

Gender inequality and HIV



KEY POINTS

- Women and young girls continue to be disproportionately affected by HIV around the world, but particularly in sub-Saharan Africa.
- Financial disparities and intimate partner violence in relationships often hinder a woman's ability to negotiate condom use and protect herself from HIV.
- Gender inequality in education and restricted social autonomy among women is directly linked to lower access to sexual health services, including HIV testing and treatment.
- Although commitments to reduce the effects of gender inequality have been made by the international community, there is a need to significantly scale up efforts as social injustices and violence against women continue to persist across the globe.

Explore this page to find out more about [how gender inequality increases a woman's vulnerability to HIV](#), [what is being done to tackle gender inequality](#) and read about [programmes tackling gender inequality and HIV](#).

Despite progress in many aspects of the global HIV response, **women** - particularly adolescent girls and young women - continue to be disproportionately affected by HIV. Women constitute more than half of all people living with HIV.¹ AIDS-related illnesses are the leading cause of death among women of reproductive age globally.²

Gender inequalities, including gender-based and intimate partner violence, exacerbate women and girls' physiological vulnerability to HIV and block their access to HIV services.³

HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact.⁴

The gender inequalities in some regions result in an even starker difference between the way HIV affects men and women. For example, in [East and Southern Africa](#), young women (15-24 years) will acquire HIV five to seven years earlier than their male peers.⁵ This equates to 4,500 new HIV infections among young women every week in 2015, double the number in young men.⁶

The power imbalance between genders also means that many young women are not able to make decisions about their own lives. For example, more than 80% of married 15 to 19 year-old women in Senegal, Niger, Burkina Faso, Côte d'Ivoire and Cameroon do not have the final say on their own healthcare.⁷

These inequalities are more severe for marginalised women, including female [sex workers](#), [transgender](#) women, women who inject drugs, migrant women and women with disabilities who are also at a heightened risk of discrimination and violence.⁸

How does gender inequality increase women's vulnerability to HIV?

HIV disproportionately affects women and adolescent girls because of their unequal cultural, social and economic status in society. This means that gender inequality must be tackled in order to end the global HIV epidemic, and achieve other, broader development outcomes.⁹

Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal power dynamics between men and women. These dynamics limit women's choices, opportunities and access to information, health and social services, education and employment. For example, in 29 countries women require the consent of a spouse/partner to access sexual and reproductive health (SRH) services¹⁰ and 75% of women aged 15 to 19 do not have a final say in decisions about their own health.¹¹

Gender assessments of national HIV epidemics and responses carried out in Burundi, Burkina Faso, Cameroon, Chad, DRC, Gabon, Nigeria and Senegal in 2016 found women and girls were vulnerable to HIV — in part due to laws and policies that maintain traditional gender roles — and that women in key populations had limited access to services.¹²

In many places, discriminatory social and cultural norms are translated into laws which repress the autonomy of young women as demonstrated by the fact that 75% of women aged 15 to 19 do not have a final say in decisions about their own health.¹³ In 146 countries, laws allow girls under 18 to marry with the consent of their parents, while in 52 countries, the same applies to girls under 15.¹⁴

Stigma and discrimination further exacerbate women's vulnerability to HIV and undermine the response to the epidemic.¹⁵ In particular, women in key populations face numerous and specific challenges and barriers, including violence and violations of their human rights, in health care settings and from uniformed personnel.¹⁶

Intimate partner violence and HIV

Although the prevalence of intimate partner violence among married or partnered women decreased

between 2000 and 2014 [17](#), it remains high across the world – affecting one in three women globally [18](#) – and is particularly common in certain regions. [19](#)

The fear of intimate partner violence has been shown to be an important barrier to the uptake of HIV testing and counselling, to the disclosure of HIV-positive status, and to treatment uptake and adherence, including among pregnant women who are receiving antiretroviral treatment (ART) as part of services to prevent mother-to-child transmission (PMTCT). [20](#)

