

WE'VE GOT THE POWER

The lower half of the image features a solid red background. It is decorated with several diagonal lines of varying lengths and colors, including white and light grey, which create a dynamic, abstract pattern.

WOMEN,
ADOLESCENT
GIRLS AND
THE HIV RESPONSE

This publication marks the 25th anniversary of the Beijing Declaration and Platform for Action. It is dedicated to the women leaders and allied community mobilizers who have devoted their lives to advancing the human rights and dignity of all people affected by the HIV epidemic, and to opposing social injustice, gender inequality, stigma and discrimination, and violence.

Unless otherwise indicated, the HIV-related statistics cited in this publication reflect the most recent UNAIDS data available.

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A decorative graphic consisting of several diagonal lines in red and grey, scattered across the page. The lines vary in length and orientation, creating a dynamic, abstract pattern.

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FOREWORD

Twenty-five years ago, governments took the historic step of adopting the Beijing Declaration and Platform for Action, to this day the most comprehensive and progressive global policy road map for fulfilling the human rights of women and girls and achieving gender equality.

Progress has been made in key areas. More girls are in school and gender gaps in primary school are closing globally; in some countries, there are more women involved in political leadership; and other countries have worked to protect women's rights in legislation. Medical breakthroughs and the activism of women and communities have saved and improved the lives of millions living with and affected by HIV. We have scaled up HIV treatment so that by 2019, there were over 24 million people on treatment, including more than 13 million women aged 15 years and over.

But no country has achieved gender equality to date. Women still have far fewer economic opportunities than men and shoulder most unpaid care and domestic work. Gender-based discrimination and violence are still far too common throughout our societies.

This report shows how the HIV epidemic holds a mirror up to these inequalities and injustices, and how the gaps in rights and services for women and girls are exacerbating the epidemic.

AIDS-related illnesses are the leading cause of death among women of reproductive age globally; every week 6000 adolescent girls and young women around the world are acquiring HIV—most of them in Africa; and women from key populations most impacted by the epidemic are between five to 19 times more likely to be living with HIV than other adult women.

This is unacceptable, it is avoidable and it must end.

Women and adolescent girls are demanding their rights. Governments must act on those demands by providing the resources and services to protect their rights and properly respond to their needs and perspectives.

In practice, this means providing all girls with at least quality secondary education, as well as comprehensive

sexuality education for all, holistic and dignified care for women and girls, and decent employment and livelihood opportunities. It also means ending violence against women and girls, and safeguarding their sexual and reproductive health and rights—which cut across every aspect of their lives. Removing discriminatory and punitive laws that stigmatize women and girls—and ensuring equality before the law—is fundamental.

The empowerment of women and girls and the fulfilment of their human rights is crucial. This must be a decade of acceleration towards reaching the 2030 Agenda for Sustainable Development, including ending the HIV epidemic.

No more excuses. We need bold feminist-led action to end gender inequities, confront taboos around women's sexuality and stop denying women their basic freedoms and autonomy regarding their own bodies and life choices.

UNAIDS is ready to work with governments, civil society, communities and other partners to step up the pace of delivery and meet the promises that were made to women and girls 25 years ago.

This is Generation Equality! Together, we've got the power!

Winnie Byanyima
UNAIDS Executive Director

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THE GAINS SINCE BEIJING: ARE WE ON THE RIGHT TRACK?

When the Beijing Declaration and Platform for Action was adopted in 1995, the global spread of HIV was approaching its peak, effective treatment was not yet available and hope was in short supply. Women were acquiring HIV at alarming rates in an epidemic that began mainly among men. Community-driven action, global political commitment and biomedical breakthroughs, however, have steadily changed that.

By the turn of the millennium, one of the greatest public health achievements of humankind was unfolding. HIV prevention and treatment programmes around the world, many of them community-based, have reversed the global trend in new HIV infections. The rapid scale-up of antiretroviral therapy prevented an

estimated 13.8 million [10.8 million–18.8 million] deaths globally between 1995 and 2018, and by mid-2019, an estimated 24.5 million [21.6 million–25.5 million] people living with HIV were receiving treatment. As a result, HIV has been transformed into a manageable chronic health condition for the majority of people living with HIV. Expanding access to treatment is also key for prevention, because people with undetectable viral loads cannot sexually transmit HIV.

These achievements were driven by the determination, energy and vision of community activists and organizations around the world, momentum that has grown into a powerful global movement. Women and girls in all their diversity are central to this: they

Box 1 Highlights of global targets—women, girls and the HIV response

2016 Political Declaration on Ending AIDS

- Reduce the number of adolescent girls and young women, aged 15 to 24 years, who are newly infected with HIV globally each year to below 100 000 by 2020 (from a 2010 baseline).
- Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and that they have access to sexual and reproductive health services by 2020.
- Ensure access to combination prevention options for at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations.
- Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020.
- Strengthen national social and child protection systems to ensure that by 2020, 75% of people living with, at risk of and affected by HIV who are in need benefit from HIV-sensitive social protection and support programmes, particularly orphans and street children, girls and adolescents living with, at risk of and affected by HIV, as well as their families and caregivers (1).

have powered the mobilization of communities and political will, set up services and programmes, and demanded accountability from governments, public health managers and pharmaceutical companies. They have brought about momentous changes in our understanding of the HIV epidemic and how best to overcome it.

Yet too many women and girls are being left behind in the HIV response. Fulfilling the Beijing promises for their empowerment and for gender equality is key to closing the remaining gaps and achieving the global goal and targets for ending the AIDS epidemic by 2030 (Box 1). This will require political leadership and investments to make gender equality and the empowerment of women and girls central to the HIV response, and to ensure women's leadership and participation at all levels of decision-making.

Gaps in progress

Although impressive, the gains made against HIV have been uneven, both geographically and by population, leaving the world off-track to reach its goal. In the countries hardest hit by HIV—all of which are in sub-Saharan Africa—adolescent girls and young women face inordinate risks of acquiring HIV. Outside that region, several dozen countries are experiencing rising numbers of new infections and deaths, mostly in communities that have been pushed to the margins by stigma and discrimination, and by punitive laws and policies.

We have the know-how to bridge those gaps, but its application and impact is muffled by political, social and economic barriers. The HIV response is most effective when state policies and social norms are transformed in ways that empower the people who are most vulnerable and enable them to access services. In many parts of the world, for instance, women and girls are prevented from controlling their own bodies, making choices about their sexual and reproductive lives, and using the health, education and social services they need.

HIV is more than a health issue: our efforts to end the epidemic are intertwined with our quest for social, economic and gender justice and human rights for all.

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Box 2 Examples of how inequities drive the HIV epidemic among women and girls

- A lack of legal protections and enforcement against gender discrimination heightens risks to the health and well-being of women and girls. For example, while intimate partner violence is linked to higher risks of HIV for women and girls in areas of high HIV prevalence, some countries still lack legislation against domestic violence, and many more fail to criminalize marital rape. Many women living with HIV also face violence because of their status from intimate partners, in health facilities and in their communities.
- Criminalization of people based on sexuality, sexual activity, drug use, HIV status and gender further exposes key populations to stigma and discrimination and keeps them away from HIV services and care. In countries that decriminalize sex work or drug use, however, new HIV infections among these groups can drop significantly.
- Restrictive laws requiring parental consent for adolescents to access basic health services—such as for contraception and HIV testing and treatment—undermine the HIV response and have a disproportionate impact on the sexual and reproductive health of adolescent girls.
- Many women and adolescent girls around the world still do not have full control over decision-making about their sexual and reproductive lives and their own health care. Adolescent girls and young women who are married or in union tend to have the least decision-making control.
- Failure to protect the human rights of women and girls in health-care settings and to ensure their access to holistic and dignified care are major barriers hindering progress in the HIV response.
- Discrimination against women and girls when it comes to educational and economic opportunities—and restricted income-earning and livelihood prospects—leaves them exposed to risk-taking strategies that can increase their chances of acquiring HIV.
- Enabling girls to complete their education, especially through secondary education, protects them against HIV and improves many other health and development outcomes. Despite this, too many are still out of school.
- Limited access to quality comprehensive sexuality education leaves adolescents and youth at risk. Levels of knowledge among young women and men about how to prevent HIV are alarmingly low in many countries.
- Unequal power dynamics rooted in gender inequality are major drivers of the epidemic among women and girls. Harmful masculinities, for example, encourage men to take risks in their sexual behaviours and keep them away from HIV prevention, testing and treatment services, increasing the risks of acquiring HIV for women and girls and undermining an effective HIV response.

THE HIV EPIDEMIC AMONG WOMEN AND ADOLESCENT GIRLS

Each year, fewer women and girls are acquiring HIV (Figure 1). In 1995, an estimated 1.2 million [930 000–1.6 million] women and adolescent girls (aged 15 years and older) acquired HIV globally, representing half of all new infections in that age group. By 2018, that number had dropped by 39%, to 740 000 [570 000–1.0 million], with women and adolescent girls accounting for 47% of new HIV infections among people aged 15 years and older. However, this falls short of the global target of reducing the number of new infections among individuals (aged 15 and older) by 75% by 2020.¹

Gender discrimination in the context of violence, poverty and insecurity continues to stoke excessive HIV risk among women and girls and block access to services, especially among those from marginalized and excluded communities (Box 2). Women and girls in sub-Saharan Africa, the region with the largest

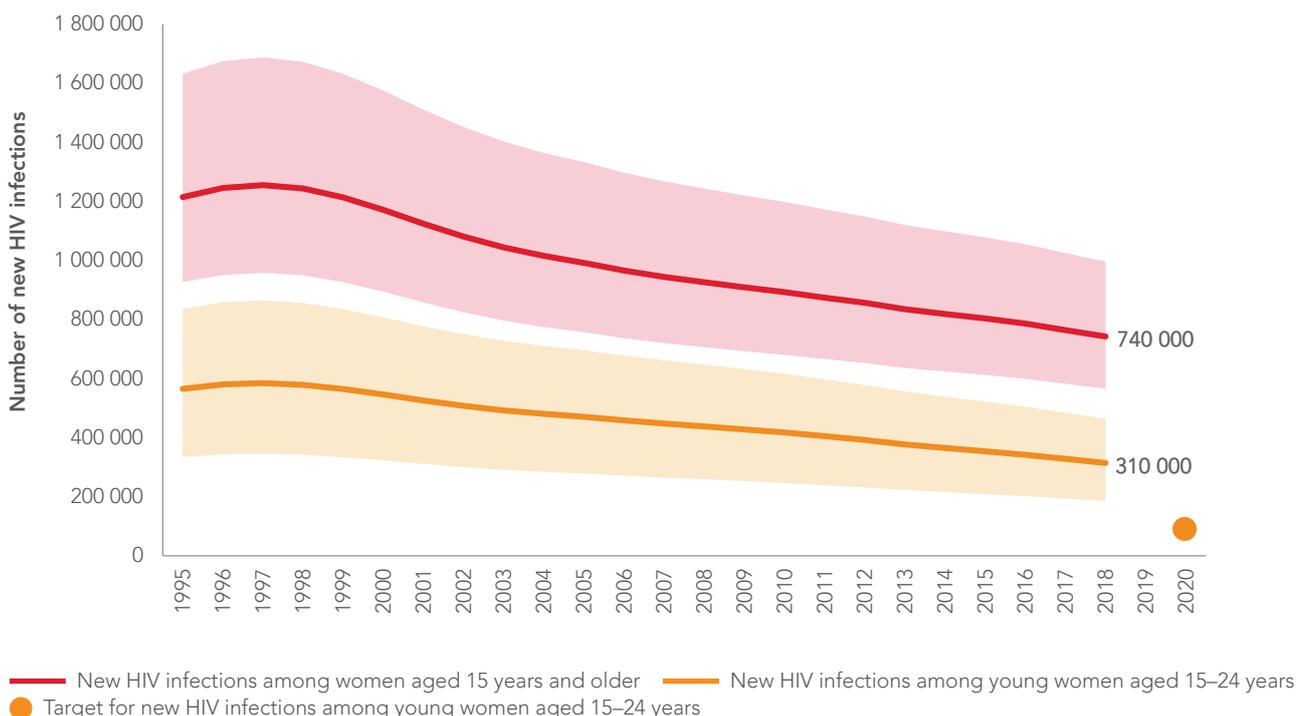
HIV epidemics in the world, are especially impacted: in 2018, women accounted for 59% of new infections among adults (15 years and older) in the region, a share that has remained largely unchanged since 1995. In eastern and southern Africa alone, an estimated 12 million [10.7 million–13.4 million] women were living with HIV.

The pace and even the direction of change varies considerably between regions (Figure 2). For instance, new HIV infections among women declined in Asia and the Pacific, the Caribbean, sub-Saharan Africa, and western and central Europe and North America. In Latin America, however, declines in HIV infections stalled in the early 2000s, while the number of new HIV infections among women has been increasing in eastern Europe and central Asia, and the Middle East and North Africa.

1 From a 2010 baseline.

Figure 1

New HIV infections among women are decreasing, but not quickly enough
Number of new HIV infections among women, by age, global, 1995–2018 and 2020 target

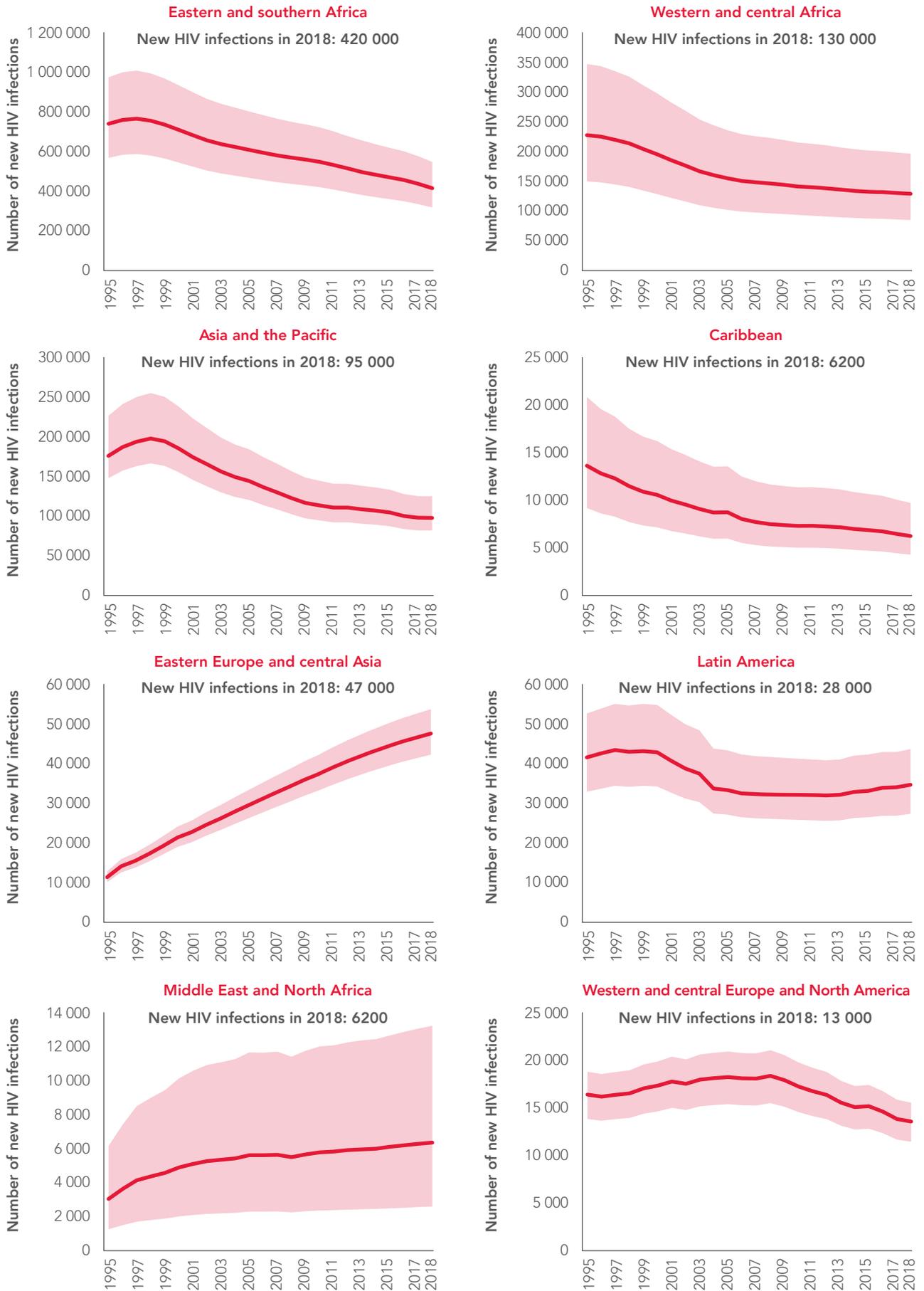


Source: UNAIDS epidemiological estimates, 2019.

