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JOINT UN PROGRAMME ON HIV/AIDS

BACKGROUND GUIDE 2017

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NATIONAL MODEL UNITED NATIONS

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Dear Delegates,

Welcome to the 2017 National Model United Nations New York Conference (NMUN•NY)! We are pleased to introduce you to our committee, the Joint United Nations Programme on HIV/AIDS (UNAIDS). This year's staff is: Directors Patrick Sandmann (Conference A) and Lauren Kiser (Conference B). Patrick completed his B.Sc. in European Business Administration in 2013 and a Master of Science in Management in 2015, and he is currently working towards his second Master's degree in European Politics. He works at a consultancy firm in Munich, Germany. This will be his third year on staff, and he is excited to return to NMUN•NY. Lauren received a double degree, a B.A. in Political Science with an emphasis on International Relations and a B.A. in International Economics, from Texas Christian University in 2013. She received her Master of Arts in 2016 from the Josef Korbel School of International Studies in Global Finance, Trade, and Economic Integration. This is her second year on staff and she is looking forward to returning to NMUN•NY.

The topics under discussion for UNAIDS are:

I. Ensuring HIV/AIDS Prevention and Treatment During Humanitarian Crises
II. Addressing the Needs of Ageing Populations Living with HIV/AIDS
III. Mitigating the Impact of HIV/AIDS on Economic Development

UNAIDS is the primary organization within the United Nations system tasked with coordinating the efforts of the international community's response to HIV/AIDS. The work of UNAIDS is primarily normative and is achieved through supporting its cosponsors on policy formation, strategic planning, research and development, and advocacy. In addition, UNAIDS assists Member States in their formation of National Strategic Plans to address the treatment, coordination, and monitoring of HIV/AIDS. In order to accurately simulate the committee, it is crucial that delegates understand how UNAIDS functions in order to fulfill its mandate.

This Background Guide serves as an introduction to the topics for this committee. However, it is not intended to replace individual research. We encourage you to explore your Member State's policies in depth and use the Annotated Bibliography and Bibliography to further your knowledge on these topics. In preparation for the Conference, each delegation will submit a Position Paper by 11:59 p.m. (Eastern) on 1 March 2017 in accordance with the guidelines in the Position Paper Guide and the NMUN•NY Position Papers website.

Two essential resources for your preparation are the Delegate Preparation Guide and the NMUN Rules of Procedure available to download from the NMUN website. The Delegate Preparation Guide explains each step in the delegate process, from pre-Conference research to the committee debate and resolution drafting processes. The NMUN Rules of Procedure include the long and short form of the rules, as well as an explanatory narrative and example script of the flow of procedure. In tandem, these documents thus serve as essential instruments in preparing for the Conference and as a reference during committee sessions.

Please take note of information in the Delegate Preparation Guide on plagiarism and the prohibition of pre-written working papers and resolutions. Additionally, please review the NMUN Policies and Codes of Conduct on the NMUN website regarding the Conference dress code; awards philosophy and evaluation method; and codes of conduct for delegates, faculty, and guests regarding diplomacy and professionalism. Importantly, any instances of sexual harassment or discrimination based on race, gender, sexual orientation, national origin, religion, age, or disability will not be tolerated. Adherence to these policies is mandatory.

If you have any questions concerning your preparation for the committee or the Conference itself, please contact the Under-Secretaries-General for the ECOSOC Department, Tsesa Monaghan (Conference A) and Dominika Ziemczonek (Conference B), at usg.ecosoc@nmun.org.

We wish you all the best in your preparations and look forward to seeing you at the Conference!

Sincerely,

Conference A
Patrick Sandmann, *Director*

Conference B
Lauren Kiser, *Director*

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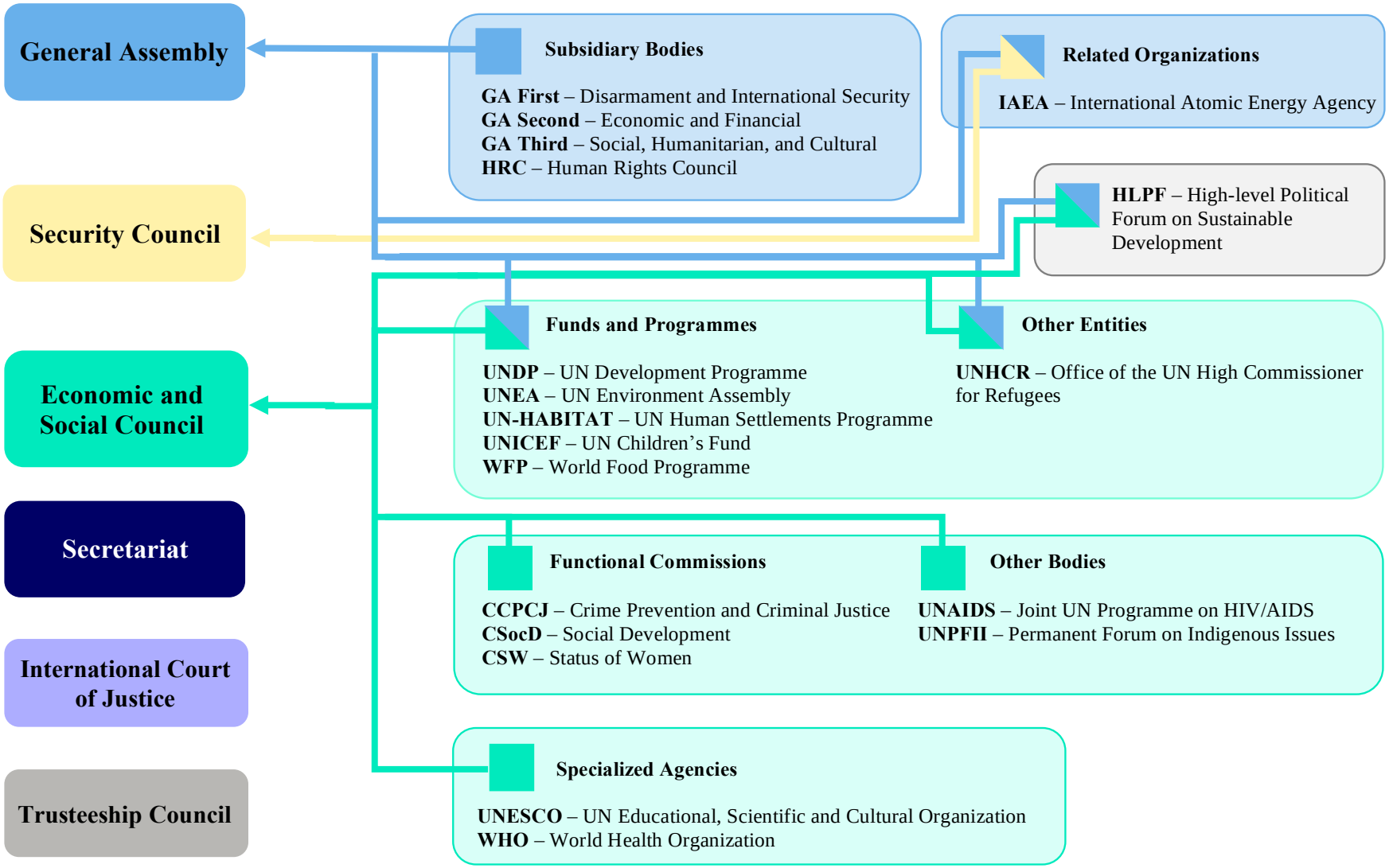
United Nations System at NMUN•NY

This diagram illustrates the UN system simulated at NMUN•NY and demonstrates the reportage and relationships between entities. Examine the diagram alongside the Committee Overview to gain a clear picture of the committee's position, purpose, and powers within the UN system.



Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CCO	Committee of Cosponsoring Organizations
CDC	Centers for Disease Control and Prevention
CSO	Civil society organization
DESA	Department of Economic and Social Affairs
ECOSOC	Economic and Social Council
ERC	Emergency Relief Coordinator
FAO	Food and Agriculture Organization of the United Nations
GBV	Gender-based violence
GDP	Gross Domestic Product
GPA	Global Programme on AIDS
HC	Humanitarian Coordinator
HIV	Human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IATT	Inter-Agency Task Team to Address HIV in Emergencies
IDP	Internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Organization
IOM	International Organization for Migration
LGBT	Lesbian, gay, bisexual, and transgender
MDG	Millennium Development Goal
MENA	Middle East and North Africa
NGO	Non-governmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCB	Programme Coordinating Board
PLHIV	People living with HIV
PMTCT	Preventing mother-to-child transmission
SDG	Sustainable Development Goal
UN	United Nations
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WASH	Water, sanitation, and hygiene
WFP	World Food Programme
WHO	World Health Organization

Committee Overview

"Ending the AIDS epidemic will involve progress across the entire spectrum of rights: civil, cultural, economic, political, social, sexual and reproductive."[1]

Introduction

The Joint United Nations Programme on HIV/AIDS (UNAIDS), launched in 1996, coordinates the efforts of the United Nations (UN) in response to the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic.[2] In the early years of the pandemic, there was skepticism that HIV/AIDS could ever become a global pandemic, resulting in a slow coordinated response and establishment of UNAIDS.[3] It was not until the 1980s that the international community began to realize that the spread of the disease represented a serious threat to global health.[4] In September 1981, the Centers for Disease Control and Prevention (CDC) in the United States published a report detailing what was believed to be a new type of pneumonia, and doctors throughout the international community realized they had been treating similar cases for several years.[5] This "new" pneumonia was in fact AIDS, and it was officially named in 1982.[6]

The **Joint United Nations Programme on HIV/AIDS** is cosponsored by 11 United Nations agencies and reports to the Economic and Social Council.

Denial of the magnitude and seriousness of the problem, stigmatization, and discrimination against persons with AIDS were significant barriers to undertaking a coherent global response to AIDS.[7] However, in late 1983, amid rising instances of new transmissions and diagnoses, the World Health Organization (WHO) held a meeting in Denmark to assess the AIDS problem in Europe.[8] At the end of 1983, another meeting was held to assess AIDS globally, which resulted in the decision that WHO was responsible for monitoring the situation.[9] In 1986, WHO's Executive Board requested funding to establish an AIDS-specific program.[10] The Control Programme on AIDS was established under the purview of WHO in 1986.[11] The program was known as the Special Programme on AIDS until 1987 and then the Global Programme on AIDS (GPA) in 1988.[12]

In its first few years, GPA advocated for equitable treatment of people living with AIDS and worked against repressive policies aimed at AIDS patients.[13] Leadership changes within GPA in the late 1980s altered the dynamic of the programme and it began to focus almost exclusively on medical approaches.[14] GPA wanted to ensure consistency of care across their activities programs and adopted standardized approaches to country programs, but it was criticized for not meeting the individual needs of Member States.[15] An external review in 1989 highlighted the successes of GPA, such as increasing public awareness, but noted that AIDS was a "multidimensional and multisectoral issue" and that the UN system failed to coordinate their efforts.[16]

In 1992, GPA submitted its own report, which recognized the need for a unified and collaborative global response to successfully end the HIV/AIDS epidemic.[17] The UN Development Programme (UNDP), the UN Children's Fund

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[1] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2015, p. 3.
[2] UN General Assembly, *Fact Sheet: What is UNAIDS?*
[3] UNAIDS, *UNAIDS: The First Ten Years*, 2008, p. 7.
[4] AVERT, *History of HIV and AIDS Overview*, 2016.
[5] UNAIDS, *UNAIDS: The First Ten Years*, 2008, p. 7.
[6] Ibid., pp. 7-8.
[7] Ibid., pp. 8-10.
[8] Ibid., p. 13.
[9] AVERT, *History of HIV and AIDS Overview*, 2016; UNAIDS, *UNAIDS: The First Ten Years*, 2016, p. 13.
[10] UNAIDS, *UNAIDS: The First Ten Years*, 2016, p. 14.
[11] Ibid.
[12] Ibid., p. 15.
[13] Ibid., pp. 15-16.
[14] Ibid., p. 18.
[15] Ibid.
[16] Ibid., pp. 19-20.
[17] Ibid., p. 20.

(UNICEF), the UN Population Fund (UNFPA), WHO, the UN Educational, Scientific and Cultural Organization (UNESCO), and the World Bank agreed to cosponsor UNAIDS.[18] In 1994, UNAIDS was established by Economic and Social Council (ECOSOC) resolution 1994/24 on the "Joint and cosponsored United Nations programme on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)."[19] UNAIDS officially began its work on January 1, 1996.[20]

Governance, Structure, and Membership

UNAIDS is cosponsored by 11 UN agencies and reports to ECOSOC.[21] The cosponsoring organizations are UNDP, UNICEF, WHO, UNFPA, UNESCO, the World Bank, the UN Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the World Food Programme (WFP), and the Office of the UN High Commissioner for Refugees (UNHCR).[22]

UNAIDS is governed by the Programme Coordinating Board (PCB), which oversees all programmatic activities including policy, strategy, finance, and the overall evaluation of UNAIDS.[23] PCB meetings are generally held twice a year and each cover two segments: decision-making and thematic issues.[24] The PCB calls for proposals from its constituencies for the thematic segments, which are decided according to four criteria: broad relevance, responsiveness, focus, and scope for action.[25] The PCB Bureau coordinates the PCB's work for the year and is comprised of the PCB chairperson, vice-chairperson, rapporteur, and the PCB non-governmental organization (NGO) delegation.[26] The Executive Director of UNAIDS serves as the secretary of the PCB.[27] The PCB reviews reports submitted to it by the Executive Director and from the Committee of Cosponsoring Organizations (CCO).[28] The PCB submits a copy of each report to the governing bodies of each of the cosponsoring organizations and to ECOSOC.[29]

The CCO operates as the forum for the cosponsoring organizations and is the standing committee of the PCB; the CCO makes determinations and recommendations to the PCB on matters of policy and strategy that pertain to UNAIDS.[30] The CCO reviews UNAIDS' financial reports, programme budget proposals, work plans, specific activities of each cosponsoring organization, and technical reports.[31] In addition, the CCO submits a report to the PCB on the status of the cosponsoring organizations' efforts to align their activities, strategies, and policies with those of UNAIDS.[32]

The PCB is composed of 22 Member States, which are elected from the Member States of the 11 cosponsoring organizations for three-year terms.[33] Regional distribution of membership is as follows: there are 7 seats from Western European and Others Group, 5 seats from Africa, 5 seats from Asia Pacific, 3 seats from Latin America and the Caribbean, and 2 seats from Eastern European and the Commonwealth of Independent States.[34] Election of new Member States is staggered and approximately one third of the PCB is up for election each year.[35] Representatives from the cosponsoring organizations have the right to participate in the meetings of the PCB, but they may not vote

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[18] UN ECOSOC, *Joint and co-sponsored United Nations programme on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (E/RES/1994/24)*, 1994.
[19] Ibid.
[20] UNAIDS, *UNAIDS: The First Ten Years*, 2016, pp. 27-30.
[21] UNAIDS, *UNAIDS Governance Handbook*, 2009.
[22] Ibid.
[23] UNAIDS, *Modus Operandi of the Programme Coordinating Board*, 2011.
[24] Ibid.
[25] UNAIDS, *UNAIDS Governance Handbook*, 2009.
[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] UNAIDS, *Modus Operandi of the Programme Coordinating Board*, 2011.
[35] Ibid.

on its matters.[36] In addition, 5 NGOs, 3 from developing states and 2 from developed states and/or economies in transition, are also invited to participate in proceedings but cannot vote.[37]

