



## UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (32)/13.5  
Issue date: 17 June 2013

### **THIRTY-SECOND MEETING**

**Date:** 25-27 June 2013

**Venue:** Executive Board Room, WHO, Geneva

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#### **Agenda item 4.1**

### **2012–2015 Unified Budget, Results and Accountability Framework**

**UNAIDS Performance Monitoring Report 2012**

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**Additional documents for this item:**

- i. 2012-2015 Unified Budget, Results and Accountability Framework ([UBRAF](#) Part I) (UNAIDS/PCB(28)/11.10)
- ii. 2012-2015 Unified Budget, Results and Accountability Framework ([UBRAF](#) Part II) (UNAIDS/PCB(29)/11.23)
- iii. Update on indicators, monitoring and evaluation of the 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) (UNAIDS/PCB(30)/12.9).
- iv. Financial report and audited financial statements for the year ended 31 December 2012 (UNAIDS/PCB(32)/13.6)
- v. Interim financial management update for the 2012–2013 biennium for the period 1 January 2012 to 31 March 2013 (UNAIDS/PCB(32)/13.7)
- vi. UNAIDS 2014-2015 budget (UNAIDS/PCB(32)/13.8)
- vii. 2014-2015 Results, Accountability and Budget Matrix (UNAIDS/PCB(32)/13.9)
- viii. Conference Room Paper 1: Country Case Study: Malawi
- ix. Conference Room Paper 2: Country Case Study: Uganda
- x. Conference Room Paper 3: Country Case Study: Ghana
- xi. Conference Room Paper 4: Joint Programme Engagement with Civil Society

**Action required at this meeting – the Programme Coordinating Board is invited to:**

- xii. *Take note* of the report and request UNAIDS to continue to refine and improve performance measurement and reporting taking into account lessons learned and views expressed by the Board, and;
- xiii. *Request* UNAIDS to carry out a mid-term review of the 2012-2015 Unified Budget, Results and Accountability Framework and report key findings back to the Board at its 34<sup>th</sup> meeting

**Cost implications of decisions:** None

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## ACRONYMS

ACRONYM	DEFINITION	ACRONYM	DEFINITION
<b>ADB</b>	Asian Development Bank	<b>MENA</b>	Middle East and North Africa
<b>AIDS</b>	Acquired immunodeficiency Syndrome	<b>MERG</b>	Monitoring and Evaluation Reference Group
<b>ALMA</b>	African Leaders Malaria Alliance	<b>MSM</b>	Men who have sex with men
<b>ARV</b>	Antiretroviral	<b>MTB/RIF</b>	Mycobacterium tuberculosis /rifampicin
<b>ART</b>	Antiretroviral treatment	<b>NASA</b>	National AIDS Spending Assessment
<b>ASEAN</b>	The Association of Southeast Asian Nations	<b>NEPAD</b>	New Partnership for Africa's Development
<b>AU</b>	African Union	<b>NGO</b>	Non-governmental Organization
<b>AUC</b>	African Union Commission	<b>PAHO</b>	Pan American Health Organization
<b>BRICS</b>	Brazil, Russia, India, China, South Africa	<b>PCB</b>	Programme Coordinating Board
<b>CD4</b>	Cluster of differentiation 4	<b>PEPFAR</b>	US President's Emergency Plan for AIDS Relief
<b>CEWG</b>	Cosponsors Evaluation Working Group	<b>PMPA</b>	Pharmaceutical Manufacturing Plan for Africa
<b>EAC</b>	East African Community	<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>ECOSOC</b>	United Nations Economic and Social Council	<b>RCRC+</b>	Red Cross Red Crescent Network for people living with HIV
<b>ECOWAS</b>	Economic Community Of West African States	<b>QCPR</b>	Quadrennial Comprehensive Policy Review
<b>EECA</b>	Eastern Europe Central Asia	<b>SERAT</b>	Sexuality Education Analysis and Review Tool
<b>EMRO</b>	WHO Eastern Mediterranean Regional Office	<b>STI</b>	Sexually transmitted infections
<b>eMTCT</b>	Elimination of mother-to-child transmission	<b>SWAN</b>	Sex Worker's Rights Advocacy Network in the Eastern Europe and Central Asia region
<b>ESCAP</b>	UN Economic and Social Commission for Asia and the Pacific	<b>TB</b>	Tuberculosis
<b>G8</b>	Group of Eight	<b>TRIPS</b>	Trade Related Intellectual Property Rights
<b>GARPR</b>	Global AIDS Response Progress Report	<b>TSF</b>	Technical Support Facilities
<b>GAVI Alliance</b>	Global AIDS Vaccine Initiative Alliance	<b>UBRAF</b>	UNAIDS Unified Budget, Results and Accountability Framework
<b>GBVIMS</b>	Gender-Based Violence Information Management System	<b>UBW</b>	Unified Budget and Workplan
<b>GFATM</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria	<b>UN</b>	United Nations
<b>GIZ</b>	German Society for International Cooperation	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>GNP+</b>	Global Network of People Living with HIV	<b>UNDAF</b>	United Nations Development Assistance Framework
<b>HHA</b>	Harmonization for Health in Africa	<b>UNDG</b>	United Nations Development Group
<b>HICs</b>	High Impact Countries	<b>UNDP</b>	United Nations Development Programme
<b>HIV</b>	Human immunodeficiency virus	<b>UNESCO</b>	United Nations Education, Scientific and Cultural Organization
<b>HLM</b>	High Level Meeting	<b>UNFPA</b>	United Nations Population Fund
<b>IATT</b>	Interagency Task Team	<b>UNICEF</b>	United Nations Children's Fund
<b>IDLO</b>	International Development Law Organization	<b>UNIDO</b>	United Nations Industrial Development Organization
<b>ILO</b>	International Labour Organization	<b>UNITAID</b>	
<b>INERELA+</b>	The International network of religious leaders living with or personally affected by HIV and AIDS	<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>IPPF+</b>	International Planned Parenthood Federation Network of People Living with HIV	<b>WAHO</b>	West African Health Organization
<b>IPSAS</b>	The International Public Sector Accounting Standards	<b>WFP</b>	World Food Programme
<b>JPMS</b>	Joint Programme Monitoring System	<b>WHO</b>	World Health Organization
<b>MDG</b>	Millennium Development Goal	<b>WTO</b>	World Trade Organization

## A. INTRODUCTION

1. This report summarizes the 2012 achievements of the UN Joint Programme on AIDS (UNAIDS) at country, regional and global level and outlines remaining challenges. The report includes seven main sections. The introduction is followed by a snapshot of progress in the response to the Human Immunodeficiency Virus (HIV) and highlights of contributions of UNAIDS Cosponsors and Secretariat to the response. The three subsequent sections review achievements and challenges in achieving UNAIDS vision of the “Three Zeros” – efforts to revolutionize prevention of HIV transmission, catalyzing the next phase of treatment care and support, and advances in human rights and gender equality. Next, leadership, coordination and accountability in the response to AIDS Acquired Immunodeficiency Syndrome) are discussed, followed by a final section on cross-cutting themes that underpin the goals of the UNAIDS 2011-2015 Strategy – young people, education for more effective AIDS responses, scaling up HIV workforce policies and programmes, integrating food and nutrition in HIV prevention and care services, and HIV interventions in humanitarian emergencies.
2. The report presents progress against the global targets established by the 2011 United Nations General Assembly Political Declaration on HIV and AIDS (“global targets”), based on a review of trends and achievements against indicators included in the 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) Part II (UNAIDS/PCB(29)/11.23). Progress against all the indicators and deliverables in the UBRAF is presented in matrix form on the [www.unaids.org/ubraf](http://www.unaids.org/ubraf) which also contains additional analyses and information. Seven country profiles have been included in the report to provide examples of the contributions that the UN makes to national AIDS responses in different countries with different HIV epidemics. In addition, case studies will be presented to the meeting of 32<sup>th</sup> Programme Coordinating Board as Conference Room Papers to provide additional in-depth analyses.

### **Performance measurement, accountability and reporting**

3. As the successor to the UNAIDS Unified Budget and Workplan (UBW), the Unified Budget and Accountability Framework (UBRAF) is an instrument to maximize the coherence, coordination and impact of the UN’s response to AIDS by combining the efforts of 11 UN Cosponsors and the Secretariat to catalyse country-level action against AIDS. The UBRAF is based on the UNAIDS 2011-2015 Strategy, with actions cascading from strategic goals and global AIDS targets. It is designed to achieve results at country level, with resources identified and allocated for global action, for High Impact Countries (HICs) and for other countries by region.<sup>1</sup>

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<sup>1</sup> Thirty-eight high impact countries: Angola, Botswana, Brazil, Burundi, Cambodia, Cameroon, Central African Republic, Chad, People’s Republic of China, Côte d’Ivoire, Djibouti, Democratic Republic of Congo, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, the Islamic Republic of Iran, Jamaica, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, the Russian Federation, Rwanda, South Africa, South Sudan, Swaziland, United Republic of Tanzania, Thailand, Uganda, Ukraine, Zambia and Zimbabwe.

As part of the UBRAF, 30+ HICs have been identified where the AIDS response can have the biggest impact. Cumulatively, the HICs bear the brunt of the HIV burden, accounting for 92% of new infections and 89% of total AIDS deaths among adults. More than half of total UBRAF funds are directed to these countries. In 2012, the first year of UBRAF operations, UN system resources to these countries totalled US\$ 1.94 billion.

