



Economic and Social Council

Distr.: General
23 December 2015

Original: English

Commission on the Status of Women

Sixtieth session

14-24 March 2016

Item 3 (c) of the provisional agenda**

**Follow-up to the Fourth World Conference on Women
and to the special session of the General Assembly entitled
“Women 2000: gender equality, development and peace
for the twenty-first century”: gender mainstreaming,
situations and programmatic matters**

Women, the girl child and HIV and AIDS

Report of the Secretary-General

Summary

The global AIDS response has made significant progress in halting and reversing the epidemic. The number of new HIV infections among women and girls has stabilized and the number of AIDS-related deaths has fallen significantly worldwide. Access to life-saving antiretroviral therapy has expanded considerably, in particular among pregnant women, and the prevention of mother-to-child transmission has resulted in fewer new HIV infections in newborns. However, the progress for women and girls is not equal across all regions. Much more needs to be done to advance gender equality and women’s empowerment, to scale up prevention and treatment efforts for women and girls and to address the legal, economic and social factors that continue to put them at greater risk of HIV infection.

* Reissued for technical reasons on 28 January 2016.

** [E/CN.6/2016/1](#).



The present report provides highlights of action taken by Member States and United Nations entities to implement Commission on the Status of Women resolution 58/3 on women, the girl child and HIV and AIDS. The report identifies good practices, challenges and gaps at the country, regional and global levels and concludes with recommendations for future action to accelerate progress for women and girls in the HIV response. It draws on recent evidence and empirical research to reflect new trends and promising approaches. The examples provided are based on submissions from 25 Member States (Austria, China, Colombia, Dominican Republic, Finland, Hungary, Japan, Latvia, Liberia, Lithuania, Malawi, Mexico, Norway, Paraguay, Peru, Philippines, Poland, Russian Federation, Sierra Leone, Singapore, Sweden, Togo, Turkey, Uganda and Uruguay) and six United Nations entities (Joint United Nations Programme on HIV/AIDS, secretariat of the Permanent Forum on Indigenous Issues, United Nations Educational, Scientific and Cultural Organization, United Nations Population Fund, United Nations Relief and Works Agency for Palestine Refugees in the Near East and United Nations Entity for Gender Equality and the Empowerment of Women).

I. Introduction

1. Progress in halting and reversing the HIV epidemic and meeting the needs of women and the girl child varies by region, country, age and key population group. In 2014, 51 per cent of the approximately 34.3 million [31.8 million-38.5 million] adults 15 years of age and older living with HIV globally were women (see table 1).¹ Of the 3.9 million young people between 15 and 24 years of age living with HIV, almost 60 per cent were young women and girls.²

2. In 2014, 48 per cent of the approximately 1.8 million [1.7 million-2.0 million] new infections among people 15 years of age and older globally were among women and girls (see table 2). Young women are particularly negatively affected: 56 per cent of the new infections among young people between 15 to 24 years of age in 2014 were among young women. Of the approximately 1.2 million [980,000-1.6 million] AIDS-related deaths in 2014, among people 15 years of age and older, 42 per cent were women and girls, and 75 per cent of those deaths occurred in sub-Saharan Africa.

3. Specific groups are disproportionately affected by HIV. A meta-analysis of studies measuring the prevalence or incidence of HIV in 50 countries calculated a pooled global HIV prevalence of 11.8 per cent among female sex workers, estimating that, globally, female sex workers are approximately 14 times more likely to be infected with HIV than other women of reproductive age.³ Data indicate that in 2013 there were some 70,000 [55,000-83,000] new HIV infections among sex workers.³ Based on data reported by 30 countries, the pooled HIV prevalence among women who inject drugs was 13 per cent compared with 9 per cent among men who inject drugs.⁴

¹ Joint United Nations Programme on HIV/AIDS (UNAIDS), *How AIDS Changed Everything: MDG 6: 15 Years, 15 Lessons of Hope from the AIDS Response* (2015).

² Key indicators from the UNAIDS 2014 estimates are available from the AIDSinfo online database. Available from <http://aidsinfo.unaids.org/>. Unless otherwise indicated, the findings in the present report are sourced from the estimates for 2014 in the AIDSinfo online database. Additional disaggregations correspond to unpublished estimates for 2014 provided by UNAIDS. These are obtained from country-specific models of their AIDS epidemics. Modelled estimates are required because it is impossible to count the exact number of people living with HIV, people who are newly infected or people who have died of AIDS during the epidemic in a country. Square brackets denote uncertainty bounds around estimates to indicate the range within which the true value lies.

³ Stefan Baral and others, "Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis", *The Lancet Infectious Diseases*, vol. 12, No. 7 (15 March 2012).

⁴ UNAIDS, *The Gap Report* (Geneva, 2014).

Table 1
Prevalence, new infections and AIDS-related deaths in 2014 among women and men 15 years of age and older

Region	Prevalence			New infections			AIDS-related deaths		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
Global	17 400 000 [16 100 000- 20 000 000]	16 900 000 [15 700 000- 19 500 000]	34 300 000 [31 800 000- 38 500 000]	870 000 [790 000- 950 000]	950 000 [870 000- 1 000 000]	1 800 000 [1 700 000- 2 000 000]	420 000 [310 000- 730 000]	610 000 [450 000- 1 000 000]	1 000 000 [760 000- 1 800 000]
Sub-Saharan Africa	13 800 000 [12 800 000- 16 000 000]	9 700 000 [9 000 000- 11 300 000]	23 500 000 [21 800 000- 26 200 000]	650 000 [600 000- 710 000]	510 000 [470 000- 550 000]	1 200 000 [1 100 000- 1 300 000]	310 000 [220 000- 570 000]	350 000 [250 000- 650 000]	660 000 [470 000- 1 200 000]
Asia and the Pacific	1 700 000 [1 500 000- 2 000 000]	3 100 000 [2 800 000- 3 500 000]	4 800 000 [4 300 000- 5 400 000]	110 000 [75 000- 150 000]	210 000 [150 000- 300 000]	320 000 [230 000- 450 000]	69 000 [47 000- 120 000]	160 000 [110 000- 280 000]	230 000 [150 000- 410 000]
Latin America	540 000 [450 000- 640 000]	1 100 000 [930 000- 1 300 000]	1 600 000 [1 400 000- 2 000 000]	25 000 [20 000- 30 000]	60 000 [48 000- 72 000]	85 000 [68 000- 100 000]	12 000 [8 700- 22 000]	28 000 [20 000- 51 000]	39 000 [29 000- 73 000]
Western and Central Europe and North America	530 000 [340 000- 770 000]	1 900 000 [1 200 000- 2 700 000]	2 400 000 [1 500 000- 3 500 000]	18 000 [10 000- 27 000]	67 000 [37 000- 99 000]	85 000 [47 000- 130 000]	4 700 [2 400- 8 500]	21 000 [11 000- 38 000]	26 000 [13 000- 47 000]
Eastern Europe and Central Asia	600 000 [520 000- 710 000]	900 000 [770 000- 1 100 000]	1 500 000 [1 300 000- 1 800 000]	54 000 [46 000- 66 000]	80 000 [67 000- 96 000]	130 000 [110 000- 160 000]	25 000 [13 000- 66 000]	36 000 [20 000- 96 000]	61 000 [33 000- 160 000]
The Caribbean	130 000 [110 000- 170 000]	130 000 [100 000- 160 000]	260 000 [200 000- 320 000]	5 800 [4 200- 7 200]	7 200 [5 100- 8 900]	13 000 [9 300- 16 000]	3 200 [1 700- 8 500]	5 000 [2 700- 13 000]	8 200 [4 400- 22 000]
Middle East and North Africa	72 000 [51 000- 92 000]	150 000 [110 000- 190 000]	220 000 [140 000- 300 000]	5 800 [3 500- 8 700]	14 000 [8 300- 21 000]	20 000 [12 000- 30 000]	3 200 [1 400- 8 900]	7 700 [3 500- 22 000]	11 000 [5 000- 30 000]

