

WHEN WOMEN LEAD CHANGE HAPPENS

*Women advancing the
end of AIDS*



18.6

MILLION WOMEN AND GIRLS
LIVING WITH HIV

NEARLY 1 MILLION NEW HIV INFECTIONS
AMONG WOMEN AND GIRLS EVERY YEAR

EVERY FOUR MINUTES THREE YOUNG WOMEN
BECOME INFECTED WITH HIV

1.1 BILLION

GIRLS IN THE WORLD TODAY, THE LARGEST GENERATION IN HISTORY

FOREWORD

Indignation. Hope.

These two words immediately come to my mind every time I address the issue of girls, women and HIV.

Indignation that girls and women are still bearing the brunt of the AIDS epidemic. Women living with HIV face stigma and discrimination at the hands of family members, in communities, at the workplace and in health-care settings. Health services, including sexual and reproductive health and HIV services, for adolescent girls and women are not yet universally available. Women and their children are still dying during childbirth.

Discrimination against women starts early. The preference for sons has led to millions of missing girls. Large numbers of adolescent girls and women all over the world are still not able to take decisions about their own health. The requirement of parental and spousal consent is stopping adolescent girls and women from taking care of their own health and the health of their loved ones.

Violence against women and girls remains a black spot on our social fabric. Every year millions of girls are being forced into marriage before they are ready and willing. Indignation feels a light word when atrocities against girls and women go unchecked, and when their rights are systematically denied.

Too many women are falling through the social safety nets. Women living with HIV, women who use drugs, sex workers, migrants, transgender women and disabled women are systematically being denied their rights to autonomy, health and education. Women are being denied recognition for their work and denied equal opportunities.

No woman should need the consent of a man to open a bank account, inherit or buy property, start a business or access health services. When girls and women are not served by social, education and health systems, they are robbed of a future of opportunities to flourish and societies and nations are denied the benefit of a precious asset.

However, much of this is changing. I see a world full of hope.

When women lead, change happens. Results follow.

The AIDS response has been led by women. When there was no treatment available, women were at the forefront of providing care for people living with and affected by HIV. Grandmothers looked after orphans. Elder sisters looked after their younger siblings. Women fought for access to treatment and mobilized.

Today, we are at the cusp of eliminating new HIV infections among children—a movement led by women. More women are accessing antiretroviral therapy than men, transferring the benefits of their good health to their families and economies. When young women are empowered and have their rights fulfilled, HIV prevalence falls, there are fewer unintended pregnancies, fewer maternal deaths and fewer dropouts from school and more women join the workforce. When young women have access to education, health outcomes dramatically improve.

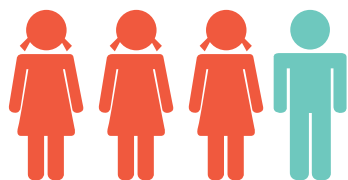
A few days ago I lost my beloved mother. At 94 years old, she had lived an extraordinary life. My mother was a strong and principled person who taught me that to be a good human being you must respect the rights and dignity of all.

Women's rights are human rights. No exceptions.

Michel Sidibé

Executive Director, UNAIDS

WOMEN AND GIRLS AND HIV AT A GLANCE



In sub-Saharan Africa, three in four new infections in 15–19 year olds are among girls

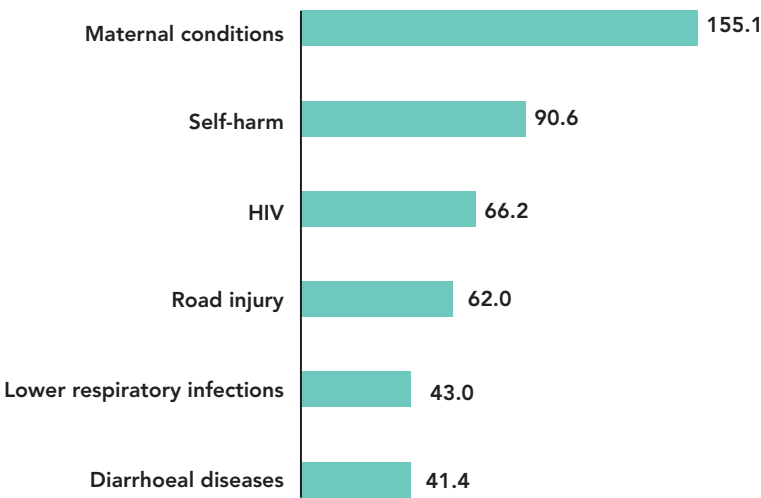
Source: UNAIDS 2016 estimates.



Approximately 75% of young women aged 15–19 report they do not have a final say in decisions about their own health

Source: Demographic and Health Surveys, 2010–2012.

HIV is the third leading cause of death among young women aged 15–29 globally (hundred thousands)



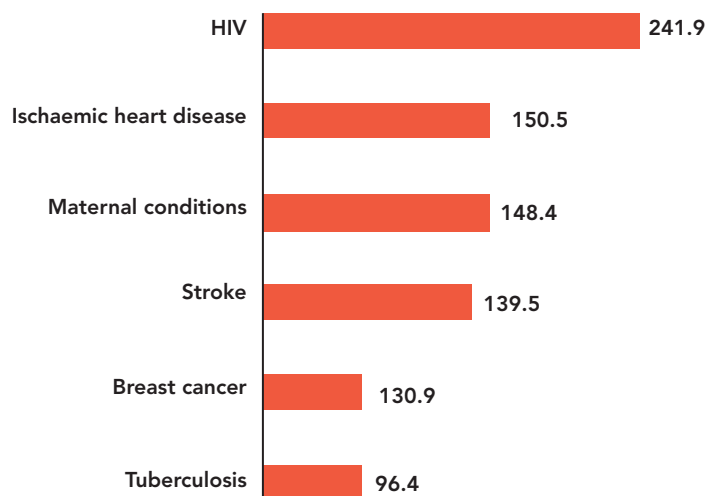
Source: Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2015. Geneva, WHO; 2016.



Globally, young women are twice as likely to acquire HIV as their male counterparts

Source: UNAIDS 2016 estimates.

HIV is the leading cause of death among women aged 30–49 globally (hundred thousands)



Source: Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2015. Geneva, WHO; 2016.

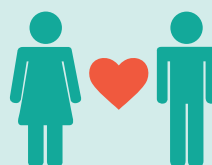
10X

HIV INCIDENCE IS 10 TIMES HIGHER AMONG FEMALE SEX WORKERS THAN AMONG THE GENERAL POPULATION

Source: UNAIDS. Prevention gap report. Geneva: UNAIDS, 2016.

HIV infection rates in married adolescents are 50% higher than in their unmarried, sexually active peers

Source: Demographic and Health Surveys.



100

More than 100 adolescents (10–19) died of AIDS every day in 2015

Source: UNAIDS 2016 estimates.

In some settings women who experience intimate partner violence are 50% more likely to acquire HIV compared to those who do not experience such violence

Source: World Health Organization. Multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization, 2015.

Each year, 15 million girls are married before the age of 18. That is 28 girls every minute—married too soon, endangering their personal development and well-being.

Source: United Nations Children's Fund, Ending Child Marriage: Progress and prospects, UNICEF, New York, 2014.

GLOBAL COMMITMENTS

FOR GIRLS' AND WOMEN'S HEALTH AND DEVELOPMENT



Sustainable Development Goals

- ▶ **SDG 3:** Ensure healthy lives and promote well-being for all at all ages.
- ▶ **SDG 4:** Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
- ▶ **SDG 5:** Achieve gender equality and empower all women and girls.
- ▶ **SDG 8:** Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
- ▶ **SDG 16:** Promote peaceful and inclusive societies for sustainable development, provide access to

justice for all and build effective, accountable and inclusive institutions at all levels.

2016 United Nations General Assembly Political Declaration on Ending AIDS

- ▶ Reduce the number of children newly infected with HIV annually to less than 40 000 by 2018.
- ▶ Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018.
- ▶ Ensure that 30 million people living with HIV have access to treatment by

2020, and 90–90–90 targets are met by 2020.

- ▶ Provide 1.6 million children aged 0–14 years and 1.2 million adolescents aged 15–19 years living with HIV with lifelong antiretroviral therapy by 2018 [reach 95% of all children living with HIV].
- ▶ Reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year.
- ▶ Ensure that 90% of adolescent girls and women at high risk of HIV infection access comprehensive prevention services by 2020.



- ▶ Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV.
- ▶ Ensure that 90% of young people in need have access to sexual and reproductive health services and combination HIV prevention options by 2020.
- ▶ Ensure universal access to quality, affordable and comprehensive sexual and reproductive health care and HIV services, information and commodities for women.
- ▶ Eliminate gender inequalities and end all forms of violence and

discrimination against women and girls, such as gender-based, sexual, domestic and intimate partner violence, including in conflict, post-conflict and humanitarian settings.

- ▶ Ensure that 90% of key populations—including female sex workers, transgender women, women who inject drugs and prisoners—access comprehensive prevention services, including harm reduction, by 2020.
- ▶ Make 20 billion condoms annually available in low- and middle-income countries by 2020.
- ▶ Review and reform laws that reinforce stigma and discrimination, including

on age of consent, HIV non-disclosure, exposure and transmission, travel restrictions, and mandatory testing by 2020.

- ▶ Eliminate stigma and discrimination in health-care settings by 2020.
- ▶ Reach 90% of all people who need tuberculosis treatment, including 90% of populations at higher risk, and achieve at least 90% treatment success; and reduce tuberculosis-related AIDS deaths by 75% by 2020.

WOMEN, GIRLS AND HIV—THE FACTS

Women living with HIV

Globally, 18.6 million girls and women were living with HIV in 2015—1.5 million more girls and women than the entire population of the Netherlands. Women account for 51% of people living with HIV worldwide, but with large regional differences—in western and central Africa, nearly 60% of all people living with HIV are women.

New HIV infections among women and girls

Nearly one million girls and women were newly infected with HIV in 2015. In sub-Saharan Africa, women accounted for 56% of new HIV infections among adults. Young women aged 15–24 accounted for 25% of new HIV infections among adults and are at particularly high risk of HIV infection, despite accounting for just 11% of the adult population.

There has been little change in the rate of new HIV infections among women in recent years. Globally, new infections among adolescent and young women aged 15 to 24 years decreased by 6% between 2010 and 2015, and by 2% among women of reproductive age (15 to 49 years). There were an additional 5.2 million women of reproductive age newly infected between 2010 and 2015, including 1.1 million in South Africa alone.

Women accounted for 59% of all adults aged 15 years and older living with HIV in eastern and southern Africa, and the rate of new HIV infections remained high among young women aged 15–24 years. There were approximately 4500 new HIV infections weekly among young women in the region, which is double the number seen in young men.

New phylogenetic data from South Africa have revealed a vicious cycle of HIV infection among older and younger people that may be at play in many high-prevalence settings: young women are acquiring HIV from adult men—as these young women grow older, they tend to transmit HIV to adult men in their peer group, and the cycle repeats. Data from other studies suggest that gender inequalities and harmful masculinities underpin this cycle. Lower access to education, lower levels of economic independence and intimate partner violence erode the ability of young women to negotiate safer sex and retain control of their bodies. Men, meanwhile, tend to be ignored by health policies and HIV strategies, they seek services infrequently, and they tend to be diagnosed with HIV and initiate treatment very late—often with deadly consequences.

To address the vicious cycle of infection, a three-year national HIV prevention campaign for adolescent girls and young women, entitled SheConquers, was launched in South Africa in 2016. SheConquers is built around a five-point strategy that aims to decrease new HIV infections, teenage pregnancies and gender-based violence among young women and adolescent girls, to increase and retain young women and adolescent girls in school, and to increase economic opportunities for young people, particularly young women.

In western and central Africa in 2015, 64% of new infections among young people were among young women. Gender inequalities and gender-based violence in the

region make girls and young women more vulnerable to HIV infection than boys and young men. In conflict situations, levels of household and intimate partner violence tend to increase, and girls and young women may be vulnerable to being married early, as families seek to find ways of protection for their daughters.