4. Supporting the achievement of the global targets within different national contexts is the foundation of UNAIDS work. At the country level, UN Joint Teams on AIDS are responsible for developing and implementing Joint Programmes of Support, which are aligned to national plans on HIV and AIDS. These form the basis of reporting on the UBRAF.
5. At the regional and global level, UNAIDS focuses on catalysing processes and driving results where global public goods and coherence are most relevant. Mobilizing partners and marshalling support for better treatment and prevention technologies are challenges that are fundamentally global in scale and scope. Similarly, ensuring the broad array of stakeholders is working towards the same specific objectives within a common framework for targeting investments and measuring results necessarily involves a great deal of coordination and leadership at global and regional levels.
6. In the UBRAF, accountability is linked to the achievement of strategic goals and targets and measurement of results and contributions of the Joint Programme against indicators and performance criteria established by the Cosponsors Evaluation Working Group (CEWG). Key criteria identified include: programmatic and financial implementation, resource allocation and leveraging, and quality and timeliness of reporting.
7. The measurement of performance has been strengthened as part of the development and implementation of the UBRAF and reporting has been expanded to include not only indicator-based reporting, but also additional information obtained from Cosponsors' internal results reports and reporting by interagency task teams and working groups. Annual performance reviews are conducted at all levels and contribute to the reporting to the Programme Coordinating Board, Cosponsor Boards, the Economic and Social Council and the UN General Assembly.
8. In 2012, a web-based tool, the Joint Programme Monitoring System (JPMS) was introduced to enhance performance monitoring and the ability to make adjustments based on performance information. Reporting in the JPMS captures the country, regional and global organizational and thematic levels, with each successive level able to provide complementary reporting. As well as being linked to the strategic goals and global AIDS targets, the JPMS reporting is also linked to country results frameworks, normally the UN Development Assistance Framework (UNDAF). An online repository of UBRAF indicator information, UBRAFinfo (based on the DevInfo platform), has also been finalized.
9. Experience of the JPMS showed that the UBRAF reporting encouraged the Cosponsors and Secretariat at country and regional level to better articulate results. It also increased transparency, accountability and access to performance information as the system acts as a database. The ability to review results for a particular theme across all parts of the Joint Programme is a major step forward. The reporting facility of the JPMS makes it possible to see 'vertical' reports by individual components, such as country and region, but the real

power of the system is its ability to 'horizontally' view all entries by a particular output, outcome or thematic area.

10. A peer review by Cosponsors and the Secretariat, more robust than any previous similar undertaking, took place at the start of 2013. The review evaluated progress and performance in the first year of the biennium and reviewed workplans and budgets for the current year and next biennium. This provided an opportunity to assess results and areas where additional efforts are needed, to ensure epidemic priorities are addressed in future work, and to consider areas of focus in the 2014-2015.
11. A [multi-stakeholder consultation](#) was held in Geneva on 4 March 2013 – with more than 70 participants, including representatives of permanent missions and civil society in addition to Cosponsor and Secretariat staff – to take stock of the lessons learned in implementing the UBRAF and to reflect these in the development of the 2014-2015 budget. The 2012 reporting provided the basis for the discussions at the multi-stakeholder meeting and helped shape the development of UNAIDS 2014-2015 budget, which is presented to the Programme Coordinating Board for approval at its 32<sup>nd</sup> meeting.
12. Overall, the 2012 performance report represents a significant advance over previous years in terms of analysis and synthesis of results and achievements, identification of areas where progress has been limited, and formulation of next steps. The report presents a summary of a vast amount of information collected primarily through the JPMS. The report presents results at outcome and output levels and describes the contributions of UNAIDS Cosponsors and Secretariat to the AIDS response.
13. In 2014 a performance report will be prepared for the Programme Coordinating Board, which will cover the full biennium, 2012-2013. This report will present a more comprehensive picture and have the advantage that it will consider achievements and results over a two year period and benefit from lessons learned and feedback from the Programme Coordinating Board on the current report. The 2014 report, which will also include findings of a midterm review of the UBRAF, is expected to improve the UBRAF as a management, results and accountability framework.

## B. PROGRESS AND HIGHLIGHTS

### Progress towards the “Three Zeros”

#### Zero new infections

- Worldwide, the number of people newly infected continues to fall; the number of people (adults and children) acquiring HIV infection in 2011 (2.5 million) was 20% lower than in 2001. The sharpest declines in the numbers of people acquiring HIV infection since 2001 have occurred in the Caribbean (42%) and sub-Saharan Africa (25%). In some other parts of the world, HIV trends (for children and adults) are cause for concern. Since 2001, the number of people newly infected in the Middle East and North Africa (MENA) has increased by more than 35% (from 27,000 to 37,000). Evidence indicates that the incidence of HIV infection in Eastern Europe and Central Asia (EECA) began increasing in the late 2000s after having remained relatively stable for several years.

#### Zero discrimination

- The number of countries, territories or areas that had HIV-related restrictions on entry, stay and residence fell from 47 to 44 between December 2011 and January 2013.
- The HIV Stigma Index, a tool devised by and for people living with HIV to build evidence and measure the level of stigma they experience within their communities, has been rolled out in more than 75 countries, 29 more than in 2010. The number of countries with laws against gender-based violence has doubled since 2010.

#### Zero AIDS-related deaths

- In 2011, 1.7 million [1.5 million–1.9 million] people died from AIDS-related causes worldwide. This represents a 24% decline in AIDS-related mortality compared with 2005 (when 2.3 million [2.1 million–2.6 million] deaths occurred).
- Antiretroviral therapy reached 8 million people by the end of 2011 – a 20-fold increase since 2003. Since 1995, antiretroviral therapy has added 14 million life-years in low-and-middle income countries, including 9 million in sub-Saharan Africa.
- In 2011, for the first time, a majority (54%) of people eligible for antiretroviral therapy in low-and-middle income countries were receiving it. Latin America (68%), the Caribbean (67%), and Oceania (69%) had the highest coverage. Coverage in sub-Saharan Africa is modestly higher than the global average, with 56% of eligible individuals receiving therapy. Coverage remains low in the EECA region (25%) and in the MENA (15%).
- Globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011.

Reference: Global Report: UNAIDS Report on the Global AIDS Epidemic. 2012

14. A snapshot of progress in the response to HIV and highlights of the contributions of the Cosponsors and Secretariat to the response are included below. Details are presented in the sections which describe the strategic goals, functions and cross-cutting themes.



## **Young people**

15. Emphasis on young people has become increasingly crucial, given that knowledge of HIV appears to have stagnated or even reduced among this target population. Consequently, the Joint Programme made it a particular priority in 2012 to ensure that young people had a central place in its HIV prevention efforts, and multiple agencies worked to support programmes in all regions targeting young people through advocacy, education policy and health services.
16. Actions to strengthen national capacity by young people and other key stakeholders for the design and implementation of quality, comprehensive age-appropriate sexuality education increased from 76% to 78% in countries with a UNAIDS presence, and from 74% to 89% in HICs between 2011 and 2012. The World Health Organization (WHO), in collaboration with UN partners, developed and disseminated guidelines on HIV testing and counselling for adolescents, as well as for treatment and care for adolescents living with HIV.
17. The political inclusion of young people in sexual and reproductive health, including HIV, was strengthened in 2012, with the implementation of the Secretary General's System-Wide Action Plan on Youth. Other key youth initiatives included a set of youth-defined recommendations developed to guide UNAIDS' work on HIV and young people.

## **Key populations (men who have sex with men, sex workers and transgender people)**

18. Interventions targeting key populations have also been at the forefront of Joint Programme activities. Globally, condom use among sex workers and men who have sex with men (MSM) is increasing. However, HIV prevalence for these key populations also rose, underlining the need for increased targeted programmes for these groups.
19. Cosponsors were involved in ground-breaking research on HIV among female sex workers and MSM which showed these two key populations are much more likely to acquire HIV than the general population (by 14 and 19 times, respectively). The findings highlight the cost-effectiveness of investing HIV resources in key populations to avert the most infections. Modes of Transmission studies were also supported in more than 30 countries to identify populations that require more focused outreach.
20. Across the UNAIDS family, combination prevention is the modality for key populations, improving access to prevention services, addressing structural issues and access to treatment. UNAIDS supported regional and country-specific roadmaps, situational analyses, sector-wide action plans, economic analyses of impact, and development of service packages for local level implementation addressing key populations.

## **Eliminating mother to child transmission (eMTCT)**

21. Progress on preventing new infections in children and keeping mothers alive includes an increase from 48% to 64% between 2010 and 2012 in the number of HIV-positive women who received antiretroviral therapy, and an unprecedented 24% decline in new HIV infections among infants from 2009 to 2011.
22. All 22 priority countries under the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive accelerated programme implementation in 2012. 17 national costed plans for prevention of vertical transmission were finalized with guidance, technical support and assistance from United Nations Children's Fund (UNICEF), WHO and the Interagency Task Team (IATT) on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Children.

23. National eMTCT policies and plans have also been improved following UNAIDS normative guidance and technical support. The number of countries with a national plan implemented for strengthening the two-way integration of sexual and reproductive health and HIV services rose from 32% to 43% between 2011 and 2012.

### **Innovative approaches in prevention**

24. With technical support from the Joint Programme, Malawi demonstrated the quick impact of Option B+, decentralizing HIV treatment services to maternal child health clinics, and bringing treatment closer to women. Eight priority countries have changed their national guidelines to adopt Option B+. A key focus for UNAIDS has been ensuring that roll-out of innovations such as Option B+ take into account the views of women living with HIV and other human rights considerations.