Source: UNAIDS, 2014, AIDSinfo online database.

Table 2
Percentage change in new HIV infections between 2001 and 2014

<i>Region</i>	<i>Women and girls</i>	<i>Men and boys</i>
Global	(34)	(31)
Sub-Saharan Africa	(38)	(39)
Asia and the Pacific	(28)	(26)
Latin America	(25)	(9)
Eastern Europe and Central Asia	27	5
Caribbean	(48)	(40)
Middle East and North Africa	15	24

Source: UNAIDS, 2014, AIDSinfo online database.

II. Normative framework

4. In 2011, the General Assembly adopted the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS (resolution 65/277, annex), which established 10 time-bound targets, including eliminating gender inequalities and gender-based violence. It built on previous commitments supporting gender equality and the empowerment of women as fundamental to the reduction of the vulnerability of women and girls to HIV and AIDS, such as the 2001 Declaration of Commitment on HIV/AIDS (resolution S-26/2) and the 2006 Political Declaration on HIV/AIDS (resolution 60/262, annex). HIV and AIDS were placed firmly on the development agenda in 2000 with Millennium Development Goal 6, which called for efforts to halt and begin to reverse the spread of HIV/AIDS by 2015.

5. In 2016, the General Assembly, pursuant to its decision 68/555, will convene a high-level meeting on HIV/AIDS, which will undertake a comprehensive review of the progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS and the 2006 and 2011 Political Declarations on HIV/AIDS. The purpose of the meeting is to reflect on successes, lessons learned, challenges and opportunities, as well as to set out recommendations to guide the AIDS response beyond 2015, including specific strategies to end the AIDS epidemic by 2030 and accelerate a comprehensive universal and integrated response. In so doing, it will pave the way to renewing political commitment to gender equality and women's rights within the response.

6. The meeting and the anticipated 2016 political declaration will be informed by the 2016 report of the Secretary-General on accelerating the AIDS response, which will highlight successes and gaps in advancing the rights of women and girls in the context of HIV, including findings and progress outlined in the present report.

7. In 2015, the General Assembly adopted two key intergovernmental frameworks, the Addis Ababa Action Agenda of the Third International Conference on Financing for Development (resolution 69/313, annex), which affirmed the mainstreaming of gender equality and women's empowerment in financing for development, and the

2030 Agenda for Sustainable Development (resolution 70/1), which includes Sustainable Development Goal 5, to achieve gender equality and empower all women and girls. The six substantive targets within that Goal — to end all forms of discrimination against all women and girls everywhere; to eliminate all forms of violence against all women and girls; to eliminate all harmful practices, such as child, early, and forced marriage; to recognize and value unpaid care work and domestic work; to ensure women’s full and effective participation and equal opportunities for leadership; and to ensure universal access to sexual and reproductive health and reproductive rights — provide benchmarks for responding to the gender dimensions of HIV/AIDS. In addition, Goal 3, to ensure healthy lives and promote well-being for all, includes the ambitious target of ending the AIDS epidemic by 2030.

8. In its resolution 29/14, on accelerating efforts to eliminate all forms of violence against women, the Human Rights Council urged States to empower women by guaranteeing their full and equal access to quality education, including comprehensive sexuality education.

9. At its fifty-ninth session, the Commission on the Status of Women undertook a review of progress made in the implementation of the Beijing Declaration and Platform for Action in the 20 years since its adoption at the Fourth World Conference on Women, in 1995 (see [E/CN.6/2015/3](#)). The results of the review showed slow and uneven progress. No country had fully achieved equality and empowerment for women and girls, with many women and girls experiencing multiple and intersecting forms of discrimination, vulnerability and marginalization throughout their lives. In the area of health, the review found an increasing number of women living with HIV, a high level of maternal mortality and challenges faced by women and girls in accessing sexual and reproductive health services. The review called for a rights-based approach to health, ensuring the participation of women in decision-making regarding health policies and services, that would be comprehensive and enhance the availability, accessibility and affordability of high-quality services, including sexual and reproductive health and rights, for women and girls across all ages.

III. Action taken by Member States and the United Nations system

10. Over the past 15 years, scientific and biomedical breakthroughs have transformed the AIDS epidemic from a crisis threatening nations and communities into a long-term, chronic public health issue. Women and girls of all ages, however, have not equally benefited from those breakthroughs. Gender inequality has long been recognized as a key factor affecting the dynamics of the epidemic. The issues vary by community and country, but women’s lack of power in relationships, families and communities, along with stigma, discrimination and violence, undermines their ability to prevent HIV infection and mitigate its impact. Notwithstanding robust normative frameworks on HIV that include gender equality commitments, national HIV responses often do not adequately respond to the effects of gender inequality. Gender biases in policies and institutions also influence access and have an impact on the ability of women and girls to seek and receive services. Disaggregating data by sex and undertaking a gender analysis are therefore prerequisites to fully understanding the different ways in which women and girls are affected by inequalities within the HIV response. HIV plans and programmes that include gender-responsive actions that

are adequately resourced will help to improve access to HIV prevention, treatment, care and support for women and girls. A supportive enabling environment is necessary to decrease women's vulnerability factors and increase protective factors. Interventions addressing the social, legal, economic and cultural drivers of the epidemic would respond to persistent and pervasive inequalities that are reflected in the HIV response. A rights-based, people-centred approach to priority-setting requires women living with HIV to be at the decision-making tables where strategies, policies, plans and budgets are being decided. Investing in the engagement and leadership in governance of women living with HIV strengthens the relevance of the response. Evidence has demonstrated that, without addressing gender inequality and implementing interventions to empower women and girls, what are known as "the three zeros", zero new HIV infections, zero discrimination and zero AIDS-related deaths, will not be achieved.

