

## Women and girls, HIV and AIDS



### KEY POINTS

- Women account for more than half the number of people living with HIV worldwide. Young women (10-24 years old) are twice as likely to acquire HIV as young men the same age.
- HIV disproportionately affects women and adolescent girls because of vulnerabilities created by unequal cultural, social and economic status.
- Unaccommodating attitudes towards sex outside of marriage and the restricted social autonomy of women and young girls can reduce their ability to access sexual health and HIV services.
- Much has been done to reduce mother-to-child transmission of HIV, but much more needs to be done to reduce the gender inequality and violence that women and girls at risk of HIV often face.

Explore this page to find out more about [why women and girls are at risk of HIV](#), [HIV testing and counselling](#), [treatment for women and girls living with HIV](#), [reducing mother to child transmission](#), [HIV prevention programmes](#) and [the way forward](#).

Since the start of the global HIV epidemic, women in many regions have been disproportionately affected by HIV. Today, women constitute more than half of all people living with HIV<sup>1</sup> and AIDS-related illnesses remain the leading cause of death for women aged between 15 and 49.<sup>2</sup>

Young women (aged 15-24), and adolescent girls (aged 10-19) in particular, account for a disproportionate number of new HIV infections. In 2017, 7,000 adolescent girls and young women became HIV-positive. This is a far higher rate than new infections among young men, with young

women twice as likely to acquire HIV as their male peers.<sup>3</sup>

In sub-Saharan Africa, despite making up just 10% of the population, one out of every five new HIV infections happens among adolescent girls and young women. In the worse-affected countries, 80% of new HIV infections among adolescents are among girls, who are up to eight times more likely to be living with HIV than adolescent boys.<sup>4 5</sup> It is estimated that around 50 adolescent girls die every day from AIDS-related illnesses.<sup>6</sup>

In [East and Southern Africa](#) young women will acquire HIV five to seven years earlier than their male peers.<sup>7</sup> In the region, seven young women become newly infected with HIV for every three young men. In western and central Africa, five young women become HIV-positive for every three new infections among young men.<sup>8</sup>

Even in regions such as Eastern Europe and Central Asia, where historically HIV has been driven by unsafe injecting drug use and men have been disproportionately affected, women account for a rising proportion of people living with HIV. In Russia, for example, despite the overall adult population of people living with HIV being predominately male (630,000 adult men living with HIV, compared to 370,000 adult women), more young women are living with HIV than young men (22,000 young women, compared to 19,000 young men).<sup>9</sup>

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This epidemic unfortunately remains an epidemic of women.

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- *Michel Sidibé, former executive director of UNAIDS* <sup>10</sup>

## Why are women and girls particularly at risk of HIV?

HIV disproportionately affects women and girls because of their unequal cultural, social and economic status in society.<sup>11 12</sup>

Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal power dynamics between men and women, with young women particularly disadvantaged. HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact.<sup>13</sup>

### Lack of access to healthcare services

In some countries, women face significant barriers to accessing healthcare services. These barriers occur at the individual, interpersonal, community and societal levels.<sup>14</sup> Barriers take many forms including denial of access to services that only women require, discrimination from service providers that stems from views around female sexuality and poor quality services.

Procedures relating to a women's sexual and reproductive health (SRH), performed without consent, including forced sterilisation, forced virginity examinations and forced abortion also deter women from accessing services.<sup>15 16</sup> In some cases, healthcare providers do not fully understand laws around childbirth and HIV. This can lead to HIV-positive women choosing to have an abortion because they are misinformed about their options and how to protect their health, as well as their child's.<sup>17</sup>

Additionally, in 29 countries women require the consent of a spouse or partner to access SRH services.<sup>18</sup>

A lack of access to comprehensive HIV and SRH services means that women are less able to look after their sexual and reproductive health and rights (SRHR) and reduce their risk of HIV infection.