The Secretariat of UNAIDS includes the office of the Executive Director, as well as any other administrative and technical staff as needed.[38] The UN Secretary-General selects the Executive Director with approval from all 11 of the cosponsoring organizations.[39] The Executive Director prepares the work plan and budget on a biannual basis, which is reviewed by the CCO and submitted to the PCB.[40]

WHO provides the administration of UNAIDS and holds in trust all funds contributed to UNAIDS.[41] Funds for UNAIDS flow from existing fundraising mechanisms of the cosponsoring organizations, from the governments of Member States of the cosponsoring organizations, from other intergovernmental organizations (IGOs) and NGOs, and from commercial entities or private individuals.[42]

Mandate, Functions, and Powers

UNAIDS' mandate, as defined in Economic and Social Council resolution 1994/24, is to coordinate the efforts of the UN system and provide global leadership on the HIV/AIDS epidemic, to care for people living with HIV, prevent new infections, and mitigate the impact of the epidemic.[43] UNAIDS' long-term vision is to have zero HIV infections, zero AIDS-related deaths, and zero HIV/AIDS-related discrimination.[44] As outlined in ECOSOC resolution 1994/24, UNAIDS' objectives are to promote consensus on policy, strengthen the capacity of the UN system to monitor trends, strengthen national governments' capacity to implement strategic activities, and promote and advocate for greater political commitment and social mobilization on addressing this issue.[45] This is achieved through its five main functions: uniting the efforts of the UN system, civil society organizations (CSOs), national governments, the private sector, individuals, and global institutions; speaking out in defense of human dignity, human rights and gender equality; mobilizing political, economic, and technical resources; empowering those with expertise and knowledge to provide it where it is most useful; and supporting country leadership to provide sustainable responses to national health and development.[46]

The work of UNAIDS is largely normative and is broken up between the global and country levels.[47] At the global level, UNAIDS provides support to the cosponsoring organizations on the formulation of policy, strategic planning, technical guidance, research and development, and advocacy.[48] At the country level, UNAIDS provides support to strengthen national planning, coordination, implementation, and monitoring capacities.[49] The CCO ensures that UNAIDS' policies and strategic and technical guidance are incorporated into the work of each of the cosponsoring organizations in a manner that reflects their mandate.[50]

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[36] Ibid.
[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] UNAIDS, *UNAIDS Governance Handbook*, 2009.
[42] Ibid.; UN ECOSOC, *Joint and co-sponsored United Nations programme on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (E/RES/1994/24)*, 1994.
[43] Ibid.; New Zealand, *United Nations Handbook 2016-2017*, 2016, p. 272.
[44] UNAIDS, *Language*.
[45] UN ECOSOC, *Joint and co-sponsored United Nations programme on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (E/RES/1994/24)*, 1994.
[46] UNAIDS, *Language*.
[47] UNAIDS, *UNAIDS Governance Handbook*, 2009.
[48] Ibid.
[49] Ibid.
[50] Ibid.

Recent Sessions and Current Priorities

The *2030 Agenda for Sustainable Development* (2015) calls a wide array of international actors to collaborate and work together to achieve the 17 Sustainable Development Goals (SDGs) and 169 targets.[51] UNAIDS' work will be critical to achieving Target 3.3, which commits the global community to end the AIDS epidemic by 2030.[52] While this particular target is key to UNAIDS' work, efforts to end the HIV/AIDS epidemic are linked to the progress towards nearly all of the SDGs, and the reverse is true.[53] Each of the SDGs has implications for ending the AIDS epidemic and reducing vulnerability to HIV.[54] For example, poverty often increases vulnerability to HIV/AIDS, as access to prevention and treatment programs can be prohibitively expensive; therefore, meeting SDG 1 by ending poverty in all its forms will reduce overall vulnerability to HIV/AIDS.[55] At the same time, ending the AIDS epidemic will contribute to ending poverty: people living with HIV often experience discrimination and stigmatization, which can prevent them from finding decent work and contributing fully to their communities.[56]

In June 2016, the General Assembly held a High-Level Meeting on Ending AIDS, which resulted in the adoption of the *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030*.[57] The Political Declaration outlines a set of targets to be achieved by 2020 in order to meet the 2030 goal of ending the AIDS epidemic.[58] Some of these targets are: to reduce new infections of HIV and AIDS-related deaths to fewer than 500,000 per year; to generate yearly investment in developing countries of $26 billion; and to ensure access to antiretroviral therapy for 30 million people living with HIV.[59] The Political Declaration requests that UNAIDS continue to support Member States in addressing the factors that contribute to the AIDS epidemic through the promotion of gender equality, the elimination of poverty, and other progressive goals.[60] Additionally, the declaration requests that UNAIDS coordinate with the Secretary-General to provide status reports to the General Assembly on the progress towards 2020 targets, as well as to contribute to reviews on the SDGs.[61]

Also in June 2016, the PCB held its 38th meeting, which stressed the need for the international community to remain committed to an accelerated approach for ending AIDS.[62] The PCB urged UNAIDS to continue to support Member States and civil society organizations in coordinating discussions on HIV financing to provide sustainable HIV programming, as well as to support them in maximizing the utility of existing funds.[63] Additionally, the PCB requested that UNAIDS support Member States' efforts in improving HIV/AIDS treatment supplies and health care systems more generally.[64] Also, the PCB encouraged Member States to increase funding for HIV/AIDS, implement universal health care coverage and social protection, and build capacity to strengthen existing HIV/AIDS treatment mechanisms.[65] The PCB reiterated the importance of ensuring that UNAIDS' 2016-2021 Strategy targets are implemented through concrete programs at the country level.[66] The Strategy has three strategic directions: HIV prevention; "treatment, care, and support"; and "human rights and gender equality for HIV response."[67] These strategic directions inform the Strategy's 10 targets, which specifically incorporate SDGs 3, 5, 10, 16, and 17, and

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[51] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016, p. 16.
[52] UN General Assembly, *Transforming our world: the 2030 Agenda for Sustainable Development (A/RES/70/1)*, 2016.
[53] UNAIDS, *AIDS and the Sustainable Development Agenda: Interdependent and Inextricably Linked*, 2016.
[54] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016, p. 27.
[55] FAO, *Underlying causes of HIV/AIDS*; UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016, p. 27.
[56] Ibid.
[57] UNAIDS, *Bold Commitments Made at the United Nations General Assembly High-Level Meeting on Ending AIDS*, 2016.
[58] Ibid.
[59] UN General Assembly, *Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and Ending the AIDS Epidemic by 2030 (A/RES/70/266)*, 2016, pp. 12-14.
[60] Ibid., p. 25.
[61] Ibid.
[62] UNAIDS, *UNAIDS board underlines the need for accelerated action and increased investment to end the AIDS epidemic by 2030*, 2016.
[63] UNAIDS, *38th Meeting of the UNAIDS Programme Coordinating Board, 28-30 June 2016: Decisions*, 2016.
[64] Ibid.
[65] Ibid.
[66] UNAIDS, *UNAIDS board underlines the need for accelerated action and increased investment to end the AIDS epidemic by 2030*, 2016.
[67] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016.

provide core actions that UNAIDS, its Member States, and cosponsoring organizations can do in order to meet these targets.[68]

Conclusion

UNAIDS is a steadfast advocate for those living with HIV/AIDS and in supporting the achievement of SDG 3 "to ensure healthy lives and promote well-being for all at all ages."[69] The work of UNAIDS is critical not only for SDG 3, but also for the achievement of all SDGs, given the interrelation between all 17 goals. UNAIDS' structure leverages the expertise of 11 other UN bodies and uniquely positions the body to provide a coordinated approach to ending the AIDS epidemic and providing quality care for those living with HIV/AIDS.[70]

Annotated Bibliography

Joint United Nations Programme on HIV/AIDS. (2009). *UNAIDS Governance Handbook.* Retrieved 24 August 2016 from: http://www.unaids.org/sites/default/files/media_asset/JC1682_GovernanceHandbook_March2011_en.pdf

The UNAIDS Governance Handbook *details the roles, functions, and mandate of the agency. This resource gives greater depth to the scope of UNAIDS and how it determines and implements programs. The Handbook describes in depth the functions of each component of UNAIDS organization, the roles of each component, and the roles of the different members of UNAIDS. The Governance Handbook clearly explains UNAIDS functions and powers, which will ensure that delegates propose appropriate policy proposals within UNAIDS' mandate.*

Joint United Nations Programme on HIV/AIDS. (2015). *2016-2021 Strategy: On the Fast-Track to end AIDS*. Retrieved 17 June 2016 from: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

The 2016-2021 Strategy is a necessary document for delegates to read as it will be one of the main guiding documents for UNAIDS over the next five years. The Strategy has ten targets to be met by 2021 that will contribute to ending the AIDS epidemic by 2030. In addition, the Strategy further shows how progress towards the Sustainable Development Goals and the strategic objective of UNAIDS are interdependent on one another. Delegates can gain a better understanding of how the Strategy was devised as well as how the committee will achieve the targets. In order to ensure that new policy proposal follow the already established Strategy, delegates must have a strong understanding of what UNAIDS has committed to and the steps it has already taken to achieve these targets.

Joint United Nations Programme on HIV/AIDS. (2016). *38th Meeting of the UNAIDS Programme Coordinating Board, 28-30 June 2016: Decisions*. Retrieved 20 June 2016 from: http://www.unaids.org/sites/default/files/media_asset/20160630_UNAIDS_PCB38_DECISIONS_FINAL_EN.pdf

The decisions of the 38th Meeting of the PCB are the short-term and longer-term strategic goals of the body. Some of the decisions of the 38th PCB meeting support Member States in developing HIV/AIDS programming and strengthening their capacity to respond to HIV/AIDS. These decisions outline the future goals of the body and the work that the PCB is encouraging Member States to undertake. Delegates should read and understand each of the decisions that the 38th PCB meeting set forth in order to ensure that their policy proposals fulfill of the strategic goals of the body.

United Nations, General Assembly, Seventieth session. (2016). *On the fast track to ending the AIDS epidemic: Report of the Secretary-General (A/70/811).* Retrieved 17 June 2016 from: http://undocs.org/A/70/811

Delegates can utilize the Secretary-General's report, which synthesizes the aim of the Fast-Track and provides insight into some of UNAIDS' previous work, to gain a better understanding of

[68] Ibid.
[69] UN General Assembly, *Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and Ending the AIDS Epidemic by 2030 (A/RES/70/266)*, 2016, p. 25.
[70] UNAIDS, *UNAIDS Governance Handbook*, 2009.

UNAIDS' activities. For example, the report provides a brief analysis of the ten strategic goals in the 2011 Political Declaration on HIV/AIDS and the achievements UNAIDS has made, as well as the shortcomings in reaching those goals. In addition, there is further insight into the necessary actions that UNAIDS will have to take in order to achieve the 10 strategic goals of the 2016-2021 Strategy. This resource will provide delegates with an overview of previous action and give them guidance in creating future policy options that UNAIDS can advocate for in order to reach the 2030 goal of ending the AIDS epidemic.

United Nations, General Assembly, Seventieth session. (2016). *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (A/RES/70/266)*. Retrieved 17 June 2016 from: http://undocs.org/A/RES/70/266

The 2016 Political Declaration formally adopts the targets and goals to accelerate the fight to end the AIDS epidemic. The 2016 Political Declaration should serve as an additional guiding document to achieving the end of the AIDS epidemic by 2030. In order to ensure that future policy proposals incorporate and build upon the commitments already made by Member States, delegates will need to have a clear understanding of what has already been decided.

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Joint United Nations Programme on HIV/AIDS. (2015). *2016-2021 Strategy: On the Fast-Track to end AIDS*. Retrieved 17 June 2016 from: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

Joint United Nations Programme on HIV/AIDS. (2016, June 8). *2016 United Nations Political Declaration on Ending AIDS Sets World on Fast-Track to End the Epidemic by 2030* [Press Release]. Retrieved 17 June 2016 from: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/june/20160608_PS_HLM_PoliticalDeclaration

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I. Ensuring HIV/AIDS Prevention and Treatment During Humanitarian Crises

"If we do not address HIV among populations affected by conflict, natural disasters and emergencies, we will not see the end of the HIV epidemic by 2030."[71]

Introduction

The United Nations (UN) Department of Humanitarian Affairs defines humanitarian crises as occurring "when a critical event, such as the onset of armed conflict or a natural disaster, threatens the health, safety and/or well-being of a community or a large group of people, demanding decision and follow-up through an extra-ordinary response and exceptional measures."[72] These events, which can be natural or man-made, include armed conflict, famine, and natural disasters, such as earthquakes, droughts, and floods.[73] Humanitarian crises can lead to the displacement of people, great loss of life, and extensive damage to infrastructure and economies.[74]

Of the 314 million people affected by humanitarian emergencies, 1.6 million of them were people living with HIV (PLHIV).[75] In 2013, 81% of PLHIV affected by a humanitarian crisis were living in sub-Saharan Africa.[76] Many of these people were displaced and could not access essential HIV services.[77] Humanitarian crises, or emergencies, present an enormous challenge in fulfilling the vision of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and ensuring that it meets existing commitments to achieving the Sustainable Development Goals (SDGs) and the 2020 targets set forth in the 2016 *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*.[78] UNAIDS has noted that in order to reach these targets, HIV programming must be incorporated into emergency preparedness programs and responses.[79] Similarly, emergency preparedness needs to be incorporated into existing HIV/AIDS programming.[80]

Humanitarian crises are serious occurrences that often lead to widespread suffering, injury, and increased mortality rates; for vulnerable populations, these crises often exacerbate existing challenges.[81] Humanitarian disasters can cause disruptions to necessary HIV/AIDS treatment and prevention services, thereby causing harm to already vulnerable groups who have or are at risk of contracting HIV.[82] Vulnerability to contracting the virus can increase in these situations due to a heightened exposure to sexual violence or the inability to meet basic needs, such as access to clean water and proper nutrition, which can increase the rate of transmission of the virus and raise the number of new infections.[83] In addition, people already living with HIV/AIDS can be especially negatively impacted by humanitarian emergencies; disasters can seriously impede access to medical facilities, lead to the destruction of medical facilities, or place a strain on the supply of necessary medications and equipment, leading to decreased quality of care.[84] These disruptions in vital healthcare services can interrupt necessary antiretroviral treatment for PLHIV and cause their health to decline.[85] In order to mitigate theses impacts on HIV-positive and at-risk individuals, the international system, with the leadership of UNAIDS, should strive to better coordinate HIV/AIDS responses to prevent transmission and ensure continuity of care during crises.[86]

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[71] UNAIDS, *HIV and Security: Past, Present and Future*, 2016.
[72] UNAIDS, *HIV in emergency contexts: Background Note*, 2015, p. 3.
[73] Ibid.
[74] Ibid.
[75] UNAIDS, *HIV in Humanitarian Emergencies*, 2015, p. 3.
[76] Ibid.
[77] Ibid.
[78] UNAIDS, *AIDS in Emergency, Conflict and Humanitarian Contexts*, 2015.
[79] UNAIDS, *37th Meeting of the Programme Coordinating Board*, 2016.
[80] Ibid.
[81] UNAIDS, *AIDS in Emergency, Conflict and Humanitarian Contexts*, 2015.
[82] Ibid.
[83] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014, p. 30; UN Women, *Facts and Figures: Humanitarian action*, 2016.
[84] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014, p. 16.
[85] UNAIDS, *AIDS in Emergency, Conflict and Humanitarian Contexts*, 2015.
[86] UNAIDS, *37th Meeting of the Programme Coordinating Board*, 2016.