Figure 2

Trends in new HIV infections among women differ across regions

Number of new HIV infections among women (aged 15 years and older), by region, 1995–2018



Source: UNAIDS epidemiological estimates, 2019.

HIV PREVENTION AMONG ADOLESCENT GIRLS AND YOUNG WOMEN

Between 1995 and 2018, the steepest decrease in new HIV infections among women occurred among adolescent girls and young women (aged 15 to 24 years)—a decline of 44% globally. Prevention programmes that focus on this age group are having an impact.

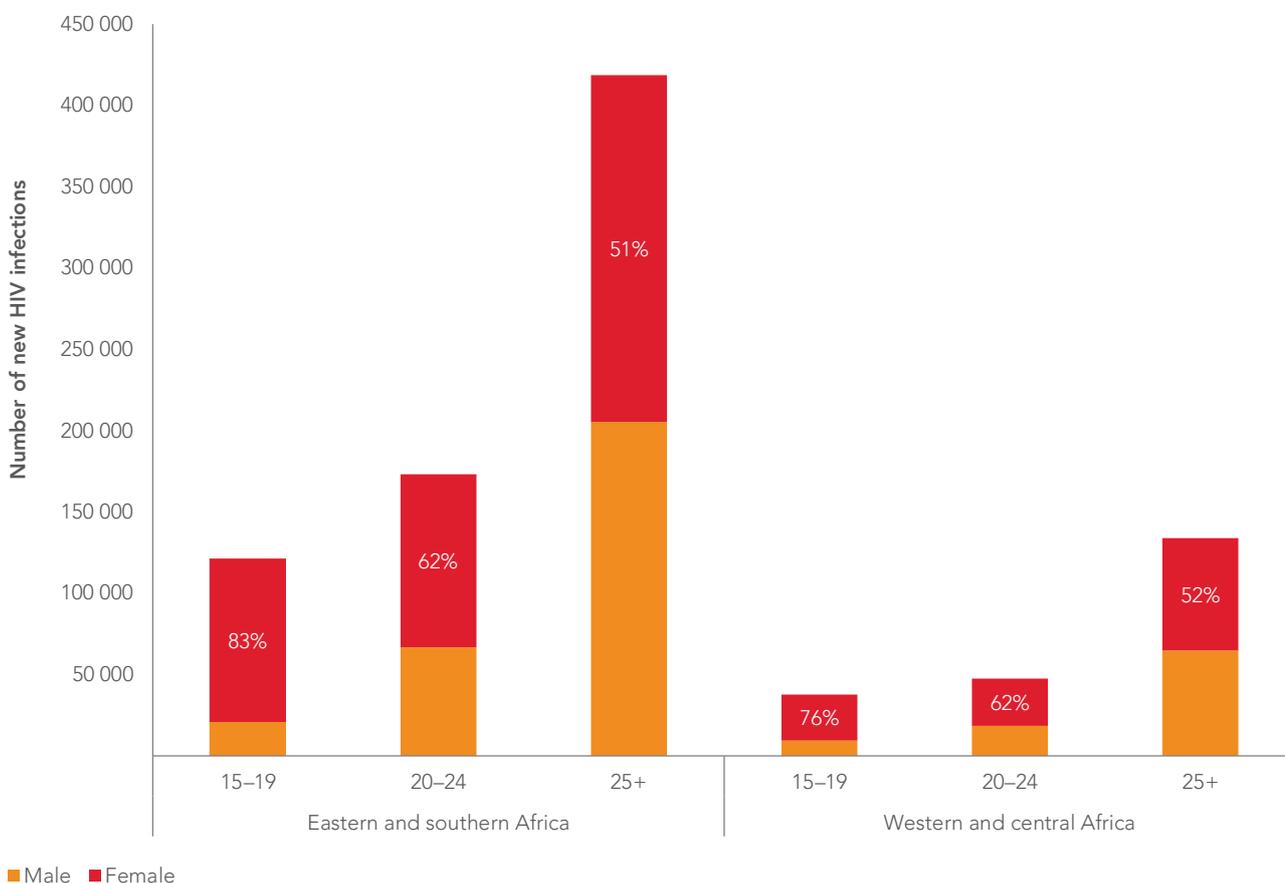
Nonetheless, in 2018, approximately 6000 adolescent girls and young women acquired HIV each week, and they accounted for 60% of the estimated 510 000 [300 000–740 000] new HIV infections in that age group. In sub-Saharan Africa, gender-related factors fueling the epidemic are especially stark: adolescent girls and young women

were more than twice (2.4 times) as likely to acquire HIV than their male peers (Figure 3).

The world is still a long way from achieving the global target of reducing new HIV infections among adolescent girls and young women to fewer than 100 000 by 2020: in 2018, that number stood at 310 000 [190 000–460 000], three times higher than the target.

Figure 3 Adolescent girls and young women in sub-Saharan Africa are much more likely to acquire HIV than their male peers

New HIV infections among women and men, by age, eastern and southern Africa and western and central Africa, 2018



Source: UNAIDS epidemiological estimates, 2019.

Women from key populations and other marginalized communities are especially vulnerable

Outside sub-Saharan Africa, most women at risk of HIV infection or those living with HIV belong to marginalized communities, such as sex workers, women who inject drugs, transgender women and women in prison (often referred to as “key populations” in HIV literature). They also may be the sexual partners of men who themselves belong to key populations (such as men who inject drugs or gay men and other men who have sex with men).

While key populations represent only a small proportion of the general population, they are at much higher risk of HIV infection. Globally, more than half of new HIV infections in 2018 were among people belonging to key populations and their sexual partners.

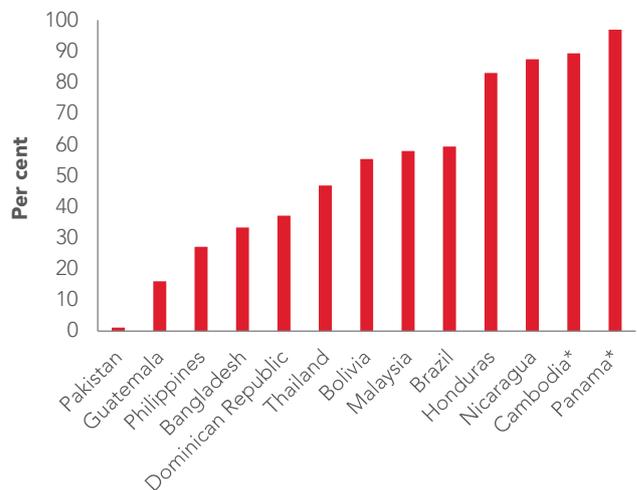
In most countries, women from key populations have much higher chances of living with HIV than other women. The risk of living with HIV is approximately 19 times higher for transgender women and 17 times higher for women who inject drugs than for other women aged 15 to 49 years. Female and transgender sex workers are 11 times more likely to be living with HIV—and women in prison are five times more likely—than other adult women. Their higher risk compared to other women is reflected in the high HIV prevalence within these populations in most countries where recent data are available.

Gender inequality, stigma and discrimination, criminalization, violence and other human rights violations prevent women from key populations from seeking and receiving the services and support they need. For example, in six of the 13 countries that reported data to UNAIDS in recent years, less than half of transgender women stated that they were able to access multiple HIV prevention services (Figure 4).

Women and girls caught in humanitarian crises also face circumstances that can heighten their risk of acquiring HIV and other health threats due to generalized instability, violence, fractured communities and collapsed health systems. Displaced and refugee populations are seldom included in national HIV policies, leaving them without reliable access to services for preventing and managing HIV infection (2). In 2019, only 25 of 97 reporting countries stated they had a strategy guiding their national HIV response that addressed internally displaced people, and the same low number of countries stated they had the same for refugees.

Figure 4 Prevention services are missing transgender women in many countries

Percentage of transgender women who reported receiving at least two prevention services in the past three months, countries with available data, 2016–2018



Note 1: The use of an asterisk (*) indicates that data for marked countries come from programme data (which tend to show higher values) and not from a survey.

Note 2: Possible prevention services received: condoms and lubricant, counselling on condom use and safe sex, and testing of sexually transmitted infections.

Source: UNAIDS Global AIDS Monitoring, 2019 (see <https://aidsinfo.unaids.org/>).

For women and girls on the move—especially undocumented and low-income migrants—discrimination, legal and policy barriers, provider attitudes, and language and cultural barriers hinder their access to HIV and health services. Social intolerance and exclusionary immigration policies heighten people’s fears of arrest and deportation if they do seek services (3–5). Migrant women and girls also face potential sexual and physical violence perpetrated by smugglers and traffickers, border patrol authorities and fellow migrants (6).

FEWER WOMEN AND GIRLS ARE DYING OF AIDS-RELATED ILLNESS

Globally in 2018, about 68% [52–82%] of women and girls (aged 15 years and older) living with HIV were receiving treatment. While immense progress has been achieved, AIDS-related illnesses remain the leading cause of death globally for women aged 15 to 49 years (7).

Women and girls comprised about 52% of people aged 15 or older who were living with HIV globally in 2018, with eastern and southern Africa home to almost two thirds (64%) of that global total (Figure 5). Two decades ago, very few people in that region were receiving life-saving antiretroviral therapy; by 2018, approximately 72% [56–84%] of women and girls (15 years and older) living with HIV were on treatment, and about 64% [55–72%] of women and girls living with HIV had reduced their viral load, enabling them to lead healthy and productive lives. Treatment coverage has also improved for men and boys, although in all but one region it remains lower than among women and girls. This disparity is most pronounced in western and

central Africa, where an estimated 61% [32–67%] of women living with HIV were receiving HIV treatment in 2018, compared with 40% [18–41%] of their male peers.

Despite progress, an estimated 770 000 [570 000–1.1 million] people globally died of AIDS in 2018. Women and girls accounted for 41% of those deaths. In eastern and southern Africa, the epidemic claimed 310 000 [230 000–400 000] lives in 2018, 49% of them women and girls. Major gaps therefore persist in the continuum of HIV care (Figure 6). In eastern Europe and central Asia and the Middle East and North Africa, regions where antiretroviral therapy is difficult to access, AIDS-related deaths among women of all ages have been rising since 1995, although there have been slight declines in recent years. Approximately 46% of women living with HIV in eastern Europe and central Asia were receiving antiretroviral therapy in 2018; in the Middle East and North Africa, that rate was roughly one in three (35%).

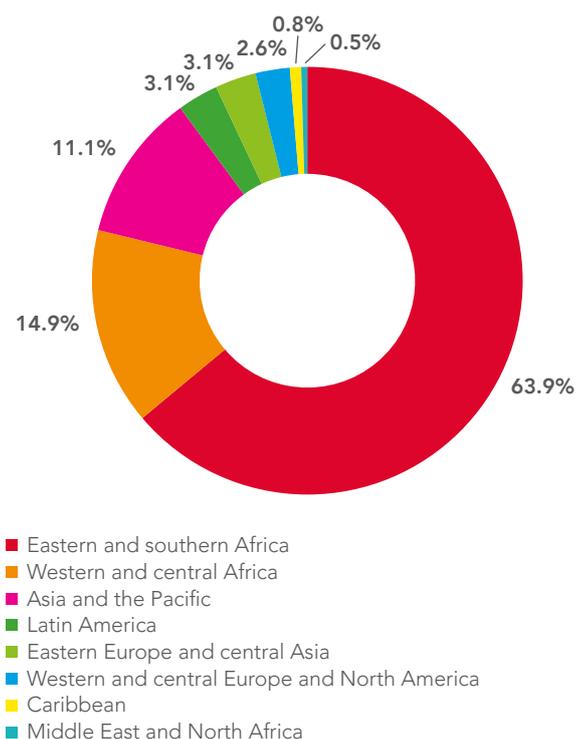
More women and girls than ever know their HIV status and are receiving treatment, but many still miss out

Levels of knowledge of HIV status among women living with HIV are close to the 2020 target of 90%. In eastern and southern Africa, an estimated 88% [78–95%] of women and girls living with HIV (aged 15 years and older) knew their HIV status in 2018, comparable to the corresponding 84% [73–95%] of women globally.

Those achievements are partly due to programmes that routinely offer HIV testing to women when they become pregnant and seek antenatal care services. Harmful gender norms also discourage men from seeking an HIV test and other health services. As such, women are more likely to know their HIV status than men. This is a cause for concern for HIV prevention among women, because HIV-positive men who do not know their HIV status and are not on treatment can transmit HIV to their sexual partners.