11. During the reporting period, Member States and the United Nations system made significant progress in meeting the needs of women and girls in the HIV response. Progress has been reported in actions to integrate gender equality commitments into the governance of HIV responses, including through support for women's leadership and participation in those responses; efforts to promote greater access for women and girls to HIV prevention, treatment, care and support services; and strategies promoting an enabling environment for women and girls by supporting their political, social, and economic empowerment as fundamental aspects in reducing vulnerability to HIV.

A. Integration of gender equality into national HIV responses

12. The integration of gender equality and human rights into national HIV responses enables countries to meet the needs and priorities of women and girls, address gender-related barriers to access to HIV prevention, treatment, care and support and allocate resources accordingly. Enhanced and comprehensive guidance on integrating gender equality dimensions into national HIV responses will enable national partners to strengthen policies and address the needs of women and girls in all their diversity. Evidence has demonstrated that transforming national HIV responses requires sustained investment at all stages of policy and programming to meet gender equality commitments.

13. Several countries reported on efforts to integrate action to address gender equality in national HIV policies, programmes, monitoring and evaluation frameworks and budgets, including Austria, China, the Dominican Republic, Finland, Liberia, Mexico, Norway, Paraguay, the Philippines, the Russian Federation, Togo and Uganda. Uganda reported the inclusion of outcome indicators disaggregated by sex and age in HIV national monitoring and evaluation frameworks. The Dominican Republic divided its 2015-2018 budget relating to HIV to benefit men and women equitably. Peru and Mexico mainstreamed priorities relating to HIV and AIDS in national action plans on gender equality.

14. A high-level meeting of Arab women leaders was convened in 2014 by the Government of Algeria and the League of Arab States, with the Joint United Nations Programme on HIV/AIDS (UNAIDS)⁵ and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), to support the implementation of the Arab AIDS strategy. The meeting resulted in a call for action aimed at advancing gender equality, universal access to HIV prevention and treatment, including the sexual and reproductive health needs of young people, and ending stigma and discrimination against women living with HIV.

15. Since the previous report of the Secretary-General to the Commission on the Status of Women (E/CN.6/2014/12), UNAIDS, with key partners, produced tools to strengthen capacity for integrating gender equality into HIV responses, including: a programming tool for addressing violence against women in the context of HIV,⁶ a guide on gender-responsive HIV services for women who inject drugs,⁷ a compendium of sexual and reproductive health and HIV linkages and indicators,⁸ and an HIV and tuberculosis gender assessment tool. The UN-Women advocacy kit on championing gender equality and women's leadership in the HIV response includes lessons learned in integrating gender equality into national HIV responses in Cambodia, Jamaica, Kenya, Papua New Guinea and Rwanda.⁹ The United Nations Population Fund (UNFPA) produced guidance on HIV and sex work, which enhanced strategic information and best practices.¹⁰

16. In 2014 and 2015, UNAIDS supported gender assessments of the HIV response in 40 countries, which resulted in the identification of gaps in data, coverage of services and action to respond to the specific needs of women and girls. UN-Women, with UNAIDS, the World Health Organization (WHO) and the Pan American Health Organization, strengthened skills on gender-sensitive monitoring for programme staff working in sexual and reproductive health and HIV from 15 countries (Brazil, Cambodia, Guatemala, Indonesia, Jamaica, Kyrgyzstan, Malawi, Panama, South Africa, State of Palestine, Tajikistan, Thailand, Tunisia, Uganda and Zimbabwe).

⁵ UNAIDS includes: Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO) and the World Bank.

⁶ World Health Organization, *16 Ideas for Addressing Violence against Women in the Context of the HIV Epidemic: A Programming Tool* (Geneva, 2013). Available from http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf?ua=1.

⁷ "Women who inject drugs and HIV: addressing specific needs", policy brief (Vienna, UNODC, 2014). Available from http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf.

⁸ International Planned Parenthood Federation, UNFPA and WHO, "Sexual and reproductive health and HIV linkages compendium: indicators and related assessment tools" (London, 2014 December). Available from http://srhivlinkages.org/wp-content/uploads/SRH-HIV-Linkages-Compendium_rev.pdf.

⁹ UN-Women, "Championing gender equality in the HIV response: the experiences of five programme countries", (2015). Available from <http://www.unwomen.org/en/digital-library/publications/2015/4/championing-gender-equality-in-the-hiv-response-the-experiences-of-five-programme-countries>.

¹⁰ See the series "HIV and sex workers", *The Lancet* (23 July 2014). Available from <http://www.thelancet.com/series/hiv-and-sex-workers>.

Early in 2015, UNAIDS and its partners, UNICEF; UNFPA; WHO; the United States President's Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Staying Alive Foundation of MTV; and the HIV Young Leaders Fund, launched the "All In" platform for improved data collection and analysis and better service coverage for adolescents. The new funding model of the Global Fund prioritizes investments that scale up services and interventions that reduce gender inequality.¹¹ In response, UNAIDS, the United Nations Development Programme (UNDP), UNFPA, UN-Women and WHO supported national partners in integrating gender equality considerations into the concept notes, which are requests for funding that prioritize interventions based on existing gaps in national strategic plans on HIV, to be submitted to the Global Fund.

Costing and financing action for women and girls in the HIV response

17. Total domestic and international funding for HIV and AIDS was estimated to have reached \$21.7 billion as at the end of 2015.³ By September 2015, the Global Fund had disbursed \$15 billion in HIV-related grants.¹² The Global Fund increased expenditure benefiting women and girls from 42 per cent of its total portfolio in 2013 to approximately 60 per cent in 2015.³ Much of the increase was in the areas of reproductive, maternal, newborn, child and adolescent health.

18. Data are not readily available on the percentage of the HIV response allocated for gender-responsive programming to meet the needs of women and girls. Evidence of cost-effective, gender-responsive interventions, together with improved costing tools, can support Governments in translating gender equality commitments into specific action with adequate budgetary allocations. Networks of women living with HIV remain significantly underfunded.³ The increased political commitment to invest in leadership for women and girls lacks commensurate resources to sustain their organizational efforts and collective action.¹³

19. Whereas data on financing for gender-responsive HIV programming are limited, some Member States have reported progress. Mexico reported the allocation of funds targeted specifically to support the retention of women living with HIV in antiretroviral treatment programmes. The new national HIV strategy of Finland allocates resources for targeted prevention for women living in areas with a high incidence of HIV, women migrants and sex workers. Poland and Sweden provided financial support to civil society organizations for HIV prevention activities, such as a national HIV testing campaign targeting women of reproductive age and surveys on the quality of life of people living with HIV.

20. UNAIDS and the London School of Hygiene and Tropical Medicine undertook a systematic review of the cost-effectiveness of gender-responsive interventions with regard to HIV.¹⁴ The review identified promising gender-responsive interventions for improving HIV service uptake, treatment adherence and behaviour change and

¹¹ The Global Fund, "Addressing gender inequalities and strengthening responses for women and girls, information note (April 2014).

