 2019: Women (CDC Special Focus Profile)
- HIV and Women (CDC fact sheet)
- Women and HIV in the United States (Kaiser Family Foundation issue brief)
- HIV and Pregnant Women, Infants, and Children (CDC fact sheet)
- Women and HIV: A Spotlight on Adolescent Girls and Young Women (UNAIDS)

You may wish to customize this packet to meet the needs or interests of particular groups, such as event participants, providers, patients, clients, or the general public. So please feel free to distribute all or part of this document as either a printout or PDF.

Diagnoses of HIV Infection in the United States and Dependent Areas 2019

cdc.gov/hiv/library/reports/hiv-surveillance/vol-32/content/special-focus-profiles.html

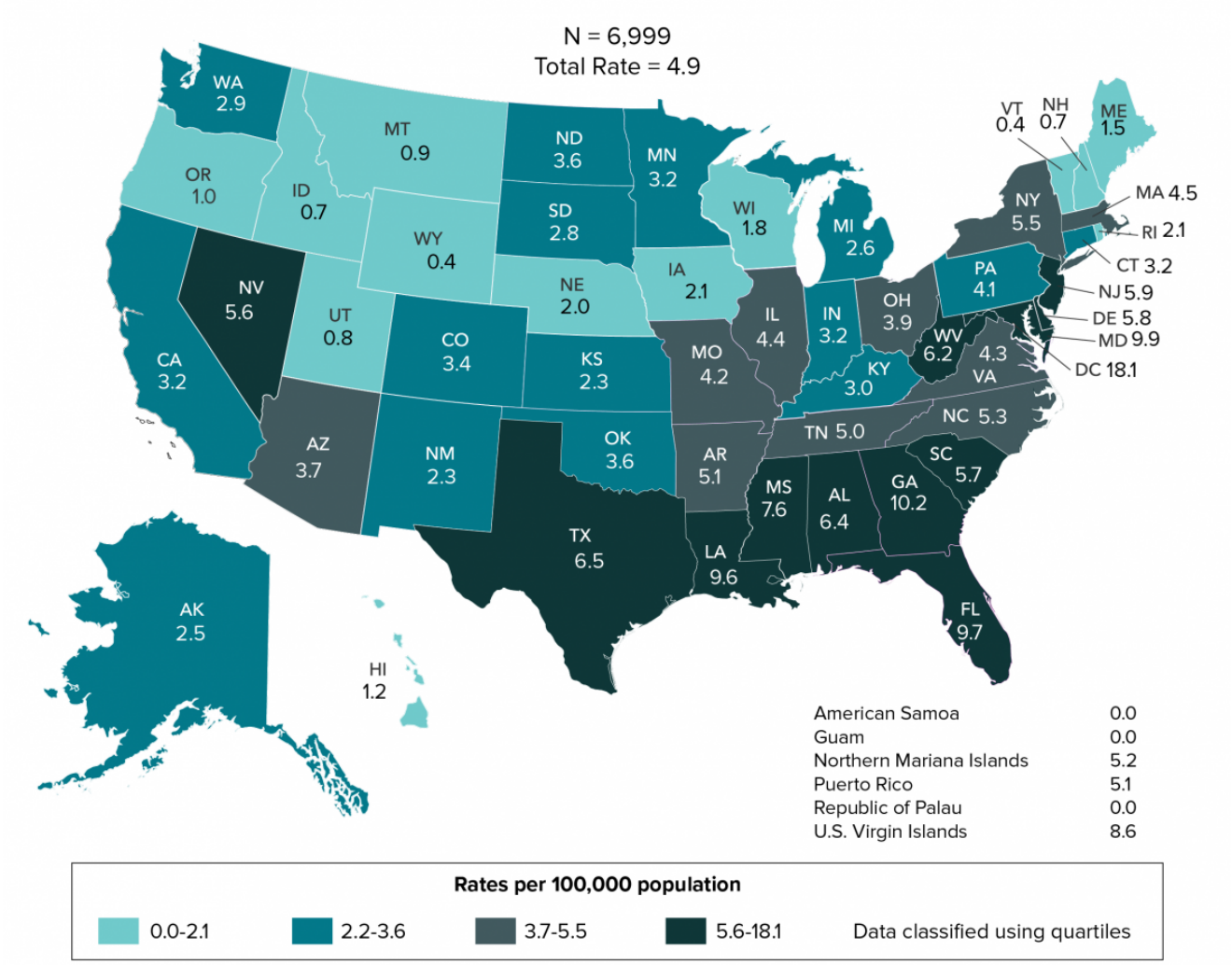
Special Focus Profiles

Women

Though HIV diagnoses among women have declined in recent years, approximately 7,000 women received an HIV diagnosis in the United States and 6 dependent areas in 2019. One in nine women with HIV are unaware they have it. Because some women may be unaware of their male partner's risk factors for HIV (such as injection drug use or having sex with men), they may not use condoms or medicines to prevent HIV. Additionally, HIV testing rates within the past year were low among women with sexual behaviors that increase their risk of acquiring HIV and especially low among those who reported anal sex.

Diagnoses of HIV infection

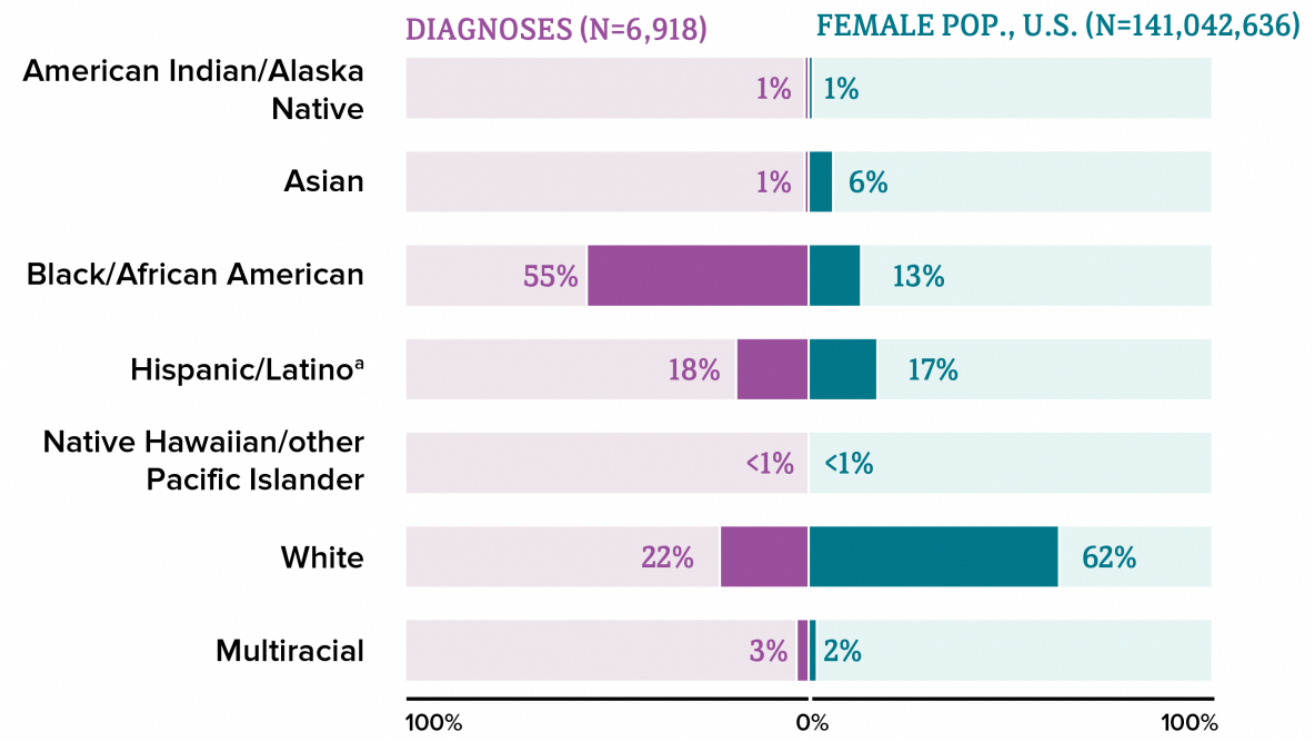
Figure 20. Rates of Diagnoses of HIV Infection among Female Adults and Adolescents, 2019—United States and 6 Dependent Areas



In 2019 in the United States and 6 dependent areas, the rate of diagnoses of HIV infection among female adults and adolescents was 4.9 (Figure 20). Rates ranged from a low of 0.0 in American Samoa, Guam, and the Republic of Palau to a high of 18.1 in the District of Columbia, followed by 10.2 in Georgia, 9.9 in Maryland, 9.7 in Florida, and 9.6 in Louisiana.

Race/ethnicity: In 2019 in the United States, Black/African American female adults and adolescents made up 13% of the female population but accounted for 55% of diagnoses of HIV infection among females (Figure 21). White female adults and adolescents made up 62% of the female population and accounted for 22% of diagnoses of HIV infection. Hispanic/Latino female adults and adolescents made up 17% of the female population and accounted for 18% of diagnoses of HIV infection. Asian female adults and adolescents made up 6% of the female population but accounted for 1% of HIV diagnoses. Multiracial females made up 2% of the female population and accounted for 3% of HIV diagnoses. Native Hawaiian/other Pacific Islander and American Indian/Alaska Native female adults and adolescents each made up 1% or less of the female population and each accounted for less than 1% of HIV diagnoses. Please use caution when interpreting data for Native Hawaiian/other Pacific Islander female adults and adolescents: the number is small.

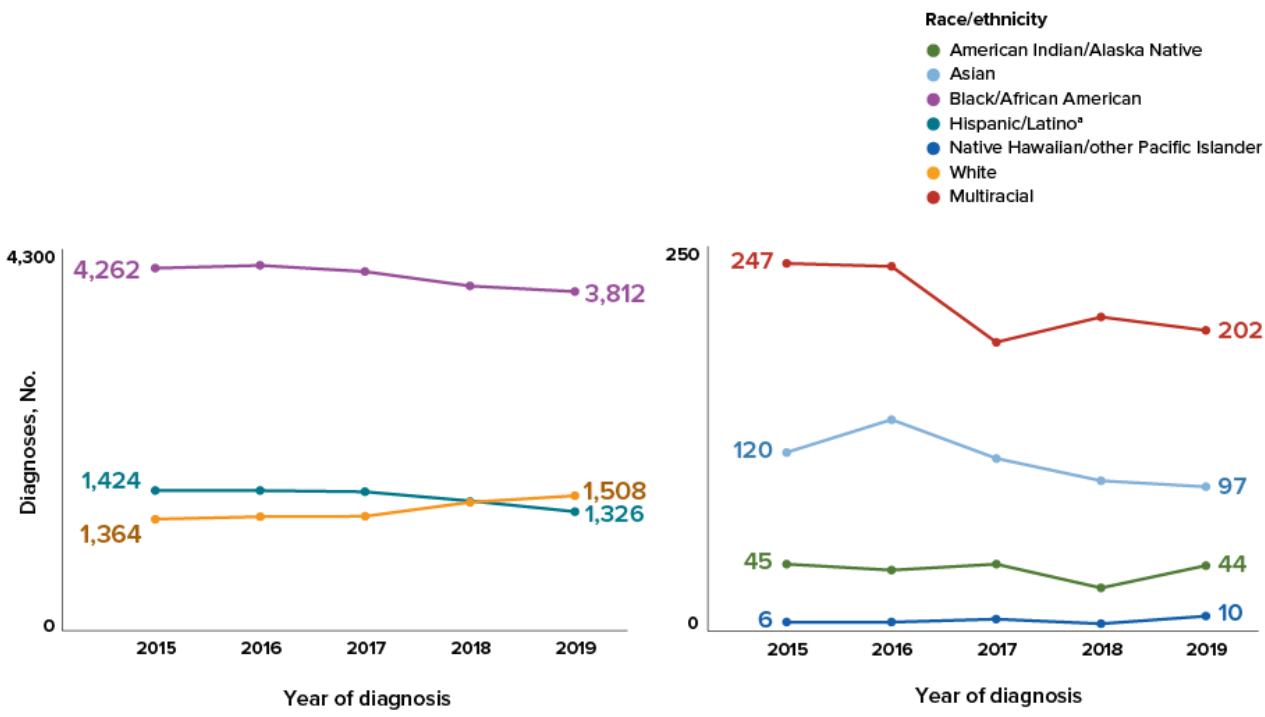
Figure 21. Percentages of Diagnoses of HIV Infection and Population among Female Adults and Adolescents, by Race/Ethnicity, 2019—United States



Note: See section D3 in the Technical Notes for more information on race/ethnicity.
[a]Hispanic/Latino persons can be of any race.