A review of evidence from Latin America and Caribbean relating to HIV-positive women's use of, and access to, SRH services found women living with HIV experienced more unplanned pregnancies, more induced abortions, a higher risk of immediate sterilisation after birth and higher exposure to sexual and institutional violence, compared to HIV-negative women.<sup>19</sup>

## Young women's lack of access to healthcare

In many settings, where SRH and HIV services exist, they are primarily for married women with children and do not meet the specific needs of unmarried young women and adolescent girls. Healthcare providers often lack the training and skills to deliver youth-friendly services and do not fully understand laws around the age of consent.<sup>20</sup>

In 45 countries, organisations cannot legally provide SRH and HIV services to people under 18 without parental consent.<sup>21</sup> In some countries, doing this is an offence linked to encouraging 'prostitution' or the trafficking of minors.<sup>22</sup> Some national laws also require healthcare providers to report underage sex or activities such as drug use among adolescents.<sup>23</sup>

Closely related to this is the finding, taken from evidence gathered in 28 sub-Saharan Africa countries, that 52% of adolescent girls and young women in rural areas and 47% in urban areas are unable to make decisions about their own health.<sup>24</sup>

As a result of age restrictions, in Kenya, Rwanda and Senegal, over 70% of unmarried sexually active girls aged 15 to 19 have not had their contraception needs met.<sup>25</sup> This is despite the fact that in sub-Saharan Africa around half of young women living in rural areas and around 40% of young women living in urban areas will have been pregnant by the time they reach 18.<sup>26</sup>

A study of young women in Soweto, South Africa, found they knew where to obtain SRH information and services but that common experiences of providers' unsupportive attitudes, power dynamics in relationships, and communication issues with parents and community members prevented respondents from accessing and using the information and services they needed.<sup>27</sup>

A study of SRH services in Indonesia found that, in large part, sexual activity outside of marriage, often referred to as 'free sex', was viewed as unacceptable by both service providers and young people themselves, due to dominant cultural and religious norms. As a result, service providers were often reluctant to provide SRH services to unmarried but sexually active young people, and unmarried young people were too ashamed or afraid to ask for help.<sup>28</sup>

Research into attitudes towards sexual and reproductive health among adolescent girls in Ghana found varying degrees of negative social and community norms, attitudes and beliefs about adolescent girls' sexuality. The study found that adolescent girls tended to endorse these stigmatising attitudes, and also observed or experienced SRH-related stigma regularly.<sup>29</sup>

Adolescent girls and young women belonging to groups most affected by HIV (sometimes known as 'key populations') are also negatively affected by laws that criminalise injecting drug use, sex work

and homosexuality.[30](#) [31](#)

Adolescent girls' and young women's vulnerability to human rights violations and HIV is further amplified by age.[32](#) Despite this, even where programmes for key populations exist, the presence of 'youth-friendly' services to address the specific needs of young people from these groups are normally lacking.[33](#) [34](#)

## Lack of access to education

Studies have shown that increasing educational achievement among women and girls is linked to better SRH outcomes, including delayed childbearing, safer births and safer abortions, lower rates of sexually transmitted infections (STIs) and unintended pregnancies.[35](#)

Women with more education tend to marry later, bear children later and exercise greater control over their fertility. [36](#), DeNeve, JW et al. (2015) '[Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment](#)', Lancet Glob Health, Volume 3, No.8, p.e470–e477 It has also been shown to be linked to reduced risk of partner violence, another factor that makes women and girls vulnerable to HIV.[37](#) Despite this, in the least developed countries in the world, 60% of girls do not attend secondary school.[38](#)

Research has shown a direct correlation between girls' educational attainment and HIV risk: uneducated girls are twice as likely to acquire HIV as those who have attended school.[39](#) In Botswana, UNAIDS reports that every additional year of school a girl completes reduces her risk of acquiring HIV by 11.6%.[40](#)

However, many young people who are in school do not receive adequate education on HIV, sex and sexuality. Based on information from the 35 countries, only 30% of young women (and 36% of young men) knew how to prevent the sexual transmission of HIV and rejected major misconceptions about how HIV is passed on. Evidence gathered from 23 countries outside sub-Saharan Africa suggests knowledge among young people in the rest of the world is even lower, with 13.6% of young women (and 13.8% of young men) demonstrating correct and comprehensive HIV knowledge.[41](#)

## Poverty

Poverty is an overarching factor that increases vulnerability to, and the impact of, HIV.

