Introduction

For a long time, women have not been seen as a high-risk group for becoming infected with HIV. Men who have sex with men, intravenous drug users and sex workers have been the standard groups that preventive and treatment services are especially geared toward. Disregarding women, especially young women, from the issue, has led to an increase in HIV infection in females. The majority of new HIV infections are in young women, and deeply rooted beliefs about gender are holding nations back from reducing the epidemic. It is important to tackle many social aspects of what it means to be a woman in the 21st century in different cultures in order to understand the issue of gender in the HIV pandemic, as well as offer concrete solutions that different countries can implement.

Definition of Key Terms

HIV (Human Immunodeficiency Virus)

The human immunodeficiency virus (HIV) is a virus that targets the immune system. This means that a person who has HIV will be more likely to die from infections and types of cancer that people with healthy immune systems can usually fight off. HIV has no specific symptoms in the early stages of infection. Without regular testing, people may only become aware that they are ill when they exhibit typical symptoms of the final stage of HIV, such as infections that occur only in immunocompromised individuals.

AIDS (Acquired Immune Deficiency Syndrome)

The acquired immune deficiency syndrome (AIDS) is the final stage of an HIV infection. An HIV infection does not necessarily progress to this stage, but the likelihood of it happening is extremely high if the patient is left without treatment.

Antiretroviral therapy (ART)

Antiretroviral therapy is the treatment of choice for HIV-positive people and recommended for all those living with the virus. It does not cure HIV; however, it improves the length and quality of life of HIV-positive people and also reduces the risk of the transmission of the virus to other people.
**PrEP (Pre-exposure prophylaxis)**

Pre-exposure prophylaxis (PrEP) is a regular type of antiretroviral therapy given to HIV-negative people who are at a high risk of HIV, such as those who have sex with HIV-positive people, those with multiple partners who have anal sex without a condom, and those who share equipment to inject drugs. The medicine must be taken every day for it to be effective and started before a potential exposure to HIV. This reduces the risk of HIV taking hold in the body and for the patient to become infected in the first place.

**PEP (Post-exposure prophylaxis)**

Post-exposure prophylaxis (PEP) is an emergency type of antiretroviral therapy given to HIV-negative people or those who do not know their status, who have potentially been exposed to HIV during sex or injecting/preparing drugs and who report to a medical practitioner within 72h. This reduces the risk of HIV taking hold in the body and for the patient to become infected in the first place.

**Preventive HIV services**

Preventive HIV services include free HIV testing, providing access to condoms and lubricants, access to PrEP and PEP, providing syringe service programs (access to and disposal of sterile injection materials), partner notification services that allow HIV-positive people to anonymously inform those they have had sex with or shared needles with that they are at risk for HIV, and comprehensive sexual education.

**HIV treatment services**

HIV treatment services include free HIV testing, access to the whole spectrum of antiretroviral treatments, access to counselling services with regards to living with HIV, and resources to prevent the patient from declining regular testing or ART.

**Social barriers**

For the purposes of the discussion of this issue, the phrase ‘social barriers’ will be defined as factors that relate to the conditions in which people are born, live, learn, work and age in that contribute to the vulnerability of women to HIV and the lack of access to treatment that HIV-positive women experience.

**Background Information**
Women have for long not been considered a risk group for HIV infections. Instead, efforts have been concentrated with regards to men who have sex with men, intravenous drug users and sex workers. However, while infection rates among these groups have generally decreased, rates of infection among women, especially young women, have increased. For example, in Eastern and Southern Africa, 79% of new HIV infections in 2017 among 10-19-year-olds were among women. More than 52% of all people over the age of 15 living with HIV worldwide are women. New infection rates around the world among women between the ages of 15-24 are 55% higher than those of their male counterparts. HIV related illnesses were the leading cause of death of women aged 15-49 around the world in 2017. These numbers mean that a response adapted to the unique problems that women face must be delivered to women all around the world. But what are those unique problems?

**Lack of access to sexual health services**

Women face unique social barriers when attempting to access sexual health services. Many of these barriers are related to the lack of independence that women have regarding their sexual health and wellbeing. For example, 29 countries require the consent of a partner for a woman to be able to access sexual health services. This means that a woman has to disclose her sexual history to the healthcare provider, as well as disclose her desire to seek healthcare services to her sexual partner. Some may argue that this violates article 12 of the Universal Declaration of Human Rights, the right to privacy. If a woman does not wish to disclose either one or both, the sexual health services will remain inaccessible to her. This is also problematic in the case that the woman was sexually assaulted, as she may not know the personal details of her abuser or may understandably not wish to communicate with the abuser.