From 2015 through 2019 in the United States and 6 dependent areas, Black/African American female adults and adolescents accounted for the largest numbers of diagnoses of HIV infection each year although the number decreased from 4,262 in 2015 to 3,812 in 2019 (Figure 22). White female adults and adolescents was the only race/ethnicity group among females where the number of diagnoses of HIV infection increased (from 1,364 in 2015 to 1,508 in 2019). In 2019, 44 diagnoses of HIV infection were among American Indian/Alaska Native, 97 among Asian, 1,326 among Hispanic/Latino, 10 among Native Hawaiian/other Pacific Islander females, and 202 among multiracial female adults and adolescents. Please use caution when interpreting data for Native Hawaiian/other Pacific Islander female adults and adolescents: the numbers are small.

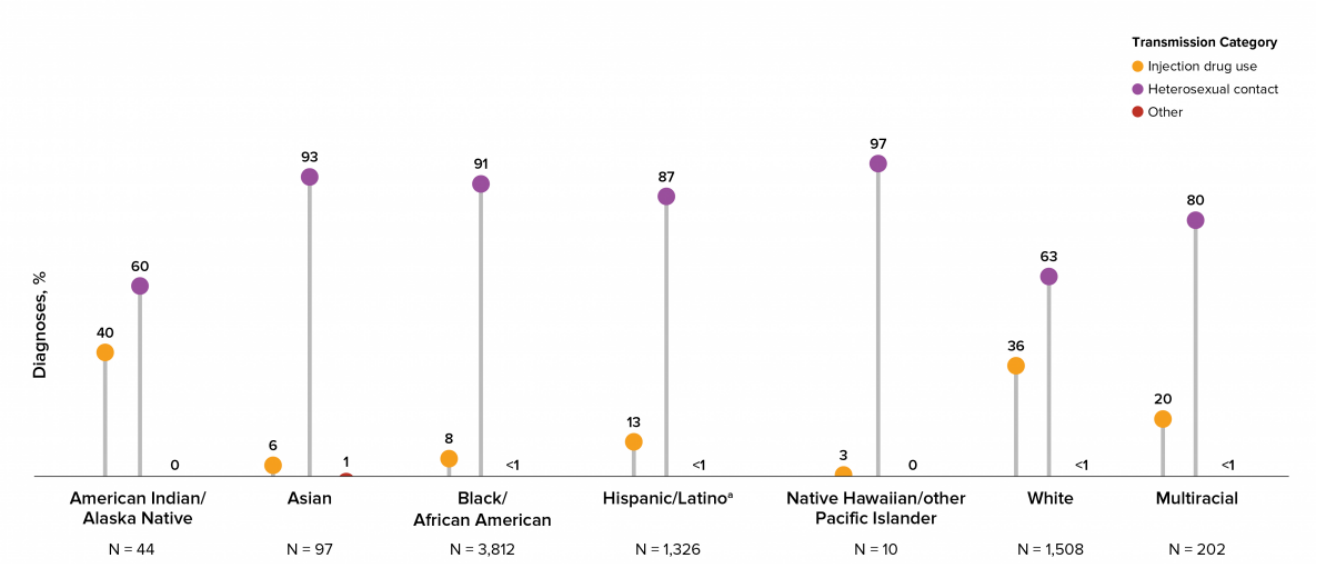
Figure 22. Diagnoses of HIV Infection among Female Adults and Adolescents, by Race/Ethnicity, 2015–2019—United States and 6 Dependent Areas



Note: See section D3 in the Technical Notes for more information on race/ethnicity.
[a]Hispanic/Latino persons can be of any race.

Race/ethnicity and Transmission category: In 2019 in the United States and 6 dependent areas, Asian female adults and adolescents had the largest percentage (93%) of diagnoses of HIV infection attributed to heterosexual contact, followed by Black/African American (91%), and Hispanic/Latino (87%) female adults and adolescents (Figure 23). The percentage (40%) of diagnoses of HIV infection attributed to injection drug use was largest among American Indian/Alaska Native female adults and adolescents, followed by White (36%) and multiracial (20%) female adults and adolescents. The perinatal and "Other" transmission categories accounted for 1% or less of diagnoses among each racial/ethnic group. Please use caution when interpreting data for Native Hawaiian/other Pacific Islander female adults and adolescents: the numbers are small.

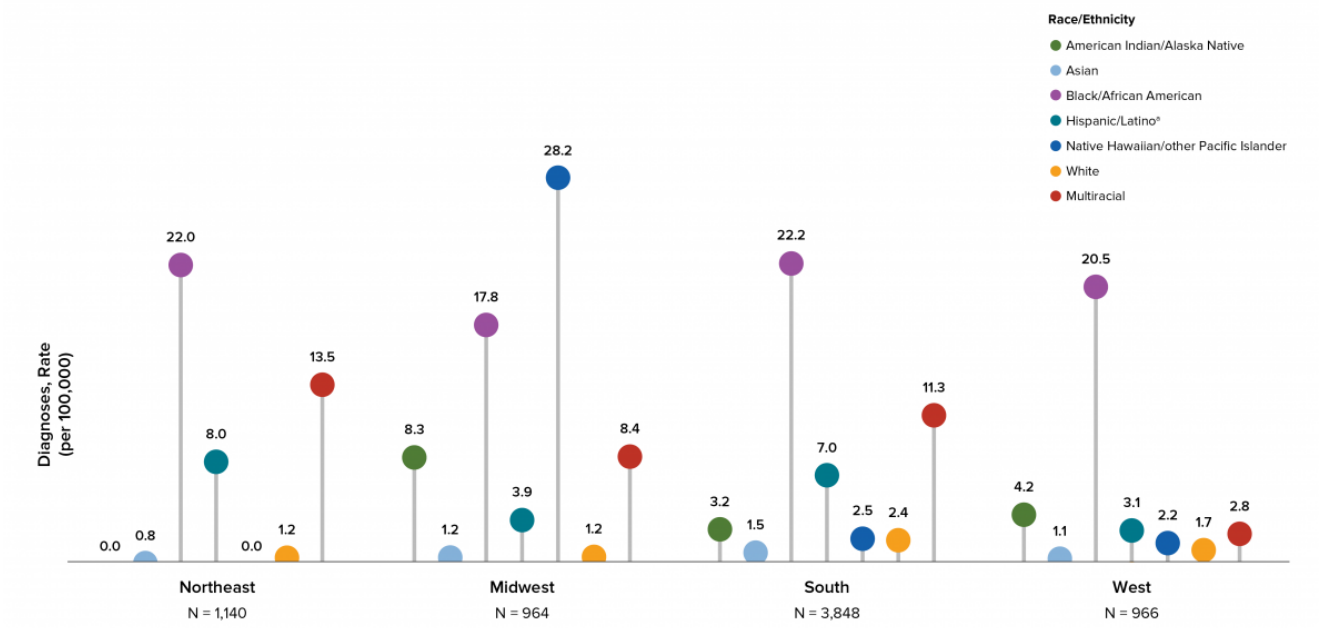
Figure 23. Percentages of Diagnoses of HIV Infection among Female Adults and Adolescents, by Transmission Category and Race/Ethnicity, 2019—United States and 6 Dependent Areas



Note: Data have been statistically adjusted to account for missing transmission category. See sections D3 and D4 in the Technical Notes for more information on race/ethnicity and transmission categories.
[a]Hispanic/Latino persons can be of any race.

Region: In 2019 in the United States among female adults and adolescents, the South had the highest number of diagnoses (3,848) of HIV infection (Figure 24). The highest rates of diagnoses of HIV infection among American Indian/Alaska Native (8.3), Asian (1.5), Black/African American (22.2), and White (2.4) female adults and adolescents were in the South. The highest rate of diagnoses of HIV infection among Hispanic/Latino (8.0) and multiracial (13.5) female adults and adolescents were in the Northeast. Please use caution when interpreting data for Native Hawaiian/other Pacific Islander female adults and adolescents: the numbers are small.

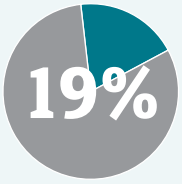
Figure 24. Rates of HIV Diagnoses among Female Adults and Adolescents by Race/Ethnicity and Region, 2019—United States



Note: See sections D3 and E1 in the Technical Notes for more information on race/ethnicity and U.S. Census Regions.
[a]Hispanic/Latino persons can be of any race.

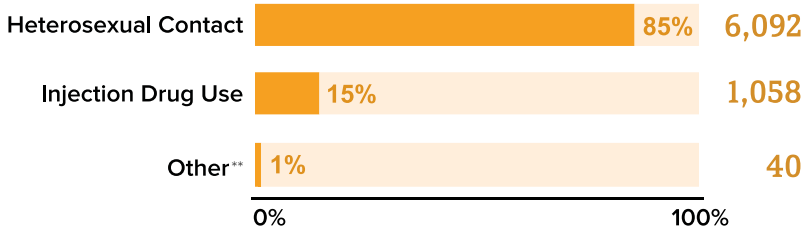
Prevalence and race/ethnicity: At year-end 2019 in the United States and 6 dependent areas, 248,144 female adults and adolescents were living with diagnosed HIV infection, of whom 57% were Black/African American, 21% Hispanic/Latino, and 16% White (Table 17b). Multiracial female adults and adolescents accounted for 5% of females living with diagnosed HIV infection, followed by Asian female adults and adolescents (1%), and American Indian/Alaska Native and Native Hawaiian/other Pacific Islander female adults and adolescents who each accounted for 1% or less.

HIV and Women



There were **37,968 NEW HIV DIAGNOSES** in the US and dependent areas in 2018.* Of those, 19% (7,190) were among women.†‡

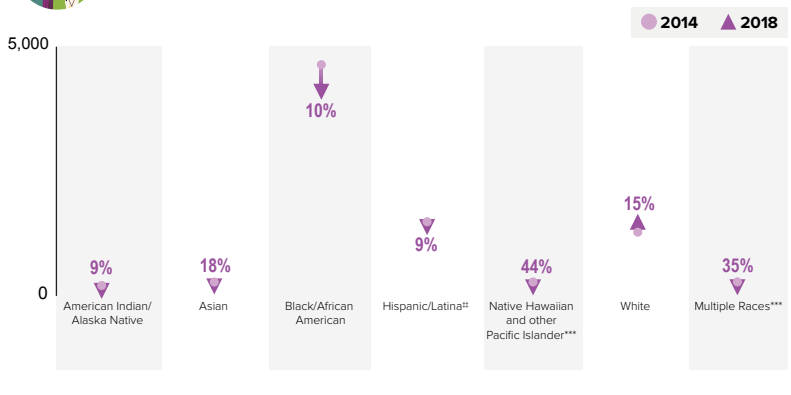
Most new HIV diagnoses among women were attributed to heterosexual contact.