The poorest women may have little choice but to adopt behaviours that put them at risk of infection, including transactional and intergenerational sex, early marriage, and relationships that expose them to violence and abuse. Poorer and less-educated women may be less knowledgeable about risks and therefore less able to adopt HIV risk-reducing behaviours.[42](#)

The risk of trafficking and sexual exploitation is also higher for young women and adolescent girls, especially those living in poverty.[43](#) [44](#)

Food insecurity, often linked to poverty, acts as a barrier to treatment for women living with HIV. This increases both the risk of HIV advancing within the body, leading to ill health, and onward transmission.[45](#)

## Gender-based violence and intimate partner violence

At some point in their lifetime, one in three women will experience physical or sexual violence from a partner, or sexual violence from a non-partner. In conflict settings and among refugee populations, seven out of ten women will experience sexual violence and/or gender-based violence.<sup>46 47</sup> Violence prevents many women, particularly young women, from protecting themselves against HIV.<sup>48</sup> In some regions it has been estimated that women who experience intimate partner violence are as much as 1.5 times more likely to acquire HIV.<sup>49</sup>

In places with high HIV prevalence, women who experience intimate partner violence are 50% more likely to acquire HIV than women who do not. In part, this is because women who have been physically or sexually abused by their partners are more likely to experience mental health issues, are more likely to misuse alcohol, and less likely to have control over sexual decisionmaking, all of which increase HIV risk.<sup>50</sup>

Intimate partner violence has been identified as a key driver of HIV transmission in East and Southern Africa. Various studies have put the proportion of adolescent girls and/or young women who have experienced sexual violence or abuse to be around 30%. In Uganda, Tanzania, Zambia and Zimbabwe, around 25% in Kenya and around 50% in Namibia.<sup>51 52</sup>

Gender-based violence, a physical manifestation of gender inequality, has been shown to act as an important barrier to the uptake of HIV testing and counselling, to the disclosure of HIV-positive status, and to antiretroviral treatment (ART) uptake and adherence, including among pregnant women who are receiving ART as part of services to prevent mother-to-child transmission (PMTCT).<sup>53 54</sup>

Fear and experiences of violence can lead women to hide their HIV status, which in turn can cause them to miss appointments and fall out of HIV care. A lack of privacy was also cited as a reason for not adhering to treatment, with no safe space at home or work to take medications without others seeing.<sup>55</sup>

A study in the regions of Brazil with the highest rates of gender-based violence and highest prevalence of HIV (São Paulo in the South-eastern region and Porto Alegre in the Southern region) found women were at increasingly more likely to experience gender-based violence during their lifetime if they were HIV-positive.<sup>56</sup> Overall, in Brazil, 98% of women living with HIV reported a lifetime history of violence and 79% reported violence prior to an HIV diagnosis.<sup>57</sup>

## Sugar daddy culture and transactional sex

Age-disparate sexual relationships between young women and older men are common in many parts of the world, with particularly high levels in both east and southern Africa and west and central Africa. In many instances, these relationships are transactional in nature, in that they are non-commercial, non-marital sexual relationships motivated by the implicit assumption that sex will be exchanged for material support or other benefits. This assumption arises from harmful gendered expectations of intimate relationships; namely, that men are responsible for providing material resources and women are responsible for providing sexual and domestic services. Many of these relationships include shared emotional intimacy, with people referring to themselves as boyfriends, girlfriends or lovers.<sup>58</sup>

