KEY FACTS

October 2003

WOMEN AND HIV/AIDS

THE HENRY J. KAISER FAMILY FOUNDATION

Prepared by

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INTRODUCTION

HIV/AIDS in the United States is increasingly likely to be represented by a woman's face. Between 1986 and 2001, women's representation among new AIDS cases more than tripled, rising from 7% to 26%. Women now account for 30% of estimated new HIV infections. Moreover, most new HIV infections among women occur among women of color, with African Americans alone comprising nearly two-thirds of new infections among women. Women living with HIV are disproportionately low-income and have limited education, complicating their ability to manage their care needs and access needed services. In addition to the challenges of managing their own illness, many women with HIV continue to shoulder traditional family responsibilities such as raising children and caring for sick or aging relatives. While medical advances have sharply reduced mortality from AIDS, research suggests that many women with HIV/AIDS still face considerable barriers to care and may not have benefited from newer therapies to the same extent as their male counterparts. Young women and women of color remain at a higher risk for contracting HIV, making it likely that advances in treatment alone will not curb the current trends.

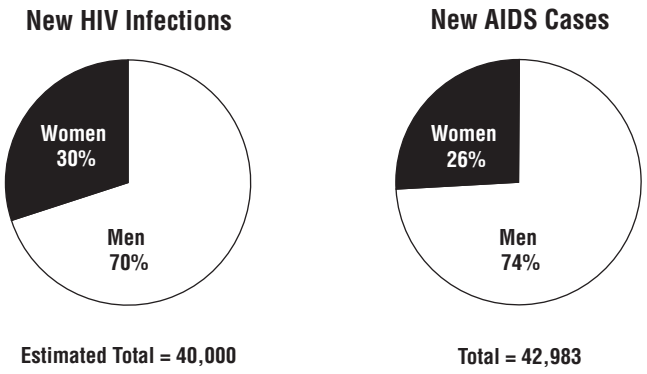
Key Facts: Women and HIV/AIDS updates an earlier report and presents an overview of the epidemic's effects on women in the United States, summarizing major epidemiologic data and research findings related to women and HIV/AIDS. This report draws heavily from Federal data sources, including caseload and trend figures on HIV infections, AIDS cases, AIDS mortality, and breakdowns by sub-populations. It also includes findings from a number of research studies and surveys that have specifically examined the epidemic's consequences for women.

Section One of *Key Facts* provides an overview of women and the HIV/AIDS epidemic. Section Two presents a profile of women living with HIV/AIDS. Section Three addresses women's use of and access to the health care system. Section Four reports on recent survey findings on women's knowledge about the epidemic as well as their personal assessment of risk.

Section 1
Overview

Figure 1

New HIV Infections and New AIDS Cases, by Sex, 2001



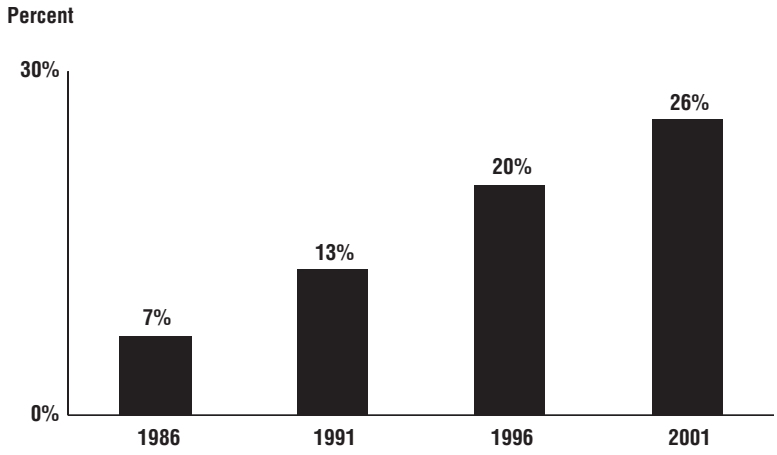
Note: New AIDS cases include reported cases among those 13 years of age and older.

Sources: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2. Centers for Disease Control and Prevention, *HIV/AIDS Update: A Glance at the Epidemic,* February 2002.

Although men continue to represent the majority of new AIDS cases and HIV infections in the U.S., women now account for approximately one quarter (26%) of newly reported AIDS cases. In addition, women represent almost one in three (30%) estimated new HIV infections—new HIV infections provide a more recent snapshot of the epidemic's reach within the population.

Figure 2

Women as a Proportion of Newly Reported AIDS Cases, 1986–2001



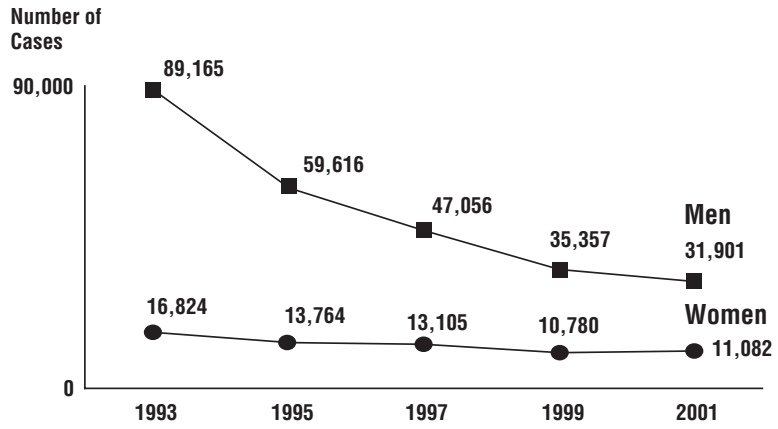
Note: Includes reported cases among women 13 years of age and older.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Reports, 1986–2001.*

The epidemic's impact on women has become more pronounced over time, with women comprising an increasing share of new AIDS cases reported each year. The proportion of new AIDS cases reported among women has more than tripled since the mid-1980s, rising from 7% in 1986 to 26% in 2001.

Figure 3

Trends in Newly Reported AIDS Cases, by Sex, 1993–2001



Note: Includes reported cases among those 13 years of age and older.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Reports, 1993–2001.*

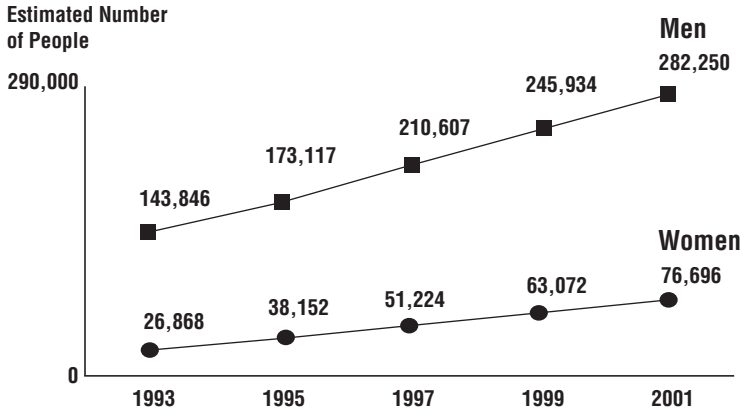
During the 1990s, important new advances were made in the treatment of HIV disease. These advances, particularly the advent of highly active antiretroviral therapy (HAART), led to a decline in the number of new AIDS cases for both men and women as more people were living longer without progressing to an AIDS diagnosis. Prevention efforts also helped to reduce the annual number of new HIV infections.

Despite these advances, the rate of decline in new AIDS cases was almost two times greater for men than women (a 64% decline for men between 1993 and 2001, compared to 34% decline for women).

The rate of decline has leveled for all groups, however, and recent data from the Centers for Disease Control and Prevention (CDC) indicate a slight increase in the number of new AIDS diagnoses in the U.S.

