United Nations Entity for Gender Equality and the Empowerment of Women

Background Note: Briefing to the Executive Board, First Regular Session 2025

"Briefing on UN-Women's follow-up to recommendations of the UNAIDS[1] Programme Coordinating Board"

Background and context on gender equality and HIV/AIDS

The *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030* (resolution 75/284) in 2021 committed Member States to putting gender equality and the human rights of all women and girls in diverse situations and conditions at the forefront of efforts to mitigate the risk and impact of HIV. The declaration reinforced the priorities identified in the *2030 Agenda for Sustainable Development* (resolution 70/1), which includes a target for ending the epidemic of AIDS by 2030 and a Goal on achieving gender equality and women's empowerment. With only five years remaining to reach these goals, and confronted by humanitarian emergencies, global pandemics, and push-back on women's rights across the globe, it is crucial to reinforce the focus on the impact of HIV on women and girls in diverse contexts, including women and girls in key populations.[2] The 30th anniversary of the Beijing Platform for Action in 2025 presents a timely opportunity to review trends in new HIV infections and HIV treatment among women and girls, and to accelerate progress by scaling up evidence-based interventions to address unequal gender norms and by empowering all women and girls living with and affected by HIV.

New infections among women and girls are declining in sub-Saharan Africa, but increasing in Eastern Europe and central Asia and the Middle East and North Africa

In 2023, 580,000 women and girls (all ages) acquired HIV, constituting 45% of the total number of new infections globally.[3] While this is a 47% decrease in incidence compared to 2010, many more of these new infections could have been prevented by advancing gender equality and women's empowerment, a shift that could have also have helped accelerate progress among men. Due to unequal gender norms, many women struggle to delay sexual debut and negotiate safer sex, and may experience intimate partner violence, factors which increase the risk of HIV.[4] Access to prevention methods is limited; national guidelines provide pre-exposure prophylaxis (PrEP) to pregnant and breastfeeding women in only 34 countries reporting and to young women (ages 18–24) in 33 countries.[5]

In terms of the sheer size of the epidemic, women in sub-Saharan Africa bear the highest burden of new HIV infections. Two-thirds (69%) of women who acquired HIV in 2023 were living in sub-Saharan Africa. While the region has experienced a 53% decline in new HIV infections among women since 2010, in 2023 there were still 400,000 new infections among women and girls (all ages), comprising 62% of all new infections in the region.[6]

In terms of mounting risk of HIV infection for women and girls, between 2010 and 2023, HIV incidence among women increased by 80% in the Middle East and North Africa, and by 13% in Eastern Europe and central Asia, mirroring trends

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[1] The Joint UN Programme on HIV/AIDS (UNAIDS).
[2] UNAIDS terminology guidelines define key populations as including gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and people in prisons and other closed settings. These groups are particularly vulnerable to HIV. https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf
[3] UNAIDS AIDSInfo estimates 2024.
[4] UN-Women. "What we do: HIV/AIDS" (website). Available from https://www.unwomen.org/en/what-we-do/hiv-and-aids. Accessed 28 October 2024.
[5] UNAIDS, WHO. "Laws and Policies Analytics: Populations to which PrEP is provided under national guidelines" (website). Accessed 25 November 2024. Available from at https://lawsandpolicies.unaids.org/
[6] 62% in eastern and southern Africa, 63% in western and central Africa

among men.[7] In these regions, the majority of new infections are among women and men in key populations and their partners.[8]

Interventions to support HIV prevention for women and girls include comprehensive sexuality education and integrated HIV and sexual and reproductive health services to increase awareness and encourage behaviour change; prevention methods such as condoms and pre-exposure prophylaxis (PrEP); and programmes to change harmful gender norms and empower women so they can act on the information and access HIV prevention methods. While interventions to change gender norms are known, they are not being implemented at scale. In particular, gender norms must be considered as part of policy interventions to avoid inadvertently reinforcing gender inequality.[9] A number of new HIV prevention options have demonstrated promising results in curbing new HIV infections. The dapivirine vaginal ring and, most recently, a long-acting injectable – lenacapavir – have the potential to expand women's options for biomedical prevention, but PrEP continues to be out of reach for many women, particularly outside sub-Saharan Africa.[10] Increased access to PrEP is also needed in sub-Saharan Africa to reduce high levels of HIV infections among adolescent girls and young women and vertical transmission of HIV to infants. In eastern and southern Africa, which accounted for 45% of new infections among children, 32% of new infections were due to mothers being unable to avoid acquiring HIV during pregnancy or breastfeeding. Expanded HIV screening for pregnant and breastfeeding women and their partners, partner testing and self-testing, improved follow-up in the postpartum period, and access to PrEP is needed.[11]