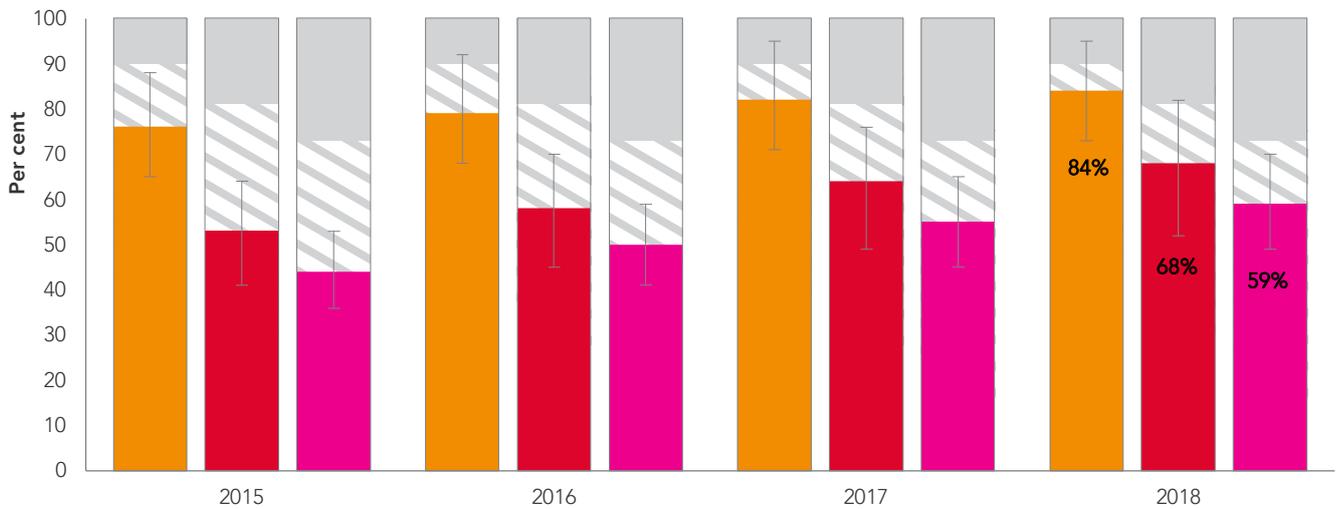
However, women's knowledge of their HIV status varies widely between countries, reflecting the different degrees of political will, social exclusion and intersecting forms of discrimination and criminalization that shape their realities. Among key populations, knowledge of HIV status is alarmingly low. Survey data show that, on average globally, only about half of people who inject drugs know their HIV

Figure 5 Distribution of women and girls aged 15 years and older living with HIV, by region, 2018



Source: UNAIDS epidemiological estimates, 2019.

Figure 6 More women and girls are benefitting from HIV services, but the gaps must be closed
Testing and treatment cascade, women and girls, 15 years and older, globally, 2015–2018



- People living with HIV who know their status
- People living with HIV who know their HIV status and are on treatment
- People living with HIV who are virally suppressed
- Gap to reaching the global 2020 targets (90–90–90)
- Gap to reaching all people living with HIV

Source: UNAIDS special analysis, 2019.

Note: The “cascade” concept is used for monitoring results and gaps at each stage of the HIV continuum of care—from testing, to starting and staying on treatment, and on to achieving viral load suppression. Full achievement of global targets by 2020 is equal to 90% of people living with HIV knowing their HIV-positive status, 81% of all people living with HIV receiving antiretroviral treatment, and 73% of all people living with HIV having a suppressed viral load.

status, as do about two thirds of sex workers and transgender persons.

Great progress has been made in keeping pregnant women and mothers healthy and preventing vertical transmission of HIV to newborns

Nearly 82% [62–>95%] of pregnant women living with HIV worldwide were receiving antiretroviral therapy in 2018, and 92% [69–>95%] were doing so in eastern and southern Africa. This means that approximately 200 000 [140 000–320 000] infants avoided acquiring HIV in 2018 alone.

However, overall progress in preventing vertical transmission of HIV and scaling up treatment coverage has stalled in recent years. Slow progress in other regions means that the 2018 global target of reaching 95% of pregnant women living with HIV with antiretroviral therapy and sustaining them on lifelong treatment was missed (8). Coverage of antiretroviral treatment among pregnant women living with HIV was only 28% [16–47%] in the Middle East and North Africa in 2018, 56% [47–71%] in Asia and the Pacific, and 59% [42–78%] in western and central Africa.

Thirteen countries or territories have been certified for having eliminated vertical transmission of HIV since 2015 (9), but none of them are in sub-Saharan Africa, which was home to about 86% of all children newly infected with HIV in 2018.

Pregnant adolescent girls, young mothers and women belonging to key populations encounter many additional barriers when trying to access and stay on treatment. Denigrating social attitudes and discriminatory practices limit their rights to access basic information and quality care, and inhibit their rights to make their own decisions, including about childbearing and breastfeeding.



UNFINISHED WORK: CONFRONTING GENDER INEQUALITY AND STIGMA AND DISCRIMINATION

A decade remains before the 2030 deadline for ending the AIDS epidemic. The remarkable achievements since 1995—in preventing HIV, saving lives and improving the quality of life of people living with and affected by HIV—are proof that concerted action can change the course of this epidemic.

Despite progress, shortcomings persist, and fulfilling the promises made in Beijing 25 years ago will be crucial to surmounting them. Discrimination against women and girls and violations of human rights, intersecting with other forms of discrimination—such as those based on income, race, ethnicity, disability, sexual orientation and gender identity—are stifling HIV responses. Gender inequality restricts women's control in deciding how, when and with whom they have sex. It also shapes women's use of HIV and other health services, and their chances of leading lives free of gender-based violence.

Discrimination in education and economic opportunities undermines women's and girls' agency and limits their decision-making power within relationships, families and societies, heightening their risks of acquiring HIV (10). Many women have limited financial autonomy, are disproportionately represented in informal and unregulated sectors of the economy, shoulder the burdens of unpaid care and domestic work to an overwhelming degree, and lack equal property and inheritance rights. These experiences shape the lives of women and girls around the world.

The empowerment of women and girls in all their diversity and the fulfilment of their human rights are essential for creating more just, equitable and prosperous societies. They also are a vital part of an effective HIV response. This must include addressing harmful gender norms rooted in patriarchal systems and boosting men's responsibility and accountability for respecting women's rights and freedoms.

Continued progress must build on achievements to date by leveraging the accumulated biomedical, behavioral and practical know-how on prevention and what works in HIV programming. Gender and other inequities holding back further progress must be challenged and eliminated. Seismic shifts are needed in the legal, policy, institutional and societal realms to take the HIV response to the next level. This will require:

1. Ensuring legal protections to end gender discrimination, stigma and criminalization, and guaranteeing women and girls equality before the law.
2. Ending punitive laws and policies based on sexuality, sexual activity, drug use, HIV status or gender.
3. Reforming laws that punish young people's sexuality and changing parental consent requirements that threaten the right to health of adolescents.

4. Prioritizing women's rights to control decisions about their health and their sexual and reproductive lives.
5. Responding to what women and adolescent girls need and want by protecting their rights to holistic and dignified prevention, treatment and care services and by addressing the range of health issues that affect women and girls living with and at high risk of HIV.
6. Making the HIV response work for adolescent girls and young women. This includes enabling them to complete their schooling and access comprehensive sexuality education and youth-friendly services, and investing in multisectoral approaches that address their multifaceted needs and rights.
7. Ending violence against women and girls and addressing the interlinkages with HIV by expanding prevention efforts and support for survivors.
8. Transforming gender norms and harmful masculinities, including through community mobilization, and starting early by engaging girls and boys.
9. Securing paths to gender equality and equity by investing in gender-transformative approaches.
10. Meaningfully engaging women and girls in all their diversity in decision-making and supporting the leadership roles of women's organizations and feminist movements in the HIV response.

Seismic shifts are needed in the legal, policy, institutional and societal realms to take the HIV response to the next level.

ENSURE LEGAL PROTECTIONS TO END GENDER DISCRIMINATION, STIGMA AND CRIMINALIZATION

Punitive and discriminatory laws and practices often target women and other groups that do not adhere to prevailing conventions around sex, sexuality and gender. It takes social mobilization and strong political leadership to shift public attitudes and promote the legislative and policy reforms that can help end such stigma and discrimination and criminalization that are undermining the HIV response.

GUARANTEE WOMEN AND GIRLS EQUALITY BEFORE THE LAW

THE BEIJING PROMISE: “Create and maintain a non-discriminatory and gender-sensitive legal environment by reviewing legislation with a view to striving to remove discriminatory provisions as soon as possible, preferably by 2005, and eliminating legislative gaps that leave women and girls without protection of their rights and without effective recourse against gender-based discrimination.”

Beijing+5, para. 68 (b)²

While some countries have worked to enshrine and protect women’s rights in laws and statutes, others have been slow to act. Laws that discriminate against women and girls remain widely in force. For instance:

- The Beijing Declaration target calling for the elimination of all gender discriminatory legislation by 2005 was missed (11). By one estimate, legal protections were inadequate for 2.5 billion women around the world in 2015 (12).
- More than 1 billion women lack legal protection against domestic and sexual violence by intimate partners or family members (13). Among

190 countries reporting these data in 2019, 35 lacked legislation addressing domestic violence (14). In 2017, only 77 of 185 countries explicitly criminalized marital rape (15).

- At least 117 countries permitted girls to be legally married before the age of 18 in 2015 (16). In more than 50 reporting countries, the minimum legal age of marriage is lower for women than men (15). Globally, more than 20% of young women were married before the age of 18 (17).³
- Thirty-six of 190 reporting countries lack any laws to counter gender-based discrimination in employment, and 50 have no legislation addressing sexual harassment in the workplace (14, 18). Only 88 of 190 countries have laws mandating equal pay for work of equal value, and nearly 65% of countries lack legislation on sexual harassment in educational institutions (14, 15).

Even where legislation protecting equality exists, discriminatory social norms and institutional practices can lead to weak enforcement. This can also happen when harmful customary law provisions are not aligned with international human rights standards and national bodies of law. Changing discriminatory legislation that limits women’s power and autonomy is essential, and it is especially important in the context of the HIV response.

BOTTOM LINE: Fast-track legal reforms and enforcement to uphold women’s human rights, backed by adequate funding and strengthened institutions. Accompany the reforms with awareness-raising, community mobilization and legal literacy so that women know their rights and entitlements, not least in relation to health and HIV, and so they know where to seek legal aid and access to justice when their rights are violated.

² The “Beijing promises” refer to select highlights from the 1995 Beijing Platform for Action or its five-year review of implementation—the Political Declaration and Outcome, which was adopted at the twenty-third special session of the General Assembly. It should be noted that subsequent reviews over the past 25 years at the intergovernmental global and regional levels further reinforce and build on the commitments cited in this report, including resolutions of the United Nations Commission on the Status of Women that are dedicated to women, girls and the HIV response.

³ Based on a subset of 98 countries covering 77% of the population of women aged 20 to 24 years.

END PUNITIVE LAWS, POLICIES AND PRACTICES THAT HARM PEOPLE

THE BEIJING PROMISE: Governments would “review and amend laws and combat practices . . . that may contribute to women’s susceptibility to HIV infection . . . and implement legislation, policies and practices to protect women, adolescents and young girls from discrimination related to HIV/AIDS”; and ensure that women living with HIV “do not suffer stigmatization and discrimination.”

Beijing Platform for Action, para. 108 (b, d)

Around the world, many countries maintain legislation and coercive practices that contradict the basic tenets of human rights. Some of these laws limit the sexual and reproductive choices of women or curb the agency of women living with HIV. Others criminalize people for their sexual identity or gender expression, for selling sexual services, for using illegal drugs, and for transmitting HIV or failing to disclose their HIV-positive status. Such laws and policies—and the stigma and discrimination they encourage—prevent people from using the services they need to protect their health and well-being (Figure 7).

Sex work is criminalized or otherwise punished in at least 88 countries. Punitive laws limit the ability of sex workers to negotiate condom use with clients and avert violence (19). For example, it is not uncommon for police to regard the possession of condoms as “evidence” that women are selling sex and to use that as a basis for harassment, bribery, arrest or violence.

Transgender persons, who are criminalized or prosecuted in at least 19 countries, are similarly deterred from seeking services. Same-sex sexual relations are criminalized in at least 66 countries and are punishable by death in at least 10 countries. Punitive laws on drug use have negative impacts on HIV prevention and treatment and they heighten the vulnerabilities of women who use drugs (20, 21, 22).

Laws criminalizing HIV transmission, non-disclosure or exposure existed in 82 of 119 reporting countries in 2019. Such laws leave open the possibility of prosecution and can heighten women’s risks of violence and being blamed for “bringing HIV to the home,” because they are often the first to know their status when tested for HIV (such as when seeking antenatal health services) (23). Six countries reported that the

vertical transmission of HIV remains a criminal offence, and 13 reported having laws, regulations or policies in place for mandatory HIV testing for marriage.

Decriminalization works and is vital for successful HIV prevention. Modelling studies suggest that between 33% and 46% of new HIV infections among sex workers and their partners could be averted over 10 years if legal reforms and other actions are implemented to create safer work environments and facilitate safer sex (24). Similarly, in countries where drug use is decriminalized and comprehensive harm reduction is available, HIV prevalence and transmission tend to drop sharply among people who inject drugs (25, 26). In 2019, however, only 45 of 106 reporting countries had needle-syringe programmes for people who inject drugs, and only 39 of 100 reporting countries provided opioid substitution therapy.

BOTTOM LINE: Reform laws to end harmful criminalization and coercive practices based on people’s sexuality, sexual activity, drug use, HIV status and gender. Laws and policies that promote and protect human rights can improve everyone’s personal security, well-being and health, and reduce their vulnerability to the HIV epidemic.

REFORM LAWS THAT PUNISH YOUNG PEOPLE’S SEXUALITY

THE BEIJING PROMISE: “Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation, for example; review existing legislation, including health legislation, as well as policies, where necessary, to reflect a commitment to women’s health.”

Beijing Platform for Action, para. 106 (b)

Laws and policies that restrict or penalize young people’s sexuality are often targeted at adolescent girls and are rooted in discriminatory attitudes and taboos about women and sex. Such measures deny adolescents basic health information and tools, undermining their health and hindering HIV prevention.

Figure 7 Criminalizing laws and coercive policies that relate to sexuality, gender and HIV remain widespread

Percentage of reporting countries with criminalizing laws and coercive policies related to HIV transmission or disclosure, mandatory HIV testing, sex work, drug use and gender identity, 2019

Laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission



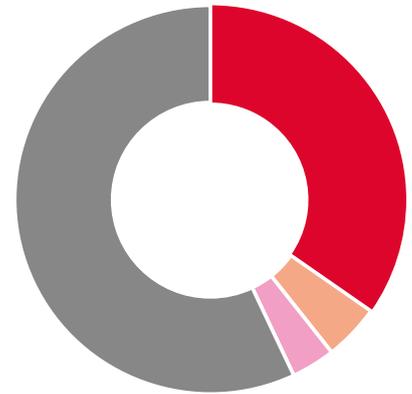
- Criminalized
- Not criminalized, but prosecutions exist based on general criminal laws
- Not criminalized
- Data not available at this time

Criminalization of sex work



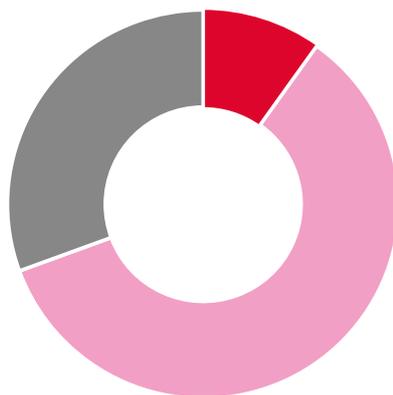
- Any criminalization or punitive regulation of sex work
- Sex work is not subject to punitive regulations and is not criminalized
- Issue is determined/differs at subnational level
- Data not available at this time

Drug use or possession for personal use is an offence



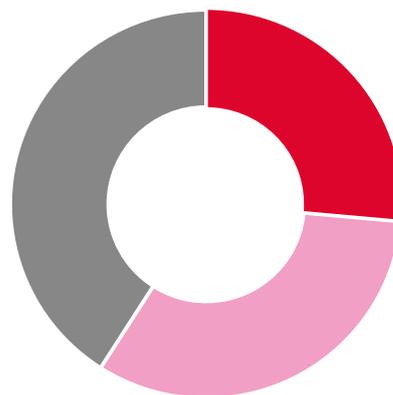
- Drug use or consumption and/or possession of drugs for personal use is specified as a criminal offence
- Drug use or consumption and/or possession of drugs for personal use is specified as a non-criminal offence
- Not an offence
- Data not available at this time

Criminalization of transgender people



- Criminalized and/or prosecuted
- Neither criminalized nor prosecuted
- Data not available at this time

Mandatory HIV testing for marriage, work or residence permits or for certain groups



- Yes
- No
- Data not available at this time

Source: National Commitment and Policy Instrument, 2017 and 2019; supplemented by additional sources (see references in Annex).