Figure 4

Trends in Number of People Estimated to be Living with AIDS, by Sex, 1993–2001



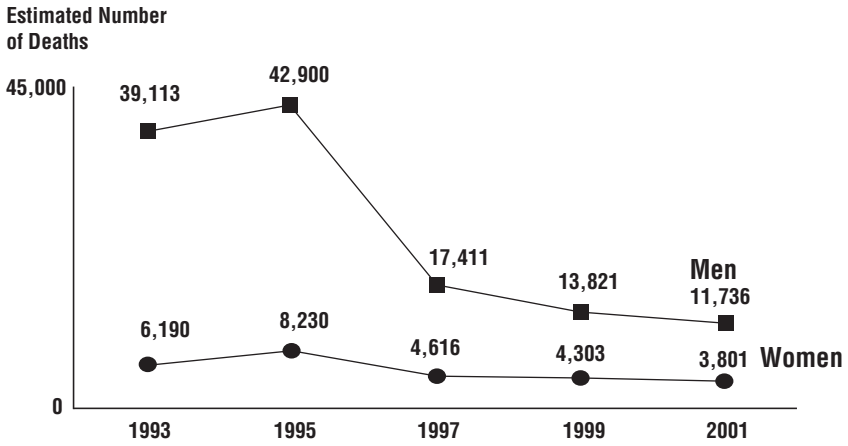
Note: Includes estimated prevalence among those 13 years of age and older.

Sources: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2. Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Supplemental Report,* Vol. 9, No. 2, 2003.

Although the number of new AIDS cases has leveled off, the number of people living with AIDS in the U.S. has increased over time. This is due largely to the availability of more effective treatments, enabling many to live longer, but also to the epidemic's continued spread in the U.S. Women represent an increasing proportion of people estimated to be living with AIDS, rising from 16% in 1993 to 21% in 2001. The number of women estimated to be living with AIDS almost tripled between 1993 and 2001, compared to slightly less than doubling of the number of men living with AIDS over this period.

Figure 5

Trends in Estimated AIDS Deaths, by Sex, 1993–2001



Note: Includes estimated deaths among those 13 years of age and older.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

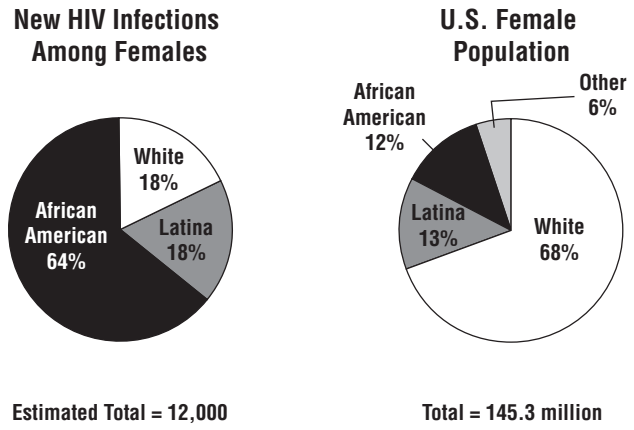
Advances in treatment have also led to a significant reduction in the number of deaths among people with HIV/AIDS. However, the rate of decline among women has been slower than among men. Estimated deaths among women with AIDS declined by 39% between 1993 and 2001, compared to a 70% decline for men.

Section 2

Profile of Women with HIV/AIDS

Figure 6

Estimated New Female HIV Infections and U.S. Female Population, by Race/Ethnicity



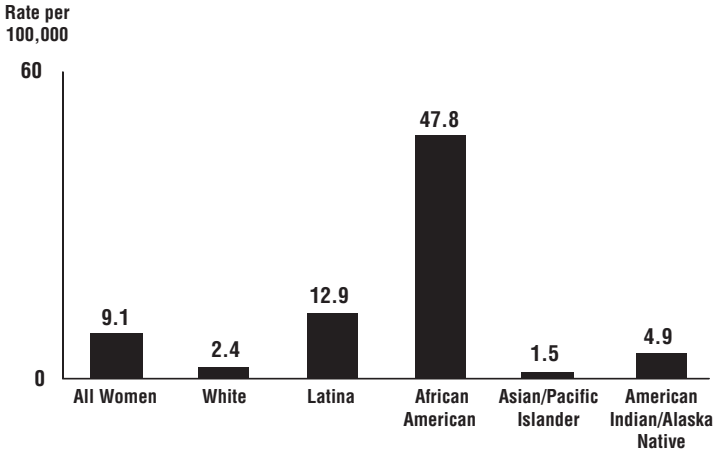
Note: White and African American women do not include those of Latino origin; May not total 100% due to rounding.

Sources: Centers for Disease Control and Prevention, *HIV/AIDS Update: A Glance at the Epidemic,* February 2002; U.S. Bureau of the Census, 2000 Summary File 1 (SF1).

Women of color have been disproportionately affected by the epidemic since its beginning, and that impact is growing. Women of color account for more than eight in ten estimated new HIV infections occurring among women in the U.S., a much greater proportion than their representation in the population of women overall. African American women alone account for almost two-thirds (64%) of estimated new HIV infections among women, but only 12% of the U.S. female population; Latinas account for 18% of new HIV infections and 13% of the U.S female population.

Figure 7

AIDS Case Rates per 100,000 Women, by Race/Ethnicity, 2001



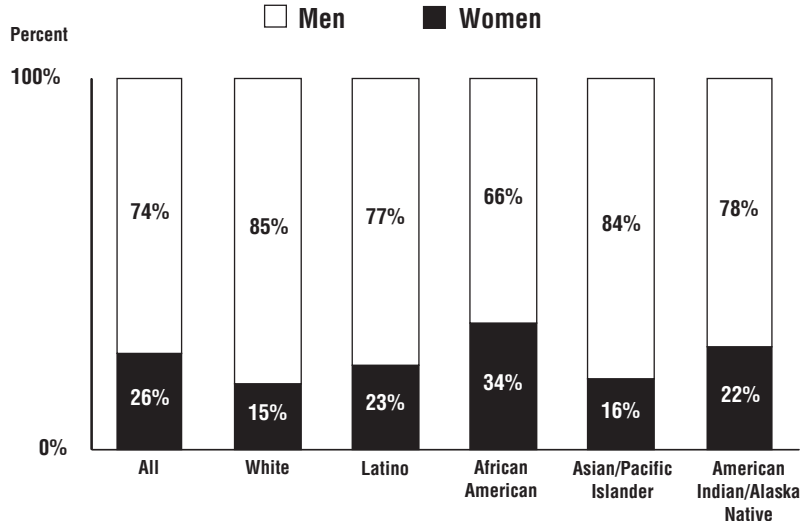
Note: Includes reported cases among women 13 years of age and older. White, African American, Asian/Pacific Islander, and American Indian/Alaska Native women do not include those of Latino origin.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

The disproportionate impact of the epidemic on women of color is more clearly seen in the annual AIDS case rate, a standardized measure of the epidemic's impact (the number of AIDS cases reported in a given year per 100,000 population). The AIDS case rate for African American women was almost 20 times higher than among white women in 2001 (47.8 per 100,000 compared to 2.4). The case rate for Latinas was more than 5 times that of white women (12.9 per 100,000 compared to 2.4). AIDS case rates for Asian/Pacific Islander and American Indian/Alaskan Native women were below the national average for women.

Figure 8

Newly Reported AIDS Cases, by Sex and Race/Ethnicity, 2001



Note: Includes estimated cases diagnosed among those 13 years of age and older, after the reclassification of cases where cause for exposure was not reported or identified. White, African American, Asian/Pacific Islander, and American Indian/Alaska Native groups do not include those of Latino origin.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

While women make up a growing share of new AIDS cases overall, this trend is more pronounced among some subgroups of women. African American women accounted for a greater proportion of new AIDS cases reported among African Americans in 2001 (34%) than did women within any other racial/ethnic group. Latinas represented almost one quarter (23%) of new AIDS cases reported among all Latinos. Asian/Pacific Islander and American Indian/Alaskan Native women represented 16% and 22% respectively of new AIDS cases reported within their racial/ethnic groups.