Research indicates that in sub-Saharan Africa, transactional sex is one of the key factors in women's heightened vulnerability to HIV and other STIs. Growing evidence suggests transactional relationships are likely to involve high-risk sex and low condom use.<sup>59</sup>

A longterm study of age-disparate sex and HIV risk for young women took place between 2002 and 2012 in South Africa. It is estimated that in South Africa a third of sexually active adolescent girls will experience a relationship with a man at least five years older. The study found a cycle of transmission, whereby high HIV prevalence in young women was driven by sex with older men (on average 8.7 years older) who themselves had female partners with HIV, many of whom had acquired HIV as young women.<sup>60</sup>

### Age-gaps and HIV risk

In the first study to demonstrate a link between the size of the age-gap in age-disparate relationships and HIV, researchers working in Zimbabwe found that when a young woman is in a relationship with a man who is older than herself, she is more at risk of acquiring HIV if the age-gap is 10 years or more.

Researchers found that older men had consistently higher HIV prevalence than younger men, thus exposing young women to an increased risk of HIV infection – particularly given the generally low levels of condom use which were also associated with this age difference.<sup>61</sup>

However, a study into age-disparate relationships between young women and older men in South Africa found HIV risk to be similar across all age gaps once the disparity reached five years and above.<sup>62</sup>

## Child marriage

Every year, around 12 million girls are married before the age of 18.<sup>63</sup>

Girls who marry as children are more likely to be beaten or threatened by their husbands than girls who marry later, and are more likely to describe their first sexual experience as forced. As minors, child brides are rarely able to assert their wishes, and are less likely than their peers to be aware of how to protect themselves from HIV and other STIs.<sup>64</sup> These factors all increase HIV risk.

## Biological factors

The risk of HIV acquisition during vaginal sex has been found to be higher for women than for men in most (but not all) biological-based studies.<sup>65</sup>

This high susceptibility can be explained by a number of factors including the ability of HIV to pass through the cells of the vaginal lining and the larger surface area of the vagina.<sup>66</sup>

A study published in 2018 has provided further insight into the specific biological conditions that increase HIV risk in women. Previously, it was thought that the presence of the lactobacillus bacteria was the biggest factor. This research provides evidence that microbial diversity is a key factor alongside the concentrations of key bacteria such as lactobacillus. Understanding the contribution of vaginal bacteria to HIV risk will be a key target of future research.<sup>67</sup>

Adolescent girls may be at further increased risk due to the existence of greater proportions of genital mucosa, which are present in an immature cervix. Adolescent girls are also susceptible to relatively high levels of genital inflammation, which may also increase the risk of HIV acquisition.<sup>68</sup> Due to the



lower uptake of ART among men, in most countries it is likely that fewer men than women are virally suppressed, which means men are more likely to pass the virus on to others. In settings where the main mode of transmission is heterosexual sex, this further increases women's risk of acquiring HIV.<sup>69</sup>

## HIV testing and counselling (HTC) for women and adolescent girls

A major gap in HIV service provision for women can be found in HIV testing and counselling (HTC), which is a vital gateway to treatment services.

A study conducted in Tanzania between 2003 and 2012 found that young women (aged 15 to 24) who were married were more likely to get tested than young women who were not. It also found antenatal care to be an important determinant for HIV testing. Women who had received antenatal care were more likely to get tested as compared with young women who had not given birth. Young women with primary and/or secondary education were also more likely than those without any formal education to test for HIV.<sup>70</sup>

## Treating women and adolescent girls living with HIV

### Antiretroviral treatment (ART) for women

Globally, adult women are more likely to be accessing antiretroviral treatment (ART) than men. In 2017, 65% of women living with HIV had access to treatment compared with just 53% of HIV-positive men<sup>71</sup> This means that, despite women being more affected by HIV globally, the AIDS-related death rate is around a third lower (27%) among women than among men, and has decreased by 33% since 2010, compared to a 15% reduction for men.<sup>72 73</sup>

