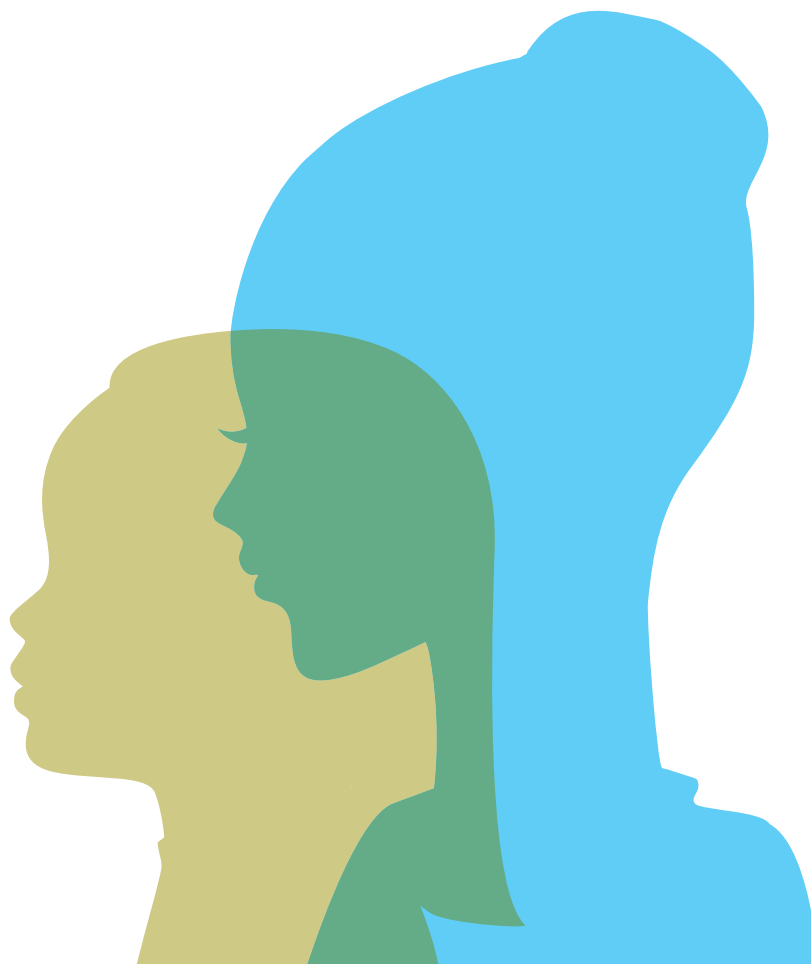


WOMEN AND ADOLESCENT GIRLS ON THE FAST-TRACK TO ENDING THE AIDS EPIDEMIC

SIDE EVENT AT THE 69TH WORLD HEALTH ASSEMBLY

MONDAY, 23 MAY 2016, 12:45-14:15 IN ROOM XXIII

PALAIS DES NATIONS



FACTS AND FIGURES

IN 2014:

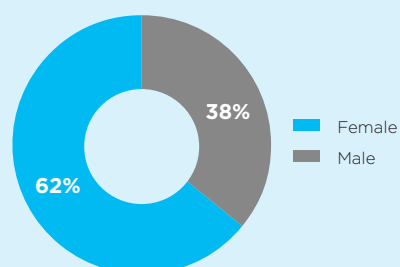
THERE WERE 220 000 NEW HIV INFECTIONS AMONG CHILDREN GLOBALLY, A REDUCTION OF 58% SINCE 2000.

17.4 MILLION WOMEN (AGED 15+ YEARS) WERE LIVING WITH HIV GLOBALLY.

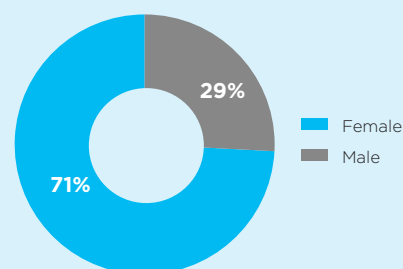
THERE WERE 870 000 NEW HIV INFECTIONS AMONG WOMEN (AGED 15+ YEARS).

