until it's over AIDS ACTION POLICY FACTS

january 2002

Women and HIV/AIDS

The number of women living with HIV/AIDS in the United States has increased significantly since the beginning of the epidemic. At the end of 2000, adult and adolescent women accounted for 17 percent, or 134,441, of the cumulative AIDS cases in the United States. There were 10,568 new AIDS cases diagnosed among women in 2000, and a total of 67,993 women living with AIDS. At the end of 2000, 66,448 women had died from AIDS in the U.S. Thirty-nine percent of AIDS cases among adolescent and adult women are the result of unprotected heterosexual sex. An additional 39 percent of AIDS cases among women are attributed to injection drug use.

Women of color account for the majority of new AIDS cases. African American women and Latinas comprise less than 31 percent of the U.S. female population, yet they represent more than 77 percent of AIDS cases in women. A comparison of the 2000 AIDS case rates demonstrates this point. The AIDS case rate for African American women was 45.9 women living with AIDS per 100,000 population and 13.8 for Latinas living with AIDS per 100,000 population. In contrast, 2.2 white women are living with AIDS per 100,000 population. As of December 2000, HIV was the third leading cause of death for all women ages 25-44, and the first leading cause of death for African American women.

HIV Prevention and Women

Although several methods of birth control exist that are largely female-controlled, there is no method of sexually transmitted disease (STD) prevention that is entirely female-controlled. Condoms are the most frequently used HIV prevention tool and are male-controlled. The female condom is a step in the right direction, but still requires the approval and acceptance of male partners due to its obvious visibility. There is no effective, truly female-controlled method of HIV prevention that gives women the power to protect themselves and their partners. Scientists are currently developing microbicides that women (and men who have sex with men) could use before sexual activity to protect themselves against HIV and other STDs. These prevention methods may even allow women to conceive a child, if desired, while practicing safer sex.

Risk Factors

Women are more than twice as likely as men to contract HIV through unprotected heterosexual sex. HIV is transmitted eight times more efficiently from men to women than from women to men. Biologically, women have a much larger area of skin and tissue that is exposed to their partner's secretions during sex than men. Additionally, HIV-infected semen has a higher concentration of the virus than vaginal secretions.

Women are at-risk for HIV transmission in part because they may not be aware of the high-risk behaviors of their partners. Women who believe that they are engaged in a monogamous relationship may be at-risk if their male partner is engaging in high-risk sexual activity with other men and/or women. Additionally, between half and four-fifths of STDs go unrecognized by women for two main reasons: there are no immediate symptoms of the STD and many women do not suspect that they are at-risk because they perceive themselves to be in a monogamous relationship. Similarly, a woman's partner may engage in unsafe injection drug use. If a woman is unaware or misled about the sexual or injection drug use behaviors of her partner, she may not feel the need to require her partner to use condoms and engage in safer sexual practices.

Consequently, long-term relationships and marriages can nonetheless provide a risk of HIV infection among women.

For a woman to protect herself from HIV infection, she must not only commit to regular condom use herself but also convince her partner to engage in the same behavior. Encouraging her male partner to use a condom may be perceived as implicitly questioning his commitment to the relationship, or threaten his fidelity. Women may have less power in relationships to insist on regular condom use, and asking a male partner to wear a condom may involve fear of rejection or other reprisals, including violence.

Physical and sexual abuse is disproportionately high among women at-risk for HIV infection. One study found that 42 percent of women at-risk for HIV reported that they had been sexually abused as a child, and a similar percent of the women also said that they had been physically abused. Violence and abuse can contribute to a heightened risk of HIV infection among women as the lingering effects of abuse can result in alcohol and drug abuse as well as other behaviors that may place women at-risk for HIV infection. This risk extends beyond women simply at-risk for HIV. In a study of 4,500 people living with HIV/AIDS, women were one-third more likely than men to die from non-HIV-related causes. Scientists attributed this result to several factors including domestic violence.

In some instances, women sell their bodies in order to obtain the basic necessities of life. This is known as "survival sex" and can contribute to higher rates of HIV among women. Immediate needs for food and shelter can take priority over HIV prevention practices, particularly when women receive higher compensation if they do not insist on condoms during sex. Women may not have the option to practice safer sex: in some instances, clients will use violence to demand unsafe sex. Substance users may turn to survival sex to obtain drugs or money to buy drugs. In one study, 68 percent of female crack cocaine users had practiced survival sex in exchange for drugs or money, and 30 percent of those women had not practiced safer sex in the past month. Female injection drug users who engage in survival sex are more likely to share needles, and/or use old or dirty needles.

HIV Works Differently in Men and Women

HIV affects men and women differently. In the beginning stages, HIV infection in women is less severe then men; however, over time, women's symptoms may be more severe than men's. Women typically have lower initial concentrations of HIV in their blood compared to men yet progress to AIDS at the same rate as men. While women appear to benefit from antiretroviral therapy as much as men, they have more frequent and more significant side effects from the drugs. This may be due to an interaction between antiretroviral therapy and female hormones or it may be the result of women's smaller physical size, which is not taken into account in prescribed antiretroviral drug regimens.

Many women are diagnosed with HIV at a later disease stage than men. Twenty-five percent of women postpone medical care due to several barriers, including limited access to health care services due to insurance status, other responsibilities as primary caregivers, and the stigma associated with HIV. Additionally, the health care system does not always provide equitable care and treatment for women as compared to men. A government audit found that women are less likely than men to be given the standard HIV treatment of combination antiretroviral therapy (49 percent of HIV-positive women compared to 61 percent of HIV-positive men were prescribed antiretroviral therapy).

Conclusion

The physical, social and economic conditions that women experience impact the success of HIV prevention and care programs. Women's HIV prevention and care programs need to go beyond than the fact that a woman is living with HIV/AIDS or is at-risk for HIV infection. These programs should address the various factors that place women at-risk for HIV infection, such as a lack of basic life needs that lead to survival sex or non-monogamous partners of women in long-term relationships. Additionally, women need contraceptive and HIV prevention methods that are female-controlled — with or without the knowledge of their sexual

partners. The development of microbicides or similar methods can alleviate this problem; however, more efforts are also needed to address the multi-faceted issues in HIV prevention and care for women.