Despite this, AIDS-related illness remains the leading cause of death among women of reproductive age.<sup>74</sup>

Coverage is higher among pregnant women attending clinics that provide prevention of mother-to-child transmission (PMTCT) services. In South Africa, for example, while ART coverage is only 53% for women over the age of 15, PMTCT coverage is over 95%. Similarly, in Uganda, ART coverage is 65% in women over the age of 15, yet PMTCT service coverage is over 95%.<sup>75</sup>

Clearly PMTCT services are proving effective. However, despite considerable progress, 20% of pregnant women living with HIV in 2017 did not access antiretroviral drugs (ARVs) for PMTCT and there is still not enough focus on reaching young women who are not pregnant.<sup>76</sup> For more information on PMTCT see our [children and HIV page](#).

A study of around 2,000 women living with HIV from Western Europe, Canada, Central and Eastern Europe, Latin America and China found 88.2% were currently taking ART. Barriers to accessing care that disproportionately affect women include transportation, lack of gender autonomy, stigma, economic constraints, lack of knowledge and gender roles.<sup>77</sup>

The same study found the most prevalent barrier to care experienced by women (in the study) was HIV-related stigma from within their own community. HIV/AIDS knowledge, lack of

supportive/understanding work environments, lack of employment opportunities, and personal financial resources were also key barriers to participants accessing care.<sup>78</sup>

## Barriers to adherence

Various factors can act as barriers to women adhering to ART, including a lack of accurate information about how to use ARVs. Misunderstandings about treatment have been linked to poor adherence and low retention in care, both of which increase the likelihood of drug resistance and treatment failure.<sup>79</sup>

Intimate partner violence, which is fuelled by gender inequality, can also affect adherence. For example, a study of African serodiscordant couples (when one person is HIV-positive and the other is not) found that women who had been exposed to intimate partner violence in the previous three months were 50% more likely not to adhere to pre-exposure prophylaxis (ARV medication taken by someone who is HIV-negative before exposure to HIV to lessen the likelihood of transmission, otherwise known as PrEP) than women who had not experienced it.<sup>80</sup>

A study based on the experiences of women living with HIV from 17 countries found different types of physical, mental and structural violence perpetrated by family, community members and healthcare professionals meant many were unable to either start or stay on treatment for a wide range of reasons. In addition, many women in the study had less access to resources than men, leading to practical difficulties in getting to clinics to receive treatment, or in affording the cost of associated services such as blood tests. Participants frequently cited being fired from their jobs or being refused work due to the HIV status as compounding their difficulties in affording the costs associated with accessing and staying on treatment.<sup>81</sup>

## Antiretroviral treatment (ART) for adolescent girls and young women

A lack of youth-friendly HIV treatment, support and care services prevents many adolescent girls and young women from accessing ART. Studies from Southern Africa have shown how loss to follow up a year after enrolling on ART is higher among young people compared to both adults and children.<sup>82 83</sup>

Young women face specific difficulties in adhering to treatment. Stigma and discrimination, especially surrounding adolescent girls' sexuality, means many struggle to test for HIV or disclose their status if positive, while issues relating to travel and waiting times at clinics also create barriers.<sup>84</sup>

## Reducing mother-to-child transmission

### Family planning

Family planning is one of the most important prevention of mother-to-child transmission (PMTCT) measures. Reducing the number of unintended pregnancies among women living with HIV would reduce the number of children born with HIV. Pregnant women living with HIV are also at greater risk of dying from pregnancy-related complications than women who are not living with HIV.