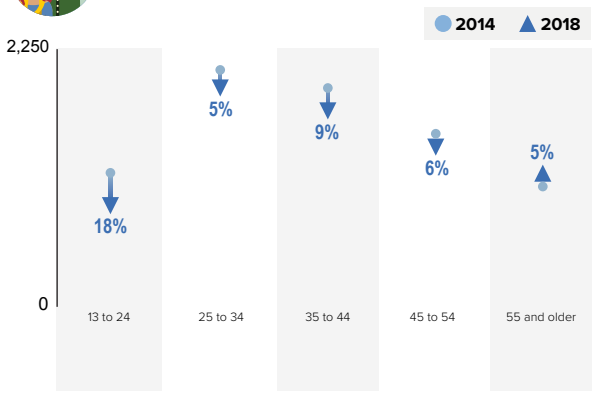
Total may exceed 100% due to rounding.

HIV diagnoses decreased 7% among women overall from 2014 to 2018. Although trends varied for different groups of women, HIV diagnoses declined for groups most affected by HIV, including Black/African American†† women and women aged 25 to 34.

Trends by Race/Ethnicity



Trends by Age



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.
† Adult and adolescent women aged 13 and older.
‡ Based on sex assigned at birth and includes transgender people.
** Includes perinatal exposure, blood transfusion, hemophilia, and risk factors not reported or not identified.
†† *Black* refers to people having origins in any of the Black racial groups of Africa. *African American* is a term often used for people of African descent with ancestry in North America.
‡‡ Hispanic/Latina women can be of any race.
*** Changes in subpopulations with fewer HIV diagnoses can lead to a large percentage increase or decrease.

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Women who don't know they have HIV can't get the care and treatment they need to stay healthy.

In 2018, an estimated **1,173,900 PEOPLE** had HIV.[†††] **Of those, 261,800 were women.**[‡‡‡]

For every 100 people with HIV

86 knew their HIV status.

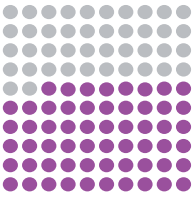
For every 100 women with HIV

90 knew their HIV status.

It is important for women to know their HIV status so they can take medicine to treat HIV if they have the virus. Taking HIV medicine every day can make the viral load undetectable. People who get and keep an undetectable viral load (or remain virally suppressed) can stay healthy for many years and have effectively no risk of transmitting HIV to their sex partners.

Compared to all people with diagnosed HIV, women have lower viral suppression rates. More work is needed to increase these rates. **For every 100 women with diagnosed HIV in 2018:**[****]

76 received some HIV care



58 were retained in care

63 were virally suppressed

For comparison, for every **100 people overall** with diagnosed HIV, **76 received some care**, **58 were retained in care**, and **65 were virally suppressed**.

There are several challenges that place some women at higher risk for HIV.

Racism, Discrimination, and HIV Stigma

Racism, discrimination, and stigma may affect whether some women seek or receive high-quality health services.

Unaware of Partner's Risk Factors

Some women don't know their male partner's risk factors for HIV (such as injection drug use or having sex with men) and may not use a condom or medicine to prevent HIV.

Risk of Exposure

Because receptive sex is riskier than insertive sex, women are more likely to get HIV during vaginal or anal sex than their sex partner.

Intimate Partner Violence (IPV)

Women who have been exposed to IPV may be more likely to engage in risky behaviors or be forced to have sex without a condom or medicines to prevent or treat HIV.

How is CDC making a difference for women?

Collecting and analyzing data and monitoring HIV trends.

Supporting community organizations that increase access to HIV testing and care.

Conducting prevention research and providing guidance to those working in HIV prevention.

Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.

Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.

Strengthening successful HIV prevention programs and supporting new efforts funded through the *Ending the HIV Epidemic* initiative.

[†††] In 50 states and the District of Columbia.
[‡‡‡] Based on sex assigned at birth.
[****] In 41 states and the District of Columbia.
For more information about HIV surveillance data, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

For more information visit www.cdc.gov/hiv

All content is based on the most recent data available in March 2021.

Women and HIV in the United States

kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states

Published: Mar 09, 2020

March 9, 2020

Key Facts

- Women have been affected by HIV since the beginning of the epidemic and face unique challenges in accessing optimal prevention, care and treatment resources.[1,2] In 2018, women accounted for about 1 in 5 (19%) new HIV diagnoses in the U.S.[3]
- Women of color, particularly Black women, have been especially hard hit and represent the majority of women living with HIV as well as the majority of new infections among women.[4,5]
- However, there has been some significant progress with new HIV diagnoses declining 24% among women since 2010.[6]
- Despite this progress, HIV prevention opportunities may not be reaching women effectively. Pre-exposure prophylaxis (PrEP), a highly effective medication, prevents acquisition of HIV but uptake has been slow among women in the U.S.[7]
- While there are promising new signs, with data indicating that HIV infections are now falling among women, including among Black women, addressing the epidemic's impact on women in the U.S., particularly women of color, remains critical to ensuring that these trends continue.[8,9]

Overview

- Today, of the more than 1.1 million people living with HIV in the U.S., 258,000, or 23%, are women.[10]
- Women with and at risk for HIV face several challenges to getting the services and information they need, including socio-economic and structural barriers such as poverty, cultural inequities, and intimate partner violence (IPV). In addition, women may place the needs of their families above their own.[11,12,13,14,15]
- Women accounted for 19% (7,139) of new HIV diagnoses in 2018, a 24% decrease since 2010.[16]
- In 2018, there were 4,106 new AIDS diagnoses (AIDS being the most advanced form of HIV disease) among women, representing 24% of all AIDS diagnoses in that year. An AIDS diagnosis suggests someone who was living with HIV for a long time before being diagnosed or suboptimal engagement in care. Like new HIV infections, new AIDS diagnoses among women are on the decline, likely linked to fewer new infections, better engagement in care, and earlier diagnoses.[17]

Age

- Women ages 25-34 accounted for the largest share (27%) of HIV diagnoses among women in 2018, followed by those ages 35-44 (24%). Most women (85%) who were diagnosed in 2018 acquired HIV through heterosexual sex (Figure 1).[18]
- Women are diagnosed with HIV at slightly older ages than men are. Men ages 13-34 accounted for 60% of HIV diagnoses among men in 2018, while women in the same age group accounted for 40% of HIV diagnoses among women in 2018.[19]

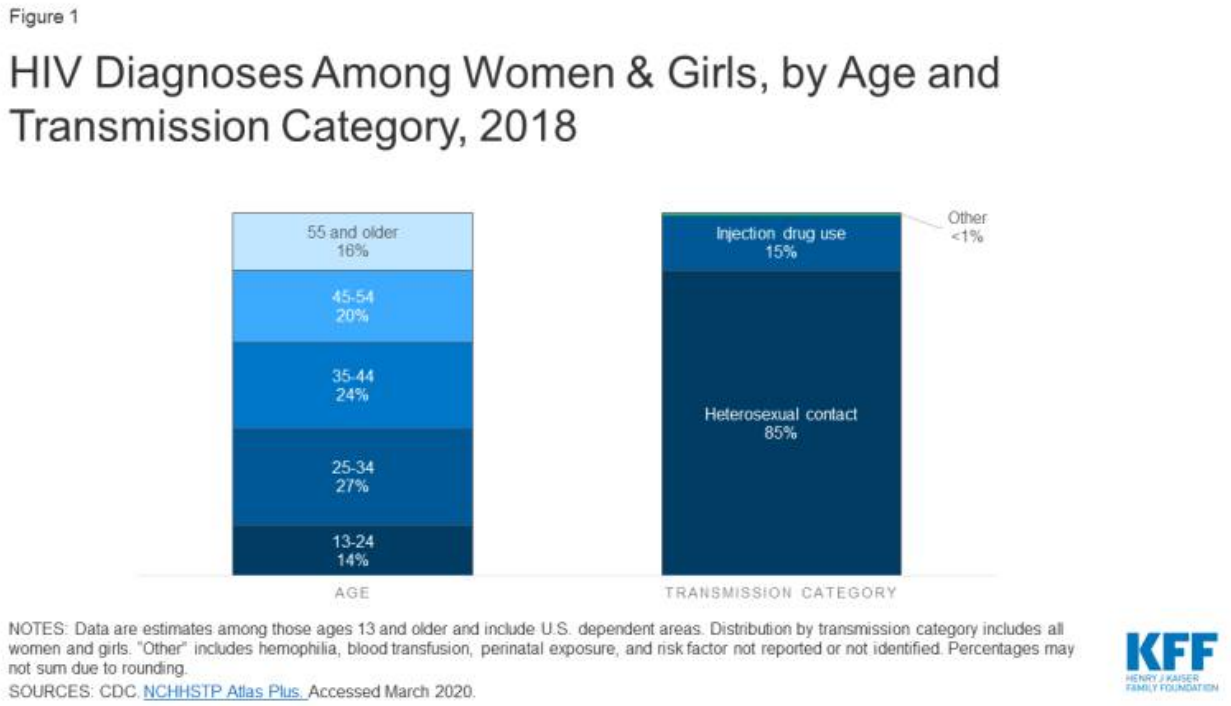


Figure 1: HIV Diagnoses Among Women & Girls, by Age and Transmission Category, 2018

Race/Ethnicity

- Women of color, particularly Black women, are disproportionately affected by HIV, accounting for the majority of new HIV infections, the greatest prevalence, and highest rates of HIV-related deaths among women living with HIV in the U.S.[20]
- In 2018, Black women accounted for over half (58%) of HIV diagnoses among women, while only accounting for 13% of the female population; white women accounted for 21% and Latinas 17% of HIV diagnoses among women (Figure 2).[21,22,23] Recent data indicate that, as with women overall, HIV diagnoses among Black women are also on the decline, decreasing by31% between 2010 and 2018.[24]
- HIV incidence rates are much higher for Black women and Latinas than for white women. In 2016, the rate of new HIV infections for Black women was 15 times higher than the rate for white women (24.2 per 100,000 compared to 1.6); the rate for Latinas (4.9) was 3 times higher.[25] Rates of women living with an HIV diagnosis follow a similar pattern. [26]

- The likelihood of a woman being diagnosed with HIV in her lifetime is significantly higher for black women (1 in 54) and Latinas (1 in 256) than for white women (1 in 941).[27]
- In 2017, HIV was the 7th leading cause of death for Black women ages 25-44 and was the 18th leading cause of death among white women in this age group.[28] Black women accounted for the greatest share of deaths among women with a diagnosed HIV infection in 2017 (58%), followed by white women (21%) and Latinas (15%).[29]
- When asked how concerned they were personally about becoming infected with HIV, a survey of Americans on HIV/AIDS found that 21% of women in the U.S. say they are "very" or "somewhat" concerned.[30] An earlier survey found that Black women are much more likely to say they are concerned than white women and that Black women are also more likely to express concern about an immediate family member acquiring HIV.[31]