In some settings, health-care providers are obliged by law to report underage sex or activities such as drug use among adolescents (27). Many countries do not allow condom promotion and distribution in schools: among the 91 countries that reported having a national condom policy in 2019, only 31 stated that the policy included condom promotion in secondary schools.

Adolescent girls pay a high price when their access to essential sexual and reproductive health services is restricted. They bear the costs of misinformed and unprotected sexual relations, including unwanted pregnancies, unsafe abortions, and HIV and other sexually transmitted infections (STIs), and they forgo educational and economic opportunities due to early childbearing.

Parental consent requirements undermine the right to health of adolescents

Many countries have laws or policies that prevent adolescents from accessing essential health services without the consent of a parent or guardian (Figure 8). The original intention may have been to protect minors, but these stipulations often have the opposite effect and increase the risk of HIV and other health problems among adolescents (28).

A large proportion of countries across all regions restrict access to HIV testing and treatment for adolescents. In 2019, for instance, adolescents younger than 18 years needed explicit parental consent in 105 of 142 countries in order to take an HIV test. In 86 of 138 reporting countries, they needed such consent to access HIV treatment and care. These kinds of laws and policies also may complicate or hinder adolescent access to pre-exposure prophylaxis (PrEP), a highly effective prevention tool (29).⁴

Research in sub-Saharan Africa shows that in countries where the age of consent is 15 years or lower, adolescents are 74% more likely to have been tested for HIV in the past twelve months compared with countries where the age of consent is 16 years or higher—with girls especially benefiting from the easier access (30).

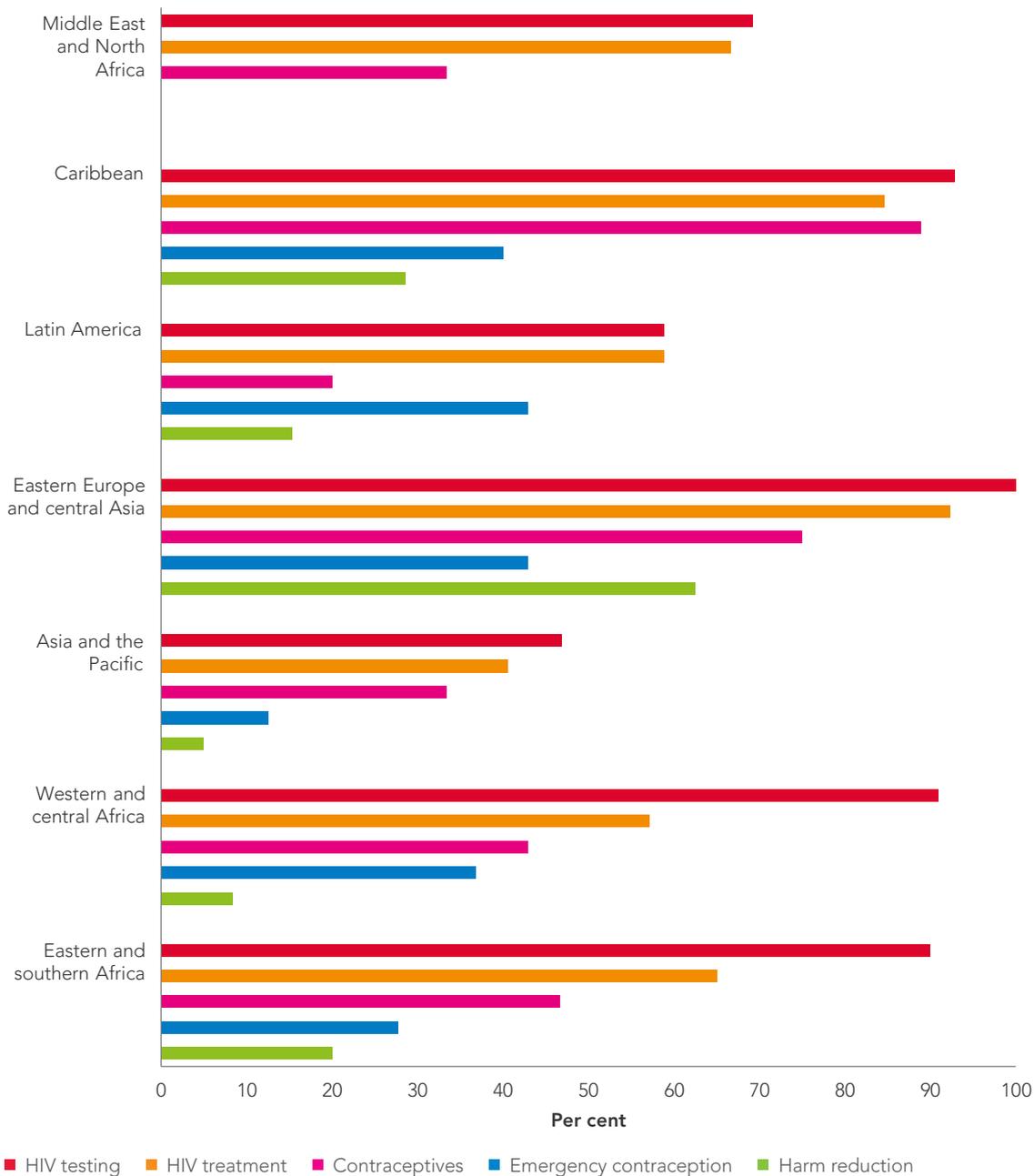
In line with international human rights standards, once adolescents are mature enough to understand that they need sexual and reproductive health support, they should be able to access those services (31). Assuring this freedom of access requires monitoring health-care providers and service delivery, as well as promoting awareness and understanding about the reforms among adolescents and parents (32).

BOTTOM LINE: Remove harmful laws and lift restrictions on access to essential health services for adolescents. Promote laws and policies that protect their rights to make informed decisions about their sexuality, relationships and health.

⁴ PrEP is an HIV prevention breakthrough. When taken regularly, this antiretroviral pill can be highly effective for reducing HIV infections among people who are at higher risk of HIV infection.

Figure 8 Parental or guardian consent is frequently required for adolescents to access health services

Percentage of reporting countries with laws requiring parental or guardian consent for adolescents to access contraceptives, HIV testing, HIV treatment, emergency contraception and harm reduction, by region, 2017–2019



Sources: UNAIDS National Commitments and Policy Instrument, 2017–2019; supplemented by additional sources (see references in Annex).

Note: Data on contraceptives, HIV testing and HIV treatment refer to countries with laws specifying that parental consent is required for adolescents younger than 14, 16 or 18 years of age to access these services. This does not include countries that have not legislated an age of consent. For a breakdown of laws by age and for specific country data, please see <http://lawsandpolicies.unaids.org/>. Data on emergency contraception and harm reduction refer to countries with laws specifying a legal age for unmarried adolescents to provide consent to access these services without parental/legal guardian consent.

WHAT WOMEN AND ADOLESCENT GIRLS WANT

Safeguarding the human rights of all women and adolescent girls, including their sexual and reproductive health and rights, requires action on many fronts: eliminating HIV-related stigma and discrimination and ensuring that women's rights are upheld when they seek HIV and other health services; reforming laws, policies and institutional practices; and uprooting harmful gender norms and patriarchal systems that perpetuate discrimination and violence against women and girls.

Women and adolescent girls have long been treated as passive recipients of health information and services. Their rights to informed and autonomous choice, to privacy and confidentiality, and to dignified and nonjudgmental care must be protected. This is especially important when it comes to women's agency around sexuality, sexual relationships and reproduction.

Leading global surveys of women and girls have canvassed them for their first-hand accounts and their priorities when it comes to their sexual and reproductive health and rights and overcoming barriers to access HIV services (33–37). Among their top demands were the following:

- Respectful and dignified care, including more respect and understanding from health providers for lesbian, bisexual and transgender women, female sex workers and women living with HIV.
- Decriminalization of issues related to sexual and reproductive health and HIV, and cracking down on stigma and discrimination and violence, especially in their communities and in health-care settings.
- Fully functional health-care facilities that are: affordable and easier to reach, especially for women in rural areas; staffed with competent and better-supported midwives and nurses; and equipped with water, sanitation, hygiene, medicines and supplies.
- Comprehensive sexuality education throughout the life cycle.
- Integrated HIV and sexual and reproductive health services that promote gender equality and human rights, sexual pleasure and respectful relationships, regardless of sexual identity, gender orientation and HIV status.

- Incorporating peer support in HIV treatment and care services.
- Active involvement in policy-making and in developing and providing leadership for programming.

Adolescent girls and young women surveyed in countries in sub-Saharan Africa had the following HIV prevention demands:

- Universal access to comprehensive information and youth-friendly, confidential, accessible and nonjudgmental services.
- Adequate, sustainable funding of initiatives for and by women and adolescent girls.
- Implementation of laws, policies and services that address gender-based violence.

PRIORITIZE WOMEN'S RIGHTS TO CONTROL DECISIONS ABOUT THEIR HEALTH AND SEXUAL AND REPRODUCTIVE LIVES

THE BEIJING PROMISE: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." Governments would "protect and promote human rights by ensuring that all health services and workers conform to ethical, professional and gender-sensitive standards in the delivery of women's health services, including by establishing or strengthening regulatory and enforcement mechanisms."

Beijing Platform for Action para. 96, Beijing+5, para. 72 (g)⁵

⁵ These concepts and the term "reproductive rights" were first recognized internationally in the 1994 Programme of Action for the International Conference on Population and Development.

A quarter century ago, the landmark International Conference on Population and Development (1994) (ICPD) and the Beijing Declaration and Platform for Action placed sexual and reproductive health and rights on the global human rights and development agendas. An increasing number of countries have sought to uphold those rights and freedoms, but more must be done.

Reports of reproductive rights violations continue in many parts of the world (38). As many as one in three women living with HIV reported experiencing at least one form of discrimination related to their sexual and reproductive health in a health-care setting in the past 12 months across 19 countries with available data. Forms of discrimination included: health-care providers advising or pressuring HIV-positive women not to have children or to terminate a pregnancy; access to HIV treatment being predicated on the use of certain forms of contraception; or women being denied sexual and reproductive health services due to their HIV status (39).

Strengthened oversight is needed to fulfill the promises in the Beijing Declaration and Platform for Action and to protect women's reproductive rights in health-care settings. This includes ensuring that countries with laws and policies on assisted partner notification implement rights-based approaches, and that such notification is always voluntary and consensual to protect women diagnosed with HIV against breaches of confidentiality and potential risks to their health and safety (40).

Around the world, women and adolescent girls still lack control over decisions regarding their own bodies, their health, and their sexual and reproductive lives. While the degree to which women make their own decisions varies widely, in almost half of 31 countries with available data, less than 50% of women (aged 15 to 49 years) who were married or in union and using contraceptives said they controlled decisions about their sexual relations, contraceptive use and health-care needs (Figure 9).

Women's decision-making control is also curtailed when it comes to making decisions about their health care more generally. Survey data from 48 countries show that, on average, about 30% of married women (aged 15 to 49 years) reported that they did not (alone or jointly with their husbands) make decisions about their own health-care. In western and central Africa, this figure was twice as high, with almost 60% of married women reporting they did not have the final say about

their own health care. Adolescent girls and young women (aged 15 to 24 years) who are married or in union tend to have the least decision-making control. While women's decision-making about their health care tends to increase with age, education and household economic status, the extent to which that autonomy is realized also differs widely among countries (41).⁶

BOTTOM LINE: Place the right of women to control decision-making about their sexual and reproductive lives at the centre of the HIV response. Protect these rights for all individuals through laws and policies, without discrimination. Ensure access to justice and legal redress for violations of sexual and reproductive health and rights.

The rights of women and girls to holistic and dignified care

THE BEIJING PROMISE: Implement measures "so that all women have full and equal access to comprehensive, high-quality and affordable health care, information, education and services throughout their life cycle; [and] reflect the new demands for service and care by women and girls as a result of the HIV/AIDS pandemic." Ensure non-discrimination "and respect for the privacy of those living with HIV/AIDS . . . including women and young people, so that they are . . . able to access treatment and care services without fear of stigmatization, discrimination or violence."

Beijing+5, para. 72 (g, n)

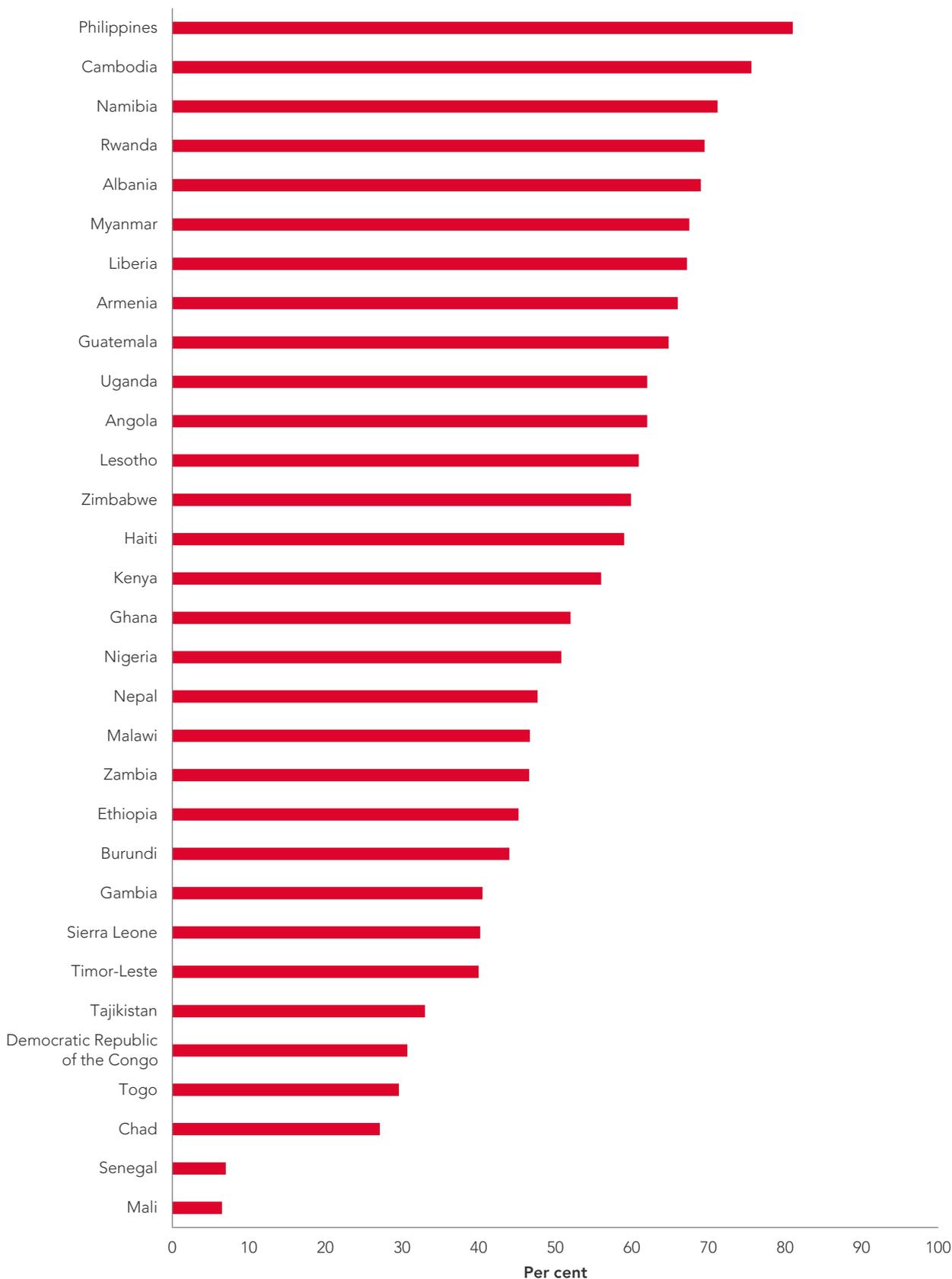
Health is one of the 12 critical areas of concern in the Beijing Declaration and Platform for Action. Fulfilling the right to health of women and girls requires approaches that reflect the varied needs, challenges and preferences of individuals as they progress through life.