5.6% OF WOMEN (AGED 15–49 YEARS) IN SUB-SAHARAN AFRICA WERE LIVING WITH HIV, COMPARED TO 3.9% OF MEN (AGED 15–49).

Proportion of new HIV infections among adolescents that are among adolescent girls, global



Proportion of new HIV infections among adolescents that are among adolescent girls in sub-Saharan Africa



32% OF CHILDREN (AGED 0–14 YEARS) LIVING WITH HIV ACCESSED ANTIRETROVIRAL THERAPY.

41% OF ADULTS LIVING WITH HIV (AGED 15+ YEARS) ACCESSED ANTIRETROVIRAL THERAPY.

46% OF WOMEN LIVING WITH HIV (AGED 15+ YEARS) ACCESSED ANTIRETROVIRAL THERAPY.

THERE WERE AN ESTIMATED 420 000 AIDS-RELATED DEATHS OF WOMEN (AGED 15+ YEARS), COMPARED TO 610 000 IN 2000.

BACKGROUND

In parts of the world, most notably sub-Saharan Africa, women and adolescent girls are at greater risk of acquiring HIV infection than men and boys. Over half of all new adult HIV infections (aged 15+) in sub-Saharan Africa and almost half of all new HIV infections among adults in the Caribbean in 2014 were among women. This increased vulnerability to HIV infection arises from a complex interaction between biological factors and social and cultural factors, such as gender-based violence, gender inequality, harmful gender norms, stigma and discrimination. Social and cultural factors may also prevent women and girls from knowing their HIV status and accessing appropriate HIV prevention and treatment services. Women also constituted approximately one third of new HIV infections among adults in the Asia and the Pacific region, the Middle East and North Africa, eastern Europe and central Asia and Latin America, where these factors also affect women's vulnerability to HIV. In response, a more meaningful engagement of women and adolescent girls in planning and implementing the strategies needed to promote gender equality, prevent gender-based violence and protect their human rights is critical to overcoming women's and girls' vulnerability to HIV.

Globally, there has been significant progress in preventing new HIV infections among children and keeping their mothers alive. New HIV infections among children declined by almost 60% between 2000 and 2014—from 520 000 to 220 000. However, progress has been less than hoped for in preventing HIV among adolescent girls and young women and ensuring access to sexual and reproductive health services.

Women have played an important role in achieving and leading the impressive progress in preventing new HIV infections among children through engagement in global advocacy, policy development, implementation, community mobilization and delivering decentralized peer outreach and education services. It is critical that more women be in leadership roles or in positions where they are driving the implementation of initiatives aiming to promote the health and sexual and reproductive health and rights of women and adolescent girls and to prevent new HIV infections. Examples include the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, Every Woman, Every Child, Women Deliver, All In, the United States President's Emergency Plan for AIDS Relief's (PEPFAR) DREAMS and ACT initiatives, the Partnership for Maternal and Child Health and Mothers2Mothers and other similar peer-to-peer education and support programmes for pregnant women.

The engagement of women is considered essential in making decisions on where and how donor assistance is directed. The main multilateral funding agency for HIV programming, the Global Fund to Fight AIDS Tuberculosis and Malaria (Global Fund), is a champion for women's leadership in its decision-making at the country level by recommending equal representation of men and women on the country coordinating mechanism (CCM). In 2015, almost 40% of CCM members in implementing countries were women. Furthermore, the Global Fund's Gender Equality Strategy, which aims to address some of the inequalities that make girls and women more vulnerable to HIV, has helped to ensure that 55–60% of Global Fund investments directly benefit women and girls.

