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Women, the girl child and HIV and AIDS

Report of the Secretary-General

Summary

The past two years have been marked by improvements in HIV prevention and treatment. More women are receiving HIV testing and, knowing their status, benefiting from antiretroviral therapy and achieving viral suppression. To accelerate HIV prevention, countries have strengthened the integration of HIV and sexual and reproductive health-care services and addressed HIV considerations in their plans and strategies to reduce gender-based violence.

Despite the robust HIV response, the reduction of the number of new HIV infections among women and girls has been slow and uneven across regions. Since 2010, the number of new HIV infections among women aged 15 and older has decreased in Asia and the Pacific, the Caribbean, Eastern and Southern Africa, Western and Central Africa and Western and Central Europe and North America. However, the number of new infections among women and girls has increased in Eastern Europe and Central Asia, the Middle East and North Africa and Latin America. Structural gender inequalities, discrimination, violence against women and girls, and unequal gender norms continue to undermine efforts by women and girls to prevent HIV and use HIV services. Furthermore, proven strategies to prevent HIV among women and girls have not been scaled up; research on female-controlled HIV prevention methods and on treatment that is safe and appropriate for women and girls has not been prioritized; and national HIV strategies and policies have not included sufficiently funded gender-responsive interventions. Globally, AIDS continues to be the leading cause of death among women and girls of reproductive age (15–49).

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I. Introduction

1. In its resolution 62/2 (see E/2018/27), the Commission on the Status of Women reiterated the continued resolve to achieve the commitments made in resolution 60/2 on women, the girl child and HIV and AIDS (see E/2016/27), urged Member States to accelerate their implementation and requested the Secretary-General to submit a progress report on the implementation of the resolution at its sixty-fourth session.

2. The present report is based on contributions from 45 Member States,[1] 13 United Nations entities[2] and one subregional intergovernmental organization.[3] It also includes recent evidence and research and Member State data submitted through the Joint United Nations Programme on HIV/AIDS (UNAIDS) Global AIDS Monitoring system.

II. Background

3. Between 2010 and 2018, the number of new HIV infections among women aged 15 years and older declined by 17 per cent globally, from 890,000 [680,000–1.2 million] to 740,000 [570,000–1 million];[4] yet this global progress hides discrepancies between regions. Between 2010 and 2018, the number of new HIV infections among women aged 15 and older declined by 24 per cent in Western and Central Europe and North America, 24 per cent in Eastern and Southern Africa, 14 per cent in Asia and the Pacific, 14 per cent in the Caribbean, and 7 per cent in Western and Central Africa. But, at the same time, new infections among women and girls increased by 27 per cent in Eastern Europe and Central Asia, 11 per cent in the Middle East and North Africa, and 8 per cent in Latin America. Since the previous report (E/CN.6/2018/8) in 2018, the number of new HIV infections among women and girls have maintained similar global and regional trends.

4. Adolescent girls and young women continue to be at a disproportionately high risk of HIV infection. In signing the 2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 (General Assembly resolution 70/266, annex), Member States committed to reducing the annual number of new HIV infections among young women aged 15 to 24 to below 100,000 by 2020. Between 2010 and 2018, progress in reducing new HIV infections among young women aged 15 to 24 varied by region,

[1] Armenia, the Bahamas, Belarus, Bosnia and Herzegovina, Botswana, Burkina Faso, Burundi, Cambodia, Central African Republic, China, Colombia, Cuba, Cyprus, Ecuador, El Salvador, Eswatini, Georgia, Greece, Guatemala, Iran (Islamic Republic of), Italy, Jamaica, Jordan, Lao People's Democratic Republic, Lebanon, Lesotho, Malawi, Malaysia, Mexico, Namibia, the Netherlands, Peru, Romania, Seychelles, Sierra Leone, Slovenia, Spain, Sri Lanka, Switzerland, Turkey, Uganda, United Republic of Tanzania, Uruguay, Zambia and Zimbabwe.

[2] The International Fund for Agricultural Development (IFAD), the International Labour Organization (ILO), International Organization for Migration (IOM), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the United Nations Children's Fund (UNICEF), the United Nations Country Team in Brazil, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Office on Drugs and Crime (UNODC), the United Nations Population Fund (UNFPA), the United Nations University (UNU), and the World Food Programme (WFP).

[3] South African Development Community (SADC).

[4] Unless otherwise indicated, the findings in the present report are sourced from the AIDSinfo online database accessed on 28 October 2019. Available from http://aidsinfo.unaids.org. Square brackets denote uncertainty bounds around estimates to indicate the range within which UNAIDS is confident that the point estimate lies.

ranging from a 28 per cent reduction in Eastern and Southern Africa to a 3 per cent reduction in Latin America. Member States are still far from the 2020 target, however, with 310,000 [190,000–460,000] new infections in this age group alone in 2018.

5. More than half of people living with HIV are women and girls. In 2018, 18.8 million [16.4–21.7 million] women aged 15 and older were living with HIV, compared with 17.4 million [14.8–20.5 million] men and boys. The majority of women living with HIV lived in sub-Saharan Africa, with 14.8 million [12.9–16.9 million] women aged 15 and older living with HIV, followed by 2.1 million [1.8–2.6 million] in Asia and the Pacific. Of the 2.2 million [1.1–3.3 million] young women aged 15 to 24 living with HIV, 1.6 million [740,000–2.3 million] lived in Eastern and Southern Africa. Globally, AIDS-related illnesses continue to be the leading cause of death among women and girls of reproductive age (15–49).[5]

6. While progress has been made towards the 90–90–90 fast-track targets for 2020 set out by UNAIDS,[6] the global targets are unlikely to be met for women and girls. Between 2017 and 2018, the proportion of women living with HIV aged 15 years and older globally who knew their HIV status increased slightly from 82 per cent [71–95] to 84 per cent [73–>95]; the proportion of women living with HIV receiving antiretroviral treatment increased from 64 per cent [49–76] to 68 [52–82] per cent; and the proportion of women living with HIV who have a suppressed viral load increased from 55 per cent [45–65] to 59 [49–70] per cent. There is significant regional variation in the achievement of the 90–90–90 fast-track targets for 2020, ranging from Eastern and Southern Africa which achieved levels of 88–72–64 to the Middle East and North Africa which achieved levels of 49–35–29. The uneven progress across regions is a cause for concern in the efforts to end HIV/AIDS among women and girls.