New infections disproportionately high among adolescent girls in most regions

Adult women (15-49 years) made up 44% of new HIV infections in 2023, and women aged 50 and older made up 42%. Startlingly, adolescent girls (10-19 years) made up almost 70% of new infections in their age group globally.[12] In sub-Saharan Africa, 78,000 adolescent girls aged 10-19 years acquired HIV in 2023, constituting 84% of the new infections in their age group. HIV prevention initiatives are insufficient: more than half of the areas with high or moderately high HIV incidence in sub-Saharan Africa are not being served by prevention programmes tailored for adolescent girls and young women.[13]

Distressingly, infection rates among adolescent girls are also disproportionately high in regions where the majority of new cases are among key populations and their sexual partners. In 2023, adolescent girls aged 10-19 years made up 77% of new cases among 10–19-year-olds in eastern Europe and central Asia and 58% in Middle East and North Africa.[14] Strategies to reach adolescent girls and young women outside sub-Saharan Africa seem to be overlooked, both in key populations and their partners and in the remaining population.

Women in key populations are at high risk of HIV infection but remain invisible

In 2022, an estimated 55% of adult (15–49 years) new HIV infections were among women and men in key populations and their sexual partners. Of the 600,000 new infections among key populations and their sexual partners, 84,000 (14%) were among female sex workers and 12,000 (2%) among transgender women.[15] In addition, 89,000 (15%) new HIV

[7] UNAIDS AIDSInfo estimates 2024.
[8] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[9] Munoz AM, et al. (2023) Addressing social and gender norms to promote gender equality. World Bank Group Gender Thematic Policy Notes Series: Evidence and Practice Note. Washington DC: World Bank.
[10] Cairns G (2023) "PrEP and women: A research briefing" (website). Available from https://www.aidsmap.com/about-hiv/prep-and-women. Accessed 28 October 2024.
[11] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[12] UNAIDS AIDSInfo estimates 2024.
[13] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[14] In Asia and the Pacific, as well as Latin America, about 30% of new infections among 10-19-year-olds were girls.
[15] 99% of available data is for transgender women, so the estimates refer to transgender women only.

infections were among nonclient partners of key populations, and 87,000 (14%) among people who inject drugs.[16,17] For these last two groups, data is not disaggregated by sex, so the number of new infections specifically among women in these key populations is unavailable.

While men are more likely than women to inject drugs, women who inject drugs are 1.2 times more likely than men who inject drugs to be living with HIV.[18] In addition to barriers faced by men, including lack of harm reduction programmes, criminalization of possession of drugs, and stigma and discrimination, women who inject drugs experience gender-specific challenges to preventing HIV and obtaining HIV services. They are often not in a position to negotiate safe injecting practices or safer sex, may concurrently be engaged in sex work, and experience up to five times higher levels of intimate partner and gender-based violence compared to women who do not inject drugs – heightening risk of HIV acquisition and deterring women from seeking HIV services.[19,20] Similarly, female sex workers face stigma, discrimination, and violence, as well as criminalization which drives other rights violations, such as denial of housing and health services.[21]

Despite importance of HIV prevention among women in key populations, few HIV prevention programmes cater to their needs.[22] For example, 0.6% of total HIV spending from 53 reporting countries allocated for prevention interventions among sex workers.[23] Lack of studies on PrEP uptake by women who use drugs and female sex workers make it difficult to design awareness campaigns that would reach them.[24]

Despite abuse and discrimination, most women achieve high treatment rates

Women in most regions have strong testing and treatment outcomes that have improved steadily over the past decade. Globally, 91% of women living with HIV knew their status in 2023, 83% received antiretroviral treatment (ART), and 78% had a suppressed viral load.[25] In most regions, women's uptake of services is higher than men's, aided by continued health system efforts to eliminate mother-to-child transmission of HIV. However, more efforts are needed in order to meet the global targets of 90% of women living with HIV receiving ART and 90% with a suppressed viral load by 2030.

Exceptions to women's strong testing and treatment outcomes include the Middle East and North Africa, where around 10% fewer women than men living with HIV know their status and are on treatment, and Latin America, where since 2021, a slightly higher proportion of men living with HIV are on ART and are virally suppressed than women living with HIV.[26] In the Middle East and North Africa, women are prevented from accessing HIV treatment by a culture of silence. While most women are infected through their husbands or partners who are mostly not aware of their own infections, they are judged and ostracized based on the assumption they had sex outside marriage. In health care settings, they facing denial of care, stigmatising attitudes, discrimination, and breaches of confidentiality.[27] In Latin America,