¹² See <http://www.theglobalfund.org/en/financials/>.

¹³ Angelika Arutyunova and Cindy Clark, "Watering the leaves, starving the roots: the status of financing for women's rights organizing and gender equality" (Ontario, Canada, Association for Women's Rights in Development, 2013).

¹⁴ Michelle Remme and others, "The cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review", *Journal of the International AIDS Society*, vol. 17 (2014).

justified increasing investment for gender equality and for co-financing with other sectors such as education.

Enhancing the engagement, leadership and participation of women and girls

21. Women's participation and leadership in decision-making in the HIV response is constrained by a lack of access to information and opportunities to engage, stigma and discrimination, caregiving responsibilities in households and communities and funding constraints. Women's representation on the country coordinating mechanisms of the Global Fund, which are multi-stakeholder bodies tasked with the development of proposals and monitoring their implementation, rose from 34 per cent in 2010 to almost 40 per cent in 2015.¹⁵ These data do not, however, offer an indication of the impact of women's voices in such mechanisms, given that the participation and influence of women, in particular women living with HIV, in national HIV responses is not systematically tracked.

22. Austria, Norway, the Russian Federation, Sierra Leone and Uganda partnered with organizations of women living with HIV and women's organizations to support the provision of HIV prevention services and awareness-raising activities on the intersections between violence against women and HIV. Latvia, Sierra Leone, Togo and Uganda supported the participation of women, including women living with HIV, in national HIV coordination mechanisms.

23. UNAIDS, UNDP, UNFPA and UN-Women invested in strengthening the capacity of women living with HIV in more than 30 countries. UN-Women facilitated the engagement at the national level of women living with HIV in the 20-year review of the Beijing Platform for Action, which provided the opportunity for sharing their key priorities. UNDP, UNFPA and UN-Women supported networks of women living with HIV in China, India, Kazakhstan, Tajikistan and Viet Nam to provide their input to the Committee on the Elimination of Discrimination against Women, raising issues of discrimination facing women living with HIV relating to access to services in health-care settings. UN-Women launched a youth strategy directed at empowering young women as leaders, focusing on the most marginalized.

B. Scaling up access to HIV prevention, treatment, care and support for women and girls

24. During the period under review, significant progress was made in the prevention and treatment of HIV. The target on universal access to treatment for HIV/AIDS, of Millennium Development Goal 6, has been achieved. More than 15 million people are receiving treatment. Evidence has demonstrated that antiretroviral medicines can be part of comprehensive prevention efforts and that beginning treatment upon knowledge of a positive diagnosis can considerably improve health outcomes. Research on paediatric HIV treatment has vastly improved. Prevention of mother-to-child transmission of HIV has succeeded in reducing new infections in newborns. Lifelong treatment options for pregnant women are more readily available. These results are reflected in evidence-based guidance for countries.

25. The updated UNAIDS strategy for the period 2016-2021 is fully aligned with the 2030 Agenda for Sustainable Development and prioritizes achieving gender

¹⁵ See <http://www.theglobalfund.org/en/womengirls/>.

equality and empowering all women and girls. It includes a target on ensuring that women and girls live a life free of gender inequalities and gender-based violence to mitigate risk and the impact of HIV. In the strategy, to maintain the momentum of the achievements with regard to Millennium Development Goal 6, UNAIDS has set out ambitious fast-track targets.¹⁶ The 90-90-90 treatment targets envisage that, by 2020, 90 per cent of all people living with HIV will know their HIV status, 90 per cent of all people diagnosed with HIV will receive sustained antiretroviral therapy and 90 per cent of all people on antiretroviral therapy will achieve viral suppression.¹⁷ Alongside key treatment targets, targets on non-discrimination and prevention have been set to promote accelerated action to address prevention, treatment, care and support needs. Without responding to the challenges that women and girls encounter throughout the prevention and treatment continuum, however, the targets will not be met.

Promoting HIV prevention and testing

26. Reaching women and girls with accurate, culturally and age-appropriate and comprehensive sexuality education is important. The lack of information on HIV prevention and the power to use this information in sexual relationships, including in the context of marriage, undermines women's ability to negotiate condom use and engage in safer sex practices. Knowledge can help women and girls to make informed decisions and prevent HIV infection. In sub-Saharan Africa, only 26 per cent of adolescent girls possess comprehensive and correct knowledge about HIV, compared with 36 per cent of adolescent boys.⁹ A review of 22 curriculum-based sexuality and HIV education programmes found that 80 per cent of them addressed gender and power relations, which contributed to a significant decrease in pregnancy and/or sexually transmitted infections.¹⁸

27. Female-controlled HIV prevention methods, such as using female condoms, or taking a combination of antiretroviral medicines as pre-exposure prophylaxis, taken by HIV-negative people to reduce their risk of contracting HIV, can provide women who are at a higher risk of contracting HIV with the means to lower that risk and protect themselves against infection.¹⁹ Even though they are comparable in terms of acceptability and efficacy, the uptake of female condoms has been hindered by accessibility and higher cost compared with male condoms.²⁰ Issues of access and affordability are also essential to address to improve the rate of effective utilization of pre-exposure prophylaxis to prevent HIV infection.

¹⁶ The fast-track approach is an agenda for quickening the pace of implementation and involved setting ambitious targets for prevention and treatment. For more see UNAIDS, *Fast Track: Ending the AIDS Epidemic by 2030* (Geneva, 2014).

¹⁷ Viral suppression is defined as suppressing or reducing the function and replication of a virus. With HIV, treatment is considered highly effective if it reduces the viral load, such as amount of virus in the blood, to an undetectable level.

¹⁸ Nicole A. Haberland, "The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies", *International Perspectives on Sexual and Reproductive Health*, vol. 41, No. 1 (March 2015).

¹⁹ National Institute of Allergy and Infectious Diseases, "Young South African women can adhere to daily pre-exposure prophylaxis regimen as HIV prevention, study finds", 20 July 2015, available from <http://www.niaid.nih.gov/news/newsreleases/2015/Pages/HPTN067.aspx>.

²⁰ What Works for Women and Girls, "Male and female condom use", available from <http://www.whatworksforwomen.org/chapters/5-Prevention-for-Women/sections/1-Male-and-Female-Condom-Use>.