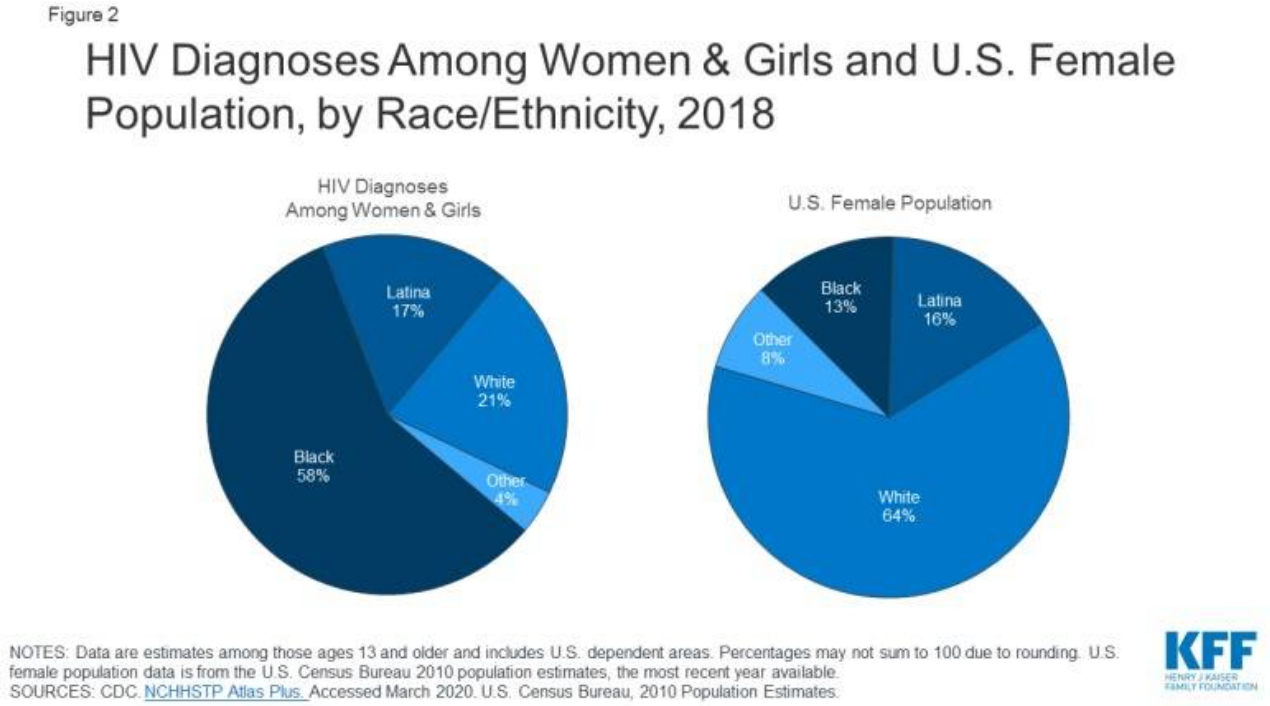


Figure 2: HIV Diagnoses Among Women & Girls and U.S. Female Population, by Race/Ethnicity, 2018

Transmission

- As seen in Figure 1, women are most likely to contract HIV through heterosexual sex (85% in 2018), followed by injection drug use (15%).[32] Heterosexual transmission accounts for a greater share of HIV diagnoses among Black women and Latinas (92% and 87%, respectively) compared to white women (65%); injection drug use accounts for a greater share of diagnoses among white women (34%).[33]

- Mother-to-child transmission of HIV in the U.S. has decreased dramatically since its peak in 1991 due to the use of antiretroviral therapy (ART), which significantly reduces the risk of transmission from a woman to her baby (to 1% or less).[34,35] Still, some perinatal infections occur each year, the majority of which are among Black women, and there continues to be missed opportunities for preventing mother-to-child transmissions, such as testing late in pregnancy.[36,37]

Reproductive Health

- HIV interacts with women's reproductive health on many levels.
- Studies have shown that HIV is transmitted more efficiently from men to women during heterosexual sexual intercourse. In addition, women with other sexually transmitted infections (STIs) are at increased risk for contracting HIV. [38,39]
- Women with HIV are at increased risk for developing or contracting a range of conditions, including human papillomavirus (HPV), which can lead to cervical cancer, and severe pelvic inflammatory disease (PID).[40]
- Research efforts are exploring a number of new HIV prevention technologies which could be particularly beneficial for women, such as cervical barriers and microbicides.[41]
- In addition, family planning sites provide an important entry point for reaching women at risk for and living with HIV. A majority of women of reproductive age (59%) report that a family planning as a site of reproductive care services; 41% say it is their only source of care.[42]

Geography

- HIV's impact varies across the country and, in some states, the epidemic is more likely to affect women than in others.
- Ten states account for the majority of women living with an HIV diagnosis (67% in 2017); with 5 states accounting for nearly half (47%) (Figure 3). While the District of Columbia has far fewer women living with an HIV diagnosis (3,848 in 2017), the rate per 100,000 women living with an HIV diagnosis is nearly 7 times the national rate for women (1,214.8 per 100,000 compared to 169.9 per 100,000 nationally).
- Twenty-five (25) counties account for almost half (44%) of all women living with an HIV diagnosis in the U.S. Bronx County, New York had the greatest number (9,960) and highest rate (1,576.5 per 100,000) of women living with an HIV diagnosis. [43]

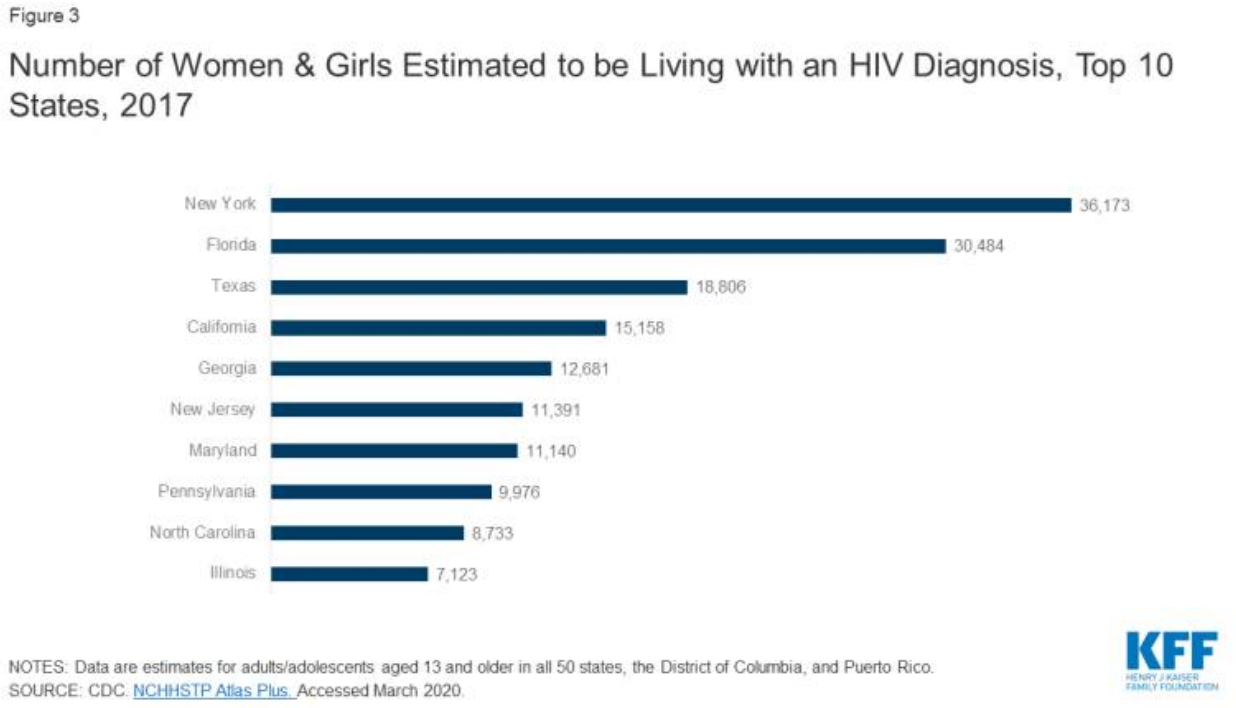


Figure 3: Number of Women & Girls Estimated to be Living with an HIV Diagnosis, Top 10 States, 2017

Intimate Partner Violence (IPV) and HIV

- Women living with HIV are disproportionately affected by intimate partner violence (IPV), including physical, sexual, and emotional abuse compared to the general population. [44,45] Intimate partner violence (IPV), sometimes referred to as domestic violence, has been shown to be associated with increased risk for HIV among women, as well as poorer treatment outcomes for those who are already infected.[46,47]
- Among all U.S. women, 36% report having experienced IPV, including rape, physical violence, and/or stalking in their lifetime; among HIV positive women in the U.S., IPV is even more prevalent, with 55% reporting having experienced IPV.[48,49,50]
- In many cases, the factors that put women at risk for contracting HIV are similar to those that make them vulnerable to experiencing trauma or IPV; women in violent relationships are at a 4 times greater risk for contracting STIs, including HIV, than women in non-violent relationships, and women who experience IPV are more likely to report risk factors for HIV.[51] These experiences are interrelated and can become a cycle of violence, HIV risk, and HIV infection.
- It has also been suggested that women are at risk of experiencing violence upon disclosure of their HIV status to partners.[52]

HIV Prevention

- The CDC recommends routine HIV screening for all adults, including women, ages 13-64, in health care settings, as well as repeat screening at least annually for those at high risk. The CDC also separately recommends all pregnant women be screened for HIV, and that those at high-risk for HIV have repeat HIV screening in their third trimester. Testing of newborns is also recommended if the mother's HIV status is unknown.[53]
- While nearly half (49%) of women in the U.S. ages 18-64 report having been tested for HIV at some point, just 1 in 6 (18%) report that they were tested in the past year. Black women are much more likely to report having been tested in the past year compared to white women (21% compared to 6%).[54]
- The United States Preventive Services Task Force (USPSTF) recommends HIV testing (including specifically for pregnant women), IPV screening, many STI screenings, and PrEP which means that most insurers are required to cover these services without cost-sharing.[55,56]

Access to Care & Treatment

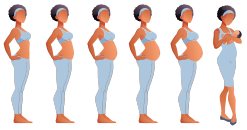
- There are a number of sources of care and treatment for women with and at risk for HIV in the U.S., including government programs such as Medicaid, Medicare, and the Ryan White Program for those who are eligible.
- Looking across the spectrum of access to care, from HIV diagnosis to viral suppression, reveals missed opportunities for reaching women. Among women living with HIV in the U.S., 9 in 10 (89%) were aware of their HIV status; however, many were tested late, many years after acquiring HIV, suggesting missed prevention opportunities. Moreover, only 65% have been linked to care and just 51% are retained in regular care and are virally suppressed.[57]
- In 2017, among women who are HIV positive, 22% were tested for HIV late in their illness – that is, simultaneously diagnosed with HIV and AIDS – a similar share as men (21%).[58]
- Pre-exposure prophylaxis (PrEP), a highly effective medication, prevents acquisition of HIV, but uptake has been slow among women in the U.S., suggesting potential barriers to the provision of PrEP for women. In 2016, women accounted for only 4.7% of PrEP users in the U.S.[59]

Future Outlook

While data indicate that HIV incidence among women in the U.S. is falling, addressing the epidemic's impact on women remains of critical importance in ensuring these encouraging trends continue. While there are a number of sources of care and treatment for women with HIV, including new coverage opportunities under the Affordable Care Act, half of women are not engaged in care and treatment and challenges remain. Looking forward, it will be important to continue to assess an evolving, epidemiological, scientific, and policy

landscape. Of particular note, whether the White House initiative to “End the HIV Epidemic” in the U.S., impacts coverage and access to prevention, care, and treatment for women with and at risk for HIV will be critical to monitor.