Figure 9

HIV as a Cause of Death Among Women, by Age, and Race/Ethnicity, 2000

Age	20–24	25–34	35–44	25–44
All Women	8th	5th	4th	4th
White Women	*	7th	9th	9th
Latinas	*	4th	4th	4th
African American Women	5th	1st	3rd	3rd

*HIV does not appear among the top 10 leading causes of death in these categories.

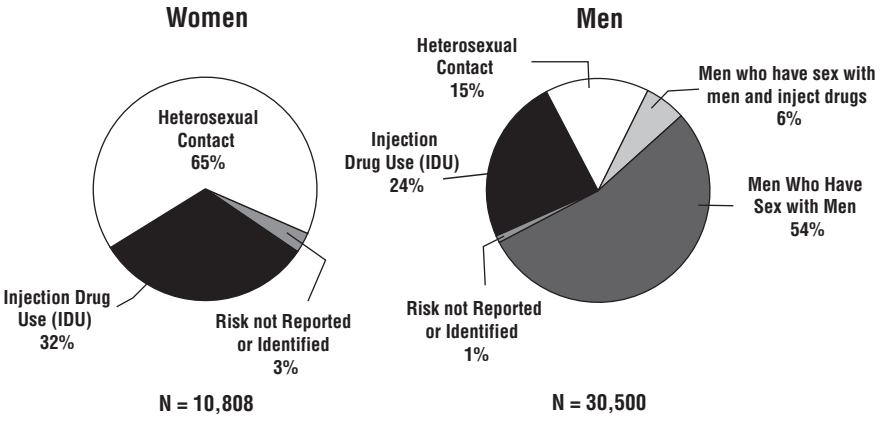
Note: White and African American women do not include those of Latino origin.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, *National Vital Statistics Reports, Leading Causes of Death for 2000,* Vol. 50, No. 16, September 2002.

HIV remains a leading cause of death for women in their reproductive years and minority women. In 2000, the most recent year for which data are available, HIV was the 4th leading cause of death for all women between the ages of 25 and 44. It was the 3rd leading cause of death for African American women and the 4th leading cause of death for Latinas ages 25 to 44, compared to the 9th leading cause for white women in this age group. HIV was the leading cause of death for African American women between the ages of 25–34.

Figure 10

Estimated AIDS Cases, by Sex and Exposure Category, 2001



Note: Includes estimated cases diagnosed among those 13 years of age and older, after the reclassification of cases where cause of exposure was not reported or identified. May not total 100% due to rounding.

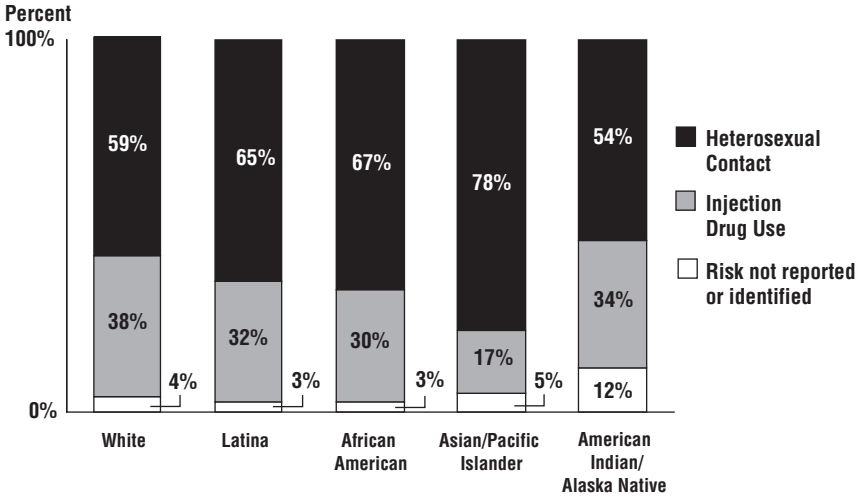
Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

Almost all women contract HIV through heterosexual transmission (65%) or injection drug use (32%). Among those cases attributed to heterosexual contact, about one quarter (24%) are due to sex with an injection drug user.

Men are most likely to have been infected with HIV through sex with other men (54%) followed by injection drug use (24%). Fifteen percent of men are estimated to have been infected through heterosexual contact.

Figure 11

Estimated AIDS Cases Among Women, by Race/Ethnicity and Exposure Category, 2001



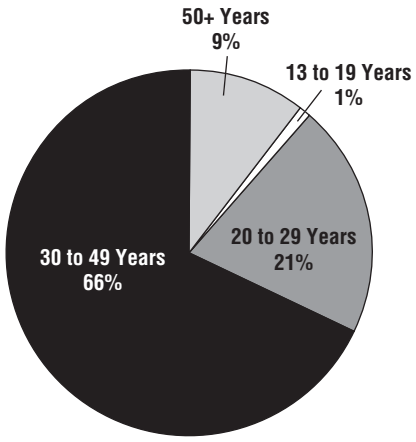
Note: Includes estimated cases diagnosed among those 13 years of age and older, after the reclassification of cases where cause for exposure was not reported or identified. White, African American, Asian/Pacific Islander, and American Indian/Alaska Native women do not include those of Latino origin.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

HIV transmission patterns among women are generally similar across all racial/ethnic groups, with most women estimated to have been infected through heterosexual contact. A smaller but significant share, ranging from 17% to 38%, are estimated to have been infected through injection drug use.

Figure 12

Cumulative AIDS Cases Reported Among Women, by Age at Diagnosis, Through 2001



N = 145,461

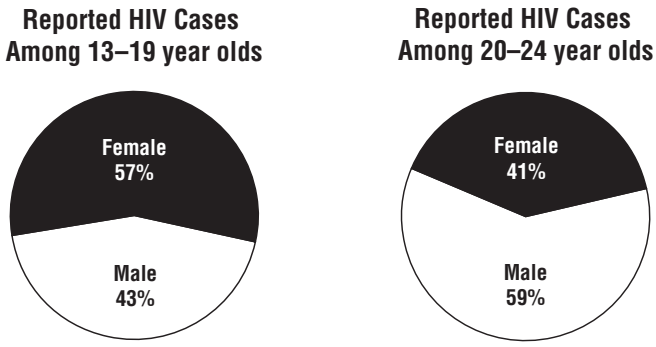
Note: Includes reported cases among women 13 years of age and older.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

Most women affected by HIV/AIDS are young. Two thirds (66%) of all female AIDS cases reported since the beginning of the epidemic were diagnosed among those ages 30 to 49; a fifth (21%) were among women ages 20 to 29.

Figure 13

Reported HIV* Cases Among Adolescents And Young Adults, by Sex, 2001



N = 1,115 N = 3,402

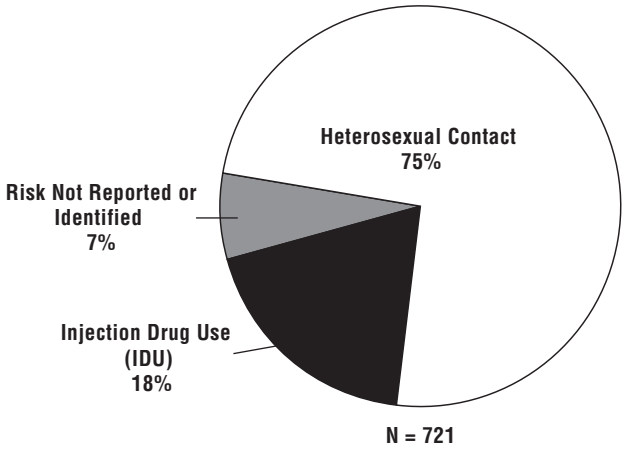
*From the areas with confidential HIV case surveillance for adults and adolescents in 2001.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

The impact of HIV on female teens and young adults is striking. Female teens between the ages of 13 and 19 represented more than half (57%) of new HIV infections reported among teens in 2001 (in those areas with confidential HIV reporting). Women between the ages of 20 and 24 represented 41% of new HIV infections in this age group. This more pronounced representation of girls and women among younger people with HIV may be a harbinger for the epidemic's trajectory.