25. In 35 countries, the Joint UN Teams on AIDS translated research on new technologies into implementation and scale-up, with most focusing support on rapid HIV testing and treatment as prevention as well as adult voluntary medical male circumcision. UNICEF, in collaboration with the Clinton Health Access Initiative, is scaling up point-of-care diagnostic technologies at lower levels of care to shape markets and improve access to HIV diagnosis and early treatment for children and pregnant women in seven sub-Saharan African countries.

### **Preventing HIV among people who inject drugs**

26. Between 2010 and 2012, the percentage of people with HIV who inject drugs saw a modest decline from 8% to 7%, while the percentage of countries where policy guidance and tools were used to support people who inject drugs expanded from 51% to 57% between 2011 and 2012. There was a slight increase in the number of countries with laws, regulations or policies that present obstacles to an effective HIV response for people who inject drugs.

27. UNAIDS coordinated and issued a joint statement of 11 UN system agencies calling for the closure of compulsory drug detention and rehabilitation centres for people who inject drugs and sex workers. A comprehensive package of interventions for people who inject drugs was produced and comprehensive HIV prevention, treatment, care and support was scaled up for people in prisons and other closed settings, many of whom are drug users, in a number of countries, including Egypt, Iran, Lebanon, Libya and Morocco.

### **Scaling up treatment**

28. Treatment scale-up over the last few years has been impressive, with nearly eight million people on HIV treatment (54% coverage) by 2011. The percentage of adults and children with HIV known to be receiving treatment 12 months after initiation of antiretroviral therapy rose from 81% to 84% between 2009 and 2011, a trend that has accelerated in 2012.
29. Extraordinary increases in HIV treatment, as well as better adherence rates, have been accompanied by an additional number of national plans which includes targets for equitable treatment access for key populations. For maximum effectiveness, in this area and several others, UNAIDS has focused its support on the HICs. The percentage of UN Joint Teams providing technical assistance for implementation of Treatment 2.0 increased from 47% to 84% in HICs from 2011 to 2012.
30. Together with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and UNITAID, UNAIDS Cosponsors and Secretariat have been jointly working on developing a programmatic approach to Treatment 2.0 and implementing its five pillars, including optimizing treatment and diagnostics, and improving service delivery models.

### **Avoiding TB deaths**

31. There has been good progress in addressing HIV/tuberculosis co-infection and UNAIDS Cosponsors have been actively collaborating to address the challenge of HIV/tuberculosis co-infection. Technical support resulted in the roll-out of the new rapid tests to 67 countries and in total, 119 countries tested more than 50% of tuberculosis patients for HIV.
32. However, the number of countries where Tuberculosis screening and Isoniazid Preventive Therapy are part of the national health system and plan has declined. There is an urgent need to scale-up collaborative activities to avert preventable mortality and to halve the number of tuberculosis-associated HIV deaths by 2015.

### **Enhancing social protection**

33. In 2012 in-country social protection lending for HICs reached US\$ 5.9 billion, of which an estimated US\$ 500 million, leveraged with support from UNAIDS, was for HIV-sensitive social protection programmes. In Kenya, Lesotho and Malawi, UN-assisted cash transfers for orphans and other vulnerable children reached 145,000 households by the end of 2012.
34. The World Bank provided US\$1.2 billion in funding for social protection in the Africa region, including HIV-sensitive social transfers. This amount is expected to increase as governments and regional bodies, including the African Union Social Protection Forum, continue to support social protection programmes and invest domestic resources in them.

## **Human rights at the centre of the response**

35. UNAIDS' action included standard-setting, advocacy and programmatic guidance in support of human rights-based and evidence-informed HIV responses that address HIV-related stigma, discrimination and punitive laws and policies. The range of initiatives and programmes addressing HIV-related stigma, discrimination and law reform appears to have increased, with more national actors and coalitions advocating for them. But such programmes are still insufficient, as stigma remains high and punitive approaches continue in many countries. HIV-related entry, stay and residence restrictions were lifted in three countries (Republic of Korea, Republic of Moldova and Mongolia), but remain in place in 44 countries, territories and areas.
36. The Stigma Index, a tool devised by and for people living with HIV to build evidence and measure the level of stigma they experience, was rolled out in more than 75 countries. Indicators by which to measure HIV-related stigma in communities and in health care settings have been developed and improved.
37. With the United Nations Development Programme (UNDP) providing its secretariat, the Global Commission on HIV and the Law completed its work and issued its Report and recommendations in 2012 on a wide range of issues relevant to HIV and the law. UNDP and UNAIDS have followed up those recommendations in several countries. UNAIDS has also reviewed and provided comments to national authorities on several HIV-related draft laws in order to ensure that these laws provide a protective and enabling environment for the national HIV response, including for key populations.

## **Eliminating gender inequalities**

38. More countries are including HIV related gender and women's issues in their national strategies and operational plans, but the engagement of women living with HIV in formal planning and review mechanisms and processes remains weak. The number of countries with laws against gender-based violence has doubled since 2010. Data availability of gender-based violence and HIV has improved, and related messaging aimed at the public has also increased.
39. The UNAIDS Agenda for Women and Girls continues to guide work on women, girls and gender equality and HIV. The mid-term review found that, since its launch, 60% of countries reported progress in translating political commitments into scaled-up action, especially in the HICs; 90% initiated action to better understand their epidemic, context and response; while 38% of the countries reported a budget component for women in their strategy.

## **Leadership and advocacy**

40. In 2012, UNAIDS continued to spearhead political advocacy to secure global, regional and national leadership in the response to AIDS in pursuing the vision of "Getting to Zero", reinforcing national ownership and promoting sustainable funding for AIDS responses worldwide. UNAIDS' strategic leadership transformed the three zeros into high-level, time-bound strategic commitments at the global, regional and country levels.
41. UNAIDS Strategy of "Getting to Zero" and the 10 global AIDS targets from the UN 2011 Political Declaration have shaped the global discourse around HIV among political bodies, decision makers, activists and civil society. At country level, "Getting to Zero" has been used to inspire and guide the development of comprehensive HIV plans and specific results-based interventions. More than 20 countries have developed new or revised national strategic plans that reflect the three zeros and the global AIDS targets, with a further 36 countries in the process of doing so.

42. Strong working partnerships at country level were forged between the Joint Programme and the Department of Peacekeeping Operations to advance the implementation of the UN Security Resolution 1983. High level dialogue resulted in leaders agreeing to jointly convene a stocktaking AIDS and security summit to review progress and agree on core action points to sustain political leadership and greater accountability.
43. With UN Women becoming the eleventh Cosponsor, and UNAIDS has expanded its range of competence and reinforced its approach to gender equality to respond to the changing environment.

### **Closing the resource gap**

44. During 2012, UNAIDS continued its advocacy on shared responsibility and global solidarity, diversification of funding sources and increasing domestic financing to ensure financial sustainability. For the first time, in 2011, domestic AIDS investments exceeded international funding in low and middle income countries and the governments of Brazil, China and India have committed to ensure that at least 90% of the national response is financed domestically.
45. More countries are rising to the challenge of filling the AIDS investment gap and sustaining the response by identifying domestic sources of funding. Innovative financing is playing a central role in increasing domestic investments in the AIDS response – for example, Rwanda and Uganda charge levies on mobile phone use to generate funds for HIV programmes.
46. In Africa, UNAIDS support contributed to the African Union (AU) Heads of State adopting a “Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa” in July 2012. The AU Roadmap offers a set of practical and African-owned solutions to enhance sustainable responses to AIDS, TB and malaria. The Roadmap also sets up an accountability structure embedded in the New Partnership for Africa's Development (NEPAD) to monitor progress in the region, as well as revitalizing AIDS Watch Africa.

### **Strengthen HIV integration**

47. During 2012, efforts to eliminate parallel systems for HIV-related services and to strengthen integration of the AIDS response in global health and development were intensified. New tools and processes have been introduced to enable countries to identify cost drivers and create incentives to eliminate parallel systems, in particular by addressing the overall design of AIDS responses, the potential efficiency gains in the delivery of responses, and the fiscal and other considerations required to sustain responses.
48. Consolidated antiretroviral guidelines treatment have been developed under the leadership of WHO to address service delivery and operational issues to increase efficiency and effectiveness of HIV programmes, including integration of HIV care and treatment with opioid substitution therapy, maternal child health and tuberculosis care; task-shifting for HIV care and treatment; and a methodology and tool for rapid assessment of the degree of integration of HIV programmes.

### **Support to multi-sectoral national strategies and investment approaches**

49. Ensuring greater returns on investment is of vital interest to national governments and their funding partners. In 2011, UNAIDS introduced the Investment Framework, a conceptual

approach to improve the impact of HIV funding. This approach is about leveraging more sustainable sources of funding for AIDS, and requires all stakeholders to think differently and more innovatively about how the various elements that make up an effective and efficient AIDS response are planned and prioritized.

50. Countries in all regions are now moving forward with an investment approach, ranging from identifying new domestic resources to developing full investment cases. The investment approach has been endorsed by the GFATM and informs the GFATM guidance to countries for the development of applications according to the new funding model. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) guidance includes a directive to support the investment approach at the country level. Leading civil society networks are supportive of, and engaged with, the investment approach.

### **Building strategic alliances**

51. With the support of UNAIDS, the African Union Commission (AUC) and NEPAD undertook a review of available data to assess the degree to which commitments made by the AU and the Group of Eight (G8) from 2001 to date have been implemented. UNAIDS also supported BRICS countries advance the shared responsibility and global solidarity agenda by advocating increased domestic investments in AIDS and encouraging BRICS countries to increase development cooperation with low income countries.
52. With the private sector, new approaches are being used to share responsibility and accountability for results. An example is the Business Leadership Council launched in 2012 in Davos to galvanize private sector engagement in support of the Global Plan on eMTCT. Other examples being used by UNAIDS include leveraging the reach, expertise, skills and institutional resources of the business sector include using social media (e.g. Twitter and Facebook) to engage CEOs of major private companies on the free movement for people living with HIV and eliminating HIV related travel restrictions.