The 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) include a comprehensive and ambitious framework until 2030 to address the inequities that result in poor health and development outcomes for women and adolescent girls. The SDGs contain a specific target on ending the AIDS epidemic as a public health threat by 2030 under the health and well-being goal (SDG 3). Additional factors that increase women's vulnerability to HIV are addressed across many other SDGs, for example ending poverty (SDG 1), ending hunger (SDG 2), achieving gender equality and empowering women and girls (SDG 5), reducing inequality in access to services and commodities (SDG 10) and promoting inclusive societies that promote non-discrimination (SDG 16).

There is a window of opportunity over the next five years to get the world on the Fast-Track to ending the AIDS epidemic by 2030. If we do not succeed in reaching the interim Fast-Track Targets by 2020, the AIDS epidemic will continue indefinitely and millions of people will become infected with HIV or die unnecessarily.

This World Health Assembly side event will elaborate and promote the leadership role that women and girls can play in health and development, focusing on the critical role of women and girls as agents of change. The session will draw from the UNAIDS 2016–2021 Strategy and the World Health Organization's (WHO) draft global health sector strategy on HIV, 2016–2021. Three main topic areas will be considered: (1) preventing new HIV infections among children; (2) HIV prevention for adolescent girls and young women; and (3) delivering HIV treatment for all.

A summary of the discussions will be submitted to the President of the General Assembly for consideration at the United Nations General Assembly High-Level Meeting on Ending AIDS, to be held in New York, United States of America, from 8 to 10 June, where Switzerland and Zambia, as co-facilitators, have assigned a formal panel session to explore HIV prevention for children, adolescent girls and young women.

PREVENTING NEW HIV INFECTIONS AMONG CHILDREN

In 2014:

- Seventy-three per cent of pregnant women living with HIV worldwide received antiretroviral medicines to prevent HIV transmission to their babies. This compares to 36% receiving effective treatment in 2009 and only 1% in 2000.
- The number of new HIV infections among children had fallen by almost 60% since 2000.
- Antiretroviral medicines had averted an estimated 1.4 million HIV infections among children since 2000.

In 2011, UNAIDS, PEPFAR and partners launched the Global Plan. The plan focused global efforts on the elimination of mother-to-child transmission of HIV in the 22 countries¹ that were home to 90% of women living with HIV in 2009. Prior to the Global Plan, the number of new childhood HIV infections only declined by 24% globally between 2000 and 2009, due to poor implementation of elimination of mother-to-child transmission of HIV services. However, the decline in new HIV infections among children between 2009 and 2014 was 45%, as a result of a more focused global effort.

Rapid progress has been made in access to antiretroviral therapy for pregnant women living with HIV. Ten years ago, very few pregnant women living with HIV in the 21 Global Plan priority countries in sub-Saharan Africa were receiving antiretroviral therapy for their own health—Option B+, the gold standard that prevents HIV transmission to infants and also provides lifelong treatment to the mother to safeguard her health. In recent years, many of the Global Plan countries have adopted and implemented Option B+. In 2014, 66% of pregnant women living with HIV in the 21 Global Plan countries in sub-Saharan Africa were receiving antiretroviral therapy for their own health. Further efforts are needed to expand coverage of lifelong treatment for pregnant women and to address barriers to adherence in order to maintain women in care following delivery, for their own health and to reduce the risk of transmission to the baby during breastfeeding.

Towards the end of the Global Plan period, South Africa had made the most progress, having reduced new child infections by 76% between 2009 and 2014. Other countries making rapid progress include the United Republic of Tanzania (72%), Uganda and Mozambique (69% each), Ethiopia (65%) and Namibia (64%). However, the eastern and southern Africa region was still home to 42% of all children newly acquiring HIV in 2014. Western and central African countries have the lowest service coverage, with smaller reductions in new HIV infections among children, including Cameroon (27%), the Democratic Republic of the Congo (27%), Côte d’Ivoire (26%), Angola (25%), Chad (19%) and Nigeria (15%).