7. Progress in the prevention and treatment of HIV among women and girls is undermined by the root causes that drive the HIV pandemic among them. Unequal gender norms in many countries discourage women from discussing HIV prevention, including with their sexual partners; hinder their access to and use of HIV information and services; and put them at risk of harmful behaviours, such as gender-based discrimination and violence. Those root causes impede women and girls from making decisions related to their sexual and reproductive health and undermine the effectiveness of the HIV response. Women and girls who are subject to multiple and intersecting forms of discrimination (such as adolescent girls and young women, women and girls in key populations,[7] women with disabilities, older women and migrant women) face an even greater risk of HIV infection and barriers in accessing treatment and care. The root causes that drive HIV among women and girls also include structural gender inequalities which result in a failure to protect the right to health of women and to impede the physical and financial access of women to health-care services, education and employment that would support their efforts to prevent HIV and obtain treatment. HIV prevention and treatment among women and girls is also influenced by physiological factors that influence the risk of HIV infection and disease progression.[8]

[5] World Health Organization, “Global Health Estimates 2016: Disease burden by Cause, Age, Sex, by Country and by Region, 2000–2016” (Geneva, 2018).

[6] The fast-track targets are that, by 2020, 90 per cent of people living with HIV know their status, 90 per cent of people living with HIV who know their status are receiving treatment and 90 per cent of people receiving treatment have a suppressed viral load.

[7] Terminology guidelines from UNAIDS define key populations as people who inject drugs, sex workers, transgender people, prisoners and gay men and other men who have sex with men.

[8] E.P. Scully, “Sex Differences in HIV Infection,” *Current HIV/AIDS Reports,* No. 15 (2018).

III. Normative framework

8. The 2030 Agenda for Sustainable Development (resolution 70/1) and the 2016 Political Declaration on HIV and AIDS continue to drive efforts towards ensuring that women and girls are free from AIDS. Since the previous report, the importance of gender equality in the HIV response was emphasized by the Human Rights Council in its resolution on human rights in the context of HIV and AIDS (resolution 38/8), where it stressed that human rights violations against women and girls aggravate the impact of the epidemic. In the 2018 political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis (resolution 73/3), the Assembly recognized that gender-responsive health services and empowering women and girls are central to providing integrated care for HIV and AIDS. Furthermore, in the political declaration of the high-level meeting on universal health coverage (resolution 74/2), the General Assembly noted the challenges related to HIV and committed to scale up gender-responsive interventions to meet the health needs of all.

9. At its sixty-second session, in reviewing the challenges and opportunities in achieving gender equality and the empowerment of rural women and girls, the Commission on the Status of Women, in its agreed conclusions, called for strengthened efforts to achieve universal access to HIV and AIDS prevention, treatment, care and support for all women and girls, including those living in rural areas (see E/2018/27). In its agreed conclusions of its sixty-third session, the Commission recognized that women and girls undertake the majority of unpaid care for people living with HIV, work that is undervalued and unrecognized. The Commission urged governments and other actors to strengthen efforts to achieve universal access to HIV and AIDS services and to provide HIV-sensitive social protection measures, such as cash transfers, to ensure that women and girls living with, at risk of, or affected by HIV and AIDS have access to HIV services (see E/2019/27).

IV. Action taken by Member States and United Nations entities

A. Advancing gender equality and women's empowerment through national HIV responses

Incorporating gender equality and women's empowerment in national HIV strategies and policies

10. To achieve HIV targets for women and girls, national HIV responses must incorporate gender equality dimensions in strategies, policies, plans and related budgets, as well as in monitoring and evaluation plans. National strategies and policies should align the HIV response with normative frameworks on gender equality and the empowerment of women and girls and engage partners across multiple sectors for broad impact. However, in 2019, just over half, or 62 per cent of countries (77 of 125) reporting to the UNAIDS National Commitments and Policy Instrument had included gender-transformative interventions [9] in their national AIDS strategies and/or policies.[10]

[9] According to the terminology guidelines from UNAIDS, a gender-transformative HIV response seeks not only to address the gender-specific aspects of HIV, but also to change existing structures, institutions and gender relations into ones that are based on gender equality.

[10] UNAIDS National Commitments and Policy Instrument data can be accessed at http://lawsandpolicies.unaids.org/.

11. The Southern African Development Community developed the gender responsive oversight model, a regional framework and programme of action to monitor and oversee the implementation of resolution 60/2 on women, the girl child, and HIV and AIDS. The model gives priority to tracking efforts to address the root causes that increase the vulnerability of adolescent girls and young women to HIV. The model was piloted and locally adapted in Angola, Lesotho, Malawi, Namibia and Zimbabwe in order to enhance government accountability for their commitments under the resolution. The HIV programme in Switzerland encourages the use of a gender perspective in the design of prevention activities and in ensuring women's access to HIV services. A number of countries, including the Bahamas, Bosnia and Herzegovina, Cambodia, China, Guatemala, Lao People's Democratic Republic, Uganda, the United Republic of Tanzania and Zambia, leveraged synergies between sectors such as health, education, women and youth, to address HIV among women and girls. For example, the National HIV/AIDS Strategic Plan 2016–2021 of the Bahamas contains objectives on increasing access to sexual and reproductive health services, promoting gender equality, preventing gender-based and sexual violence, and reaching greater numbers of adolescent girls and young women.