### **Strategic information and technical support**

53. UNAIDS continued to support focused efforts to generate and use strategic information to make the response to AIDS more effective in addressing the dynamics of the epidemic and its underlying factors. In addition to the roll out of the HIV Stigma Indexes and Modes of Transmission studies, National AIDS Spending Assessments (NASA) were supported in 15 countries. Gender assessments were conducted in six countries (Bolivia, Djibouti, Jamaica, Liberia, Rwanda and Tajikistan).
54. During 2012, technical support offered by UNAIDS continued to be a focus to ensure targeted assistance to countries in accessing and managing external investments in the AIDS response. UNAIDS provided technical contributions to 19 Global Fund HIV grants under review, yielding funding decisions worth US\$1.9 billion. As highlighted in the new *GFATM Strategy 2012-2016*, "The United Nations partners, especially WHO and UNAIDS, have a special role in this regard in providing the necessary norms, standards and evidence to enable more strategic investment."
55. In addition, the Technical Support Facilities (TSFs) assisted in unblocking GFATM grant implementation challenges in over 30 countries through more than 70 technical support assignments. External reviews of the TSFs completed in 2012 found the TSFs to be effective, relevant and able to offer value for money in response to growing demand for their services. As part of an on-going drive to obtain the best possible value for money, the TSFs were consolidated from five to three in 2012: the TSF Eastern and Southern Africa; the TSF West and Central Africa; and the TSF Asia Pacific.

### **Strategically positioning AIDS in the post-2015 agenda**

56. In 2012, UNAIDS led efforts to position AIDS in the post-2015 agenda and integrating the AIDS response with broader health and development goals. The catalyst for debate was initiated through UNAIDS' active engagement in the Rio+20 UN Conference on Sustainable Development. During the year, UNAIDS prepared a paper called "UNAIDS and post-2015 AIDS, Health and Human Rights: Toward the end of AIDS in the Post-2015 Development Era", as a contribution to the Post-2015 Global Thematic Consultation on Health. UNAIDS supported consultations on post-2015 in 40 countries. In December 2012, responding to calls from country partners and civil society, "The UNAIDS and Lancet Commission: From AIDS to Sustainable Health" was launched, which is exploring the future of AIDS, health and global development post 2015.

**Guatemala****EDUCATING THE NEW GENERATION**

UN HIV-related expenditure in 2012

**US\$ 583,853****UBRAF core and non-core**

**Joint UN Team members:** ILO, Secretariat, UN Women, UNDP, UNESCO, UNFPA, UNICEF, WFP and WHO [**14 members**]

**Epidemic type:** concentrated/geopolitical relevance  
**Principal modes of transmission:** men having sex with men

The Government of Guatemala has developed a strategy to integrate the elimination of new HIV infections among children with a programme to eliminate congenital syphilis. UNICEF, PAHO and the Secretariat have worked closely with the Ministry of Health to elaborate a 2012–2016 national plan to eliminate both infections. The programme is expected to improve access to prenatal care and diagnostic tests, ensuring treatment, strengthening primary health care in young people, and reinforcing the management of service delivery, strategic information and monitoring. The overall objective is to ensure comprehensive care for all pregnant women and to prevent transmission to their children. Through advocacy and technical support by UNICEF and the Secretariat, national authorities and the country coordination mechanism have been engaged in discussions to re-programme GFATM resources in order to increase the prevention of mother-to-child transmission (PMTCT), including rapid testing for pregnant women and appropriate treatment for children. There are challenges, such as access to antenatal care, prophylaxis for PMTCT and the provision of antiretroviral prophylaxis to mothers, but the development of a national plan is a significant step forward.

Another approach where Guatemala is making good progress is in introducing education programmes to support young people in HIV prevention. The UNICEF non-formal programmes ensure training to more effectively reduce sexual transmission. In 2012, adolescents in 13 municipalities were trained as peer counsellors in the prevention of HIV and other sexually transmitted diseases, using an innovative approach which included playful (lúdicas) methodologies. In supporting the development of self-care and life-enhancing practices, UNICEF is supporting Guatemalan teenagers to live independently and make the transition to adulthood, while sustaining safer sex behaviours. Preventing high-risk behaviours will reduce sexual transmissions, ensuring a more effective response to achieving the global AIDS targets.

Addressing gender issues has been less straightforward. The HIV epidemic in Guatemala is concentrated among key populations at higher risk, such as transgender populations, MSM and sex workers. High levels of discrimination against these groups make it difficult for them to access HIV and other health services. Stigma and discrimination have been identified as one of the main obstacles to an effective AIDS response. To address this situation, a national Gender Identity Law is being promoted, with the Secretariat, UNFPA, UNDP and other UN organizations defining the way to advance the process. Guatemala is developing a draft of the law with the lead of the country's transgender population and has initiated discussions with key stakeholders, focusing on congressional representatives, the general population and the private sector. Guatemala led the way at the global level by using the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV to create awareness of the need for the Gender Identity Law.



## C. REVOLUTIONIZE HIV PREVENTION




### Reduce sexual transmission of HIV





Target: Reduce sexual transmission by 50% by 2015

#### **Significant trends and indicators**

*Global shipments of male condoms rose steadily from 2003 to 2008 but since then have levelled off. In contrast, shipments of female condoms have risen markedly throughout the decade, although there are still more than 40 male condoms shipped for every female condom. Global condom use among sex workers and MSM slightly increased, and prevalence for these key populations also rose, underlining the need for programmes to address these groups.*

Status	Data
	Median percentage of sex workers reporting using a condom with their most recent client increased from 81% to 85% from 2010–2012
	Median percentage of MSM reporting using a condom the last time they had anal sex with a male partner increased from 57% to 60% from 2010–2012
	Median HIV prevalence among MSM and sex workers increased from 6% to 7.6% and 3% to 4.5% respectively from 2010–2012

*Young peoples' knowledge of HIV appears to have stagnated or even reduced. UNAIDS needs to translate an increased focus on sexuality education into improved knowledge levels.*

Status	Data
	UNAIDS actions to strengthen national capacity among key stakeholders to design and implement quality, comprehensive age-appropriate sexuality education in policy and curricula increased from 76% to 78% of countries with a UNAIDS presence and from 74% to 89% in HICs from 2011–2012
	Median percentage of young people aged 15–24 correctly identifying ways of preventing sexual transmission of HIV and rejecting major misconceptions about HIV transmission was static for women (28%) and fell (from 34% to 32.6%) for men from 2009–2011

#### **Achievements**

66. Sexual transmission represents the great majority of new HIV infections and most aspects of the AIDS response have a role in reducing sexual transmission. Therefore, reporting on this section of UBRAF is intended to be illustrative and not exhaustive and is organized in three main parts. First, addressing the achievements from a population perspective, (considering the target populations of young people, followed by MSM, sex workers and transgender people). Secondly, from the perspective of programming modalities by reflecting on progress imperatives, including in the areas of new and emerging HIV prevention technologies followed by condom programming. Finally, by using a progress approach, covering the areas in strategic information and normative guidance.

### Prevention among young people

67. Young people have been a major focus for UNAIDS in 2012 and multiple agencies have been working in all regions to support programmes targeting young people through advocacy, education policy and health services. Agencies have sought to improve health service delivery to young people by assisting governments to develop national standards and address concerns about the quality of services that often hinder access.
68. The Asia Pacific Inter-Agency Task Team on youth and key populations, (chaired by UNESCO and with support from UNICEF, UNDP, UNFPA, UNODC, UN Women, WHO, the Secretariat and many other partners), developed guidance to enhance country-level capacity to address the needs of adolescent key populations. The NewGen Asia initiative trained more than 100 young people from key populations in leadership, providing them with crucial information on preventing sexual transmission of HIV.

UNFPA-supported programmes reached nearly 3.3 million young people through various HIV prevention, communication and outreach activities in the East and Southern Africa region. Zimbabwe's national behaviour change survey showed 71% of young women and men aged 18–24 were reached by the UNFPA-supported behaviour change programme. Exposure was associated with higher condom use and HIV testing and counselling uptake.

69. With the support of UNICEF, UNFPA and UNESCO, 17 African countries have strengthened capacity and resources to review and develop curricula to reduce risk behaviours among young people. This support is leading to increased implementation; for example curricula in Lesotho, Namibia and the United Republic of Tanzania now incorporate comprehensive sexuality education, and are rights-based, gender-responsive, and age- and culturally appropriate.
70. UNFPA supported HIV prevention efforts among young people in 14 countries in West and Central Africa, reached more than 100,000 young people with youth-friendly HIV and sexual and reproductive health services and social and behaviour change communication.
71. The Pan American Health Organization (PAHO) supported seven countries in Latin America to develop adolescent health plans for the health sector, with a focus on sexual and reproductive health and HIV prevention, while pilot projects to integrate HIV and sexual and reproductive health services for adolescents are under way in Honduras and Nicaragua.
72. UNICEF's work in Brazil to increase prevention services and reduce adolescent vulnerability by resulted in the expansion of outreach services and enhancement of treatment, care and support to thousands of pregnant adolescents/young women, including those who inject drugs. As a result, UNICEF Brazil will increase its own funding by US\$ one million to strengthen initiatives for HIV-positive adolescents, a large cohort in the country.
73. UNICEF, in collaboration with civil society organizations in five countries in Eastern and Central Europe, promoted and built key stakeholder capacity to increase access to and uptake of HIV testing and counselling among young people, particularly most-at-risk adolescents. Online surveys of 2,500 young people explored their experiences, needs and preferences to tailor HIV testing and counselling programmes.