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[16] Data for key populations and their sexual partners also include 210,000 new infections among men who have sex with men and 110,000 among clients of female sex workers. These populations are not discussed in the text as they do not include women.
[17] Korenromp E, et al. (2024) New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation. *J Acquir Immune Defic Syndr*, 95:S34–S45.
[18] Based on limited data from 18 (on injecting drug use) and 58 (on living with HIV) countries. UNAIDS (2024) HIV and people who inject drugs. 2024 Global AIDS Update Thematic briefing note. Geneva: UNAIDS.
[19] UNAIDS (2024) HIV and people who inject drugs. 2024 Global AIDS Update Thematic briefing note. Geneva: UNAIDS.
[20] UNAIDS (2021) HIV and people who use drugs. Human Rights Fact Sheet series. Geneva: UNAIDS.
[21] UNAIDS (2021) HIV and sex work. Human Rights Fact Sheet series. Geneva: UNAIDS.
[22] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[23] UNAIDS (2024) HIV and sex workers. 2024 Global AIDS Update: Thematic briefing note. Geneva: UNAIDS.
[24] JL Glick and others, "The PrEP Care Continuum among Cisgender Women who Sell Sex and/or use Drugs Globally: A Systematic Review," *AIDS Behaviour*, 24(5): 1312–133 (2020).
[25] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[26] UNAIDS (2024) "AIDSinfo: Epidemic & Response" (website). Data for Treatment cascade, Testing and treatment cascade – Female adults (15+) and Male adults (15+). Available from https://aidsinfo.unaids.org/. Accessed 17 October 2024.
[27] Oraby D (2018) Women living with HIV in the Middle East and north Africa. *Lancet*, 3(2):e63. doi: 10.1016/S2468-2667(18)30007-0.

indigenous women, afro-descendent women, and migrant women have higher prevalence rates, reflecting the compounded barriers to accessing HIV services experienced by women who belong to marginalized groups.[28]

Gender-related barriers to accessing HIV treatment include women's lack of access to finances, restrictions on physical mobility, stigma, and gender-based violence. Across all regions, women's uptake of services is also impeded by discrimination within health care settings, particularly while exercising their sexual and reproductive health and rights. Nearly 20% of women living with HIV have experienced some form of coercive practice in their lifetime, such as denial of care, stigmatizing comments or insults, physical and sexual abuse, and inappropriate use of medical intervention. These experiences were more common among younger women living with HIV, women living with HIV who were migrants, women who reported engagement in sex work or drug use, and women living with disabilities.[29]

HIV testing and treatment are not reaching adolescent girls and young women and women in key populations

To reach HIV testing and treatment, adolescent girls and young women face a series of hurdles. Laws requiring parental consent are common obstacles to adolescent HIV testing, often disproportionately applied to girls,[30] and reduce HIV testing coverage among both girls and boys.[31] Health facilities that offer HIV services may be far away, expensive, or poorly managed, and girls' mobility may be restricted. Experiences at health facilities can also be discouraging, ranging from lack of provider capacity in youth-friendly counselling to outright hostility and discrimination, particularly targeted at adolescent girls and young women seeking HIV other sexual and reproductive health services. Only 65% of adolescent girls and boys living with HIV globally were receiving ART in 2023.[32] Sex-disaggregated data is limited, but some studies from South Africa found retention in care to be especially poor among female and pregnant adolescents, while others have found male adolescents were least likely to be virally suppressed.[33]

Women who are sex workers, inject drugs, transgender, or sexual partners of people in key populations, also experience significant obstacles in accessing HIV care. Similar to men in key populations, women encounter intense stigma and discrimination and risk harassment or arrest. In addition, they face gender-related barriers including the lack of HIV services that respond to their realities. Among sex workers living with HIV, antiretroviral therapy coverage is only 66%.[34] Women who inject drugs have poor ART adherence compared to men, due to socio-economic vulnerabilities and histories of trauma.[35] Women in prisons and other closed settings do not have access to HIV programmes tailored to their needs.[36] The reluctance in some places to prioritize services for key populations, particularly the women among these populations, increases their risk of being left behind.

UN-Women's results in responding to the HIV/AIDS epidemic

UN-Women's approach to gender equality and HIV, as prioritized in the *UN-Women Strategic Plan 2022–2025*, leverages its triple mandate: normative support, UN system coordination, and operational activities. Operationally, in 2023, UN-Women had HIV programming in over 40 countries and continues to sustain its portfolio. In all its efforts, UN-Women prioritizes