In 2015, WHO estimated that globally 4,700 maternal deaths were caused indirectly by AIDS-related illnesses.<sup>85</sup>

Various studies suggest that, despite improvements in coverage of family planning, women living with



HIV are more likely than other women to have experienced unintended pregnancy.[86](#) [87](#)

Despite this, programmes to help women living with HIV avoid unwanted pregnancies remain inadequate. The most recent population-based surveys show that, although some countries (notably Malawi, Eswatini and Zimbabwe) have made noticeable efforts to improve family planning services, 11 of the 21 countries identified as a priority by UNAIDS still do not meet the need for family planning for 20% or more of married women.[88](#). This creates a situation whereby more than 200 million women experience unmet contraceptive needs each year, leading to approximately 80 million unintended pregnancies.[89](#)

In a study linking HIV with family planning services in Mumbai, India, two hospitals were involved, one of which integrated HIV and family planning services, while the other offered standard HIV services. At each site, 150 HIV-positive women who did not intend to get pregnant in the next year and were eligible to use dual methods, were enrolled in the study.[90](#)

At the end of one year, 60% of women in the intervention group reached Family Planning Centres compared to 8% in the control group. In the intervention group, there was three times more acceptance of, and continued use of, dual protection methods along with increases in condom use and less unplanned pregnancies than in the control group.[91](#)

## Integrating healthcare

Integrating health services so that they cover maternal and child health as well as HIV and SRH services have been shown to produce better health outcomes for pregnant women.[92](#)

### The Integra Initiative

The Integra Initiative, implemented by the International Planned Parenthood Federation (IPPF), the Population Council, and the London School of Hygiene & Tropical Medicine, has generated important evidence on the feasibility, effectiveness, cost, and impact of different models for delivering integrated HIV/SRH services in settings with high and medium HIV prevalence in sub-Saharan Africa.[93](#)

Conducting studies in Kenya and Eswatini between 2008 and 2013, the project found that integrating HIV services into family planning and postnatal care services can improve the use of HTC.

The vast majority of women in the studies preferred fully integrated SRH//HIV services to save time and money. Yet many women living with HIV preferred SRH services, such as family planning, to be integrated into specialist HIV units as they trusted the providers at these facilities, enjoyed continuity of care from them, had reduced fear of stigma within specialist sites, and benefited from the opportunity to meet other clients living with HIV.

The study also found there was potential for integrated services to improve cost efficiencies at facilities but this often went unrealised.[94](#)

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Let's say today I am going for family planning and I am using vehicles... that is money. Tomorrow family planning, the following day for HIV, that way it becomes expensive.

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- *Woman living with HIV in Kenya*<sup>95</sup>

Evidence from various integrated SHRH/HIV programmes show the positive impact they can have on at-risk women and girls' ability to claim their right to sexual and reproductive health.<sup>96</sup>

For instance, IMPACT (improving parent and child outcomes) focuses on women from six high HIV prevalence African countries who face a heightened risk of ill health during pregnancy and childbirth, including women living with HIV. The programme pairs pregnant women with 'Mother Buddies', community peers who talk to them about contraception, HIV and wider SRHR issues. IMPACT has increased participants' access to family planning counselling by 34% and modern contraceptives by 11%. It has also increased the number of women attending antenatal care and giving birth in health facilities. The number of infant HIV infections has also reduced. For instance, in Malawi, the mother-to-child transmission rate has dropped from 14% to below 2%.<sup>97</sup>

## Increasing male involvement

Involving male partners in SRHR issues, including family planning, antenatal and PMTCT services, can improve health outcomes for women, infants and men.<sup>98</sup>

A study from Kenya recorded a 45% decrease in mother-to-child transmission (MTCT) rates and mortality among women whose partners attended antenatal clinics, and a 41% decrease in MTCT among women with partners who had tested for HIV.<sup>99</sup> Involving male partners also provides an opportunity to identify mixed status couples and facilitate access to treatment.<sup>100</sup>

As part of the Integra Initiative, studies were conducted in Kenya and Eswatini to assess the barriers to accessing SRH services for couples. It found that, among men who used health facilities for SRH services, only a few reported positive experiences. Many highlighted a lack of privacy and confidentiality as barriers, while some also reported unavailable staff, a lack of staff motivation and long waiting times as problematic. Having to take time off work was also a common barrier for working men.