The rapid progress made by many countries towards eliminating new HIV infections among children can be attributed to a number of factors, including unprecedented political will at the country and global levels, the widespread use of standardized once-daily, fixed-dose combination antiretroviral treatment regimens, global partnerships and women’s leadership at all levels to drive the agenda, increased knowledge of services and expanded provision of outreach and support services to mothers living with HIV, innovations and improved medicines to prevent transmission from mother to baby, and, most of all, the motivation of women living with HIV.

¹ Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Swaziland, Zambia and Zimbabwe.

While these achievements are encouraging, global gaps remain. HIV transmission rates from mother to child remain unacceptably high—in excess of 10% at the end of the breastfeeding period in some countries. Of the 220 000 new HIV infections among children in 2014, approximately 60% were estimated to be acquired during breastfeeding, when women often do not receive treatment. In 2014, an estimated 2.6 million children aged under 15 years worldwide were living with HIV and were less likely to receive treatment than adults. Less than a third of children living with HIV were accessing life-saving antiretroviral medicines, compared to 41% of adults.

The Global Plan goal of reducing new HIV infections among children by 90% between 2009 and 2015 has not been reached. A new framework to achieve the elimination of new infections among children is being finalized. It will build on the successes of the Global Plan to date and will close the gaps in treatment for children living with HIV and services for the prevention of HIV and unintended pregnancies among adolescent girls and young women, taking the world to the elimination of mother-to-child transmission of HIV by 2030.

HIV PREVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN

In 2014:

- More than 5000 young women and adolescent girls acquired HIV each week, most of whom live in sub-Saharan Africa.
- In sub-Saharan Africa, 60% of adolescents (aged 15–19 years) living with HIV were girls.
- Of the estimated 1.8 million young women (aged 15–24 years) living with HIV in sub-Saharan Africa, fewer than one in five knew that she was HIV-positive.
- Globally, new HIV infections among adolescents (aged 15–19) were declining, but with uneven progress across regions.
- More than half of all new HIV infections among adolescents and young people (aged 15–24 years) occurred among adolescent girls and young women. In some countries, such as the Congo, Eritrea, Gabon and Niger, adolescent girls and young women accounted for 70% of new HIV infections among adolescents and young people.
- Half of new HIV infections among adolescents (aged 15–19 years) in the Asia and the Pacific region and the Caribbean, and 71% of new HIV infections among adolescents in eastern Europe and central Asia, in 2014 were among adolescent girls. More than 40% of new HIV infections among adolescents in Latin America and the Middle East and North Africa were among adolescent girls.
- Worldwide, only three out of every 10 young women and adolescent girls (aged 15–24 years) had comprehensive and correct knowledge about HIV.
- Every year, more than 200 million women have unmet needs for contraception, leading to approximately 80 million unintended pregnancies.
- Adolescent girls and young women in sub-Saharan Africa were acquiring HIV at almost twice the rate as boys and men of the same age.

There has been a limited increase in the percentage of young people having accurate and comprehensive knowledge about HIV prevention and transmission. Many young women are not able to access sexual and reproductive health services. Parental or spousal consent is a legal barrier for young people and adult women to access services safely in many countries. Every day, 20 000 girls below the age of 18 years give birth in developing countries. Nine out of 10 adolescent births in developing countries occur within marriage or a union. Early marriage can increase girls' vulnerability to HIV by limiting access to education and increasing the risk of intimate partner violence. An estimated one in three women globally report having experienced physical and/or sexual violence by an intimate partner. Prevalence of recent intimate partner violence is often highest among young women. Girls are often unable to protect their rights or negotiate safe sex and may be pushed into transactional sex.

The UNAIDS 2016–2021 Strategy makes a clear call to address the disparities in comprehensive sexuality education and for youth-friendly HIV, sexual and reproductive health and harm reduction information and services to be accessed independently and equally by young women and men. Access to comprehensive sexuality education and sexual and reproductive health services is critical to preventing HIV infections and unintended pregnancies among adolescent girls and young women, yet access to comprehensive sexual and reproductive health and rights education and services is often limited.