Pregnant women

The gold standard for offering HIV tests to pregnant women involves an HIV test at their first antenatal visit and repeat testing in the third trimester and during the breastfeeding period.

As a result of increased coverage and improved regimens, rates of HIV transmission from mothers to infants during pregnancy and breastfeeding have decreased around the world. *The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* (Global Plan) was launched in June 2011. At the end of 2015, the 21 Global Plan focus countries in sub-Saharan Africa had reduced new infections among children by 60% since 2009, with 80% of pregnant women living with HIV receiving antiretroviral medicines to prevent mother-to-child transmission of HIV.

The largest decline in transmission from mothers to infants during pregnancy and breastfeeding was in eastern and southern Africa, where it fell from 18% in 2010 to 6% in 2015—a threefold decrease. In some countries, however, inadequate health-care infrastructure, poor linkages between HIV and maternal and child health services, and lack of awareness of the importance of routinely offering HIV testing prevent many women living with HIV from being reached.

The region that showed the least amount of progress was the Middle East and North Africa, where nearly one third of women living with HIV pass the virus on to their children. The mother-to-child transmission rates in Asia and the Pacific and western and central Africa also were well above the global average of 10%.

Collectively, countries have reduced new HIV infections of children from 270 000 [230 000–330 000] in 2009 to 110 000 [78 000–150 000] in 2015. But, although in 2015 some 77% of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their babies, more than 300 000 pregnant women living with HIV did not receive the vital medicines.

Countries with low HIV testing coverage among pregnant women have many challenges in common, such as a lack of test kits due to poor procurement and supply chain systems. In addition, traditional beliefs, cultural practices, stigma and discrimination, mandatory testing, lack of confidentiality within health-care settings and transportation challenges hinder access and contribute to underutilization of services. In the United Republic of Tanzania, for example, a study found that concerns about confidentiality of testing and test results, quality of HIV counselling and testing services, and practical considerations such as accessibility and availability of ancillary services all had an impact on the uptake of HIV testing services for pregnant women.

Access to antiretroviral therapy

In 2015, 9.2 million women aged 15 years and older living with HIV were accessing life-saving antiretroviral therapy. Treatment coverage is higher among women (52% [48–57%]) than men (41% [33–49%]), resulting in a reduction in AIDS-related deaths since 2010 that has been greater among adult women (a 33% decrease) compared with adult men (a 15% decrease).

Coverage is higher among pregnant women attending clinics that provide prevention of mother-to-child transmission services. In South Africa, for example, while antiretroviral therapy is only 53% for women over the age of 15, prevention of mother-to-child transmission services coverage is over 95%. Equally, in Uganda antiretroviral therapy coverage is 65% in women over the age of 15, yet prevention of mother-to-child transmission services coverage is over 95%. Clearly services to prevent transmission of HIV from mother-to-child are proving effective. However, efforts are failing to reach young and older women who are not pregnant.

Women and tuberculosis

In 2014, over 60% of new cases of tuberculosis (TB) occurred among men, but incidence of TB is higher among women aged 15–24 years in areas of high HIV prevalence in sub-Saharan Africa. Female-specific risks include higher stigma, delayed diagnosis, less access to treatment services and previous policies of passive TB case-finding. High rates of extra-pulmonary TB among women also mean they are harder to screen and diagnose.

TB disease occurring among pregnant women living with HIV is associated with higher maternal and infant mortality, and maternal TB is also independently associated with a 2.5-times increased risk of HIV transmission to exposed infants.

Age-appropriate comprehensive sexuality education

The latest available data show that most young people lack the knowledge required to protect themselves from HIV. In sub-Saharan Africa, survey data from 35 countries show that only 36% of young men and 30% of young women correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. In 23 countries outside of sub-Saharan Africa, just 13.8% of young men and 13.6% of young women had correct and comprehensive knowledge about HIV.

Knowledge on specific risk factors, such as transmission in sexual networks, risk of age-disparate sex and anal sex, newer biomedical prevention methods such as pre-exposure prophylaxis or links between HIV and gender-based violence is also likely to be low. Furthermore, there are gaps in personal risk perception. In one survey, a significant proportion of young adults living with HIV who did not yet know their HIV status said they did not perceive themselves at high risk of HIV.

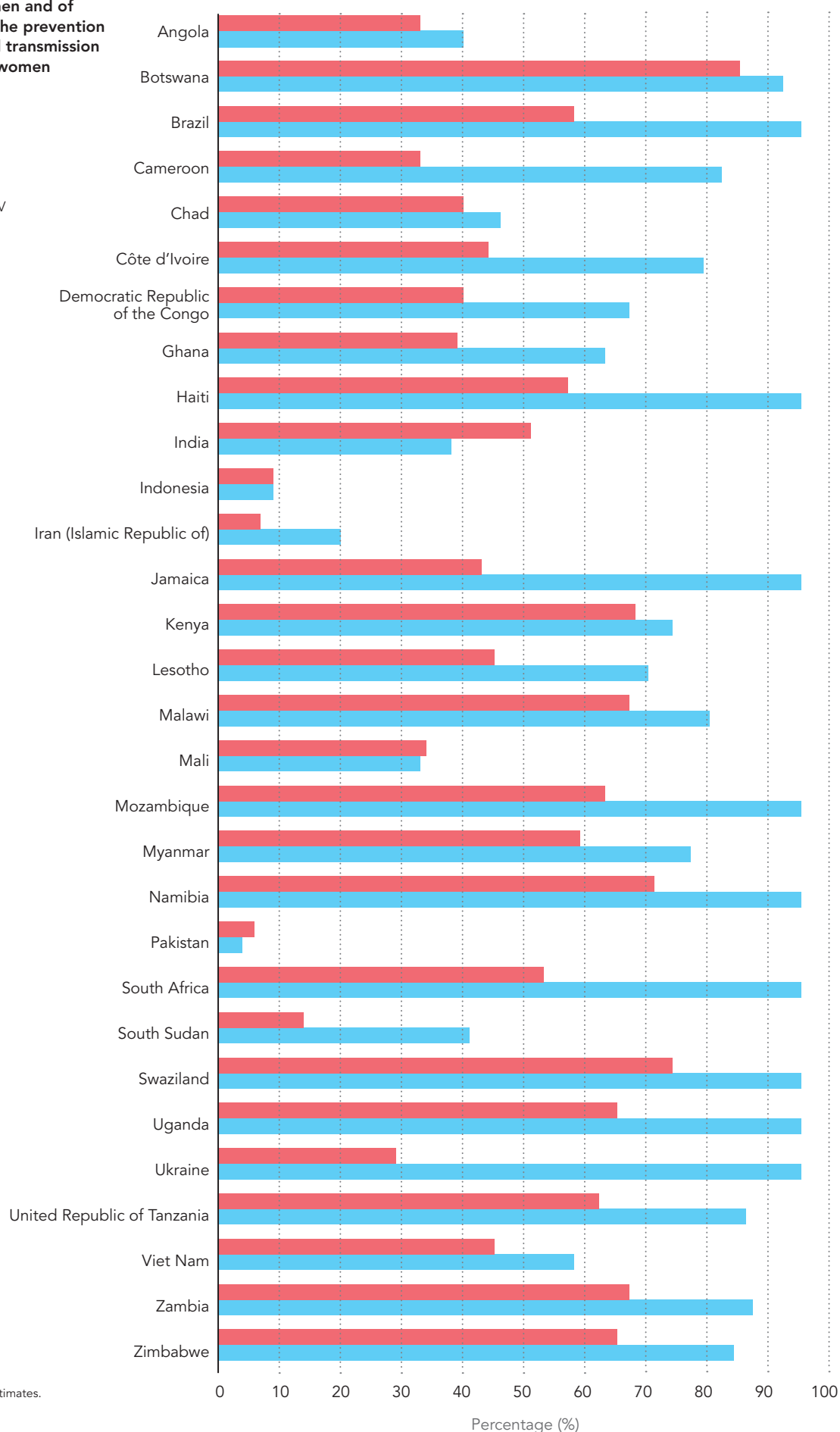
Analysis of surveys conducted in sub-Saharan Africa from 2000 to 2008 and from 2009 to 2015 show that rates of correct and comprehensive knowledge increased by 6.8 percentage points among young men and by 4.4 percentage points among young women.

Many countries have, however, embraced the concept of age-appropriate comprehensive sexuality education and are engaged in strengthening its implementation at the national level. In 2015, UNAIDS and the African Union included age-appropriate comprehensive sexuality education as one of five key recommendations to Fast-Track the HIV response and end the AIDS epidemic among young women and girls across Africa. Meanwhile, many countries in Asia and the Pacific, western Africa and Europe were revising their policies and approaches to scale up sexuality education.

**Coverage of antiretroviral therapy
among adult women and of
antiretroviral for the prevention
of mother to child transmission
among pregnant women**

■ Antiretroviral
therapy coverage
among women
aged 15+

■ Prevention of
mother-to-child
transmission of HIV
coverage

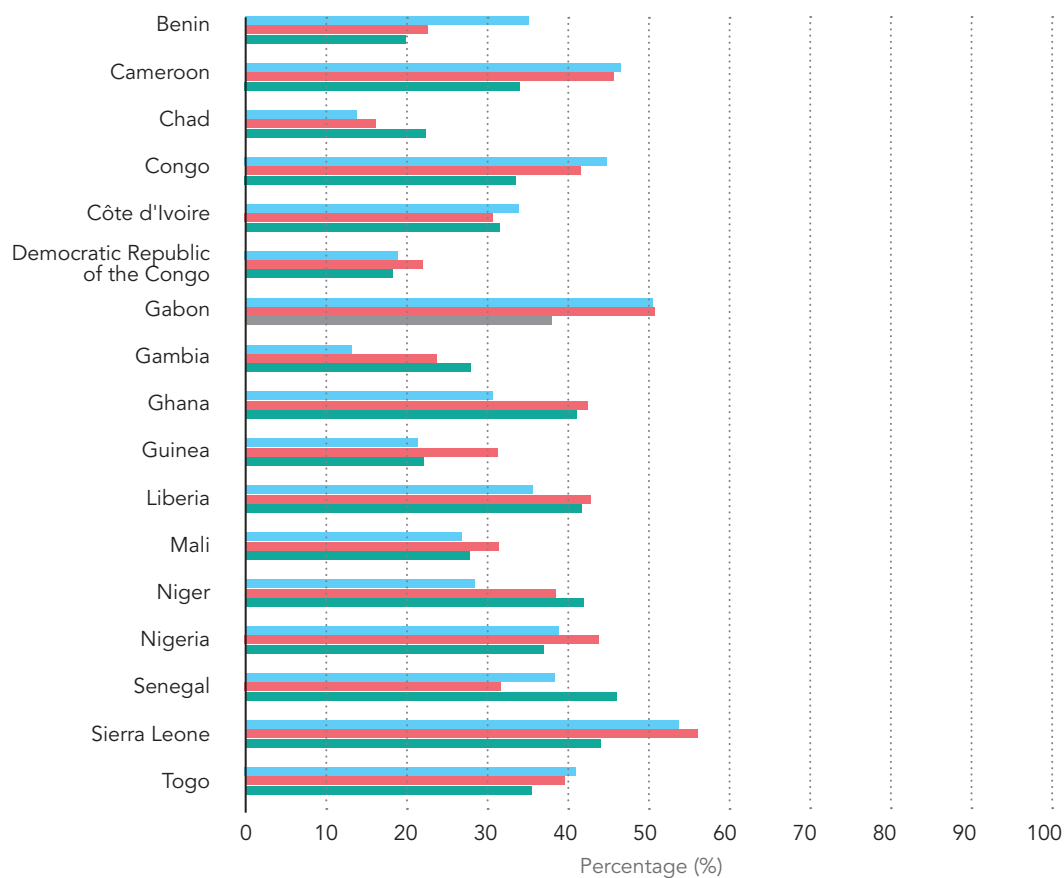


Source: UNAIDS 2016 estimates.