[28] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[29] Data from 23 countries. International Community of Women Living with HIV (2024) Confronting Coercion: A global scan of coercion, mistreatment and abuse experienced by women living with HIV in reproductive and sexual health services. ICW.
[30] Data from 51 countries. University of Southern California, UNAIDS (2022) A framework for understanding and addressing HIV-related inequalities. Geneva: UNAIDS.
[31] Rosen JG, Stone EM, Mbizvo MT (2023) Age-of-consent requirements and adolescent HIV testing in low-and middle-income countries: multinational insights from 51 population-based surveys. *Int J STD AIDS*, 34(3):168–174.
[32] UNICEF (2024) "Adolescent HIV treatment" (website) Available from https://data.unicef.org/topic/hivaids/adolescent-hiv-treatment/. Accessed 28 October 2024.
[33] UNAIDS (2024) The urgency of now: AIDS at a crossroads. 2024 Global AIDS update. Geneva: UNAIDS.
[34] UNAIDS (2024) HIV and sex workers. 2024 Global AIDS Update: Thematic briefing note. Geneva: UNAIDS.
[35] Bazzi AR, Drainoni M-L, Biancarelli DL, et al. (2019) Systematic review of HIV treatment adherence research among people who inject drugs in the United States and Canada: evidence to inform pre-exposure prophylaxis (PrEP) adherence interventions. *BMC Public Health*, 19:1–10.
[36] UNAIDS (2024) HIV and people in prisons and other closed settings. 2024 Global AIDS Update: Thematic briefing note. Geneva: UNAIDS

reaching furthest behind first – particularly women and girls living with and affected by HIV, and adolescent girls and young women. The UN-Women Strategic Plan prioritizes this critical work through HIV-dedicated indicators and inclusion of HIV as one of the five "leave-no-one-behind" sub-categories of programmatic disaggregation. We're seeing results at all levels, transforming norms/policies, institutions, and communities to better reach women most affected by HIV/AIDS, to invest in gender-responsive actions, and to address intersecting discrimination.

Selected achievements

1. Global normative frameworks and gender-responsive laws, policies, and institutions

In 2022-2023, UN-Women strengthened gender equality expertise and increased availability of, and access to, gender analysis and knowledge on gender and HIV among AIDS coordinating bodies and HIV programmes across **35 countries**.[37] With the support of UN-Women in **Cameroon**, the Ministry of Women Empowerment and Family successfully finalized the Women and Families sectoral plan to combat HIV and Sexually Transmitted Infections. The plan includes specific targets focusing on needs and priorities of women and girls in the context of HIV, as well as links to the overall strategic framework for combating HIV/AIDS in Cameroon. As a result of UN-Women's technical guidance, the new National Strategic Plans for HIV until 2027 in **Burundi** and **Lesotho** prioritized outcomes on ending gender-based discrimination and violence against women. In **Malawi**, **Rwanda** and **Zimbabwe**, UN-Women helped the Ministries of Health and Ministries of Gender Equality to develop and implement national strategies and programmes that engage men and boys to improve harmful gender norms, reduce gender-based violence, promote gender equality, and encourage seeking of health services.

To advance the implementation of the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, UN-Women worked with women's organizations and networks of women living with HIV in **Indonesia, Malawi, Papua New Guinea, Tajikistan, Uganda and Viet Nam** to repeal discriminatory HIV-related laws. In **Tajikistan**, UN-Women supported the network of women living with HIV and other partners to advocate for reform of the country's criminal code and its article 125, which criminalizes HIV transmission. While not removing the article, a new Supreme Court resolution calls for a more objective application of the article in alignment with international standards, including recognition of evidence that people living with HIV who have undetectable viral load cannot sexually transmit the virus to others. To meet the unique HIV-related needs and priorities of transgender people, UN-Women collaborated with the Ministry of Health of **Viet Nam** and other partners to draft and promote the new Gender Affirmation Law.

UN-Women continued to support Member States adopt and implement global norms and standards on gender equality and women's empowerment in the context of HIV. In the lead up to the sixty-eighth session of the Commission on the Status of Women, UN-Women led the preparation of the ***Report of the Secretary-General on women, the girl child and HIV and AIDS*** (E/CN.6/2024/6), and provided policy support to the Southern African Development Community, which resulted in the adoption by Member States an updated ***Resolution 60/2 on Women, the Girl Child and HIV and AIDS*** (E/CN.6/2024/L.5). To facilitate implementation of this resolution, UN-Women provided policy support to the Southern African Development Community to adopt and roll-out the gender-responsive oversight model, which has been adapted by Angola, Lesotho, Malawi, Mozambique, Namibia and Zimbabwe to enhance government accountability.

UN-Women provided technical support to the Member States during the fifty-sixth session of the **Human Rights Council**, helping integrate gender considerations into four resolutions relevant to women's rights to health, particularly sexual and reproductive health and rights: on menstrual hygiene management, human rights and gender equality (A/HRC/56/L.26); on human rights in the context of HIV and AIDS (A/HRC/56/L.13); on preventing adolescent girls' pregnancy (A/HRC/56/L.24); and on elimination of all forms of discrimination against women and girls (A/HRC/56/L.25/Rev.1). The resolutions called for reinvigorated efforts to protect human rights and promote gender equality, including in the context of HIV/AIDS.

2. Financing for gender equality

[37] Botswana, Burundi, Cameroon, Central African Republic, Côte D'Ivoire, Democratic Republic of Congo, El Salvador, eSwatini, Ethiopia, Guatemala, Indonesia, India, Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Liberia, Malawi, Morocco, Mozambique, Namibia, Nepal, Nigeria, Papua New Guinea, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Tajikistan, Uganda, United Republic of Tanzania, Viet Nam and Zimbabwe.

