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Women, the girl child and HIV and AIDS

Report of the Secretary-General

Summary

Persistent gender inequality and human rights violations that put women and girls at greater risk of infection continue to hamper progress in preventing the spread of HIV and increasing access to antiretroviral treatment. In addition to women's and girls' biological susceptibility to HIV, many interacting sociocultural, economic and legal challenges compound their vulnerability to infection.

The challenges to the health and well-being of women and girls, including the lack of accessible and affordable health services, education and employment opportunities, inequitable property and inheritance rights, harmful cultural norms and child marriage, persist across countries and hinder efforts to mitigate the epidemic.

Member States have made progress in improving the situation of women and girls infected with and affected by HIV. However, given the multidimensionality of the epidemic's impact on women and girls, further accelerated action is required at the national, regional and international levels. Significant gaps persist in actions and funding to provide gender-responsive programmes and services that take into account the challenges and barriers brought on by structural and social realities. There is a need to do more to eradicate harmful gender norms and discriminatory laws and to promote the meaningful participation of women and girls in national and international decision-making processes.

The present report highlights progress reported by Member States and within the United Nations system to implement Commission on the Status of Women resolution 56/5, along with the related gaps and challenges, and concludes with recommendations for future actions.

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I. Introduction

1. In its resolution 56/5, the Commission on the Status of Women requested the Secretary-General to report to the Commission at its fifty-eighth session on the situation of women, the girl child and HIV and AIDS,[1] with an emphasis on accelerated actions taken, in accordance with the Beijing Declaration and Platform for Action, the Programme of Action of the International Conference on Population and Development, the 2006 and 2011 Political Declarations on HIV/AIDS and the 2011 Commitments on HIV/AIDS. The present report is submitted in accordance with that request.

2. The examples set out in the present report are based on contributions by 18 Member States[2] and 11 United Nations entities[3] for the period from September 2011 to October 2013. In addition, it incorporates other relevant information based on research, including the findings from the midterm review of the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV.

II. Background

3. Globally, an estimated 35.3 million adults and children were living with HIV at the end of 2012; of the 32.1 million adults living with HIV in 2012, 17.7 million were women. This represents an increase of 1 million since 2011.[4] In 1997, 41 per cent of adults living with HIV were women. This increased to 49 per cent in 2001 and to 55 per cent in 2012. Since the previous report (E/CN.6/2012/11), the proportion of women among those living with HIV has decreased in all regions except Eastern Europe and Central Asia, in which the rate increased from 26 per cent in 2010 to 33 per cent in 2012. However, the pace of decline in new HIV infections among women worldwide has slowed since 2008.[4] Among adults aged 15 years and older, 47 per cent of new infections were among women in 2012,[4] although women were particularly affected in sub-Saharan Africa, where 56 per cent of new infections among adults were among women, and in the Caribbean, where women accounted for 52 per cent of new infections among adults.[5] Girls are at a particularly high risk of infection. Approximately two thirds of new HIV infections

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[1] AIDS is an epidemiological definition based on clinical signs and symptoms. It is caused by HIV, which destroys the body's ability to fight off infection and disease, which can ultimately lead to death. Antiretroviral therapy slows down the replication of the virus but does not eliminate HIV infection.

[2] Brazil, Burkina Faso, Cameroon, Colombia, Denmark, Finland, Gambia, Japan, Kenya, Netherlands, Norway, Paraguay, Poland, Romania, Qatar, Spain, United Kingdom of Great Britain and Northern Ireland and United Republic of Tanzania. The number of responses received from Member States has been decreasing since 2009, from 30 to 18 for the present report.

[3] Economic and Social Commission for Asia and the Pacific, International Labour Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Industrial Development Organization, United Nations Office on Drugs and Crime, United Nations Research Institute for Social Development, United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and World Food Programme.

[4] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva, 2013).

[5] UNAIDS 2012 unpublished HIV estimates.

in adolescents (aged 15-19 years) were among girls at the end of 2012.[6] According to UNAIDS, every hour 50 young women are newly infected with HIV.[7] In 2012 36 per cent of all AIDS-related deaths were of women,[4] and AIDS remains the leading cause of death for women of reproductive age worldwide.[8]

4. Women with HIV infection also face a higher risk of morbidity from other diseases. In settings with a high HIV prevalence, young women ages 15 to 24 experience tuberculosis rates 1.5 to 2 times higher than men in the same age group.[4] Women with HIV also face a heightened risk of cervical cancer. A recent meta-analysis showed that women with HIV had a sixfold increased risk of cervical cancer.[9]

5. Heterosexual transmission accounts for the largest proportion of HIV prevalence worldwide. Marriage rarely protects women and may even serve to increase exposure to HIV. More than four fifths of new HIV infections in women occur in marriage or long-term relationships with primary partners.[10] Indeed, in Asia and the Pacific, significant numbers of women are becoming infected with HIV not because of their own sexual behaviours but because their male partners engage in unsafe behaviours.[11] Women, in all their diversity,[12] also face increased risk: for example, female sex workers are 13.5 times more likely to be living with HIV than other women worldwide,[13] and transgender women are almost 49 per cent more likely to be living with HIV compared with adults of similar age, on the basis of a meta-analysis undertaken in 15 countries.[14]

III. Normative framework

6. The normative framework for women's and girls' full enjoyment of human rights, including equality and non-discrimination, in the context of HIV and AIDS is derived from a number of sources. The most notable include the 2011 Political Declaration on HIV and AIDS (General Assembly resolution 65/277, annex), which

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[6] UNICEF, *Towards an AIDS-Free Generation: Children and AIDS — Sixth Stocktaking Report, 2013* (New York, 2013).

[7] UNAIDS, "AIDS by the numbers" (Geneva, 2013).

[8] UN-Women, "The gender dimension of the Millennium Development Goals Report 2013", 1 July 2013. Available from www.unwomen.org/en/news/stories/2013/7/the-gender-dimension-of-the-millennium-development-goals-report-2013.