28. Colombia, the Dominican Republic, Finland, Hungary, Mexico, Singapore and Sweden reported on support to HIV prevention, health and sexuality education in schools and various youth-oriented programmes on health and HIV-related issues. Singapore is implementing educational initiatives in the workplace to support HIV prevention. Sierra Leone reported the provision of condoms through HIV and AIDS information and documentation centres and adolescent-friendly sexual and reproductive health-care services. In Colombia, both male and female condoms are offered through a mandatory health plan. The PEPFAR,²¹ launched by DREAMS (determined, resilient, empowered, AIDS-free, mentored and safe women) Initiative, seeks to reduce new HIV infections among adolescent girls and young women in 10 countries in Eastern and Southern Africa through the implementation of a core package of evidence-based prevention interventions that decrease the risk of HIV infection among girls.²²

29. UNFPA promoted comprehensive condom programming in 52 countries and distributed 750 million male condoms and 15 million female condoms. The United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNFPA supported the expansion of high-quality, age-appropriate, culturally sensitive and comprehensive sexuality education in 97 countries. These efforts included a specific focus on the 21 East and Southern African countries in follow-up to the 2013 ministerial commitment for comprehensive sexuality education.

30. Scaling-up of testing is important for HIV prevention, treatment and care. Approximately 17.1 million people who live with HIV do not yet know their status.³ Most women access HIV testing as part of antenatal care. According to UNAIDS estimates, approximately 40 per cent of pregnant women in low-income and middle-income countries received HIV testing and counselling in 2012, an increase from 26 per cent in 2009. Evidence suggests, however, that, with the exception of antenatal care services, women are tested less frequently than men.²³ Integrating testing services with sexual and reproductive health and family planning services is essential to reaching women who are not pregnant and ensuring that women in key population groups, such as female sex workers and women who inject drugs, receive access to services free of discrimination and stigma. In addition, women with disabilities and other marginalized groups of women need targeted support so that their needs are also considered in HIV responses.

31. Finland, Liberia, Lithuania, Malawi, Mexico, Peru, the Philippines, Poland, Sierra Leone, Singapore and Uruguay took measures to provide HIV testing and counselling as part of antenatal screening services and advocacy campaigns. Colombia, Singapore and Malawi encouraged broader HIV testing by providing expanded community testing services for women and girls, rapid HIV testing and anonymous HIV test sites. UNAIDS supported a strengthened focus on testing in the context of preventing mother-to-child transmission of HIV.²⁴

²¹ The DREAMS Initiative is a public-private partnership with the Bill and Melinda Gates Foundation and the Nike Foundation.

²² See PEPFAR, "Fact sheet", September 2015. Available from <http://www.pepfar.gov/documents/organization/247548.pdf>.

²³ Carla Malhlouf Obermeyer and Michelle Osborn, "The utilization of testing and counseling for HIV: a review of the social and behavioral evidence", *American Journal of Public Health*, vol. 97, No. 10 (October 2007).

²⁴ UNAIDS, "UNAIDS performance monitoring report 2014", paper prepared for the thirty-sixth meeting of the UNAIDS Programme Coordinating Board, Geneva, 30 June-2 July 2015 (2015).

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

32. Significant progress towards meeting the goals of the Global Plan towards the Elimination of New HIV Infections in Children by 2015 and Keeping Their Mothers Alive and the Secretary-General's Global Strategy for Women's and Children's Health in the area of mother-to-child transmission of HIV has been achieved. As at the end of 2014, 73 per cent of pregnant women living with HIV globally had received antiretroviral therapy, and new HIV infections among children declined by 58 per cent between 2000 and 2014.³ The proportion of pregnant women living with HIV receiving antiretroviral therapy for their own health increased from 11 per cent in 2009 to 62 per cent in 2014. Many countries, including almost all of the 22 high-priority countries of the Global Plan are implementing Option B+, the offer of lifelong HIV treatment to pregnant women living with HIV. Whereas HIV transmission rates from mother-to-child have declined globally, not all pregnant women living with HIV are accessing antiretroviral therapy. Coverage rates in the Middle East and North Africa and in Asia and the Pacific are particularly low, 13 and 38 per cent, respectively.²⁵

33. In June 2015, Cuba was declared the first country to have eliminated mother-to-child transmission of HIV.²⁶ Finland, Latvia, Liberia, Lithuania, Malawi, Mexico, the Philippines, Poland, Sierra Leone, Singapore, Togo and Uruguay reported significant progress in eliminating such transmission. Liberia, Malawi and Sierra Leone reported on provision of lifelong antiretroviral treatment to all pregnant women living with HIV, consistent with WHO guidelines.

Ensuring access and adherence to treatment for women and girls living with HIV

34. As at March 2015, 15 million people living with HIV had access to antiretroviral treatment, which is 41 per cent of the estimated people living with HIV.³ In 2013, women made up 59 per cent of all those receiving treatment.²⁷ This figure hides, however, the significant differences among women. Studies have found inadequate treatment access for adolescent girls and women over age 50 years of age.²⁸ Fewer women who inject drugs are accessing treatment, and only 36 per cent of female sex workers living with HIV in low-income and middle-income countries are receiving treatment.³ The identification of treatment access gaps is constrained by the lack of data disaggregated by sex, age and population group.

35. In 2014, UN-Women, with the ATHENA Network, the AIDS Vaccine Advocacy Coalition and the Salamander Trust, undertook a global review of key gender-related barriers and facilitators to women's access to HIV treatment. Preliminary findings suggest that barriers include a lack of autonomy in decision-making concerning

²⁵ UNAIDS, "How AIDS Changed Everything: MDG 6: 15 Years, 15 Lessons of Hope from the AIDS Response — fact sheet", 2014. Available from http://www.unaids.org/sites/default/files/media_asset/20150714_FS_MDG6_Report_en.pdf.

²⁶ WHO, "WHO validates elimination of mother-to-child transmission of HIV and syphilis in Cuba", 30 June 2015. Available from <http://www.who.int/mediacentre/news/releases/2015/mtct-hiv-cuba/en/>.

²⁷ WHO, UNICEF and UNAIDS, *Global Update on HIV Treatment 2013: Results, Impacts, and Opportunities* (Geneva, June 2013).

²⁸ Melanie Croce-Galis, Jill Gay and Karen Hardee, "Gender considerations along the HIV treatment cascade: an evidence review with priority actions", Treatment brief (Washington, D.C., What Works Association, September 2015).

health, violence and fear of violence, and stigma and discrimination from family, community members and health-care professionals.²⁹

36. Food and nutrition are essential to ensuring adherence to antiretroviral therapy. Studies have found that the provision of food can improve adherence to HIV treatment, and unresolved food insecurity can have an impact on good treatment outcomes.³⁰ Mexico reported on a programme implemented in 29 states that provided women living with HIV with comprehensive services, including food and nutrition, to achieve greater adherence to antiretroviral therapy and retention in care. Malawi produced nutrition guidelines to aid in assessing the nutritional needs of people living with HIV. The World Food Programme (WFP) provided technical support to national prevention of mother-to-child transmission programmes to include food and nutrition support through maternal, newborn and child health services provided to pregnant malnourished women.