International and Regional Framework

The work of UNAIDS is fundamentally guided by the *Universal Declaration of Human Rights* (UDHR) (1948), specifically article 25, which states that everyone has the right to a standard of living that promotes health and well-being and access to "medical care and necessary social services."[87] In 2001, the General Assembly adopted the *Declaration of Commitment on HIV/AIDS*, which recognized that conflicts and disasters could contribute to the spread of HIV/AIDS.[88] The declaration also called on Member States to "implement strategies to incorporate HIV/AIDS awareness, prevention, care and treatment in their emergency response programs."[89] In addition, General Assembly resolution 60/1 (2003) requested that the Secretary-General address ways and means of ensuring HIV/AIDS treatment, prevention, and care through the greater mobilization of resources for vulnerable populations during humanitarian emergencies.[90] This commitment was reiterated in the 2006 *Political Declaration on HIV/AIDS,* adopted through General Assembly resolution 60/262, and again in the 2011 *Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS*, adopted through General Assembly resolution 65/277.[91] As a result of the actions and recommendations laid out in the 2011 Political Declaration, the number of PLHIV with access to antiretroviral therapy (ART) rose to 15 million people nine months ahead of schedule.[92]

Most recently, the 2016 *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030,* adopted by General Assembly resolution 70/266, called on Member States to recognize the unique ways that conflict, post-conflict situations, and other humanitarian emergencies affect women and girls.[93] The declaration notes that forced marriage, sexual exploitation, and rape can contribute to HIV vulnerability in women and girls during and after humanitarian emergencies.[94] In addition, the Political Declaration calls on Member States to ensure that there is continuity of care for displaced PLHIV affected by humanitarian emergencies and conflict situations.[95]

In June 2015, the General Assembly adopted resolution 69/283, which endorsed the *Sendai Framework for Disaster Risk Reduction 2015-2030*.[96] The Sendai Framework has four action priorities that can help Member States be more resilient and respond quickly to disasters.[97] These are "understanding disaster risk"; "strengthening disaster risk governance to manage disaster risk"; "investing in disaster risk reduction for resilience"; and "enhancing disaster preparedness for effective response in recovery, rehabilitation and reconstruction."[98] Improving resilience can reduce risks that lead to HIV vulnerability and includes building national healthcare system resilience to ensure continuity of healthcare services during crises, especially in relation to sexual and reproductive health.[99]

In addition, two Security Council resolutions have highlighted the relationship between peace and security and HIV/AIDS, calling on stakeholders to take these issues into account in all peace and security operations.[100] In particular, Security Council resolution 1308 (2000) on "HIV/AIDS and international peacekeeping operations" calls on the Secretary-General to increase HIV/AIDS-related training for peacekeeping personnel on the risks that lead to the spread of HIV/AIDS and the strategies to mitigate these risks.[101] It calls for increased international cooperation

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[87] UN General Assembly, *Universal Declaration of Human Rights (A/RES/217 A(III))*, 1948.
[88] UN General Assembly, *Declaration of Commitment on HIV/AIDS (A/RES/S-26/2)*, 2001.
[89] Ibid.
[90] UN General Assembly, *2005 World Summit Outcome (A/RES/60/1)*, 2006.
[91] UN General Assembly, *Political Declaration on HIV/AIDS (A/RES/60/262)*, 2006; UN General Assembly, *Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS (A/RES/65/277)*, 2011.
[92] UN General Assembly, *On the fast track to ending the AIDS epidemic: Report of the Secretary-General*, 2016, p. 3.
[93] UN General Assembly, *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 (A/RES/70/266)*, 2016.
[94] Ibid.
[95] Ibid.
[96] UNISDR, *Sendai Framework for Disaster Risk Reduction*.
[97] Ibid.
[98] Ibid.
[99] UN General Assembly, *Sendai Framework for Disaster Risk Reduction 2015-2013 (A/RES/69/283)*, 2015.
[100] UN Security Council, *HIV/AIDS and International Peacekeeping Operations (S/RES/1308 (2000))*, 2000; UN Security Council, *Maintenance of international peace and security (S/RES/1983 (2011))*, 2011.
[101] UN Security Council, *HIV/AIDS and International Peacekeeping Operations (S/RES/1308 (2000))*, 2000.

to create policies for HIV/AIDS prevention, testing, and counseling for peacekeeping personnel.[102] The resolution also commended the work of UNAIDS and encouraged further capacity-building efforts in order to promote best practices on HIV/AIDS prevention education, testing, counseling, and treatment.[103] Security Council resolution 1983 (2011) on "Maintenance of international peace and security," reiterates the issues raised in resolution 1308 and further calls for increased outreach to vulnerable populations in peacekeeping operations.[104]

In 2004, the Inter-Agency Standing Committee (IASC) issued the first version of guidelines for people working in emergency response to deliver a minimum set of HIV preventions in emergencies.[105] The minimum response guidelines cover awareness building, basic sanitation, and provision of ART, among other medical treatments.[106] IASC updated the guidelines in 2011 to incorporate improvements in coordination and a growing understanding that ART can be provided even in low-resource conditions.[107] The IASC guidelines cover nearly all facets of humanitarian emergency response activities, including the coordination of HIV response, an action framework that summarizes the responses by each actor, and monitoring and evaluation mechanisms.[108]

Role of the International System

UNAIDS coordinates the efforts of the international community in the global response to HIV/AIDS.[109] At the global level, there are several different organizations that work on humanitarian affairs through policy formation, operational coordination, or both.[110] In 2015, UNAIDS co-organized a meeting with the Regional/Arab Network against AIDS (RANAA) and the General Secretariat of the League of Arab States to develop national capacities in the Middle East and North Africa (MENA) region to implement the Arab AIDS Strategy.[111] UNAIDS provided technical and strategic support to incorporate the HIV response in emergency contexts.[112]

In 2006, as part of the UN Humanitarian Reform process, the Cluster Approach was instituted as a way to more effectively address humanitarian emergencies.[113] There are 11 clusters at the global level led by UN bodies, intergovernmental organizations (IGOs), and non-governmental organizations (NGOs).[114] The clusters are logistics; nutrition; emergency shelter; camp management and coordination; health; protection; food security; emergency telecommunication; early recovery; education; and sanitation, water, and hygiene.[115] Since the introduction of the Cluster Approach, at the advisement of the 19th meeting of UNAIDS Programme Coordinating Board (PCB), HIV preparedness has been integrated into the different global clusters.[116] Within four years of the recommendation to incorporate HIV preparedness in the Cluster Approach, more than half of Member States had integrated HIV humanitarian concerns into their National Strategic Plans (NSPs).[117]

The UN Office for the Coordination of Humanitarian Affairs (OCHA) coordinates directly with humanitarian actors during emergencies through mobilizing and uniting the efforts of different humanitarian organizations.[118] For example, OCHA has worked on the ground in Somalia with the World Health Organization (WHO) and the UN Children's Fund (UNICEF) on an emergency response program on HIV/AIDS prevention and treatment.[119] This program focused on blood safety, personnel training, and delivery of prevention and treatment interventions such as

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[102] UN Security Council, *HIV/AIDS and International Peacekeeping Operations (S/RES/1308 (2000))*, 2000.
[103] Ibid.
[104] UN Security Council, *Maintenance of international peace and security (S/RES/1983 (2011))*, 2011.
[105] IASC, *Guidelines for Addressing HIV in Humanitarian Settings*, 2010, p. 3.
[106] Ibid., pp. 11-14.
[107] Ibid.
[108] Ibid., p. 5.
[109] UNAIDS, *Language*.
[110] Humanitarian Response, *Who Does What?*.
[111] UNAIDS, *Resilient HIV responses needed in countries affected by humanitarian crises*, 2015.
[112] The League of Arab States, *Arab Strategic Framework for the Response to HIV and AIDS (2014-2020)*, 2014.
[113] UN WHO, *The Cluster Approach*, 2007.
[114] Ibid.
[115] UN OCHA, *Cluster Coordination.*
[116] UNAIDS, *27th Meeting of the UNAIDS Programme Coordinating Board*, 2010, p. 3.
[117] Ibid.
[118] UN OCHA, *Coordination.*
[119] UN OCHA, *Somalia 2013*, 2013.

HIV counseling and testing.[120] In addition, OCHA supports in-country humanitarian leaders known as Humanitarian Coordinators (HC) through data collection and information management, reporting, and strengthening the Cluster Approach.[121] Under OCHA, the Emergency Relief Coordinator (ERC), who is the Under-Secretary-General for humanitarian affairs, leads the IASC, a forum for coordination, policy development, and decision-making for UN and non-UN humanitarian actors.[122] The ERC leads IASC in developing coherent humanitarian policies, ensuring that there is a transparent division of labor, and assessing shortfalls in humanitarian responses and proposing solutions.[123]

The Inter-Agency Task Team on Addressing HIV in Emergencies (IATT), which is co-chaired by the Office of the UN High Commissioner for Refugees (UNHCR) and the World Food Programme (WFP), works with various organizations to integrate HIV interventions into key global cluster areas such as health, food security, and education.[124] IATT developed implementation guidelines for humanitarian actors on preventing mother-to-child transmission (PMTCT) in humanitarian settings to ensure effective PMTCT programming in emergency responses.[125] In the absence of PMTCT programming, the mother-to-child infection rate is between 20-45%, but PMTCT programming can reduce the transmission rate to less than 2%.[126] Patients on ART through PMTCT programs can experience disruption of treatment during humanitarian emergencies, which affects the mother's health and leads to potential new pediatric HIV infections.[127]

In 2013, UNHCR, UNICEF, UNAIDS, WFP, Save the Children, and World Vision International updated the internally displaced persons (IDP) assessment tool to better assess HIV in humanitarian emergencies.[128] UNHCR helped train stakeholders in refugee camps in Ethiopia, Ecuador, and Mexico in HIV interventions for sex workers.[129] In Mozambique, UNICEF, UNAIDS, and Save the Children assisted with developing provincial HIV emergency response plans, which resulted in these plans being incorporated in the national contingency plan.[130] Additionally, UNHCR, UNAIDS, and the International Organization of Migration (IOM) partnered with the Kenyan National AIDS Control Council in 2013 to develop the *Kenyan National Guidelines for HIV Interventions in Emergency Settings* after anticipating post-polling unrest following the presidential election.[131] Due to this collaboration, in counties that experienced post-election unrest, ART delivery was decentralized to ensure continuity of treatment.[132]

Treating People Living with HIV During Crises

During humanitarian crises, affected populations often flee crisis-stricken areas; people may travel to a different Member State, becoming refugees, or move to a different community within their home state as an IDP.[133] Displaced PLHIV can face numerous barriers to HIV treatment, such as high costs or destruction of property and infrastructure that make it difficult to travel to medical facilities for treatment.[134] Displaced persons can face barriers that inhibit their access to medical care within and outside of their own Member States due to differences in language or dialects, as well as other difficulties involved in navigating new communities, such as knowing where clinics are located.[135] Refugees living with HIV may also face discrimination and fear of identification due to unclear legal

[120] Ibid.
[121] UN OCHA, *Coordination*.
[122] Humanitarian Response, *Who Does What?*.
[123] Ibid.
[124] UNAIDS, *2014-2015 UBRAF thematic report: addressing HIV in humanitarian emergencies*, 2014, p. 3.
[125] IATT, *PMTCT in Humanitarian Emergencies: Part II: Implementation Guide*, 2015.
[126] UNICEF, *Prevention of Mother To Child Transmission*, 2015.
[127] IATT, *PMTCT in Humanitarian Emergencies: Part II: Implementation Guide*, 2015.
[128] UNAIDS, *2014-2015 UBRAF thematic report: addressing HIV in humanitarian emergencies*, 2014, p. 3.
[129] Ibid.
[130] Ibid.
[131] Ibid.
[132] Ibid.
[133] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014.
[134] Ibid.
[135] Ibid., p. 16.

status and whether they have been formally recognized as refugees by the state.[136] Discrimination and unclear legal status can make it difficult for PLHIV to access necessary medical treatment without the proper documentation for fear that that they may be deported or detained if found.[137] Healthcare systems can become weakened due to destruction of property, high demand leading to a decrease in supplies and equipment, and fewer medical personnel to administer treatment as individuals flee the crisis-affected area or are unable to access their place of work.[138] Due to these factors, and others, more than one million people in 2013 did not have access to ART in humanitarian crises due to disruption in services.[139]

While individuals may experience economic barriers to treatment, Member States may also experience funding shortages that cause clinics to close.[140] Many developing countries rely on external funding for HIV spending.[141] In 2014, 44 states relied on funding from outside sources for 75% or more of their HIV/AIDS-related spending.[142] Humanitarian emergencies often require additional funding related to the crisis that existing programs may not be able to cover.[143] Over the course of a long-term crisis, funding may decrease as donors do not want to continue supporting the same programs.[144] Funding for emergency situations can be inflexible and use only what the funding package originally detailed.[145] In some cases, funding for HIV-specific programs in emergency situations may be entirely overlooked, and as a result, HIV/AIDS programming in emergency situations may not have sufficient resources.[146] Similarly, emergency situations may be neglected in regular HIV program funding, which may not be sufficient to cover emergency contexts.[147] Flexible funding packages and incorporating contingency funds within HIV/AIDS funding schemes can allow for quick responses should an emergency arise.[148]

Mitigating Emergency-Related Impacts on People Living with HIV

Social capital is an important coping resource for any person during a crisis. Social capital refers to networks and relationships among people who live in a society that build trust between people and with persons in power.[149] This trust between individuals can decrease violence during crises and can help people work collaboratively to ensure that they receive necessary resources and assistance.[150] During emergencies, people who have close social networks can receive help, such as food, shelter, water, and information from those in the community even when the formalized private and public sectors cannot yet act.[151] PLHIV can have a more difficult time coping with disasters than others, due in part to decreased social and family connections.[152] Stigma and discrimination can isolate PLHIV from the rest of the community, which can make it more difficult during emergencies to access informal networks for food and shelter or to find reliable sources of information that could guide them to these resources.[153]

Natural disasters, conflict, and other humanitarian crises often limit access to medical care through the destruction of clinics or by inhibiting access to medical facilities through the destruction of roads.[154] PLHIV may run out of

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[136] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014, p. 15.
[137] Ibid.
[138] International HIV/AIDS Alliance, *Responding to HIV and health in fragile states*.
[139] UNAIDS, *HIV in Humanitarian Emergencies*, 2015, p. 2.
[140] AVERT, *HIV and AIDS in Sub-Saharan Africa Regional Overview*, 2016.
[141] Ibid.
[142] AVERT, *Funding for HIV and AIDS*, 2015.
[143] UNAIDS, *HIV in emergency contexts: Background Note*, 2015, p. 11.
[144] Hanson et al., *Refocusing and prioritizing HIV programmes in conflict and post-conflict settings: funding recommendations*, 2008.
[145] UNAIDS, *HIV in emergency contexts: Background Note*, 2015, p. 11.
[146] Ibid., p. 27.
[147] Ibid.
[148] Ibid., p. 28.
[149] Aldrich, *Social Capital and Resilience: Informal Policy Brief for the World Humanitarian Summit*, 2015, p. 3.
[150] Ibid.
[151] Ibid.
[152] ODI, *HIV and AIDS in Emergency Situations*, 2008, p. ix.
[153] Ibid.
[154] Gomez, Natural Disasters and People Living with HIV/AIDS, *United States Department of Health and Human Services, AIDS*, 2012.