Although cash transfers have been shown to keep girls in school and thus reduce their risk of HIV infection, progress in scaling up access to cash transfers and other HIV prevention services is not sufficient or quick enough and is failing to reach the adolescent girls at higher risk of HIV infection. Human rights violations, along with widespread gender-based violence and stigmatization and discrimination, continue to hinder access to health services, particularly for children, adolescents, young women and members of key populations. In addition, there are substantial disparities in access to treatment and care, with boys and men lagging behind in many countries, further increasing the risk of heterosexual HIV transmission.

Women's ability to prevent HIV infection is often limited by their inability to negotiate safe sex with their long-term partner and the inadequacy of female-controlled HIV prevention methods. Recent advances in the use of oral pre-exposure prophylaxis (PrEP) offer new hope in this area, with other topical or injectable formats being further investigated. Community and health services need to collaborate closely to ensure that the most vulnerable women and adolescent girls have access to these biomedical and structural HIV prevention innovations, as they are most likely to benefit from them.

Effective HIV prevention and empowerment programmes must reach adolescent girls and young women. PEPFAR has established the ambitious DREAMS initiative, which aims to reduce HIV incidence among adolescent girls and young women by 40% by the end of 2017 across 10 countries in sub-Saharan Africa by implementing a comprehensive package of social, structural and biomedical interventions that will reach the most vulnerable

young women. Social change is also required, which must involve men and boys. Male involvement is critical to preventing HIV among women and adolescent girls through addressing gender-based violence, harmful gender norms and harmful alcohol use, and to ensure that men and boys living with HIV are accessing HIV testing, started on HIV treatment and virally suppressed, to keep them healthy and to reduce HIV transmission. In parallel, voluntary medical male circumcision and condom programming should be promoted where HIV incidence is high in order to prevent transmission to women and adolescent girls. Addressing the specific challenges of women and girls will only be possible with the full engagement of men and boys and if the voice of youth is brought to the forefront. Switzerland has demonstrated its commitment in this area by supporting ACT!2015 to engage young people in a dialogue around HIV and sexual and reproductive health and rights in global and national discussions around the SDGs.

There needs to be a new generation of young people, especially young women and girls, who are empowered decision-makers, able to make the right choices about sex, protecting themselves against HIV and other sexually transmitted infections and contraception.

HIV TREATMENT FOR ALL

- HIV remains the leading cause of death of women of reproductive age globally.
- HIV is the leading cause of death of adolescent girls in sub-Saharan Africa.
- Almost 60% of adults living with HIV were not accessing life-saving HIV treatment—almost half of them were women living with HIV in sub-Saharan Africa.

The factors that affect women's access to HIV prevention and treatment services are complex. In many settings, women's knowledge of HIV status and access to HIV treatment is higher than that of men, primarily because they are more frequent attendees at primary health-care clinics, where they are offered HIV testing during pregnancy or when bringing children for vaccination or treatment.

In heterosexual couples, it is often the woman who is diagnosed with HIV first. This may expose her to stigma, blame and violence from her partner and family and can thus inhibit disclosure of HIV status, making access to treatment and treatment adherence challenging. Women living with HIV have cited violence or fear of violence, treatment side-effects, inability to meet basic needs and gender roles as some of the barriers to adherence. However, counselling has been highly effective in securing voluntary and informed consent for partner and couple HIV testing in some settings, bringing men into treatment and supporting adherence through mutual disclosure. Community and workplace outreach and couples counselling should be encouraged to ensure that adolescent boys and men are being reached with HIV testing, treatment and prevention services, including voluntary medical male circumcision. HIV self-testing is becoming more widely available and has been shown to be highly acceptable for younger populations.