Promoting the integration of HIV-related services and information into sexual and reproductive health services

37. Integrating HIV-related services and information with sexual and reproductive health services improves women's access to such services and leads to better health outcomes. Integration reduces HIV-related stigma, increases the use of services and improves programme efficiency and cost-effectiveness. Linking tuberculosis screening with HIV testing as part of reproductive health services is essential, owing to the increased risk of maternal mortality with tuberculosis and HIV co-infection during pregnancy and after childbirth.³¹

38. Finland, Mexico and Paraguay described their support with regard to HIV prevention within national sexual and reproductive health strategies. In 2014, Finland updated its sexual and reproductive health action programme to include measures for the prevention and early detection of HIV. The Mexican sexual and reproductive health strategy places special emphasis on adolescents, pregnant women and key populations.³² It seeks to ensure a supply of contraceptives and early testing for HIV and other sexually transmitted infections. In Paraguay, the national plan for sexual and reproductive health for 2014-2018 guides rights-based actions in seven areas, including the prevention and control of sexually transmitted infections. In the context of addressing HIV and tuberculosis co-infection, Latvia and the Russian Federation pursue joint HIV and tuberculosis programming in their national health policies.

39. UNFPA supported the Southern African Development Community in developing regional minimum standards on sexual and reproductive health and HIV integration, which were approved by the Southern African Development Community Ministers of Health and ministers responsible for HIV and AIDS-related matters in January 2015.²⁴ UNFPA also supported the integration of sexual and reproductive health and rights

²⁹ UN-Women and others, "Key barriers to women's access to HIV treatment: making fast-track a reality" (2015).

³⁰ Saskia de Pee and others, "The enabling effect of food assistance in improving adherence and/or treatment completion for antiretroviral therapy and tuberculosis treatment: a literature review", *Aids and Behaviour*, vol. 18, supp. 5 (12 March 2014).

³¹ WHO, "Tuberculosis in women", 2014, available from http://www.who.int/tb/publications/tb_women_factsheet_251013.pdf.

³² UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs, as the four main key population groups, see UNAIDS, "Terminology guidelines 2015" (Geneva, 2015).

and HIV into broader national health and development efforts in Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe.

C. Prioritizing interventions that support an enabling social and legal environment for HIV prevention and mitigation

40. The removal of discriminatory laws, stigma and gender-based violence accelerates progress for women and girls in the HIV response. Investing in greater access to education and economic empowerment for women can contribute to strengthened livelihood security and an enabling environment for reducing the risk of HIV infection. Transforming gender norms and stereotypes and discriminatory cultural dynamics through dialogue and engagement with men and boys can improve prevention efforts and mitigating the impact of HIV and AIDS.

Enabling legal and policy frameworks to support HIV prevention and mitigation

41. Prevention, treatment and care programmes for women and girls will succeed only if they operate within a legal and policy environment that seeks to protect and promote the rights of women and girls, including property and inheritance rights, protection against violence, freedom from discrimination in the workplace and the right to make independent decisions on marriage, divorce and childbearing. Laws and policies in many cases continue to discriminate against women and girls and reinforce gender inequalities, which in turn create challenges to accessing services (see [E/CN.6/2015/3](#)). Whereas the practice of child, early and forced marriage is declining globally, there are still 700 million girls worldwide who were married before their eighteenth birthday.³³ Member States have committed themselves, in the Sustainable Development Goals, to eliminating all harmful practices, such as child, early and forced marriage. Ending child marriage is essential to reducing HIV vulnerability and risk among girls and young women. They often have limited access to prevention information and limited power to protect themselves from HIV infection. Laws and policies on the age of consent can be a factor in limiting young women's access to HIV-related services, including HIV testing and counselling and sexual and reproductive health care.⁹ Realizing property and inheritance rights for women improves their economic security and can play a critical role in preventing the spread of HIV. It gives women greater bargaining power within households, which increases their ability to negotiate safer sex, thereby reducing their risk of HIV infection. Securing property and inheritance rights for women is therefore an essential component of effective national HIV responses. Countries that criminalize key populations deter female sex workers and women who inject drugs from seeking critical HIV health services. Access to justice remains a protracted and costly process for women and girls living with HIV.

42. Colombia, Finland, Latvia, Lithuania, Mexico, Poland, Sweden and Uruguay reported on existing constitutional guarantees and laws on non-discrimination and equality between women and men, including laws protecting the right to health. Austria, Paraguay and Uganda referred to specific laws safeguarding the human rights of people living with HIV. Liberia reported on efforts to draft a domestic violence act, and Colombia indicated that it had developed laws combating all forms of stigma and discrimination. Malawi took an important step in eliminating child, early and forced

³³ UNICEF, "Ending child marriage: progress and prospects" (New York, 2014).

marriage, with the passing of the Marriage, Divorce and Family Relations Act, in 2015, which raised the minimum age of marriage without parental consent to 18 years. The African Union rolled out a region-wide campaign to end child marriage, targeting 10 countries, to advocate for the implementation of laws prohibiting child marriage.

43. UNAIDS supported the revision of discriminatory laws and policies on parental consent requirements for adolescent HIV testing and counselling, domestic violence and sexual offences, social protection and HIV decriminalization in Bangladesh, Cambodia, Indonesia, Jamaica, Kenya, Myanmar, Thailand and Viet Nam. UN-Women continued to support access to property and inheritance rights for women living with or affected by HIV and AIDS in Kenya, Nigeria, Uganda, the United Republic of Tanzania and Zimbabwe, resulting in increased legal literacy for women and capacity of paralegals to provide legal and social services. UNDP supported enabling legal and policy environments for HIV-affected women and girls in 41 countries, including through the amendment of laws that prevent women and girls, people living with and at a higher risk of HIV infection and key populations from accessing HIV services.

Ending the twin epidemics of gender-based violence and HIV and AIDS

44. Gender-based violence is a human rights violation and public health concern, with immediate and long-term health and social consequences, including heightened risk of HIV infection. It undermines the ability of women and girls to negotiate safe sexual practices, disclose their HIV status and seek essential health-care services. It also leads to a deterioration in women's HIV-related health and contributes to a higher incidence of opportunistic infections and a greater risk of mortality.³⁴

45. WHO estimates that more than one third of women worldwide have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner at some point in their lives.³⁵ Women who have experienced intimate partner violence are 50 per cent more likely to be living with HIV.³⁶ Women living with HIV are more likely to experience intimate partner violence in addition to violence from family members, the community and within institutional settings, including coerced abortion and forced sterilization. According to a recent study, male controlling behaviour, as an indicator of ongoing and severe violence, was found to independently put women at risk of HIV infection.³⁷ Female sex workers, women who inject drugs and women with disabilities experience higher rates of violence than women in the wider population.⁹

46. In Finland, the prevention of and response to gender-based violence forms part of the sexual and reproductive action programme, which is aligned with the national HIV strategy. In Paraguay, the Ministry of Women launched a national campaign to promote a life without risk and without violence, which included messages on the

³⁴ Abigail M. Hatcher and others, "Intimate partner violence and engagement in HIV care and treatment among women: a systematic review and meta-analysis", *AIDS*, vol. 29 (2015).