In places with high HIV prevalence, women who experience intimate partner violence are 50% more likely to acquire HIV than women who do not. [21](#) It can also disrupt HIV prevention services. For example, a study of African couples 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 (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. [22](#)

An assessment of Demographic and Health Survey results in ten sub-Saharan African countries in 2015 found physical and emotional intimate partner violence to be strongly associated with HIV infection in women. [23](#)

Despite 15 of 19 countries in East and Southern Africa having laws against domestic violence and sexual offences, more than 30% of ever married or partnered women (aged 15–24 years) experienced physical or sexual violence from a male intimate partner in the previous 12 months in Uganda, Tanzania, Zambia and Zimbabwe. This figure was 50% among girls aged 15 to 19 years in Namibia. [24](#)

Some of the intimate partner violence experienced by young women occurs within the context of child marriage. 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, such as whether to practice safer sex. [25](#) These factors all increase HIV risk.

Women from key populations are especially vulnerable to intimate partner violence and the increased risk of HIV associated with it. A study in Vancouver, Canada found women who inject drugs who had experienced sexual violence were more likely to be living with HIV than other women who inject drugs. [26](#) Despite such evidence, services for women who have experienced violence and services for people who use drugs are often disconnected. [27](#)

Cultural and social norms

Intimate partner violence is typically underpinned by dominant cultural and social norms about masculinity, femininity, and sexuality. [28](#) Research shows that gender inequality results from the patriarchal nature of many societies, especially where control of women and male strength and power is highly valued. [29](#)

Violence against women, including intimate partner violence and rape, is one consequence of gender inequality. However, such violence also reinforces and perpetuates gender inequality at both societal and relationship levels. [30](#)

Educational factors

Studies have shown that increasing educational achievement among women and girls is linked to

better SRH outcomes, including lower rates of HIV infection, delayed childbearing, safer births and safer abortions.³¹³²

In many settings, cultural and social norms mean that girls in families affected by HIV are the ones who drop out of school to care for sick parents or generate income for the family.³³ Less than one in three girls in sub-Saharan Africa are enrolled in secondary school.³⁴ The United Nations Children's Fund estimates that 18.8 million children in [West and Central Africa](#) are not in school. Girls are particularly disadvantaged: just over half (54%) of young women in the region are literate.³⁵

The education and empowerment of women and girls is also fundamental to preventing intimate partner and gender-based violence.³⁶ An analysis of data from 44 countries found that completing secondary education significantly reduces a woman's risk of intimate partner violence and that a girl's education is more strongly associated with reduced risk of partner violence in countries where spousal abuse is more common.³⁷

However, in many places schools are not guaranteed safe learning environments for young women. Studies by Plan International in Senegal, Mali, Ghana, Guinea Bissau, Togo, Liberia and Uganda found violence in primary and secondary schools, while varying across countries, to be prevalent. The research found that inappropriate sexual relations between male teachers and female students, including transactional sex to cover school fees and the cost of school materials and sex for grades to be common. When asked about early pregnancy, 16% children in Togo named a teacher as responsible for the pregnancy of a classmate; this figure was 15% in Mali and 11% in Senegal.³⁸

Legal factors

In many places, discriminatory social and cultural norms are translated into laws which act as barriers to HIV services for women, increasing their vulnerability to HIV. Nine countries in 2014 reported laws that obstruct women and girls from accessing HIV services.³⁹

Mandatory parental consent has been shown to deter young women from accessing vital HIV and SRH services due to fear of disclosure or violence.⁴⁰ A 2017 study on sexual and reproductive health and rights among young people in Kenya, Uganda, Myanmar, Bangladesh and Ethiopia found young women frequently lacked the freedom to access contraceptives, particularly when parental or spousal consent was required due to their being under the legal age of consent.⁴¹

Age-restrictive laws, such as those that ban contraception under a certain age, act as barriers to healthcare for young women, while women belonging to other key affected populations are negatively affected by laws that ban drug use, sex work and homosexuality.⁴²

For example, one study of 77 countries reported that 18 countries had age restrictions for accessing [needle and syringe programmes](#), and 29 had restrictions for accessing opioid substitution therapy. Most commonly, the age restriction was 18 years.⁴³

Poverty and gender inequality

Poverty is an overarching factor that increases vulnerability to HIV and is further complicated by gender inequalities.