Demand for family planning satisfied with modern methods. Percentage of women of reproductive age (15–49 years old) who have their demand for family planning satisfied with modern methods

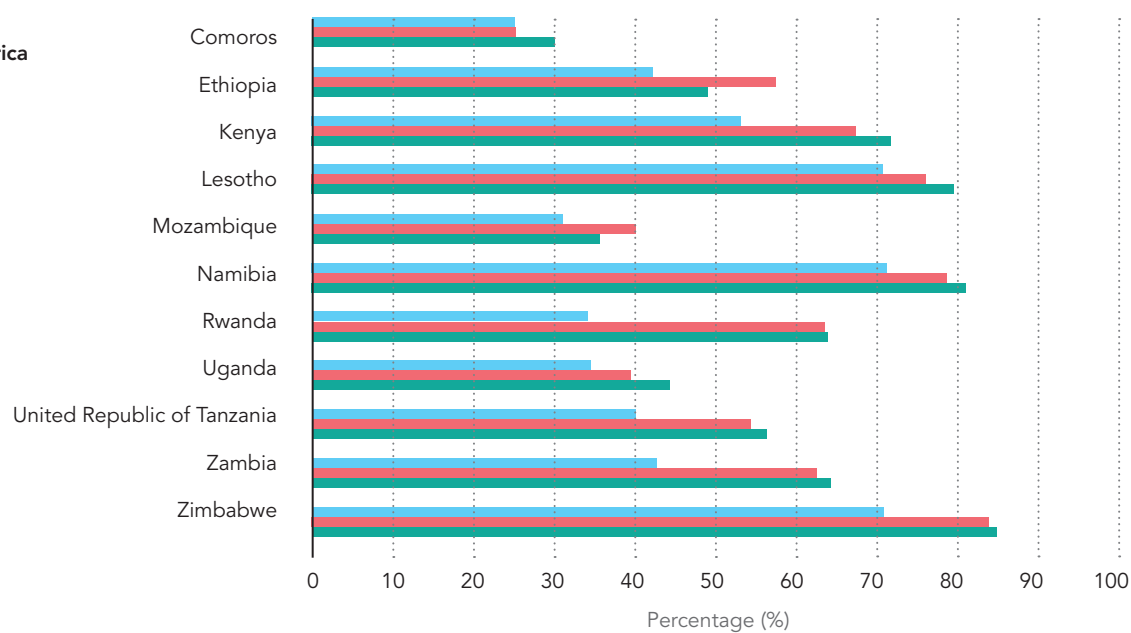
Western and central Africa

■ Aged 15–19
■ Aged 20–24
■ Aged 25–49



Eastern and southern Africa

■ Aged 15–19
■ Aged 20–24
■ Aged 25–49

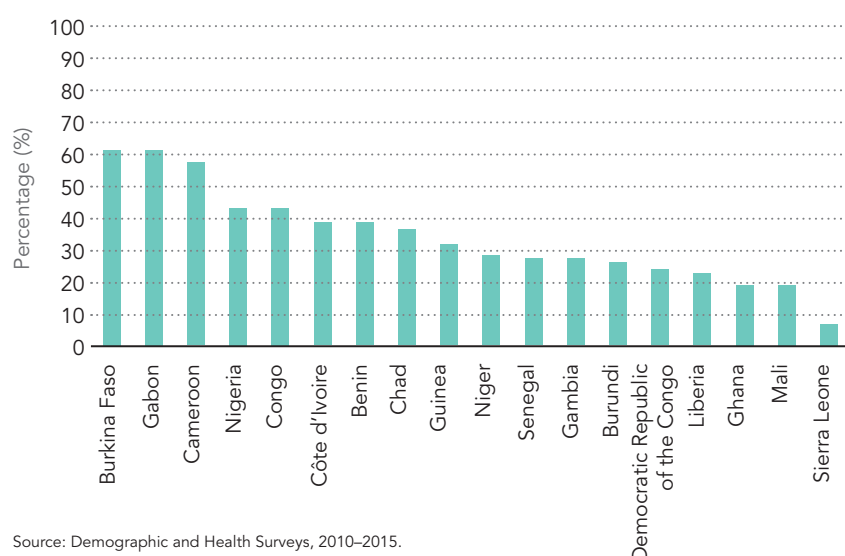


Source: Demographic and Health Surveys 2011–2015.

Availability and use of condoms and access to contraception

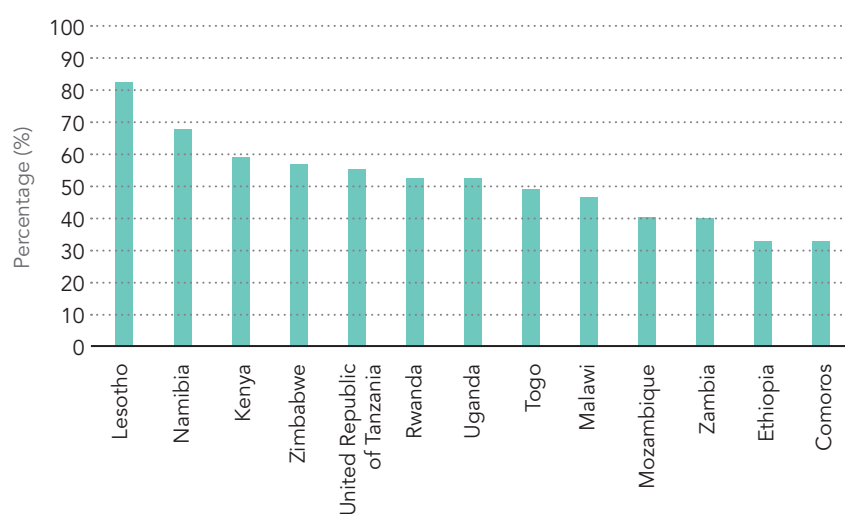
Surveys of condom use highlight the inability of adolescent girls and young women to exercise their right to protect their own health through condom use. In 15 of 18 countries in western and central Africa, less than 50% of young women aged 15–24 who had a non-marital, non-cohabiting partner in the past 12 months reported not using a condom at last sexual intercourse. Of eastern and southern African countries with available data, less than 50% of young women aged 15–24 who had a non-regular partner in the previous 12 months reported having used a condom at last sexual intercourse with such a partner. However, in Lesotho, more than 80% (81.9%) of young women aged 15–24 who had a non-regular partner in the previous 12 months reported having used a condom at last sexual intercourse.

Percentage of young women (aged 15–24) reporting use of a condom at last sexual intercourse with a non-regular partner in the 12 months prior to the survey, 18 countries in western and central Africa



Source: Demographic and Health Surveys, 2010–2015.

Percentage of young women (aged 15–24) reporting use of a condom at last sexual intercourse with a non-regular partner in the 12 months prior to the survey, 13 countries in eastern and southern Africa

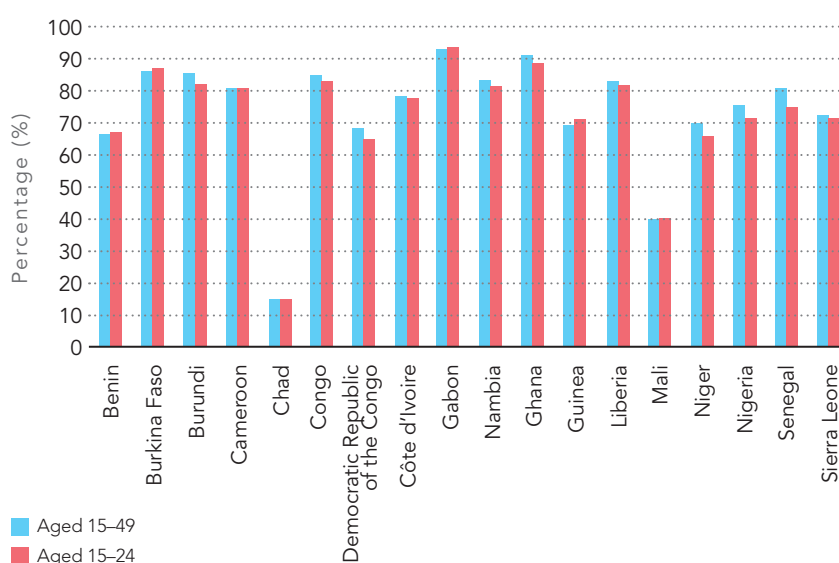


Source: Demographic and Health Surveys, 2010–2015.

In 2015, in addition to the estimated 1.9 million [1.7 million–2.2 million] adults (15+) who were newly infected with HIV—the vast majority through sexual transmission—an estimated 357 million people acquired chlamydia, gonorrhoea, syphilis or trichomoniasis. Every year, more than 200 million women have unmet needs for contraception, leading to approximately 80 million unintended pregnancies. Condoms effectively prevent all of these conditions.

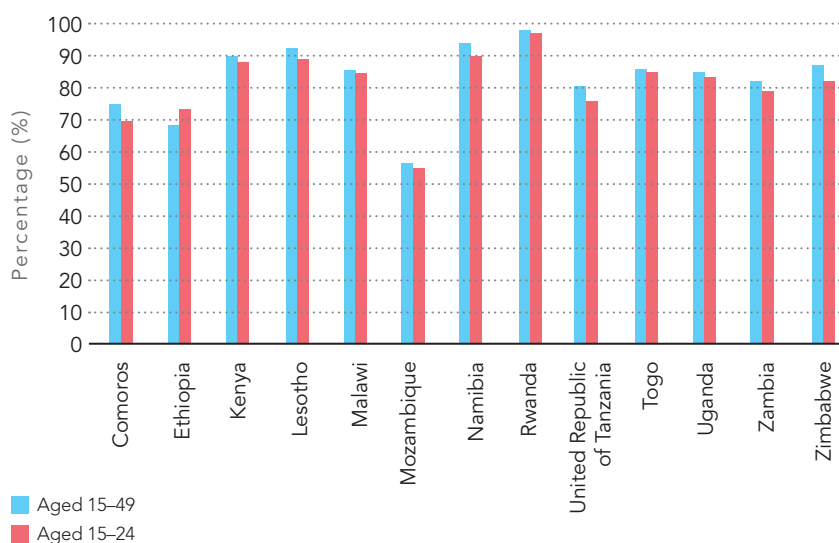
Globally, roughly 16 million girls aged 15–19—and an additional 1 million girls under 15—give birth each year, according to the World Health Organization. The majority of these girls live in low- and middle-income countries, and many of them lack access to sex education and contraception. Roughly three million unsafe abortions among 15–19-year-old girls take place each year, the World Health Organization estimates, which can lead to lasting health problems and in some cases maternal death.

Percentage of women who believe that a woman is justified in asking that they use a condom if she knows that her husband has a sexually transmitted infection, 18 western and central African countries



Source: Demographic and Health Surveys, 2010–2015.

Percentage of women who believe that a woman is justified in asking that they use a condom if she knows that her husband has a sexually transmitted infection, 13 eastern and southern African countries



Source: Demographic and Health Surveys, 2010–2015.

In 2015, in sub-Saharan Africa, an average of 10 male condoms per year was available for every man aged 15–64 years and just one female condom per eight women aged 15–64 years. The number of female condoms distributed was only 1.6% of the total condom distribution. Condom availability varied between as many as 40 condoms per man aged 15–64 years in Namibia and South Africa to fewer than five condoms per man aged 15–64 years in Angola and South Sudan. Condom distribution was particularly low in some countries in western and central Africa, such as Burundi, Chad, Guinea and Mali.

In sub-Saharan Africa, overall levels of condom use remain low. In 23 of 25 countries in sub-Saharan Africa with available data, condom use at last sex among men with multiple sexual partners was lower than 50%. In 13 of the 25 countries with available data, women with multiple partners in the 12 months preceding the survey were more likely to use condoms than their male counterparts.