Figure 14

Estimated AIDS Cases Among Women, Ages 13 to 24, by Exposure Category, 2001



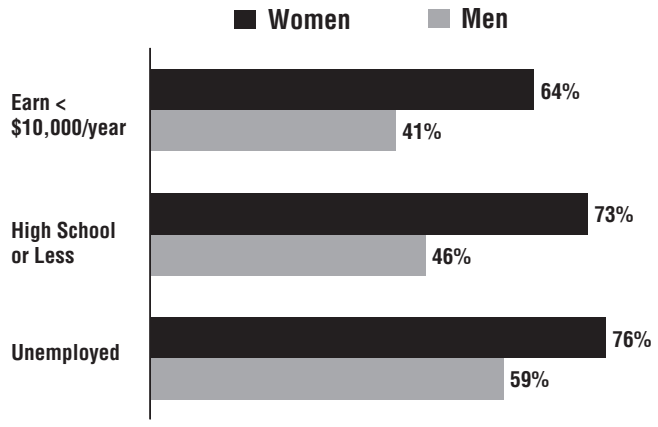
Note: Includes estimated cases diagnosed among women 13–24 years of age, after the reclassification of cases where cause for exposure was not reported or identified.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

Most newly reported AIDS cases among young women, ages 13 to 24, are estimated to be due to heterosexual contact (75%). Approximately one in five (18%) are estimated to be due to injection drug use.

Figure 15

Selected Characteristics of People with HIV/AIDS in Care, 1996



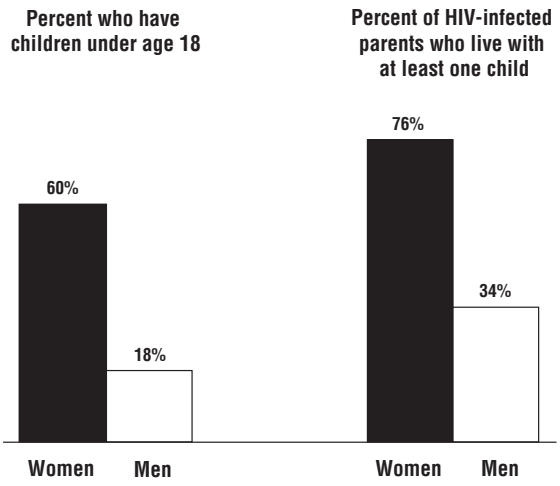
Note: Includes persons 18 years and older.

Source: Bozzette, et al., "The Care of HIV-Infected Adults in the United States," *New England Journal of Medicine,* Vol. 339, No. 26, 1998.

In the HIV Cost and Services Utilization Study (HCSUS), a nationally representative study of people with HIV/AIDS in care in 1996, women with HIV/AIDS were more likely to be poor, unemployed, and have less education than their male counterparts. All of these factors contribute to difficulties in accessing and affording health care.

Figure 16

Child Rearing Responsibilities of People Living with HIV/AIDS in Care, by Sex, 1996–1997

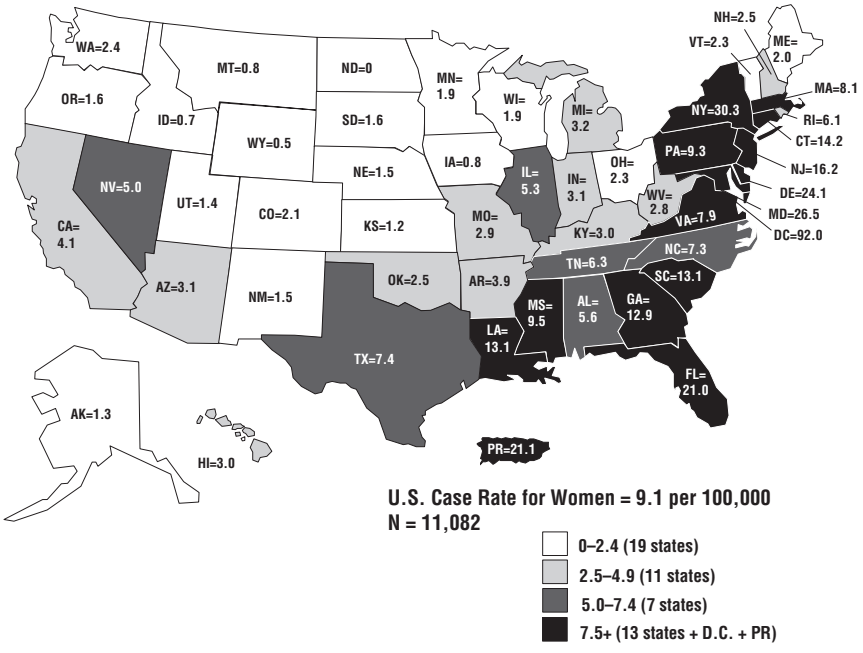


Source: Schuster, et al., "HIV-Infected Parents and Their Children in the United States." *American Journal of Public Health, V*ol. 90, No. 7, 2000.

In addition, women with HIV/AIDS in care were much more likely than men to have dependent children (60% compared to 18%). Of these parents, mothers were also more likely than fathers to live with their children (76% compared to 34%). In addition to managing their own illness, these parents are also responsible for their children's health needs and well-being.

Figure 17

AIDS Cases Rates Among Women, by State, 2001



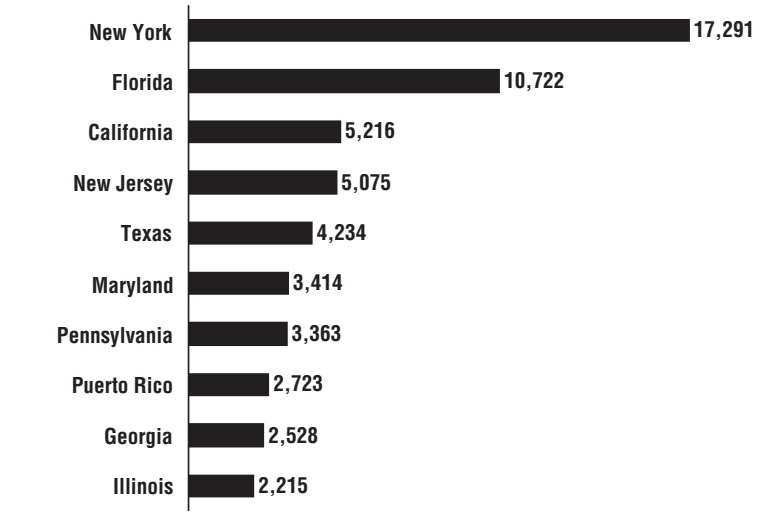
Note: Rates per 100,000 women. Includes reported cases among women 13 years of age and older. These rates should be interpreted with caution—high rates in some states may be more indicative of a small population of women rather than a large number of AIDS cases.

Sources: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance in Women, L264 Slide Series, Through 2001;* Kaiser Family Foundation, *State Health Facts Online,* 2003.

The impact of the epidemic on women is not uniformly distributed across the country. AIDS case rates among women are highest in the Northeast and South. The District of Columbia has the highest AIDS case rate among women in the nation—92.0 per 100,000 women—a rate more than 10 times that of the U.S. average rate among women, followed by New York and Maryland.