12. United Nations entities including UNAIDS, the United Nations Development Programme (UNDP), UNICEF and UN-Women, provided support in the design and implementation of gender-responsive HIV strategies and policies at both national and subnational levels. For example, UN-Women built the capacity of national AIDS commissions in nine countries to effectively integrate gender equality issues into national HIV strategies. In the United Republic of Tanzania, this support resulted in giving priority to actions that address unequal gender norms and eliminate violence and discrimination against young women in the new National Multisectoral Strategic Framework for HIV and AIDS 2019–2023.

Enhancing the engagement, leadership and participation of women and girls

13. The engagement and leadership of women is essential to ensuring that HIV services are accessible to women and girls and meet their comprehensive prevention, treatment and care needs. A key role is played by women's organizations and networks of women living with HIV. However, their ability to effectively influence policies and programmes is often limited by their lack of multi-year, core funding that would allow them to strengthen organizational capacity and more effectively lead advocacy efforts.

14. In the Bahamas, Belarus, Bosnia and Herzegovina, Burundi, China, El Salvador, Lao People's Democratic Republic, Lebanon, Peru, Seychelles, Sierra Leone, Sri Lanka, Uganda, United Republic of Tanzania, Uruguay and Zimbabwe action was taken to strengthen the participation and leadership of women in the HIV response. For example, the National STD/AIDS Control Programme in Sri Lanka worked closely with the Positive Women's Network to plan and implement the national HIV strategic plan. Uganda trained women living with HIV to engage and influence national and district level planning and budgeting processes and to hold decision makers accountable.

15. Both UN-Women and OHCHR worked to strengthen engagement and leadership of women. For example, in Uganda and Zimbabwe, UN-Women helped to facilitate the involvement of women living with HIV in the design of the concept notes to the Global Fund to Fight AIDS, Tuberculosis and Malaria. This resulted in the approved concept notes giving priority to programmes on adolescent girls and young women and HIV, with a total of a $8 million allocation in Zimbabwe and $10 million in Uganda.

Financing for women and girls in the HIV response

16. The total domestic and international funding for HIV and AIDS declined from $19.9 billion in 2017 to $19 billion (in constant 2016 United States dollars) in 2018.[11] Data are limited on how much of the funding is allocated to or spent on interventions for women and girls. Analysis of AIDS spending in eight countries[12] conducted by the United Nations University found that between 0.7 and 15.2 per cent of expenditures were spent on women-specific programmes and less than 1 per cent on interventions to promote gender equality.[13] Some donors have sought to increase HIV investments targeting women and girls. In 2019, the United States President's Emergency Plan for AIDS Relief (PEPFAR), which supports efforts in over 50 countries, announced it will invest nearly $2 billion to empower and support women and girls.[14] Between 2017 and 2019, the Global Fund allocated over $5 billion to HIV programmes; during the same time period, the Global Fund's matching funds programme used $55 million to mobilize an additional $140 million for programmes for adolescent girls and young women in the 13 countries with the highest HIV infection rates.

17. In the Bahamas, Bosnia and Herzegovina, Cambodia, Colombia, El Salvador, Guatemala, Jordan, Lao People's Democratic Republic, Malaysia, Mexico, Seychelles, Sierra Leone, Slovenia and Uganda actions were taken to reduce financial barriers faced by women in accessing HIV services. For example, the free health-care initiative in Sierra Leone, part of its social health insurance scheme, exempts women living with HIV who are pregnant or lactating from paying premiums.[15] The move towards universal health coverage provides an important opportunity to ensure that health financing responds to the needs of women and girls. In the Bahamas and El Salvador, universal health coverage programmes were used to improve coverage of HIV services for women and girls.

18. An expert group meeting was convened by UN-Women, with the United Nations University International Institute for Global Health, to discuss how to strengthen financing for gender equality in the HIV response. In reviewing the evidence, the experts agreed that little information is currently available on the financing of gender-responsive HIV strategies, plans and programmes. The experts emphasized the urgency to strengthen the resource needs estimation process to adequately define and cost gender equality interventions and to advocate for their inclusion in national HIV budgets. Innovative strategies such as co-financing for gender equality programmes between the HIV and other sectors such as education, health and social development were recommended.[16]

Measuring gender inequalities in the HIV response

19. Programmes to address HIV among women and girls must be informed by analysis of gender-sensitive indicators and analysis of how gender inequality impacts

[11] UNAIDS, AIDSinfo, Financial dashboard. Global: Trends in Resource Availability (constant 2016 United States dollars) (accessed 28 October 2019).

[12] Eswatini, Guatemala, Haiti, Jamaica, Kenya, Nigeria, South Africa and the United Republic of Tanzania.

[13] United Nations University International Institute for Global Health, "Financing for Gender Equality in HIV and Health Responses: Discussion Paper" (New York, 2019).

[14] United States President's Emergency Plan for AIDS Relief, "PEPFAR will invest nearly $2 billion this year to empower and support women and girls", press release, 4 June 2019.

[15] Sierra Leone, *Country report on the implementation of the Beijing Platform of Action (1995) and the outcome of the Twenty-Third Special Assembly of the General Assembly (2000)* (Freetown, 2019).

[16] United Nations University International Institute for Global Health and UN-Women, "Report of the Expert Group Meeting on Financing for Gender Equality in the HIV Response" (5–6 February 2019).

HIV prevention, treatment and care. In 2019, 90 per cent (80 of 89) of countries reporting to the UNAIDS National Commitments and Policy Instrument included gender-sensitive indicators in their national HIV monitoring and evaluation plan or strategy. The lack of data on access to antiretroviral therapy by specific groups (such as adolescent girls and young women, women and girls in key populations, and women with disabilities) hinders effective HIV programming for these groups.