Among young people in sub-Saharan Africa condom use has remained low. In 15 of 23 countries less than 60% of young men aged 15–24 with multiple partners used a condom during their last sexual intercourse. In 19 of 23 countries, less than 60% of young women with multiple partners reported condom use. In some countries, it is challenging for women, especially young women, to negotiate condom use with their male partners. Evidence from Asia suggests that women with greater autonomy in decision-making are more likely to negotiate safer sex, have higher HIV-related knowledge and to use condoms.

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) empowers people with an additional HIV prevention option to take control over their HIV risk. Randomized control trials have confirmed the efficacy of daily oral PrEP. Demonstration projects offering PrEP as a choice through user-friendly services have shown its potential value in diverse settings, including for some young women and female sex workers.

PrEP can be used during pregnancy. It is being increasingly considered as an additional HIV prevention option for pregnant and breastfeeding women in settings with continuing high HIV incidence during this period of their life. The World Health Organization recommends that women taking PrEP should continue taking it when they become pregnant and during breastfeeding if they remain at substantial risk of infection. Preventing HIV infection during pregnancy and breastfeeding has important implications for transmission to the child because women who seroconvert during pregnancy or breastfeeding are 18% and 27% likely to transmit the virus to their unborn child, respectively.

Cervical cancer

Cervical cancer diagnosed in a woman living with HIV is an AIDS-defining illness. Yet it is largely preventable if the human papillomavirus (HPV) vaccine is provided to girls and generally curable if diagnosed and treated early.

Women living with HIV are at four to five times greater risk of developing cervical cancer. Each year 528 000 women are diagnosed with cervical cancer and 266 000 die of the disease. Ninety per cent of these women live in low- and middle-income countries. This risk is linked to HPV, a common infection among sexually active men and women that is difficult for women with compromised immune systems (such as women living with HIV) to clear. Among women living with HIV, HPV prevalence rates can reach levels as high as 80% in Zambia and 90–100% in Uganda.

Minimizing deaths from cervical cancer requires a comprehensive approach. A key strategy is vaccination of adolescent girls, before sexual exposure. HPV immunization programmes to date have been predominantly in high-income countries. Of the estimated 118 million women aimed to be reached by HPV immunization programmes conducted from June 2006 to October 2014, only 1% were from low-income or lower-middle-income countries.

Synergies between the HIV response and efforts to prevent, diagnose and treat cervical cancer through HPV vaccination, education, screening and treatment must be maximized. The Cervical Cancer Prevention Program in Zambia has demonstrated that linking cervical cancer screening and HIV services is a cost-effective way of improving cervical cancer screening and treatment. This programme, which integrated a national cervical cancer prevention programme into an existing HIV programme, led to an expansion of cervical cancer screening to more than 100 000 women (28% of whom were living with HIV) over a period of five years.

Violence faced by girls and women

Further undermining the ability of adolescent girls and women to influence and negotiate their own health is the threat of intimate partner violence. Violence, or even the fear of violence, from their sexual partner has a negative influence on the capacity of adolescent girls and women to protect themselves from HIV infection.

Multiple studies have shown that exposure to violence during childhood and adolescence increases HIV-related risk behaviour among adolescent girls and young women. In some regions, women who are exposed to intimate partner violence are 50% more likely to acquire HIV than women who are not exposed. Studies have linked intimate partner violence and even the fear of violence to women's reluctance or inability to negotiate condoms or to use contraceptives. Among women living with HIV, violence and trauma can lead to lower adherence to treatment, lower CD4 counts and higher viral loads.

The fear of intimate partner violence has been shown to be an important barrier to the uptake of HIV testing and counselling, to the disclosure of HIV-positive status, and to treatment uptake and adherence, including among pregnant women living with HIV who are receiving antiretroviral therapy as part of services to prevent mother-to-child transmission. Experiences of physical and emotional intimate partner violence in settings with male controlling behaviour and HIV prevalence above 5% have been strongly associated with HIV infection in women. In some regions, women who experienced physical or sexual intimate partner violence were 1.5 times more likely to acquire HIV than women who had not experienced violence.

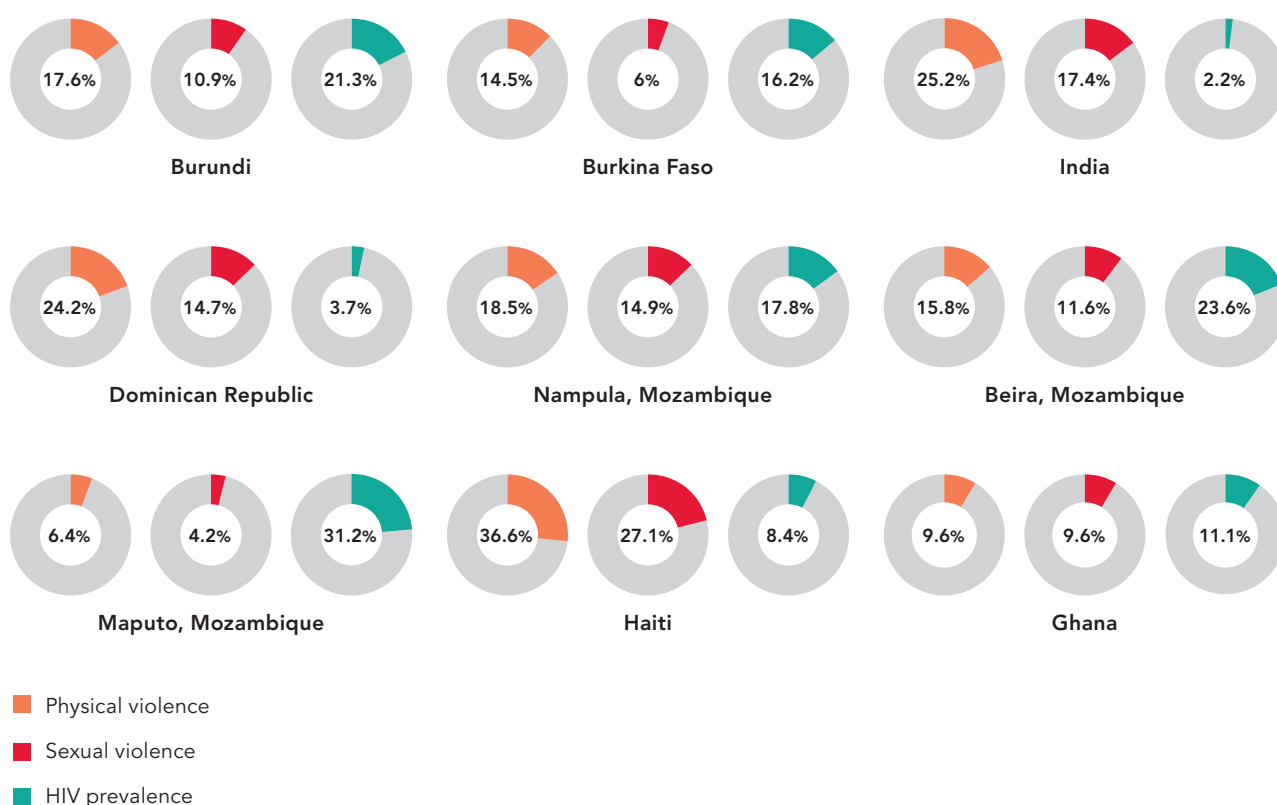
Adolescent girls are more vulnerable to intimate partner violence. In 22 of the 32 countries with available data, young women reported experiencing more recent intimate partner violence than women in older age groups.

Female sex workers

Female sex workers face multiple challenges in life, from violence to criminalization to increased HIV prevalence. Sex workers are 10 times more likely to acquire HIV than adults in the general population. In 2015, new infections among sex workers remained at 125 000 a year. In 2014, 4% of new HIV infections were among sex workers.

Studies have shown that female sex workers are subjected to high levels of violence—in Haiti, for example, 36.6% of female sex workers report physical violence and 27.1% report sexual violence.

Female sex workers face multiple challenges



Source: national surveys.

The criminalization of sex work puts sex workers at risk of violence from clients and law enforcement officers because sex workers lose their recourse to protection under the law. Selling and/or buying sex is partially or fully criminalized in at least 39 countries. In many more countries some aspect of sex work is criminalized, and in other countries general criminal law is applied to criminalize sex work (for example, laws against loitering and vagrancy). When possession of condoms is used by the police as evidence of sex work, this greatly increases the risk of HIV among this key population. Even where sex work is not criminalized, sex workers are rarely protected under the law.

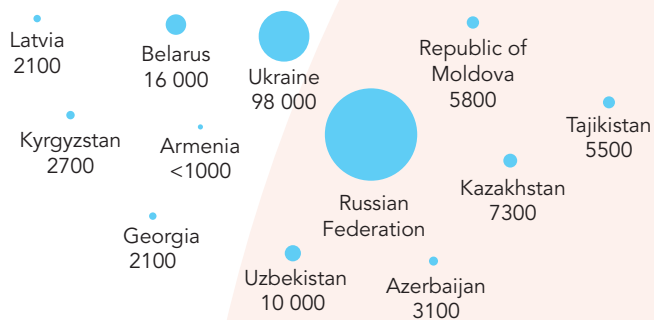
Many programmes working with female sex workers have proved successful. HIV prevalence among female sex workers in Johannesburg, South Africa, is 71.8%. The South African Government tackled this challenge through a comprehensive HIV programme focused on sex workers that has inspired a national action plan specifically targeting sex workers' needs.

The Red Umbrella programme of the National AIDS Council of South Africa, implemented from October 2013 to March 2016, combined biobehavioural, social and structural interventions. The nationwide programme enlisted peer motivators to assist in the distribution of condoms and lubricant, information on sexually transmitted infections and HIV prevention, paralegal services and health service referrals. Community empowerment services that aim to reduce violence, stigma and discrimination included sensitization training and a helpline for sex workers. Red Umbrella exceeded its targets, reaching 34 638 sex workers with HIV testing services (129% of the target). Attitudes of health-care workers and law enforcement officers

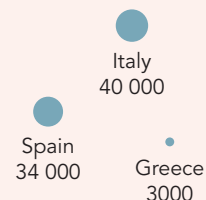
18.6 MILLION GIRLS AND WOMEN LIVING WITH HIV

Girls and women make up more than half of the 36.7 million people living with HIV. Ending AIDS by 2030 requires that we address girls' and women's diverse roles by putting them at the centre of the response.