[9] Myassa Dartell and others, "Risk factors for high-risk human papillomavirus detection among HIV-negative and HIV-positive women from Tanzania", *Sexually Transmitted Diseases*, vol. 40, No. 9 (September 2013), pp. 737-743.

[10] UNFPA, *State of World Population 2005: The Promise of Equality — Gender Equity, Reproductive Health and the Millennium Development Goals* (New York, 2005).

[11] See, for example, Asia-Pacific Inter-Agency Task Team on Women, Girls, Gender Equality and HIV, *Country Briefs on HIV and Key Affected Women and Girls in ASEAN* (2013).

[12] This includes women in rural and hard-to-reach areas, young women, women living with HIV, women with disabilities, women in conflict areas, transgender women, women who have sex with women, women involved in sex work, refugees, women who use drugs and indigenous women (as defined in Athena Network and others, "In women's words: action agenda" (2011)).

[13] Deanna Kerrigan and others, *The Global HIV Epidemics among Sex Workers* (Washington, D.C., World Bank, 2013).

[14] Frits van Griensven, Prempreeda Pramoj Na Ayutthaya and Erin Wilson, "HIV surveillance and prevention in transgender women", *The Lancet Infectious Diseases*, vol. 13, No. 3 (March 2013), pp. 185-186.

established a set of 10 specific and time-bound targets to be met by 2015, including meeting the specific needs of women and girls and eliminating gender inequalities and gender-based abuse and violence; the 2006 Political Declaration on HIV/AIDS (Assembly resolution 60/262, annex), in which States were called upon to take all measures necessary to create an enabling environment for the empowerment of women; and the 2001 Declaration of Commitment on HIV/AIDS (Assembly resolution S-26/2), in which States committed to implementing national strategies that promote the advancement of women and their full enjoyment of human rights. Alongside these, the Convention on the Elimination of All Forms of Discrimination against Women provides the guiding human rights principles and framework for actions to address HIV/AIDS in women and girls.

7. During the period under review, issues of gender equality in the context of HIV and AIDS were raised with regard to peace and security, children's rights, violence against women and human rights. In its resolution 2106 (2013), the Security Council noted the link between sexual violence in armed conflict and post-conflict situations and HIV infection, and the disproportionate burden of HIV and AIDS on women and girls as a persistent obstacle and challenge to gender equality. In the same resolution, the Council urged United Nations entities, Member States and donors to support the development and strengthening of capacities of national health systems and civil society networks in order to provide sustainable assistance to women and girls living with or affected by HIV and AIDS in armed conflict and post-conflict situations.

8. In its general recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations (CEDAW/C/GC/30), the Committee on the Elimination of Discrimination against Women acknowledged the association between gender-based violence and HIV, including deliberate HIV transmission, encouraging greater action to address the connections, and urged emphasis on women's access to HIV prevention, treatment, care and support in these settings. In its general comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), the Committee on the Rights of the Child urged States to "review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion" (CRC/C/GC/15, para. 31). In the agreed conclusions on the elimination and prevention of all forms of violence against women and girls, adopted by the Commission on the Status of Women at its fifty-seventh session (E/2013/27-E/CN.6/2013/11, sect. I.A), the Commission called for the acceleration of efforts to address the intersection of HIV and AIDS and violence against women and girls, as well as for the elimination of discrimination and violence against women and girls living with HIV and the caregivers of persons living with HIV.

9. The African Commission on Human and Peoples' Rights adopted a general comment pertaining to article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, in which it enumerated State obligations to ensure women's right to self-protection from HIV.[15]

[15] Available from www.achpr.org/news/2012/11/d65.

IV. Actions taken by Member States and the United Nations system

10. Since the issuance of the previous report to the Commission, some progress has been made among Member States, the United Nations and other key stakeholders to meet the needs of women and girls in the context of HIV and AIDS, as evidenced in the actions and results reported. Progress has been reported in actions to eliminate gender inequalities, including through the integration of gender equality dimensions into national AIDS strategies and plans; increased funding for interventions targeting women and girls in the context of HIV; actions taken to strengthen the empowerment and rights of women and girls and to promote their participation in the HIV/AIDS response; efforts undertaken to ensure equal access for women and girls to prevention, treatment, care and support programmes and integrated sexual and reproductive health and HIV services; and accelerated actions towards eliminating gender-based violence and engaging men and boys in the promotion of gender equality.

A. Integration of gender equality into national HIV and AIDS responses

11. Member States have employed different approaches to address gender equality in the HIV and AIDS response at the policy level, including incorporating gender perspectives into their national policies, frameworks, programmes and plans that address HIV and AIDS (Brazil, Burkina Faso, Colombia, Finland, Gambia, Kenya, Paraguay and United Republic of Tanzania). Some Member States reported integrating measures to address HIV and AIDS in their national action plans on gender equality (Cameroon, Gambia, Paraguay, Spain and United Republic of Tanzania).

12. While such efforts are in line with translating commitments and targets within the 2011 Political Declaration on HIV and AIDS into national policies, research is showing a different picture. Member States have made strides in acknowledging and applying a gender lens to national HIV and AIDS policies, but interventions do not go far enough towards tackling the structural drivers of the epidemic, which are a critical aspect of the response.[16] A review of the national strategic plans of 20 countries in Southern and Eastern Africa found that few provided concrete interventions to tackle the structural drivers of HIV transmission, including creating a supportive legal and policy framework to promote gender equality.[17]

13. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and its co-sponsoring agencies, in particular the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), in collaboration with partners, have expanded their support for Member States in integrating gender equality dimensions

[16] Structural drivers include the social, economic, political and environmental factors that contribute to the HIV epidemic by increasing susceptibility to HIV and undermining prevention and treatment efforts.