³⁵ *The World's Women 2015: Trends and Statistics* (United Nations publication, Sales No. E.15.XVII.8).

³⁶ UNAIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2013* (Geneva, 2013).

³⁷ Dirk Durevall and Annika Lindskog, "Intimate partner violence and HIV in ten sub-Saharan African countries: what do the demographic and health surveys tell us?", *Lancet Global Health*, vol. 3, No. 1 (January 2015).

various types of violence, as well as on how to prevent HIV and other sexually transmitted infections. In Peru, the national programme against domestic and sexual violence integrated specific care provisions for people living with HIV into a new guide for comprehensive care at women's emergency centres. These centres provide legal, psychosocial and social care to survivors of gender-based violence. Sierra Leone provides HIV testing and counselling, including post-exposure prophylaxis, to survivors of sexual violence.

47. The Office of the United Nations High Commissioner for Refugees strengthened the integration of HIV and sexual and gender-based violence prevention, treatment, care and support into humanitarian protection and coordination mechanisms, as well as at the community level. UNFPA, UN-Women and WHO developed a clinical handbook for health-care providers on service and care provision to survivors of violence, including the provision of post-exposure prophylaxis to prevent HIV transmission.³⁸ UNDP supported the provision of integrated gender-based violence and health services through facilities that offer comprehensive legal, health and psychosocial assistance to women and girls, all under one roof, in Burundi, the Sudan and Togo.

Enhancing education of girls to promote HIV prevention

48. Evidence shows that educating girls saves lives through the improvement of HIV prevention and care. Educating young women reduces their risk of HIV infection by empowering them with knowledge of how HIV is transmitted.³⁹ In 17 countries in Africa and 4 in Latin America, girls with more education were found to delay having sexual intercourse for the first time and were more likely to use condoms.³ A study in Botswana found that, with each additional year of secondary schooling, HIV infection risk among girls was reduced by 12 per cent.⁴⁰ New evidence from clinical trials focused on school-based, conditional cash transfers to reduce the risk of HIV infection among girls in South Africa shows promising results in terms of reduction of HIV-risk behaviours, including young women reporting significantly fewer partners, less unprotected sex and increased HIV testing.⁴¹ Additional evidence demonstrates that an integrated social protection package offered to young women halved their HIV-risk behaviour.⁴² These approaches show that cash transfer programmes can bring about healthy behavioural outcomes. Such programmes have demonstrated promising potential for keeping girls in school and having a positive outcome on HIV prevention. To ensure a sustained impact, however, cash transfer programmes need to

³⁸ WHO, "Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook" (Geneva, 2014). Available from http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf?ua=1.

³⁹ UNESCO, "Education transforms lives" (Paris, 2013).

⁴⁰ Jan-Walter De Neve and others, "Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment" *The Lancet Global Health*, vol. 3, No. 8 (August 2015).

⁴¹ Quaraiasha Abdool Karim and others, "Impact of conditional cash incentives on herpes simplex virus 2 (HSV-2) and HIV in rural South African high school students" and Audrey Pettifor and others, "HIV Prevention Trials Network 068 conditional cash transfer to prevent HIV infection among young women in South Africa: results of a randomized controlled trial", presentations at the eighth International AIDS Society conference on HIV pathogenesis, Vancouver, Canada, July 2015.

⁴² Lucie D. Cluver and others, "Cash plus care: social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa", *AIDS*, vol. 28, supp. 3 (2014).

be part of broader cross-sectoral approaches⁴³ that address key barriers to girls staying in school, including unsafe school environments and early, forced and child marriage. Given the conditionality and time-bound nature of the programmes, however, more evidence is needed as to their longer-term effectiveness.

49. Malawi reported on a social cash transfer programme for children, including orphans and girls, whose parents have died of AIDS, who drop out of school to take care of siblings. The programme focuses on encouraging school enrolment, retention of pupils and completion of education and has reached 70 per cent of orphans and other vulnerable children. UNESCO focused on improving the quality of education for girls and women at the secondary school level in Ethiopia, Nigeria, Pakistan, Senegal and the United Republic of Tanzania, as part of the Global Partnership for Girls' and Women's Education. WFP school feeding programmes improved school attendance among girls in the Congo, Ghana, Ethiopia, Lesotho, Myanmar, Swaziland and Zambia.

Promoting economic empowerment to prevent and mitigate the impact of HIV

50. Women's economic dependence on men and women's unequal access to land and productive resources can increase their vulnerability to HIV infection owing to transactional or coerced sex.⁴⁴ The disproportionate burden of care work that falls on women and girls reinforces their socioeconomic disadvantage by limiting their access to education, health care and income-generating opportunities.⁴⁵ In Africa, the impact of HIV and AIDS influences the demands on women to provide care within the household.⁴⁶ Combining economic empowerment and HIV interventions has shown promising results with regard to addressing the risk of HIV infection and vulnerability factors among women and girls.

51. Liberia and Togo provide credit to increase women's economic opportunities and reduce their vulnerability to HIV infection. The International Labour Organization and UNAIDS, in partnership with the Southern African Development Community, supported economic empowerment alongside efforts with regard to HIV prevention and addressing gender norms in Malawi, Mozambique, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe. The programme improved business skills, which resulted in increased profits and savings among community members. It also promoted peer education, which improved knowledge on HIV prevention. The programme included referrals to relevant health-care services. Together, they resulted in strategies to reduce the risk of HIV infection being adopted by community members.

⁴³ Lori Heise, and others, "Cash transfers for HIV prevention: considering their potential", *Journal of the International AIDS Society*, vol. 16 (2013).

⁴⁴ Karen Hardee and others, "Strengthening the enabling environment for women and girls: what is the evidence in social and structural approaches in the HIV response?", *Journal of the International AIDS Society*, vol. 17 (2014).

⁴⁵ UN-Women, *Progress of the World's Women 2015-2016: Transforming Economies, Realizing Rights* (New York, 2015).

⁴⁶ Nancy Folbre, "The care economy in Africa: subsistence production and unpaid care", *Journal of African Economies*, vol. 23, supp. 1 (2014).

Eliminating stigma and discrimination among people living with HIV

52. Women and girls, especially those living with HIV, experience multiple forms of discrimination within their families, in their communities, at the workplace and in health-care settings. The People Living with HIV Stigma Index⁴⁷ shows that women living with HIV in the Asia-Pacific region are more likely than men living with HIV in that region to be the target of verbal abuse and physical violence owing to their HIV status. HIV-related stigma and discrimination faced by women and girls, including women in key populations, such as sex workers and women who inject drugs, remain the gravest and often-cited barriers to the uptake of HIV prevention, treatment, care and support.