74. In Africa, UNICEF supported the Shuga Radio programme that communicated information on HIV prevention to more than 250,000 young people over a six-week period. Data from the Democratic Republic of Congo showed that HIV testing and counselling among young people aged 15–24 increased during the implementation period. Visits by young people aged 10–24 to voluntary testing and counselling sites rose from 1,040 to 1,534 from the first to the second half of the year. In Cameroon, training was completed in 2012 to strengthen monitoring and reporting of HIV testing and counselling for adolescents and youth.

#### Prevention among MSM, sex workers and transgender people

75. The Joint Programme's emphasis on key populations meaningfully participating in the response at global, regional and country levels is shaping its approach to normative guidance, strategic information, capacity development and programming, and influencing national responses. Across the UNAIDS family, the main approaches to support key populations efforts are to ensure integrated access to services and treatment, and to address structural issues.

76. Effecting change in metropolitan areas and municipalities is a key focus of the Joint Programme's work for key populations. The Urban Health and Justice Initiative, developed by UNDP in partnership with UNFPA and other Cosponsors, helped develop and implement innovative municipal plans on HIV that focused on key populations in 24 cities across five regions.

UBRAF core funds were used to leverage financing and ensure resources were targeted to achieve maximum impact. Using a US\$ 35 million specific investment loan, the World Bank-funded Viet Nam HIV/AIDS Prevention project that supported programmes designed to halt HIV transmission among key populations and between these populations and the general population. Key outcome indicators include an increase from 20% to 70% of people in key populations reporting safer injection practices. Key populations in participating provinces reported an increase in condom use from an estimated 40% at baseline to 80% by the end of the project.

77. The WHO European Action Plan for HIV/AIDS, 2012–2015, adopted by all 53 Member States of the WHO European Region, has a special focus on access to services for key populations, with guidance on service integration and leveraging broader health outcomes through AIDS responses as well as reducing vulnerability and removing structural barriers to accessing services.

78. WHO technical assistance on HIV interventions and programme target-setting for MSM and sex workers in Egypt, Morocco, Sudan and Tunisia has offered an improved understanding of the strengths and weaknesses of their policies, strategies and service delivery approaches. They were also given recommendations and action plans to build service-provider capacities.

79. UNFPA provided support for combination HIV prevention in key populations, particularly sex workers, in 11 countries of the West and Central Africa region, with a focus on situation analysis, strategy development, peer education and sexual and reproductive health/HIV service delivery. In the five countries that reported direct UNFPA financial support for service delivery through partners, more than 6,700 sex workers were reached. UNFPA supported

initial partnerships between sex-worker networks and government representatives in Kyrgyzstan, Russia and Tajikistan.

The World Bank and the Secretariat conducted an HIV financial sustainability study in Jamaica. Intended to provide best-practice advice for other countries to replicate, the study highlighted the need to ensure efficient and effective prevention programmes, particularly for key populations. The cost of one adult infection was estimated at US\$ 5,800. The programme for stopping new infections in children and keeping mothers alive averts about 50 HIV infections each year, saving an estimated US\$ 390,000.

80. The Asia Pacific Regional Thematic Working Group on HIV and Sex Work (co-convened by UNFPA, UNDP and the Asia Pacific Network of Sex Workers) brings together regional UN agencies and regional and national sex-worker organizations. It has continued to lead regional initiatives on sex work, coordinate joint efforts to provide country technical support for evidence-informed policies and programmes, and analyse and disseminate strategic information and programme and policy guidance.

There has been progress in condom programming in Latin America. Peru and Ecuador with UNFPA support are well underway in implementing comprehensive condom programming, purchasing female condoms with resources from their national budget. Brazil has also developed a national distribution policy on male condoms and is distributing female condoms widely, prioritizing groups of women at risk, and is piloting male condom distribution in schools. As part of a regional strategy adopted in late 2011, UNHCR successfully implemented three projects in Costa Rica, Panama and Venezuela focused on HIV and sexually transmitted infection prevention information, condom distribution, access to voluntary tests, pre- and post-counselling, and other health services for young people.

#### New and emerging HIV prevention technologies

81. Alongside well-established prevention programmes such as condom programming, behaviour change efforts and integrated programmes for key populations, 2012 has seen a focus on augmenting the impact of prevention programming through additional biomedical methods, especially maximising the impact of HIV treatment on prevention, and the expansion of adult voluntary medical male circumcision.

82. The use of antiretroviral therapy in preventing the further spread of HIV has been highly successful in certain contexts, e.g. the elimination of mother-to-child transmission in resource-rich settings and the recent study showing that in the controlled setting of a clinical trial among sero-discordant couples, there was a 96% reduction in the risk of HIV transmission where the HIV infected partner received early treatment. Expanding treatment as prevention will require significant improvements in HIV infrastructure and health care human resources.

83. UNAIDS has actively supported changes to policy settings as well as system strengthening efforts to expand the impact of treatment in prevention. This includes assessments of critical steps in the treatment cascade, including ensuring that timely diagnosis of HIV infections is made through greater access to HIV testing, including consideration of self-testing modalities, better linkage to care, and greater support for retention in fully effective treatment.

84. A number of modelling exercises have been conducted suggesting that an end to AIDS will require the addition of a vaccine to the HIV prevention mix, and UNAIDS has continued to support partners including the AIDS Vaccine Enterprise and the International AIDS Vaccine Initiative in ensuring a globally-coordinated and concerted effort to develop an AIDS vaccine continues. Significant developments in 2012 included advances in characterizing neutralizing antibodies effective against HIV, and better understanding of vectors for the delivery of vaccines.
85. Progress in scaling up adult voluntary medical male circumcision in the 15 countries where it is a priority (with high rates of HIV and low rates of circumcision) has continued in 2012. Verified data on the number of circumcisions conducted in 2012 is still being collected, but there appears to be a considerable increase on the cumulative 1.4 million circumcisions conducted between 2008 (when policy recommendations were adopted and 2011), with 880,000 of those circumcisions conducted in 2011 alone. Nevertheless, this remains only a small proportion of the more than 20 million male circumcisions needed among men aged 15 to 49 years in the priority countries. UNAIDS has provided policy, advocacy and implementation support to scale up, including the development of an advocacy strategy and coordinated implementation support by WHO.
86. In 35 countries, the Joint UN Teams translated research on new technologies into implementation and scale-up, with most focusing support on rapid HIV testing and treatment as prevention as well as adult voluntary medical male circumcision. In 71 countries the Joint Teams provided support to strengthen national capacity in logistics management of commodities.
87. UNICEF, in collaboration with the Clinton Health Access Initiative, is scaling up point-of-care diagnostic technologies at lower levels of care to shape markets and improve access to HIV diagnosis and early treatment for children and pregnant women in seven sub-Saharan African countries.

#### Normative guidance in the area of prevention

88. In 2012 there were significant gains in the availability of normative guidance. Guidance on prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries was launched in December by UNFPA, WHO, the Secretariat and the Network of Sex Work Projects, and was also translated into Russian. [\*The HIV and sex work collection: Innovative responses in Asia and the Pacific\*](#) was published by UNFPA, UNAIDS and the Asia Pacific Network of Sex Workers.
89. UNHCR published [\*International protection no. 9: claims to refugee status based on sexual orientation and/or gender identity\*](#); and UNDP, UNFPA, UNODC, WHO, the Secretariat and partners finalized the *Operational guidelines on monitoring and evaluation for MSM, sex workers and transgender people*. Additionally, region specific guidelines were developed.
90. Also in the area of prevention, [\*Female condom generic specification and prequalification guidelines\*](#) were published, together with an advisory note on additional lubricants by UNFPA, WHO, the Secretariat and key partners, and UNDP initiated research on

interventions in the Eastern and Central Europe region related to HIV transmission in intimate relationships.

91. Guidelines on HIV testing and counselling for adolescents, and treatment and care for adolescents living with HIV have been developed by WHO in collaboration with UN partners.
92. The Secretariat published a comprehensive handbook on HIV and outreach programmes for MSM in the MENA region, titled- [\*From a process of raising awareness to a process of commitment\*](#). The handbook, available English and French, with an Arabic version nearing completion, provides countries that currently implementing MSM programmes with additional tools to improve these programmes. It also provides other countries willing to initiate MSM programmes with sufficient elements to design them.
93. The World Bank and the Secretariat partnered with PEPFAR to produce and disseminate 13 country-specific briefs containing the latest voluntary medical circumcision estimates using best available epidemiologic, demographic and service costing data. This information was used to estimate the potential cost and impact of scaling up services to 80% coverage and the briefs were used to make the economic argument for investing in male circumcision.

#### Strategic information in the area of prevention

94. UNFPA, the World Bank and the Secretariat conducted a comprehensive review of evidence for HIV prevention in generalized epidemics in 12 HICs in the East and Southern Africa region and shared the findings at the AIDS 2012 conference. The final report summarizes evidence for intervention efficacy, effectiveness and population-level impact, while assessing the extent to which this evidence has been considered in national strategies.
95. UNFPA, UNDP, UNODC, the World Bank and Johns Hopkins Bloomberg School of Public Health partnered on ground-breaking research on global epidemics of HIV among female sex workers and MSM. In particular, new data sets on the elevated prevalence of HIV among MSM and among sex workers were compiled across many countries in all regions for the first time. The research showed these two key populations are much more likely to acquire HIV than the general population (by 14 and 19 times, respectively). The findings represent critical data for countries on the cost effectiveness of investing their HIV resources in key populations to avert the most infections.
96. UNAIDS elaborated investment approaches to HIV which provided systematic focus on the potential return on investment for optimized AIDS responses in infections averted and lives saved.