HIV and Pregnant Women, Infants, and Children



HIV can be passed from mother-to-child anytime during pregnancy, childbirth, and breastfeeding. This is called *perinatal transmission*.

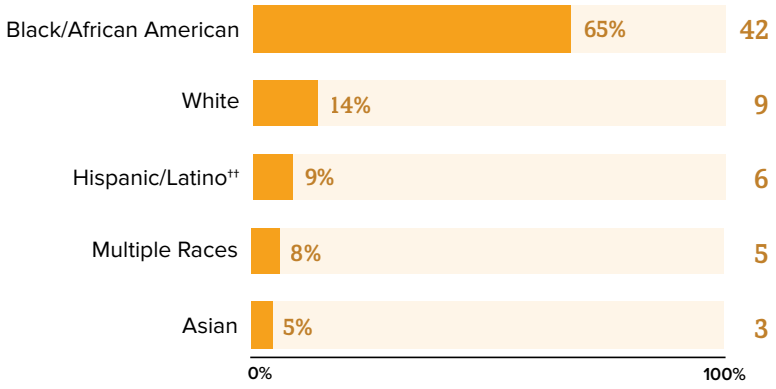
BUT THERE IS GOOD NEWS:

For a woman with HIV, the risk of transmitting HIV to her baby can be **1% OR LESS** if she:

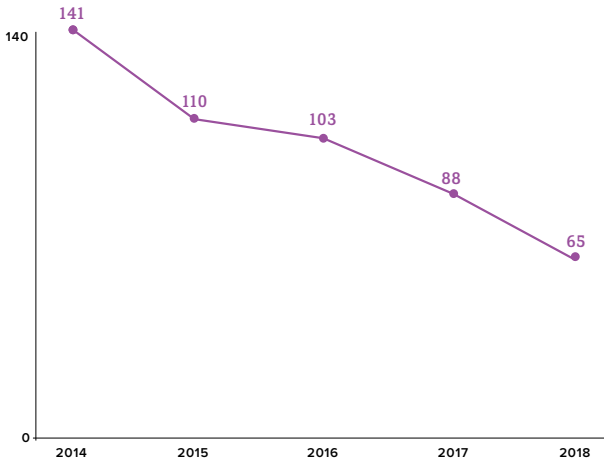
- Takes HIV medicine as prescribed throughout pregnancy, birth, and delivery.
- Gives HIV medicine to her baby for 4 to 6 weeks after giving birth.
- Does NOT breastfeed or pre-chew her baby's food.

Of the **37,968 NEW HIV DIAGNOSES** in the US and dependent areas* in 2018, <1% (65) were due to perinatal transmission.

Most new perinatal HIV diagnoses were among Black/African American† children. ‡**



HIV diagnoses declined 54% among children overall from 2014 to 2018.



* American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, the Republic of Palau, and the US Virgin Islands.

† *Black* refers to people having origins in any of the black racial groups of Africa. *African American* is a term often used for Americans of African descent with ancestry in North America.

‡ Children under the age of 13.

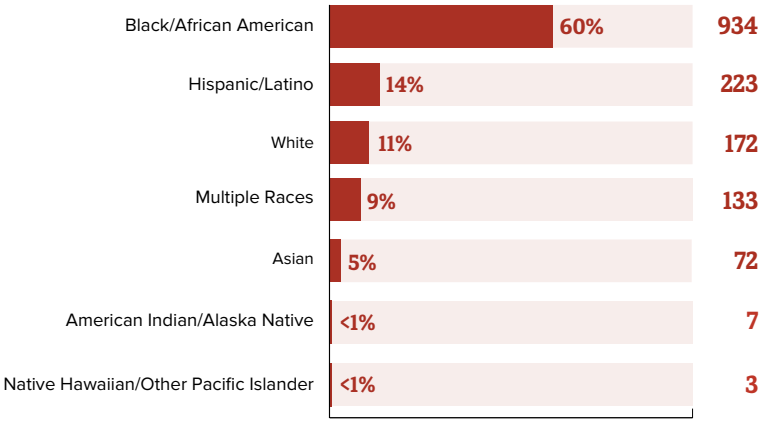
** In 2018, there were no cases of perinatal HIV among Native Hawaiians/Other Pacific Islanders and American Indians/Alaska Natives.

†† Hispanics/Latinos can be of any race.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention

Of the **1,042,270 people with diagnosed HIV** at the end of 2018, <1% (1,544) were among children with diagnosed perinatal HIV.

Most children with diagnosed perinatal HIV are Black/African American.



If you are pregnant or planning to get pregnant, **get tested for HIV** as soon as possible. If you have HIV, the sooner you start treatment the better—for your health and your baby's health and to prevent transmitting HIV to your sex partner. If you don't have HIV, but your partner does, ask your doctor about medicine to prevent getting HIV called pre-exposure prophylaxis (PrEP).

There are several challenges that place some babies at risk for HIV.

Unaware of HIV Status

Pregnant women with HIV may not know they have the virus. CDC recommends HIV testing for all women as part of routine prenatal care.

Unsure of the Care They Need

Women with HIV may not know they are pregnant, how to prevent or safely plan a pregnancy, or what they can do to reduce the risk of transmitting HIV to their baby.

Not Taking HIV Medicine as Prescribed

To get the full protective benefit of HIV medicine, the mother needs to take it as prescribed throughout pregnancy and childbirth and give HIV medicine to her baby after delivery.

Social and Economic Factors

Pregnant women with HIV may face more barriers to accessing medical care and staying on treatment.

How is CDC making a difference for pregnant women and their babies?

- Collecting and analyzing data and monitoring HIV trends.
- Supporting community organizations that increase access to HIV testing and care.
- Conducting prevention research and providing guidance to those working in HIV prevention.
- Promoting testing, prevention, and treatment through the *Let's Stop HIV Together* campaign.
- Supporting health departments and community-based organizations by funding HIV prevention work and providing technical assistance.
- Strengthening successful HIV prevention programs and supporting new efforts funded through the *Ending the HIV Epidemic* initiative.

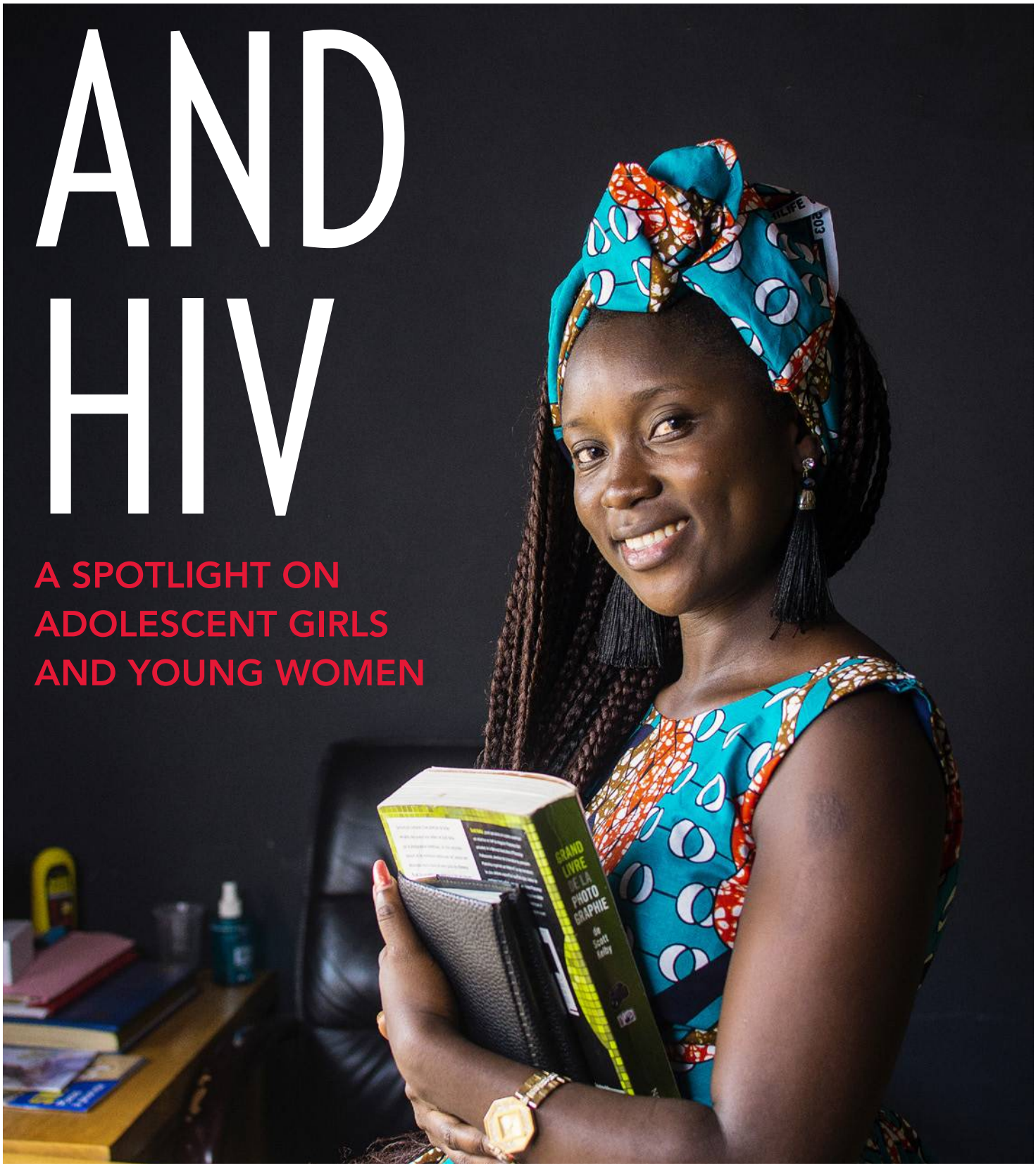
For more information about HIV surveillance data and how it is used, read the "Technical Notes" in the HIV surveillance reports at www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

For more information visit www.cdc.gov/hiv

All content is based on the most recent data available in August 2020.

WOMEN AND HIV

A SPOTLIGHT ON ADOLESCENT GIRLS AND YOUNG WOMEN



FOREWORD

IT IS TIME TO EMPOWER WOMEN AND GIRLS.

On International Women's Day, I am calling for the provision of HIV services and the protection of the rights of adolescent girls and young women to be stepped up.

Adolescent girls and young women are still disproportionally affected by HIV. In eastern and southern Africa in 2017, 79% of new HIV infections among 10–19-year-olds were among females. An estimated 50 adolescent girls die every day from AIDS-related illnesses. And each day, some 460 adolescent girls become infected with HIV.

Accountability is critical and we are far behind reaching the Fast-Track Targets for 2020 agreed by all countries in the 2016 United Nations Political Declaration on Ending AIDS.

Services for adolescent girls and young women are especially failing to reach those who are falling the furthest behind—adolescent girls and young women who experience gender-based violence, who are sexually exploited or who use drugs, among others.

Fuelled by gender inequalities, adolescent girls and young women face discrimination that compounds their vulnerabilities to HIV. They are largely invisible, underserved and underrepresented in policies, services and investments.

When girls can't uphold their human rights—especially their sexual and reproductive health and rights—efforts to get to zero exclusion, zero discrimination, zero violence and zero stigma are undermined.