Health-care systems should therefore offer holistic care that takes into account not only the health needs of women and girls, but also other physical, emotional, social and economic considerations. This includes: integrating HIV with other sexual and reproductive health services; ensuring that basic needs such as food and nutrition are met; and addressing noncommunicable diseases (such as depression, diabetes, cardiovascular diseases and cancers) (1, 42–45). Services must reflect what women and girls want: they should be rights-based and gender-

⁶ Data for 2013 to 2018. The aggregated totals refer to data from 48 countries, including 12 countries in western and central Africa, and 13 countries in eastern and southern Africa.

Figure 9 Women don't have full control of decisions about their sexual and reproductive health and lives

Percentage of women (aged 15 to 49 years) currently married or in union who are currently using contraceptives who make their own informed decisions regarding sexual relations, contraceptive use and health care, countries with available data, 2013–2018



Source: UNFPA Global Database, 2019; Demographic and Health Surveys, 2013–2018.

responsive, provided in ways that are acceptable to those receiving them. Outdated approaches and models of care that are gender-blind and ignore the voices of women and girls must be transformed.

Findings from the recent Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial in eastern and southern Africa, for example, underscore the need for women-centred approaches that combine biomedical, social and economic interventions. Despite access to HIV prevention services, women participating in that trial had very high HIV incidence (about 3.8%); it was even higher among women younger than 25 years (46). This highlights the need to tackle the underlying gendered dynamics that make it difficult for women to avoid acquiring HIV infection.

Special attention must be paid to address the range of health issues that affect women and girls living with or at risk of HIV. For example, despite some progress, HIV and other sexual and reproductive health services are often narrowly focused: HIV-related services are not always integrated with family planning services or linked with mental health services or support for survivors of violence. Similarly, women from key populations require special attention, as they face very high rates of unmet need for contraception, unintended pregnancies, abortions and sexual violence (47). In addition, the organizations that are best-placed to provide support—women and peers living with HIV—too often struggle to make ends meet and are seldom integrated with mainstream service delivery systems.

Valuable opportunities to protect women's rights and health are being lost, as illustrated by the following key issues that are also critically important in the context of the HIV response.

The use of modern contraceptives has increased around the world by 25% since the 1994 ICPD conference (48). However, in low- and middle-income countries, more than 230 million women and adolescent girls who want to avoid pregnancy are not using modern methods of contraception (48). In sub-Saharan Africa, almost 50% of women of reproductive age (15 to 49 years) do not have their demand for modern contraceptive methods satisfied, a gap that widens to approximately 60% among adolescent girls (aged 15 to 19 years) (41).

Knowledge, access and use of female and male condoms has stagnated in the region with the largest HIV epidemics: in sub-Saharan Africa, for example, less than half the estimated need for female and

male condoms was met in 2017, despite condoms still being the only tool that provides triple protection against unintended pregnancy, HIV and other STIs. By comparison to the early 2000s, the large population of adolescents growing up in Africa are not being exposed to the same degree of intense messaging and skills-building on condom use. In addition, rural and poor populations, who are priority groups for HIV prevention in some areas, have limited access to condoms (49).

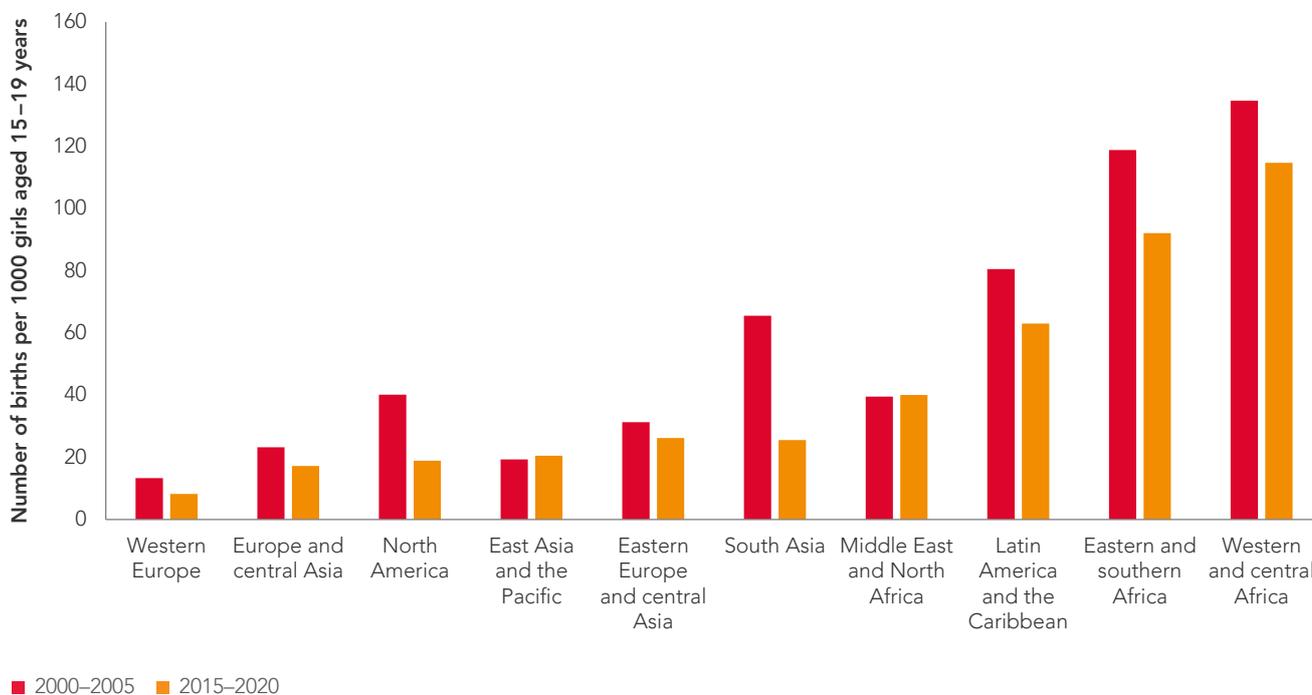
Pregnancy and childbearing rates among adolescent girls declined by about 30% between 1994 and 2017 (50). Nonetheless, some 21 million adolescent girls (aged 15 to 19 years) every year become pregnant, and 16 million give birth (51, 52). Rates of early childbearing among adolescent girls are highest in sub-Saharan Africa (Figure 10). While maternal mortality has decreased by 38% since 2000 (53), it remains the top cause of death among adolescent girls (aged 15 to 19 years), and it is the second leading cause among women of reproductive age globally (7). Many more women and girls suffer severe and chronic morbidities from complications related to pregnancy and childbirth (53). Women living with HIV are also at greater risk of poor health outcomes associated with malaria such as maternal and infant mortality and morbidity, with potentially serious drug interactions that hamper effective treatment for both infections (55-56). However, an encouraging development is that HIV-related effects on maternal mortality had been reduced by 2017 in comparison to 2005 (53).

One million new cases of STIs occur each day around the world (57). Some STIs increase the likelihood of HIV infection and transmission, but are curable (58). STIs can also be more difficult to treat and can lead to more rapid disease progression in people living with HIV. Women who have the human papillomavirus (HPV), the principal cause of cervical cancer, are almost twice as susceptible to acquiring HIV (59), and nearly 90% of cases of cervical cancer are attributable to HPV (60).

An estimated 570 000 women develop cervical cancer each year. In 2018, the disease claimed the lives of more than 300 000 women (61), nine in ten of them in low- and middle-income countries (62). Cervical cancer is the most common cancer among women living with HIV: their risk of developing invasive cervical cancer is five times greater, and they progress to cervical cancer much more quickly than women not living with HIV (63). Cervical cancer can also be treated if detected early, but integration of screening in HIV services is far from the norm: only about half of reporting countries recommend it in their national

Figure 10 Childbearing among adolescent girls remains very high in some regions

Estimated number of annual births per 1000 adolescents (aged 15 to 19 years), by region, 2000–2005 and 2015–2020



Source: World population prospects 2017—data booklet. 2017 revision. New York: United Nations Department of Economic and Social Affairs, Population Division; 2017.

HIV policies. Cervical cancer can be prevented with the HPV vaccine, which is most effective when administered in adolescence before girls become sexually active (64). In 2019, 51% of countries reported that they had incorporated HPV vaccination into their national immunization programmes (65).

Mental health conditions affect many women and adolescent girls, and they can also compromise the ability of people to prevent or manage HIV infection (66). For women living with HIV, these conditions include depression, anxiety, post-traumatic stress and substance use disorders (67, 68). Pregnant women living with HIV tend to have poorer mental health than pregnant women who have not acquired HIV (69), and an estimated one in three women living with HIV experiences postnatal depression (70). Access to psychosocial and mental health support for women and adolescent girls living with HIV should include counselling on sexuality, sexual and intimate partner relations, self-stigma, self-esteem, body image and depression.

BOTTOM LINE: Intensify efforts and investments to ensure universal access to quality, integrated and affordable sexual and reproductive health services, including for HIV prevention, testing and treatment, for all women and adolescent girls who need and want them, with special attention to providing holistic and dignified care to those living with and at risk of HIV. Transform health systems to be gender-responsive and monitor them for compliance with human rights standards. Support and guide health-care workers to deliver on the Beijing promises.

More choice and medical innovations for women

THE BEIJING PROMISE: Develop “safe, affordable, effective and easily accessible female controlled methods, including such methods as microbicides and female condoms that protect against sexually transmitted infections and HIV/AIDS.”

Beijing+5, para. 103 (b)

Biomedical innovations have been invaluable for averting illness and death and for improving quality of life. New methods are on the horizon that can significantly improve the landscape of HIV tools tailored for women and expand their options and choice.

Women have been demanding better access to both a full range of contraceptives and to more HIV prevention options that they can control and that work for them in their different realities and phases of life. For too many women and adolescent girls, access to the current options are limited by provider and health system biases, and by a lack of information. Gender-related social and economic barriers that women face also are underlying determinants of their access to available medical tools and their use of them. For example, as PrEP rolls out in sub-Saharan Africa as an additional prevention option for young women at higher risk of HIV infection (71), practical, social and gender-related considerations must be taken into account to facilitate its use (72). This includes ensuring that it is made available in youth-friendly ways, with screening and support for gender-based violence and mental health issues (72), and enabling support from peers, parents and family members (73).

Investments in the search for HIV prevention options for women hold promising potential. For example, the monthly Dapivirine microbicide vaginal ring, which is pending regulatory approval, would provide a long-acting HIV prevention tool (74). Promising and innovative HIV prevention technologies under development also include implants the size of a matchstick (75) and other microbicide intravaginal rings that would protect against HIV, unintended pregnancy and/or STIs (76, 77). Such methods would offer women discretion, convenience and more solutions for their health care.

BOTTOM LINE: Expand options and choice for women and girls to prevent unwanted pregnancy, HIV, STIs and other sexual and reproductive problems, including through biomedical research on women-controlled methods that involves them throughout the process. Pay particular attention to young women and women from key populations.

Universal health coverage

Universal health coverage involves a push for equitable access to quality health care (78). It needs to entail a wide range of improvements, including removing gender-specific barriers, eliminating stigma and discrimination, developing tailored strategies for adolescents, and engaging diverse communities of women in decision-making and monitoring access to their entitlements.

It is important that HIV and women’s sexual and reproductive health and rights issues are not neglected as countries roll out universal health coverage. Currently, provisions for HIV, STIs and other sexual and reproductive health issues vary widely in universal health coverage plans, some of which envisage coverage of only a few components or are vague about service coverage, as found in a study of six sub-Saharan African countries (79). Adolescent health needs, comprehensive sexuality education, the prevention and management of gender-based violence, and the health rights and needs of key populations also need to feature prominently in the universal health coverage plans and funding decisions of countries (80).

Universal health coverage plans must also guarantee that all people living with HIV have access to lifelong treatment and care, and that they incorporate support to sustain community services led by women and people living with HIV. Furthermore, since policies are not always implemented as planned, national accountability mechanisms will need to be strong and inclusive of women’s organizations and civil society in order to ensure that both public and private providers meet their obligations.

MAKE THE HIV RESPONSE WORK FOR ADOLESCENT GIRLS AND YOUNG WOMEN

THE BEIJING PROMISE: Develop “educational programmes for girls and boys and the creation of integrated services . . . taking into account the importance of such education and services to personal development and self-esteem, as well as the urgent need to avoid unwanted pregnancy, the spread of sexually transmitted diseases, especially HIV/AIDS, and such phenomena as sexual violence and abuse.”

Beijing Platform for Action, para. 83(l)

In recent years, there has been progress in understanding and applying effective approaches to prevent HIV among adolescent girls and young women (81). Those approaches need to be taken to scale, with tailored strategies for diverse groups and the active participation of young women in shaping, innovating and implementing them.

Among the 28 countries that have joined the Global HIV Prevention Coalition, for example, only one third of the administrative areas with very high HIV incidence had dedicated comprehensive HIV prevention programmes for adolescent girls and young women in 2018. This is well short of the global target to reach 90% of adolescent girls, women and their partners who are at higher risk of HIV in high-incidence settings with effective prevention services by 2020 (82).

Countries that do invest in scaling up effective programmes show impressive results. In Lesotho, for example, where a comprehensive package of services is being provided in all 10 districts, new HIV infections among adolescent girls and young women were reduced by 41% between 2010 and 2018 (82).