The World Bank and the Secretariat supported Colombia to conduct an evidence-based implementation efficiency analysis of the AIDS national response, analysing programmatic, budgetary and service-delivery efficiency.

#### **Issues and challenges**

97. There are two key challenges in halving sexual transmission of HIV by 50% by 2015. The first concerns continuing significant incidence in high prevalence settings, in particular the hyper-endemic contexts of southern Africa. Here, combination prevention efforts which use

full-scale access to and effective implementation of biomedical, behavioural and structural responses to HIV will continue to be necessary to reduce transmission. The second challenge is that of HIV infection which is often extremely high among key populations in many countries. Programmes to reach key populations (sex workers, MSM, transgender people and people who inject drugs), account for about 4% of HIV expenditure globally.

98. Globally, the health sector scale-up of HIV testing and counselling to adolescents is inadequate due to policy constraints and limited health worker knowledge, and in all regions there are inadequate resources and a lack of strategic information for evidence-informed programming for young people. Often excluded from important decision-making processes, young people are not usually recognized and supported as partners and leaders. HIV and sexuality education is a necessity but the role of HIV education as a critical enabler is not well understood by all partners in the AIDS response.
99. Addressing community empowerment, access to acceptable health services and redress for human rights violations need to be significantly scaled up with the requisite level of funding. Similarly, condom programming for key populations needs to be increased, with key populations participating meaningfully in designing, delivering and monitoring actions.
100. There needs to be greater emphasis on HIV messaging for men in all settings. These messages must address men's responsibility for their own sexual health and sexual behaviour, including reducing (or eliminating) their demand for unprotected paid sex.
101. While city-focused responses can address key population hot-spots for HIV transmission, services for key populations beyond capital cities are minimal. Reaching undocumented migrant and mobile populations, including via interventions targeting key economic sectors where they work, and clients of sex workers, is also essential.
102. Local governments are uniquely positioned to coordinate efforts to address health inequalities affecting key populations. In many countries, municipal authorities have autonomy in setting policies and administering local health, social and legal services, and policing. They are often best placed to lead, mobilize and coordinate a wider response at the local level to HIV. In particular, they can help realign and influence national responses to the specific needs of key populations. Joint advocacy to prevent/remove punitive laws is an important structural response in reducing HIV-related vulnerabilities.
103. Obtaining reliable data is challenging; there is often a significant difference between community reports, demographic and health surveys and Global AIDS Response Progress Report data, and research is hampered by the limited availability and quality of routine data on HIV incidence and mode of transmission. In addition, under-reporting of the risk status of key populations in surveillance systems is likely in settings where social stigma is greatest. Despite recent improvements, the availability of rigorously gathered, longitudinal data, particularly on young people and key populations, remains limited in many countries and regions.
104. While HIV education programmes have been mainstreamed into education responses for a considerable period, the lack of significant progress in the measured HIV knowledge levels of young people is disheartening. While it is well understood that HIV knowledge does not in itself produce positive behaviour change, basic HIV knowledge is a pre-condition for

more intensive HIV efforts suggesting that a clearer focus on achieving adequate rates of correct and comprehensive HIV knowledge among young people is necessary.

### **Future plans**

105. The strategic targeting of key populations and young people has been identified as main contributor to the goal of halving sexual transmission, and these groups are a priority of planned work for 2013 as well as 2014-2015 work plan finalization.
106. Priorities include developing target-setting guidance for MSM, transgender people and sex workers, based on the existing framework for people who inject drugs, contributing to the generation of strategic information and evidence on key populations, and strengthening the incorporation of condom programming for key populations. A new list of priority countries (beyond the identified HICs), specifically addressing key populations, is needed and all countries should conduct a modes of transmission survey.
107. The 2013 Inter-Agency Working Group workplan on key populations includes significantly enhanced support to empower community-led organizations and networks of MSM, sex workers and transgender people.
108. For a strengthened response for adolescents and young people, support will be provided for bottleneck analysis on adolescents and youth, a global action framework for adolescents and HIV, and for scaling up adolescent/youth HIV testing and counselling, treatment and care, including sexual and reproductive health. Other initiatives focusing on young people include: developing guidance for governments to self-assess consent policies; programmatic and policy guidance on key populations and minors; and scaling up comprehensive sexuality education through the education sector, in collaboration with the health sector.
109. There will also be more contributions to developing guidance on adolescent key populations, and for rolling out operational guidelines for monitoring and evaluating HIV programmes for sex workers, MSM and transgender people at national, subnational and service-delivery levels.



**Kenya**

**MOBILIZING NEW SOURCES OF FINANCING**

**UN HIV-related expenditure in 2012**

**US\$ 122,395,918**

**UBRAF core and non-core**

**Joint UN Team members:** FAO, ILO, IOM, OCHA, Secretariat, UN Women, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UNON, WFP, World Bank and WHO **[51 members]**

**Epidemic type:** high-burden country

**Principal modes of transmission:** stable partnerships, multiple heterosexual partners, men having sex with men

The Government of Kenya has placed HIV at the top of the political agenda and become a global leader in several areas of the response. Scaling up male circumcision, which reduces the risk of female-to-male HIV transmission by at least 60%, is one example, and the UN has been an active partner in this and other initiatives. Kenya has one of the world's highest coverage rates for PMTCT, with 69% of HIV-positive pregnant women receiving antiretroviral prophylaxis in 2011 and the proportion of HIV-exposed infants who contract HIV falling from 27% in 2007 to 14.9% in 2011. The UN continued to support the scale-up of these prevention efforts in 2012. UNICEF assisted in integrating HIV into the wider maternal, newborn and child health programme, and in eliminating mother-to-child transmission (eMTCT) activities in six focus districts in high HIV burden provinces in Nyanza and the Rift Valley where 80% coverage targets were achieved at antenatal clinics for HIV screening and prophylaxis provision. WHO, UNICEF, UNFPA, UN Women and the Secretariat successfully advocated for a ministerial commitment to implement Option B+ (lifetime antiretroviral therapy for all HIV-infected pregnant women), and along with UNFPA and other stakeholders, collaborated with the National AIDS Control Council to develop the National Prevention Revolution Road Map.

Kenya has sought to mobilize new sources of HIV financing, particularly domestic sources. The UN is working with the government to help it reverse its 80% external funding ratio and in 2012 provided technical advice on the Cabinet-approved HIV Trust Fund to finance scaling up prevention, treatment, care and support. Under the scheme, the government would contribute 0.5%- 1% of its annual ordinary tax revenue to the fund, which would receive contributions from partners and the private sector.

Despite the progress made in eMTCT initiatives, challenges remain. UNICEF, WHO, UNFPA, UNODC and the Secretariat helped develop a national eMTCT framework and communication strategy and PMTCT guidelines, but overall universal access to these services is yet to be achieved. In fact, the nurses and doctors strike over pay and conditions in 2012 led to a decrease for the first time in women receiving effective prophylaxis to prevent mother to child transmission, pointing to the importance of adequate human resources for health. Similarly, a shortage of funds has limited the UN's ability to support the country to disseminate revised antiretroviral therapy guidelines, and service delivery and training aids; dissemination was completed at national down to district level, but full dissemination is reliant on local partners support.

In 2012, the UN contributed to improved HIV service delivery to key populations by advocating for HIV service provision for people who inject drugs, MSM, sex workers, prisoners and mobile populations. Kenya is the first country to establish an HIV and AIDS Equity Tribunal that addresses HIV-related stigma, discrimination and other human rights violations on the basis of HIV status. In 2012, the UN was actively involved in reducing discrimination, providing technical support for the HIV and AIDS Equity Tribunal to develop rules and regulations to underpin its operation and develop a three-year strategic plan.



## Prevent mothers from dying and babies from becoming infected with HIV



Target: Eliminate new HIV infections in children and reduce AIDS-related maternal deaths by 50% by 2015

### Selection of significant trends and indicators

*Continued progress on stopping new infections in children and keeping mothers alive has included an increased number of HIV-positive women receiving antiretroviral therapy as well as improved national policies and plans as a result of UNAIDS technical and normative support.*

Status	Data
	Percentage of HIV-positive pregnant women who receive antiretroviral therapy to reduce the risk of mother-to-child transmission increased from 48% to 64% from 2010–2012
	The number of countries who have implemented a national plan to strengthen the two-way integration of sexual and reproductive health and HIV services has increased from 32% to 43% from 2011–2012

### Achievements

110. In 2012, all 22 priority countries under the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive<sup>2</sup> accelerated their implementation programmes, with 17 countries finalizing their fully costed prevention of vertical transmission plans. There were also examples of innovation. Malawi demonstrated the impact of Option B+, decentralizing HIV treatment services into maternal child health clinics and thereby bringing treatment closer to women. Eight of the priority countries have changed their national guidelines to adopt Option B+. The Secretariat also supported a consultation to ensure that rolling out innovations such as Option B+ take into consideration the voices of women living with HIV.

One of the highlights in the area of 2012 was a ministerial meeting in May attended by 16 health ministers from the 22 priority countries. Results presented showed an unprecedented 24% decline from 2009 to 2011 in new HIV infections among infants. Seven of the 22 countries have had a decline of more than 30% in the number of new HIV infections among children.