Stigma and discrimination, including in health-care settings, has also been raised by women living with HIV as a key barrier to HIV-related services and treatment adherence. One in eight people living with HIV report having been denied health care. HIV-related stigma and discrimination may also be reflected as lower-quality care, forced sterilization, stigmatizing treatment, negative attitudes and discriminatory behaviour from providers, lack of privacy and/or confidentiality and mandatory testing or treatment without informed consent. Discriminatory practices undermine access to HIV services and the quality of care.

The WHO health sector strategy focuses on expanding access to HIV testing to reach a target of 90% of people living with HIV being aware of their HIV status. Under the umbrella of universal health coverage, the strategy aims to ensure that 90% of people who know their status have access to antiretroviral therapy and 90% of people accessing treatment are treated successfully and have a fully suppressed viral load. This aligns with the UNAIDS 90–90–90 treatment target. To achieve this ambitious target, action will be required across many sectors—the private sector, to ensure the availability of HIV testing services and affordable, high-quality, safe and effective antiretroviral regimens; education, to ensure knowledge of testing and treatment; community adherence support mechanisms, to optimize individual and public health benefit; and health services, to prevent and diagnose and treat co-morbidities, such as tuberculosis and viral hepatitis.

New WHO guidelines recommend that all people diagnosed with HIV be initiated on antiretroviral therapy at any CD4 level and as soon as they are ready. New models of service delivery will be critical to ensuring that people are diagnosed early, linked to treatment services to facilitate rapid treatment initiation, helped to adhere to treatment and retained in care to ensure sustained suppression of their viral load. Increasing demands on the health-care system to expand treatment access will need to be addressed by providing differentiated care, decentralization of services and strengthening of community-based care. These services must be accessible and affordable and sensitive to the needs of women and adolescent girls.

The expansion of antiretroviral therapy has resulted in a dramatic reduction in HIV-related mortality in most populations and countries. However, such benefits are not being experienced among adolescents, with HIV mortality increasing among adolescents living with HIV. There is an urgent need to reach adolescent girls living with HIV, to ensure that they can access the broad range of health and social services that they require, including antiretroviral therapy. HIV testing services should be able to reach and diagnose adolescent girls early after HIV infection so that they can be given access to effective treatment. A particular challenge is to ensure the smooth transition of girls living with HIV from paediatric treatment services to adult treatment services, a transition period when there is a high risk that girls will drop out of care.

CONCLUSION

This World Health Assembly side event will consider the critical role of women's leadership in overcoming the inequalities that increase the vulnerability of women and adolescent girls to HIV and prevent them from accessing prevention and treatment services. The conversation will be guided by the UNAIDS 2016–2021 Strategy and the WHO draft global health sector strategy on HIV, 2016–2021, which put the needs of women, especially young women and adolescent girls, and their families at the centre of the response. The session aims to further the dialogue on addressing the gender inequalities in the HIV response as we move towards the United Nations General Assembly High-Level Meeting on Ending AIDS, to be held in New York from 8 to 10 June 2016.

SPEAKER BIOGRAPHIES



Lorena Castillo de Varela, First Lady of Panama

Panama

The First Lady of Panama has demonstrated a strong commitment to humanitarian and social causes, such as cancer research, children's health and poverty reduction. A mother of three, she devotes part of her life to strengthening social solidarity and the family. In her role as Special Ambassador for AIDS in Latin America, Ms Castillo de Varela will encourage individuals, communities and leaders to stand up for zero discrimination and gender equality.



Ricardo Barros

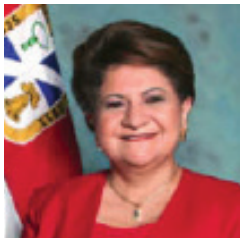
Brazil

Ricardo Barros was recently appointed as Brazil's new Minister of Health. He was the Mayor of Maringá from 1989 to 1992, has been elected as a congressman five times since 1995 and was the president of a parliamentary group on the pharmaceutical industry in Brazil. Mr Barros has a degree in civil engineering from the State University of Maringá and later studied public policy.