[17] Andrew Gibbs and others, “The inclusion of women, girls and gender equality in national strategic plans for HIV and AIDS in Southern and Eastern Africa”, *Global Public Health*, vol. 7, No. 10 (2012).

into their national HIV strategic plans, including supporting increased capacity and expertise on gender equality in national HIV and AIDS coordinating bodies. The United Nations entities, in collaboration with MEASURE Evaluation, the United States President's Emergency Plan for AIDS Relief, the United States Agency for International Development and a number of national and civil society partners, have also developed tools to conduct a gender assessment of the epidemic and response; conduct a gender audit to evaluate gender expertise in key institutions or undertake a gender road map for advocacy; and draw on a compilation of evidence on effective strategies for women and girls, including programmatic guidance on addressing HIV and its interlinkage with violence against women and a compendium of gender equality and HIV indicators to support the comprehensive monitoring and tracking of results.

B. Financing the HIV/AIDS response for women

14. Overall, Member States did not report having specifically tracked budgetary allocations for gender equality priorities in national HIV/AIDS responses. One notable exception is the United Republic of Tanzania, which reported efforts to track expenditures on resources allocated to programmes for women, girls, gender equality and HIV through a gender-sensitive national AIDS spending assessment. Additional research indicates that Rwanda introduced a gender budget statement to guide adequate resource allocations for women in HIV-related policies and programmes.

15. Domestic and international HIV-specific funding increased from $15 billion in 2010 to an estimated $18.9 billion in 2012, although it still fell short of the estimated $22 billion to $24 billion needed for a comprehensive response to HIV worldwide. The Global Fund to Fight AIDS, Tuberculosis and Malaria has approved more than $15.5 billion for HIV efforts in more than 140 countries to date,[18] and the private sector, including foundations and corporations, has also played a major role in funding the HIV/AIDS response, in particular the Bill and Melinda Gates Foundation. The limited collection of HIV expenditure data disaggregated by sex and the lack of assessment tools to track expenditures for interventions that address the structural drivers of the epidemic make it difficult to estimate the extent to which HIV and AIDS funding has been allocated towards interventions that meet the needs of women and girls. According to UNAIDS, only 57 of 104 reporting countries had an HIV strategy that included a specific budget for women.[19] Further complicating the collection of evidence is the lack of clear criteria for interventions that seek to address gender inequalities in the HIV and AIDS responses, which could potentially be included in spending assessment tools and guidance.[20]

16. Despite the general lack of data to track allocations of funding for gender-responsive interventions, analysis of the existing data on HIV expenditure for women and girls indicates that preventing new infections in children and keeping

[18] The Global Fund to Fight AIDS, Tuberculosis and Malaria, Grant portfolio. Available from http://portfolio.theglobalfund.org/.

[19] UNAIDS, report on the UNAIDS 2014-2015 results, accountability and budget matrix (UNAIDS/PCB(32)/13.9).

[20] UNAIDS, *Women Out Loud: How Women Living with HIV Will Help the World End AIDS* (Geneva, 2012).

mothers alive account for a large proportion of HIV interventions targeting women. From the data available, of the total HIV funding specific to interventions on women between 2009 and 2011, an estimated 71 per cent was allocated to preventing vertical transmission; 23 per cent to prevention programmes for sex workers and their clients (including men and women); 5 per cent to programmes to reduce gender-based violence; and only 1 per cent to all other programmes specific to women.[20] In this landscape, civil society organizations, including networks of women living with HIV, have expressed concerns about shrinking financial support for their efforts, which impedes their ability to effectively engage and participate in the response. An estimated 42 per cent of Global Fund investments go to support the health of women and girls by reducing child mortality and improving maternal health.[21] Countries implementing programming to end new infections in children and keep mothers alive have requested funds mainly for the provision of antiretroviral drugs for women during pregnancy and/or labour, rather than the long-term treatment needs of women living with HIV, comprehensive reproductive health services or family planning.[22] Among the significant donors to the international HIV/AIDS response, the United States President's Emergency Plan for AIDS Relief has made significant investments in women and HIV. Among other gender equality initiatives, the Emergency Plan targeted $155 million in funds at combating gender-based violence between 2010 and 2011.

C. Empowerment, participation and rights of women and girls in the context of HIV and AIDS

1. Legal framework for addressing the rights of women, adolescents and girls in the context of HIV/AIDS

17. The enactment of laws to protect the human rights of women and girls living with and affected by HIV and AIDS is essential to creating an enabling environment for effective HIV responses. In particular, legal frameworks to support women and girls and to mitigate the epidemic are important in terms of decriminalizing HIV transmission, prohibiting early, child and forced marriage and enhancing property rights for women. Recognizing the importance of these frameworks, the Global Commission on HIV and the Law, an independent panel of legal, political and public health experts convened by UNDP and UNAIDS, urged Governments to use the law to protect women from inequality and all forms of violence. In a paper prepared for the Global Commission, it was reported that discriminatory laws related to HIV often had a disproportionate impact on women.[23]

18. Early, child and forced marriage and early sexual debut exacerbate the risk of HIV infection among young women and girls. In 146 countries, State or customary law allows girls younger than 18 to marry with the consent of parents or other

[21] The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Strategic Investments for Impact: Global Fund Results Report 2012* (Geneva, 2012).

[22] The Global Fund to Fight AIDS, Tuberculosis and Malaria, "An analysis of gender-related activities in Global Fund-approved proposals from rounds 8 and 9" (2011).