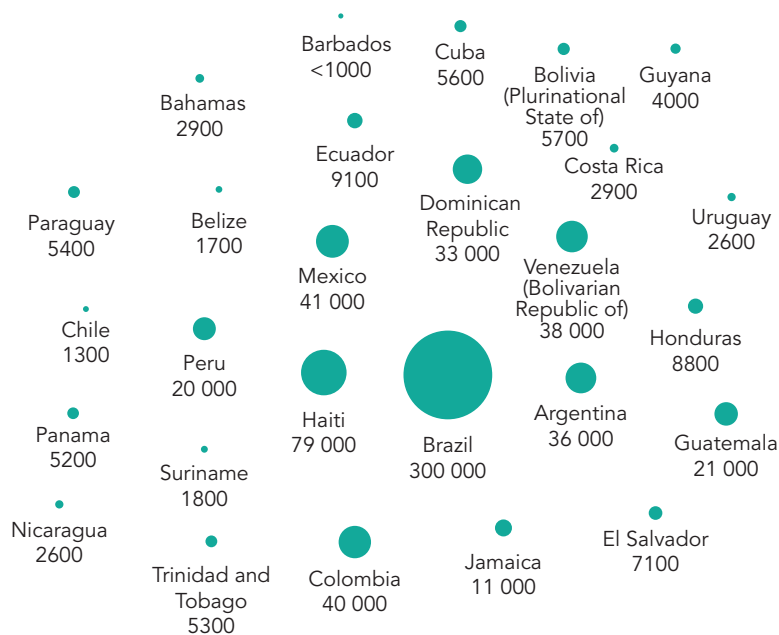
Eastern Europe and central Asia



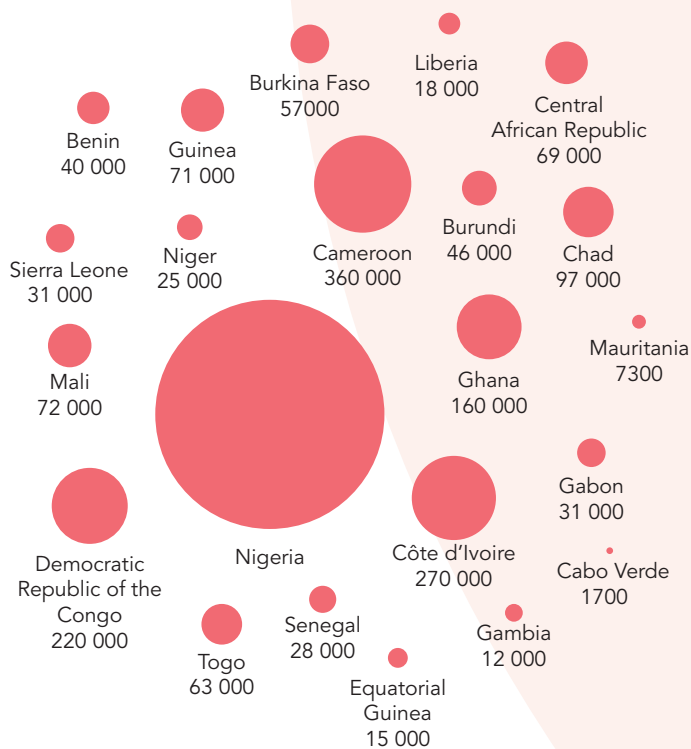
Western Europe



Latin America and the Caribbean



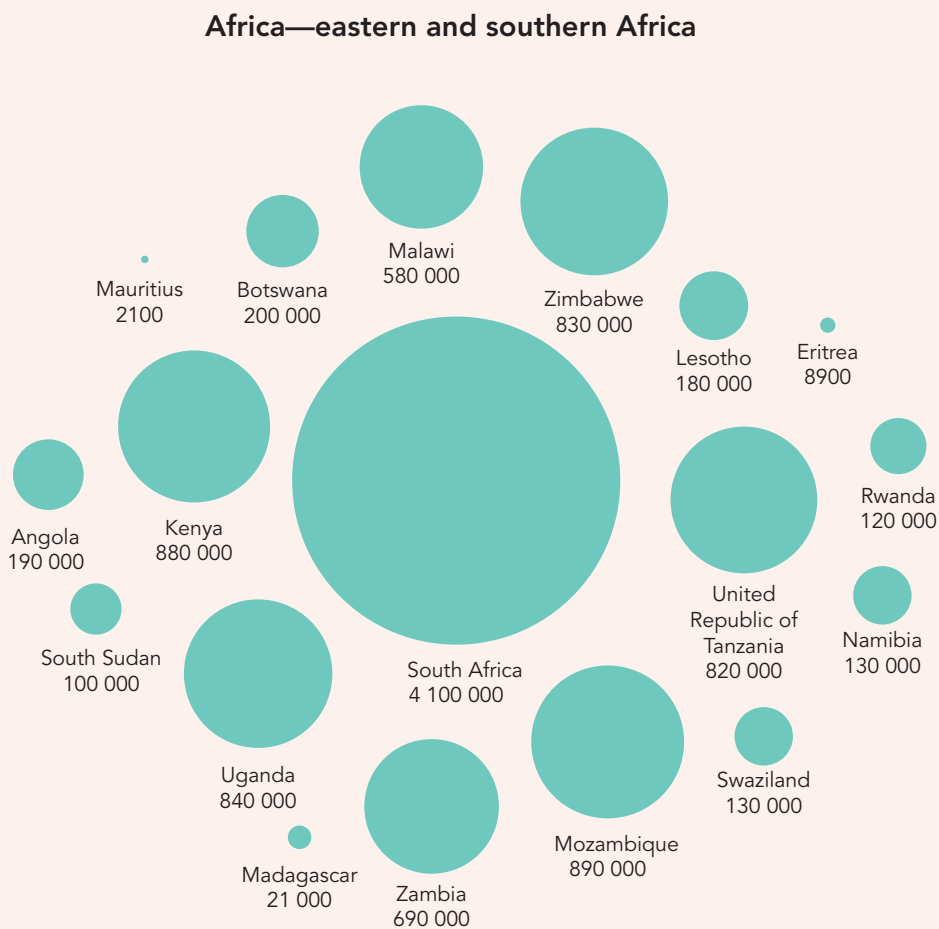
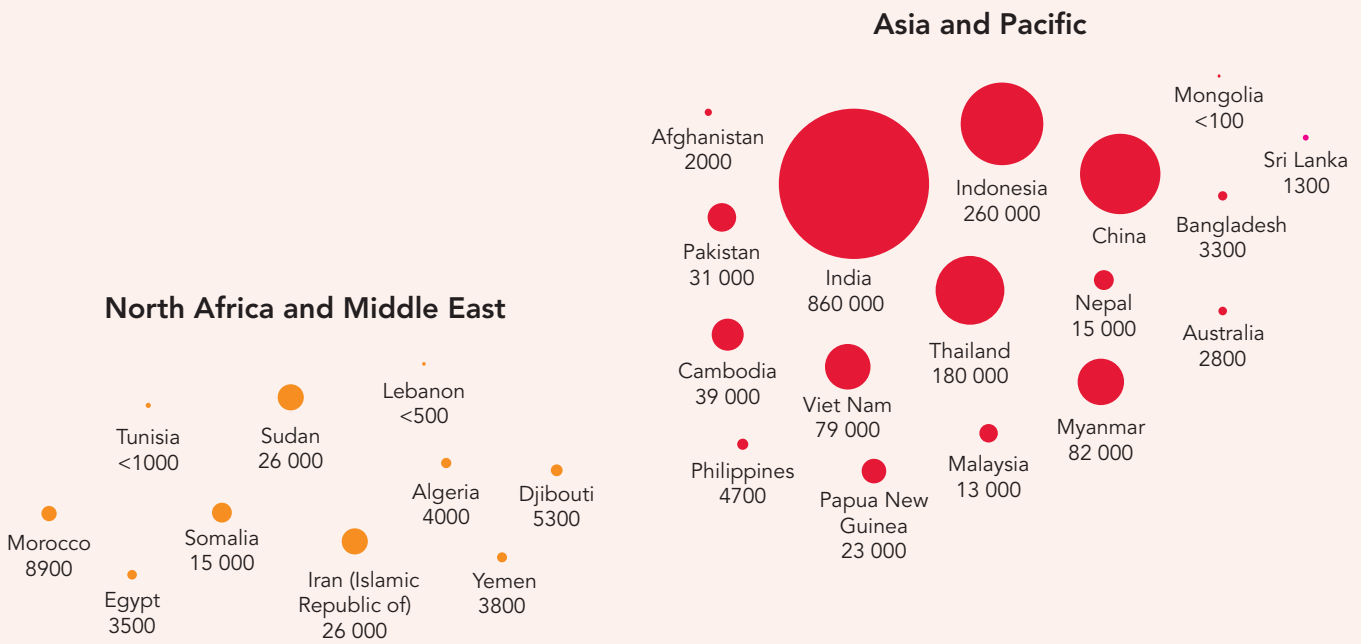
Africa—western and central Africa



No data available for those countries not listed.

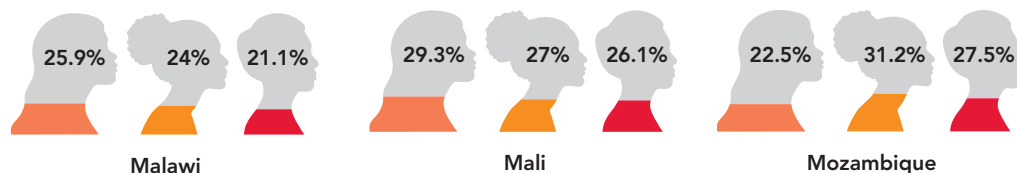
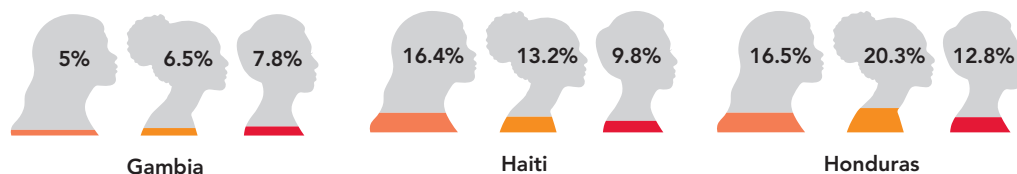
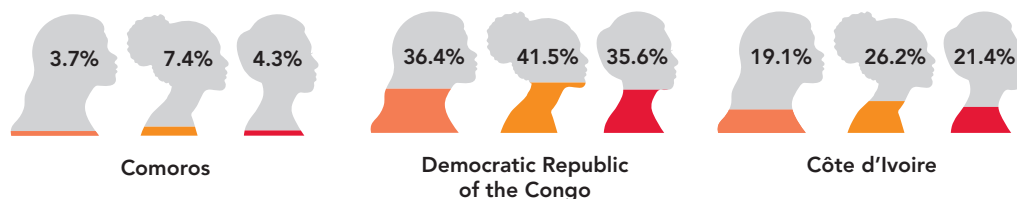
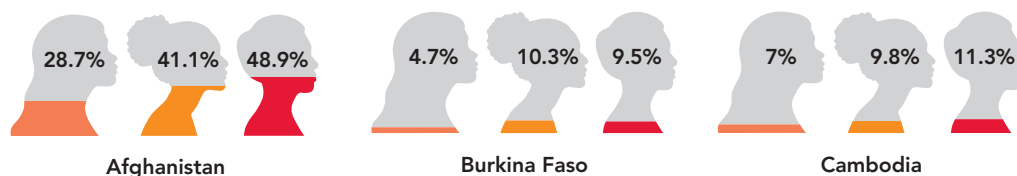
Source: UNAIDS 2016 estimates.

Global 18 600 000



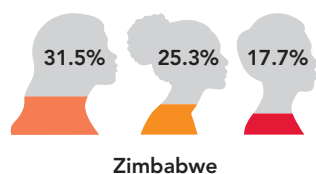
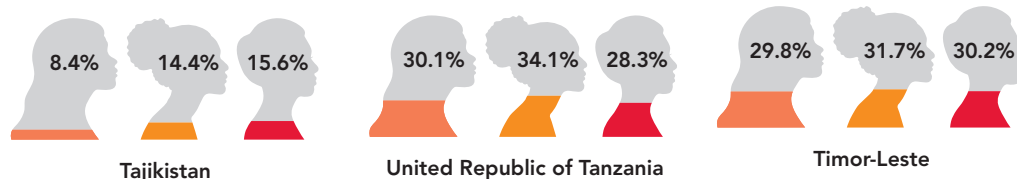
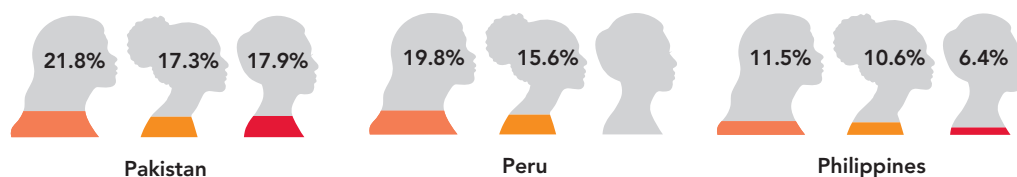
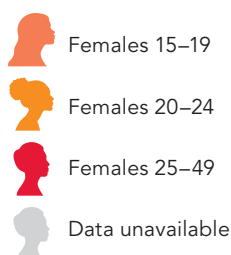
ELIMINATE INTIMATE PARTNER VIOLENCE

Globally, one in three women report experiencing physical or sexual violence by a partner or sexual violence by a non-partner in their lifetime. Recent studies show just how pervasive intimate partner violence is across age bands. In some settings, women who experience intimate partner violence are 50% more likely to acquire HIV compared with women who do not experience violence.