45 countries also require parental consent for people under the age of 18 to access sexual health services, including HIV testing and an additional 50 countries have such kind of laws for people younger than 16 or 14 years of age. It’s important to note that the requirement isn’t parental notification, but parental consent, hence parents have the right to make sexual health services inaccessible to their child, even if it is in the child’s best interest to access these services. This also affects underage young men, however as stated before, new infection rates among young women are especially elevated and the sexuality of adolescent girls is stigmatised. The intention of these laws is often to protect children, which is understandable, however these laws mostly do the opposite— they discourage adolescents from accessing the services that they need in order to stay healthy. If adolescents become infected with HIV and are unable to know that, they have a higher risk of HIV progressing into AIDS and have a worse prognosis than those who have access to confidential HIV testing. Indeed, healthcare professionals should treat young patients that report that they are sexually active, with tact and keep child protection in mind. However, when such laws are imposed, it can also discourage those children that have been sexually abused from seeking help, as parental consent is required prior to accessing services and children may not wish to or know how to speak...
to their parents about sexual abuse. This is something that a healthcare professional could assist them with.

It is beneficial that many adolescents have access to sexual health services without parental consent, but 145 countries do require parental consent for people under the age of 18 to obtain HIV treatment. This means that adolescents have to disclose their HIV-positive status to their parents and their parents must agree to their child obtaining life-saving treatment. In communities where traditional medicine is an important part of the culture and where there is a distrust in the medical community, it could lead to the parents refusing ART. The requirement for parental consent to obtain HIV treatment also contributes to the disparity between the number of HIV-positive people and HIV-positive people that are on ART.

**Lack of access to (sexual) education**

Not only is the lack of access to sexual healthcare an issue, but the lack to sexual education and education in general as well. Studies in Sub-Saharan Africa have shown that girls who don’t graduate from high school are twice as likely to become infected with HIV than those girls who do graduate from high school. This correlation can be explained in multiple ways and we often hear that education is the answer to many social issues. Girls that are less educated are more likely to have a lower social status and hence are more likely to have less access to healthcare services, including sexual health services. They also are less likely to have independence when it comes to their healthcare choices. However, in this section, we will focus on the lack of access to sexual education. In Sub-Saharan Africa, 70% of young women do not have even basic knowledge about how to protect themselves from HIV. Only one in three young people globally can demonstrate accurate knowledge about HIV prevention and transmission. Without this knowledge, girls cannot even begin protecting themselves from HIV nor are they aware of the importance of regular testing and of the different treatment options should they test HIV-positive. There are different ways that one can reach young girls, one of them being introducing comprehensive sexual education as part of the curriculum. However, this means that the groups of people reached would be those that are privileged enough to receive formal schooling. This means that it is important to find a way to deliver sexual education to all girls to ensure that they have accurate information about HIV and hence can better protect themselves from becoming infected.

**Role of women in society**

As mentioned earlier, the social barriers what make women vulnerable to HIV and hinder their access to HIV services, are a product of complex social interactions that go back thousands of years. Violence against women and girls is a consequence and a cause of high HIV transmission rates in women and girls. For example, intimate partner violence or the fear of violence can stop women from disclosing their HIV status, negotiating safer sex and accessing HIV services. But women and girls who have experienced violence are at a greater risk for various mental illnesses and substance abuse, which leads to them having
less control over sexual decision-making and makes them easier to take advantage of. This often leads to a higher risk of contracting HIV and a higher risk of non-adherence to PrEP or ART. Not only does the rate of intimate partner violence affect girls and women, but in some cultures, they are also seen as property of their father or husband. This greatly affects their decision-making power regarding healthcare decisions, especially as female sexuality is still greatly stigmatised. Furthermore, mostly women are involved in sex work, which can also put women in a situation where they don't feel safe to advocate for their own health. A ‘sugar daddy’ culture has become more and more popular worldwide, and its effects are clearly documented in South Africa. This culture glorifies intergenerational relationships where the older man provides the younger woman with gifts in exchange for a romantic and sexual relationship. These wealthy older men (also called blessers in South Africa), who are often married men with multiple sexual partners, contribute to the HIV epidemic in South Africa, according to local health experts. The director of the Centre for the AIDS Program of Research in South Africa has stated that “reducing age-disparate sex is key to slowing HIV infection rates among young women”.

**Major Countries and Organizations Involved**

**UNAIDS (Joint United Nations Programme on HIV/AIDS)**

Established by an ECOSOC resolution in 1994, UNAIDS is the main UN organisation in charge of the global action on the HIV/AIDS pandemic. It mobilises resources to support an effective response depending on each region’s needs, works on civil society engagement in response to the pandemic and also monitors the pandemic and responses to it. According to internal memos, UNAIDS has had issues with abuse of power and a lack of gender parity. However, since the resigning of the previous executive director, it seems the issue has been resolved.

**South Africa**

South Africa is by far the country most affected by the HIV pandemic, with 20.4% of adults between the ages of 15-49 being HIV-positive. In 2017, more than 4600 new infections occurred every week. Nationally, around 57% of sex workers are estimated to be HIV-positive, reinforcing the need for a special strategy for those involved in sex work. Explain their current strategies and how well they have worked.