[23] Aziza Ahmed, "Property and inheritance laws: the impact on women and OVC in the context of HIV", paper prepared for the third meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, July 2011.

authorities.[24] Once married, girls are, in many cases, powerless to negotiate safer sex with their husbands, who are commonly older and more sexually experienced.[25] They are also more likely to drop out of school. All these factors render girls especially vulnerable to HIV and other sexually transmitted infections.[25] Given that in many countries the early initiation of sex occurs frequently, laws preventing girls and adolescents from seeking sexual and reproductive health services, including HIV testing, also contribute to the increased risk of HIV infection.[24] Several countries in Eastern and Southern Africa and South Asia, the regions with particularly high rates of child, early and forced marriage, are making some progress towards eradicating these types of marriages, including Bangladesh, Ethiopia, Lesotho, Nepal, Rwanda, Uganda, the United Republic of Tanzania and Zimbabwe. However, the practice remains prevalent in the majority of these regions.[24]

19. Cameroon and Kenya reported that the promotion of awareness-raising campaigns on the harm caused by early marriage was important to a comprehensive approach to HIV prevention. The United Republic of Tanzania identified the prevalence of early marriage as a challenge to the implementation of HIV/AIDS policies and programmes. A number of countries reported developments related to the legal rights of women living with or affected by HIV: Burkina Faso reported that it was moving towards ensuring women's equal access to land and property, and Kenya reported that it had enhanced women's access to legal recourse by eliminating court legal fees. Member States also reported on laws prohibiting stigma and discrimination based on HIV status (Paraguay, United Kingdom and United Republic of Tanzania).

20. Addressing child marriage is a key component of the work of UNFPA to uphold the rights of adolescents and youth. For example, a UNFPA-supported programme in Nepal, Choose Your Future, teaches girls who are not in school about health issues and encourages the development of basic life skills.

21. Property and inheritance legal regimes may distribute property and other assets in a manner that results in economic inequalities, thereby affecting women's health.[26] Women living with HIV and AIDS are particularly vulnerable to violations of their property and inheritance rights because of the stigma associated with HIV. Women's limited access to legal services and legal recourse in certain countries undermines their ability to claim property rights when such rights do exist.[26]

22. Among United Nations entities, UN-Women partnered with 20 grass-roots and community-based groups in nine countries in sub-Saharan Africa to reduce women's vulnerability to HIV and mitigate the impact through programmes that improve women's access to property and inheritance rights. Outcomes included increased legal literacy for more than 15,000 women living with or affected by HIV and AIDS. UNDP, in collaboration with a number of non-governmental organizations, recently launched "Tools for change", a resource that brings together international human rights instruments on women's property and inheritance for easy reference and use by advocates.

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[24] UNFPA, *Marrying Too Young: End Child Marriage* (New York, 2012).

[25] UNFPA and UNICEF, *Women's and Children's Rights: Making the Connection* (New York, 2010).

[26] UN-Women, *Progress of the World's Women 2011-2012: In Pursuit of Justice* (New York, 2011).

2. Participation of women and girls in the context of HIV and AIDS

23. It is a central tenet of the global AIDS response, and one reason for its success, that people living with and affected by HIV must be full participants in decision-making processes. This is both strategically imperative, as women's and girls' participation is essential to creating effective policies and programmes, and a normative obligation, as articulated in a number of international agreements, commitments and declarations (see A/HRC/20/26). Globally, there has been a decline in women's and girls' participation in national HIV planning processes. UNAIDS reported that in countries where it was present, women living with HIV participated in formal planning in 61 per cent of the countries in 2012, down from 66 per cent in 2010.[27] Likewise, women comprised only 29 per cent of representatives on The Global Fund's country coordinating mechanisms in 2012, down from 36 per cent at the end of the fourth quarter of 2010.[28] Research has shown that women's participation is affected by stigma and discrimination, the lack of access to information and resources, the burden of caregiving and responsibilities within the home and illiteracy.[29] Research also indicates that greater participation can be supported by an enabling environment.[30]

24. Few Member States reported on progress in ensuring women's participation in national HIV and AIDS responses. In particular, Burkina Faso reported that networks of civil society organizations had been established to provide a platform for exchange and to enhance advocacy at the national and subnational levels on gender-responsive HIV programming. As part of the national HIV/AIDS response, the Ministry of Women's Affairs of Cameroon has undertaken awareness-raising activities for women through organized groups and events for people living with HIV.

25. United Nations entities highlighted actions to support women's leadership and participation in the HIV response. The Inter-Agency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children, with the support of the United Nations Children's Fund (UNICEF), UNFPA and other partners, launched a 22-country accountability project on building the leadership of women living with HIV. In Asia and the Pacific, a United Nations inter-agency task team on women and girls supported the "Unzip the lips" platform, contributing to a more effective and systematic engagement on the part of key affected women and girls in policy advocacy at the regional level. In sub-Saharan Africa, the African Union, with support from UNDP, UN-Women, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNAIDS, launched the GlobalPOWER Africa Women Network in 2012. This women-led initiative, first conceptualized by African female decision makers and their American counterparts, will provide a strategic political platform in which to accelerate HIV prevention and sexual and reproductive health and rights responses for women and girls in Africa.

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[27] UNAIDS, performance monitoring report 2012 (UNAIDS/PCB(32)/13.5).

[28] The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2012 country coordinating mechanisms composition report: 2009-2011 global and regional data on gender balance. Available from www.theglobalfund.org/en/ccm/data.

[29] United Nations Development Fund for Women (UNIFEM) and Athena Network, *Transforming the National AIDS Response: Advancing Women's Leadership and Participation* (New York, UNIFEM, 2010).

[30] UNAIDS, final report of the midterm review of the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV (UNAIDS/PCB(31)/12.20).

In addition, utilizing a variety of strategies, UNAIDS, UNDP, UN-Women, and the Food and Agriculture Organization of the United Nations invested in the leadership capacity of women and girls living with HIV and key populations[31] in 60 countries. UNAIDS promoted women's voices through the publication of *Women Out Loud: How Women Living with HIV Will Help the World End AIDS* in 2012.

D. Universal access to prevention programmes, treatment, care and support

26. Meeting the health needs and ensuring the rights of women and girls remain a challenge in HIV and AIDS responses. Stigma and discrimination persist. Efforts to integrate the HIV response with sexual and reproductive health services, including the expansion of services and sexuality education for adolescents, are not being undertaken as fast or as comprehensively as they could. Although health systems are trying to meet the demands, in many settings they are inadequate, and there continues to be a disproportionate burden of caregiving shouldered by women and girls.