Figure 18

Number of Women Estimated to be Living With AIDS: Top 10 States, 2001



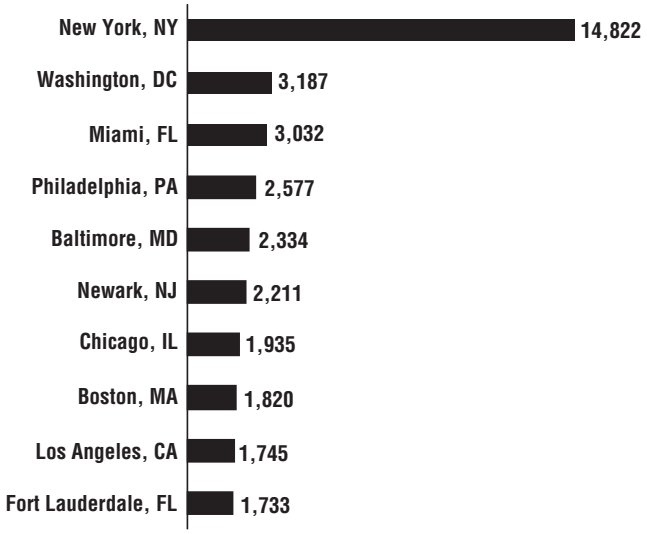
Note: Women estimated to be living with AIDS as of the end of 2001.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Supplemental Report,* Vol. 9, No. 2, 2003.

Similarly, the number of women estimated to be living with AIDS is clustered in a handful of states. Ten states accounted for 72% of the 78,529 women estimated to be living with AIDS as of the end of 2001; five states accounted for over half (54%). New York had the highest number of women estimated to be living with AIDS as of the end of 2001 (17,291), followed by Florida (10,722).

Figure 19

Number of Women Estimated to be Living With AIDS: Top 10 Metropolitan Areas, 2001



Note: Women estimated to be living with AIDS as of the end of 2001. Metropolitan areas include those with over 500,000 population.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Supplemental Report,* Vol. 9, No. 2, 2003.

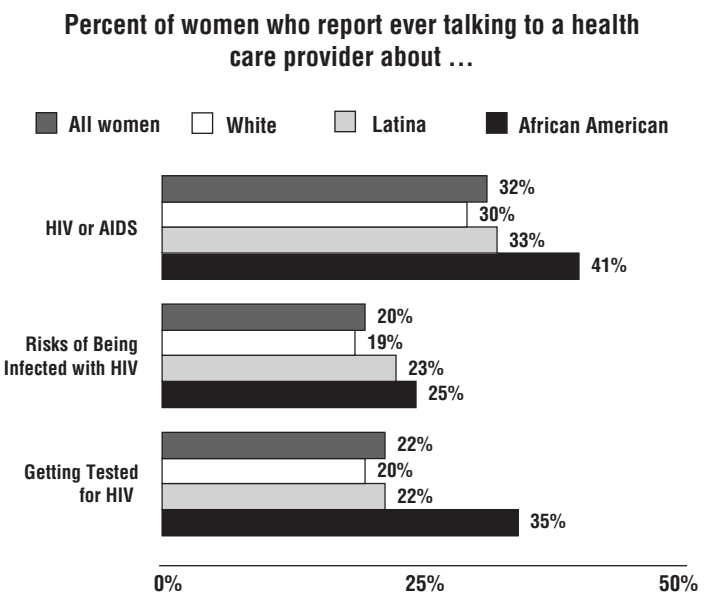
Nearly half (45%) of women estimated to be living with AIDS in the U.S. reside in 10 metropolitan areas; one third (33%) live in five metropolitan areas. The largest number live in New York City (14,822), followed by Washington, D.C. (3,187) and Miami, FL (3,032).

Section 3

Access to and Use of Health Services

Figure 20

Women's Communication with Health Care Providers about HIV/AIDS, 2000

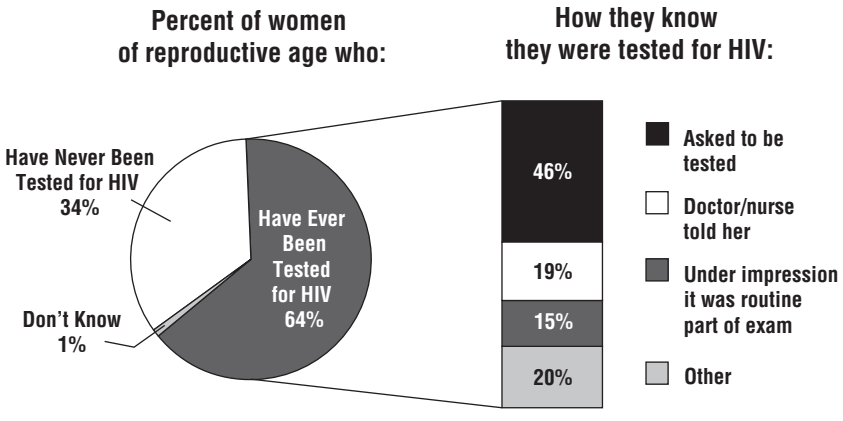


Source: Kaiser Family Foundation, *The AIDS Epidemic at 20 Years, The View from America: A National Survey of Americans on HIV/AIDS,* 2001.

The health care system can be an important source of information about HIV/AIDS; however, most women have not discussed it with their providers. About one-third (32%) of women have talked to a provider about HIV/AIDS, and even fewer women (20%) have discussed their personal risk for infection or HIV testing. On all three measures though, African American women are more likely to have talked with a provider than women of other races/ethnicities.

Figure 21

HIV Testing Practices of Women of Reproductive Age, 2003



Note: Includes women ages 18 to 49.

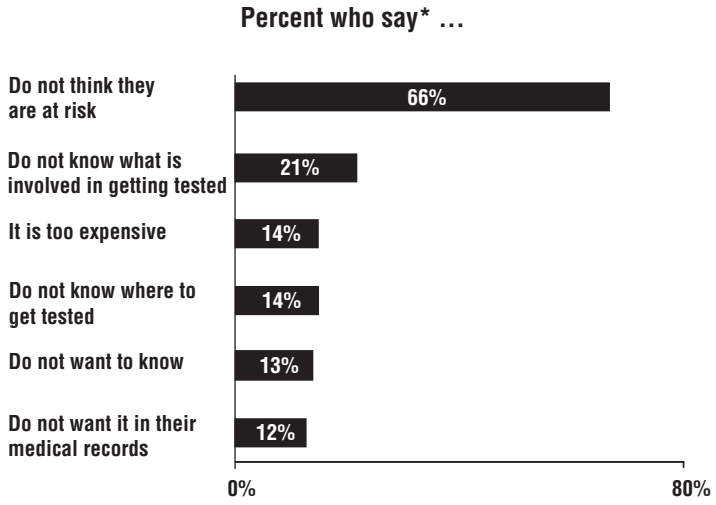
Source: SELF/Kaiser Family Foundation, *A National Survey of Women About Their Sexual Health,* Summer 2003.

Almost two thirds (64%) of women of reproductive age report that they have been tested for HIV at some point. This may be an overestimate, however, since 15% of them were under the impression that that an HIV test is a routine part of an exam.

HIV testing is generally not performed without a patient's direct informed consent. Almost half (46%) of those who say they were tested say they asked for the test; 19% say that a health care professional told them a test was done.

Figure 22

Reasons for Not Being Tested for HIV or STDs Among Women of Reproductive Age, 2003



*Combines "very" and "somewhat" responses

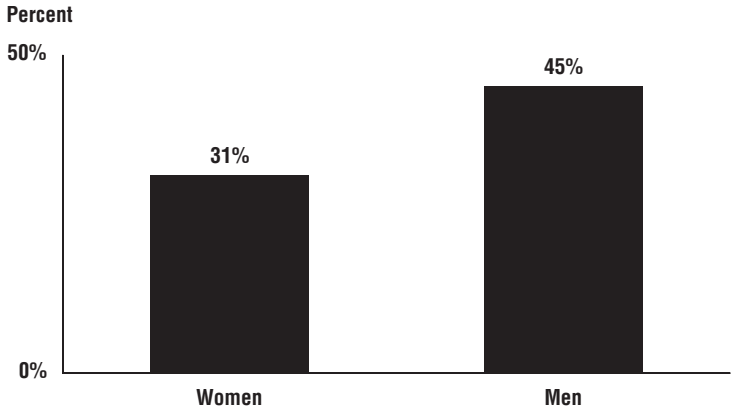
Note: Includes women ages 18 to 49.