111. However, results in seven countries (Angola, Chad, Democratic Republic of the Congo, India, Mozambique, Nigeria and the United Republic of Tanzania) are showing signs of stagnation, and during the year emphasis shifted to these countries with accelerated engagement from the Global Steering Group co-chaired by UNAIDS and PEPFAR. The steering group is now fully operational and its secretariat in Nairobi fully staffed. It has hosted meetings with focal points to review country progress, most recently, in December 2012, during a mid-term review consultation.

<sup>2</sup> The Secretariat co-chairs the Global Plan Steering Group with PEPFAR.

112. The IATT on the prevention and treatment of HIV infection in pregnant women, mothers and children, co-convened by UNICEF and WHO, has aligned its work across 28 partners (including civil society and UN agencies) to the Global Plan. The task team [website](#) was launched and technical assistance for strategy and mapping completed. The team developed a [toolkit](#) and support materials to assist countries in the transition to triple drug regimens (Option B/B+).
113. UNICEF, UNFPA and WHO supported finalizing regional recommendations for increased and strengthened HIV/sexual and reproductive health linkages, including guidance on leadership and coordination, policies, systems and services, monitoring and evaluation and data needs. UNICEF, UNFPA, UNODC, UN Women, WHO and the Secretariat developed regional policy guidelines on HIV and sexual and reproductive health needs for women and girls.
114. In monitoring and evaluation, global reporting has been coordinated and key guidance provided; the Global Plan monitoring framework was developed under WHO and UNICEF leadership and released in 2012<sup>3</sup>. Countries have been supported to improve the quality of their reporting. There was rigorous monitoring of prevention of vertical transmission efforts in more than 15 countries, including Brazil, Nicaragua, Paraguay and Peru, where significant progress was made.
115. In 10 priority countries, UNICEF supported the development, finalization and costing of national strategic and operational plans and monitoring and evaluation frameworks to prevent vertical transmission, including through advocacy, mobilization and technical support. UNICEF provided technical support to eight countries with the phasing out of single-dose nevirapine and adoption of more efficacious combination antiretroviral regimens.
116. Support for integrating HIV and sexual and reproductive health services included UNFPA initiatives in 13 countries. A majority of countries now have prevention of vertical transmission plans incorporating primary prevention for women of reproductive age and prevention of unintended pregnancy.
117. The Regional Elimination Initiative for Latin America has been aligned to the Global Plan, together with a framework to monitor and validate it. The initiative has contributed to a significant increase in tests for pregnant women and increased access to antiretroviral therapy in at least 15 countries in Latin America.
118. PAHO and UNICEF led comprehensive monitoring and advocacy of the regional initiative. Evidence-based policy guidance was provided in more than 15 countries and strategies to successfully implement the initiative were promoted region-wide.
119. The prevention of vertical transmission [conceptual framework for the MENA region](#) was launched during a WHO Regional Committee meeting in collaboration with UNICEF, UNFPA and the Secretariat. The WHO Eastern Mediterranean Regional Office (EMRO) supported Morocco to develop the national plan to stop new infections in children and keep mothers alive; Iran, Somalia and Sudan to develop guidelines; and South Sudan to mobilize a

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<sup>3</sup> [http://www.who.int/hiv/pub/me/monitoring\\_framework/en/index.html](http://www.who.int/hiv/pub/me/monitoring_framework/en/index.html)

GFATM grant for preventing vertical transmission. Nine priority countries developed national prevention of vertical transmission plans based on bottleneck and disparity analysis and began implementing key activities. Nine other countries conducted equity bottlenecks analysis and finalized or worked on national plans. A total of 107 subnational prevention of vertical transmission plans were developed in six countries.

UNICEF, together with other UN agencies and civil society partners (Open Society Foundations, the Clinton Health Access Initiative) supported national governments in Kyrgyzstan and Ukraine to introduce gender-responsive comprehensive services in selected pilot sites that address the specific needs of pregnant women who inject drugs, and their children. For the first time, comprehensive services addressing the needs of women who inject drugs (addiction, family planning, pregnancy and parenting) became available and are being delivered in an integrated model of care.

120. All but one of the 25 countries in the Asia Pacific region have adopted the target of at least 90% of HIV-positive mothers and exposed infants receiving antiretroviral therapy contained in the Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia-Pacific 2011–2015 [Conceptual Framework](#). Cambodia, China and Indonesia have also adopted joint targets for preventing vertical transmission of HIV and syphilis. Cambodia, Fiji, Indonesia, Maldives, Nepal, Papua New Guinea and Thailand have adopted Option B+ while the other countries in the region have chosen Option B.

121. UNICEF, PAHO and the Secretariat collaborated in the Caribbean to provide technical support to achieve the Dual Elimination Initiative goals for congenital syphilis and HIV. UNICEF, UNFPA and WHO supported prevention of vertical transmission programmes in 14 focus countries in Eastern and Southern Africa by reviewing draft plans and providing technical support, including costing for plans and reviewing progress towards eliminating syphilis and new HIV infections in children and keeping mothers alive. WHO promoted inclusion of elimination of congenital syphilis into vertical transmission prevention plans and facilitated country-level collection of information.

122. Given high levels of rejection and stigma experienced by pregnant women who inject drugs, UNICEF continued to advocate for a better understanding of the implications of maternal drug addiction on a newborn's health and development. Demonstration programmes on providing services for pregnant women who inject drugs have been developed and are being implemented.

### **Issues and challenges**

123. There is moderate coverage of antiretroviral prophylaxis and therapy for pregnant women in low- and middle-income countries, averaging 57% and ranging from 30% to 85%. However, some key countries and regions are lagging in prevention of vertical transmission programmes, and there is low uptake of key components, such as early infant diagnosis, family planning, and paediatric treatment coverage, pointing to the need for simplified strategies and capacity building.

124. In some countries, there is still limited integration of prevention of vertical transmission programmes with maternal, newborn and child health services. Community systems need to be strengthened and better linked with health systems to reach targets set by the Global Plan.

125. Data systems are weak, and guidance, capacity building and support are needed to improve data collection and use, including individual patient data, longitudinal data that tracks clients over time and country surveys.
126. Country support to implement simplified strategies via the 2013 *Consolidated guidelines on the use of antiretrovirals* and other key guidelines (such as those related to infant feeding) is crucial, as is continued support to countries to strengthen linkages between maternal and neonatal child health, sexual and reproductive health, and HIV.
127. In monitoring and evaluation, high-quality data and impact measurement are needed at global, regional and country levels to measure progress towards milestones and identify gaps.
128. Over the past several months, women living with HIV have raised serious concerns about the way Option B+ is being rolled out in several countries – they have cited insufficient information, time for deliberation, informed consent and choice – and have asked UNAIDS to provide guidance. Women living with HIV raised these concerns again during a civil society consultation on Option B+ in Malawi and Uganda in February 2013 in support of the forthcoming WHO Consolidated antiretroviral treatment Guidelines.

### **Future plans**

129. Continued advocacy and technical support are crucial to eliminating vertical transmission. Regions and countries that are failing to meet prevention of vertical transmission milestones will require support and improved local capacity to mobilize communities and reach women living with HIV and their families with HIV treatment and prophylaxis. Decentralized management and service provision will also need to be strengthened.
130. Both the Global Support Group for the Global Plan on elimination of new HIV infections among children and keeping their mothers alive (GSG) and the Inter-agency task team on the prevention and treatment of HIV in pregnant women and their children (IATT) are providing on-going remote assistance to countries and in country assistance when more intensive support is required. Progress is being closely monitored and there is regular follow up.




## Protect drug users from becoming infected with HIV



Target: Prevent HIV among people who use drugs by half by 2015

### Selection of significant trends and indicators

While the percentage of people who inject drugs living with HIV fell, there was a slight increase in the percentage of countries with laws, regulations or policies that present obstacles to an effective AIDS response. The percentage of countries with a UNAIDS presence where policy guidance and tools were used to support people who inject drugs expanded.

Status	Data
	Median percentage of people who inject drugs who are living with HIV fell from 8% to 6.9% from 2010 to 2012
	Percentage of countries where policy guidance and tools addressing the needs and vulnerability of people who inject drugs had been adapted and implemented in the past 12 months increased from 51% to 57% in countries with a UNAIDS presence and from 53% to 66% of HICs from 2011 to 2012
	Percentage of countries with laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for people who inject drugs increased in countries with a UNAIDS presence from 50% to 53% (government reporting) and from 65% to 70% (civil society reporting) from 2009 to 2011

### Achievements

131. The Thematic Inter-Agency working groups on drug use and HIV, and prison and HIV established by UNODC, jointly identified and prioritized areas of activity. The [WHO/UNODC/UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care](#) was revised. Other key documents produced in 2012 included guidance on HIV in prisons in the UNODC/ILO/UNDP/WHO/UNAIDS policy brief, *HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*.
132. UNODC expanded needle and syringe programmes in Nepal, and methadone maintenance treatment centres in Bangladesh, India, Maldives and Nepal. The agency's Regional Office for South Asia successfully developed, implemented and scientifically evaluated an opioid substitution therapy programme in prisons in Tihar in India and expanded its coverage to larger groups of prison inmates.
133. UNICEF, UNAIDS, WHO and UNODC assessed the situation and needs of young people who inject drugs in Kazakhstan and Ukraine to identify where adolescents and young people with problem drug-use can turn to for services.
134. Comprehensive HIV prevention, treatment, care and support was rolled out and scaled up, with opioid substitution therapy for people who inject drugs, and HIV prevention, treatment, care and support for people living in prisons and other closed settings in Egypt, Iran, Lebanon, Libya and Morocco. Technical support to align national policies and operational plans on illicit drugs and prison settings within national HIV strategic frameworks benefitted from UNODC support in Egypt and Morocco.