Poor women are often economically dependent on men. The need for economic support may partly drive earlier marriage and existing gender inequalities may make it difficult for young women to insist

on safer sexual practices.

The poorest women may have little choice but to adopt behaviours that put them at risk of infection, including transactional and intergenerational sex, earlier marriage, and relationships that expose them to violence and abuse.⁴⁴

In many parts of rural Africa, food insufficiency can also drive the adoption of high-risk behaviours such as transactional sex.⁴⁵ A 2015 study of young women in rural Zimbabwe found poorer women were more likely to have experienced earlier sexual debut; to have had more partners and partners who were six or more years older and to report having had sex for material or financial support. Women who reported having insufficient food were more likely to report two or more high-risk behaviours than women with sufficient food supply.⁴⁶

Poverty can also push girls into relationships with older men for the promise of money or gifts. Age-disparate sexual relationships between young women and older men are common in both East and Southern Africa and West and Central Africa. This is more likely to expose young women to unsafe sexual behaviours, low condom use and an increased risk of sexually transmitted infections.⁴⁷

The risk of trafficking and sexual exploitation is also higher for young women and adolescent girls living in poverty.⁴⁸ Poverty also increases the risk of child marriage. Worldwide, girls belonging to the poorest 25% are 2.5 times more likely to be married as children compared with girls in the richest 25%.⁴⁹

Gender inequality and HIV in humanitarian emergencies

Women and girls also experience heightened vulnerability to HIV in [conflicts](#), [emergencies](#) and post-conflict periods. For example, rape can be used as a weapon of war. In other cases, adolescent girls are abducted and used for sexual purposes by armed groups.⁵⁰

For example, a survey of internally-displaced families living in three camps in Sierra Leone found that 9% of female respondents reported having been victims and survivors of sexual violence related to the war.⁵¹

What is being done to tackle gender inequality?

There are a number of international commitments which recognise that tackling gender inequality is vital to ending the global HIV epidemic and achieving wider development outcomes.

International commitments to tackling gender inequalities

Empowering women and girls...with the agency to claim their rights, receive a quality education, enjoy healthy lives and take measures to protect themselves from HIV is a requisite component of combination HIV prevention—structural change that reflects the

interconnected nature of the Sustainable Development Goals. 52

For many years, tackling gender inequality has been regarded as key to achieving a broad range of development goals. Many of the United Nation's Sustainable Development Goals (SDGs), which set out the global development goals between 2015 and 2030, specifically recognise women's equality and empowerment as both an objective and part of the solution. Target 5 in particular, is dedicated to achieving gender equality and contains a number of goals relating to gender inequality and HIV including:

- end all forms of discrimination against all women and girls everywhere
- ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life
- ensure universal access to sexual and reproductive health and reproductive rights
- adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.[53](#)

Underneath these broad commitments sit a number of pledges to tackle gender inequality as a driver of the global HIV epidemic.

UNAIDS Fast-Track Strategy, which calls for a dramatic scaling-up of existing efforts in low- and middle-income countries to end the HIV epidemic by 2030, also identifies addressing gender inequality as crucial to achieving this aim. Under the 'Zero discrimination' target, the strategy calls for "increasing commitment to achieving gender equality and eliminating gender-based violence."[54](#)

In 2015, UNAIDS and the African Union outlined three commitments to advance the rights and empowerment of Africa's young women and girls to enable a Fast-Track response to the HIV epidemic.[55](#)

The commitments are to:

- stop new HIV infections among young women and adolescent girls in order to ensure that AIDS is no longer the leading cause of death among adolescents
- empower young women and adolescent girls through comprehensive sex education
- prevent HIV infections among children and keep their mothers alive.[56](#)

As part of the UNAIDS Fast-Track Strategy, in 2016 the UN General Assembly ratified a Political Declaration on HIV and AIDS. This acknowledges the link between violence and HIV, and calls for an end to all forms of violence and discrimination against women and girls.[57](#)

To stay on track to ending the AIDS epidemic by 2030, UNAIDS has set a global target of achieving less than 500,000 new infections by 2020. To achieve this UNAIDS describes five 'prevention pillars', one of which is comprehensive sexuality education, economic empowerment and access to SRH services for young women and adolescent girls and their male partners in high-prevalence locations.[58](#)

To close current gender-related HIV prevention gaps, UNAIDS recommends the following:

- strengthen legislation, law enforcement and programmes to end intimate partner violence
- increase girls' access to secondary education
- use cash transfers to empower women economically, to keep them in school and to enable them to make healthy partner choices
- remove third-party authorisation requirements and other barriers to women and young people's access to HIV and sexual and reproductive health services.⁵⁹

Translating international commitments into policy and practice

Equality before the law is crucial for tackling gender inequality. As of 2014, 143 countries guarantee equality between women and men in their constitutions; 132 have equalised the minimum age of marriage (without parental consent) at 18 years or older, at least 119 have passed legislation on domestic violence and 125 have passed laws to make workplaces and public spaces safer for women by prohibiting sexual harassment.⁶⁰

Progress towards equality before the law has been less consistent when it comes to family laws (also called 'personal status laws'). Often derived from customary or religious laws, family laws shape the rights and obligations of spouses in marriage and divorce, the relationship between parents and children, marital property, child custody, guardianship and inheritance. They are of particular significance for women because they underpin power relations within the home and have a direct impact on women's ability to access and control resources.⁶¹

Globally, the scale-up of interventions specific to gender inequality and HIV has not been fast enough, despite political commitments to increase the capacity of women to protect themselves from HIV infection. Indeed, translating these commitments into effective policies and programmes remains a challenge. In 2014, a survey of 104 countries found that only 57% had an HIV strategy that included a specific budget for women.⁶² For example, the UNAIDS Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive has seen significant progress in the [prevention of mother-to-child transmission \(PMTCT\)](#) to avert new HIV infections among [children](#) but has had a very limited impact in terms of the needs and priorities of women and girls.⁶³

In 2013, ministers of health and education from countries across East and Southern Africa committed to the implementation of a raft of gender-transformative HIV programming to address the barriers that prevent girls and young women from accessing services. These include keeping girls in school, comprehensive sexuality education, girl-friendly SRH services, eliminating gender-based violence and female genital mutilation, and economic and political empowerment.⁶⁴ Despite this, the responsiveness of HIV programmes and strategies to meet women's needs remains uneven in the region and in neighbouring West and Central Africa. For example, although Nigeria had several strategies on gender equality and HIV, budget allocations for these interventions were less than 1% of the total expenditure on HIV in 2015.⁶⁵

The meaningful involvement of women living with HIV in the global AIDS response

The Greater Involvement of People Living with HIV and AIDS (GIPA) promotes the right of people living with HIV to "self-determination and participation in decision-making processes that affect their lives."⁶⁶ However, GIPA was not developed with acknowledgment of socially structured gender inequities. This has caused many in the HIV response to argue that the concept of GIPA should move toward a more women-centred model, which is sometimes known as the Meaningful Involvement of

Women with HIV/AIDS (MIWA).[67](#)

Women living with HIV face a number of barriers to meaningful participation in HIV policy and decision-making. These include stigma and discrimination, economic insecurity, and a lack of access to information and resources, as well as insufficient opportunities for training and support.[68](#) There are also few institutional mechanisms to ensure women's leadership or inclusion in the design, implementation, monitoring and evaluation of the HIV response. Even where opportunities exist, organisational and resource constraints hinder the participation of women living with HIV.[69](#)

In fact, the evidence suggests that women and girls participation in national HIV planning processes is declining globally. In 2012, UNAIDS reported that 61% of women living with HIV participated in formal planning and review mechanisms where they are present, down from 66% in 2010.[70](#)

Moreover, research by the Association for Women's Rights in Development (AWID) found that, while women and girls are recognised as key agents in development, a large majority of women's organisations are underfunded.