1. Prevention programmes, treatment, care and support coverage

27. The percentage of pregnant women living with HIV who receive antiretroviral therapy to reduce the risk of mother-to-child transmission significantly increased from 48 to 65 per cent between 2010 and 2012 in low- and middle-income countries; however, progress was uneven across regions. Coverage was highest in Eastern and Central Europe and the Caribbean (more than 90 per cent), while coverage was much lower in Asia and the Pacific and the Middle East and North Africa (less than 20 per cent).[32] Despite the increases, services that prevent mother-to-child transmission continue to be out of reach for many women living with HIV. Such services, particularly in rural areas and at the primary-health-care level, are often unavailable owing to inadequate decentralization, limited financial resources, a weak infrastructure, severe human resource constraints and a lack of provider capacity. In 2012, among pregnant women who needed antiretroviral therapy for their own health, only 58 per cent received it.[32] While data are not disaggregated by sex, in priority countries identified in the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive, only 3 in 10 children receive HIV treatment.[32] Although research is limited, there is some evidence that indicates that the accessibility and the quality of HIV treatment services for sex workers and transgender persons are severely lacking.[33]

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[31] These include women and girls with disabilities, those who inject drugs and those who are incarcerated, transgender, migrant or sex workers.

[32] UNAIDS, *2013 Progress Report on the Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive* (Geneva, 2013).

[33] Kerrigan and others, *The Global HIV Epidemics among Sex Workers;* Sam Winter, *Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region* (Bangkok, UNDP Asia-Pacific Regional Centre, 2012); The Global Coalition on Women and AIDS, *Women who Use Drugs, Harm Reduction and HIV* (Geneva, 2011).

2. Implementation efforts to address prevention, treatment, care and support

28. A majority of Member States that submitted inputs (Burkina Faso, Cameroon, Colombia, Finland, Gambia, Japan, Kenya, Netherlands, Norway, Paraguay, Poland, Romania, Qatar and United Republic of Tanzania) reported gender-specific efforts related to HIV prevention, treatment, care and support. Finland, the Netherlands and Norway provided funding to non-governmental organizations that conduct programmes, including sharing information related to HIV services, for immigrant women living with and affected by HIV. In the context of prevention, countries reported on the expansion of the use of and access to contraceptives, including male and female condoms (Brazil, Burkina Faso and Colombia) and of efforts to prevent mother-to-child transmission (Brazil, Burkina Faso, Colombia, Finland, Gambia, Japan, Kenya, Norway, Poland, Romania and United Republic of Tanzania). A number of Member States reported the expansion of HIV prevention, treatment and counselling services for women and girls, including sex workers (Brazil, Colombia, Finland and Poland) and injecting drug users (Romania). The provision of treatment to all those eligible was reported by a number of Member States (Denmark, Finland, Netherlands, Poland, Romania and United Kingdom).

29. In 2013, WHO issued new guidelines for the use of antiretroviral medicines for HIV treatment and prevention, recommending the initiation of lifelong antiretroviral therapy for all pregnant and breastfeeding women living with HIV. To spur the accelerated scaling-up of HIV treatment, Malawi implemented the guidelines and began to offer lifelong antiretroviral therapy to pregnant women living with HIV (known as “Option B+”), resulting in a 7.5-fold increase in the number of such women receiving therapy over a 15-month period. In addition to Malawi, seven countries have changed their national guidelines to adopt Option B+ (Cambodia, Fiji, Indonesia, Maldives, Nepal, Papua New Guinea and Thailand). However, women living with HIV have raised concerns about how Option B+ is being implemented. They have cited insufficient information, inadequate time for deliberation, and limited efforts to promote informed consent and choice.[34]

30. In 11 countries in the West and Central African region, UNFPA supported a combination HIV prevention strategy for women and girls, with a focus on situation analysis, strategy development, peer education, sexual and reproductive health and HIV service delivery.[34] In Nepal, on the basis of the specific needs of women who use drugs, the United Nations Office on Drugs and Crime, together with a local non-governmental organization, initiated an innovative health camp using a low-cost community-based care and support model. WHO, in partnership with UNFPA, UNAIDS and the Global Network of Sex Work Projects, has developed new guidelines to improve sex workers’ access to health services.[35] UNAIDS, WHO and UNICEF reported on their continued support towards meeting the targets of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive. UNICEF, UNFPA and UNDP supported countries in expanding coverage of effective programmes and interventions for the prevention of heterosexual transmission of HIV, including multiple concurrent partnerships. The World Food Programme integrated food and nutrition support with

[34] UNAIDS, document UNAIDS/PCB(32)/13.5.

[35] WHO, *Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low- and Middle-Income Countries: Recommendations for a Public Health Approach* (Geneva, 2012).

HIV treatment to increase treatment success and adherence and reduce malnutrition. UN-Women supported the engagement of communities in advocacy towards increasing treatment and integrating services with maternal health care and actions to address violence against women.