medication and may be unable to access facilities to replenish their supply.[155] Due to mail service disruption, those that receive medical benefits through the mail may be unable to receive benefit checks, without which PLHIV may not be able to afford their treatment.[156] This can lead to discontinuity of treatment that can harm PLHIV's long-term health.[157] The destruction of infrastructure can make it difficult to access certain areas to deliver medical supplies, leading to shortages; in cases of conflict, it can also be too dangerous to reach certain areas.[158]

Emergencies and infrastructure damage can also impede access to or even damage wells.[159] Humanitarian emergencies, such as natural disasters, can lead to runoff and sewage contamination of drinking water.[160] This may cause people to leave their homes in search of water sources, but there may not be adequate infrastructure, such as latrines and water sanitation plants, where they resettle.[161] Fecal contamination of water can occur when latrines and toilets are not readily accessible, when there are insufficient facilities, or when they are in close proximity to the drinking water.[162] This contamination also occurs when there is improper hygiene, such as infrequent handwashing or bathing.[163] Ensuring that there are separate facilities, plenty of access to soap, and education on proper hygiene can decrease fecal-oral waterborne disease.[164] Due to PLHIV's compromised immune systems, poor hygiene can further endanger their health.[165] PLHIV are less able to fight off fecal-oral diseases contracted from ingesting contaminated water.[166] Sanitation, such as frequent and proper hand washing, is also critical for PLHIV, as they are especially susceptible to diarrheal disease.[167] PLHIV immune systems cannot quickly fight off diarrheal diseases, leading to prolonged and more severe episodes of diarrhea, which can result in dehydration and interfere with the efficacy of ART treatment.[168] On average, PLHIV suffering from diarrheal disease need 20 more liters of water per day to wash soiled clothing and sanitize infected areas.[169] In humanitarian emergencies, if water becomes scarce, ensuring the prevention of fecal-oral disease is critical to long-term positive health outcomes for PLHIV.[170]

Humanitarian emergencies may also exacerbate food insecurity for the general population and PLHIV.[171] Nutrition is an important component of PLHIV's treatment, as malnutrition can further weaken their already compromised immune systems.[172] PLHIV can have decreased appetites and also experience challenges absorbing nutrients from food, making food insecurity a particularly difficult problem.[173] Malnutrition arising from food insecurity is associated with decreased ART efficacy, thereby contributing to a further decline in immune health and resulting in increased secondary infections, hospitalizations, and/or mortality.[174]

Addressing Vulnerability to HIV Transmission and Infection

The International Federation of Red Cross and Red Crescent Societies (IFRC) defines vulnerability as the inability to anticipate, cope with, or recover from natural or man-made disasters.[175] Political, economic, social, and physical

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[155] Ibid.
[156] Ibid.
[157] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014, p. 7.
[158] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2015.
[159] The Johns Hopkins & IFRC, *Water, sanitation and hygiene in emergencies*.
[160] UNAIDS, *HIV in emergency contexts: Background Note*, 2015, p. 21.
[161] The Johns Hopkins & IFRC, *Water, sanitation and hygiene in emergencies*.
[162] Ibid.
[163] Ibid.
[164] Ibid.
[165] UNAIDS, *HIV in emergency contexts: Background Note*, 2015, p. 21.
[166] WASH Advocates, *WASH and HIV/AIDS*.
[167] IASC, *Guidelines for Addressing HIV in Humanitarian Settings*, 2010, p. 55.
[168] WASH Advocates, *WASH and HIV/AIDS*.
[169] Ibid.
[170] Ibid.
[171] UNAIDS, *HIV in Humanitarian Emergencies*, 2015, p. 3.
[172] Ibid., p. 9.
[173] Ibid., p. 3.
[174] USAID, *Multi-Sectoral Nutrition Strategy 2014-2025 Technical Guidance Brief: Nutrition, Food Security and HIV*, 2015.
[175] IFRC, *What is Vulnerability?*,

factors can determine a person's or a group of people's vulnerability to a situation.[176] Some examples of potentially vulnerable groups are displaced populations, migrants, returnees, impoverished people, women, and unaccompanied children.[177] PLHIV in any of these groups can be even more vulnerable to emergency situations.[178]

Emergencies can increase threats to vulnerable groups, and women and children are often disproportionately affected by food insecurity, lack of resources, and susceptibility to contracting diseases.[179] Underlying social and cultural factors, such as unequal power dynamics between men and women or lower social status, may impact the ability of women and girls to find adequate work.[180] If emergencies heighten job scarcity, the opportunities available to women may be inadequate to provide their basic needs.[181] Therefore, women and girls are more likely to engage in transactional sex in order to provide for their families if they do not have access to others means of income, which consequently puts them at a greater risk for HIV transmission.[182] Youth, aged 15 to 24, are often unable to cope with emergency situations and may be vulnerable to transmission due to increased HIV-risk behaviors, including relying on transactional sex to meet basic needs.[183] Some factors that can increase young people's vulnerability to HIV during a humanitarian emergency are separation from families, sexual and gender-based violence, disruption of health services, and lack of information about HIV transmission and prevention measures.[184]

An estimated one in five refugee or displaced women in humanitarian crises experiences gender-based violence (GBV).[185] In locations of already high HIV prevalence, this can increase instances of HIV transmission, as victims of sexual violence are unable to take adequate prevention measures.[186] Instances of rape, trafficking, and intimate partner violence can increase during and after disasters, leading to increased vulnerability of women and girls.[187] Increased stress levels due to loss of property or livelihood, destruction of social networks, mental-health disorders, such as post-traumatic stress disorders, scarcity of basic provisions, and breakdown of law enforcement and violence prevention, are all potential factors leading to increased levels of GBV and therefore of HIV transmission.[188]

Conclusion

Humanitarian emergencies impact PLHIV differently than others: PLHIV often have a lower ability to cope with emergencies due to strained social networks, isolation, and higher daily nutritional and clean water needs.[189] PLHIV, especially female PLHIV, may experience stigmatization and discrimination that make it more difficult meet basic needs.[190] Disruptions arising from barriers caused by an emergency can decrease ART and medical treatment adherence, leading to worsened healthcare outcomes.[191] In addition, people in humanitarian emergencies may become more vulnerable to the transmission of HIV through sexual violence or engaging in HIV-risk activities.[192]

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[176] Ibid.
[177] Ibid.
[178] UNAIDS, *HIV in Humanitarian Emergencies*, 2015.
[179] IATT, *Integrating HIV in the Cluster Response*, 2014, p. 3.
[180] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014, p. 30.
[181] UN-Women, *Facts and Figures: Humanitarian action*, 2016.
[182] UNICEF, *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*, 2014, p. 30; UN-Women, *Facts and Figures: Humanitarian action*, 2016.
[183] UNICEF, *Inter-Agency Task Team on HIV and Young People: Guidance Brief*, 2008, p. 2.
[184] Ibid., p. 3.
[185] UN-Women, *Facts and Figures: Humanitarian action*, 2016.
[186] IFRC, *Gender Sensitive Approaches for Disaster Management*, p. 28; Mayer, *What is the link between Gender Based Violence and HIV/AIDS?*, 2013.
[187] UNDP, *Gender and Disasters*, 2010, p. 1.
[188] WHO, *Violence and disasters*, 2005.
[189] IFRC, *What is Vulnerability?*.
[190] WASH Advocates, *WASH and HIV/AIDS*; Aldrich, *Social Capital and Resilience: Informal Policy Brief for the World Humanitarian Summit*, 2015; USAID, *Multi-Sectorial Nutrition Strategy 2014-2025 Technical Guidance Brief: Nutrition, Food Security and HIV*, 2015.
[191] IFRC, *What is Vulnerability?*,
[192] UNAIDS, *AIDS in Emergency, Conflict and Humanitarian Contexts*, 2015.

Ensuring access to treatment and prevention during humanitarian crises requires increased coordination of efforts across the international community.[193]

Further Research

Ensuring continuity of access to medical care, adequate funds for HIV emergency programming, and disaster preparedness is important for ensuring that HIV treatment and care is not disrupted and that HIV rates do not rise in the event of an emergency.[194] Moving forward, delegates should consider questions specific to how UNAIDS can contribute to mitigating the impacts of humanitarian emergencies on HIV prevention and treatment programming: What are specific way in which humanitarian emergencies can support those vulnerable to and living with HIV/AIDS? How can UNAIDS, its cosponsors, and other interested stakeholders mitigate vulnerability to humanitarian crises? What new strategies can be developed? How can existing strategies and programs be improved to ensure disaster preparedness? How can UNAIDS engage other stakeholders and advocate for greater political commitment, such as increased HIV-specific emergency funding, to ensuring continuity of treatment and access during humanitarian crises?

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This source, while specific to sub-Saharan Africa and not limited to humanitarian crises, clearly defines barriers to HIV/AIDS treatment that are applicable to other regions and in different situations. It describes programs that have been successful in expanding access to screening and testing. While some of the barriers described in the source may be region-specific, sub-Saharan Africa represents around 71% of the global total of PLHIV. Thus, understanding these barriers will be helpful in ensuring delegates understand the difficulty in achieving the 90-90-90, 2020, and 2030 targets and potential areas to mitigate and overcome these barriers.

Forced Migration Review. (2010). *HIV/AIDS security and conflict: making the connections* [Report]. Retrieved 18 June 2016 from: http://www.fmreview.org/sites/fmr/files/FMRdownloads/en/Aids.pdf

Delegates will find useful information in this report regarding the intricacies of forced migration due to conflict or other types of disasters and its relationship to HIV/AIDS prevention and treatment. This report highlights the achievements made in HIV/AIDS responses in emergency situations, but also provides areas in which there is room for future growth. Delegates will find this document provides another look at past activities that have attempted to ensure HIV/AIDS treatment and prevention in emergency situations, as well as guidance for improving upon past attempts.

Inter-Agency Standing Committee. (2010). *Guidelines for Addressing HIV in Humanitarian Settings*. Retrieved 18 June 2016 from: http://www.unaids.org/sites/default/files/media_asset/jc1767_iasc_doc_en_0.pdf

This document is useful for understanding the guidelines of UNAIDS and other organizations in response to HIV/AIDS programs in crises and emergency situations. It is the foundation for the necessary response requirements in these situations. Delegates will gain a better understanding of the existing response guidelines for ensuring that future programs meet the minimum requirements and for identifying potential areas for improvement.

Inter-Agency Task Team on Addressing HIV in Emergencies. (2014). *Integrating HIV in the Cluster Response* [Report]. Retrieved 28 August 2016 from: http://hivinemergencies.org/wp-content/uploads/2015/02/Integrating-HIV-in-the-Cluster-Response-Guidance-Briefs-2014.pdf

This document details the importance of integrating HIV response in existing humanitarian cluster approaches. Vulnerable groups can be disproportionately impacted by humanitarian crises and therefore more susceptible to HIV during emergencies. In addition, PLHIV may become vulnerable after humanitarian crises, which can disrupt medical care and lead to adverse health

[193] Ibid.
[194] UNAIDS, *Language.*

outcomes. Understanding how HIV has been integrated in existing cluster responses provides delegates with a foundation for potential policy proposals.

International HIV/AIDS Alliance. (2014). *The HIV/AIDS Response in Conflict: Lessons Learnt from South Sudan*. Retrieved 18 June 2016 from: http://www.ifrc.org/Global/Publications/Health/South%20Sudan%20report%20FINAL.pdf

This document refers to a specific conflict, describing the activities that proved to be successful in the HIV/AIDS response in South Sudan. In addition, it identifies areas where there were gaps and unmet needs during the response. Delegates may find this resource useful in understanding the previous responses that were utilized in a recent conflict in order to understand areas that may need improvement or in which previously implemented programs could be duplicated.

The Johns Hopkins & International Federation of Red Cross and Red Crescent Societies. (n.d.). *Water, sanitation and hygiene in emergencies*. Retrieved 20 October 2016 from: http://www.jhsph.edu/research/centers-and-institutes/center-for-refugee-and-disaster-response/publications_tools/publications/_CRDR_ICRC_Public_Health_Guide_Book/Chapter_8_Water_Sanitation_and_Hygiene_in_Emergencies.pdf

This report details the impacts of humanitarian emergencies on water, sanitation, and hygiene (WASH) and specifically highlights the importance of WASH for PLHIV. Delegates will gain a detailed understanding of the different impacts that emergencies have on water sanitation and mechanisms to mitigate these impacts. WASH is a critical component of ensuring that PLHIV's health is not negatively affected. Specific mechanisms to decrease the likelihood that PLHIV's health will be negatively impacted from poor water safety should be incorporated into future HIV emergency programming.

Joint United Nations Programme on HIV/AIDS. (2016). *2014-2015 UBRAF thematic report: Addressing HIV in humanitarian emergencies.* Retrieved 18 June 2016 from: https://results.unaids.org/sites/default/files/documents/Addressing_HIV_in_humanitarian_emergencies_Jun2016.pdf

This resource highlights the most recent achievements in HIV treatment and prevention programming in emergency situations. It provides a brief synopsis of the role of the international system in integrating HIV in emergency response programs. It shows the steps that have already been taken to ensure HIV prevention and treatment programs are integral parts of emergency response activities. Understanding the recent steps that UNAIDS has taken to incorporate HIV programs into humanitarian responses is crucial to understanding what the committee can and cannot do and where delegates can build on already successful programs.

United Nations Children's Fund. (2014). *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa*. Retrieved 28 August 2016 from: http://www.unicef.org/aids/files/ART2014-189014B-LOWRES_(1).pdf

While this report has guidelines that are designed for ART in sub-Saharan Africa, it comprehensively identifies key definitions and specific barriers that crisis-affected persons face. The report breaks down specific recommendations for clinicians, program managers, and policy makers. Many of these recommendations can be adapted and applied to other regions and states affected by humanitarian emergencies and can expose delegates to actual policy recommendations. Understanding current recommendations can help delegates formulate new ideas or build upon existing policy recommendations to address this issue.

United Nations Population Fund. (2014). *HIV Prevention in Emergencies* [Website]. Retrieved 18 June 2016 from: http://www.unfpa.org/resources/hiv-prevention-emergencies

This resource provides delegates with an accessible breakdown of the issue areas that must be addressed in crisis situations in relation to HIV/AIDS. It highlights the necessity of ensuring the dissemination of and access to information and education, safety in healthcare facilities, access to prevention and treatment resources, and working with the armed forces. This resource is a starting point for understanding some of the particularities of treatment and prevention in humanitarian emergencies and will give delegates a foundational understanding of what needs to be addressed in the future.

United Nations, Security Council, 6547th meeting. (2011). *Maintenance of international peace and security (S/RES/1983 (2011))* [Resolution]. Retrieved 18 June 2016 from: http://undocs.org/s/res/1983(2011)

This resolution reaffirms the international community's responsibility to ensure access to prevention and treatment for all persons living with HIV/AIDS, regardless of whether or not they are situated in conflict or post-conflict zones. In addition, this resolution recognizes the gendered aspect of HIV/AIDS in conflict and post-conflict zones and urges Member States to take this into consideration for future efforts. Understanding the work that the international community has already done is crucial for ensuring that future policy builds upon the existing international framework.