The few men who described positive experiences with healthcare providers at facilities reported friendliness and lack of invasive questioning. Many men perceived questioning from staff as embarrassing, especially if the provider was a young female.<sup>101</sup>

The study also found that men strongly preferred traditional healers, particularly for sexually transmitted infections. This was due to the fact that many traditional healers are male, and they were perceived as offering greater privacy, were more easily accessible and did not carry out physical examinations. Traditional healers also offer flexible or delayed payment schemes, which incentivised men to consult healers when they needed.<sup>102</sup>

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## HIV prevention programmes for women and girls

Ensuring women and girls have access to HIV prevention services is critical. This is particularly important for adolescent girls and young women in high prevalence settings. Evidence suggests that adolescent girls and young women tend to perceive themselves as being at low risk of HIV and will be unaware of the need to protect themselves from HIV and other STIs through condom use or by taking PrEP (see our [PrEP page](#) for more about PrEP use among women and adolescent girls). Many in age-disparate or transactional relationships are unaware that their partner could be engaging in multiple sexual partnerships.<sup>103</sup>

### Addressing poverty and promoting economic empowerment

WHO promotes a number of approaches to help reduce women's vulnerability to HIV.<sup>104</sup>

Addressing poverty has been shown to reduce high-risk sexual behaviour, particularly among young women in low- and middle-income countries, and thereby prevent the sexual transmission of HIV.<sup>105</sup> fn]Pettifor, A et al. (2012) '[Can money prevent the spread of HIV? A review of cash payments for HIV prevention](#)', AIDS and Behaviour, Volume 16, Issue 7, p1729-1738.

#### HEAL in Uganda

In Uganda the Health Empowerment and Livelihoods (HEAL) programme combined HIV prevention training, testing and counselling with savings and business-enterprise coaching and lifeskills training, helping young women secure access to higher earnings and increasing overall levels of confidence and self-esteem.

HEAL has found that engaging local leaders, authorities and men makes women more likely to participate in savings groups and less likely to fear repercussions as a result of their involvement. This engagement helped the wider community to see the benefits of women's participation in savings groups for the family and the community.<sup>106</sup>

HEAL also arranged for a bank representative to go to villages and speak to the community directly about the project. In an evaluation, programme implementers Act4Africa found a 25% reduction in men and women reporting high-risk sexual behaviour compared with the project baseline.

By the end of the project, the vast majority (80%) of those testing HIV-positive were taking up healthcare referrals compared to only 48% at the start.[107](#)

## Cash transfers

For adolescent girls, several randomised control trials in Africa found school attendance and safer sexual health to be directly incentivised by a cash transfer scheme, which had a positive effect on HIV outcomes.[108](#) However, studies suggest that financial support augmented with social support from parents or teachers increases HIV-prevention benefits over cash alone.

A study in South Africa found a cash transfer support programme which included social support led to a reduction in multiple and concurrent partners, and other HIV-risk behaviours among both young women and men.[109](#)

## School-based interventions

In 2015, UNAIDS and the African Union included age appropriate comprehensive sexuality education (CSE) as one of five key recommendations to fast-track the HIV response and end the AIDS epidemic among young women and girls across Africa. In the same year, many countries in Asia and the Pacific, West Africa and Europe were revising their policies and approaches to scale up CSE.[110](#)

If girls are able to access CSE before becoming sexually active they are more likely to make informed decisions about their sexuality and approach relationships with more self-confidence. CSE is also known to increase adolescent girls' condom use, increase voluntary HIV testing among young women and reduce adolescent pregnancy, especially when linked with non-school-based youth-friendly SRH services, provided in a stigma-free environment.[111](#) [112](#)