Specifically, AWID mapped 170 initiatives that committed US\$14.6 billion in total under the broad umbrella of 'women and girls', yet in 2010, the average income of over 740 women's organisations around the world was just US\$20,000.[71](#)

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Programmes tackling gender inequality and HIV

A number of international recommendations and successful interventions to address gender inequality are outlined below.

SASA!

Community activists lead on a wide range of activities in their own neighbourhoods designed to decrease the social acceptability of violence by influencing knowledge, attitudes, skills and behaviours on gender, power and violence.[72](#)

When implemented in four communities, the programme was associated with significantly lower incidence and acceptance of intimate partner violence among men and women as well as more supportive community responses to women who experienced it. SASA! has been implemented by over 25 organisations in sub-Saharan Africa in diverse settings such as religious, rural, refugee, urban and pastoralist communities.⁷³

DREAMS

This ambitious US \$385 million programme aimed to reduce HIV infections among adolescent girls and young women in Kenya, Lesotho, Malawi, Mozambique, South Africa, Eswatini, Tanzania, Uganda, Zambia, and Zimbabwe. It focused on social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, intimate partner violence, gender-based violence and education. It aimed to achieve a 40% reduction in HIV incidence among females aged 15–24 in the hardest-hit areas of the DREAMS countries by the end of 2017.⁷⁴ Plans for the evaluation of the project have now been set out, and a comprehensive review will be carried out over the next four years. ⁷⁵

SheConquers

SheConquers was launched in South Africa in 2016 to break the cycle of HIV infection among older and younger people in many high-prevalence settings (whereby young women acquire HIV from adult men then go on to transmit HIV to adult men in their peer group as they grow older, and the cycle repeats). This three-year national HIV prevention campaign aims to: decrease new HIV infections, teenage pregnancies and gender-based violence among young women and adolescent girls; increase and retain young women and adolescent girls in school, and increase economic opportunities for young people, particularly young women.⁷⁶

Scaling up and integrating HIV with sexual and reproductive health and rights services

Social norms and taboos relating to gender and sexuality can create a culture of silence, particularly among adolescent girls, which prevents them from asking about issues relating to their sexual and reproductive health and rights (SRHR). The lack of a confidential and judgment-free environment can also be a barrier to girls obtaining SRHR information and expressing their concerns.⁷⁷

Because of this, scaling up comprehensive, integrated and youth-friendly SRHR and HIV services for young women and adolescent girls is vital.

CASE STUDY: Safe Spaces

Several programmes have tried to develop girls' agency around their SRHR through a safe spaces model. This model includes providing a physical space where girls can meet regularly; supporting adolescents through an older or peer mentor; and providing life skills (e.g., SRHR information, negotiation skills, literacy training) and/or vocational skills training, along with socialisation and recreation. Some also include financial literacy and microcredit/microfinance components, recognising that economic empowerment is not sufficient in isolation of other social empowerment approaches.⁷⁸

Safe spaces interventions have been implemented in Burkina Faso, Egypt, Ethiopia, Guatemala, India, Kenya, Nigeria, Rwanda, Tanzania, and Uganda. Most of them have targeted girls

between the ages 15 and 17 years, although some have also started focusing on younger adolescent girls (10 to 14 years), recognising that they need to be reached before the ages when they are likely to drop out of school or be married. These interventions have not yet been evaluated comprehensively as they are either ongoing or have been implemented as pilot projects. Assessing the impact of these programmes is not simple because many effects may not be seen until years later. Some have looked at specific outcomes such as in the Ishraq project in Egypt in which, among girls who participated and stayed in the intervention for 30 months, 92% passed the literacy test. Other interventions show an improvement in knowledge of health issues and expanded life goals among girls.⁷⁹