Prevalence of recent intimate partner violence (%)

Proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence from a male intimate partner in the past 12 months



Source: Demographic and Health Surveys, 2010–2015.



Cameroon



Chad



Colombia



Dominican Republic



Egypt



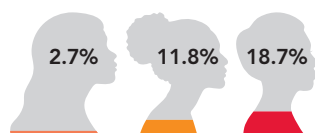
Gabon



Jordan



Kenya



Kyrgyzstan



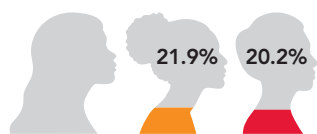
Namibia



Nepal



Nigeria



Rwanda



Sierra Leone



South Africa



Togo



Uganda



Zambia

improved over the course of the programme, and the programme also fostered high levels of social cohesion and mutual support among sex workers.

In Ouagadougou, Burkina Faso, 321 HIV-negative female sex workers living with HIV aged 18–25 years old enrolled in a tailored community-based programme that provided a comprehensive package of prevention, treatment and care services, with the community and peers playing a pivotal role in service delivery. The services included peer-led education sessions, psychological support, sexually transmitted infection screening and treatment and HIV care, general routine health care and reproductive health services, and as many condoms as they required. No participant became HIV-positive during the study, partly owing to the increase in consistent condom use with casual and regular clients and a reduction in the number of regular partners and clients.

Women who inject drugs

HIV prevalence among women who inject drugs is often greater than their male peers, highlighting a need for gender-sensitive harm reduction programmes. In 24 of 35 countries reporting to the 2016 Global AIDS Response Progress Reporting Mechanism, median HIV prevalence among women was 50% higher, with a range of 2% to 530%.

Women who inject drugs faced higher levels of stigma, discrimination and vulnerability to harm than their male counterparts.

Girls, education and HIV

Increased school attendance can reduce the risk of adolescent girls acquiring HIV, in three different ways. First, being in school reduces early marriage and risky sexual partnerships. Second, in advanced HIV epidemics, higher educational attainment is itself associated with reduced HIV prevalence later in life and with safer behaviours. Third, keeping girls in school ensures that greater numbers of adolescent girls can access HIV prevention information in the context of comprehensive sexuality education or school-based campaigns.

Increasing educational achievement among women and girls has been linked to better sexual and reproductive health outcomes, including lower rates of HIV infection, delayed childbearing, safer births and safer abortions, and other development outcomes. The education and empowerment of women and girls also are fundamental to preventing gender-based violence. An analysis of data from 44 countries found that completing secondary education significantly reduces a woman's personal risk of partner violence (sexual or physical violence in the past 12 months), and that a girl's education is more strongly associated with reduced risk of partner violence in countries where spousal abuse is more common. Girls with at least six years of school education are more likely to be able to protect themselves from HIV and other diseases.

Cash transfers have been found to help girls remain in school, which in turn leads to reduced HIV prevalence and incidence. In several randomized control trials, school attendance and safer sexual health were directly incentivized through a cash transfer, and there was a positive effect on HIV-associated outcomes.

A study in South Africa found that financial support augmented with social support from parents or teachers increased HIV-prevention benefits over cash alone, with reductions in incidence of multiple and concurrent partners and other HIV-risk behaviours for both boys and girls. A follow-up study found that combining cash transfers with free education and psychosocial support programmes led to cumulative reductions in HIV risk behaviours among adolescents.

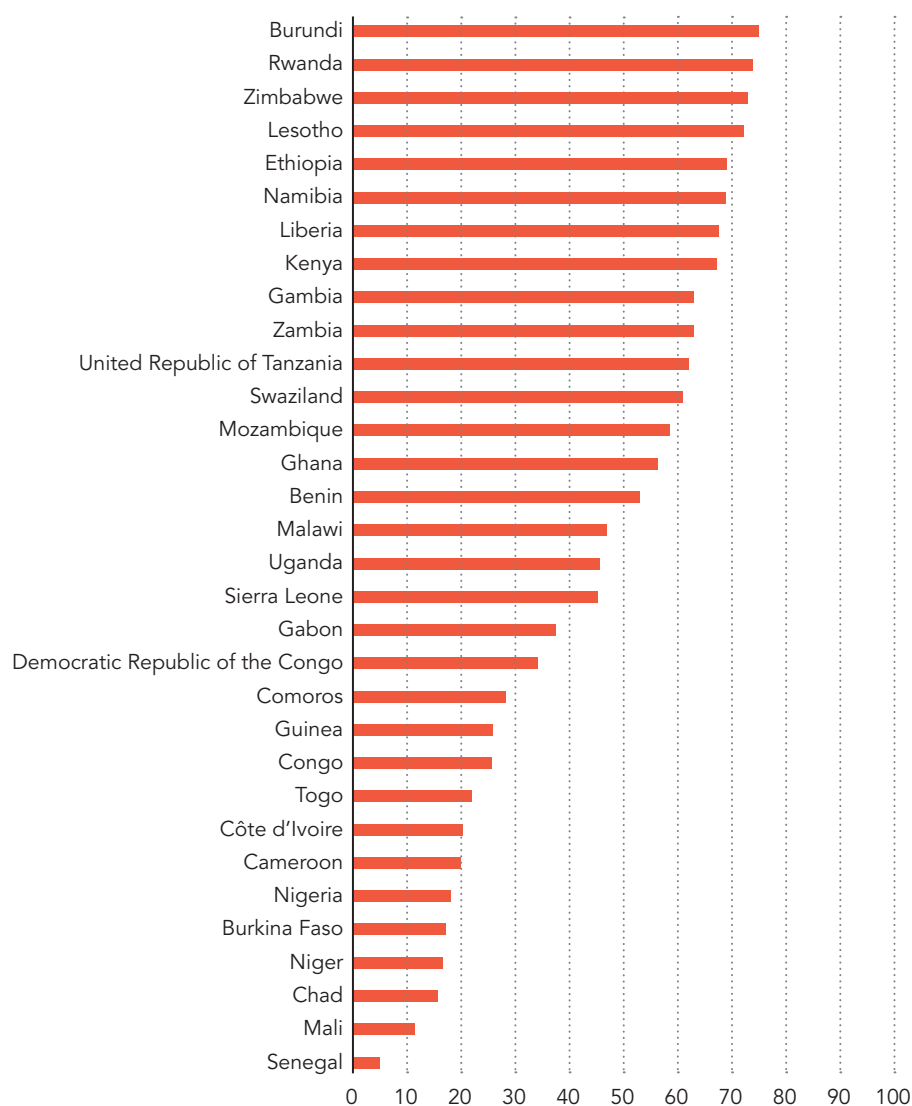
Law and policies affecting girls and women

Lack of an enabling legal and policy environment that enables women and girls to exercise their rights has a detrimental impact on their health and well-being. In many settings, parental and other third-party consent requirements for access to HIV and sexual and reproductive health services remain an important barrier to their uptake. Adolescents often are reluctant to seek services that require the consent of a parent or spouse.

Laws that foster the wide dissemination of objective age-appropriate comprehensive sexuality information improve knowledge not only of what protects or damages sexual health, but also where and how to seek further information, counselling and treatment.

Further efforts are needed to ensure that the legal framework is responsive and sensitive to the challenges that young people face when attempting to access HIV and sexual and reproductive health services. This includes striking down requirements for parental or spousal consent, which poses additional challenges, particularly for adolescent girls and young women. Young key populations also must be ensured a protective legal environment where their rights are respected and protected, and their access to health and social services is guaranteed.

Percentage of women aged 15–19 who say that they alone or jointly have the final say in own health care

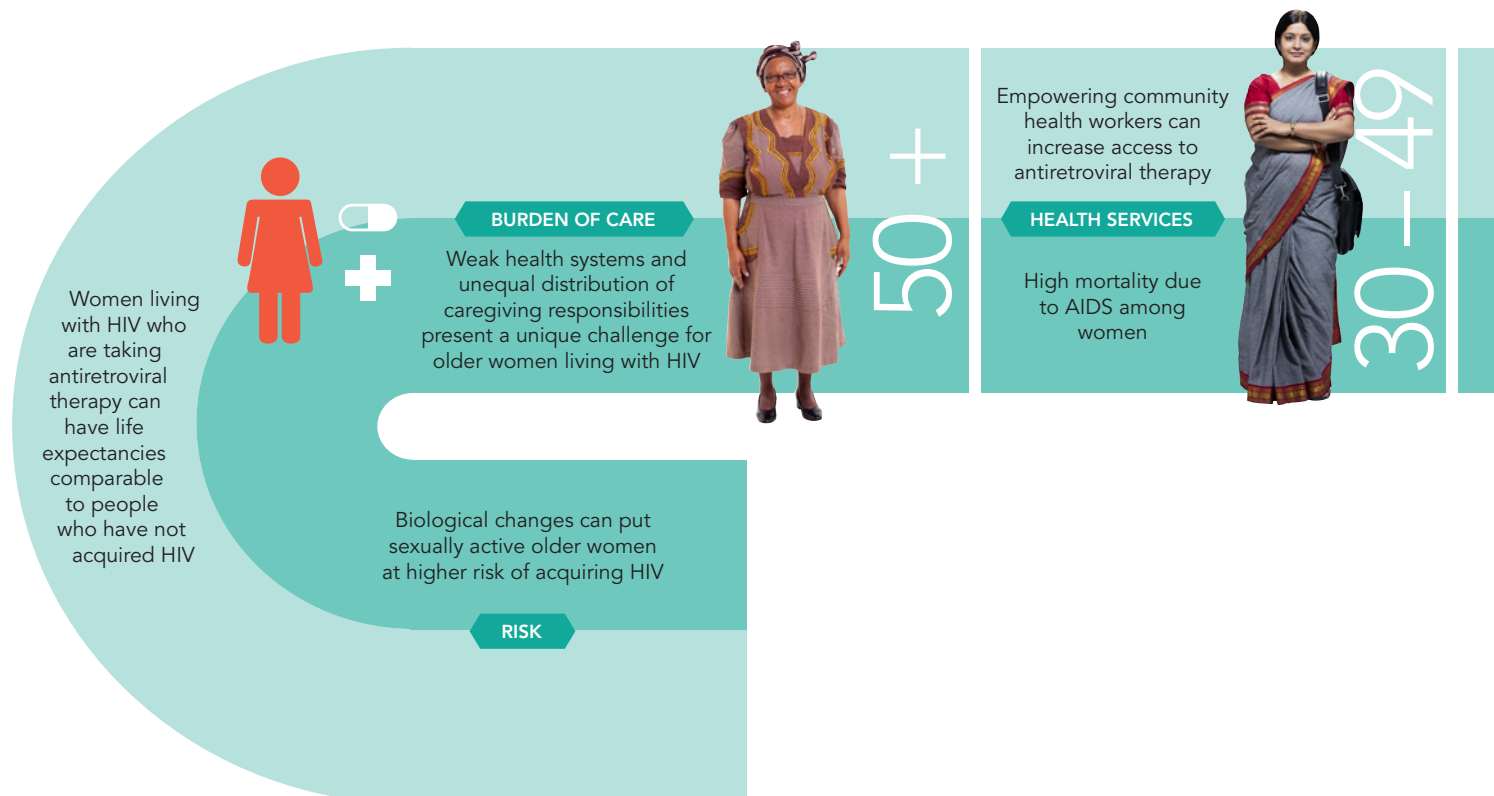
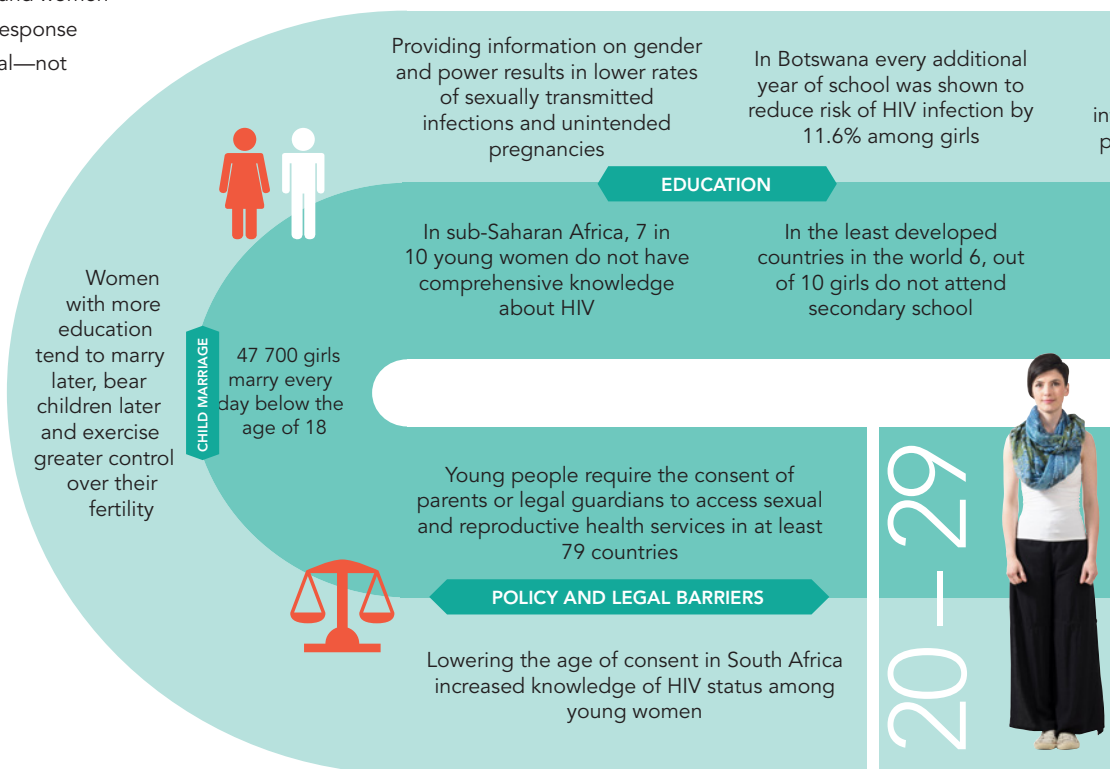
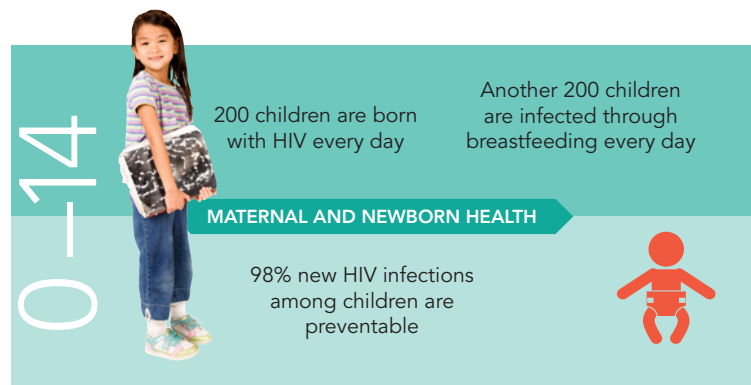


