

Reframing women's vulnerability through a gendered and structural lens: Women economic empowerment as an HIV prevention strategy

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Abstract

Women and girls continue to experience disproportionate HIV vulnerability across regions marked by deep-rooted gender inequality and economic insecurity. While biomedical advances have expanded prevention options, the structural determinants particularly poverty, economic dependence and limited financial autonomy remain under-addressed drivers of HIV risk. Economic vulnerability reduces women's bargaining power, heightens exposure to gender-based violence and restricts access to HIV prevention and treatment services. Emerging evidence shows that economic empowerment interventions including cash transfers, savings groups, livelihood programs and financial literacy training can reduce HIV risk behaviors and enhance agency. This commentary argues that economic empowerment must be recognized as a central pillar of HIV prevention and care beyond a peripheral development issue. Integrating economic strengthening within sexual and reproductive health and HIV programs offers a gender-transformative pathway to reduce vulnerability and improve long-term outcomes. Achieving global HIV targets requires confronting economic inequities as core health challenges.

Introduction

Women and girls across regions including sub-Saharan Africa, Asia and the Pacific, the Caribbean and Eastern Europe and Central Asia experience disproportionate HIV vulnerability shaped by persistent economic inequalities. Globally, women account for over half of all people living with HIV [1], and in many settings they continue to face lower wages, limited access to formal employment and reduced ownership of financial assets relative to men [2–3]. While biological factors and gender norms contribute, economic vulnerability is a major structural driver of women's HIV risk. Limited access to secure work, financial resources and independent income often creates conditions in which HIV vulnerability becomes embedded. Yet global HIV responses continue to prioritize biomedical solutions over structural interventions that address inequities in economic power, despite evidence that within-country inequality and gendered disparities in wealth and income remain pronounced worldwide [2,3]. Since these vulnerabilities are economic in nature; the limited access to education, livelihoods and financial resources constrains women's agency and negotiating power, leading pathways to HIV risk. Consequently, economic empowerment interventions have become a critical complement to biomedical and behavioural HIV prevention strategies [4].

Economic Vulnerability as a Driver of HIV Risk

Poverty and income shocks significantly increase women's HIV vulnerability. Evidence shows that unexpected income shocks may push women toward transactional or survival sex due to acute financial pressures. The complete economic dependence on their male partners expose women to unequal power relations and reduces their ability to negotiate condom use, refuse sex or exit unsafe relationships. Such dependence is closely linked to intimate partner violence [4,5], a well-documented pathway driving HIV acquisition risk.

Women's HIV vulnerability is not merely a health issue but is rooted in unequal access to wealth and income compared to men and elite groups. Although global income gaps between countries have narrowed, persistent within-country inequality, especially widening disparities between rich and poor, continues to undermine women's economic agency and access to essential health services. Gender disparities in labor income and asset ownership are a central dimension of this inequality, with women consistently holding a smaller share of wealth and economic power compared to men, further exacerbating their vulnerability to HIV [2].

Economic insecurity also limits access to HIV services. Transport costs, childcare burdens, workplace stigma and lost wages reduce women's ability to test regularly, initiate or remain on Pre-exposure prophylaxis (PrEP), adhere to treatment and stay engaged in clinical care. Women living with HIV who lack stable income face greater risk of treatment interruptions and poorer clinical outcomes [6]. These barriers highlight the necessity of integrating economic empowerment into HIV programs.

Economic Empowerment Interventions and HIV Outcomes

Economic empowerment interventions, including cash transfer programmes and Village Savings and Loan Associations (VSLAs), have demonstrated promise in reducing HIV vulnerability, specifically among adolescent girls and young women. Such cash transfer programmes may be conditional, requiring school attendance or health service utilisation, or even unconditional, providing direct financial support without behavioural requirements. Evaluations of such programmes have assessed outcomes including school retention, delayed early marriage, reductions in transactional sex, and improvements in agency and decision-making.

Such economic empowerment programs like VSLAs, which promote collective saving, access to small loans, and financial literacy, have been shown to enhance economic security and social cohesion, strengthening women's ability to make autonomous decisions related to health and relationships. These interventions contribute to HIV prevention by reducing reliance on risky coping strategies and improving negotiating power within intimate relationships [7,8].

Livelihood strengthening and skills-building initiatives improve long-term financial stability and reduce reliance on high-risk income strategies. Integrated interventions that combine financial literacy with communication and relationship-strengthening components have been shown to improve joint decision-making among HIV-affected couples, with potential benefits for treatment adherence and relational wellbeing [9].

Economic empowerment also intersects with gender-based violence reduction. HIV and gender-based violence are mutually reinforcing epidemics rooted in women's social and economic subordination [10]. Interventions that enhance financial independence may reduce exposure to violence, thereby indirectly lowering HIV risk.

Limitations of Predominantly Biomedical Responses

Biomedical innovations such as HIV self-testing, oral PrEP and rapid antiretroviral therapy initiation have significantly advanced global HIV responses. However, their impact is constrained when women lack the economic or social resources to consistently access

or adhere to prevention and treatment. Even promising tools such as long-acting injectable PrEP cannot achieve equitable impact without addressing affordability, accessibility and structural inequalities.

The Integration of Economic Empowerment into HIV Responses and Policy Implications

Effective HIV prevention for women requires a multisectoral approach that positions economic empowerment as a crucial axis. Poverty reduction strategies should be conceptualized as HIV prevention tools. Integrated economic empowerment within SRHR and HIV platforms through savings groups, livelihood programs, digital skills training and financial literacy can substantially increase women's resilience.

Digital livelihoods offer new opportunities for economic participation, particularly for young women, but these must be paired with digital safety protections [11]. Economic programming should also be gender-transformative, promoting equitable financial decision-making, reducing violence and challenging harmful norms regarding control of resources.

Donors and governments must integrate economic empowerment into national HIV responses and global funding frameworks (especially in current times). Monitoring and evaluation systems should include measures of financial autonomy, livelihood stability and economic resilience. Cross-ministerial collaboration among Health, Finance, Labor and Women's Affairs ministries is essential for sustainable, integrated interventions. Scaling up microfinance groups, livelihood programs and economic strengthening initiatives can align HIV responses with Sustainable Development Goals on gender equality and equitable health.

Conclusion

Women's disproportionate HIV vulnerability is shaped profoundly by economic inequities that limit agency, diminish access to health services and increase exposure to violence. Economic empowerment through cash transfers, savings groups, livelihood support and financial skills development is a powerful yet underutilized approach to reducing HIV vulnerability and strengthening resilience. Integrating economic empowerment into HIV prevention and treatment frameworks is non-negotiable for building gender-equitable, sustainable health systems. A global HIV response that centers women's economic rights is not only evidence-based but necessary for ending the HIV epidemic.

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