3. Meeting the sexual and reproductive health needs and ensuring the rights of women and girls

31. Integrated sexual and reproductive health services, including HIV prevention, treatment and care, cervical cancer screening and treatment, maternal health care and family planning services, are essential in the fight against HIV. For young women and girls, access to HIV prevention, treatment and care services is impeded by a range of factors, including inadequate sexuality education and health information and unequal power relations in relationships with men. A recent UNESCO report found that all countries in the Eastern and Southern African region had a policy or strategy to promote life skills-based HIV education for young people. However, the limited evidence available indicated that few of those policies or strategies were fully operationalized and costed. Such trends are reflected in the low number of sexually active young people with knowledge of appropriate prevention information.[36] In nine[37] of the countries with the highest prevalence of HIV among adolescents, only 30 per cent of adolescent girls have been tested and know their HIV status.[38] Young women and girls with disabilities are at a particularly heightened risk, as they may not have access to prevention information, either because they are believed to be asexual and therefore not at risk or because they do not attend school, where they can receive information on HIV prevention.[39]

32. Increasing educational opportunities for girls is a critical step in decreasing their vulnerability to HIV. Evidence shows that school attendance reduces early sexual debut and risky behaviours, which, in turn, have an impact on HIV transmission. Girls are at increased risk of dropping out of school as they approach adolescence, which is also when the risk of HIV infection increases.[40] Cash transfer programmes have targeted girls to keep them in school and to reduce early marriage and pregnancy rates. A recent study in Malawi found that cash transfers aimed at keeping girls in school led to a 64 per cent reduction in the prevalence of HIV infection after 18 months.[41] However, the long-term benefits of such programmes are still unclear. The structural conditions that drive gender inequality are not

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[36] Global Commission on HIV and the Law, *HIV and the Law: Risks, Rights and Health* (New York, UNDP, 2012).

[37] Kenya, Lesotho, Mozambique, Namibia, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

[38] *Progress for Children: A Report Card on Adolescents*, No. 10 (United Nations publication, Sales No. E.12.XX.2).

[39] Poul Rohleder and others, “HIV/AIDS and disability in Southern Africa: a review of relevant literature”, *Disability and Rehabilitation*, vol. 31, No. 1 (January 2009), pp. 51-59.

[40] UNICEF, “Promoting equity for children living in a world with HIV and AIDS” (2012).

[41] Sarah J. Baird and others, “Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomized trial”, *The Lancet*, vol. 379, No. 9823 (April 2012), pp. 1320-1329.

addressed through cash transfer programmes, so their effectiveness in the longer term is still unclear.[42]

33. Brazil, Kenya, the Netherlands, Paraguay, Romania, Spain and the United Republic of Tanzania reported on their efforts to integrate their HIV response with sexual and reproductive health services, while Brazil, Cameroon, Finland, the Netherlands and Spain reported actions to improve HIV and sexual and reproductive health education for adolescents.

34. UNESCO supported ministries of education in 75 countries in strengthening comprehensive sexuality education curriculums, with a consistent focus on gender equality as a prerequisite for successful impact. With support from UNICEF, UNFPA and UNESCO, 17 African countries have strengthened their capacity and resources to review and develop their curriculums with a view to reducing risk behaviours among young people.[34]

35. Another significant challenge to women's and girl's health and well-being is the burden of caregiving shouldered by women and girls. Indeed, women and girls carry out most of the unpaid care work in the household and constitute the majority of home-based caregivers supporting those living with HIV or dealing with AIDS. Studies have demonstrated that this care, most often unrecognized and uncompensated, has a negative impact on women's physical and mental health.[43] Furthermore, women and girls pay an opportunity cost when undertaking unpaid care work for HIV- and AIDS-related illnesses, since their ability to participate in income generation, education and skills-building diminishes. Measuring and valuing the contribution of this work is important. In Kenya, community organizations of women caregivers of persons with HIV have collected data on the time that women spend volunteering and providing care and support in communities. Women caregivers have mobilized around the data and are now represented in decision-making structures, such as district health committees.[44]

E. Eliminating gender-based violence and engaging men and boys

36. Gender-based violence is a staggeringly widespread public health and human rights issue. A WHO study in 2013 found that more than 35 per cent of women worldwide had experienced either non-partner sexual violence or physical and/or sexual violence by an intimate partner, or both, with the highest prevalence in Africa (45.6 per cent) and South-East Asia (40.2 per cent).[45] Nonetheless, countries have taken action towards stemming the tide of gender-based violence. The number of

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[42] Paul Pronyk and Brian Lutz, "Policy and programme responses for addressing the structural determinants of HIV", Structural Approaches to HIV Prevention Position Paper Series (Arlington, Virginia, and London, United States Agency for International Development and Department for International Development, 2013).

[43] See A/68/293; see also Olagoke Akintola, "Towards equal sharing of AIDS caring responsibilities: learning from Africa", paper prepared for the expert group meeting on equal sharing of responsibilities between men and women, including caregiving in the context of HIV/AIDS, Geneva, October 2008.

[44] Shannon Hayes, "Valuing and compensating caregivers for their contributions to community health and development in the context of HIV and AIDS: an agenda for action" (New York, Huairou Commission, 2010).

[45] WHO, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva, 2013).

countries with laws against gender-based violence doubled between 2010 and 2012.[46] The midterm review of the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV brought into relief the urgent need for more evidence on gender-based violence and HIV to inform country-level policies and programmes. Although almost two thirds of the countries that launched the Agenda reported national policies to fight gender-based violence, one third of those do not have data available on the links between gender-based violence and HIV.[47]

37. HIV and gender-based violence are inextricably linked and mutually reinforcing. Women and girls are more physiologically vulnerable to HIV than men, with increased transmission risk due to injuries as a result of forced sex. Consequently, in some regions women who have experienced intimate partner sexual violence are 1.5 more times more likely to acquire HIV than women who have not.[45] During conflict situations, women and girls face an elevated risk of sexual and physical violence, including rape, increasing their risk of contracting HIV.[48]

38. Inversely, women living with HIV may face a particularly high risk of violence as a result of their HIV status.[49] Findings from the People Living with HIV Stigma Index indicate that women living with HIV are more frequent targets of verbal abuse and physical violence than their male counterparts.[50] Stigma, shame and discrimination often keep survivors of violence and women and girls living with HIV from seeking services, and those who do seek services often find them to be non-existent or discriminatory. A study carried out in six countries in Asia showed that 30 per cent of the women surveyed were encouraged to consider sterilization.[51] In addition, instances of involuntary sterilization of women living with HIV have been reported in Argentina, Chile, Mexico and Namibia.[52]

39. Although there is a strong legislative framework for gender-based violence in a number of countries, insufficient budgets and political commitment often undermine the implementation of effective programming and policies. It was found that service providers addressing the needs of survivors of violence who were living with HIV were typically overstretched, underfunded and inadequately supported.[53] Consistent with this trend, although 12 countries in Southern Africa have accessible, affordable and specialized services for survivors of gender-based violence, these

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[46] UNAIDS, document UNAIDS/PCB(32)/13.5.