Successfully preventing HIV and other health threats among adolescent girls and young women requires approaches that are comprehensive—and that go beyond health services. Among them is building gender-equitable relationships and social norms to engage men and boys in shared responsibilities and to shift the onus currently placed upon young women to prevent pregnancy and use PrEP. Multifaceted social and economic strategies are also very much needed to reduce their vulnerabilities. For example, young women in studies in South Africa who have been involved in transactional sex—often with older men and often in the context of limited educational

and livelihood opportunities—had roughly two to three times the risk of living with HIV than other young women (83). Rather than being narrowly focused on single health issues or interventions, strategies should encompass the broader needs and concerns that shape young women’s lives, beginning with their rights to information and education.

Ensure all girls and boys can complete school, and close gender gaps in education

THE BEIJING PROMISE: “[A]dvance the goal of equal access to education by taking measures to eliminate discrimination in education at all levels on the basis of gender, race, language, religion, national origin, age or disability, or any other form of discrimination and, as appropriate, consider establishing procedures to address grievances; . . . close the gender gap in primary and secondary school education by the year 2005.”

Beijing Platform for Action, para. 80 (a, b)

Access to education is essential for people’s well-being and personal development. Closing gender gaps in education and enabling all children to complete a quality education has many benefits, including improving health outcomes, advancing gender equality and reducing poverty (84, 85). Education for girls, especially secondary education, also has a protective effect against HIV (86–88).

Despite this, an estimated 258 million children, adolescents and youth were not in school in 2018, representing one sixth of the global population of this age group. Poverty, political conflict and humanitarian crises are key factors that keep children out of school (89). In sub-Saharan Africa, 38% of girls and 35% of boys of secondary school age were out of school in 2018 (90). Overall, nearly one in three adolescent girls (aged 10 to 19 years) from the poorest households around the world has never been to school (91).

BOTTOM LINE: Fulfill the Beijing commitments to: ensure universal access to quality education for all girls and boys, at least through secondary education; close the remaining gender gaps at all levels of education; and eliminate all forms of gender stereotyping, discrimination and violence in educational systems. This is paramount for their health, well-being and empowerment—and for an effective HIV response.

Get real about comprehensive sexuality education

THE BEIJING PROMISE: “Recognize the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS”; and “disseminate accessible information, through public health campaigns, the media, reliable counselling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction.”

Beijing Platform for Action, para. 107 (e, g)

Universal access to quality comprehensive sexuality education is crucial, especially for young people. It enables young people to make informed decisions and be empowered as they explore their sexuality and relationships. It helps them acquire the skills and values of mutual respect, tolerance, gender equality and non-violence, and it equips them with the knowledge they need to protect their health and well-being more effectively (92).

Research indicates that sexuality education and HIV prevention programmes that address gender inequality and power dynamics in relationships are five times more effective at preventing STIs and unplanned pregnancies than programmes that ignore those issues (93). When tailored to the diverse needs of young people, comprehensive sexuality education can also promote more inclusive attitudes and behaviours (92). In many countries, however, sexuality education is still inadequate and fails to support young people to make healthy, informed choices about sexuality and relationships.

Although most countries report that they have education policies that provide life skills-based HIV and sexuality education in secondary schools (87 out of 103 reporting countries in 2019), knowledge of HIV prevention among young people is alarmingly low. Surveys in low- and middle-income countries with data for 2013 to 2018 show that fewer than one in three young people had accurate knowledge about HIV transmission and prevention (Figure 11). In those countries, only 23% of young women and 29% of young men demonstrated comprehensive and correct knowledge of HIV (41). In sub-Saharan Africa, seven in ten young women did not have comprehensive

knowledge about HIV. These knowledge gaps extend to other aspects of sexual and reproductive health, including STIs, contraception and misconceptions about menstruation (94).

Levels of HIV knowledge vary across countries, depending on the national and local context, and they often are associated with social and economic inequities. In many countries, levels of comprehensive and correct knowledge of HIV among adolescent girls and women are low, but they tend to be lowest among those who live in poverty (Figure 12) and those with lower levels of education. They also are lower among rural women than those in urban areas (41).

Adults in some communities are reluctant to support comprehensive sexuality education because they believe it encourages promiscuity and risk-taking. The evidence indicates that those assumptions are mistaken: quality sexuality education has been shown to delay sexual initiation, improve the use of condoms and contraceptives, and support the prevention of HIV infection (95).

Many parents have not had the benefit of sexuality education themselves, and they may be uncomfortable discussing sex and relationships with their adolescents. Once properly engaged in understanding the importance of such education for their children, however, parents can be very supportive.

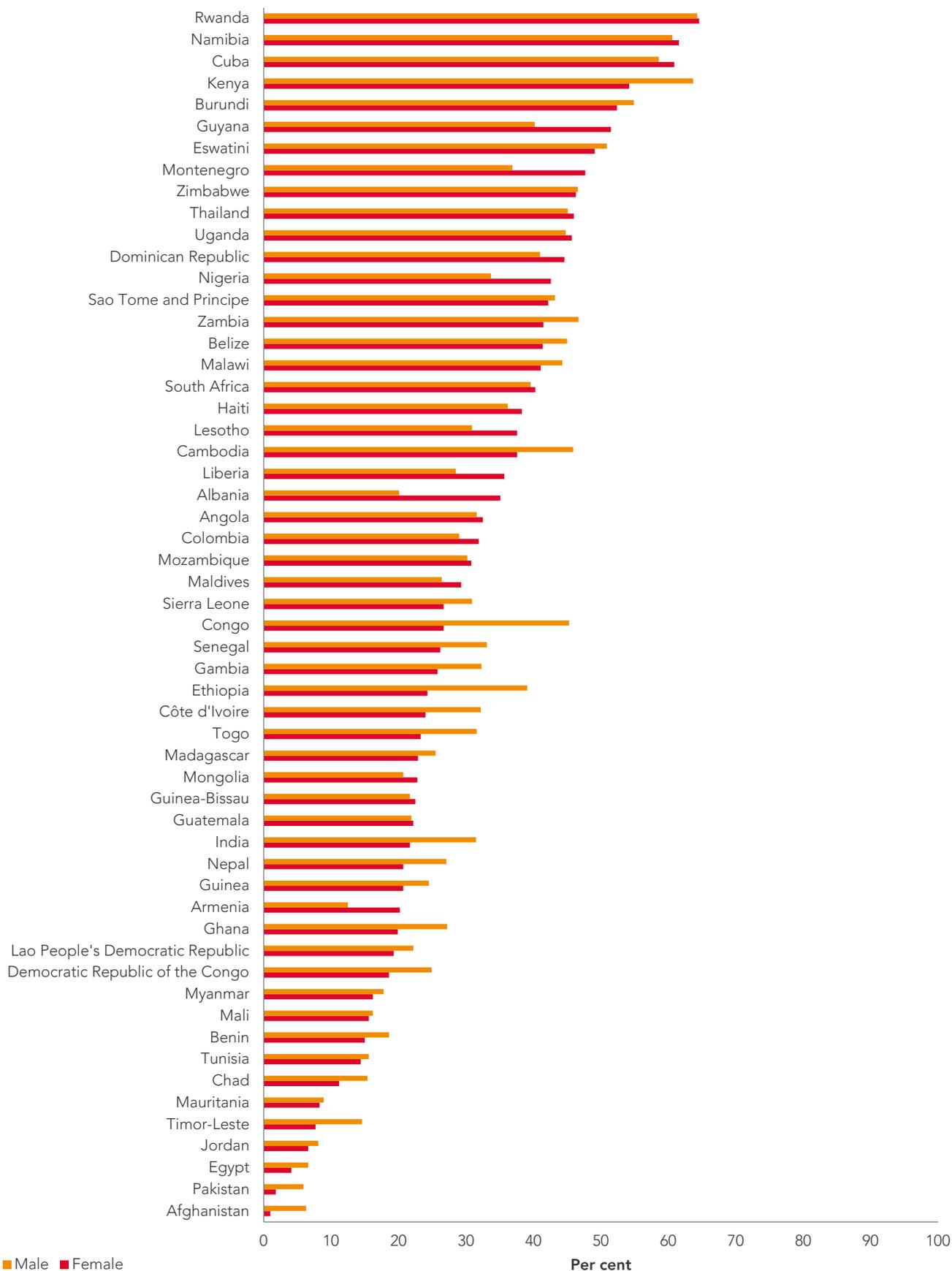
BOTTOM LINE: Make comprehensive sexuality education available to all adolescents and young people, both in and out of school, in accordance with international standards (92). Develop programmes with their direct engagement, incorporate issues of gender, violence and rights (92), and ensure referrals to the range of services and supports they may need—backed by adequate funding. Provide teachers and outreach workers with sustained support and guidance (96, 97). Seize opportunities to expand access to sexuality education in the digital era.

Improve HIV treatment and care for adolescent girls and young women

Adolescent girls and young women who are at high risk of or living with HIV are a missed priority in testing, treatment and care programmes (98). For example, pregnant adolescent girls are less likely than adult women to know their HIV status (99, 100), to access and receive HIV treatment, and to receive timely antenatal care (101). They also face major challenges in disclosing their HIV status to partners and families, and in adhering to HIV treatment (102).

Figure 11 Young people's knowledge of HIV prevention varies across countries, but remains low overall

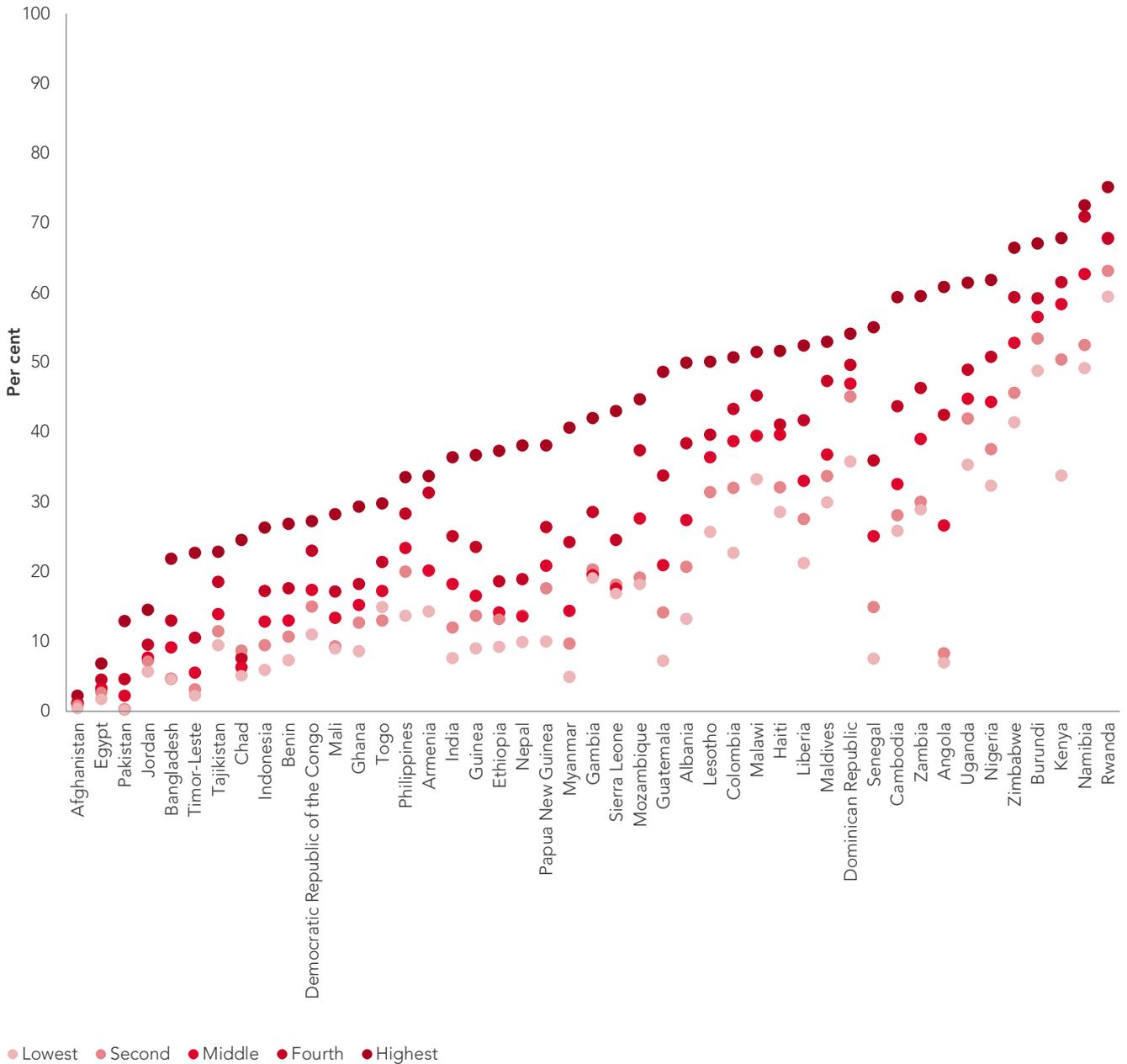
Percentage of young people aged 15 to 24 years with comprehensive correct knowledge of HIV, countries with available data, 2013–2018



Source: Population-based surveys, 2013–2018.

Figure 12 Knowledge of HIV among women tends to be greater among those with higher incomes

Percentage of women aged 15 to 49 years with comprehensive correct knowledge of HIV, by wealth quintile, countries with available data, 2013–2018



Source: Demographic and Health Surveys, 2013–2018.

Those challenges can be especially difficult for young women from key populations, such as sex workers and women who use drugs.

Adolescents born with HIV—or those who acquired it during breastfeeding—require particular attention to ensure they are not left behind. They were missed by HIV services as infants, and some remain unaware of

their HIV status or are not receiving treatment. Although a majority of countries state that they have strategies to transition adolescents born with HIV to adult care, actual adolescent-focused approaches are rare (103), even though evidence shows that adolescents have better treatment results when services are tailored for them and when they receive appropriate support, including from peers and parents (104).

BOTTOM LINE: Make the HIV response work for adolescent girls and young women by training and equipping health-care providers to provide friendly, nonjudgmental HIV-related services, and to respect their rights to information and decision-making. Develop new models of care—including psychosocial and mental health support and counselling about sexuality and gender relations—with peer outreach and support systems that are shaped and led by young women themselves.

Adopt comprehensive, multisectoral approaches that respond to young women's realities

THE BEIJING PROMISE: “Develop gender-sensitive multisectoral programmes and strategies to end social subordination of women and girls and to ensure their social and economic empowerment and equality.”

Beijing Platform for Action, para. 108 (e)

Programmes and interventions that span different sectors and aspects of the lives of young women can have a big impact on their health, well-being and personal development.

Eliminating school fees, for example, has been shown to improve school attendance and completion rates (105). As studies also show, education is associated with reduced HIV infection among young women (106). When Botswana extended mandatory secondary education, for instance, it found that each additional year of schooling after Year 9 was associated with a 12% reduction in girls' risks of acquiring HIV (107).

The impact of more holistic responses can be seen in the PEPFAR DREAMS partnership, which is active across 15 countries, primarily in sub-Saharan Africa, providing prevention interventions that address the multiple causes of vulnerability to HIV among young women.⁷ In 2019, PEPFAR reported a 25% or greater reduction in new HIV cases among adolescent girls and young women in most of the areas where the partnership was being implemented within the 10 original DREAMS countries (108). The economic empowerment of women and girls, such as via cash transfers, has been shown to improve their health, well-being and nutrition status, and it can reduce unsafe transactional sex and lower their chances of

acquiring HIV (83, 108-111). In Eswatini, an intervention linking health, education and economic empowerment interventions for adolescent girls and young women reported both a 25% reduction in their risk of acquiring HIV and fewer teen pregnancies, and it enabled pregnant girls to return to school (111).