53. Singapore offered social support for people living with HIV and their families, to reduce stigma and discrimination, and encouraged better retention in care. UNAIDS supported an analysis of violations of the legal rights of HIV-affected women in health-care settings in Asia and led a similar effort in Latin America and the Caribbean.⁴⁸ The study drew attention to the discrimination, violence and abuse experienced by women living with HIV when seeking health services.

Engaging men and boys in the HIV response

54. Engaging men and boys is essential for transforming gender norms that perpetuate the unequal status of women and girls in society and their vulnerability to HIV. Interventions at the community level that engage women and girls and men and boys in discussions of gender inequality have been effective in changing gender norms.⁴⁹ Malawi, Sierra Leone, Togo and Uganda reported on engaging men and boys to support efforts to address violations of women's rights in the context of HIV. In Malawi, traditional leaders have signed a declaration to raise the minimum age of marriage and eliminate child marriage. In Uganda, approximately 500,000 cultural and religious leaders increased their capacity to promote maternal health and prevent gender-based violence and HIV infection. The United Nations Trust Fund in Support of Actions to Eliminate Violence against Women supported the Coalition of Women Living with HIV and AIDS in Malawi to engage women, men and traditional leaders to challenge cultural and community norms that fuel gender-based abuse. Communities in 12 districts were mobilized to advocate for more effective laws, including one criminalizing marital rape.⁴³

IV. Conclusions and recommendations

55. Ending HIV and AIDS is a public health imperative that hinges upon a transformative response. Clear progress has been made in combating AIDS. The world has achieved the AIDS-related targets of Millennium Development

⁴⁷ The People Living with HIV Stigma Index is a tool used by, and for, people living with HIV in order to collect evidence and increase understanding of how stigma and discrimination is experienced by people living with HIV. Available at <http://www.stigmaindex.org>.

⁴⁸ UNAIDS, "Performance monitoring report highlights", paper prepared for the thirty-sixth meeting of the UNAIDS Programme Coordinating Board, Geneva, 30 June-2 July 2015 (2015).

⁴⁹ Tanya Abramsky and others, "Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda", *BioMed Central Medicine*, vol. 12, No. 122 (31 July 2014).

Goal 6. The epidemic has been halted and reversed. In the year 2000, fewer than 700,000 people were receiving antiretroviral medicines; today, some 15 million people have access to such treatment, meaning that one of the most important treatment goals in history has been reached. As reported by UNAIDS, in the past 15 years, new HIV infections have been reduced by 35 per cent, and, since a peak in 2004, AIDS-related deaths have declined by 42 per cent. Many countries also made robust strides to ensure wider antiretroviral treatment coverage for pregnant women living with HIV and to eliminate mother-to-child transmission through enhanced integration with sexual and reproductive health services. Member States and United Nations entities have made important progress towards meeting the needs of women and girls in the HIV response. There is stronger representation of gender equality priorities in national strategic plans on HIV and greater participation of women in policymaking and decision-making arenas.

56. Notwithstanding progress, the number of new HIV infections among adolescent girls is rising. Adolescent girls are the only group in which AIDS-related deaths are increasing, and, in sub-Saharan Africa, AIDS is the leading cause of death among adolescent girls. Gaps in the HIV and AIDS response remain and threaten to undermine and reverse existing gains. Zero tolerance for gender-based violence, stigma and discrimination, along with meeting the sexual and reproductive health needs and rights of women must be fully integrated and resourced in HIV, health and broader development policies, programmes and services. The adoption of the Sustainable Development Goals provides the framework through which to achieve gender equality and the empowerment of women, with a target to end the AIDS epidemic by 2030. The adoption of the new UNAIDS strategy for the period 2016-2021 and the new Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 explicitly emphasize the rights of women and girls in the context of HIV and provide important guidelines for achieving the 2030 Agenda for Sustainable Development. Ending gender inequality and empowering all women and girls is essential to ending the AIDS epidemic by 2030.

57. The Commission may wish to encourage Member States:

(a) To align national legal and policy frameworks with the global normative frameworks on gender equality and the empowerment of women and girls, by revising discriminatory laws and working to eliminate gender norms and stereotypes that perpetuate the unequal status of women and girls in societies and exacerbate the risk of HIV infection;

(b) To strengthen the integration of commitments to gender equality and the empowerment of women into all national plans on HIV and health, as well as development strategies, operational plans, monitoring and evaluation frameworks and budgets;

(c) To implement strategies that promote an enabling environment for the social, political, and economic empowerment of women in order to reduce their risk of HIV infection and mitigate its impact;

(d) To expand evidence-based approaches to address the specific vulnerabilities of young women and girls in order to reduce the risk of HIV infection and support young women and girls living with HIV;

(e) To enhance efforts to improve dissemination of knowledge and information on HIV, including through comprehensive sexuality education;

(f) To strengthen the integration of services to address HIV within broader health services, including sexual and reproductive health services, including collaborative HIV/tuberculosis activities, as well as within legal services to address gender-based violence and violations of women's rights, including to property and inheritance;

(g) To undertake interventions that transform gender norms which have a negative impact on and increase the risk of HIV infection among women and girls, including in key populations;

(h) To expand access to HIV prevention, treatment, care and support services for women and girls in all their diversity;

(i) To eliminate stigma and discrimination against women and girls, in all their diversity, and ensure that human rights violations are addressed in order to improve access to prevention, treatment, care and support services;

(j) To support the leadership of women living with HIV, including through the financing of their groups and networks, as active participants in HIV policy coordination and decision-making mechanisms.

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

(a) To track allocations and expenditure that address gender equality and priorities and the needs of women and girls in the HIV response across institutions in order to record investments in gender equality in the HIV response;

(b) To support national capacity to collect, analyse and use data disaggregated by sex, age and key population group, and improve capacity for the analysis of data in terms of gender in order to accurately reflect the priorities of women and girls in programming and policies;

(c) To promote efforts at the national level to scale up prevention, treatment, care and support services for women and girls, in all their diversity;

(d) To prioritize investments in improving the availability and affordability of and access to safe, effective and comprehensive prevention approaches that include women-initiated HIV prevention technologies and promote approaches that empower women with the knowledge, skills and power to utilize these options to protect themselves against HIV infection;

(e) To identify gender-related barriers that women and girls face in accessing treatment and respond accordingly, ensuring that efforts are guided by the human rights principles of equality, non-discrimination, confidentiality and informed consent;

(f) To enhance support for networks and organizations of women living with HIV through multi-year funding support, organizational development, alliance-building and mobilizing of constituencies to promote participation and expand their leadership as key actors engaged in the response to HIV;

(g) To ensure the greater integration of HIV services with other development sectors, including education, social protection, employment, food security, human rights and law enforcement and the judiciary, to better leverage synergies and achieve maximum impact for women and girls.