[47] UNAIDS, document UNAIDS/PCB(31)/12.20.

[48] WHO, “Violence against women and HIV/AIDS: critical intersections — sexual violence in conflict settings and the risk of HIV”, WHO Information Bulletin Series, No. 2 (Geneva, 2004).

[49] E. L. Machtinger and others, “Psychological trauma and PTSD in HIV-positive women: a meta-analysis”, *AIDS and Behavior*, vol. 16, No. 8 (November 2012), pp. 2091-2100.

[50] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2012* (Geneva, 2012).

[51] Asia Pacific Network of People Living with HIV/AIDS, “Positive and pregnant: how dare you? A study on access to reproductive and maternal health care for women living with HIV in Asia” (March 2012).

[52] Lilian Sepúlveda, “Forced sterilization preys on women living with HIV/AIDS”, 27 July 2012. Available from http://reproductiverights.org/en/press-room/chile-forced-sterilization-lilian-hiv-aids-oped.

[53] United Nations Trust Fund to End Violence against Women and UN-Women, “Effective approaches to addressing the intersection of violence against women and HIV/AIDS: findings from programmes supported by the United Nations Trust Fund to End Violence against Women” (2012).

service providers remain underresourced, with limited capacity to deliver on their mandates.

40. A number of Member States (Brazil, Burkina Faso, Cameroon, Colombia, Gambia, Spain and United Republic of Tanzania) have increased efforts to prevent gender-based violence. For example, the Gambia developed a plan for the accelerated abandonment of female genital mutilation. In Brazil, a women and rights campaign was launched using multimedia tools to highlight the severity of violence against women. The Government of Cameroon trained community health workers to address violence against women and girls. These efforts have the potential to reduce the risk of HIV infection.

41. United Nations agencies have taken a range of actions towards the elimination of gender-based violence. As a result of collaboration between the International Labour Organization and Governments, employers and workers' organizations, eight countries (Botswana, Cambodia, Cameroon, Chile, Dominican Republic, Kenya, Mozambique and Zambia) adopted national HIV and AIDS workplace policies that specifically address gender-based violence and/or harassment. UNICEF is piloting a social norms and community-based care programme for survivors of gender-based violence in conflict settings in Somalia and South Sudan. UNDP launched the first-ever rapid assessment of institutional readiness to deliver gender-based violence and HIV services in Papua New Guinea to support a better integration of services.

42. After the inclusion in 2011 of an indicator on intimate partner violence in the UNAIDS guidelines for reporting progress on the global AIDS response, 50 of 186 countries reported data on this indicator in 2013 national reports.[54] Given that the indicator represents a proxy indicator for gender inequality, it would be important to see more countries reporting data on this indicator in order to support better monitoring.

43. A growing evidence base has demonstrated that interventions that engage men and boys in addressing harmful gender norms and practices can reduce violence and increase safer sexual behaviours.[55] However, much more needs to be done in this regard. Globally, only 1 in 10 countries effectively engage men and boys in national efforts to promote healthy gender norms in the context of HIV.[56]

44. Few Member States reported programmes that engaged men and boys in promoting gender equality in the context of HIV and AIDS (Netherlands, Romania and United Republic of Tanzania). Among civil society organizations and United Nations entities, the Athena Network, the Sonke Gender Justice Network, UNFPA, UNDP, WHO, UNAIDS and UN-Women provided technical and financial support to 36 countries to engage men and boys in preventing violence within the HIV response.

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[54] UNAIDS, *Global Report 2013.*

[55] Shari L. Dworkin, Sarah Treves-Kagan and Sheri A. Lippman, "Gender-transformative interventions to reduce HIV risks and violence with heterosexually active men: a review of the global evidence", *AIDS and Behavior*, vol. 17, No. 9 (November 2013), pp. 2845-2863.

[56] African Union Commission, New Partnership for Africa's Development and UNAIDS, *Delivering Results Toward Ending AIDS, Tuberculosis and Malaria in Africa: African Union Accountability Report on Africa-G8 Partnership Commitments 2013* (2013).

V. Conclusions and recommendations

45. **Member States, United Nations entities and civil society organizations have taken important steps to increase the integration of gender equality in national and international HIV responses. Member States reported actions to enhance gender equality priorities in national HIV and AIDS plans and strategies and in gender equality action plans; promote the participation of women and girls in decision-making bodies and their legal rights; increase access to HIV prevention programmes, treatment, care and support; and implement actions towards reducing the incidence of gender-based violence. However, obstacles remain. Structural barriers, including discriminatory laws and stigma, unequal power relations and lack of access to education and economic security, as well as insufficient funding and political commitment, impede progress. Moreover, efforts to hold States accountable and to monitor and evaluate initiatives are frustrated by the fact that key data, including on new infections, are seldom disaggregated by sex.**

46. **Concerted action is needed to ensure that gender equality is integrated into HIV and AIDS responses at all levels. Achieving the Millennium Development Goals depends on Member States' addressing gender equality and the empowerment of women and girls as human rights and as essential development objectives, all of which are core elements of effective and sustainable HIV and AIDS plans and programmes. Discussions on the post-2015 development agenda create an additional opportunity to take account of the specific needs of women and girls in the context of HIV, both in terms of formulating a stand-alone target on health and setting other relevant goals, including those on gender equality, education and sexual and reproductive health and rights. However, to date few national consultation reports have highlighted the particular needs of women and girls in the context of HIV and AIDS in the post-2015 agenda.**[57]