Source: SELF/Kaiser Family Foundation, *A National Survey of Women About Their Sexual Health,* Summer 2003.

When asked why they haven't been tested, most women of reproductive age say it is because they do not think they are at risk for HIV (66%). Approximately one fifth (21%) say they have not been tested because they do not know what is involved in getting an HIV test. Others cite cost as a barrier or not knowing where to go to get tested (14%, respectively) and some say they do not want to know (13%). Privacy and confidentiality are concerns for a sizable minority—12% say they have not been tested because they do not want an HIV test in their medical records.

Figure 23

Percent of People with HIV/AIDS Learning of Diagnosis Late in Illness, by Sex,1994–1999



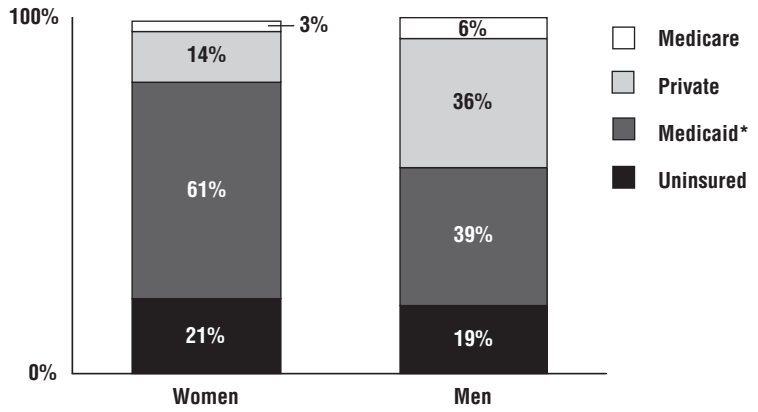
Note: Based on national HIV/AIDS surveillance data from 104,780 persons in 25 states between 1994 and 1999. Late diagnosis was defined as having an AIDS diagnosis at time of first HIV test or developing AIDS within one year of testing positive.

Source: Neal, J. and Fleming P., "Frequency and Predictors of Late Diagnosis in the United States, 1994 through 1999;" *9th Conference on Retroviruses and Opportunistic Infections Poster Presentation 474M,* Centers for Disease Control and Prevention, February 2002.

Early diagnosis is critical for linking people with HIV to needed and ongoing care and treatment. Studies indicate, however, that many people with HIV are diagnosed late in their illness—that is, diagnosed with AIDS at the time of their first HIV test or developing AIDS within one year of testing positive. For example, a CDC study in 25 states found that almost a third (31%) of women tested between 1994 and 1999 were tested late. Women, however, were less likely to be tested late than men (45%). This may be because women are more likely to have contact with the health care system and are often tested for HIV when they are pregnant.

Figure 24

Insurance Coverage of People Living with HIV/AIDS in Care, by Sex, 1996



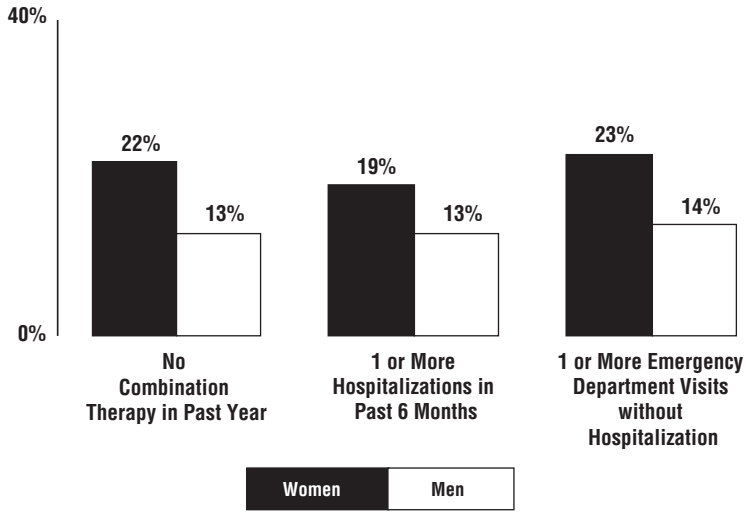
Note: Includes persons 18 years and older. Medicaid includes those with other coverage, primarily Medicare. May not total 100% due to rounding.

Source: Fleishman, J. Personal communication, Analysis of data from the HIV Cost & Services Utilization Study (HCSUS), January 2002.

Women with HIV/AIDS in care were much more likely to be covered by Medicaid than their male counterparts (61% compared to 39%), according to HCSUS. This may in part be due to the fact that women are more likely to meet Medicaid's eligibility criteria than men (be low-income and pregnant or the parent of a dependent child). About one in five women and men with HIV/AIDS in care were uninsured. Men were more than twice as likely to be privately insured than women (36% compared to 14%).

Figure 25

Differential Access to Care Among People with HIV/AIDS in Care, by Sex, 1998



Note: All results shown are significantly different from men ($p < .05$) after adjustment for CD4 count.

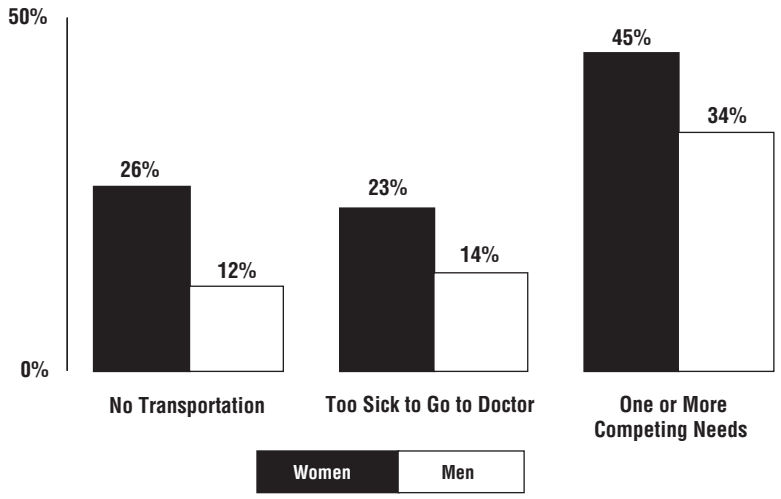
Includes persons 18 years and older. Higher hospitalization rates result from failure to receive indicated outpatient therapy.

Source: Shapiro, et al., "Variations in the Care of HIV-Infected Adults in the United States," *Journal of the American Medical Association,* Vol. 281, No. 24, 1999.

Women also fare more poorly than men on several important access and quality measures. For example, women were less likely than men to have received combination therapy and more likely to have more hospitalizations and emergency room visits without an associated hospitalization, according to HCSUS.

Figure 26

Reasons for Postponing Care Among People with HIV/AIDS in Care, by Sex, 1996



Note: All results shown are significant at p<0.01. Includes persons 18 years and older.

Source: Cunningham, et al., "The Impact of Competing Subsistence Needs and Barriers on Access to Medical Care for Persons with Human Immunodeficiency Virus Receiving Care in the United States," *Medical Care,* Vol. 37, No. 12, 1999.

The reasons for disparities between men and women with HIV/AIDS are not well understood; however, HCSUS provides evidence that women with HIV may face greater barriers to care than men. For example, one fourth of women (26%) with HIV report postponing medical care due to the lack of transportation, compared to 12% of men. Women were also more likely than men to report that they postponed care because they were too sick to go to the doctor or had at least one competing need. In addition, as shown in Figure 15, women with HIV/AIDS in the care system were more likely to be poor, unemployed, and have less education than men, factors associated with diminished access to care.