Source: Demographic and Health Surveys, 2010–2015.

WHAT WOMEN WANT

Issues and opportunities through the life cycle

Girls and women are at the centre of the AIDS response. Factors including age, ethnicity, gender inequities, disability, sexual orientation, profession and socioeconomic status compound to influence girls' and women's ability to protect themselves from HIV. Programming efforts must recognize the complexity of the everyday lives of girls and women as they mature and grow and build the response around their needs. Placing the individual—not the virus—at the centre of all our efforts creates the space for inclusion of the diverse opportunities and needs of girls and women and improves HIV outcomes.



Many children are diagnosed late with HIV, leading to high infant mortality

Cervical cancer is expected to claim nearly half a million lives per year by 2030

Women living with HIV are five times more likely to develop cervical cancer

INTEGRATED HEALTH SERVICES

The number of children aged 0–14 years on antiretroviral therapy globally has doubled in the past five years

HPV vaccine given to girls between 9 and 13, before they become sexually active, prevents cervical cancer

HPV vaccine costs as little as US\$ 8



Providing integrated HIV and sexual and reproductive health services prevents HIV infection and prevents unwanted pregnancies and safe deliveries

HEALTH SERVICES

16 million girls aged 15–19 years give birth every year



15–19

Post-exposure prophylaxis can prevent HIV infection

Zero tolerance for violence against children



VIOLENCE AGAINST CHILDREN

Violence can increase survivors' risk of HIV and other sexually transmitted infections

120 million girls have experienced rape or other forced sexual acts at some point in their life

Globally only 55% of women participate in the labour force

Women still earn 50% less than men for the same work

Female sex workers are 10 times more likely to acquire HIV than other women

EMPLOYMENT

The cash transfer programme in Malawi reduced the school dropout rate of girls by 35% and had a 40% reduction in early marriages and a 30% reduction in teenage pregnancies and a 64% reduction in HIV risk

HIV SERVICES

Provision of a comprehensive package of community-based prevention and treatment services for female sex workers resulted in zero new HIV infections in a cohort in Burkina Faso

Regular screening and treatment for precancerous cervical lesions could prevent 250 000 women from dying each year



Community-based programmes like SASA! in Kampala, Uganda, combined community mobilization on HIV and intimate partner violence prevention, helped change norms around intimate partner violence

HEALTH SERVICES

AIDS is still the main cause of death among women of reproductive age globally

In high HIV prevalence settings women experiencing intimate partner violence are 50% more likely to have acquired HIV than women who have not experienced violence

One in three women experience intimate partner violence globally

In 29 countries women require the consent of a spouse/partner to access sexual and reproductive health services

PROTECTION FROM INTIMATE PARTNER VIOLENCE



WOMEN FACE MULTIPLE INEQUALITIES AND CHALLENGES ACROSS THE LIFE CYCLE

Girls and women are at the centre of the AIDS response. Factors including age, ethnicity, gender inequalities, disability, sexual orientation, profession and socioeconomic status compound to influence girls, and women's ability to protect themselves from HIV. Three out of four new HIV infections in 15 to 19 year olds in sub-Saharan Africa are in girls. In 2015, an estimated 7500 young women between the ages of 15 and 24 acquired HIV every week. The vast majority of these new infections are in sub-Saharan Africa. Every four minutes three adolescent girls between the age of 15 and 19 are infected with HIV. In 2015, every day more than 100 adolescents between the ages of 10 and 19 died of AIDS-related illnesses. Girls and women are being left behind in our efforts to end the AIDS epidemic.

Girls and women play multiple and overlapping roles in their families and communities as students, educators, politicians, scientists, employers, employees, sisters, wives, mothers and daughters. As they move through their life cycles, these roles combine and converge to influence girls, and women's vulnerability to HIV and affect their capacity to secure a safe future for themselves. A young girl forced to leave school in order to supplement her family's income through petty commerce in a market is unlikely to be sufficiently informed or empowered to protect herself against the advances of older men. However, with the benefit of cash transfers, she would be able to return to school, delay marriage, increase her economic potential, gain the knowledge and skills need to negotiate a healthy future free of HIV.

THE LIFE CYCLE OF GIRLS TO WOMEN

In order to successfully Fast-Track efforts to end AIDS, programming efforts must address the complexity of the every day lives of girls and women as they mature and grow and build the response around their needs. Placing the individual—not the virus—at the centre of all our efforts creates the space for inclusion of the diverse opportunities and needs of girls and women and improves HIV outcomes. Thinking beyond the immediate HIV service needs and ensuring that girls and women are educated, empowered and enabled not only improves their individual opportunities but benefits families, communities and the economy.

More and more it is clear that women and girls face different levels of vulnerability to HIV infection at different stages in their lives. The capacity of adolescent girls and women to make decisions about who they are having sex with and the extent to which they can negotiate safer sex with their partners is influenced by factors relating to age and access to health services, education and protection from violence.

Developing strategies to meet the needs of different age groups should be informed by an awareness of the factors that influence behaviours and the ability to make and execute healthy choices. These factors can be broadly divided into three categories: structural, behavioural and biological.

Structural factors are the formal laws, rules and norms influence girls and women's ability to protect themselves from HIV.

Harmful social and gender norms perpetuate the belief that girls and women are lesser than or even the possessions of men. These norms leave them disempowered, unable to influence or control decisions around sex and vulnerable to gender-based violence and HIV.

Limited access to primary and secondary school leaves girls and young women without the basic literacy and numeracy skills they need to participate fully in their local economy and community and denies them access to higher education. Lack of education contributes to higher HIV vulnerability.

Parental and spousal consent, stigma and health worker bias deters or prevents girls and young women from accessing HIV and health services. Without access to condoms, testing, PrEP, contraception or the knowledge and ability to use them, girls and young women are unable to protect themselves from HIV and unintended pregnancies.

Children who are or have been subject to sexual abuse are not only extremely vulnerable to HIV transmission, but often suffer psychological and developmental consequences that lead to risky behaviours, including early sexual debut, more sexual partners and substance abuse. Orphans are particularly vulnerable.

Early marriage denies young girls and adolescent women the opportunity to continue in school, to establish economic independence and places them at risk of violence and exposure to HIV. Child brides in particular struggle to access health services—denying them the opportunity to seek contraception, the means of protecting themselves from HIV or access testing and treatment services.

Gender-based violence and intimate partner violence is associated with increased risk of HIV infection. Violence, or even the fear of violence, prevents girls and young women from being able to negotiate sex and condom use. Women living with HIV who are exposed to violence tend to have lower adherence, lower CD4 counts and higher viral loads.

Behavioural factors are the choices we make relative to our relationships with friends, peers and elders. The capacity of adolescent girls and women to make judgements about the risks associated with their sexual partners and their ability to make choices about their own sexual health and HIV prevention and treatment is heavily influenced by behavioural factors.

Age-disparate sex between older men—who are more likely to be living with HIV—and adolescent girls is a key factor to increasing infection. The power dynamics of age-disparate relationships prevents adolescent girls and young women from negotiating condom use with older men.

Early sexual debut, in particular sex before the age of 15, can place girls at high risk. Often the sexual partners of adolescent girls are significantly older and more likely to be living with HIV.

Transactional sex—the exchange of sex for food, items or other non-monetary benefit—places vulnerable girls and women at even greater risk of being exposed to HIV. Reviews show that women engaging in transactional sex are more likely to be living with HIV.

Sex workers and sexually exploited girls and young women are at high risk of acquiring HIV. Multiple and concurrent partners, inability to negotiate condom use and the potential for intimate partner violence are all factors.

Gaps in knowledge and limited perception of risk mean that adolescent girls and young women engaged in age disparate, risky and perhaps violent sexual relationships are unaware of their potential for exposure to HIV or of the means to protect themselves through condom use or PrEP. Young women and adolescent girls show little awareness of the risk that their sexual partner may have multiple sexual partners in addition to themselves.

Biological factors relate to the specific physiological dimensions of HIV transmission that affect the ability to transmit or receive the virus.

Women are more vulnerable to HIV than men. This is due to the ability of HIV to pass through the cells of the vaginal lining, the larger surface area of the vagina compared to the penis, increased mucosal HIV exposure time, the potential for micro-abrasions and tears in the vagina and cervix, higher concentration of HIV in semen than in vaginal fluids, high concentration of HIV co-receptors in cervical cells and the high levels of activation of the immune cells in the female genital tract.