20. Authorities in Armenia, Bosnia and Herzegovina, Cambodia, El Salvador, Eswatini, Greece, Italy, Jordan, Lesotho, Malawi, Malaysia, Namibia, Seychelles, Spain, Sri Lanka, Uganda, the United Republic of Tanzania, Uruguay, Zambia and Zimbabwe improved the collection of data for, and analysis of, gender-responsive HIV indicators. Angola used the Southern African Development Community gender responsive oversight model to develop baseline indicators for monitoring the implementation of the regional framework and programme of action for resolution 60/2. Member States also conducted research to collect information on HIV among specific groups of women. For example, Italy studied HIV transmission among women in prison to inform the delivery of gender-sensitive HIV care. Burkina Faso conducted a survey of HIV among people with disabilities, finding that women with disabilities were considerably more likely to be living with HIV than men with disabilities.

21. In order to guide the integration of gender equality dimensions into the HIV strategies, UNAIDS updated the gender assessment tool. UNODC developed a training module on monitoring and evaluation of HIV services for women who use drugs and organized capacity-building workshops in 15 countries.

B. Increasing access to quality HIV treatment, care and support for women and girls

Increasing access to and uptake of testing and treatment

22. Access to HIV testing for women and girls has been expanded through diverse approaches such as provider-initiated testing, community-based testing, self-testing and increased integration of HIV testing with other health-care services. For example, in 2019, 91 per cent (90 of 99) of countries reporting to the UNAIDS National Commitments and Policy Instrument have integrated HIV counselling and testing with sexual and reproductive health services at least partly. Access to and use of HIV testing services by specific groups such as adolescent girls and young women, women in key populations, women with disabilities and migrant women is not well understood due to limited data.

23. Even as more women living with HIV are receiving antiretroviral therapy globally, significant gaps remain in research on effective treatment regimens tailored for women and in supporting women in treatment uptake and adherence. A systematic review of clinical studies on antiretroviral drugs found that women represented only 19 per cent or less of participants, and in half of the studies focused on finding a cure, women represented a mere 11 per cent or less of participants.[17] In 2018, women living with HIV mobilized in response to concerns about the use of the antiretroviral drug dolutegravir, halting its introduction in many countries. While further research found that dolutegravir is in fact safe for women living with HIV, the importance of engaging women living with HIV in discussions about testing and treatment was highlighted.

[17] Mirjam Curno and others, “A systematic review of the inclusion (or exclusion) of women in HIV research: from clinical studies of antiretrovirals and vaccines to cure strategies”, *Journal of Acquired Immune Deficiency Syndromes*, Vol. 71, No. 2 (February 2016).

24. Gaps also exist in understanding the social and structural barriers faced by women and girls in accessing HIV testing and adhering to treatment. These barriers can include discriminatory laws, social stigma and discrimination, caregiving responsibilities and gender norms that undermine the efforts of women in seeking care. Although limited data is available, evidence suggests that those challenges are exacerbated for adolescent girls and young women and for women and girls in key populations.[18]

25. Mexico and Colombia researched the uptake of testing and treatment by women and girls. Mexico studied barriers to treatment adherence among women and girls living with HIV to inform efforts to improve gender-sensitive service delivery.[19] Colombia helped health institutions assess why pregnant women were not accessing services for sexually transmitted infections, including HIV, and develop plans to address the barriers.

26. Authorities in Armenia, the Bahamas, Belarus, Bosnia and Herzegovina, Botswana, Burkina Faso, Burundi, Cambodia, Central African Republic, China, Cuba, El Salvador, Eswatini, Georgia, Greece, Iran, Italy, Jordan, Lao People's Democratic Republic, Lebanon, Lesotho, Malawi, Malaysia, Namibia, the Netherlands, Seychelles, Sierra Leone, Slovenia, Sri Lanka, Switzerland, Uganda, the United Republic of Tanzania, Uruguay, Zambia and Zimbabwe strengthened the delivery of HIV testing and treatment services for women and girls. For example, Bosnia and Herzegovina established a mobile clinic to reach female sex workers with HIV counselling and testing. Zambia integrated HIV testing and treatment into youth-friendly reproductive health-care services for adolescent girls and young women. Italy trained HIV service providers to recognize and address the cultural barriers faced by migrant women. Botswana used a peer outreach approach to encourage young women and female sex workers to access HIV treatment.

27. With support from UNICEF, Botswana finalized a national standard package of HIV testing and treatment services for adolescents and young people, which includes specific considerations for adolescent girls and young women. UNODC trained service providers in 14 countries to deliver gender-responsive HIV services for women who inject drugs and helped five countries address gaps in health-care service provision for women in prisons. Between 2016 and 2018, IOM and its partners provided over 4,560 women and 3,440 men with HIV testing and treatment through integrated HIV and sexual and reproductive health services.

Providing HIV care and support services to women and girls living with HIV

28. Women and girls living with HIV need access to a broad array of health services that meet their lifelong changing health-care needs, including services for sexual and reproductive health, for the management of HIV-related co-infections and opportunistic infections, and for illnesses for which women living with HIV are often at increased risk such as cardiovascular disease, stroke, cervical cancer and tuberculosis. However, progress in ensuring access to comprehensive health services has been slow. For example, women living with HIV face an up to five-fold greater risk of invasive cervical cancer than women who are not living with HIV. However, in 2019 only 52 per cent (66 of 126) of countries submitting information using the UNAIDS National Commitments and Policy Instrument recommended cervical cancer screening and treatment for women living with HIV in their national HIV strategic plans.

[18] UNAIDS, "Women and HIV: A spotlight on adolescent girls and young women" (Geneva, 2019).

[19] Instituto Nacional de las Mujeres, "Informe Nacional Exhaustivo de México en cumplimiento de la Plataforma de Acción de Beijing" (Mexico City, June 2019).

29. In the Bahamas, Bosnia and Herzegovina, Botswana, Central African Republic, China, Colombia, Cuba, El Salvador, Eswatini, Lao People's Democratic Republic, Lesotho, Seychelles, Sierra Leone, Slovenia, Spain, Uganda and Uruguay activities were implemented to support access for women and girls living with HIV to sexual and reproductive health services, including prevention of opportunistic infections and psychosocial support. For example, to prevent and treat opportunistic infections, Uganda developed the advanced disease management care package addressing the identification and management of tuberculosis, cryptococcal meningitis and severe bacterial infections that contribute to HIV-related morbidity and mortality, in particular in women and children.