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II. Addressing the Needs of Ageing Populations Living with HIV/AIDS

"The ageing of the world's population is one of the most significant demographic trends of this era, and there are a growing number of people aged 50 and older living with HIV in the world today. With the size of this demographic growing, there will be an increased need for long-term access to HIV and other health services."[195]

Introduction

In the global response to human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), a new public health issue and discussion has begun gaining more attention: addressing the health needs of adults over the age of 50 who are currently living with HIV or AIDS, resulting from three main causes.[196] Firstly, due to successful public health and HIV/AIDS interventions, more people living with HIV are receiving antiretroviral therapy (ART), thus experiencing improved health outcomes and living longer, especially in developing countries with stronger health systems.[197] Secondly, as increasingly fewer young people become infected with HIV, the older population with HIV will continue to increase as a percentage of total infections.[198] However, the most concerning cause of this trend is that prevention efforts have not been targeted at this age group, although they are often engaging in risk taking behavior, leading to 120,000 new infections every year.[199] In total, there are an estimated 5.5 million adults around the world aged 50 years and older who are living with HIV out of a global total of approximately 36 million.[200] More importantly, the majority of these, totaling around 2.9 million people 50 years or older, are living in low and middle-income countries.[201]

The Joint United Nations Programme on HIV/AIDS (UNAIDS) recognizes that HIV/AIDS poses a formidable challenge to sustainable development, and it is one of many actors participating in the international response to HIV/AIDS.[202] UNAIDS has implemented the UNAIDS *2016-2021 Strategy*, which reaffirms the importance of fast-tracking the HIV/AIDS response, especially for demographic groups often left behind in response efforts.[203] This Background Guide will provide introductory information on the international and regional framework on the topic and will elaborate on what the international system has done in response to the challenges of ageing populations living with HIV/AIDS. Additionally, it will overview the most pressing challenges and needs of this population, including prevention and effective treatment services.

International and Regional Framework

There are a number of international and regional agreements and resolutions underpinning the international response to the HIV/AIDS epidemic. However, while there is a strong international framework in place on the general HIV/AIDS response, which recognizes the needs of distinct population groups, the issues of an ageing population living with HIV/AIDS has received less attention by the international community.[204] One of the most important framework documents is the UNAIDS *2016-2021 Strategy*, which guides the work of the organization. This document expresses the needs and challenges presented currently in the HIV and AIDS response.[205] There is also special emphasis placed on groups that have been left behind in the HIV/ AIDS response, and highlights that the protection of human rights in all dimensions will ensure that those left behind obtain health services and also empower others to be outspoken, mobilize, and engage to end HIV/AIDS as a public health threat globally.[206] Other

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[195] UNAIDS, *The Gap Report 2014: People Aged 50 Years and Older*, 2014, p. 1.
[196] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries are Aged 50 and Over*, 2013.
[197] Ibid.
[198] Ibid.
[199] Ibid.
[200] UNAIDS, *On the Fast-Track to end AIDS*, 2015, p. 35.
[201] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries are Aged 50 and Over*, 2013.
[202] UNAIDS, *The Gap Report 2014: People Aged 50 Years and Older*, 2014.
[203] UNAIDS, *On the Fast-Track to end AIDS: UNAIDS 2016-2021 Strategy*, 2015, p. 17.
[204] Cumming & Negin, *HIV Infection in Older Adults in Sub-Saharan Africa: Extrapolating Prevalence from existing data*, 2010, p. 1.
[205] UNAIDS, *On the Fast-Track to end AIDS*, 2015, p. 6.
[206] Ibid., p. 5.

international documents have acknowledged that "those over age 50 and pregnant women are also being left behind in many parts of the world."[207]

A number of documents exist to further guide the work of the international community on HIV/AIDS more generally. For example, the Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS jointly developed *The International Guidelines on HIV/AIDS and Human Rights*, adopted by the Second International Consultation on HIV/AIDS and Human Rights in 1996.[208] These guidelines emphasize the importance of governments and organizations to share best practices for promoting, protecting, and meeting human rights when responding to the HIV epidemic.[209] Further, the *Declaration of Commitment on HIV/AIDS* was adopted in in 2001 at the United Nations (UN) General Assembly Special Session on HIV/AIDS.[210] The document outlines leadership among international and regional agencies, discusses prevention and treatment methods for those living with HIV/AIDS, and reiterated the importance of protecting human rights for those affected.[211]

The General Assembly resolution entitled "Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS" also expresses key aspects in the fight against HIV/AIDS such as welcoming the involvement of the UN Entity for Gender Equality and the Empowerment of Women (UN-Women) in the response to HIV/AIDS.[212] In April 2015, the UN Economic and Social Council (ECOSOC) adopted resolution 2015/2 on the "Joint United Nations Programme on HIV/AIDS," recognizing the work of UNAIDS and sharing the concerns that in order to end the HIV/AIDS epidemic by 2030, a fast-track approach is required and the next five years will be crucial.[213]

The issue of HIV/AIDS has also received international attention by being included in the Sustainable Development Goals (SDGs), adopted by the General Assembly in 2015.[214] SDG goal 3 highlights the need to "ensure healthy lives and promote well-being for all at all ages;" its target includes ending AIDS as a public health threat by 2030.[215] While young populations are especially vulnerable to HIV/AIDS, meeting the needs of those over 50 will be important to achieve this goal.[216]

Role of the International System

A number of actors are involved globally in the response to HIV/AIDS. UNAIDS serves as the major UN organization in leading the collaborative agenda in the HIV/AIDS response.[217] The agency follows the UNAIDS *2016-2021 Strategy*, which emphasizes the importance of including particularly vulnerable populations who have been "left behind" in the global HIV/AIDS response.[218] Included in this are people over the age of 50, whose needs are often not met by HIV response services and systems.[219] Moreover, the UNAIDS *2016-2021 Strategy* has outlined in detail plans and goals towards the accomplishments of response strategies within the next five years.[220] The strategy embraces that people living with HIV/AIDS all "have the equal opportunity to grow, develop, flourish, work, and enjoy prosperous and fulfilling lives," emphasizing the important role the international system plays in creating change.[221]

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[207] UN General Assembly, *Future of the AIDS response: building on past achievements and accelerating progress to end the AIDS epidemic by 2030 (A/69/856)*, 2015, p. 3.
[208] OHCHR & UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 2006. pp. 9-11.
[209] Ibid.
[210] UN General Assembly, *Declaration of Commitment on HIV/AIDS*, 2001.
[211] Ibid.
[212] UN General Assembly, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (A/RES/65/277)*, 2011, p. 4.
[213] UN ECOSOC, *Joint United Nations Programme on HIV/AIDS (E/RES/2015/2)*, 2015.
[214] UN General Assembly, *Transforming our world: the 2030 Agenda for Sustainable Development (A/RES/70/1)*, 2015.
[215] UNAIDS, *On the Fast-Track to end AIDS*, 2015, p. 18.
[216] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries are Aged 50 and Over*, 2013; UN SDGs, *Goal 3: Ensure healthy lives and promote well-being for all at all ages*.
[217] UNAIDS, *UNAIDS: An Overview*, 1996, p. 3.
[218] UNAIDS, *On the Fast-Track to end AIDS*, 2015, p. 44.
[219] Ibid., p. 33.
[220] Ibid., p. 23.
[221] Ibid., p. 9.

The World Health Organization (WHO), with the *Global Health Sector Strategy 2016-2021*, has built from past achievements of the WHO Special Programme on AIDS in 1986 and works in close collaboration with UNAIDS.[222] For example, one report analyzing UNAIDS data concluded that younger populations with HIV/AIDS live on average thirteen years after infection, while those older populations over the age of 50 only live on average four years after being diagnosed with HIV/AIDS.[223] WHO's research has further shown that with age comes decreased immunity to illness, thus older age individuals with HIV/AIDS are at a higher risk of health problems.[224] The WHO reinforces that greater research amongst the elderly population is needed to truly analyze the high risk and effects that have been yet fully unexplored and to develop new intervention systems among those over 50 years of age who are greater at risk.[225]

Many UN agencies work on the HIV/AIDS response based on their specific mandate. One of numerous stakeholders in the global response, UN-Women focuses on issues such as stigma and discrimination.[226] However, although focusing on women with HIV and AIDS, UN-Women, does not play much special emphasis on women over the age of 50.[227] Another organization, OHCHR, works to include human rights in the HIV/AIDS global response on the international, regional, and local levels.[228] Therefore, OHCHR has collaborated with UNAIDS to focus on implementing the protection of human rights into HIV/AIDS response frameworks.[229]

Civil society also plays an important role in the response to HIV/AIDS, including in supporting older adults with HIV. Activists living with HIV have been important actors since the beginning of the HIV/AIDS epidemic; their ability to organize and provide support has influenced the national and international responses.[230] One of the main purposes why civil societies are important is because local people can organize and conduct services that otherwise governments could simply not address.[231] More importantly, civil society actors are among the most effective in beginning discussion over key populations being left behind; thus civil society can play a major role in advocating for the ageing population.[232]

HIV Prevention Services for Adults over 50

Due to the fact that the overwhelming majority of people living with HIV/AIDS, as well as new HIV infections, are children and young adults, most prevention services are focused on those populations. However, people over the age of 50 account for 120,000 new infections every year, demonstrating the need for effective prevention services.[233] This population group is currently underserved by national and global HIV prevention services.[234] This group is often not the target of specific prevention services, thus many older individuals also engage in high risk behavior, such as unprotected sex and drugs, which has led to new HIV cases.[235]

HIV prevention can take many forms, but is most successful when a "combination prevention" approach is taken.[236] This means that prevention approaches are right-based, based on scientific evidence, and adapted to local communities and the needs of the target population.[237] Further, they are based off of a combination of "biomedical,

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[222] WHO, *Global Health Sector Strategy on HIV 2016-2021: Towards Ending AIDS*, 2016, p. 51.
[223] Schmid et al., *The Unexplored story of HIV and Ageing*, 2009.
[224] Ibid.
[225] Ibid.
[226] UN-Women, *Leadership and Participation*.
[227] UN-Women, *Fast Tracking the End of the AIDS Epidemic for Women*, 2016.
[228] UN HRC, *The Protection of Human Rights in the Context of HIV/AIDS (A/HRC/RES/16/28)*, 2011, p. 3.
[229] OHCHR, *The Role of OHCHR*.
[230] WHO, *2006 Report on the Global AIDS Epidemic: The Essential Role of Civil Society*, 2006, p. 2.
[231] Ibid.
[232] Ibid., p. 4.
[233] UNAIDS, *On the Fast-Track to end AIDS*, 2015, p. 35.
[234] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries Are Aged 50 and Over*, 2013.
[235] Ibid.
[236] UNAIDS, *Combination HIV Prevention*, p. 8.
[237] Ibid.

behavioral, and structural interventions."[238] This means, for example, that a singular action like condom distribution is not adequate, but should instead be undertaken alongside educational initiatives. Such prevention measures have been shown to work: the rate of HIV infection has been declining globally, and this has been "clearly linked with changes in behavior and social norms together with increased knowledge of HIV."[239]

However, since people over the age of 50 are not the group highest at risk of contracting HIV, fewer resources have been invested into prevention measures for this population; both HIV awareness and education for older adults are low.[240] Thus, it is vital to increase information and awareness over the risk of HIV in order to reduce infection rates among elderly people.[241] Data shows people over the age of 50 have a low perception of the risk of acquiring and know little over the disease as well as the services provided for them.[242] Additionally, since HIV/AIDS was first understood and addressed as public health threat in the 1980s, the risk factors have changed.[243] Accordingly, there could be common misunderstandings of how HIV is transmitted and who is vulnerable.[244] For example, United States Center for Disease Control and Prevention (CDC), found that many older adults did not believe HIV to be an issue affecting their population group.[245]

Health care providers and political decision makers who are responsible for national HIV prevention services can be important actors in changing this trend.[246] For example, medical professionals should not maintain stereotypes about adults over the age of 50; many may believe that older individuals are no longer sexually active, or feel uncomfortable asking important questions that can identify risk factors.[247]

Providing Effective Treatment for People over the Age of 50

People over the age of 50 living with HIV have unique health concerns that must be addressed by national health systems to ensure effective treatment at all stages of the disease, ranging from testing to providing life-saving treatment. UNAIDS has emphasized the importance of integrating HIV/AIDS treatment and testing into standard health services in order to increase the effectiveness and efficiency.[248] Effective treatment must reach the 5.5 million people living with HIV/AIDS around the world who are over the age of 50.[249] One of the greatest challenges, though, is that international experts do not fully understand why this age group is becoming infected with HIV as very few studies exist to examine HIV infection in older adults and sexual habits of this group.[250]

HIV Testing and Early Treatment

The first step to successful treatment is ensuring that older individuals are getting tested for HIV. Current HIV screening rates among older adults is lower than other age groups.[251] One reason is that older population might feel less inclined to share sexual habits when visiting their doctor, thus making medical professionals less likely to advocate testing for HIV, in addition to the aforementioned lower perception of risk.[252] Doctors further may not identify HIV as a cause of an older patient's medical complaints.[253]

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[238] Ibid.
[239] Ibid., p. 5.
[240] UNAIDS, *The Gap Report*, 2014, p. 277.
[241] Ibid., p. 5.
[242] Ibid., p. 3.
[243] Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.
[244] Ibid.
[245] Center for Diseases Control and Prevention, *HIV Among People Aged 50 and Over*, 2016.
[246] Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.
[247] Ibid.
[248] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries Are Aged 50 and Over*, 2013.
[249] Ibid.
[250] Schmid et al., *The Unexplored story of HIV and Ageing*, 2009.
[251] Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.
[252] Center for Disease Control and Prevention, *HIV Among People Aged 50 and Over*, 2016.
[253] Schmid et al., *The Unexplored story of HIV and Ageing*, 2009.