**UNWOMEN (United Nations Entity for Gender Equality and the Empowerment of Women)**

UNWOMEN is an organisation advocating for women’s empowerment. They were created by the UN General Assembly in July 2010. In June 2012, it became a cosponsoring agency of UNAIDS, helping to ensure that gender equality is included in the global action on HIV/AIDS. They are the main international organisation advocating for women that are HIV-positive or are at risk of becoming infected.

**WHO (World Health Organisation)**
WHO came into existence in April 1948 and their primary role is to direct and coordinate international health within the United Nations system. Their main objectives in the context of HIV/AIDS is to develop standards and guidelines to help countries tackle the HIV pandemic, to enhance treatment and prevention interventions and to collect data about all aspects of the pandemic worldwide, among others.

**Timeline of Events**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of event</th>
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<tbody>
<tr>
<td>1959</td>
<td>First known case of HIV occurs in a man living in Congo. HIV status confirmed from preserved blood samples later on.</td>
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<tr>
<td>September 24, 1982</td>
<td>The United States Centre for Disease Control recognises AIDS as a disease</td>
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<td>January 1983</td>
<td>HIV isolated at the Pasteur Institute from lymph system of an AIDS patient</td>
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<tr>
<td>1987</td>
<td>First antiretroviral medicine becomes available to treat HIV</td>
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<td>December 1, 1988</td>
<td>First World AIDS day takes place</td>
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<tr>
<td>1996</td>
<td>HIV resistance gene in humans discovered</td>
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<tr>
<td>2007</td>
<td>First case of someone being cured of HIV thanks to a bone marrow transplant with the HIV resistance gene is confirmed</td>
</tr>
<tr>
<td>2015</td>
<td>New, aggressive strain of HIV discovered in Cuba</td>
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**Relevant UN Treaties and Events**

- Women, the Girl Child and HIV and AIDS, 24 March 2016 *(E/RES/60/2)*
- Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight Against HIV and to Ending the AIDS Epidemic by 2030, 8 June 2016 *(A/RES/70/266)*
- Integrating Gender into HIV/AIDS Programmes in the Health Sector, WHO 2009

**Previous Attempts to solve the Issue**

This issue has only become recognised fairly recently when considering when the HIV/AIDS pandemic began. This means that there haven't been many previous attempts to solve the issue. UNWOMEN became affiliated with UNAIDS only in 2012 and gender issues within the HIV/AIDS pandemic have only recently started to be talked about. However, since South Africa is the single hardest hit country when it comes to HIV infections in women, they launched a campaign called She Conquers, which aimed to reduce the number of teen pregnancies, new HIV infections, non-adherence to ART and rates of dropping out of school. There have been no evaluations of the project yet, as it is ongoing.
Provider-initiated HIV-testing in pregnant women has become the standard of care in almost all developed countries. It is important to keep pushing for this to become standard procedure in developing countries as well. Keeping in mind, however, that this is done mainly not for the health of the woman, but rather to reduce the chance of the infection passing onto the child.

**Possible Solutions**

One important, tangible solution is to counsel nations about working toward changing their restrictive laws and policies, such as requiring parental/spousal consent to have access to sexual health services and/or obtain HIV treatment. Since this would be a major shift in the child protection policies and/or morality policies in those countries, it is important that they receive individualised support of UNAIDS and WHO. With that, it is important to kindly point out how their policies harm women and girls and their entire community instead of helping them whilst providing possible alternatives to current legislation. In countries where that is the case, it is only the tip of the iceberg. The social barriers will still remain up for likely a very long time, and it is crucial to remember that complex problems such as this one will not be solved in one resolution. Changing these laws is a start.

Furthermore, a potential UNAIDS, WHO and MSF intervention in hardest hit countries, specifically in Sub-Saharan Africa, could be envisioned. This could include information offices, harm reduction services (needle exchanges), free condom and lubricant dispensers in pharmacies, mass media campaigns about the importance of HIV testing, etc. In this case, the sky is the limit. However, it is also important to consider the human resources of these organisations and the willingness of different nations to participate in this program.

It could also be helpful to develop a global standard HIV education plan in conjunction with WHO for countries to use when developing their national curriculum. This way, the standards would be consistent worldwide. Many would say that HIV education should be part of comprehensive sexual education, but some countries have cultural norms that do not allow them to, all of a sudden, implement such a curriculum. An evidence-based HIV education programme would be a starting point. Such a programme could include at the very least basic immunology related to HIV, statistics about HIV transmission nationally and internationally, ways that HIV can spread, how to protect oneself from HIV and what life looks like for an HIV-positive person.

**Bibliography**


UNAIDS. “Women and HIV.” UNAIDS, 2019.

Appendix
Some useful links to get research started
https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/women
https://undocs.org/en/A/70/L.52