30. UNAIDS supported country implementation of the Consolidated guideline on sexual and reproductive health and rights of women living with HIV and the accompanying checklist for community engagement developed by WHO in collaboration with UNAIDS, the United Nations Population Fund (UNFPA), OHCHR, and other partners. UNAIDS, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the George W. Bush Institute launched a partnership to end AIDS and cervical cancer among women living with HIV in Africa, improving integration of cervical cancer screening and care with HIV services in eight sub-Saharan countries.

C. Providing universal access to HIV prevention

Scaling up prevention to meet the needs of women and girls

31. To prevent new HIV infections, women and girls must have knowledge of HIV, access to prevention methods and the power to negotiate condom use and engage in safer sex practices. However, implementation of proven prevention strategies remains limited, in particular for adolescent girls and young women. For example, comprehensive sexuality education is a part of effective prevention programmes, but in 2019, only 54 per cent (36 of 67) countries reporting to the UNAIDS National Commitments and Policy Instrument were implementing their education policies on life skills-based HIV and sexuality education at a majority of their secondary schools (at least 76 per cent).

32. Women are underrepresented in research on preventive vaccines for HIV; in half of clinical studies, women represented only 38 per cent or less of participants.[20] In 2018, only 21 per cent of investment in pre-exposure prophylaxis research was focused on women,[21] resulting in medications, such as the recently approved drug Descovy, that were not tested in heterosexual women. Research funding for female condoms has stagnated, and although users report high levels of satisfaction and willingness to pay, use is hampered by lack of availability and funding for marketing and advertising, as well as gender norms that disparage women's condom use.[22] Countries have also struggled to design and take to scale HIV prevention programmes specifically targeting adolescent girls and young women. For example, among the countries in the Global HIV Prevention Coalition, less than half of locations with high

[20] Curno and others, "A systematic review of the inclusion (or exclusion) of women in HIV research".

[21] Resource Tracking Working Group, "HIV prevention research and development investments 2018: investing to end the epidemic" (New York, 2018).

[22] Chastain Mann, "The woman's condom: lessons learned from Malawi and considerations for female condoms in West Africa", *18th General Membership Meeting of the Reproductive Health Supplies Coalition*, Brussels, 20–22 March 2018.

HIV incidence had dedicated HIV prevention programmes for adolescent girls and young women in 2018.[23]

33. Strategies have been implemented in Armenia, the Bahamas, Botswana, Burundi, Cambodia, China, Lesotho, Malaysia, the United Republic of Tanzania and Zambia to prevent HIV among women and girls. For example, women's federations in China trained over 1,600 members to offer health education and face-to-face HIV counselling to women in their communities. Cambodia and Armenia organized HIV education activities for migrant women who lacked access to HIV information. In Botswana, the "Condomize!" programme trained young women volunteers and comprehensive sexuality education facilitators to teach women and girls about the female condom. In the United Republic of Tanzania, a clinical trial was held to test a vaginal microbicide gel for protecting women against HIV.

34. Focusing specifically on adolescent girls and young women, Botswana, Eswatini, Lesotho, Malawi, Mozambique, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe implemented the DREAMS (determined, resilient, empowered, AIDS-free, mentored and safe women) Initiative of the United States President's Emergency Plan for AIDS Relief, providing a multisectoral package of prevention interventions, HIV and sexual and reproductive health, education, and social and economic empowerment. In the 10 original DREAMS countries,[24] new HIV cases among adolescent girls and young women continued to decline in 85 per cent of DREAMS-supported communities and districts. China developed a training programme that, between 2015 and 2017, provided 1,000 girls aged 16 to 21 with both vocational and life skills, including HIV prevention. In Armenia, Burkina Faso, Burundi, Cambodia, Cuba, Cyprus, Greece, Malawi, the Netherlands, Sri Lanka and Zambia sexuality education programmes were offered that contributed to increased knowledge on HIV prevention. The importance of providing adolescents and youth, in particular girls, with information and services to protect themselves from HIV/AIDS was reiterated by governments and partners in the Nairobi Statement, which emanated from the Nairobi Summit celebrating the 25th anniversary of the International Conference on Population and Development.

35. UNAIDS, UNFPA, UNICEF and WHO launched 2gether 4 SRHR (together for sexual and reproductive health and rights) in 2018 to scale up integrated HIV and sexual and reproductive health services for adolescent girls and young women. In Lesotho, the initiative increased comprehensive knowledge of HIV among pregnant adolescents from 36 per cent to 87 per cent. In Eastern and Southern Africa, UNFPA designed the Tune Me mobile site to provide young girls and boys with information on sexual and reproductive health and HIV prevention. UNFPA supported Brazil in developing a national strategy on female condom programming. The Our Rights, Our Lives, Our Future programme, implemented by UNESCO and which supports comprehensive sexuality education programmes in sub-Saharan Africa, reached over two million boys and girls through school programmes and over five million young people through social and new media platforms in 2018.

Eliminating mother-to-child transmission of HIV and keeping mothers alive and well

36. Mother-to-child transmission of HIV can occur during pregnancy, labour or delivery, or after delivery through breastfeeding. Globally, 82 per cent [62–>95] of pregnant women with HIV received antiretroviral therapy for elimination of mother-

[23] UNAIDS, "Global HIV Prevention Coalition Second Progress Report: April – December 2018" (Geneva, 2019).

[24] Eswatini, Kenya, Lesotho, Malawi, Mozambique, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

to-child transmission in 2018. However, there was wide regional variation, from 92 per cent [69–>95] in Eastern and Southern Africa to only 28 per cent [16–47] in the Middle East and North Africa.[25] Global progress is hindered by weak health-care systems and legal and policy barriers such as criminalization of vertical transmission.