BOTTOM LINE: Invest in multisectoral approaches and interventions in areas with high prevalence that address the multifaceted rights and needs of adolescent girls and young women so they are empowered—including to prevent HIV.

END VIOLENCE AGAINST WOMEN AND GIRLS

THE BEIJING PROMISE: Governments would “[c]ondemn violence against women and refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination”; “[e]nact and/or reinforce penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs done to women and girls who are subjected to any form of violence, whether in the home, the workplace, the community or society”; and “[p]rovide women who are subjected to violence with access to the mechanisms of justice.”

Beijing Platform for Action, para. 124 (a, c, h)

Among the 12 critical areas of concern adopted in Beijing, violence against women and girls is one of the most widespread human rights violations in the world. Violence against women is deeply rooted in gender discrimination and is used to exert male control over women.

Numerous government commitments to end violence against women and girls have been made over the years, yet hundreds of millions of women and girls continue to be subjected to abuse and violence, at grievous cost to them and their families, communities and societies.

HIV and violence against women and girls are interlinked in women's lives (112, 113). Intimate partner violence remains very common around the world (Figure 13) and has been found to increase the risks

⁷ Botswana, Côte d'Ivoire, Eswatini, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe. The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) package combines biomedical, behavioural and structural interventions.

of women acquiring HIV by 50% in areas with high HIV prevalence (112). Men who are perpetrators of violence against women tend to be at higher risk of HIV themselves, and they use condoms less frequently, which increases the risk of HIV transmission (114). Abuse during pregnancy makes it less likely that women will seek HIV testing or services to prevent vertical HIV transmission to newborns (115).

Being HIV-positive is a trigger for violence: women living with HIV frequently report experiences of violence or fear of violence, including from intimate partners and family members (36). For many, the violence starts or increases after being diagnosed with HIV (116). Women living with HIV are especially susceptible to institutional violence, mistreatment and reproductive rights violations in health-care settings, including forced sterilization and forced abortion (117).

Violence and the fear of violence block access to HIV services, making it especially challenging for women to decide whether they will have sex (and with whom), or to negotiate safer sex (36, 118). Violence (or the potential for it) also discourages many women living with HIV from disclosing their HIV status to partners, families and health providers, and it makes it more difficult for women and girls to stay on HIV treatment (37, 119).

Women belonging to key populations, such as sex workers, are especially vulnerable to violence (Figure 14). According to one estimate, 45–75% of adult female sex workers are assaulted or abused at least once in their lifetime (120). Repressive policing practices increase the risk of physical or sexual violence among sex workers threefold and increase their risk of contracting HIV or other STIs twofold (121). Women who inject drugs also report high rates of sexual violence, including at the hands of law enforcement officials (122, 123).

Gender-based violence is also targeted at people on the basis of their sexual orientation, gender identity or expression. For example, transgender people are at substantial risk of violence across the world. In a study in eight sub-Saharan African countries, 33% of transgender women said they had been physically attacked at some point, 28% had been raped and 27% said they were too afraid to use health-care services (124).

Women belonging to other marginalized communities are also highly vulnerable, including women belonging to ethnic and other minorities (Box 3) (85). For example,

an estimated 14 million refugees and displaced women and girls were targets of sexual violence in 2019 (125). Women and girls living with disabilities and mental health conditions are especially susceptible to physical and sexual violence and other forms of abuse, including by caretakers and in their communities (126, 127). Violence against women itself is a cause of mental health problems (128, 129).

Violence against women and girls has received greater policy attention in recent decades. For instance, 86 of 100 reporting countries stated in 2019 that they had a national strategy that addresses gender-based violence and includes HIV dimensions. In practice, though, violence against women and girls remains a blind spot in the HIV response.

BOTTOM LINE: Take intensified action to prevent and respond to violence against women and girls, building on the body of evidence of what works (85, 113). Make full use of all entry points and opportunities in HIV programmes to contribute to these efforts, including by integrating supports for survivors in HIV-related services and paying particular attention to women and girls at risk of or living with HIV, including those from key populations. Invest in national implementation scale-up and community-level good practices that shift underlying gender norms and unequal power dynamics, including programmes that are led by women, and strengthen complaint and redress mechanisms for rights violations.⁸

Ending violence against adolescent girls

THE BEIJING PROMISE: “Due to such factors as their youth, social pressures, lack of protective laws, or failure to enforce laws, girls are more vulnerable to all kinds of violence.” Governments and partners would “organize and fund . . . educational and training programmes in order to sensitize girls and boys and women and men to the personal and social detrimental effects of violence in the family, community and society”; and “teach them how to communicate without violence”.

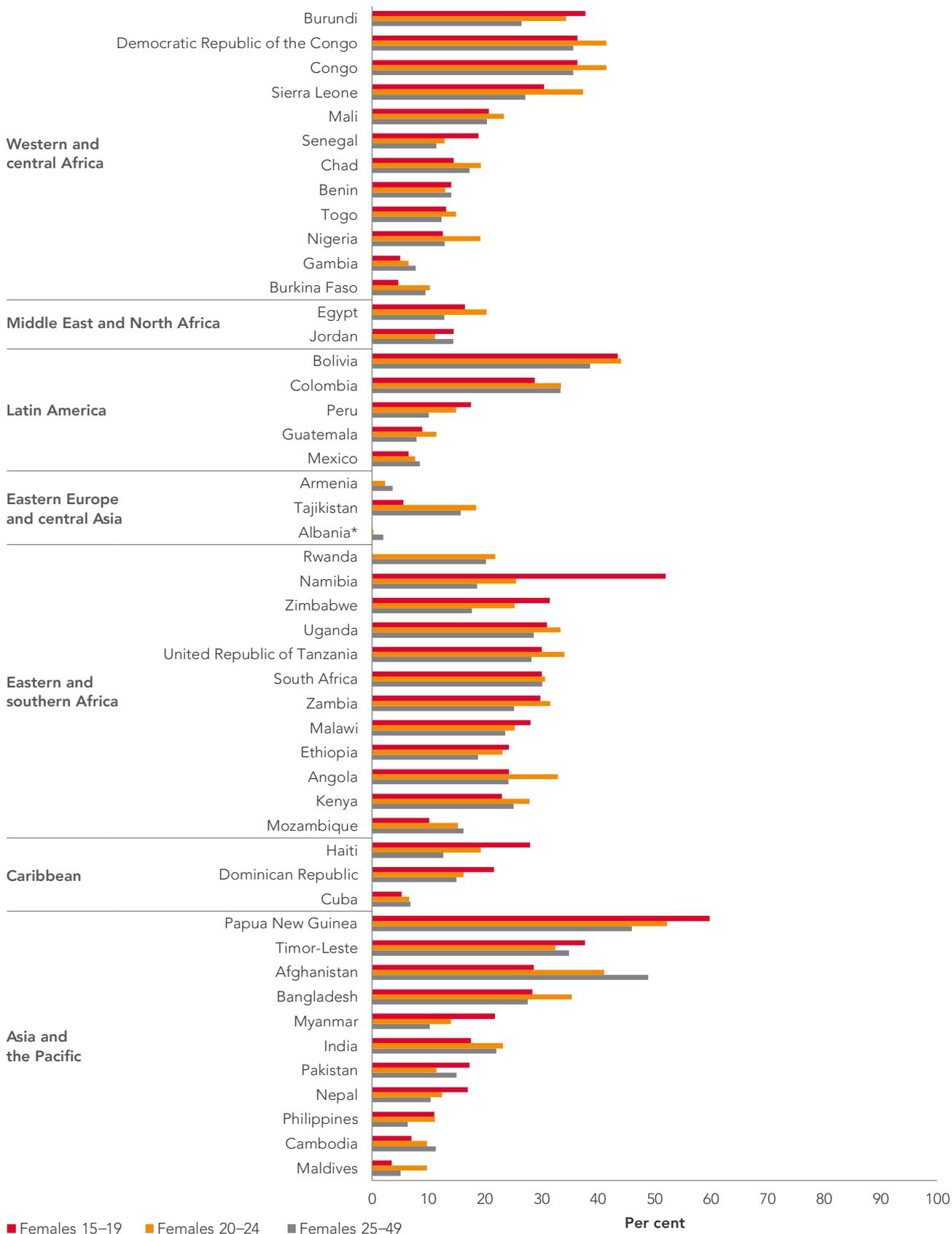
Beijing Platform for Action, paras. 125 (g) and 269

Adolescent girls experience very high rates of gender-based and sexual violence in many countries around the world. In about half of all countries with age-disaggregated data available, a greater percentage of

⁸ See the *Social norms change at scale* series, including CUSP’s *collective insights* and the accompanying *Insights from SASA!*, *Insights from IMAGE*, *Insights from GREAT* and *Insights from Stepping Stones*.

Figure 13 Intimate partner violence against women and adolescent girls is widespread

Percentage of women and girls (aged 15 to 49 years) who experienced physical and/or sexual violence by an intimate partner in the past 12 months, by age, countries with available data, 2013–2018

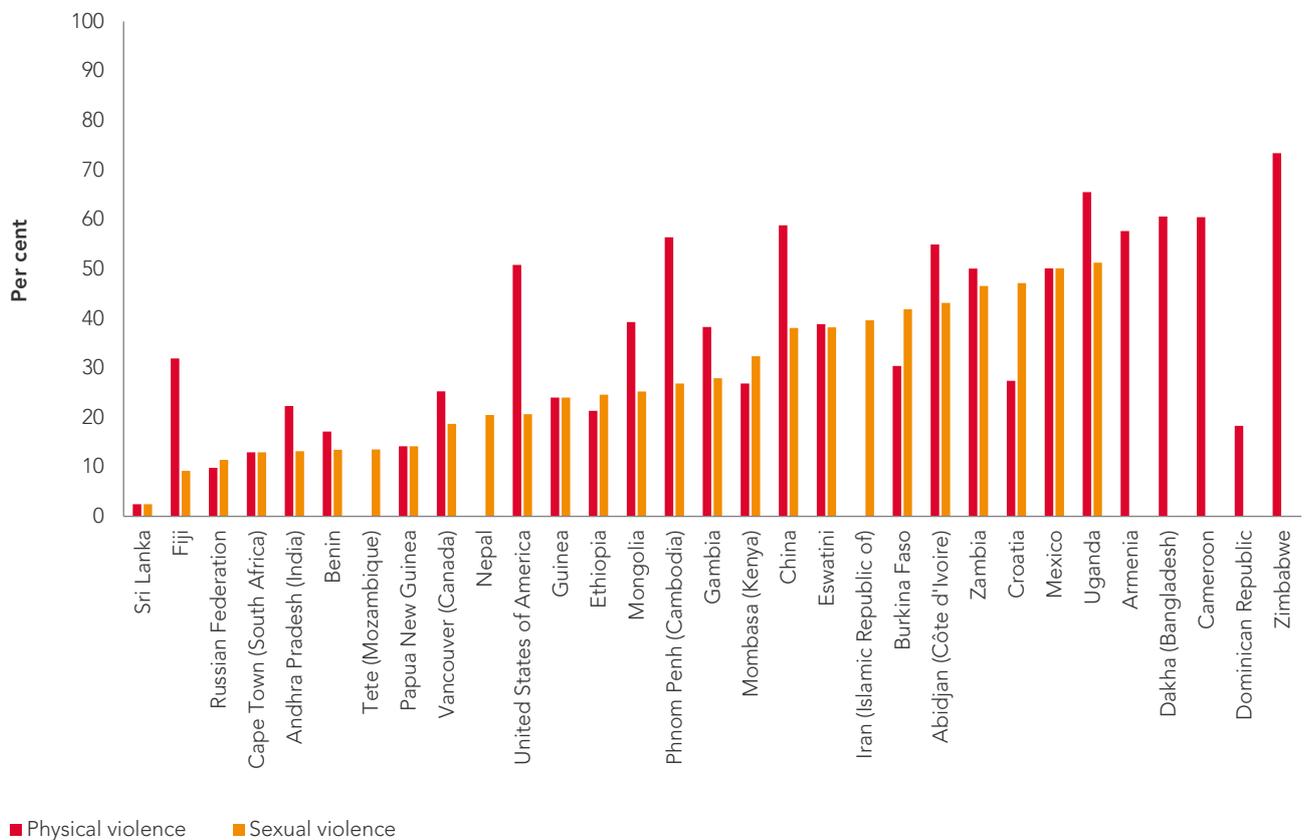


* Data for Albania refer to the percentage of married women who had experienced physical violence often or sometimes by their husband in the past 12 months.

Source: Population-based surveys, 2013–2018.

Figure 14 Violence against female sex workers is common

Percentage of female sex workers experiencing physical and sexual violence, selected countries, 2014–2018



Source: Literature review by UNAIDS and the Key Populations Program of the Center for Public Health and Human Rights, Johns Hopkins University. For a full list of sources, please see references in Annex.

adolescent girls (aged 15 to 19 years) had experienced intimate partner violence in the past 12 months compared to adult women overall (41).

Their experiences of violence start early in life. For example, one in four women aged 18 to 24 years reported having experienced sexual violence during childhood in Rwanda (24%) and Nigeria (25%), while one in three women reported having experienced sexual violence during childhood in Uganda (35%). Many of them also reported that their first sexual experience was unwanted or forced (131–133). Overall, many young women have experienced sexual violence and abuse during childhood, but few report sexual abuse to the authorities and support services are scarce in most countries (131–134).

Sexual violence in childhood and adolescence can do lifelong harm. For instance, girl survivors of abuse are more likely to be abused again and to engage in sexual and other risk-taking, while boys who were

abused or who witnessed violence are more likely to become perpetrators themselves (85, 135, 136). Violence against girls and boys can lead to depression and suicidal thoughts, and it can increase their risk of acquiring HIV (137).

Girls and boys also face violence in schools, but girls are more likely to be targets of sexual and gender-based violence, including from school staff and peers (137, 138). Children and adolescents who are perceived to be gender-diverse are especially at risk of sexual violence and bullying (139, 140).

The current implementation of interventions is not effective enough: a recent study found that less than half of gender-based violence interventions for young people living with HIV or affected by the epidemic in low- and middle-income countries actually reduced gender-based violence (141). In southern Africa, similar findings show that interventions addressing HIV and gender-based violence are failing to achieve

Box 3 New insights: violence against women living with HIV in Latin America

A new landmark study is casting light on the violence experienced by women living with HIV in Latin America. It was carried out in 2019 in seven countries (Colombia, the Dominican Republic, Guatemala, Honduras, Paraguay, Peru and the Plurinational State of Bolivia) and included indigenous, Afro-descendant and other groups of marginalized women.