As only 0.1% of total official development assistance reaches organizations advocating for women's rights, UN-Women continuously advocates for increased investment in women's organizations, including networks of women living with HIV. In 2022-2023, the ***UN Trust Fund to End Violence Against Women***, managed by UN-Women, awarded over US$3 million in grants to local and grassroots women's organizations that work directly with women living with HIV, women who use drugs, and sex workers, empowering them to demand access to non-discriminatory legal aid, HIV care and support and other health services.

UN-Women continued to provide technical support to governments' funding requests to the ***Global Fund to Fight AIDS, Tuberculosis and Malaria*** (Global Fund). This resulted in more consistent and comprehensive engagement of women living with and affected by HIV in the design and inclusion of gender-responsive actions and budgets into the requests. For example, in 2023, with UN-Women's support the national network of women living with HIV and women in key populations in **Indonesia**, which includes organizations of women who use drugs, sex workers, transgender people and LGBTIQ+ communities, engaged in the review of the Global Fund funding request to ensure gender equality and human rights issues of affected populations were prioritized. In **Thailand**, **Central African Republic** and **Nigeria**, UN-Women's technical assistance was instrumental in ensuring women living with HIV were engaged in the development of funding requests to the Global Fund, and that the requests prioritized gender-responsive approaches.

2. Positive social norms

Across **21 countries**[38], UN-Women implemented evidence-based interventions to transform unequal gender norms, including harmful masculinities, which have resulted in preventing violence against women and HIV, and improving male health-seeking behaviour. UN-Women assisted **Indonesia and Ukraine** to improve uptake of HIV treatment and care services that are free of gender-based discrimination and violence. Across **13 countries**,[39] UN-Women mobilized traditional and faith-based leaders to promote positive social norms and women's empowerment, and prevent HIV and violence against women, including early and forced marriage. For example, in **Burundi**, UN-Women mobilized men and traditional leaders to promote access to HIV services for pregnant women by encouraging couples' testing. To provide countries with programmatic guidance on addressing violence against women who use drugs and affected by HIV, UN Women collaborated with UNODC on a joint *Briefing Paper on Gender-Based Violence and Women Who Use Drugs*, which was launched at the 2024 Commission on Narcotic Drugs.

During the Sexual Violence Research Initiative Forum in October 2024, UN-Women shared learning and evidence, raised the visibility and importance of investing in programming that address gender-based violence and prevent HIV through transforming harmful norms and young women's empowerment. The event provided opportunities to unpack and address unequal gender norms that drive HIV and violence against women with participants involved in research and programming on responding to sexual violence.

3. Women's equitable access to services, goods and resources

Across **20 countries**,[40] UN-Women worked to ensure that no women or girls are left behind in the HIV response by strengthening access to HIV information, testing, treatment and care, and availability of services for women living with and affected by HIV, including women in key populations and facing gender-based violence. UN-Women supported **Rwanda** National AIDS Control Commission to develop and pilot a community-based monitoring and reporting tool that helps to identify specific gender-related barriers in accessing HIV services, particularly violence against women, and improve quality and inclusivity of HIV services for both women and men, and key populations. In **Botswana**, **Burundi**, **Cameroon**, **Cote D'Ivoire**, **Ethiopia**, **Indonesia**, **Malawi**, **Mozambique**, **Nigeria**, **Rwanda**, **Senegal**, **Sierra Leone**, **South Africa**, **Uganda**,

[38] Botswana, Burundi, Cambodia, Cameroon, eSwatini, Ghana, Guatemala, Haiti, Kyrgyzstan, Lesotho, Liberia, Malawi, Morocco, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, South Sudan, Uganda and Zimbabwe.
[39] Burundi, Cote D'Ivoire, Kenya, Kyrgyzstan, Lesotho, Liberia, Malawi, Mozambique, Namibia, Sierra Leone, Uganda, United Republic of Tanzania and Zimbabwe.
[40] Burundi, Cambodia, Cameroon, China, Côte D'Ivoire, Indonesia, Haiti, Jamaica, Kenya, Malawi, Liberia, Nepal, Nigeria, Papua New Guinea, Rwanda, Senegal, Uganda, Ukraine, Viet Nam and Zimbabwe.

United Republic of Tanzania, **Viet Nam** and **Zimbabwe,** UN-Women built the capacity of service providers to promote access to post-exposure prophylaxis (PEP), HIV testing, counselling, treatment and care for women survivors of violence.