37. In addition to Armenia, Belarus, Cuba and Thailand which were certified by WHO as having eliminated mother-to-child transmission between 2015 and 2016, eight new countries and areas were certified between 2017 and 2019: Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Malaysia, Maldives, Montserrat and Saint Kitts and Nevis.[26]

38. Among the 23 countries participating in the UNAIDS Start Free, Stay Free, AIDS Free initiative for the elimination of mother-to-child HIV transmission, five countries achieved the target of 95 per cent coverage of pregnant women receiving antiretroviral medicines to prevent vertical transmission (Botswana, Malawi, Mozambique, Namibia and Zambia). Authorities in Armenia, the Bahamas, Belarus, Burkina Faso, Burundi, Cambodia, China, Colombia, Cuba, Cyprus, Georgia, Greece, Iran, Italy, Lao People's Democratic Republic, Lebanon, Lesotho, Malawi, Malaysia, Mexico, Namibia, Peru, Seychelles, Sierra Leone, Slovenia, Spain, Sri Lanka, Switzerland, Uganda, the United Republic of Tanzania and Uruguay, worked to provide HIV services that met the needs and preferences of pregnant women and new mothers. For example, hospital innovations in Lesotho included clinics where women living with HIV and their partners were advised on family planning and encouraged to become pregnant only once they were virally suppressed.[27] Peru incorporated guidelines for cultural sensitivity into standards for the prevention of mother-to-child transmission to ensure that the needs of indigenous women were met.

39. The World Health Organization updated the global validation guidance on prevention of mother-to-child HIV transmission to include an assessment tool on human rights, gender equality and civil society engagement. UNODC, WHO, UNFPA and UN-Women developed the Technical Guide on prevention of mother-to-child transmission of HIV in prisons. In Ethiopia, WFP provided 26,000 women participating in the elimination of mother-to-child HIV transmission programme with food and nutrition assistance to support treatment adherence, resulting in close to zero HIV infections among their infants.

D. Addressing the root causes that drive the HIV epidemic among women and girls

40. The root causes that drive the HIV epidemic among women and girls influence all areas of the HIV response. Unequal gender norms often limit the access of women to HIV information and services, and put them at risk of gender-based discrimination and violence, including harmful practices, such as child, early and forced marriage and female genital mutilation, that may increase the risk of contracting HIV. Structural drivers of HIV include laws and policies that fail to support the rights of women and girls to health, including HIV services, or to prevent discrimination and violence against them. Structural drivers also include lack of access to education and employment which can provide them with the resources to prevent HIV and to access treatment.

[25] AIDSinfo, accessed 28 October 2019.

[26] Validation of elimination of mother-to-child HIV transmission requires that a country achieves and maintains targets related to the mother-to-child HIV transmission rate, rate of new paediatric HIV infections due to mother-to-child transmission, antenatal care coverage, coverage of HIV testing of pregnant women, and treatment coverage of HIV-positive pregnant women.

[27] Lesotho, "Final report for a joint review of HIV/tuberculosis and hepatitis programmes" (2 December 2017).

Strengthening legal and policy frameworks that support gender equality and women's empowerment

41. An enabling legal and policy framework is essential for accelerating progress for women and girls in the HIV response. A 2018 review by the Global Commission on HIV and the Law found that 89 countries have strengthened their legal and policy framework to support their HIV response by enacting or reforming laws recognizing the right to comprehensive sexuality education, for example, or by protecting women from gender-based violence that increases their risk of HIV. At the same time, in many countries, women's reproductive rights are being curtailed, limiting women's access to sexual and reproductive health services.[28] In 2019, 82 out of 104 countries reporting to the UNAIDS National Commitments and Policy Instrument required parental consent for adolescents to access HIV testing.

42. Authorities in Bosnia and Herzegovina, Botswana, Burundi, Cambodia, Cyprus, El Salvador, Greece, Guatemala, Italy, Lao People's Democratic Republic, Lebanon, Malawi, Mexico, Namibia, Sierra Leone, Slovenia, Spain, Switzerland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe developed, revised, or implemented legal and policy frameworks to support their HIV response. For example, Malawi enacted the HIV and AIDS (Prevention and Management) Act, prohibiting any harmful practices that put a person at a risk of HIV infection and HIV-related discrimination. Mexico and Spain prohibited child marriage in 2019. Namibia lowered the age of parental consent for HIV testing from 16 to 14 years.

43. UN-Women trained law enforcement officers, magistrates, health workers, journalists, representatives of people living with HIV, and community representatives on the new HIV and AIDS (Prevention and Management) Act in Malawi and supported the development of workplans to raise public awareness of the Act. In Viet Nam, UNAIDS, UN-Women and WHO supported dialogue for women in key populations and women living with HIV with members of parliament on gender-responsive implementation of laws on HIV prevention and control.

Eliminating stigma and discrimination against women and girls living with HIV

44. Stigma and discrimination limit women's and girls' ability to prevent HIV, and access health-care services. However, less than half (43 per cent) of the national reports prepared by Governments on the occasion of the twenty-fifth anniversary of the adoption of the Beijing Declaration and Platform for Action (1995) included information on specific measures taken to prevent discrimination and promote the rights of women and girls living with HIV during the past five years.

45. In Bosnia and Herzegovina, Burundi, China, El Salvador, Greece, Jamaica, Mexico, Sierra Leone and Spain stigma against women and girls living with HIV was addressed through laws and policies, by training health and social service providers on gender and HIV, and through public awareness raising activities. In Spain, a new social pact for non-discrimination and equal treatment of people living with HIV emphasizes gender equality and the sexual and reproductive rights of women. The United Republic of Tanzania trained over 8,000 government officials on how to implement the National Multisectoral HIV and AIDS Stigma and Discrimination Reduction Strategy and its Gender Operational Plan in their communities.