Early identification is key for ensuring the health of older people living with HIV; indeed, this group is more likely to find out about their HIV infection at a later stage in the disease's progression.[254] This contributes to the risk that a patient's HIV will progress more quickly into AIDS due to delayed treatment.[255] One study found that individuals who were affected at age 65 or older had an average life expectancy of 4 years after infection.[256]

Because of older adults' generally weaker immune systems, early ART is especially important.[257] The affordability and availability for such services is always a challenge, however.[258] While WHO has recognized that ART has been successful in developed countries, ART has been less effective in developing countries because of the delayed introduction of treatment and the limited availably of services.[259]

Effective Treatment

UNAIDS has highlighted the importance of psychological and medical support for this age group.[260] Additionally, a particular health concern for this demographic is the co-morbidities, meaning the presence of multiple chronic health conditions.[261] As ART has increased life expectancy, other health issues have emerged, such as chronic diseases, management of multiple medications, and decreased physical and cognitive abilities alongside HIV or AIDS itself.[262] There are a multitude of non-communicable diseases (NCDs) such as cardiovascular disease, osteoporosis, diabetes, pneumonia, heart attacks, strokes, and cancer that can increase the risk of serious health effects or death for those living with HIV over the age of 50.[263] Thus, such illness have the potential of increasing the danger of HIV progression.[264] Accordingly, HIV/AIDS response services must be integrated into national health plans that also address NCDs [265] Additionally, researchers believe that the increase of HIV-related comorbidities in the older population are because of drastic changes in the immune system; ageing and weaker immune system brings the onset of age-related chronic diseases and fragility.[266] For example, one condition to focus attention on is HIV-Associated Neurocognitive Disorder in which one may experience attention deficits, impaired language and motor skills, and weakened memory or sensory perception.[267]

An important element of HIV treatment is ART, which reached about 13.6 million people and 12.1 million of them were from low- and middle-income countries.[268] Although numerous countries and regions have made great strides towards reaching reduction of HIV/AIDS-related deaths, others have seen slow progress and backward results.[269] The implementation of discriminatory laws have served to distanced certain groups from receiving proper services, thus the international and regional framework must improve here.[270]

Stigma and Discrimination

UNAIDS defines stigma related to HIV as "negative beliefs, feelings and attitudes" against those individuals and populations living with HIV.[271] Discrimination in regards to HIV is defined as unreasonable and wrongful treatment

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[254] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries Are Aged 50 and Over*, 2013; Schmid et al., *The Unexplored story of HIV and Ageing*, 2009, p. 161-244.
[255] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries Are Aged 50 and Over*, 2013.
[256] Schmid et al., *The Unexplored story of HIV and Ageing*, 2009.
[257] UNAIDS, *The Gap Report 2014: People Aged 50 Years and Older*, 2014, p. 8.
[258] Ibid., p. 131.
[259] Schmid et al., *The Unexplored story of HIV and Ageing*, 2009.
[260] UNAIDS, *The Gap Report 2014: People Aged 50 Years and Older*, 2014, p. 8.
[261] Valderas et al., *Defining Comorbidity: Implications for Understanding Health and Health Services*, 2009.
[262] AIDS.gov, *Aging with HIV/AIDS: Growing older with HIV*, 2015.
[263] Carter, *Burden of non-AIDS-related illness increases as patients with HIV age*. *AIDS Map*, 2011.
[264] UNAIDS, *HIV & Aging: A special supplement to the UNAIDS report on the global AIDS epidemic*, 2013, p. 7.
[265] Valderas et al., *Defining Comorbidity: Implications for Understanding Health and Health Services*, 2009.
[266] National Institute of Aging, *Aging with HIV: Responding to an emerging challenge*, 2015.
[267] Ibid.
[268] UN DESA, *The Millennium Development Goals Report 2015*, 2015, p. 46.
[269] UN General Assembly, *Future of the AIDS response: building on past achievements and accelerating progress to end the AIDS epidemic by 2030 (A/69/856)*, 2015, p.1.
[270] Ibid., p. 2.
[271] UNAIDS, *Guidance Note: Reduction of HIV Related Stigma and Discrimination*, 2014, p. 5.

of people who happen to have HIV.[272] Discrimination against and stigma towards people living with HIV/AIDS stems from various causes, including negative societal and personal views of lesbian, gay, bisexual, and transgender (LGBT) individuals and misunderstandings of HIV/AIDS.[273] The ramification of is that fewer older people with HIV seek treatment due to fear of negative perceptions of them.[274]

In addition to leading some to avoid treatment, sometimes discrimination is codification in law and policies, or patients are denied health services due to their HIV status.[275] Therefore, the UNAIDS Programme Coordinating Board see programs that focus on stigma and discrimination as imperative to the HIV/AIDs response and accomplishment of HIV/AIDS strategies.[276] Moreover, OHCHR has expressed that there is increased vulnerability among key populations because of their inability to secure their human rights.[277] Those living with HIV/AIDS face stigmatization and discrimination and higher risk of complicated health issues.[278] Thus, a violation of human rights impedes the effectiveness of response.[279]

A current report on governments expressed that about 90% have implemented guidelines to address stigma and discrimination in their established HIV programs, but that budgeting and implementation fell short of commitments.[280] In connection with this, UNAIDS expresses that strategies to deal with HIV/AIDS are hindered by the fact that numerous countries report a lack of protecting human rights.[281] Additionally, while experiencing negative stigma, discrimination, and inequality within their respected communities and societies, those over the age of 50 face overwhelming risks.[282] For example, receiving negative attitudes from family and peers, combined with poor quality and delay of health services decreases the success of HIV treatment.[283]

Conclusion

UNAIDS as the primary agency in the HIV/AIDS response has acknowledged that those over the age of 50 are being left behind, thus the international community must work to address the needs of this population.[284] Although the response to end HIV/AIDS has been a significant effort by the international and regional communities, the demographic shift that is presently occurring has brought new attention to issues and obstacles faced by an ageing population[285]. Individuals over the age of 50 who are now living longer due to the success and implementation of ART.[286] In order to ensure the health and well-being of this population, efforts must be made to increase prevention services to those age 50 and older, as they are currently underserved and are at risk of acquiring HIV.[287] Further, effective treatment will require early detection and treatment, as well as tailoring treatment to address the additional risks of co-morbidities. It will also be critical to address the stigma and discrimination that continue to prevent this population from seeking treatment or block them from doing so.

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[272] UNAIDS, *Guidance Note: Reduction of HIV Related Stigma and Discrimination*, 2014, p. 5; Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.
[273] UNAIDS, *Guidance Note: Reduction of HIV Related Stigma and Discrimination*, 2014, p. 5.
[274] Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.
[275] UNAIDS, *Guidance Note: Reduction of HIV Related Stigma and Discrimination*, 2014, p. 5; Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.
[276] UNAIDS, *Guidance Note: Reduction of HIV Related Stigma and Discrimination*, 2014, p. 5.
[277] OHCHR, *HIV/AIDS and Human Rights*.
[278] Ibid.
[279] Ibid.
[280] Ibid.
[281] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010*, 2010, pp. 124-128.
[282] UNAIDS, *The Gap Report 2014: People Aged 50 Years and Older*, 2014, p. 7.
[283] Ibid.
[284] UNAIDS, *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries are Aged 50 and Over*, 2013.
[285] Ibid.
[286] Ibid.
[287] Whiteman, *Older Adult HIV Risk Prevention*, 2014, p. 26.

Further Research

As the ageing population living with HIV/AIDS continues to increase, it is crucial that delegates begin to understand how to address the needs of this population. Acknowledging that international and regional frameworks have addressed the HIV/AIDS response, what can be done to include population over the age of 50 as part of the broader discussion? How can the gap in research and specific information on this population group be bridged? How can the international community increase effectiveness of providing prevention services and treatment to those most vulnerable, including adults over the age of 50? What can Member States and UNAIDS do to connect HIV/AIDS health services with primary health services for older adults? Emphasizing that those over the age of 50 face stigmatization and discrimination, what can UNAIDS, OHCHR, and Member States do to protect their human rights? Furthermore, how can barriers and limitations be overcome by UNAIDS and its partners in order to properly address the needs of this ageing population?

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Centers for Disease Control and Prevention. (2016). *HIV Among People Aged 50 and Over* [Website]. Retrieved 29 July 2016 from: http://www.cdc.gov/hiv/group/age/olderamericans/index.html

The website elaborates about prevention challenges faced by those living with HIV aged 50 and over. It specifically mentions a few key issues for the population over 50 years of age. It reaffirms that awareness among this population group is low, thus posing a risk for them to acquire HIV. It also explains the issue of stigma and the discrimination that derives from not just having HIV/AIDS, but also being affected by other medical conditions. The source will be critical for delegates seeking to understand how HIV and other diseases can be treated together.

Joint United Nations Programme on HIV/AIDS. (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010.* Retrieved 25 October 2016 from: http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

The UNAIDS Global Report on the Global AIDS Epidemic provides detailed information from the year 2010 about the impact of the global AIDS epidemic. The report provided information about HIV prevention and treatment possibilities, a human rights overview, and actions for investments towards the HIV response. It offers a background overview for UNAIDS. In regards to the topic at hand about ageing population, the report mentions key populations, which could help understand the topic and create connections. Additionally, since the report was produced five years before the MDGs expire, it can shed light on the differences from then to now.

Joint United Nations Programme on HIV/AIDS. (2013). *HIV & Aging: A special supplement to the UNAIDS report on the global AIDS epidemic 2013*. Retrieved 29 July 2016 from: http://www.unaids.org/sites/default/files/media_asset/20131101_JC2563_hiv-and-aging_en_0.pdf

This report expands on the increase prevalence of HIV in population over the age of 50, while also focusing on prevention services provided to these individuals. Moreover, the document explains the ideas behind providing effective treatment such as ART which has showcased success in numerous regions. However, it also notes that antiretroviral therapy amongst people aged 50 and over might face distinct challenges. In conclusion, the report from UNAIDS reiterates that this group of people are a growing part of the HIV/AIDS global issue so new responses and frameworks need to be put in place to effectively assist this key population.

Joint United Nations Programme on HIV/AIDS. (2013, November 1). *UNAIDS Reports that More than 10% of Adults Living with HIV in Low- and Middle-Income Countries Are Aged 50 and Over* [Press Release]. Retrieved 30 July 2016 from: www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2013/november/20131101praging/

This press release from UNAIDS provides an effective and quick overview of data on those over the age of 50 living with HIV/AIDS in low- and middle-income countries and regions. It is recognized that ageing is an important factor for those living with HIV/AIDS and it is necessary to implement and connect primary health services provided with HIV/AIDS treatment. Lastly, the document also elaborates on the fact that the lack of awareness of HIV and AIDS is increasing the risk taking factor among those over the age of 50 and thus leading to possible new HIV/AIDS infections.

Joint United Nations Programme on HIV/AIDS. (2014). *The Gap Report 2014: People Aged 50 Years and Older*. Retrieved 29 July 2016 from: http://www.unaids.org/sites/default/files/media_asset/12_Peopleaged50yearsandolder.pdf

The report by UNAIDS elaborates on the shifting demographic in HIV/AIDS population and gives information on the aspects why people over the age of 50 are being left behind. It also explains some of the burdens that this key population faces by providing four main reasons, those being: low perception of HIV risk, the complicated nature of managing HIV alongside other health issues, limited access to services, and stigma and discrimination. It calls for action in those four areas in order to improve the well-being and health of those over 50 living with HIV/AIDS. Furthermore, it elaborates upon each area and provides basic important information needed to understand the issue at hand.

Joint United Nations Programme on HIV/AIDS. (2014). *Guidance Note: Reduction of HIV Related Stigma and Discrimination*. Retrieved 21 October 2016 from: http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

The UNAIDS Guidance Note defines stigmatization and discrimination in regards to human rights and HIV. It focuses on explain the connection between these two terms and the negative effects they have on individuals living with HIV. In addition, it provides context for key elements under protecting human rights and the response by UNAIDS. The guidance note emphasizes implementation challenges present such as scale, resources, and community engagement to help diminish stigma and discrimination. Important for delegates, the document provides numerous questions under sub-divisions, which can serve to stimulate further research and potential answers to the topic at hand.

Joint United Nations Programme on HIV/AIDS. (2015). *On the Fast-Track to end AIDS: UNAIDS 2016-2021 Strategy*. Retrieved 30 July 2016 from: www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

The UNAIDS 2016-2021 Strategy focuses on the idea of fast-tracking response in order to end AIDS by 2030. It emphasizes that the next five years are critical in the response and agenda of ending HIV/AIDS. The strategy notes how important the recognition of people 50 years or older as a growing population suffering from HIV/AIDS is and calls for greater collaboration,, and effectiveness throughout the next five years.

United Nations, General Assembly, Sixty-fifth session. (2011). *Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS (A/RES/65/277)* [Resolution]. Adopted without reference to a Main Committee (A/65/L.77). Retrieved 18 August 2016 from: http://undocs.org/A/RES/65/277

Resolution 65/277 is important as it emphasizes multiple issues such as stigmatization, discrimination, unavailability of services, and high cost, which hinder the elimination of HIV/AIDS. It strongly recognizes the concerns HIV /AIDS play in the global view towards development and peace and security. In regards to stigmatization and discrimination it expresses that order to end HIV/AIDS human rights must be protected at all levels. Additionally, the resolution welcomes the creation and effectiveness UN-Women can have in responding to HIV/AIDS in areas of greater risk, by focusing on protecting women rights and their ability to obtain treatment and prevention services

United Nations, General Assembly, Sixty-ninth session. (2015). *Future of the AIDS response: building on past achievements and accelerating progress to end the AIDS epidemic by 2030: Report of the Secretary-General (A/69/856)*. Retrieved 21 August 2016 from: http://undocs.org/A/69/856

This report by the UN Secretary-General focuses on understanding the achievements of the Millennium Development Goals (MDGs) and other initiatives in accelerating the progress to end HIV/AIDS by 2030. The report expresses that although the previous response and framework to HIV and AIDS has enjoyed many achievements, one must recognize that those living with HIV and AIDS are still exposed to many risks and burdens. It reiterates that accelerating the progress towards the end of AIDS by 2030 is of utmost concern and that the global community must allocate more resources for such response. Furthermore, it mentions that even with today's achievements, a key population being left behind is those over the age of 50. This is important

information for because this key population will not just have health complications from HIV/AIDS but also face discrimination because of their HIV/AIDS status.

World Health Organization. (2006). *2006 Report on the Global AIDS Epidemic: The Essential Role of Civil Society*. Retrieved 25 October 2016 from: http://www.who.int/hiv/mediacentre/2006_GR_CH09_en.pdf

The report presented by WHO elaborates on the importance of civil society as an active entity implementing the HIV/AIDS response. It explains in detail the potential civil society has in addressing the needs of those who have HIV/AIDS. Additionally, it mentions how civil societies are targeting prevention services, effective treatment, and dealing with key population affected by the epidemic. It is essential to note that the report sees civil society as having the potential to beginning discussion about key populations. This is critical since at the moment discussion about ageing populations and those over 50 is very limited.

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III. Mitigating the Impact of HIV/AIDS on Economic Development

"[HIV/AIDS] is an epidemic that undermines development, significantly impacts on economic growth and can be a major concern in conflict and post-conflict situations."[288]

Introduction

Around the world, an estimated 35 million people have died from causes related to acquired immune deficiency syndrome (AIDS).[289] But the impact of AIDS goes beyond the impact on human lives; it has also detrimentally impacted economies around the world as the epidemic primarily affects adults who are the driving force for economic growth and who are responsible for taking care of the very young and the elderly.[290] The prevalence of the human immunodeficiency virus (HIV) has proven to have a negative effect to the productivity and economic performance of a country, directly affecting the chances of a country to grow.[291] While much has been achieved in the past few decades to respond to the HIV/AIDS epidemic, such as expanding access to antiretroviral therapy (ART) to 17 million people living with HIV, as well as a 43% decrease in annual AIDS-related deaths since 2003, the HIV/AIDS epidemic remains both a serious public health and economic threat around the globe.[292] The Joint United Nations Programme on HIV/AIDS (UNAIDS) therefore follows the fast-track approach, which calls for increasing investment over the next five years to accelerate investment and establish momentum to end the AIDS epidemic as a public health threat by 2030. These highly ambitious goals are necessary when keeping in mind the economic effects the disease has on countries and populations, ranging from weakened labor supply due to high mortality rates, reduced savings, and challenged public budgets.[293] In particular low-income countries face reinforced economic disadvantages.[294] The region of sub-Saharan Africa accounts for almost 70% of the global total of new HIV infections, leading to a deteriorating situation in regard to workforce and income.[295] The epidemic is not just seen as a health issue anymore, but a substantial threat to economic growth and development.[296]

UNAIDS expects that increased investments for the fast-track approach would have a severe positive impact and produce benefits of US$3.2 trillion, going beyond the year 2030.[297] When bearing in mind that health as a form of human capital is among the basic inputs to create production in an economy, investments targeting an improved health situation by reducing the impact of HIV/AIDS on societies are of utmost importance.[298] Investing in health and measures to curtail the HIV/AIDS epidemic thus translates into direct effects on the economic development of a society.[299] By building the global commitment to "ending the AIDS epidemic as a public health threat by 2030," the international community has the unique opportunity to end one of the most devastating health challenges around the world, and, at the same time, to accelerate results across the sustainable development agenda.[300] After a brief introduction to the international legal framework and the most important actors that focus on the economic impact of HIV/AIDS, this Background Guide will first overview the general economic implications of the HIV/AIDS epidemic, and then take a deeper look at the role of women and how the epidemic hinders their economic participation. Further, the agricultural sector and the severe impact HIV/AIDS has on it will also be elaborated on.