UN-Women worked to strengthen the ability of HIV programmes to meet the specific needs of women with disabilities and promote their rights to health, including sexual and reproductive health in **Democratic Republic of Congo, eSwatini, Indonesia, Malawi, Rwanda, Uganda, United Republic of Tanzania and Zimbabwe**. For example, in **Malawi**, UN-Women provided rapid humanitarian support to women with disabilities and living with HIV who were displaced by Tropical Storm Freddy, ensuring to meet their needs for hygiene products, HIV diagnostics, and providing access to HIV treatment.

4. Women's voice, leadership and agency

Between 2022 and 2023, 30,000 women living with HIV across **34 countries**[41] have directly benefited from UN-Women's work to increase advocacy skills and opportunities, expand access to decision-making spaces, and improve uptake of HIV treatment and care services and livelihood support. UN-Women invested in the institutional capacities of the networks of women living with HIV in **Cambodia, China, El Salvador, Indonesia, Nepal, Nigeria, Papua New Guinea, Senegal, South Africa, Tajikistan, Ukraine, Viet Nam and Zimbabwe** to drive the gender equality and women's empowerment agenda in national HIV responses. With technical and financial support from UN-Women, the association of women living with HIV in **Nigeria** successfully developed and adopted its new strategic plan until 2026 and engaged in reviewing national HIV strategic frameworks, and the national network in **China** expanded its institutional capacity and reach at provincial level. In **Cambodia** and **Nepal**, UN-Women invested in increasing the leadership skills of the LGBTIQ+ organizations and by creating safe spaces for raising and advocating for repealing discriminatory practices in the health care settings.

To strengthen the voice of young women and adolescent girls, UN-Women fostered their leadership skills and created spaces for their meaningful engagement across **18 countries**.[42] In partnership with the United States President's Emergency Plan for AIDS Relief (PEPFAR), UN-Women matched 185 young women across **15 sub-Saharan African countries**[43] in mentoring relationships with established women leaders. A 2022 UN-Women convening of the young women leaders with ministers of health, gender/women's affairs, and representatives of national AIDS commissions resulted in an agreed set of actions on reducing rates of HIV among adolescent girls and young women in sub-Saharan Africa, and a multisectoral, cross-country, intergenerational collective launched by UN-Women's Executive Director. In **South Africa**, UN-Women supported young women to organize themselves into the Young Women for Life Movement. The movement has grown to over 3,000 members and reached tens of thousands of other young women with information about HIV prevention, treatment and care services, and is now expanding to **Botswana**, **eSwatini**, **Lesotho** and **Namibia**. UN-Women strengthened **Tajikistan**'s "Teenergizer" youth network to support adolescent girls and young women living with HIV and their families, including on disclosure of their status. In addition, peer support groups and psychological support helped to improve adherence to antiretroviral treatment.

UN Women also successfully promoted women and girl's voices and leadership in the HIV response at the **25th International AIDS Conference** by supporting women living with HIV to convene the Women's Networking Zone, present results from UN Women's programme, *Investing in Young Women's Leadership in the HIV Response*, and convening a *Strategic Dialogue on Gender Justice in the HIV Response: Putting women and girls first!*. The result has been increased visibility of women's organizations and networking spaces for women living with HIV, as well as opportunities for advocacy for greater accountability, funding and implementation of actions for women's priorities.

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[41] Botswana, Burundi, Cambodia, Cameroon, China, Cote D'Ivoire, Democratic Republic of Congo, El Salvador, eSwatini, Ethiopia, India, Indonesia, Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Liberia, Malawi, Mozambique, Namibia, Nepal, Nigeria, Papua New Guinea, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Tajikistan, Tanzania, Uganda, Ukraine, Viet Nam and Zimbabwe.

[42] Botswana, Cameroon, Cote d'Ivoire, eSwatini, Ethiopia, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Rwanda, South Africa, Tajikistan, Tanzania, Uganda, Zambia and Zimbabwe.

[43] Botswana, Rwanda, South Africa, Cote d'Ivoire, Cameroon, Mozambique, Eswatini, Zimbabwe, Kenya, Tanzania, Lesotho, Malawi, Uganda, Namibia, Zambia.

Across **26 countries**[44], UN-Women invested in economic empowerment initiatives for women living with HIV, with the aim of bolstering their livelihoods and economic security, and as means to remove barriers that women face in accessing HIV prevention, treatment and care. In **Cameroon**, **Liberia** and **Uganda**, UN-Women's support to the organizations of sex workers has been crucial in building capacity of women to access financial services, such as banking, loans and saving schemes. In **Cambodia** and **Viet Nam**, UN-Women empowered women living with HIV to access, produce and disseminate personal protective equipment (PPE) and reliable COVID-19 information. In **India**, UN-Women worked with UNAIDS, local authorities and women's organizations to provide women living or affected by HIV with vocational and entrepreneurship skills trainings and educational opportunities, including access to continuing education through the National Institute of Open Schooling.