46. In 2018, UNAIDS, UN-Women, UNDP and the Global Network of People Living with HIV launched the Global Partnership for Action to Eliminate All Forms of HIV-related Stigma and Discrimination, to accelerate actions to end stigma and discrimination faced by people being left behind in the HIV response, including

[28] Global Commission on HIV and the Law, *HIV and the law: risks, rights and health*. (New York, 2018).

women and girls. At the country level, UNAIDS supported Brazil to implement the agenda for zero discrimination in health-care settings by facilitating dialogues between health-care providers and women living with HIV, sex workers and transgender women.

Ending the twin epidemics of gender-based violence and HIV

47. Violence, or the fear of violence, makes it difficult for women to insist on safer sex, use HIV prevention methods and start and adhere to antiretroviral therapy. Women experiencing violence have worse clinical outcomes and lower viral suppression than other women living with HIV. Most countries recognize the link between gender-based violence and HIV; in 2019, 86 out of 100 countries reporting to the UNAIDS National Commitments and Policy Instrument included HIV in their national plan or strategy addressing gender-based violence or violence against women. Ending violence requires strengthening institutional responses to violence, for example in health-care and educational settings, and shifting gender norms by empowering women, engaging men and mobilizing communities.

48. Authorities in the Bahamas, Bosnia and Herzegovina, Burundi, Central African Republic, Colombia, Ecuador, El Salvador, Eswatini, Georgia, Greece, Jamaica, Jordan, Lao People's Democratic Republic, Peru, Romania, Sri Lanka, Switzerland, Uganda, Uruguay and Zambia took action to reduce and respond to gender-based violence, a root cause of HIV. For example, Georgia developed standardized forms to help health-care professionals deliver services to victims of gender-based violence. The forms include procedures for post-exposure prophylaxis for HIV prevention; a risk assessment tool and guidance on counselling and referral; and data reporting guidance. Between 2016 and 2018, 300 health-care providers were trained on the use of the forms.

49. The United Nations trust fund in support of actions to eliminate violence against women supported the adaptation and scale-up of the "SASA!" community mobilization approach to prevent violence and HIV. In Haiti, the programme resulted in 96 per cent of women and 90 per cent of men recognizing that violence increases the risk of HIV for women. To address violence in schools, UNESCO and UN-Women published the global guidance on addressing school-related gender-based violence. UNESCO also supported Eswatini, the United Republic of Tanzania, Zambia and Zimbabwe in the implementation of the "Connect with Respect" tool which builds teacher capacity on gender-based violence in schools.[29]

Promoting the education of girls and the economic empowerment of women

50. Education and economic empowerment can strengthen livelihood security and support women and girls in preventing HIV and accessing HIV services. A 2018 study by the World Bank found that women with secondary education more than double their income compared to those with no education, have higher knowledge of HIV/AIDS and ability to make decisions about their own health care.[30] One barrier to girls' education and women's employment in settings with high prevalence of HIV is their caregiving responsibilities, which are higher for women than for men.[31] A study in three countries with generalized epidemics found that women living in a household with a family member with HIV were less likely to be working for pay or profit.[32]

[29] UNESCO, *Connect with respect: preventing gender-based violence in schools. Classroom programme for students in early secondary school (ages 11–14)* (Bangkok, 2018).

[30] Quentin Wodon and others, "Educating girls and ending child marriage: a priority for Africa." (Washington, DC, 2018).

[31] World Bank, "World Bank Country and Lending Groups." (Washington DC, 2019).

[32] Cattaneo and others. *The impact of HIV on care work and the care workforce*. (International Labour Office, Geneva, 2019).

This increases financial hardship, in particular in female-headed households, and may contribute to increased risk of HIV. Policies that recognize, reduce and redistribute unpaid care support women's economic autonomy and may reduce the impact of HIV.

51. Authorities in Burundi, Cambodia, Central African Republic, Eswatini, Georgia, Greece, Iran, Lao People's Democratic Republic, Lesotho, Malawi, Namibia, Seychelles, Sierra Leone, South Africa, Zambia and Zimbabwe strengthened educational and economic opportunities for women and girls, increasing their ability to protect themselves against HIV and to obtain HIV services. For example, Malawi and South Africa used cash transfers to keep girls in schools and to encourage healthy behaviours that prevent HIV. Namibia and Zambia used cash transfers to increase utilization of HIV services by adolescents.

52. In Eastern and Southern Africa, ILO combined activities to increase women's economic independence with the promotion of their rights and increased access to HIV services. In Djibouti, WFP trained women living with HIV on business entrepreneurship and provided them small business loans. The programme improved the quality of life of the participating women, allowing them to regain dignity in their communities and strengthen their financial security.

Shifting gender norms by empowering women, engaging men and mobilizing communities

53. Gender norms are the shared social expectations or informal rules as to how women and men should behave. In many cases, gender norms disadvantage women in the HIV response by discouraging discussion about sexuality and HIV prevention by women; limiting independent decision-making of women and girls related to their sexual and reproductive health; restraining women's and girls' access to HIV testing and treatment; or by putting them at risk of discrimination and gender-based violence. Effective interventions to change gender stereotypes and norms are often multisectoral and engage women and men, community and religious leaders, health-care providers, and law enforcement officials in dialogue about the impact of gender norms on health.

54. Authorities in Bosnia and Herzegovina, Botswana, Georgia, Greece, Italy, Jamaica, Malawi, Malaysia, Romania, Switzerland, the United Republic of Tanzania and Zambia increased awareness and supported community dialogue on gender equality and on harmful gender norms that increase the risk of women and girls to HIV by engaging traditional and religious leaders, through traditional and social media, and through theatre performances and activities in schools. For example, Cambodia, the United Republic of Tanzania and Zambia worked to engage men to prevent HIV among women and girls. South Africa empowered women and girls directly through the "She Conquers" campaign which builds self-esteem, life skills and self-confidence to prevent HIV.