Figure 27

Ryan White CARE Act, Major Programs and Key Provisions for Women

Program	Overview	Important Services for Women (Selected)	Women as Percent of Population Served
Title I	Provides funding to eligible Metropolitan Areas (EMAs) that are most severely affected by HIV/AIDS; includes a range of care and support services.	• Outpatient medical and dental care and support services • Early intervention services • Substance abuse and mental health services • Case management	32% of Total, 2001[a,1]
Title II	Provides funding to states, territories, and associated jurisdictions; includes a range of care and support services, including the AIDS Drug Assistance Program (ADAP).	• Outpatient medical care and support services • Early intervention services • Home and community-based care • Insurance continuation • Medications (through ADAP)	32% of Total, 2001 (Overall)[a,1] ADAP: 21% of Total, June 2002[2]
Title III	Provides funding to organizations that provide primary health care to people with HIV, such as community health centers and family planning clinics; also supports capacity building and service planning efforts.	• Risk reduction counseling, testing • Medications • Case management • Outreach	29% of clients receiving primary care services in 2001[1]
Title IV	Addresses the specific needs of women, infants, children and youth living with HIV disease.	• Primary and specialty medical care; • Psychosocial services; • Case management • Outreach • Enhanced access to clinical trials and research	42% of Total, 2001[1]

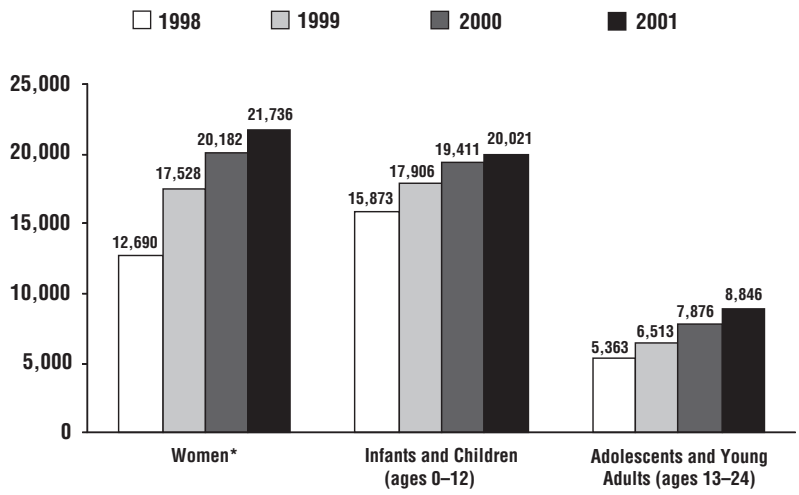
Notes: [a]Counts are duplicated, including all individuals who had at least one visit for any eligible service during the reporting period. Clients with unknown or missing gender data are excluded from totals.

Sources: [1]Health Resources and Services Administration, HIV/AIDS Bureau; [2]NASTAD/KFF/ATDN, *National ADAP Monitoring Project, Annual Report,* April 2003.

In the U.S., one of the most important sources of financing of care for women with HIV/AIDS is the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act is largest HIV/AIDS-specific federal program providing medical, support, and other services for uninsured and low-income people with HIV/AIDS. Many of the components of the CARE Act support services that are of particular importance to women.

Figure 28

Number of People Served by Title IV of Ryan White CARE Act, 1998–2001



Note: Clients with unknown service population data are excluded.

*Includes all women over the age of 24 and pregnant women of all ages.

Source: Health Resources and Services Administration, HIV/AIDS Bureau, *2001 Ryan White CARE Act Title IV Slide Set; Title IV 2000 Program Data Report,* September 2000.

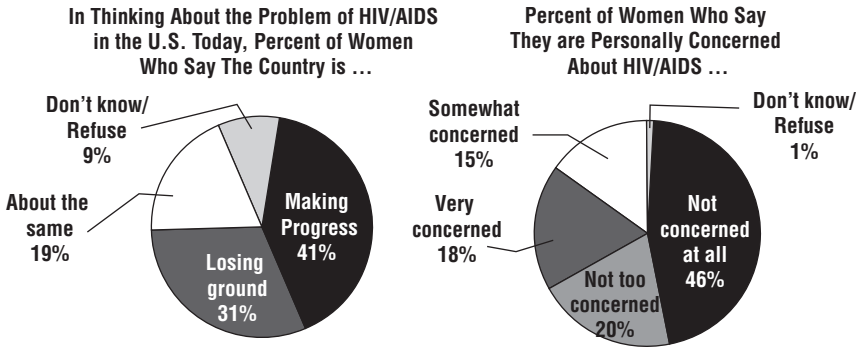
Title IV of the CARE Act is designed to specifically address the needs of women, infants, children and youth living with HIV disease. Services include: primary and specialty medical care; psychosocial services; logistical support and coordination; and outreach and case management. Title IV programs are also intended to enhance client access to clinical trials and research. The number of women served by Title IV rose from over 12,000 in 1998 to over 21,000 in 2001.

Section 4

Perceptions of HIV/AIDS

Figure 29

Women's Perceptions of Progress on HIV/AIDS in the U.S. and Personal Concern About Risk, 2003



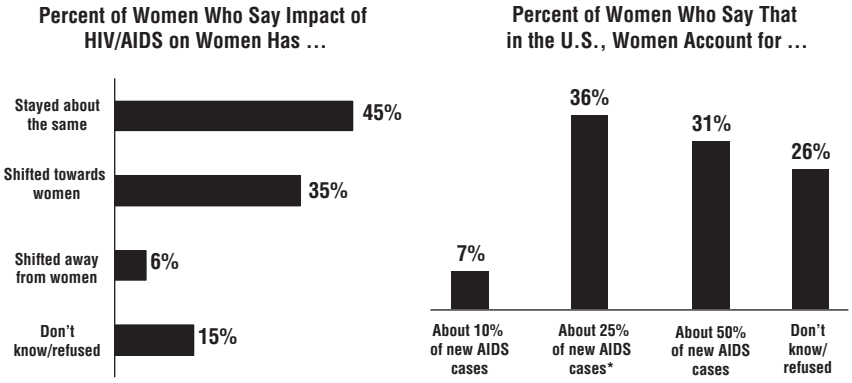
Source: Kaiser Family Foundation, *Health Poll Report*, October 2003.

Women are somewhat divided on the nation's level of progress on addressing HIV/AIDS. While four in ten women feel the U.S. is making progress, almost one third feel that the country is losing ground.

Most women are not personally concerned about becoming infected with HIV (66% are not at all concerned or not too concerned); one third say they are at least somewhat concerned.

Figure 30

Women's Knowledge of the HIV/AIDS Epidemic's Impact on Women, 2003



*As reported in Figure 2, women accounted for 26% of new AIDS cases reported in 2001, according to the Centers for Disease Control and Prevention.

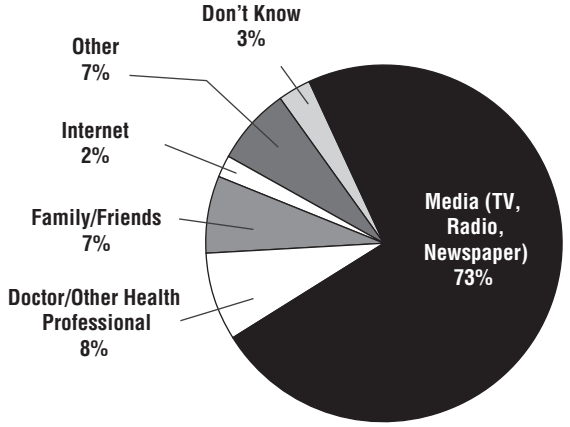
Source: Kaiser Family Foundation, *Health Poll Report*, October 2003.

Most women are not aware of the increasing impact of HIV/AIDS on women. Close to half (45%) of women think that the epidemic's impact on women has remained about the same over the past few years, while approximately one third are aware that the epidemic has shifted more towards women. A little more than one third know that women represent approximately a quarter of new AIDS cases.

Figure 31

Women's Main Sources of Information About HIV/AIDS, 2003

Percent of Women Who Say They Mainly Get Information About HIV/AIDS From …



Source: Kaiser Family Foundation, *Health Poll Report,* October 2003.

Most women say that they mainly get information about HIV/AIDS from the media, such as radio, TV, and newspapers (73%). Other sources include doctors or other health care professionals, friends and family, and the internet, but to a much lesser extent.