47. **Thus, the Commission may wish to encourage Member States to demonstrate stronger political commitment to ensuring the well-being and protecting the rights of women and girls in order to accelerate the prevention, increase treatment coverage and support the mitigation of the impact of HIV and AIDS by adopting comprehensive strategies that address gender inequality and harmful gender norms and laws, such as:**

(a) **Ensuring that national HIV plans and policies prioritize the needs of women and girls and that targeted programmatic actions, including institutionalizing structures to support the operationalization of policies and establishing robust monitoring frameworks to ensure accountability, are costed, budgeted for and implemented;**

(b) **Expanding the evidence base, including the collection and disaggregation of data by sex and age at the local, national and international levels, to guide targeted interventions and ensure that the specific needs of women and girls in all their diversity are accurately addressed;**

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[57] Megan Dersnah, "An analytical review of national post-2015 consultation reports from a gender perspective", background paper prepared for the expert group meeting on structural and policy constraints in achieving the Millennium Development Goals for women and girls, Mexico City, October 2013.

(c) **Reviewing existing laws, regulations and programmes that address the rights of women and girls living with and affected by HIV and institutionalizing legal frameworks to ensure, inter alia, the elimination of all forms of discrimination on the basis of HIV status, gender and sexual orientation; women's enjoyment of equal rights in marriage and cohabitation; women's property and inheritance rights; the decriminalization of HIV status and transmission; and the elimination of all forms of coercive and discriminatory practices in health-care settings, such as coerced and forced sterilization;**

(d) **Increasing cooperation and willingness to include women living with and affected by HIV in the development of national strategic frameworks, including capacity-building and resource allocations to enable networks of women and girls to meaningfully participate and lead in decision-making at all levels, including in the design, implementation and monitoring and evaluation of HIV programmes; and establishing minimum targets and monitoring mechanisms to ensure the participation of women and girls;**

(e) **Scaling up interventions and increasing investments in programmatic activities that factor in the differential impact of HIV and AIDS on women and girls and transform gender dynamics towards greater equality and justice for women and girls, including ensuring that national investment cases apply gender equality as a central principle;**

(f) **Investing in actions that tackle the structural drivers of HIV, which may include activities to increase the access of women and girls to employment and educational opportunities, economic resources, property and inheritance, as well as programmes to reduce stigma and discrimination against women and girls living with and affected by HIV;**

(g) **Increasing access to treatment, prevention and care services for women and girls in all their diversity, including outside the perinatal setting and for adolescents; and expanding voluntary HIV counselling and testing for women and girls, with an emphasis on consent and confidentiality;**

(h) **Recognizing the sexual and reproductive health needs and rights of women and girls in all their diversity, including the implementation of all national, regional and international legislation and commitments that promote and protect women's and girls' sexual and reproductive rights, in addition to integrating family planning and other reproductive health services in HIV interventions without exception; strengthening linkages between HIV services and those for non-communicable diseases; implementing programmes that provide universal access to comprehensive sexuality education for girls and boys both in and out of school; and addressing practices that are harmful to the health and rights of women and girls, such as early, forced and coerced marriage;**

(i) **Providing financial support to women and girl caregivers in the context of HIV/AIDS as part of relevant national policies and programmes and enabling their participation in HIV and AIDS-related decision-making processes, in addition to interventions to increase their access to social services;**

(j) **Implementing a multisectoral response to gender-based violence by strengthening the legal and policy environment to ensure that laws prohibiting**

gender-based violence are enacted and enforced and to prevent and provide redress for gender-based violence in all its forms; providing adequate funding for interventions to support survivors' access to justice and remedies and prevent and reduce the occurrence of gender-based violence, including those that sensitize law enforcement, health-care workers and the judiciary to respond more effectively to gender-based violence;

(k) **Scaling up efforts to encourage men and boys to challenge harmful social norms and practices and supporting their participation in efforts to eliminate the vertical transmission of HIV and adopt safer and responsible sexual and reproductive behaviour.**

48. **The Commission may also wish to encourage the United Nations system and other international and regional actors to:**

(a) **Work closely with Member States, civil society and development partners to assess the effectiveness of the HIV response in terms of equality and inclusion, including supporting monitoring and accountability mechanisms and providing technical assistance to the national AIDS coordinating authority and its partners in developing and tracking targets and indicators to measure the gender-related outcomes and impacts of the HIV and AIDS responses;**

(b) **Ensure sustained and scaled-up funding for networks of women and girls living with and affected by HIV to substantially enhance the full and active participation of women in national and international HIV and AIDS responses, including investing in capacity development and mentoring efforts;**

(c) **Provide guidance for ensuring that the strategic investment frameworks and cases being developed in countries apply gender equality as a key principle across all programme areas;**

(d) **Provide sustained, long-term support to national partners, including civil society organizations, in their efforts to promote gender equality in HIV/AIDS strategies and programmes.**

49. **The Commission may wish to encourage civil society organizations to:**

(a) **Support, through organizing, capacity training and mentoring, the active engagement of women and girls, in particular young women and adolescent girls living with and affected by HIV, in identifying and designing programmes and plans related to the response to HIV and AIDS, including in the development of strategies to monitor results, allocated funding and assessments of expenditures towards the priorities and needs of women and girls in all their diversity, and hold Governments accountable for implementing commitments;**

(b) **Engage with Governments to advocate for establishing mechanisms for ongoing interaction with women living with HIV and those affected by HIV and AIDS, and to influence and inform policies and programmes on HIV and AIDS at the national and subnational levels;**

(c) **Reach out to partners working across the spectrum of gender- and HIV and AIDS-related issues to build synergies and joint strategies and to increase collaboration in implementing programmes.**

50. **The Commission may wish to encourage the private sector to review HIV funding and proposal guidelines to ensure that they encourage the development of proposals that advance gender equality and address the needs of women and girls in all their diversity; and integrate gender equality targets and indicators into performance monitoring and evaluation frameworks.**