Raymonde Goudou Coffie
Côte d'Ivoire

As Minister of Health of Côte d'Ivoire since 2012, Dr Coffie is strongly committed to promoting the role of women in decision-making positions in the political, economic and social domains. She is a champion for democracy and the rights of women and their involvement in conflict resolution. She is actively involved in fundraising, charitable organizations and social work to raise awareness around women's rights and the importance of their financial autonomy. She was previously the Minister of Sports and Recreation and the Minister for Family, Women and Children. She is a member of the Board of Roll Back Malaria and the Board of the GAVI Alliance.



Elvia Violeta Menjivar Escalante
El Salvador

Dr Menjivar became Minister of Health in El Salvador in 2014 after being Vice-Minister from 2009 to 2014. She has also held several high-level positions in public hospitals and with health programmes delivering services to rural and marginalized populations. She is a strong advocate for access to health for all, public health services and non-discrimination on the grounds of HIV status. She was a parliamentarian in the Legislative Assembly and the first female mayor of El Salvador's capital city, from 2006 to 2009.



Francisco Javier Terrientes
Panama

Dr Terrientes graduated from the University of Panama, specializing in radiology. He has over 20 years' experience in the medical field and has made notable contributions to the Panamanian Council of Osteoporosis and other professional organizations. Prior to his appointment as Minister of Health in 2014, Dr Terrientes worked at the Clinica Hospital San Fernando. One of his priorities as Minister of Health is to focus on preventive medicine, as the long-term investment in this is more efficient than curative medicine.



Adalberto Campos Fernandes

Portugal

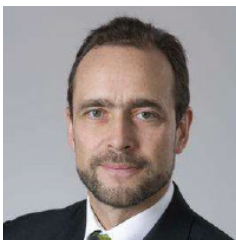
Minister of Health of Portugal since November 2015, Dr Campos Fernandes is a medical doctor and Professor at the National School of Public Health, Nova University, Lisbon. He holds a PhD in health administration and a master's in public health and health service administration from Lisbon University. As a public health specialist, he has been recognized for his competency in health systems management and pharmaceutical medicine by the Portuguese Medical Association (Ordem dos Médicos). He has been in charge of hospital management in several Portuguese hospitals and sat on the working group to reform the internal organization of Portuguese hospitals. He is author or co-author of several papers related to the administration and management of health services.



Aaron Motsoaledi

South Africa

Minister of Health of South Africa since 2009, Dr Motsoaledi is a medical doctor by training, educated at the then University of Natal (now the University of KwaZulu-Natal). He ran a successful surgery in the small rural town of Jane Furse prior to his appointment in government. He served as a member of the Limpopo Provincial Legislature from 1994 to 2009, a member of the Limpopo Provincial Executive Council (MEC) for Education from 1994 to 1997, MEC for Transport from 1998 to 1999 and MEC for Agriculture, Land and Environment in 1999. His main topics of interest are national health insurance, the sustainability of the South African AIDS response to HIV and tuberculosis and maternal and child mortality, noncommunicable diseases and lifestyle diseases and road traffic accidents and injury.



Pascal Strupler

Switzerland

After studying law at the University of Berne, the current Secretary of State for Health and Director General of the Swiss Federal Office of Public Health pursued a career in the federal administration of Switzerland, where he took on various positions in four different ministries (Federal Department of Finance, Federal Office for Foreign Economic Affairs, Swiss Embassy in Moscow, European Integration Office). He also worked at the Federal Department of Economic Affairs as a personal adviser to the minister and spent eight years as the Secretary-General of the Federal Department of Home Affairs.