CSE not only plays an important role in preventing negative SRH outcomes, but also offers a platform to discuss gender inequality and human rights and to promote respectful, non-violent relationships. An evidence review involving 64 studies from six continents found both male and female students that received sex education at school had significantly better HIV knowledge and were more likely to use condoms as a result. They were also more likely to delay the age of sexual debut than students who lacked such education.[113](#) [114](#)

## Addressing violence

Risk-reduction education and counselling includes specific messages about equitable decision-making with partners, and violence against women and its links to HIV. It also supports women to negotiate safer sex in unequal power relationships and provides referrals to support services.[115](#)

A number of successful interventions that address gender and intimate partner violence as part of wider empowerment programmes for women include SASA!, a community mobilisation programme developed by Raising Voices in Kampala, [Uganda](#); DREAMS in sub-Saharan Africa and SheConquers in

South Africa (see our [gender inequality](#) page for further information).

HIV testing and counselling, [PMTCT](#) and treatment services can provide opportunities for the issue of violence towards women to be addressed. Healthcare workers can be trained to recognise the signs of intimate partner violence, promote gender equality in the community, increase women's access to services and teach women about partner communication and negotiation skills.[116](#)

However, a systematic review of universal screening interventions where women were routinely asked by a healthcare professional if they have experienced intimate partner violence, showed that screening is not effective in either reducing violence or improving women's quality of life.[117](#)

As a result, WHO recommends identifying women based on signs and symptoms of intimate partner violence rather than universal screening.[118](#)

#### Utilising antenatal services to reduce intimate partner violence

Part of the [MenCare+](#) project, the Bandedereho ('role model') programme in Rwanda is using antenatal services to reach expectant fathers in order to reduce intimate partner violence. The programme invites men to attend weekly sessions on issues relating to gender and power, fatherhood and couple communication. Other local fathers lead the sessions, with nurses and police officers also contributing. Female partners are invited to join around half of the classes.

An assessment of the programme's impact found men who had gone to the classes were 50% less likely to be violent toward their partners, and were more likely to contribute to care work and household chores. Female partners reported greater involvement in decision-making, including around when to have children.[119](#)

## Laws addressing gender inequality and violence against women

Laws and policies that promote gender equality create an environment that increases the likelihood of success and sustainability of efforts to reduce violence against women and their vulnerability to HIV.[120](#) [121](#)

As of 2016, 74% of countries legislated against intimate partner violence against women. Around 72% had laws relating to physical violence, 56% had laws relating to sexual violence, 71% had laws relating to psychological control and 46% addressed economic control. However, 20% of countries did not recognise rape as a crime in cases where the perpetrator is married, or intends to marry, the victim.[122](#) For more information see our [gender inequality](#) page.

## The way forward

To better address the impact of HIV on women, particularly on young women and adolescent girls, approaches are needed that consciously adopt the perspectives of women in all their diversity.[123](#)

As recommended by WHO, programmes need to better integrate SRH and HIV services and adopt a woman-centred approach, underpinned by two guiding principles: human rights and gender equality. Women must be seen as active participants in, as well as beneficiaries of, health systems served by

programmes that respond to women's specific needs, rights and preferences.<sup>124</sup>

Better strategies are needed across health systems to improve the accessibility, acceptability, affordability, uptake, equitable coverage, quality, effectiveness and efficiency of services, particularly for adolescent girls.<sup>125</sup> This population must be better empowered to drive the design and implementation of services so that they are truly able to meet their needs.

Integrated services must be provided in ways that respect women's autonomy in decision-making about their health, and include provision of information and options to enable women to make informed choices about all aspects of their SRH, including family planning, sexual rights and HIV.<sup>126</sup>

*Photo credit: iStock.com/peeterv. Photos are used for illustrative purposes. They do not imply any health status or behaviour on the part of the people in the photo.*



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