It is time to break the vicious cycle of gender inequities, gender-based violence and HIV infection, once and for all. Oppression and power imbalances must be reversed and harmful masculinities must be consigned to the history books.

It is time to empower women and girls.

Let's start now.

MICHEL SIDIBÉ

UNAIDS EXECUTIVE DIRECTOR

COMMITMENTS FOR ADOLESCENTS

In the 2016 United Nations Political Declaration on Ending AIDS, countries made commitments for adolescent girls and young women. However, the world is currently off-track in reaching those commitments.

- **Commitment: reduce the number of new HIV infections among adolescent girls and young women from 390 000 in 2015 to below 100 000 in 2020.**
  - In 2017, there were 340 000 new HIV infections among adolescent girls and young women (15–24 years old), well short of the target for 2020.
  - Between 2010 and 2017, there was a 19% decline in new HIV infections among adolescent girls (10–19 years old) globally, and a 25% decline in eastern and southern Africa. In western and central Africa, the number of new HIV infections has remained stable since 2010.

- **Commitment: ensure that 90% of young people have the skills, knowledge and capacity to protect themselves against HIV.**
  - An alarming seven in 10 young women in sub-Saharan Africa do not have comprehensive knowledge about HIV.
  - Knowledge about HIV prevention among young people has remained stagnant over the past 20 years. Only one in three young people globally can demonstrate accurate knowledge about HIV prevention and transmission.[1] Comprehensive sexuality education programmes are often limited.
  - Only 36.4% of young men and 29.8% of young women in sub-Saharan Africa have basic knowledge about how to protect themselves from HIV.[2]
  - In western and central Africa, both knowledge about HIV and condom use are low among young people (aged 15–24 years), with fewer than one in three (30.7%) young men and one in four (23%) young women possessing comprehensive and correct knowledge about how to prevent HIV.

- **Commitment: 90% of young people in need have access to sexual and reproductive health services and combination HIV prevention options by 2020.**

While recent years have seen important progress, critical gaps remain:

- In the majority of countries with available data, adolescent girls (aged 15–19 years) have lower rates of satisfied demand for family planning than all women aged 15–49 years.
- In sub-Saharan Africa, more than 50% of rural young women (15–24 years of age) have been pregnant before their 18th birthday.[3]
- Two hundred million women and girls living in developing countries who want to avoid pregnancy are not using modern methods of contraception.[4]
- Globally, cervical cancer claims the lives of an estimated 300 000 women each year.[5] Nine out of 10 of those women live in low- and middle-

income countries. Cervical cancer is preventable with the human papillomavirus vaccine, which is most effective when administered in adolescence before initiation of sexual activity.[6]

- Women living with HIV face a fourfold to fivefold greater risk of invasive cervical cancer than women who are not living with HIV. Access to quality integrated sexual and reproductive health information, counselling and services that include prevention of HIV and for sexually transmitted infections and unwanted and early pregnancy are critical for the empowerment of adolescent girls and women and achieving gender equality.

ADOLESCENT GIRLS DISPROPORTIONATELY AFFECTED BY HIV

Gender discrimination and gender-based violence fuel the HIV epidemic. Gender norms in many cultures combined with taboos about sexuality have a huge impact on the ability of adolescent girls and young women to protect their health and prevent HIV, seek health services and make their own informed decisions about their sexual and reproductive health and lives.

The vulnerabilities of marginalized groups of adolescent girls and young women are compounded by multiple forms of discrimination.[a]

In various contexts, adolescent girls are also the unpaid care workers for younger siblings, the ill, the elderly or people living with HIV.

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[a] Discrimination can include discrimination against people living in poverty, against people living with HIV, against people living with disabilities, against survivors of gender-based violence and of early or forced marriage, against people who are sexually exploited, against people who use drugs and against migrants, domestic workers and young widows. Discrimination can also be based on sexual orientation.

Photo: UNICEF/Giacomo Pirozzi

In 2017:

- One million adolescent girls were living with HIV.
- HIV was the leading cause of death for women (aged 15–49 years) worldwide.
- Globally, HIV was among the top 10 causes of death among adolescents (aged 10–19 years). HIV was also among the top five causes of death for younger adolescent girls aged 10–14 years. Every day, 50 adolescent girls died from AIDS-related illnesses and 460 adolescent girls became newly infected with HIV.
- More than 90% of deaths worldwide from AIDS-related illness among adolescents occurred in sub-Saharan Africa.
- Every week, 7000 adolescent girls and young women aged 15–24 years became newly infected with HIV.
- Three in every five new HIV infections among young people (aged 15–24 years) were among young women globally.
- In sub-Saharan Africa, adolescent girls and young women (aged 15–24 years) accounted for one in five new HIV infections, despite being just 10% of the population.
- In the hardest-hit countries, adolescent girls accounted for more than 80% of new HIV infections in their age group.

- For every three new HIV infections among young men (aged 15–24 years) in eastern and southern Africa, there were seven new infections among young women.
- In Malawi, Zambia and Zimbabwe, less than 50% of young people living with HIV were aware of their HIV status, compared to between 74% and 80% of adults aged 35–49 years living with HIV in the same countries.
- In western and central Africa, for every three new HIV infections among young men (aged 15–24 years), there were five new infections among young women.

GENDER-BASED VIOLENCE AND HIV

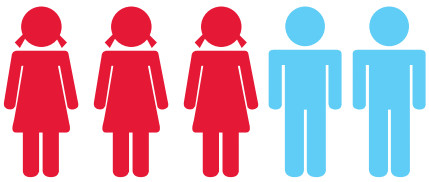
Violence against women and girls is both a consequence of and cause of HIV. Violence or the fear of violence can stop women and girls from negotiating safer sex, accessing HIV and sexual and reproductive health services and disclosing their HIV status to partners, family members and health providers.

Women and girls who are survivors of violence suffer a range of health consequences, including mental health issues such as depression and anxiety, higher use of alcohol, less control over sexual decision-making and poor sexual and reproductive health outcomes.

Studies show that women living with HIV who have experienced intimate partner violence were significantly less likely to start or adhere to antiretroviral therapy and had worse clinical outcomes than other women living with HIV. Women and girls who experience violence are also less likely to adhere to both pre-exposure and post-exposure prophylaxis.

- In some regions, women and girls who have suffered intimate partner violence are 1.5 times more likely to acquire HIV than women who have not suffered such violence.
- More than one in three women and girls worldwide have experienced physical and/or sexual violence, often at the hands of their intimate partners.
- A global review found women who have experienced violence are 16% more likely to have a baby with a low birth weight and almost twice as likely to experience depression.

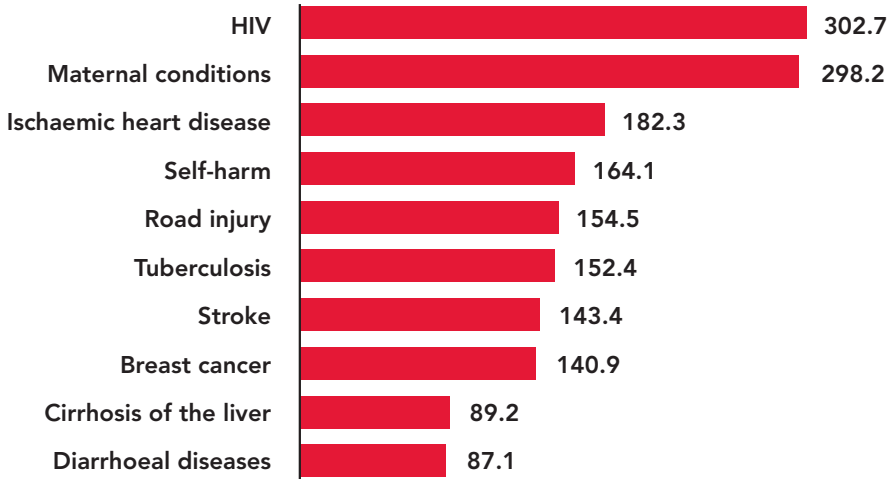
AT A GLANCE



In sub-Saharan Africa, three in five new HIV infections among 15–19-year-olds are among girls.

Source: UNAIDS 2018 estimates.

AIDS-related illnesses are the leading cause of death among 15–49-year-old females globally (hundred thousands)



Source: Global health estimates 2016: deaths by cause, age, sex, by country and by region, 2000–2016. Geneva, World Health Organization; 2018.

10X

HIV INCIDENCE IS 10 TIMES HIGHER AMONG FEMALE SEX WORKERS THAN AMONG THE GENERAL POPULATION

Source: UNAIDS, 2018.

52%

of adolescent girls and young women in rural areas are unable to make decisions about their own health, compared with

47%

in urban areas.

Source: Population-based surveys, 2011–2016. The statistics are based on available data from 28 countries in which 83% of all women aged 15–24 years in sub-Saharan Africa live.

IN SUB-SAHARAN AFRICA, 42% OF WOMEN LIVING IN URBAN AREAS AGED 15–24 HAD A PREGNANCY BEFORE THE AGE OF 18.

IN RURAL AREAS, MORE THAN 50% OF WOMEN AGED 15–24 HAD A PREGNANCY BEFORE THE AGE OF 18.

Source: Population-based surveys, 2011–2016.The statistics are based on available data from 27 countries in which 80% of all women aged 15–24 years in sub-Saharan Africa live.

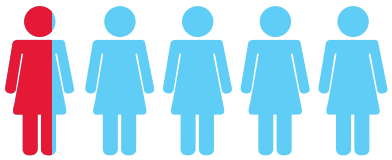
7 out of **10 women** in conflict setting and in refugee populations are exposed to gender-based and sexual violence.

Source: www.unwomen.org/en/what-we-do/humanitarian-action/facts-and-figures.

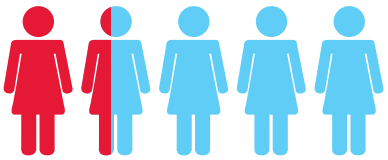
Women who have experienced violence are **50%** more likely to be living with HIV.

Women who have been physically or sexually abused by their partners report higher rates of mental health issues, including depression and anxiety, higher use of alcohol and less control over sexual decision-making.

Source: Jewkes, R. et al (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet 376(9734):41-48.



16% of **rural** currently married adolescent girls and young women who live in sub-Saharan Africa report using a modern contraceptive.



23% of **urban** currently married adolescent girls and young women who live in sub-Saharan Africa report using a modern contraceptive.

Source: Population-based surveys, 2011–2016. The statistics are based on available data from 28 countries in which 83% of all women aged 15–24 years in sub-Saharan Africa live.

Of every five new HIV infections among young people (15–24 years), three are among young women.

Source: UNAIDS 2018 estimates.

Each year, 12 million girls are married before the age of 18—married too soon, endangering their personal development and well-being.

Source: United Nations Children's Fund 2018 estimates.

AROUND

100

adolescents (10–19 years) died of AIDS-related illnesses every day in 2017.

Source: UNAIDS 2018 estimates.

KEY POPULATIONS: TARGETS OF VIOLENCE

Adolescent girls are prime targets of gender-based violence, which includes incest, sexual abuse, intimate partner violence, early and forced marriage, marital rape, female genital mutilation, sexual exploitation and trafficking.

Women and adolescent girls belonging to especially marginalized groups face elevated risks of violence, discrimination and stigma, compounding the risks of HIV. While data and research specific to the experiences of adolescent girls and young women from those groups are lacking, and data are not systematically disaggregated by sex, age and other variables, the information available shows that pregnant women from key populations experience high rates of unintended pregnancies, sexual violence, abortion and unmet need for contraception.