CONCLUSION

To date, only modest attention has been paid to the effect of the HIV/AIDS epidemic on women in the U.S. As greater numbers of women in the United States are living with HIV/AIDS, understanding the underlying factors that affect access to care for women who are infected is critical. The disproportionate concentration of the epidemic among women within communities of color, particularly those in the South and Northeast and among women with limited resources is especially striking. Furthermore, the more pronounced representation of girls and women among younger people with HIV may be a harbinger for the epidemic's future trajectory. HIV has serious clinical consequences for women, particularly for their reproductive health. HIV is transmitted more efficiently from men to women during sexual intercourse, and women with HIV are at risk for a host of reproductive conditions, including cervical cancer. In addition to basic differences between the sexes in the manifestation of HIV/AIDS, societal and economic differences between the roles of men and women also affect their ability to attain optimal care and support. Women with HIV are more likely than men to have childcare responsibilities as well as to face challenges such as lack of transportation or housing. Evidence suggests that these barriers have limited women's access to treatment and health care services. However alarming, these trends have developed with relatively little attention and public recognition.

The course of the HIV/AIDS epidemic has changed dramatically over its history. In particular, the advent of antiretroviral therapies has significantly reduced death from HIV and allowed many more people to live healthier, longer lives with HIV infection. However, the epidemic's increasing effects on younger women, combined with the gaps in knowledge about testing, underscore the importance of reaching out to those who are at risk with information about how they can protect themselves. As HIV continues to exact a severe toll on the nation, further research and policy attention to the epidemic's effects on women is warranted.

Section 5
Tables

Table I

Female AIDS Case Rates Per 100,000 Women and Newly Reported AIDS Cases Among Women, by State, 2001

State/Territory	Female AIDS Case Rate per 100,000 Women	Total AIDS Cases Reported Among Women	Women as Percent of Total AIDS Cases Reported Among Women in the U.S.	Women as Percent of Total AIDS Cases in State
United States Total	**9.1**	**11,082**	**100.0%**	**25.8%**
Alabama	5.6	109	1.0%	25.0%
Alaska	1.3	3	0.0%	16.7%
Arizona	3.1	67	0.6%	12.5%
Arkansas	3.9	45	0.4%	22.6%
California	4.1	562	5.1%	13.1%
Colorado	2.1	38	0.3%	13.2%
Connecticut	14.2	207	1.9%	35.4%
Delaware	24.1	82	0.7%	33.3%
District of Columbia	92	243	2.2%	28.0%
Florida	21	1,488	13.4%	29.2%
Georgia	12.9	452	4.1%	25.9%
Hawaii	3	15	0.1%	12.1%
Idaho	0.7	4	0.0%	22.2%
Illinois	5.3	279	2.5%	21.1%
Indiana	3.1	81	0.7%	21.9%
Iowa	0.8	10	0.1%	11.2%
Kansas	1.2	14	0.1%	14.3%
Kentucky	3	52	0.5%	15.7%
Louisiana	13.1	248	2.2%	28.8%
Maine	2	11	0.1%	22.9%
Maryland	26.5	605	5.5%	32.7%
Massachusetts	8.1	223	2.0%	29.3%
Michigan	3.2	136	1.2%	24.9%
Minnesota	1.9	39	0.4%	24.8%
Mississippi	9.5	116	1.0%	27.8%
Missouri	2.9	70	0.6%	15.8%
Montana	0.8	3	0.0%	20.0%
Nebraska	1.5	11	0.1%	14.9%
Nevada	5	41	0.4%	16.3%
New Hampshire	2.5	13	0.1%	32.5%
New Jersey	16.2	588	5.3%	33.7%
New Mexico	1.5	11	0.1%	7.7%
New York	30.3	2,481	22.4%	33.4%
North Carolina	7.3	254	2.3%	27.0%
North Dakota	0	0	0.0%	0.0%
Ohio	2.3	114	1.0%	19.7%
Oklahoma	2.5	36	0.3%	14.8%
Oregon	1.6	23	0.2%	8.9%
Pennsylvania	9.3	501	4.5%	27.4%
Rhode Island	6.1	28	0.3%	27.7%
South Carolina	13.1	230	2.1%	31.9%
South Dakota	1.6	5	0.0%	20.0%
Tennessee	6.3	156	1.4%	25.9%
Texas	7.4	637	5.7%	22.1%
Utah	1.4	12	0.1%	9.7%
Vermont	2.3	6	0.1%	24.0%
Virginia	7.9	243	2.2%	25.7%
Washington	2.4	60	0.5%	11.3%
West Virginia	2.8	22	0.2%	22.2%
Wisconsin	1.9	44	0.4%	23.0%
Wyoming	0.5	1	0.0%	20.0%
Puerto Rico	21.1	324	2.9%	26.1%
Virgin Islands	27.1	13	0.1%	37.1%
Guam	1.6	1	0.0%	8.3%
Residence Unknown	NA	25	0.2%	22.1%

NA = not available.

Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report, Year End Edition 2001,* Vol. 13, No. 2.

Table II

Estimated AIDS Prevalence (Number of People Living with AIDS) Among Women, by State, as of December 2001

State	Estimated AIDS Prevalence Among Women	Women as Percent of Total Estimated AIDS Prevalence Among Women in the U.S.	Women as Percent of Estimated Prevalence in State
United States Total*	**78,529**	**100.0%**	**21.7%**
Alabama	691	0.9%	20.3%
Alaska	38	0.0%	16.9%
Arizona	438	0.6%	11.2%
Arkansas	350	0.4%	18.9%
California	5,216	6.6%	10.6%
Colorado	294	0.4%	9.2%
Connecticut	1,906	2.4%	30.1%
Delaware	410	0.5%	28.8%
District of Columbia	1,818	2.3%	24.2%
Florida	10,722	13.7%	26.6%
Georgia	2,528	3.2%	20.8%
Hawaii	98	0.1%	8.8%
Idaho	34	0.0%	14.2%
Illinois	2,215	2.8%	19.1%
Indiana	435	0.6%	14.2%
Iowa	82	0.1%	12.9%
Kansas	153	0.2%	14.4%
Kentucky	307	0.4%	15.5%
Louisiana	1,336	1.7%	21.6%
Maine	67	0.1%	14.3%
Maryland	3,414	4.3%	30.3%
Massachusetts	2,066	2.6%	26.8%
Michigan	1,074	1.4%	20.2%
Minnesota	279	0.4%	16.0%
Mississippi	654	0.8%	27.3%
Missouri	568	0.7%	12.3%
Montana	19	0.0%	10.6%
Nebraska	90	0.1%	16.9%
Nevada	339	0.4%	14.7%
New Hampshire	101	0.1%	19.6%
New Jersey	5,075	6.5%	31.8%
New Mexico	94	0.1%	8.8%
New York	17,291	22.0%	28.6%
North Carolina	1,431	1.8%	24.2%
North Dakota	7	0.0%	14.9%
Ohio	833	1.1%	15.7%
Oklahoma	209	0.3%	12.4%
Oregon	212	0.3%	9.1%
Pennsylvania	3,363	4.3%	24.3%
Rhode Island	266	0.3%	26.8%
South Carolina	1,450	1.8%	26.6%
South Dakota	17	0.0%	17.9%
Tennessee	978	1.2%	18.7%
Texas	4,234	5.4%	16.6%
Utah	108	0.1%	9.7%
Vermont	39	0.0%	17.1%
Virginia	1,490	1.9%	21.3%
Washington	493	0.6%	10.6%
West Virginia	87	0.1%	15.4%
Wisconsin	271	0.3%	16.0%
Wyoming	9	0.0%	11.1%
Puerto Rico	2,723	3.5%	26.9%
Virgin Islands	98	0.1%	33.4%
Guam	5	0.0%	15.2%
Residence Unknown	NA	NA	NA

*Total includes cases with unknown state of residence.
Source: Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Supplemental Report,* Vol. 9, No. 2, 2003.

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