5. Production, analysis and use of gender data and knowledge

To inform national planning and budgeting, UN-Women supported gender assessments of the HIV response in **11 countries**.[45] This resulted in the identification of persisting inequalities that informed the integration of efforts to address gender inequality issues in national HIV strategies and plans, budgetary allocations and supported development of gender-responsive indicators to track progress.

UN-Women and the Sexual Violence Research Initiative engaged diverse women's rights organizations, including the networks of women living with HIV, to develop and launch the **Africa Shared Research Agenda for ending Gender-Based Violence**, identifying practitioner-informed research priorities tailored to the region that also incorporate a priority on preventing HIV, promoting health-seeking behaviour and referral to HIV testing, treatment and care services.

In 2023, UN-Women's analysis of the income security of people living with HIV in **Jamaica** highlighted the challenges experienced by young women and young mothers living with and affected by HIV, including stigma and discrimination that prevent access to the labour market and a lack of awareness of existing social programmes. In response to the findings, UN-Women supported local women's organizations to develop communication strategies and products highlighting services that are available for people living with HIV, including young women living with HIV.

UNAIDS Programme Coordinating Board recommendations

Since 2015, the Joint Programme has experienced shortfalls in funding the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF), which provides the blueprint for the Joint Programme's contribution for its implementation. The 2022–2026 UBRAF envisioned annual core funding for UNAIDS of up to US$210 million, although UNAIDS has been operating with an annual budget of US$160 million since 2022. In October 2024, the UNAIDS Secretariat announced an additional $10 million reduction in the projections for core resources for 2025, lowering the total budget for 2025 to US$150 million and requesting all cosponsoring organizations to absorb a US$ 4 million cut for 2025.

In December 2023, the UNAIDS Programme Coordinating Board requested[46] "the Executive Director and the Committee of the Cosponsoring Organizations (CCO)[47] to continue to ensure that the Joint Programme remains sustainable, resilient and fit-for-purpose by revisiting the operating model". In response, a **High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response** was established in May 2024 and is currently co-convened by the UNAIDS Executive Director, and the Director-General of International Labour Organization (ILO) as the incoming 2025 Chair of the CCO. Co-chaired by H.E. U.S. Global AIDS Coordinator, H.E. Ambassador of

[44] Botswana, Burundi, Cambodia, Cameroon, Cote D'Ivoire, Democratic Republic of Congo, eSwatini, India, Jamaica, Liberia, Malawi, Mali, Moldova, Namibia, Nepal, Nigeria, Papua New Guinea, Rwanda, Senegal, Sierra Leone, South Africa, Tajikistan, Uganda, Ukraine, Viet Nam and Zimbabwe.
[45] Burundi, Indonesia, Kazakhstan, Kenya, Moldova, Nigeria, South Sudan, Uganda, Ukraine, United Republic of Tanzania and Zimbabwe.
[46] Decision 6.5 of the 53rd meeting of the UNAIDS Board, December 2023.
[47] The UNAIDS Committee of Cosponsoring Organizations (CCO) is a standing committee to the UNAIDS Board, is comprised of the Heads of Agencies of 11 Cosponsoring Organizations of the UNAIDS Joint Programme and reviews regularly the matters of strategic importance.

Kenya to the UN in Geneva and the Executive Director of the Global Action for Trans Equality (GATE), the Panel is comprised of a number of experts from government, civil society and private sectors, with the United Nations Development Programme (UNDP), World Health Organization (WHO) and UN-Women serving as resource people. Within the remit of the United Nations Economic and Social Council Resolution 1994/24 that established the UNAIDS Joint Programme,[48] the Panel is expected to provide a set of recommendations to the UNAIDS Secretariat, CCO and the UNAIDS Board for a fit-for-purpose UNAIDS Joint Programme that is responsive to the current political, socio-economic and epidemiological context and to the needs and priorities of people living with and affected by HIV.

The funding challenges for cosponsors of the Joint Programme are **particularly concerning for UN-Women** given the Global AIDS Strategy identified ending inequalities as a strategic focus for ending AIDS. To mitigate the impact of the funding shortfall, **UN-Women re-programmed its work** across 40 countries, prioritizing the critical, high-value, and timely areas of work to meet the demands from the partners, and further **integrated HIV into other areas of work** (e.g., ending violence against women, or promoting economic empowerment) to maximize efficiencies with the resources available. As a co-convener of the UNAIDS Global Strategic Initiatives such as Education Plus, the Global Partnership to End All Forms of HIV-Related Stigma and Discrimination, UN-Women also **contributes to joint resource mobilization** efforts to secure funding for these initiatives, particularly for countries. In addition, UN-Women is **expanding resource mobilization efforts** for specific areas of work, such as the partnership with the US Government's PEPFAR programme on young women's leadership within the HIV response.