Women who inject drugs have reported high rates of sexual violence from law enforcement officials. Some studies find that survivors of violence are more likely to inject drugs than women who had not experienced assault.

Lesbian, gay, bisexual, transgender and intersex (LGBTI) adolescents are more likely to experience bullying in schools than in their homes or communities, correlating with higher rates of depression, suicide and homelessness.

High rates of gender-based violence against adolescent girls and young women underscore the need to screen for sexual violence history and provide post-violence care as part of HIV prevention programmes. However, programmes for such services have not been scaled-up sufficiently to provide quality care and access. Community-based social programmes that include combined livelihood and training programmes have been shown to reduce intimate partner violence.

- In 16 of 36 countries with recent age-disaggregated data, adolescent girls aged 15–19 years reported a higher prevalence of intimate partner violence than women aged 15–49 years. [7]
- A study from Kenya showed that approximately one in five adolescent girls and young women (aged 15–24 years) had been sexually assaulted or abused by an intimate partner in the previous 12 months, and one in four had suffered sexual violence at the hands of a non-intimate partner. [8]
- Alarmingly, in 2017 only 41 countries that reported data to UNAIDS indicated they have specific legal provisions prohibiting violence against people living with HIV or people belonging to a key population.
- The proportion of LGBTI students experiencing school violence and bullying ranges from 16% to 85%. The prevalence of violence is between three and five times higher among LGBTI students than among their non-LGBTI peers.[9]
- Sex workers are at high risk of violence from intimate partners, clients and law enforcement officials. By one estimate, 45–75% of adult female sex workers are assaulted or abused at least once in their lifetimes.
- In a study in eight sub-Saharan African countries, 33% of the transgender women surveyed said they had been physically attacked at some point in their lives, 28% had been raped and 27% said they were too afraid to use health-care services.

- Seven out of 10 women in conflict settings and in refugee populations report being exposed to gender-based and sexual violence.[10]

RESTRICTIVE POLICIES AND LAWS

Restrictive laws and policies—including criminalization, age of consent laws and adult-oriented HIV services that are perceived as intimidating and of poor quality—discourage service uptake by adolescents. Adolescent girls are especially affected when approval by a parent, guardian or spouse is required before seeking basic health information and services. In many countries that have lowered the age of consent, guidance to health-care providers and awareness-raising among adolescents and parents is absent, resulting in the policy not being effectively implemented.

Many countries prohibit condom promotion and distribution in schools and other venues where adolescents socialize. The criminalization of consensual sex among adolescents, as well as of same-sex sexual relations and sexual relations outside of marriage, further compounds the stigma and health risks that adolescents face. In some settings, health-care providers are obliged by law to report underage sex or activities such as drug use among adolescents.

- Forty-five countries have laws that impose the need for parental consent for adolescents and young people below 18 years to access HIV testing.
- An additional 50 countries have such laws for adolescents younger than 14 years and 16 years.
- Seventy-eight countries require parental consent for adolescents to access sexual and reproductive health services.[11]
- Only 50 countries have no laws requiring parental consent for adolescents to access HIV treatment.
- Of the 100 countries that reported to UNAIDS having a national plan or strategy related to condoms in 2017, only 26 reported that the plan included condom promotion in secondary schools.
- At least 67 countries criminalized same-sex sexual relations in 2019.[12]
- Ninety-eight countries have criminalizing laws or other punitive regulation of sex work.[13]

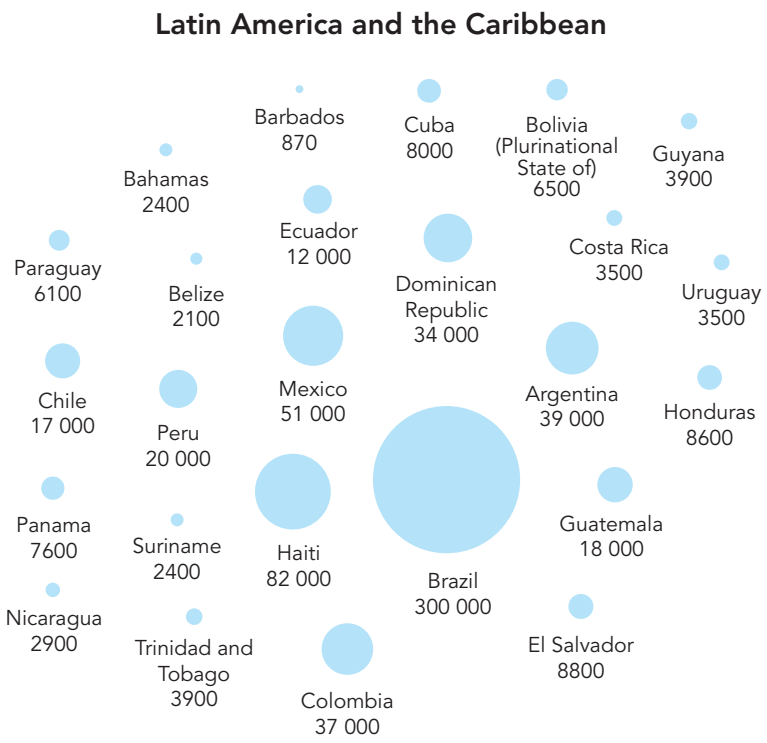
STIGMA AND DISCRIMINATION–MILES TO GO

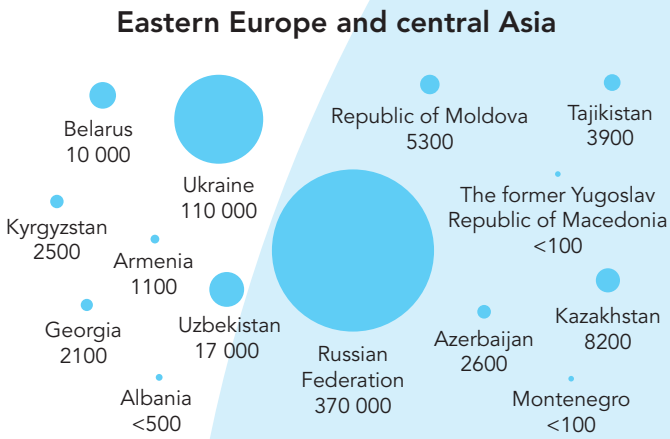
Punitive legal frameworks undermine HIV prevention efforts among adolescent girls and young women at higher risk.

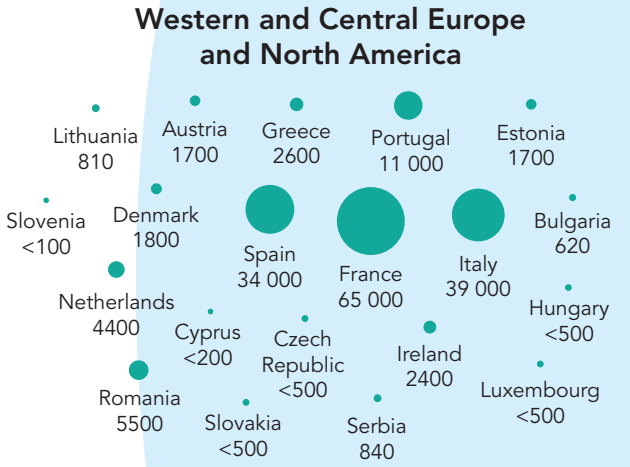
One study based on modelling estimates from Canada, India and Kenya has projected that the decriminalization of sex work could avert 33–46% of new HIV infections over a decade. Eliminating violence by clients, law enforcement officials and strangers could avert 17–20% of new HIV infections among female sex workers and their clients within the next decade.

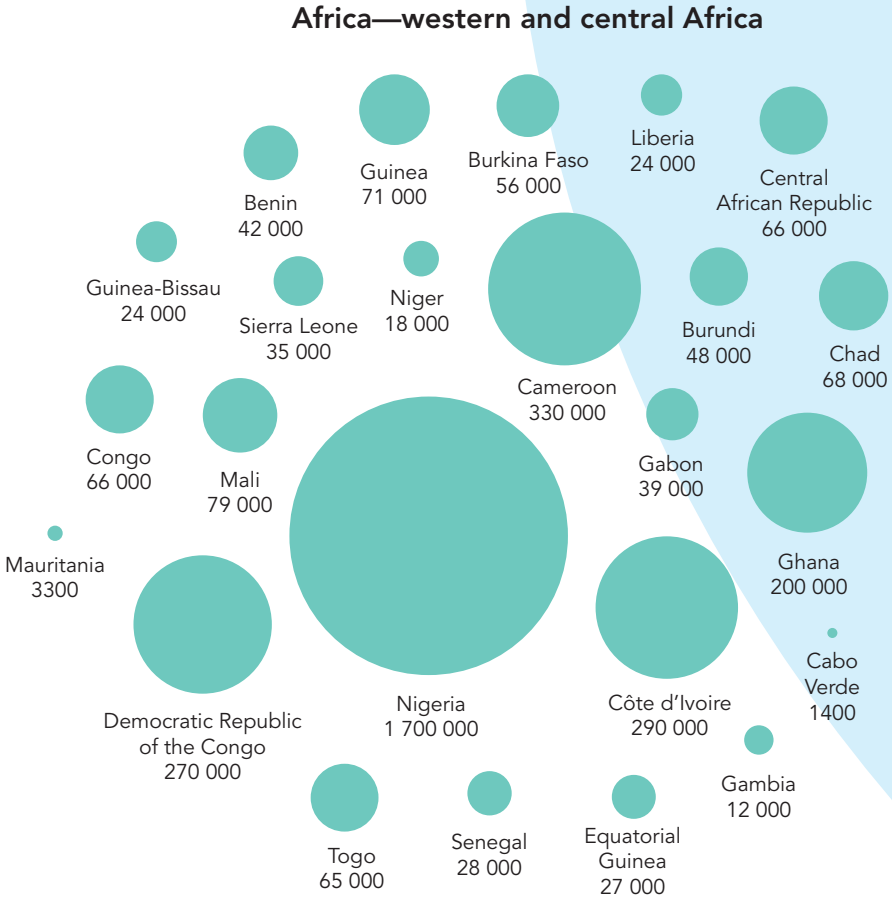
19.1 MILLION GIRLS AND WOMEN LIVING WITH HIV

Girls and women make up more than half of the 36.9 million people living with HIV. Ending AIDS by 2030 requires that we address girls' and women's diverse roles by putting them at the centre of the response.