Adolescent girls, in addition to being at increased risk for all the same reasons as women, are at even more risk because the mucosa of the immature cervix is very susceptible to HIV. Their physical immaturity and smaller size may also make adolescent girls more vulnerable to micro-abrasions and tears.

Harmful practices, including the introduction of substances to dry the vagina or intravaginal washing with soap, further exacerbates vulnerability of girls and women. Anal sex and “virginity testing” can increase transmission.

Poor viral load suppression in men due to lower rates of antiretroviral therapy means that they are more likely to pass on the virus to their partners.

Other sexually transmitted infections make adolescent girls and women even more susceptible to HIV. For example, women who are infected with the HPV virus are more vulnerable to HIV, and women living with HIV progress to cervical cancer much more quickly than those not infected by HIV.

INCLUSION IS THE FUTURE

Globally, 1.1 billion adolescent girls are progressing towards womanhood. Efforts to address the needs of girls and women must acknowledge the interrelated dimensions of girls, and women’s lives. By addressing the areas of compounded vulnerabilities, the HIV response has the potential to create the space for development benefits to influence multiple development dimensions. The Sustainable Development Goals call for an inclusive approach to accelerate economic growth, support political and social stability, and ensure better health outcomes for all. Investing in a multi-sectoral approach that recognizes the complexity of the every day lives of girls and women as they mature is key to ending AIDS by 2030.

➔ Comprehensive sexuality education

programmes with an explicit focus on gender rights and gender power dynamics are five times more effective than those that do not, particularly in reducing unwanted pregnancies and incidence of HIV and other sexually transmitted infections

➔ In Botswana, every additional year of school a girl completes has been shown to reduce her risk of HIV infection by 11.6%

FOUR WAYS TO ENSURE INCLUSION

Respecting the human rights of women and girls and ensuring their inclusion will accelerate economic growth. Providing support for girls, and women’s empowerment lays the path towards political and social stability, and ensures better health outcomes for all.

Education

- ▶ When girls have access to secondary education, including comprehensive sexuality education, they stay in school, are less likely to marry early and the risk of unintended pregnancies and HIV acquisition decreases.
- ▶ When girls have access to comprehensive sexual education, they have the opportunity to explore their own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.

➡ **Every day, approximately 47 000 girls are married** before their 18th birthday: that means that more than 700 million women alive today were married as children.

➡ **Sex workers** are 10 times more likely to acquire HIV than women in the general population.

➡ **Effective legal aid** can make justice and equality a reality for people living with HIV, contributing to better health outcomes. Court actions and legislative initiatives, informed by fairness and pragmatism, can introduce gender-sensitive sexual assault laws and recognizes the sexual autonomy of young people.

➡ **Cervical cancer**, an AIDS defining illness, is highly preventable. The HPV vaccine is given to girls between 9 and 13 before their sexual debut. It costs as little as US\$ 8.

➡ **Tuberculosis** remains the leading cause of death among people living with HIV. Early diagnosis of HIV and access to treatment reduces the risk of contracting TB by 65%. When treatment of latent TB infection is combined with antiretroviral therapy, the risk of developing active TB disease falls by about 90%

➡ **An increase of only 1%** in girls' secondary education attendance adds 0.3% to a country's GDP.

Empowerment

- ▶ When women are elected as political representatives, they champion issues of gender equality, elimination of gender-based violence, health and education.
- ▶ When women and girls are economically empowered, such as through cash transfers, transactional sex is reduced.
- ▶ When programmes to reduce intimate partner violence in communities are taken to scale, HIV incidence is reduced.
- ▶ When women have the final say over their health and childbearing, it has a direct impact, reducing the spread of HIV as well as mother-to-child transmission.
- ▶ When laws and policies that act as barriers to the full realization of the sexual and reproductive health and rights of women and girls are removed, gender equality can start becoming a reality.






Integrated health services

- ▶ When the full range of sexual and reproductive health services are integrated, it improves access to services for HIV-related illnesses, such as tuberculosis diagnosis and treatment and cervical cancer screening, prevention and treatment.
- ▶ When comprehensive post-rape care services are available, accessible and promoted, they can prevent women and girls from acquiring HIV and other sexually transmitted infections, unintended pregnancies and psychological trauma.
- ▶ When sexual and reproductive health services are integrated, it prevents women from dying of HIV-related cervical cancer or TB.
- ▶ When female-initiated HIV prevention methods are available and promoted, women and girls feel empowered and their sexual and reproductive health and rights are more easily respected and realized.

Economics

- ▶ When women participate in the economy, poverty decreases and GDP grows.
- ▶ An additional year of primary education for girls results in a 15% increase in future earnings, and that figure increases with the level of education.
- ▶ Globally, only 55% of women participate in the labour force, compared to 80% of men.

Effects of conditional cash transfers in Zomba, Malawi. Results after 18 months among schoolgirls

INVESTMENT	OUTCOMES
▶ Transfer scheme to keep girls in school in Zomba	➡  35% reduction in school drop-out rate
▶ US\$ 10 a month provided to in- and out-of-school girls (13–22)	➡  40% reduction in early marriages
▶ 30% went directly to girls	➡  76% reduction in HSV-2 risk
	➡  30% reduction in teen pregnancies
	➡  64% reduction in HIV risk

Source: Remme M, Vassall A, Lutz B, Luna J, Watts C. Financing structural interventions: going beyond HIV-only value for money assessments. AIDS. 2014 Jan 28;28(3):425–34. doi: 10.1097/ QAD.0000000000000076.

PARTNERSHIPS

UNAIDS works through partnerships to ensure that throughout their life cycle the multiple and diverse needs of girls and women are recognized and supported.

Start Free, Stay Free, AIDS Free

The Start Free Stay Free AIDS Free framework and action plan builds on remarkable success achieved between 2011 and 2015 in reducing the number of new HIV infections among children as well as increasing the number of children living with HIV on treatment. It provides a menu of policy and programmatic actions designed to enable countries and partners to close the remaining HIV prevention and treatment gap for children, adolescents, young women, and expectant mothers. The initiative is co-chaired by UNAIDS and PEPFAR. It brings together key organizations at the forefront of ending paediatric AIDS, including WHO, UNICEF, Caritas Internationalis, EGPAF, ICAP, mothers2mothers, Viiv/PACF, and the International Coalition of Women Living with AIDS. The partnership works within the initiative's three workstreams grounded in country needs and capabilities.

ACT!2030

ACT!2030, originally ACT!2015, is a youth-led social action initiative in collaboration which aims to inspire a new wave of activism in the HIV response using social media and online technology to advance young people's sexual and reproductive health and rights (SRHR). ACT!2030 was conceptualized by the PACT, a global coalition of 25 youth-led and youth-serving organizations working on HIV and SRHR, of which UNAIDS is co-chair. The project is currently in its fourth phase, focusing on indicator advocacy, youth-led evidence gathering and policy change advocacy to hold governments to account on their commitments with the HIV response and SRHR. ACT!2030 is active in 12 countries: Algeria, Bulgaria, India, Jamaica, Kenya, Mexico, Nigeria, Philippines, South Africa, Uganda, Zambia, and Zimbabwe.

All In

All In to #EndAdolescentAIDS is a platform for action and collaboration to inspire a social movement to drive better results for adolescents through critical changes in programmes and policy. It aims to unite actors across sectors to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents by 2020, towards ending the AIDS epidemic for all by 2030. It is convened by a leadership group that includes UNAIDS, UNICEF, UNFPA, WHO and PEPFAR, as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the MTV Staying Alive Foundation and the adolescent and youth movement represented by the HIV Young Leaders Fund on behalf of the PACT and Y+.

Global Coalition for Women and AIDS

The Global Coalition on Women and AIDS (GCWA) alliance brings together civil society groups working on HIV, women, girls and gender equality, including networks of women living with HIV, women's rights organizations, AIDS service organizations, faith-based organizations, networks of women from key populations, care-giving networks, men and boy's organizations working explicitly for gender equality, the private sector, and the United Nations system.

WhatWomenWant

WhatWomenWant, coordinated by the Athena Network with the support of UNAIDS and others, mobilizes advocates and thought leaders across issues of gender equality, HIV, gender-based violence, women's rights, and sexual and reproductive health and rights (SRHR) for women in all of our diversity, to expand who is in the conversation and who has access to it. The WhatWomenWant campaign had a virtual reach of over 13 million accounts on Twitter in a six week period in the run up to the High-Level Meeting on Ending AIDS. WhatWomenWant are putting women and young women squarely at the centre of the HIV response to realize gender equality within and outside the HIV movement.

DREAMS

DREAMS is an ambitious US\$ 385 million partnership that aims to help girls develop into “Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe” women in 10 sub-Saharan African countries. At country level, UNAIDS work closely with country partners and PEPFAR to deliver DREAMS’ core package of evidence-based approaches that go beyond the health sector to address the structural drivers that directly and indirectly increase girls’ HIV risk, including poverty, gender inequality, sexual violence, and a lack of education.

Pink Ribbon Red Ribbon

Pink Ribbon Red Ribbon is an innovative partnership that works to expand the availability of vital cervical cancer screening, treatment and breast care education—especially for women living with HIV. UNAIDS works in partnership with Pink Ribbon Red Ribbon to develop creative new models to integrate HIV services with other primary health care interventions in order to save lives and build sustainable health systems. In 2016 the Zambian cervical cancer programme together with the HIV/TB programme and bilateral partners, with resources from the Global Fund, are introducing 25 cervical cancer screening clinics targeting women living with HIV across the country. The ministry has brought all partners working on cervical cancer and HIV to coordinate these forward thinking, integrated and adaptive response activities ensuring the resources are leveraged and programming is being delivered in an integrated manner to women living with HIV. Pink Ribbon Red Ribbon has been providing technical support to the effort.

International Community of Women living with HIV and the Global Network of People Living with HIV/AIDS

The International Community of Women living with HIV (ICW) and Global Network of People Living with HIV/AIDS (GNP+) jointly with WHO and the UNAIDS Secretariat developed a tool for assessing whether eliminating mother-to-child transmission (EMTCT) criteria had been met in a manner consistent with human rights. Through a consultative process led by ICW and GNP+, women living with HIV identified the key human rights, gender equality and community engagement considerations necessary for country validation. EMTCT validation—with a Global Validation Committee at the centre—opens up an important dialogue with country authorities and commitments to address human rights barriers towards women and children. The validation process is a unique disease elimination certification process that brings human rights standards to sound public health.

UN WOMEN and UNAIDS

Created in July 2010, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) promotes gender equality not just as an inalienable human right but as a central tenet of social, economic and cultural development.

In June 2012, UN Women became the eleventh Cosponsor of UNAIDS, an important step towards ensuring that gender equality is at the heart of global action on HIV. UN Women supports efforts to integrate gender equality in all 10 of the key goals of the UNAIDS 2016–2021 Strategy and collaborates closely with UNAIDS Secretariat and other Cosponsors in working towards achieving these goals and meeting the needs of girls and women, including ending gender-based violence and ensuring that national AIDS strategies address their rights and needs in the context of HIV.

UN Women's strategic approach to HIV includes providing technical and financial support to Member States and women's organizations, particularly those of women living with HIV, in the area of gender equality and AIDS. To reduce the vulnerability of women and girls to HIV, UN Women seeks to address the challenges that stem from unequal power relations between women and men.

Copyright © 2017
Joint United Nations Programme on HIV/AIDS (UNAIDS)
All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. UNAIDS does not warrant that the information published in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

Unless otherwise indicated, photographs used in this document are used for illustrative purposes only. Unless otherwise indicated, any person depicted in the document is a “model”, and use of the photograph does not indicate endorsement by the model of the content of this document nor is there any relation between the model and any of the topics covered in this document.

UNAIDS/JC2901E





UNAIDS
Joint United Nations
Programme on HIV/AIDS

20 Avenue Appia
CH-1211 Geneva 27
Switzerland

+41 22 791 3666

unaids.org