55. After three years in the International Fund for Agricultural Development programme in Malawi, women farmers became more assertive in planning; their husbands became more appreciative of the roles women play in the home and in farming; high-risk behaviours decreased; and families became less vulnerable to the impact of AIDS due to increasingly equitable access to and control over resources. In South Africa, UN-Women HeForShe campaign, which encourages men to take action against negative stereotypes and behaviours, organized a series of dialogues on the role that gender norms play in relationships which influence abilities to prevent HIV and violence against women. After eight months of implementation, 57 per cent of the initiative's participants reported accessing HIV testing and, if diagnosed with

HIV, accessing care. Participating men also demonstrated positive changes in attitudes and behaviour relating to HIV and violence prevention.[33]

V. Conclusions and recommendations

56. **Progress has been made in preventing HIV and ending AIDS among women and girls. But the rates of new HIV infections among women and girls are still rising in Eastern Europe, Central Asia, the Middle East and North Africa and Latin America. More women are accessing testing and treatment, especially as most countries have integrated HIV services with sexual and reproductive health services for women. A majority of pregnant women living with HIV obtain services to eliminate mother-to-child HIV transmission, and WHO has certified 12 countries and areas as having eliminated mother-to-child HIV transmission. At the same time, proven strategies to prevent HIV among women and girls have not been scaled up; research on female-controlled HIV prevention methods and on treatment that is safe and appropriate for women and girls has not been prioritized; and gender-responsive approaches have been barely included in national HIV strategies, policies and budgets. Insufficient attention has been paid to addressing the root causes that drive HIV among women and girls, including unequal gender norms and structural gender inequalities.**

57. **The Commission may wish to encourage Member States:**

(a) **To implement their commitment to achieve gender equality and empower all women and girls, made under the Sustainable Development Goals, by integrating gender-responsive approaches and interventions into national HIV strategies and policies;**

(b) **To engage women's organizations and networks of women and girls living with HIV as key partners in the design, budgeting, implementation and monitoring of the HIV response at the regional, national and subnational levels;**

(c) **To collect and use sex- and age-disaggregated HIV data and to conduct gender analysis of the root causes that drive the HIV epidemic among women and girls, in particular among specific groups such as adolescent girls and young women, women in key populations, migrant women, older women and women with disabilities;**

(d) **To adequately budget for gender-responsive HIV approaches and interventions, to reduce financial barriers faced by women in accessing HIV services and ensure that resources are made available to meet the needs and priorities of specific groups such as adolescent girls and young women and women in key populations;**

(e) **To achieve universal health coverage which can best meet the broad needs of women and girls, throughout their life and reduce the gender inequalities that affect the HIV epidemic;**

(f) **To scale up proven strategies for HIV prevention among women and girls, including female-controlled prevention methods and by addressing the underlying risk factors that cause high HIV infection rates, in particular gender inequality and a lack of education on sexual and reproductive health;**

[33] UNAIDS, "Communities at the centre: Global AIDS Update 2019" (Geneva, 2019).

(g) **To support and reinforce women's sexual and reproductive health and rights, and strengthen the integration of HIV and sexual and reproductive health services for women and girls;**

(h) **To develop and expand dedicated HIV prevention programmes for adolescent girls and young women and to ensure the availability of youth-friendly HIV testing and treatment services;**

(i) **To implement research on effective female-controlled HIV prevention methods and antiretroviral treatment regimens for women and girls throughout their life course and substantially increase the participation of women and girls in research and treatment clinical trials;**

(j) **To identify gender-related barriers to HIV testing and treatment and take action to reduce those barriers, providing services that meet the needs and preferences of women and girls living with HIV, including pregnant women and girls and those who are marginalized;**

(k) **To facilitate the access of women and girls living with HIV to a broad array of health services that meet their lifelong health-care needs, including access to services for sexual and reproductive health, HIV-related co-infections and opportunistic infections, non-communicable diseases and tuberculosis;**

(l) **To support women and girls caring for people living with HIV by implementing policies that recognize, reduce, and redistribute unpaid care work;**

(m) **To address the structural drivers of HIV by enacting and enforcing laws and policies that support women's and girls' right to health, eliminate gender-based discrimination and violence, and promote women's and girls' access to education and a fair and equal wage;**

(n) **To empower women, engage men, and mobilize communities to shift gender norms that impact HIV prevention and treatment among women and girls, including norms around women's independent decision-making in relation to their sexual and reproductive health and rights and norms related to stigma, discrimination, gender-based violence, and harmful practices such as child, early, and forced marriage and female genital mutilation.**

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

(a) **To prioritize gender-responsive approaches and interventions in their programming and funding for HIV, prioritizing strategies to reach adolescent girls and young women, women and girls in key populations, and other marginalized groups of women and girls;**

(b) **To leverage synergies between development sectors including health, education, and economic empowerment to achieve shared gender equality outcomes and accelerate progress on ending AIDS;**

(c) **To facilitate women's organizations and networks of women living with HIV to engage in and provide leadership to decision-making in the HIV response, including by providing long-term funding for internal capacity-building and advocacy;**

(d) **To track allocations and expenditure in HIV programming directed at strengthening gender equality and the empowerment of women;**

(e) **To ensure that global and national efforts to achieve universal health coverage identify strategies that meet the needs of women and girls throughout their life course, and effectively reduce gender inequality;**

(f) **To support national research capacity and gather evidence of effective approaches and interventions that help achieve HIV prevention and treatment targets for women and girls;**

(g) **To implement evidence-based, high-impact approaches that address the specific needs of adolescent girls and young women in HIV prevention, testing, treatment, and care;**

(h) **To advocate for the inclusion of women and girls in clinical trials and support research to develop HIV prevention methods and treatment specifically for women and girls;**

(i) **To improve the quality of HIV prevention, testing, and treatment services so they take into account the social and structural drivers of HIV that hinder uptake by women of HIV services;**

(j) **To support efforts for women and girls living with HIV to have access to a wide range of health services based on their needs;**

(k) **To engage men and boys and support communities in examining the impact of gender norms on HIV risk for women and girls and access to HIV services and put actions in place to address them.**