International and Regional Framework

HIV/AIDS is considered to be one of the worst pandemics the world has ever seen, and the response to the epidemic has been central in international development and public health efforts ever since.[301] While the disease was initially

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[288] UN DPI, *UN General Assembly adopts political declaration to fast-track progress on ending AIDS*, 2016.
[289] AIDS.gov, *Global AIDS/HIV Overview*, 2015.
[290] UNAIDS, *The first 10 years*, 2008, p. 255.
[291] Maijama'a et al., *HIV/AIDS and Economic Growth: Empirical Evidence from Sub-Saharan Africa*, 2015, p. 39.
[292] UNAIDS, *Global AIDS Update*, 2016, p. 2.
[293] UN DESA, *The impact of AIDS*, 2004, p. 81.
[294] Haacker, *Framing AIDS as an Economic Development Challenge*, 2011, p. 68.
[295] UNAIDS, *Fact Sheet*, 2014.
[296] Maijama'a et al., *HIV/AIDS and Economic Growth: Empirical Evidence from Sub-Saharan Africa*, 2015, p. 31.
[297] UNAIDS, *How AIDS changed everything: MDG 6: 15 years, 15 lessons of hope from the AIDS response*, 2015, p. 435.
[298] Maijama'a et al., *HIV/AIDS and Economic Growth: Empirical Evidence from Sub-Saharan Africa*, 2015, p. 31.
[299] Ibid.
[300] UN General Assembly, *On the fast track to ending the AIDS epidemic: Report of the Secretary-General*, 2016, p. 1.
[301] UNAIDS, *The First 10 Years*, 2008, p. 5.

seen as a general health issue and not viewed as a globally significant concern, a UN General Assembly Special Session in 2001 displayed the growing consensus in the global community for the first time that HIV/AIDS was much more than that, that it was, in fact, a major threat to global human and economic development.[302] In the outcome document *Declaration of Commitment on HIV/AIDS*, Member States called for actions to alleviate the social and economic impact of the epidemic through policies targeting economic growth, labor productivity, and measures to reduce pressure on public resources.[303]

After the expiration of the Millennium Development Goals (MDGs) in 2015, the UN created the framework for global action to promote development by 2030 with the Sustainable Development Goals (SDGs).[304] In particular, SDG 3, "Ensure healthy lives and promote well-being for all at all ages," calls for the end of the AIDS epidemic by 2030 and thus anchors the response to HIV/AIDS in the action plans and programs of the global community.[305] Beyond the MDGs and SDGs, several UN organizations have emphasized the links between development and responding to HIV/AIDS. General Assembly resolution 65/277 of 2011 called for greater integration of HIV/AIDS within the area of development.[306] Additionally, in resolution 1983 on "Maintenance of international peace and security," the UN Security Council acknowledged "that HIV constitutes a major challenge to the development, progress and stability of societies."[307] The important work of UNAIDS was highlighted in this regard as the actor responsible for coordinating and strengthen the global, regional, national, and local responses.[308]

More recently, in June 2016, UNAIDS gathered diplomats, experts, non-governmental organizations (NGOs), and many other stakeholders in New York for the United Nations General Assembly High-Level Meeting on Ending AIDS and adopted the *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*.[309] In the declaration, Member States recognized the high priority of the fight against HIV/AIDS as essential in order to allow all individuals to enjoy economic, social, cultural, and political development.[310] The document reaffirmed the stance that the spread of HIV is often a cause and consequence of poverty and inequality and thus constitutes a great burden for economic development.[311]

Role of the International System

UNAIDS is the leading organization within the UN system on the topic of HIV/AIDS, and coordinates the global response to the epidemic.[312] The World Health Organization (WHO) takes the lead on HIV treatment and care and supports Member States through the development of key normative policies on the virus and the supply of strategic information and guidance.[313] While WHO was initially responsible for leading the undertaking, the epidemic's rapid and devastating spread resulted in the foundation of the UNAIDS, which formulates targets in support of development efforts and to achieve an improved economic and social environment.[314] However, while many UN agencies work on the international response to HIV/AIDS, a few in particular work with communities to promote projects targeting economic development. The International Labour Organization (ILO) started an initiative in 2013 to reach 5 million workers with voluntary and confidential HIV counselling and testing, ensuring they live longer, stay productive, and are able to remain part of the workforce without stigma or discrimination.[315]

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[302] Ibid., p. 110.
[303] UN General Assembly, *Declaration of commitment on HIV/AIDS*, 2001, p. 30.
[304] UNAIDS, *UNAIDS welcomes adoption of new United Nations Sustainable Development Goals*, 2015.
[305] UN General Assembly, *Transforming our world: the 2030 Agenda for Sustainable Development*, 2015, p. 16.
[306] UN General Assembly, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (A/RES/65/277)*, 2011.
[307] UN Security Council, *Maintenance of international peace and security (S/RES/1983 (2011))*, 2011, p. 1.
[308] Ibid.
[309] UNAIDS, *Bold Commitments to action made at the UN General Assembly High-Level Meeting on ending AIDS*, 2016.
[310] UN General Assembly, *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (A/RES/65/277)*, 2016, p. 3.
[311] Ibid.
[312] UN Special Session on HIV/AIDS, *Fact sheet: What is UNAIDS?*, 2001.
[313] UNAIDS, *UNAIDS Cosponsor 2015: WHO*, 2015.
[314] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016, p. 15.
[315] ILO, *ILO launches new initiative to reach 5 million workers with voluntary HIV testing by 2015*, 2013.

The UN Development Programme (UNDP) recognizes the impact of HIV on development and the link between health and sustainable development in the *UNDP's Strategic Plan 2014–2017*.[316] UNDP contributes to the AIDS response by addressing social and economic factors that occur with the epidemic and consults on strategies on how the consequences can be mitigated.[317] The organization aims to enhance the economic contribution of people living with HIV, in particular women.[318]

Since its inception, UNAIDS has supported the participation of non-governmental organizations (NGOs) in its work to represent the perspective of civil society.[319] UNAIDS acts as an advocate for community-based programs because it allows the agency to get in touch with hard-to-reach and marginalized communities and provide them with the required services.[320] Through this link UNAIDS can incorporate the concerns of these communities into its sustainable development efforts.[321] During its engagement with civil society in Cambodia, for example, UNAIDS tried to integrate HIV policies, programs, and mechanisms into areas of health and development.[322] ILO is a cooperation partner with this program and supported a feasibility study trying to link social protection and employment services for poor and vulnerable habitants.[323]

HIV/AIDS Hindering Economic Growth

The HIV/AIDS epidemic remains one of the biggest health challenges worldwide, with 36.7 million people currently living with the disease and 2.1 million people becoming newly infected yearly.[324] Since first being monitored, 78 million people have become infected with HIV, and 35 million individuals have died from AIDS-related illnesses, showing the immense number of people affected by the epidemic.[325] Putting these numbers in a broader macroeconomic context, it becomes clear that HIV/AIDS has seriously impaired the economic situation of many countries and their populations by hurting and killing many of its citizens. This results in fewer people who are able to work, and consequently reduces productivity in addition to shortened life expectancy.[326]

From a governmental perspective, this leads to disruptions to public services and a change of the age composition of public servants, while costs for public health services are at the same time increasing.[327] Moreover, foreign direct investment, which is essential for economic development, is less likely to be directed to a country hit by the epidemic.[328] Investors refrain from providing money to countries and businesses where there are high rates of HIV/AIDS because of the perception that this can lead to lower productivity and increased absenteeism from work.[329] Additionally, firms operating in high-prevalence regions report that HIV/AIDS has an overall negative impact on their operations, and that the effects of the epidemic are considered to be worse than of other severe diseases such as malaria or tuberculosis.[330] In order to generate development, countries must undertake measures that reduce the infection rate and ensure effective treatment.[331]

From a microeconomic perspective, families have less money to invest in the economy due to higher expenditures for treatment.[332] Once a household is affected by HIV/AIDS, the income earning capacity and possibilities to save

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[316] UNDP, *UNDP Strategic Plan 2014: Changing with the World*, 2013, p. 21.
[317] UNDP, *Fast Facts: United Nations Development Programme*, 2012; UNAIDS, *UNAIDS Cosponsor 2015: UNDP*, 2015.
[318] UNDP, *UNDP Strategic Plan 2014: Changing with the World*, 2013; UNAIDS, *UNAIDS Cosponsor 2015: UNDP*, 2015.
[319] UNAIDS, *NGO/Civil Society Participation in PCB*, 2016; UNAIDS, *UNAIDS engagement with civil society Case study 3: Middle East and North Africa Region*, 2015, p. 11.
[320] UNAIDS, *How UNAIDS supports civil society engagement and community responses to HIV*, 2015.
[321] Ibid.
[322] UNAIDS, *UNAIDS engagement with civil society Case study 1: Cambodia*, 2015, p. 14.
[323] Ibid., p. 15.
[324] UNAIDS, *Facts Sheet 2016*, 2016.
[325] Ibid.
[326] UN DESA, *The HIV/AIDS epidemic and its social and economic implications*, 2003, p. 2.
[327] Haacker, *The Macroeconomics of HIV/AIDS*, 2004, p. 199.
[328] Asiedu et al., *The Impact of HIV/AIDS on Foreign Direct Investment: Evidence from Sub-Saharan Africa*, 2015, p. 2.
[329] Ibid., p. 7.
[330] Ibid., p. 8.
[331] Ibid., p. 16.
[332] UN DESA, *The HIV/AIDS epidemic and its social and economic implications*, 2003, p. 9.

and build assets decrease.[333] If the possibility for a household to provide for itself is reduced, dependency ratios increase because fewer adults are available to care for children and the elderly.[334] In particular, the loss of a man in the family can have severe impacts since women and children often have fewer economic opportunities and less control over productive assets.[335] On the other hand, losing a female family member results in amplified malnutrition and fewer possibilities to care for children.[336] In general, it can be said that the HIV/AIDS epidemic is causing damage to human capital since children's education, nutrition, and health suffer.[337]

In the framework of the SDGs, UNAIDS sees possibilities to work against HIV/AIDS and promote economic growth through the creation of safe and secure working environments, which facilitate access to HIV services for particularly affected groups; decrease the stigmatization of people living with HIV, who are more likely to be unemployed; and by strengthening the labor rights of people living with HIV in the world of work in order for them to enjoy full and productive employment.[338] UNAIDS also supports investments in HIV treatment and care because it allows infected individuals to be productive and support their families, while at the same time investments in prevention decrease rates of new infections in many countries.[339] Access to antiretroviral (ARV) drugs boost the immune system of people living with HIV and puts infected workers in a position to live a productive life, which could make a country generally more attractive of investors to provide funds for businesses.[340]

HIV/AIDS and its Impact on Women

Women are particularly vulnerable to the negative impacts of HIV/AIDS due to poverty, gender norms and inequalities, food insecurity, and violence; further, they often face serious hurdles accessing services and care addressing the medical treatment of the disease.[341] In sub-Saharan Africa, for example, of the 2.8 million young people aged 15-24 years living with HIV in 2014, 63% were female.[342] In order to allow women a way out of poverty, efforts must target decent work and social protection and services.[343] Further, stigmatization must be addressed, as women living with HIV/AIDS are often excluded from economic life within their communities.[344] UNAIDS strongly emphasizes the need for support of women and young girls in the AIDS response so they have the freedom to make life-defining choices, enabling them to create lives for themselves, their families, communities, and societies.[345]

Families

The consequences of HIV/AIDS on women's participation in the economy are manifold, particularly regarding broader family structures. First of all, the medical costs associated with an HIV or AIDS infection means that families often have to drain their household's savings, which are used to covers these expenses.[346] At worst, the family also may have to pay for funeral-related services.[347] Beyond the direct costs, HIV/AIDS often leads to further financial insecurity for families; if women start to suffer due to HIV-related diseases, the family or household loses income and household productivity.[348] While the epidemic leaves women missing from the workforce and leads to instable family financial situations, women are also very likely to fall into poverty if their husband or partner dies as a consequence of the disease, since in many communities the death of the male breadwinner results in a much

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[333] UN ECA, Commission on HIV/AIDS and Governance in Africa, *The Impacts of HIV/AIDS on Families and Communities in Africa*, 2005, p. 4.
[334] Ibid., p. 5.
[335] Ibid.
[336] Ibid.
[337] UN DESA, *The HIV/AIDS Epidemic and its Social and Economic Implications*, 2003, p. 10.
[338] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016, p. 27.
[339] UNAIDS, *Investment in health is an investment in economic development*, 2011.
[340] Asiedu et al., *The Impact of HIV/AIDS on Foreign Direct Investment: Evidence from Sub-Saharan Africa*, 2015, p. 14.
[341] UNAIDS, *2016-2021 Strategy: On the Fast-Track to end AIDS*, 2016, p. 14; UNAIDS, *Global AIDS Update*, 2016, p. 8.
[342] UN General Assembly, *On the fast track to ending the AIDS epidemic: Report of the Secretary-General*, 2016, p. 6.
[343] UNAIDS, *Empower Young Women and Adolescent Girls: Fast-tracking the End of the AIDS Epidemic in Africa*, 2015, p. 15.
[344] UNAIDS, *Global AIDS Update*, 2016, p.10.
[345] UNAIDS, *UNAIDS calls for the empowerment of young women and girls on international day of the girl child*, 2015.
[346] UN DESA, *The HIV/AIDS epidemic and its social and economic implications*, 2003, p. 3.
[347] Ibid.
[348] Ibid.

worsened situation for the women and the rest of the family.[349] Further, for those who are affected by HIV/AIDS in a community where stigmatization is common, women may face more sever cultural backlash.[350]

It is important to keep in mind, however, that implementing actions that benefit women have a greater potential economic impact since investing in women translates into supporting families and children and thus all of society.[351] The position of women as economic agents that can help mitigate the consequences of HIV/AIDS on economic development.[352] The participation of women in the economic life and their preference for investing resources in child well-being can help create future development and reduce poverty.[353]

Empowerment

Actions and programs aiming to support the role of women in the response to HIV/AIDS and increase their role in mitigating the economic challenges of the epidemic must focus on their empowerment.[354] UNAIDS's cosponsor UN-Women believes that the most effective strategy to combat the epidemic is vesting women with responsibility and guaranteeing their rights so they are able to protect themselves from infection and overcome the stigmatization that follows HIV/AIDS.[355] Various strategies exist to fulfill this goal, including cash transfers and micro-loans as well as improved access to education and training to allow women to put themselves in a positon where they can provide for their families and take steps toward self-reliance.