- **Levels of violence by intimate partners are high.** More than one in three women reported experiencing emotional violence in the previous year, and 75% of the women reported that their partners exhibited controlling behaviours, including controlling their money (30%). The risk of violence tended to be highest for indigenous women and young women. In the Plurinational State of Bolivia, 73% of women reported physical and/or sexual violence at the hands of an intimate partner in their lifetime.
- **Violence during childhood and forced first sexual experiences are common.** Between 26% (Honduras) and 59% (Plurinational State of Bolivia) of women reported having been sexually abused before their 15th birthday.
- **Violence or coercion occurs frequently in health-care settings.** More than 20% of women said they had felt coerced to undergo sterilization and/or an abortion, and 48% said they had been denied cervical cancer or breast cancer services due to their HIV status.
- **Institutional violence.** An average of 13% of women were forced to move or were unable to rent housing because of their HIV status, and between 4% (Guatemala and Honduras) and 18% (Plurinational State of Bolivia) of women said they had lost their jobs or other income sources for the same reason.
- **Health and well-being.** One in four women reported having suicidal thoughts in the previous month. Among women who had been pregnant and had been assaulted during pregnancy, up to 28% (Plurinational State of Bolivia) had undergone a miscarriage as a result of the violence.
- **Women's coping strategies.** Most women survivors of violence have never gone to formal services or people in positions of authority for help. Only 15% sought help from the police, 9% from the prosecutor's office, 5% from child protection agencies and 5% from health services. Less than half of survivors said that a health-care provider had ever asked them about their experiences of violence (130).

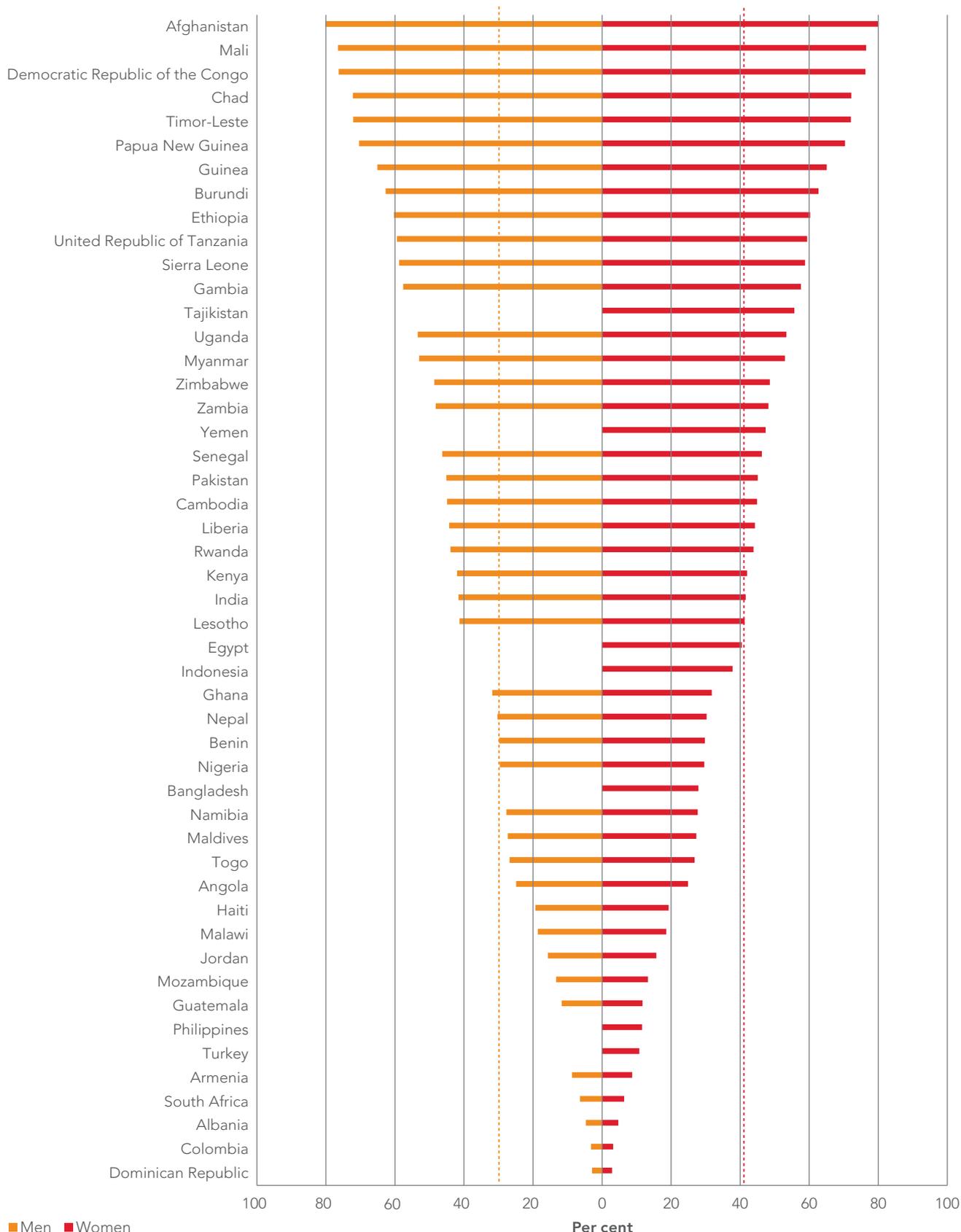
comparable results for young women as they have for adult women (142). Attitudes about gender-based violence also need to change: surveys indicate that many young women and men still justify violence against women by intimate partners (Figure 15).

Political and community leaders, educational systems, service providers and parents all have major obligations to protect children and adolescents from violence. A basic step is to provide quality comprehensive sexuality education that promotes zero tolerance for gender-based violence and equips students with skills around gender relations, safe dating, sexual consent and protecting their peers (143).

BOTTOM LINE: Take urgent action to prevent violence against children and adolescents and to support survivors of violence, drawing on the knowledge of what works (134, 138, 140, 143–145). Start prevention efforts early to enable girls and boys to question and challenge prevailing gender norms that justify violence against women. Engage adolescent girls and boys directly in the search for effective interventions, and ensure those approaches take account of the broader gender, social and economic dynamics that shape their lives (143–145).

Figure 15 Many young women and men justify violence against women

Percentage of young women and men aged 15 to 24 years who agree that a husband is justified in hitting or beating his wife for at least one specific reason, countries with available data, 2013–2018



Source: Demographic and Health Surveys, 2013–2018.

Note: The dotted lines represent the median values across all countries with available data. Reasons included as justifications for a husband hitting or beating his wife are burns food, argues with her husband, goes out without telling her husband, neglects the children and refuses to have sex with her husband.

Transform gender norms and harmful masculinities

THE BEIJING PROMISE: “Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.” Programmes should “enable men to assume their responsibilities to prevent HIV/AIDS” and “educate men regarding the importance of women’s health and well-being, placing special focus on . . . the elimination of harmful attitudes and practices, including violence against women, sexual exploitation [and] sexual abuse.”

Beijing Platform for Action, paras. 96, 107 (a) and 108 (e)

Involving men and boys in HIV prevention and sexual and reproductive health matters has gained increasing attention over the past decades. However, a recent global systematic review of sexual and reproductive health interventions involving men and boys found that only 8% of them included components to transform gender relations and unequal power dynamics (145), with most of the latter activities focused on HIV and addressing violence against women.

Harmful gender norms have to be tackled early; they are instilled in childhood and subsequently reinforced (146). According to one recent study across different cultures, boys aged 10 to 14 years are already more likely to endorse harmful gender norms than their girl peers (147).

Harmful masculinities undermine the health and well-being of both men and women (148). Social norms that associate so-called manhood with being tough, aggressive and controlling contribute to risk-taking behaviours such as alcohol and drug abuse and multiple sexual partners. They keep men from seeking HIV and other health services, which further increases both women’s and men’s risks of acquiring HIV (149, 150). Efforts are needed to facilitate better access to services for men and to improve their own health-seeking behaviours, which in turn can reduce risks of HIV transmission to women and girls.

To achieve gender-equitable attitudes and behaviours, men and boys have to be engaged to respect women’s sexual and reproductive health and rights and decision-making, to be agents of change for gender equality, and to refrain from and oppose gender-based violence.

For example, as Programme H in Brazil and India has shown, well-designed interventions that promote changes in social norms do bring results (151). In Kampala, Uganda, a five-year community mobilization activity worked with community members, leaders and institutions to question imbalances in power between men and women. The interventions helped change attitudes and behaviours, with cases of intimate partner violence decreasing by nearly 50% (152).

BOTTOM LINE: Revisit policies and programmes involving men and boys to leverage missed opportunities for undoing harmful masculinities, advancing respect for women’s rights and adopting gender-transformative approaches. Meet men and boys for HIV-related outreach and services in spaces where they gather and are comfortable. Apply a gender lens that responds to masculine perspectives to reach them more effectively with the care and supports they need.



PATHS TO GENDER EQUALITY AND EQUITY

The HIV response must protect the human rights of women and adolescent girls in all their diversity. It should promote their empowerment and advance gender equality and equity for all. Unless the underlying social norms and inequalities that fuel the HIV epidemic among women and adolescent girls are confronted, we will not succeed in ending the AIDS epidemic by the 2030 deadline for achieving the Sustainable Development Goals (SDGs).

The commitments set in Beijing 25 years ago remain as crucial as ever and serve as signposts for the paths towards transformation. Decades of hard work and creative efforts point to effective approaches and interventions. Those efforts must be scaled up, with political will and funding from national governments and donors—and with the leadership and expertise of women.

1. The next generation of the HIV response must make gender equality and the empowerment of women and girls a core priority.

Gender-transformative interventions reduce gender inequities and shift power dynamics. Grounded in feminist principles, these actions and investments are meant to confront and transform the values, practices and institutions that perpetuate gender stereotypes, discrimination and violence against women and girls. HIV policies and programmes should build on approaches that have been proven to foster gender equality.

2. Laws and policies must pave the way for gender equality and equity.

Legal reforms are needed to uphold the equal rights of all women and girls and remove any legislative basis for discrimination against them by fulfilling the unkept promises of the Beijing Declaration and Platform for Action. They must include measures to end the stigma and discrimination, violence and criminalization that

are directed at women and girls. Women must have recourse to justice when their rights are violated, and accountability mechanisms must be strengthened so that laws are enforced and policies are implemented. Renewed attention should be paid to legal and rights literacy and awareness-raising, with special attention to women and girls most affected by social exclusion and injustice.

3. Greater investments in the education and economic empowerment of women and girls are needed to end the HIV epidemic.

In line with the Beijing commitments, multisectoral strategies for the social and economic empowerment of women and girls should be implemented. Women and girls must have control over the decisions that affect their health, bodies and lives—and access to quality HIV prevention, testing and treatment services that work for them—if the world is to end the AIDS epidemic. Education, at least to the end of secondary school, is imperative.

All barriers to the education of girls should be removed, including user fees and discriminatory policies and practices. Education systems must provide inclusive environments, with special attention given to pregnant girls, young mothers, girls living with HIV or disabilities, and children who are gender-diverse. Also vital is comprehensive, quality sexuality education for all young people, in school and out of school, in order to build knowledge, promote equitable gender norms, and foster respect for equal rights and shared responsibilities.

The economic autonomy of women is crucial in its own right and an important component of the HIV response. Gender inequalities persist in the world of work and are underpinned by the burdens of unpaid care and domestic work that are overwhelmingly shouldered by women and girls. Laws and policies that improve access to educational and economic opportunities for

women and girls are associated with improved health outcomes (153). Increased investments are needed to realize the economic rights of women and to improve their livelihoods, especially for those living in poverty and experiencing stigmatization and marginalization.

4. Gender-responsive policies and greater investment for gender equality should be the norm.

Beijing promised “to create and improve gender-sensitive policies and programmes on HIV/AIDS” and called for “political commitment to make available human and financial resources for the empowerment of women” (154). In 2019, 57 of the 97 countries with a national strategy or policy guiding their AIDS responses reported that the policy included interventions for achieving greater gender equality. Only 37 countries had a dedicated budget for those activities.

In terms of international donor support, overseas development assistance for gender equality peaked in 2016–2017, with bilateral donors contributing an average of US\$ 44.8 billion per year. However, only 4% of that support went to programmes where gender equality was the main objective, and 62% of the aid was “gender blind” (155).⁹ Investments in gender equality, women’s organizations and feminist movements need to increase. In particular, there is a major lack of funding for feminist organizations: by one estimate, 99% of global investment in interventions addressing gender equality is not reaching feminist and women’s rights organizations (156). Furthermore, increased funding should be accompanied by more effective use of existing resources, ensuring gender-transformative approaches are integrated into policies and programmes.

5. Meaningful participation of women and girls in decision-making is a must.

Beijing promised to “[e]nsure the involvement of women, especially those infected with HIV/AIDS . . . or affected by the HIV/AIDS pandemic, in all decision-making relating to the development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS” (154). The leadership and engagement of women in their full diversity is crucial at all levels of the HIV response. Many countries have increasingly involved women and young people in developing HIV policies, guidelines or strategies, but it is not clear to what extent their perspectives are actually taken into

account when decisions are made (157). As well, data reported to UNAIDS show that not all countries are respecting the right of the most-affected communities to participate in national decision-making about HIV.

6. Support for leadership in the HIV response by women and young people needs to increase.

In the Beijing Declaration and Platform for Action, countries pledged to “facilitate the development of community strategies that will protect women of all ages from HIV . . . and mobilize all parts of the community in response to the HIV/AIDS pandemic to exert pressure on all responsible authorities to respond in a timely, effective, sustainable and gender-sensitive manner” (154). This is very difficult when women- and youth-led organizations operate in hostile environments, receive unpredictable and often scant funding, and rely on overburdened staff.

Political, institutional and financial support is needed to boost the impact of those organizations and popularize and sustain the solutions they are spearheading. Emphasis should be placed on support for feminist-informed approaches to achieve gender equality and equity in the context of the HIV response. Investing in and meaningfully involving women- and youth-led organizations and movements will open new paths for ending the AIDS epidemic and building more equitable societies.

For decades, women’s organizations have been at the forefront of the HIV response, mobilizing communities to demand accountability, social justice for people living with HIV, and an inclusive, rights-based agenda. Their work and creativity have been vital to the progress made against the epidemic and for upholding the rights of women and girls. These organizations, and the communities they serve, must remain at the heart of the HIV response. If that happens and the Beijing Declaration and Platform for Action commitments are realized, a world in which younger generations can lead lives free of HIV and are fully enabled to thrive will be within reach.

⁹ The OECD Development Assistance Committee is an international forum of the largest providers of aid. In their reporting to the Development Assistance Committee Creditor Reporting System, donors are requested to indicate for each activity whether or not it has gender equality as one of its policy objectives. To qualify as “gender equality focussed,” an activity must explicitly promote gender equality and women’s empowerment (see <https://www.oecd.org/dac/stats/aidinsupportofgenderequalityandwomens empowerment.htm>).

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ANNEX

Figure 7. Percentage of reporting countries with criminalizing laws and coercive policies related to HIV transmission or disclosure, mandatory HIV testing, sex work, drug use and gender identity, 2019

Laws criminalizing the transmission of, non-disclosure of or exposure to HIV

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Criminalization of sex work

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Drug possession for personal use is an offence

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Mandatory HIV testing

1. UNAIDS National Commitments and Policy Instrument, 2019.

Criminalization of transgender people

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Figure 8. Percentage of reporting countries with laws requiring parental or guardian consent for adolescents to access contraceptives, HIV testing, HIV treatment, emergency contraception and harm reduction, by region, 2017–2019

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Figure 14. Percentage of female sex workers experiencing physical and sexual violence, selected countries, 2014–2018

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