Condom programming designed to reach young people, such as through schools, can increase accessibility and use among those who are sexually active.⁸⁰ Removing barriers like parental and spousal consent is critical for scaling up services and increasing access.⁸¹

Keeping girls in school

Education allows girls to gain better knowledge about HIV and their SRHR.⁸² It lowers exposure to intimate partner violence and increases their chances of becoming financially secure and independent.⁸³

In Africa, the most effective interventions that reduce the risk of HIV infection among adolescent girls, are the ones that keep them in school. These include making education free for girls, supporting orphans and other vulnerable children to stay in school, and conditional cash transfers that reward parents for keeping their daughters in school.^{84 85 86}

A cash transfer programme in Malawi reduced the school dropout rate of girls by 35%. It also resulted in a 40% reduction in early marriages, a 30% reduction in teenage pregnancies and a 64% reduction in HIV risk within 18 months.⁸⁷

Offering comprehensive sex education

There is clear evidence that comprehensive sexuality education (CSE) that explicitly focuses on gender rights and gender power dynamics is five times more effective than CSE programmes that do not, particularly in reducing unwanted pregnancies, new HIV infections and other sexually transmitted infections.⁸⁸

Despite this, a major gap remains between global and regional policies and the actual implementation of comprehensive sexuality education on the ground. Gender-responsive and life-skills-based HIV and sexuality education is only covered in the national curriculum by 15% of the 78 countries analysed in UNESCO's 2016 Global Education Monitoring Report.⁸⁹

Zambia is one of the countries to have implemented a gender-responsive CSE programme. The curriculum focuses on puberty, HIV prevention, gender equality, sexual and reproductive health, relationships and human rights. This is helping adolescents and young people in Zambia enjoy better sexual and reproductive health and have better health outcomes overall. ⁹⁰

I saw the need to get more involved in teaching comprehensive sexuality education because of the way our society hides information on sexuality. I remember growing up and being told that if you sit next to a boy at school you would conceive. I don't want the current generation to go through what we went through.

- *Agather Shindende, a teacher at Kabulonga Primary School, Zambia*[91](#)

Including women in the decision making process

In 2014, UN Women commissioned a global review of HIV treatment access for women, led by women living with HIV. Known as the Global Reference Group (GRG), this is the first ever peer-led global study of treatment access for women living with HIV on this scale.[92](#)

Participants in the GRG reside in 11 different countries and come from a diverse range of backgrounds. They have led the design and review of the programme, were involved in setting the parameters of the GRG's literature review and identified the topics for focus group discussions, one-to-one interviews and an online survey. Some members are also involved in country case studies that investigate the issues and concerns that the GRG raises.[93](#)

The GRG's study involved 945 women living with HIV (832 in the survey and 113 in the focus groups), from 94 countries aged 15 to 72. It found 89% of respondents feared or had experienced gender-based violence, 56.7% had had an unplanned pregnancy, 72.3% had received advice on safe conception and 58.8% had suffered poor mental health after discovering their HIV-positive status.[94](#)

This was used to update World Health Organisation global guidelines on the care, treatment and support for women living with HIV and their children in resource constrained settings.[95](#)

We know the critical steps that must be taken on the path to gender equality, and we must scale up and invest in what works for women and girls in the context of HIV and AIDS. This includes empowering women and girls, particularly those living with HIV, advancing their leadership; eliminating barriers and constraints to women's access to prevention treatment and care services; eradicating gender-based violence; and ensuring adequate financing for women's needs and priorities in the AIDS response.

- *Phumzile Mlambo-Ngcuka, Executive Director, UN Women* [96](#)

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