Direct financial support can assist women in both prevention and treatment of HIV/AIDS. Cash transfers can be understood as "direct, regular, and predictable non-contributory payments."[356] They have been demonstrated to be effective in preventing women from being forced into situations of transactional sex, where they are vulnerable to HIV infections, because they become more economically independent.[357] An initiative of cash transfers to young women in Malawi has shown that these programs decrease HIV infections causes by economic pressure, increase school attendance as well as reduce teenage pregnancy and child marriage.[358] Another example is the Power of Love Foundation, which provides women affected by HIV/AIDS in Zambia with micro-loans and gives them complementary training, so they are able to start their own business and break the cycle of poverty.[359] Other civil society organizations (CSOs) exist around the world that offer economic support to women to enable them to better manage their own lives, such as El-Hayet in the Middle East and North Africa region.[360]

Another focus is on social empowerment, which is the process of developing a sense of independence and self-confidence.[361] One approach is ensuring access to education, both in general, as well as specifically on HIV/AIDS. Women, in particular young women and girls, benefit from access to secondary education, including comprehensive sexuality education, which reduces their risk of contracting HIV/AIDS and empowers them to participate in their community.[362] Strengthening the role of women also requires the involvement of men to promote equitable gender norms and engaging men and boys through school education.[363]

Initiatives catering to increase the role of women in the response to HIV/AIDS are, for example, the Sunflower Support Groups in Vietnam, where women receive support to get improved access to social, health, and economic services.[364] Another example of an initiative to empower women is the Mothers2Mothers initiative in South Africa,

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[349] Ibid.
[350] UN DESA, *The HIV/AIDS epidemic and its social and economic implications*, 2003, p. 3.
[351] UNAIDS, *Impact of the global economic crisis on women, girls and gender equality*, 2012, p. 3.
[352] Sabarwal et al., *The global financial crisis: assessing vulnerability for women and children*, 2009, p. 1.
[353] Ibid.
[354] UNAIDS, *How AIDS changed everything: MDG6: 15 years, 15 lessons of hope from the AIDS response*, 2015, p. 39.
[355] UNAIDS, *UNAIDS Cosponsor 2015: UN Women*, 2015, p. 2.
[356] United Kingdom, *Cash Transfers*, 2011, p. 2.
[357] Baird et al., *Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi*, 2012.
[358] UNAIDS, *HIV prevention among adolescent girls and young women*, 2016, p. 49.
[359] Power of Love, *What we do*, 2016.
[360] UNAIDS, *Communities deliver*, 2015, p. 53.
[361] Governance and Social Development Resource Centre, *Social and economic empowerment*, 2016.
[362] UNAIDS, *Women and girls*, 2016, p. 2.
[363] Avert, *Women and HIV/AIDS*, 2016.
[364] UNDP & Japan, *A review of socio-economic empowerment initiatives for women living with HIV in Asia*, 2012, p. 10.

which trains and employs mothers living with HIV as mentors so they can advise other pregnant women living with the disease and thus help them remain situated in their regular environment.[365] This allows the mentoring mothers to gain financial security for themselves while demonstrating in their communities that as women with HIV, they can successfully contribute to their communities, helping in turn to reduce HIV-related stigma and discrimination.[366]

HIV/AIDS and the Agricultural Sector

Many populations affected by the HIV epidemic are living in rural areas, where farming and other rural occupations are the most frequent source of making a living.[367] Since manpower is the most necessary tool to conduct farming, the effects of HIV/AIDS have severe consequences for the agricultural sector in those countries and the security of the food supply chain.[368] These range from the reduction of the area of land under cultivation to declining yields to the reduction of the size of the harvest and the loss of knowledge about farming methods.[369] Moreover, ART requires a diet based on very regular food intake, which people living with HIV/AIDS and food insecurity often face difficulties adhering to.[370] In particular, sub-Saharan countries are affected by this since this is the leading sector of the economy and contributes significantly to the Gross Domestic Product (GDP) and export earnings.[371] Additionally, increasing support for the agricultural sector is necessary to guarantee food and nutrition security, due to the fact that HIV/AIDS has impacted the ability of many households to produce sufficient and nutritious food.[372]

UNAIDS supports comprehensive and multi-sectoral responses which incorporate actions for governments, international partners, civil society, and other UN agencies.[373] The Food and Agriculture Organization of the UN (FAO) has released several strategies aimed at alleviating the consequences of HIV/AIDS-related illnesses and deaths of household members on families and their participation in farming.[374] These include labor-saving technologies such as low-input agriculture, lighter tools which can be used by women and older children, improved seed varieties, and good access to potable water.[375] Other possibilities are knowledge preservation and transmission through educational programs targeting youth and orphans, as well as the establishment of social and economic safety nets.[376] These should ensure that individuals and households affected by the epidemic are receiving immediate support through social support groups, savings clubs, and other community-based organizations since community support is fundamental to these households.[377] Moreover, countries are encouraged to invest in rural institutions and capacity-building in order to cope with the impacts of HIV/AIDS by supporting activities like labor-sharing arrangements and communal farming or community credit and micro-finance associations.[378] In some countries local public authorities have developed workplace policies that instruct their staff on HIV/AIDS and also include support for staff with HIV.[379]

A project by Concern Worldwide Kenya and Women Fighting AIDS in the Homa Bay district was conducted in order to understand the difficulties of farming for HIV/AIDS-affected households and how farming can help reverse the impacts of the epidemic on them.[380] The project encompassed training, on-farm-mentoring, and extending services to the beneficiaries so they could produce their own food. It encouraged the involvement of people who are infected but whose health condition is stable, since their involvement increases the food security of the affected households and it helps to reduce stigmatization.[381] It concludes that initiatives from HIV/AIDS-focused

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[365] UNAIDS, *Communities deliver*, 2015, p. 13.
[366] Mothers2Mothers, *What we do and why*, 2016.
[367] UN DESA, *The impact of AIDS*, 2004.
[368] Ibid.
[369] Ibid.
[370] Datta & Njuguna, *Food security in HIV/AIDS response: Insights from Homa Bay, Kenya*, 2009, p. 171.
[371] Wiegers, *The role of the agricultural sector in mitigating the impact of HIVjAIDS in Sub-Saharan Africa*, 2008, p. 157.
[372] Ibid., p. 160.
[373] UN WFP et al., *HIV, Food Security and Nutrition*, 2008.
[374] FAO, *Mitigating the Impact of HIV/AIDS on Food Security and Rural Poverty*, 2003.
[375] Ibid.
[376] Ibid.
[377] Ibid.
[378] Ibid.
[379] Wiegers, *The role of the agricultural sector in mitigating the impact of HIVjAIDS in Sub-Saharan Africa*, 2008, p. 161.
[380] Datta & Njuguna, *Food security in HIV/AIDS response: Insights from Homa Bay, Kenya*, 2009, p. 173.
[381] Ibid., p. 175.

organizations that cater to farming activities should take into account the aspects of treatment and support to HIV/AIDS-affected households, micro grant schemes enabling farmers to purchase farming tools and other farm inputs and intensive on-farm training.[382] Another study conducted in Kenya highlighted the importance of access to water and equipment such as water pumps, since they support farming and the cultivation of fields.[383] The Wellness and Agriculture for Life Advancement project in Malawi has provided farmers in affected communities with special training to improve depleted soils and extend growing seasons.[384] Another example is the urban gardens program for HIV-affected women and children in Ethiopia that builds communal and school-based vegetable gardens to use it as a community-based platform to transfer knowledge and skills as well as AIDS treatment and care.[385]

Conclusion

The AIDS epidemic is one the biggest health-related challenges to mankind and has claimed millions of lives over the past few decades.[386] In addition to the cost to human lives, its impact on the economies in countries affected has been well documented since HIV/AIDS endangers the economic participation of the affected populations.[387] Women and young girls are particularly impacted since they faced increased risks of marginalization in their communities and often struggle to support their families.[388] The economic effects are also highly visible in the agricultural sector, where the epidemic reduces the manpower needed to cultivate and harvest fields and where the lack of food challenges secure nutrition.[389] In order to mitigate the economic impact of HIV/AIDS on affected communities, strategies and initiatives must take into account that the epidemic necessitates special requirements to sustainable development.

Further Research

Questions that may arise in regard to this topic are: what are suitable and sustainable solutions to mitigate the economic impact of HIV/AIDS? What institutions and stakeholders can play a leading role in these efforts? How can women and girls be supported in order to facilitate their participation in the economic life of their communities? How can the agricultural sector help to integrate people with HIV into their communities? In order to further elaborate on the topic, delegates may ask: are there any other important industries and sectors that are heavily affected by the epidemic? How can UNAIDS and the greater UN system support governments and local authorities to implement policies that benefit people living with HIV/AIDS on their way to self-reliance? What are ways to help support the economic development and reduce the stigmatization of people living with HIV/AIDS at the same time?

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This paper looks at AIDS as a challenge to economic development. In order to understand the complex issue, the paper begins with a discussion of international policy documents and their stance on the adverse economic development impact of the epidemic. Continuing with an analysis of the available studies, the paper reveals some interesting facts about the topic. This well-researched document allows delegates to look at often complex nature of HIV/AIDS and economic development.

Joint United Nations Programme on HIV/AIDS. (2008). *The First 10 Years* [Report]. Retrieved 16 July 2016 from: http://data.unaids.org/pub/Report/2008/JC1579_First_10_years_en.pdf

This report details the coming into existence of UNAIDS. It is separated into different chapters, each telling the milestones of UNAIDS in that period and the different challenges the Programme

[382] Ibid.
[383] Eplett, *In Kenya, Improving Food Security and HIV Outcomes through Farming*, 2015.
[384] Project Concern International, *Malawi*, 2015.
[385] DAI, *Urban Gardens Program for HIV-Affected Women and Children (UGP)*, 2012.
[386] UN General Assembly, 2016, *On the fast track to ending the AIDS epidemic: Report of the Secretary-General*, p. 1.
[387] Maijama'a et al., *HIV/AIDS and Economic Growth: Empirical Evidence from Sub-Saharan Africa*, 2015, p. 39.
[388] UNAIDS, *Global AIDS Update*, 2016, p.10.
[389] UN DESA, *The impact of AIDS*, 2004.

was facing. While the document is very extensive, it is a must-read to understand the work of the committee and its mandate. The country cases that are inserted in between chapters tell the situation of different countries affected by the epidemic and how challenging it is for their societies and economies. The last section, entitled "The Challenges," is important for everyone trying to understand why the fight against HIV/AIDS is still necessary today and why even in 2016 there is still much left to be done.

Joint United Nations Programme on HIV/AIDS & African Union. (2015). *Empower Young Women and Adolescent Girls: Fast-tracking the End of the AIDS Epidemic in Africa* [Report]. Retrieved 18 July 2016 from: http://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf

This documents takes a look at women and girls in Africa and why they are considered to be left behind from the HIV/AIDS response. After giving insightful background information on the situation of young women in Africa and their exposure to the disease, five key recommendations for improvement are made. These include increasing women's participation and leadership, strategies to reduce intimate partner violence and vulnerability to HIV, as well as efforts to enhance social protection and poverty reduction measurements. Since improving the role of women on economic, social, and political levels will help reduce the spread of HIV/AIDS, this document gives students good background knowledge to deal with the issue at hand.

Joint United Nations Programme on HIV/AIDS. (2015). *How AIDS Changed Everything: MDG 6: 15 years, 15 Lessons of Hope from the AIDS Response* [Report]. Retrieved 1 August 2016 from: http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf

This document reflects on how Millennium Development Goal number 6 played a vital role in the mobilization of resources to build the global AIDS response. It recalls the events that took place to ensure that more than 15 million people today have access to antiretroviral medicines. After some informative graphics showing the success of the global AIDS response and an interview with the Executive Director of UNAIDS, there are sections on the state of AIDS, the lessons learned, and what needs to be done to end the AIDS epidemic by 2030. Throughout the document there are references explaining how different strategies and actions have tried to mitigate the economic and social impact of HIV. Students will find this report useful because it provides great information about AIDS response in the last 15 years.

Joint United Nations Programme on HIV/AIDS. (2015). *UNAIDS engagement with civil society: Case study 1: Cambodia* [Report]. Retrieved 16 September 2016 from: https://results.unaids.org/sites/default/files/documents/Cambodia%20-%20Case%20Study%20on%20UNAIDS%20Engagement%20with%20Civil%20Society_0.pdf

This case study by UNAIDS shows how the Joint Programme engages with civil society in Cambodia, where different groups are suffering from the consequences of HIV/AIDS. It explains how UNAIDS provides, facilitates, and mobilizes different types of support (financial, political, and technical) to help the people affected. Cambodia is success story in the AIDS response; delegates will find this document useful as it allows a great insight into the operational work of UNAIDS and how its support can make a difference in a country.

Joint United Nations Programme on HIV/AIDS. (2016). *2016-2021 Strategy: On the fast-track to end AIDS.* Retrieved 16 July 2016 from: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf

This document is a detailed overview of the UNAIDS strategy for the next five years, which outlines the future milestones and challenges in the response to HIV/AIDS. The document calls for the Fast-Tracking of the response of the global community to ensure that the costs of the epidemic to national economies and to human lives will not grow. The strategy encompasses eight result areas including reduced inequalities, tailored HIV prevention services, gender equality, and partnerships. The strategy emphasizes the need to end the AIDS epidemic as a public health threat in all places and among all populations by 2030. As the strategy is the heart of the work of UNAIDS for the next five years, students must be familiar with the document and incorporate the goals formulated here into their own strategies and negotiations.

Joint United Nations Programme on HIV/AIDS. (2016). *Women and Girl*s [Fact Sheet]. Retrieved 16 July 2016 from: http://www.unaids.org/sites/default/files/media_asset/women-girls_snapshot_en.pdf

This short but very comprehensive fact sheet gives a useful overview on the situation of women and girls in the context of the AIDS response. It outlines the demands to establish a situation where women are economically and politically empowered and points out the remaining gender gaps that weaken the effectiveness of the fight against HIV/AIDS. Moreover, it lists in a very clear and succinct fashion the targets for sexual and reproductive health and rights for women as part of the UNAIDS Fast-Track approach. The actions needed here will allow women and young girls to be a part of development efforts and join the AIDS response. To prepare the important role of women in ending the AIDS epidemic, this document allows an easy start into further research.

Maijama'a, D. et al. (2015). HIV/AIDS and Economic Growth: Empirical Evidence from Sub-Saharan Africa. *Research in Applied Economics*, 7 (4): 30-47. http://www.macrothink.org/journal/index.php/rae/article/view/8426/7056

This paper presents an empirical base on the severe consequences HIV/AIDS has had on the economy of countries in the sub-Saharan region. After a general overview of the situation in the countries, the paper explains what the effects look like in theory and what other studies on this subject have found. The main part of the document consists of a very comprehensive and long-term data horizon to show the effects of HIV and AIDS on per capita GDP growth. For delegates gaining in having a deep theoretical insight into the topic, this paper could be of great interest.

United Nations, Department of Economic and Social Affairs, Population Division. (2003*). The HIV/AIDS Epidemic and its Social and Economic Implications (UN/POP/MORT/2003/12)* [Report]. Retrieved 16 July 2016 from: http://www.un.org/esa/population/publications/adultmort/Popdiv12.pdf

While this report by the Population Division of the Department of Economic and Social Affairs (DESA) was not published recently, it remains one of the most comprehensive and well-written documents on the social and economic consequences of the HIV/AIDS epidemic. It is grouped into eight subsections that clearly explain the impacts on different demographics, private households, firms and businesses, the agricultural sector, and healthcare systems. It can be considered one of the foundational documents for this topic and is the base for further research, in particular macroeconomic implications of the epidemic.

United Nations, General Assembly, Seventieth session. (2016). *On the fast track to ending the AIDS epidemic: Report of the Secretary-General (A/70/811)*. Retrieved 1 August 2016 from: http://undocs.org/A/70/811

Delegates will find this report very useful when looking for a current document on the status of the AIDS response. The report begins with the common aspirations of the global community to end the global challenge that is HIV/AIDS. It then goes into detail about the shortfalls in implementation of the Political Declaration of 2011, before embedding the fight against HIV/AIDS into the sustainable development agenda. The various tables and overviews can be considered very useful in visualizing the work of the committee and the UN in general. In order to prepare for the Conference, students are advised to read this report as it represents a useful source of information.

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