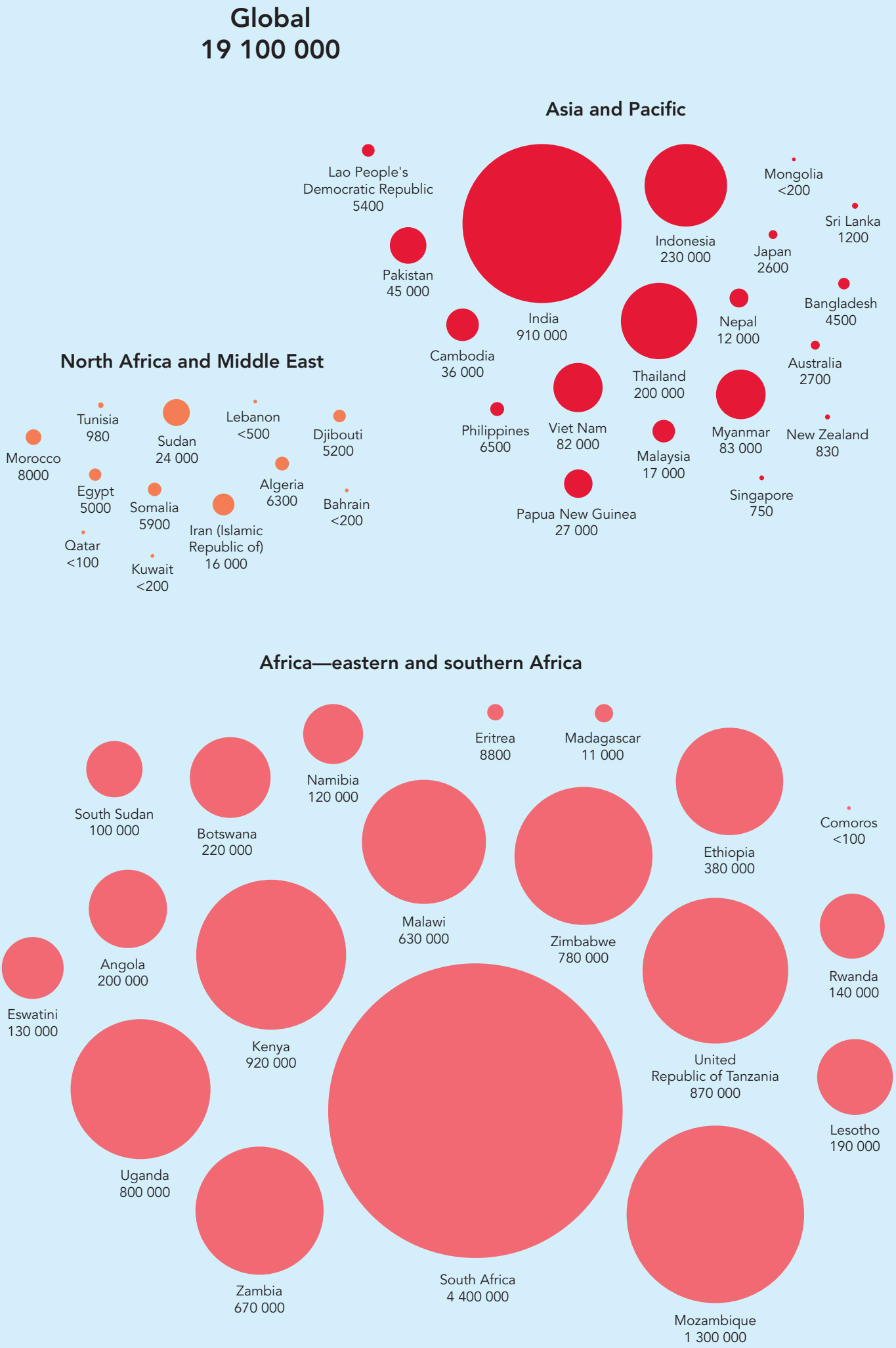








No data available for those countries not listed.
Source: UNAIDS 2018 estimates.


Global
19 100 000
Asia and Pacific
Lao People's Democratic Republic 5400
Pakistan 45 000
India 910 000
Indonesia 230 000
Mongolia <200
Sri Lanka 1200
Japan 2600
Bangladesh 4500
Nepal 12 000
Cambodia 36 000
Thailand 200 000
Australia 2700
Philippines 6500
Viet Nam 82 000
Malaysia 17 000
Myanmar 83 000
New Zealand 830
Singapore 750
Papua New Guinea 27 000
North Africa and Middle East
Tunisia 980
Morocco 8000
Sudan 24 000
Lebanon <500
Djibouti 5200
Egypt 5000
Somalia 5900
Algeria 6300
Bahrain <200
Qatar <100
Iran (Islamic Republic of) 16 000
Kuwait <200
Africa—eastern and southern Africa
South Sudan 100 000
Botswana 220 000
Namibia 120 000
Eritrea 8800
Madagascar 11 000
Ethiopia 380 000
Comoros <100
Malawi 630 000
Zimbabwe 780 000
Angola 200 000
Eswatini 130 000
Kenya 920 000
Rwanda 140 000
United Republic of Tanzania 870 000
Uganda 800 000
Lesotho 190 000
Zambia 670 000
South Africa 4 400 000
Mozambique 1 300 000

Surveys of people living with HIV indicate that stigma and discrimination at the hands of health-care providers—including denial of care, poor-quality care, breach of confidentiality or coercion into accepting certain services—is a distressingly regular experience for people living with HIV and key populations at higher risk of HIV infection.

Stigma and discrimination particularly affects women and adolescent girls living with HIV. Anticipated or actual mistreatment and abuse from health-care workers prevent them from linking to and staying engaged in HIV care services. Women living with HIV have also reported being subjected to involuntary sterilization or forced abortions.

Across 19 countries with available data:

- One in five people living with HIV reported having been denied health care owing to their HIV status.
- One in four people living with HIV reported experiencing some form of discrimination when using health-care services.
- One in three women living with HIV reported discrimination related to their sexual and reproductive health.

ACCESS TO SERVICES FOR YOUNG WOMEN, ESPECIALLY YOUNG PREGNANT WOMEN LIVING WITH HIV

Tailored strategies are needed to support adolescent girls and young women, including young pregnant women living with HIV.

Ensuring access to HIV prevention services is critical. Because adolescent girls and young women often have a perceived low risk, uptake of pre-exposure prophylaxis and condoms is limited. Education plays a critical role. Uneducated girls are twice as likely to acquire HIV than those who have some schooling.

Better integration of HIV services with sexual and reproductive health services and antenatal care is also needed. Once enrolled in HIV-related care, young people aged 15–19 years are more likely than adults to drop out. Young women face major challenges with adherence to lifelong antiretroviral therapy, including difficulties disclosing their HIV status to partners and families.

Pregnant adolescent girls and young women in particular are less likely than older pregnant women to know their HIV status before starting antenatal care. Adhering to HIV treatment can be especially difficult for pregnant teenagers and girls subjected to violence, among other groups of adolescent girls living in vulnerable situations. Stigma and discrimination, especially surrounding adolescent girls' sexuality, alongside HIV disclosure issues and travel and waiting times at clinics, are among the reasons for low adherence.

WHAT WOMEN WANT

ISSUES AND OPPORTUNITIES THROUGH THE LIFE CYCLE

0–14

230 children are born with HIV every day

Another 260 children are infected through breastfeeding every day

MATERNAL AND NEWBORN HEALTH

98% of new HIV infections among children are preventable

Providing information on gender and power results in lower rates of sexually transmitted infections and unintended pregnancies

Studies in sub-Saharan Africa show that girls who don't finish high school are twice as likely to be infected with HIV

EDUCATION

In sub-Saharan Africa, seven in 10 young women do not have comprehensive knowledge about HIV

In the least developed countries in the world, six out of 10 girls do not attend secondary school

Women with more education tend to marry later, bear children later and exercise greater control over their fertility

CHILD MARRIAGE

12 million girls below the age of 18 years marry every year

20–29

Young people require the consent of parents or legal guardians to access sexual and reproductive health services in at least 78 countries

POLICY AND LEGAL BARRIERS

Lowering the age of consent in South Africa increased knowledge of HIV status among young women

30–49

Empowering community health workers can increase access to antiretroviral therapy

HEALTH SERVICES

High mortality due to AIDS among women

50+

BURDEN OF CARE

Weak health systems and unequal distribution of caregiving responsibilities present a unique challenge for older women living with HIV

Women living with HIV who are taking antiretroviral therapy can have life expectancies comparable to people who have not acquired HIV

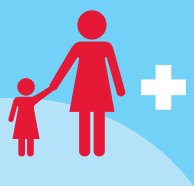
Biological changes can put sexually active older women at higher risk of acquiring HIV

RISK

Many children are diagnosed late with HIV, leading to high infant mortality

Globally, cervical cancer claims the lives of 300 000 women each year

Women living with HIV are five times more likely to develop cervical cancer



INTEGRATED HEALTH SERVICES

The number of children aged 0–14 years on antiretroviral therapy globally has increased by 71% in the past 10 years

HPV vaccine given to girls between nine and 13, before they become sexually active, prevents cervical cancer

HPV vaccine costs as little as US$ 8

15–19

Providing integrated HIV and sexual and reproductive health services prevents HIV infection, prevents unwanted pregnancies and helps ensure safer deliveries

HEALTH SERVICES

9 million girls aged 15–19 years experienced forced sex this year

Post-exposure prophylaxis can prevent HIV infection

Zero tolerance for violence against children

VIOLENCE AGAINST CHILDREN

Violence can increase survivors' risk of HIV and other sexually transmitted infections

At least 17 million women report having experienced forced sex in childhood

Globally, only 48.5% of women participate in the labour force

Women still earn 20% on average less than men for the same work

Female sex workers are 10 times more likely to acquire HIV than other women

EMPLOYMENT

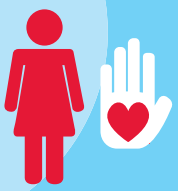
A cash transfer programme in Malawi reduced the school dropout rate of girls by 35% and saw a 40% reduction in early marriages, a 30% reduction in teenage pregnancies and a 64% reduction in HIV risk

HIV SERVICES

Provision of a comprehensive package of community-based prevention and treatment services for female sex workers resulted in zero new HIV infections in a cohort in Burkina Faso

Regular screening and treatment for precancerous cervical lesions could prevent 300 000 women from dying each year

Community-based programmes like SASA! in Kampala, Uganda, which combined community mobilization on HIV and intimate partner violence prevention, helped change norms around intimate partner violence



HEALTH SERVICES

AIDS is still the main cause of death among women of reproductive age globally

PROTECTION FROM INTIMATE PARTNER VIOLENCE

In high HIV prevalence settings women experiencing intimate partner violence are 50% more likely to have acquired HIV than women who have not experienced violence

One in three woman experience intimate partner violence globally

In 29 countries women require the consent of a spouse/ partner to access sexual and reproductive health services

Girls and women are at the centre of the AIDS response. Factors including age, ethnicity, gender inequities, disability, sexual orientation, profession and socioeconomic status compound to influence girls' and women's ability to protect themselves from HIV. Programming efforts must recognize the complexity of the everyday lives of girls and women as they mature and grow and build the response around their needs. Placing the individual—not the virus—at the centre of all our efforts creates the space for inclusion of the diverse opportunities and needs of girls and women and improves HIV outcomes.

Pregnant adolescent girls and young women living with HIV are much less likely than their older peers to start antiretroviral therapy. They, and their children, have poorer health outcomes.

Women living with HIV should have access to the best quality HIV treatment and be provided with the opportunity to make fully informed choices about the treatment they take. They also should have access to comprehensive sexual and reproductive health services, including family planning.

Addressing stigma and discrimination, particularly in the health-care sector, is an important factor. Studies from the Eastern Cape in South Africa have shown that addressing stigma and discrimination and providing greater support—including accompanied clinic visits, money for transportation and basic kindness and concern—greatly increases treatment adherence among adolescents aged 10–19 years.

TAILORED STRATEGIES NEEDED

In all countries—whether they are high-income, middle-income or low-income—a common pattern has emerged. Gains on HIV, health and development have overlooked the people in the greatest need: adolescent girls and young women among them.

A life-cycle approach is needed for addressing HIV among women and girls at every stage in their life. The Sustainable Development Goals with their targets of reaching universal health coverage and ending AIDS offer a unique opportunity to provide better integrated services and develop people-centred and human rights-based strategies with people at the centre.

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