The High-Level Panel provides a unique opportunity to ensure the revised operating model of the Joint Programme, as well as its resource allocation and funding mechanisms, reinforce the centrality of human rights, gender equality and women's empowerment to the HIV response and the need for multi-sectoral response to achieve the SDG target of ending AIDS by 2030. The revised operating model should also prioritize maintaining and sustaining spaces for communities to engage and inform the HIV response. The Panel has convened its first two meetings in October and had substantive discussions on partnerships, programming and resource mobilization. The recommendations of the panel will be discussed with Heads of Agencies at the UNAIDS CCO meeting in May 2025 and then presented to the UNAIDS Board in June 2025.

During the 54th and 55th meetings of the UNAIDS Programme Coordinating Board held in 2024, UN-Women provided policy support to and engaged in a number of other substantive discussions. These have included the mid-**term review of the Global AIDS strategy 2021-2026**, comprehensive **evaluation of the UNAIDS Joint Programme** that in its first phase focused on the review of the Joint Programme's evaluations and assessments, the update on **HIV in prisons and other closed settings**, the background for the thematic discussion on **addressing inequalities in children and adolescents**, the report by the NGO Delegation on **Community Leadership**, and the **annual 2022-2023 reporting**. In its follow-up discussions to the thematic segments **on HIV and testing** and **on sustainability of the HIV response**, the UNAIDS Board has requested Member States to implement gender-responsive, gender-sensitive differentiated approaches in HIV service delivery (Decision 5.2(g)).

Conclusion

1) As countries struggled to turn their commitments to gender equality in the context of HIV into action, 580,000 women and girls acquired HIV in 2023. Two-thirds of new infections among women and girls were in sub-Saharan Africa, where the numbers have been declining steadily but still remain extraordinarily high. New infections among women are increasing in the Middle East and North Africa and in Eastern Europe and central Asia. Because of unequal power dynamics, many women struggle to negotiate safer sex, and may experience intimate partner

[48] UNAIDS is mandated, by ECOSOC resolution 1994/24, to (a) Provide global leadership in response to the epidemic; (b) Achieve and promote global consensus on policy and programmatic approaches; (c) Strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level; (d) Strengthen the capacity of national Governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level; (e) Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions; (f) Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

violence, including during the postpartum period. Others lack access to female-controlled prevention methods due to policies restricting availability, financial barriers, or criminalization of sex work and drug use, which prevents women from seeking information or HIV prevention methods. Intersecting inequalities increase risks for adolescent and young women, women engaged in sex work or using drugs, women in ethnic and racial minorities, and women who have disabilities. HIV prevention programmes must be designed to meet their specific needs and priorities.

2) Women in most regions have strong testing and treatment outcomes that have improved steadily over the past decade, but continue to face barriers such as lack of transportation, financial resources, and time restrictions to their physical mobility due to unequal gender norms, as well as HIV-related stigma which causes them to hide their status to avoid facing discrimination and violence in the family, community, and in health care settings. Women who are younger, engaged in sex work or drug use, migrants, or have disabilities face exacerbated challenges. To achieve the targets of 90% of women living with HIV knowing their status, 90% receiving ART, and 90% with a suppressed viral load by 2030, it is essential to scale up interventions to address the social and structural barriers to accessing health care, transform health care systems towards improving the quality of care, and advance women's empowerment and gender equality.

3) Women, particularly those living with HIV, are instrumental in shaping HIV policies and programmes that recognize and address the barriers they experience. Resisting the erosion of women's rights and providing women the space to engage and lead in the HIV response is fundamental not only for ending AIDS, but for achieving the Sustainable Development Goals more broadly. Yet women's organizations and networks of women living with HIV, particularly in the global South, have limited access to funding that would facilitate their advocacy and engagement. The HIV response would benefit from recognizing women's leadership and making flexible, multi-year funding accessible to local women's organizations.

4) Given the significant impact of HIV on women and girls, and their underutilized potential to ensure effective programming, UN-Women is committed to leading efforts to attain gender equality and the empowerment of all women and girls in the context of HIV/AIDS. UN-Women works closely with Member States and UN agencies to influence the governance of the HIV response, ensuring gender equality and women's rights are integrated in policies, plans, budgets, and monitoring framework, as well as invest in women's leadership; coordinate activities with other cosponsors of the Joint UN Programme on HIV/AIDS to increase efficiencies in gender equality policy-making and programming, and support country-level efforts to integrate gender equality and women's empowerment into national HIV responses, including supporting women's leadership, particularly young women's leadership, in the HIV response.

5) Ending AIDS requires multisectoral collaboration across global, national, and community partners, with leadership provided by the UNAIDS Joint Programme, as mandated by the ECOSOC Resolution 1994/24. UN Women is highly concerned about the declining availability of financial resources for implementing priority actions across the ten result areas and five crosscutting issues of the Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS, including promotion of gender-equitable social norms and gender inequality (Result area 6). Following through on global commitments to end HIV is essential for the empowerment of all women and girls and their full enjoyment of their rights.