Pamela Hamamoto
United States of America

As Permanent Representative of the United States of America to the United Nations and Other International Organizations in Geneva, Ambassador Hamamoto oversees the United States Mission in Geneva's engagement on issues as diverse as refugees/migration, global health, sustainable development, Internet governance, international law, climate change and human rights. In 2015, Ambassador Hamamoto launched the Future She Deserves, an initiative focused on collaboration and innovative solutions. She also co-founded the Geneva Gender Champions, a leadership network uniting more than 100 ambassadors and heads of international organizations in Geneva to break down gender barriers. Ambassador Hamamoto received a bachelor of science and a master of science in civil engineering from Stanford University and a master of business administration from the University of California, Los Angeles, Anderson School of Management and has previously worked in the energy, telecommunications and financial sectors.



Michel Sidibé
UNAIDS

Mr Sidibé has spent more than 30 years in public service. His passion for advancing global health began in his native Mali, where he worked to improve the health and welfare of the nomadic Tuareg people. In 2009, he was named Executive Director of UNAIDS and Under-Secretary-General of the United Nations by Secretary-General Ban Ki-moon.



Margaret Chan
World Health Organization

Dr Chan has been Director-General of the World Health Organization (WHO) since 2006. Before being elected Director-General, Dr Chan was WHO Assistant Director-General for Communicable Diseases as well as Representative of the Director-General for Pandemic Influenza. Prior to joining WHO, she was Director of Health in Hong Kong. During her nine-year tenure as director, Dr Chan confronted the first human outbreak of H5N1 avian influenza in 1997. She successfully defeated the spate of severe acute respiratory syndrome in Hong Kong in 2003.



Mark Dybul

Global Fund to Fight AIDS, Tuberculosis and Malaria

Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria since 2013, Dr Dybul has worked on HIV and public health for more than 25 years as a clinician, scientist, teacher and administrator. After graduating from medical school, Dr Dybul joined the National Institute of Allergy and Infectious Diseases, where he conducted research on HIV virology, immunology and treatment optimization, including the first randomized, controlled trial with combination antiretroviral therapy in Africa. Dr Dybul was a founding architect and driving force in the President's Emergency Plan for AIDS Relief and was appointed its leader, becoming United States Global AIDS Coordinator, with the rank of ambassador at the level of an Assistant Secretary of State. He served until early 2009.



Flavia Bustreo

World Health Organization

Assistant Director-General for Family, Women's and Children's Health at the World Health Organization since 2010, Dr Bustreo is also Vice-Chair of the Board of the GAVI Alliance and previously served as Director of the Partnership for Maternal, Newborn & Child Health and Interim Deputy Director of the Child Survival Partnership. A former clinician, she has extensive experience at the country, regional and global levels, with a focus on policy development concerning child and maternal health, policy implementation and partnership-building with a wide range of stakeholders, including the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030).



Angelina Namiba
Salamander Trust

Originally from Kenya, Ms Namiba has over 16 years' experience in the HIV sector advocating for the greater involvement of women living with HIV in strategy and policy development and supporting the needs of adolescents and young people living with HIV. Currently she leads a perinatal peer mentoring project with women living with HIV at the Salamander Trust in the United Kingdom. As a woman living with HIV for two decades, she is a passionate advocate for the sexual health and reproductive rights of women living with HIV. Angelina is an active community representative on many national and international advisory boards and working groups.



Annemarie Hou
UNAIDS

Annemarie Hou is the Director of Communications and Global Advocacy at UNAIDS. She oversees the communications and advocacy portfolio for the organization. She is responsible for positioning HIV and development issues in the global landscape and advancing UNAIDS' vision and strategies. Prior to joining UNAIDS, Ms Hou worked in the philanthropic field. She was the Communications Director at Casey Family Programmes, a foundation dedicated to child welfare issues. Ms Hou served as the first Global Health Communications Manager at the Bill & Melinda Gates Foundation and also as the family's spokesperson. She started her career as a television journalist. She is an adviser to Graça Machel and Grassroot Soccer.