135. UNODC provided technical assistance to develop national programmes on HIV prevention and treatment for people who inject drugs and people in detention. In Kazakhstan, Kyrgyzstan, Tajikistan and Turkmenistan, UNODC provided technical assistance to develop national drug control programmes and relevant legislation.
136. WHO has provided technical guidance on opioid substitution therapy and on how to implement and scale up such programmes to Bulgaria, Estonia, Germany, Latvia, Lithuania, Poland, Portugal and Romania. Research by the Secretariat in Kazan, Russia, among females who inject drugs revealed structural and behavioural factors impeding their access to health care. This important evidence has been shared with national partners to guide further effective prevention interventions.
137. WHO has systematically reviewed, identified and synthesized prevalence estimates and risk factors for HIV among people who inject drugs in Central and Eastern Europe and Central Asia, including brief characterizations of the policy environments.

### Issues and challenges

138. An estimated three million people who inject drugs are living with HIV, and the epidemics driven by unsafe injecting drug use are among the fastest growing epidemics in the world, exacerbated by limited political will in the most affected countries.
139. Many countries do not offer clean syringes and opioid substitution therapy, and criminalizing drug use continues to impede access to services. Access to any HIV services among women who inject drugs remains low when compared with their male counterparts; harm-reduction services are often not gender-responsive and inaccessible for women due to pregnancy, positive HIV status or if they have children.
140. Evidence and responses on HIV prevention, treatment and care for non-injecting cocaine, crack and amphetamine-type stimulant users and related risks for sexual transmission have not been given adequate attention.

### Future plans

141. National AIDS and drug policies, strategies and programmatic responses will be revised to allow all [nine WHO/UNODC/UNAIDS comprehensive package interventions for people who inject drugs to be implemented](#). Plans for its roll out are included in 2013 workplans.
142. Urgent priority is being given to needle and syringe programmes, opioid substitution therapy, antiretroviral therapy and sexual risk reduction programmes, both in community and prison settings, and to allocating resources for their implementation. Tailored strategies are required for different populations, such as men, women, transgender people and MSM.
143. Addressing the HIV epidemic driven by injecting drug use in Eastern Europe and Central Asia (EECA) is a key priority and significant additional funding has been mobilized from the Russian Federation to invest in efforts to slow down the epidemic in the region. The HIV epidemic in Ukraine will also receive particular attention.

**Islamic Republic of Iran****HARM REDUCTION AT THE HEART OF THE AIDS RESPONSE****UN HIV-related expenditure in 2012****US\$ 3, 072,865****UBRAF core and non-core****Joint UN Team members:** FAO, RC Office, Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNIC, UNIDO, UNICEF, UNODC, WFP and WHO**[17 members]****Epidemic type:** concentrated/geopolitical relevance**Principal modes of transmission:** injecting drug use, multiple heterosexual partners

The Government of the Islamic Republic of Iran has put harm reduction for people who inject drugs at the top of its AIDS agenda, making it a key component of the third national strategic plan (2010–2014) developed in partnership with UNAIDS and other stakeholders. Measures have slowed infections but shared injecting equipment continues to be the key factor fuelling the epidemic. The prevalence of HIV stands at 15% among people who inject drugs, though figures vary between provinces, the greatest number of new HIV infections is among people who inject drugs and their spouses. The UN has supported the national harm reduction strategy by providing guidelines and tools to develop and implement HIV services, including drug dependence treatment as well as assisting to document Iran's best practices in this area. Needle and syringe programmes have been stepped up with UNAIDS and GFATMs assistance and by August 2011, 421 centres had delivered 6,022,834 free needles during the previous year. Iran's contribution in this area has been widely recognized. For example, an Iranian non-governmental organization (NGO) won the 2012 Red Ribbon Award in recognition of its work in the field of harm reduction.

Iran has also identified the growing role of sexual transmission in the spread of HIV, and its links with drug use. Sexual intercourse among people who inject drugs, frequently unprotected, and high-risk sexual practices have been observed among young people using amphetamine-type stimulants. With technical assistance from the Joint UN Team on AIDS, the government is working to establish interventions to reduce high-risk sexual practices, and this is being reflected in changes to national strategic plan priorities. For these reasons condoms are provided free at family planning units, centres for behavioural disease counselling and prison conjugal visit rooms. A study funded by the UNAIDS Country Office found that increasing condom use for people who inject drugs from 30% to 90% could reduce new cases of HIV in their sex partners by 93%. The Joint UN Programme of Support on AIDS has supported the scale-up in prevention and care programmes for vulnerable women, among whom prevalence of HIV has reached 4.5%, with the majority not using condoms consistently. Within an agreed framework with the Government, UNFPA and UNODC conducted culturally sensitive education activities on reproductive health and prevention of HIV and sexually transmitted infections for the relevant target populations.

The constitution of the Islamic Republic of Iran guarantees access to health care for all. Within this framework, the Secretariat, UNDP and GFATM have supported the Ministry of Health to establish 14 "Positive Clubs" across the country, serving some 4,500 people living with and affected by HIV, thereby creating an enabling platform for the meaningful reintegration of people living with HIV into the community. In order to achieve its national targets, the national AIDS response aims to expand its services over the next years.



## D. CATALYSE THE NEXT PHASE OF TREATMENT, CARE AND SUPPORT





### Ensure that people living with HIV receive treatment



Target: Reach 15 million people living with HIV with life-saving antiretroviral treatment

#### **Selection of significant trends and indicators**

*Extraordinary increases in treatment, as well as better adherence rates, have been accompanied by more national plans calling for equitable treatment access for key populations. For maximum effectiveness, in this area and a number of others, UNAIDS is focusing its technical assistance in HICs.*

Status	Data
	Percentage of eligible adults and children receiving antiretroviral therapy rose from 36% to 54% from 2009 to 2011
	Median percentage of adults and children with HIV known to be receiving treatment 12 months after initiation of antiretroviral therapy rose from 81% to 83.5% from 2009 to 2011
	Percentage of countries where the national HIV plan includes policies and programmes targeting key populations for equitable access to treatment, care and support increased from 74% to 77% in countries with a UNAIDS presence and from 63% to 71% in HICs from 2010 to 2012
	Percentage of UN joint teams providing technical assistance for implementing Treatment 2.0 fell from 58% to 37%* in countries with a UNAIDS presence but increased from 47% to 84% in HICs from 2011 to 2012

\*A positive value in the indicator is achieved when a UN Joint Team records that four out of five of different types of technical support – funding, normative guidance, resource mobilization, technical assistance and training – were provided. A decline suggests that technical support provided by UNAIDS may have become less diverse, but not non-existent, in a country.

#### **Achievements**

156. Treatment scale-up has been impressive with nearly eight million people on HIV treatment (54% coverage) and this trend accelerated in 2012. UNICEF, WFP, UNDP, UNESCO, WHO, the Secretariat, the GFATM and UNITAID have been jointly working on Treatment 2.0 programmatic approach development and implementation of its five pillars, including optimized treatment regimens, simplified diagnostic tools and improved service delivery models.

157. UNDP managed GFATM HIV grants as interim Principal Recipient in 25 countries<sup>4</sup>. At the end of 2012, up to 1 million people were receiving life-saving antiretroviral treatment through UNDP-managed GFATM programmes<sup>5</sup>, and in Malawi where UNICEF directly supports the Government as the procurement agent of antiretrovirals for over the last 10 years.

<sup>4</sup> Angola, Belarus, Belize, Bolivia, Bosnia and Herzegovina, Congo (Democratic Republic), Cuba, El Salvador, Haiti, Iran, Kyrgyzstan, Maldives, Mali, Montenegro, Nepal, Sao Tome and Principe, Sudan, South Sudan, Syrian Arab Republic, Tajikistan, Togo, Uzbekistan, Yemen, Zambia, Zimbabwe.

<sup>5</sup> Figures are not cumulated since the beginning of the programmes and relates to people on antiretroviral treatment.

158. The Secretariat worked on antiretroviral security as part of pillar two of the African Union roadmap on shared responsibility and global solidarity. The Pharmaceuticals Manufacturing Plan, a guiding plan for regulating and producing pharmaceutical drugs in Africa was finalized and presented at the China-Africa Health roundtable in Beijing. The Secretariat provided extensive briefs for African leaders on the political, economic and technical case for local pharmaceutical manufacturing and regulatory functions, from the perspective of the AIDS response.
159. At the regional level, WHO, the Secretariat, and other UN and civil society organizations, set up the Asia Pacific Regional Treatment 2.0 Task Team, which plays an important role in promoting new service delivery models, advocating quality antiretroviral drugs and diagnostic commodities. With technical assistance from UNDP, WHO and other agencies, the Pooled Procurement Strategy for Essential Medicines and Health Commodities was approved by the Southern African Development Community Ministers of Health. The strategy will result in the strengthening of the consolidated purchasing power among community member states. It will improve the capacity for procurement and supply management and for monitoring and evaluating systems.
160. WHO has also worked with countries to phase out Stavudine (d4T) and has measured, through its antiretroviral survey, countries' movement towards reducing non-recommended antiretroviral drug use.

Approximately 15% of Ghana's antiretroviral response needs are met by local production, though the goal is to provide for 15,000 patients per year. The UN system and other development partners are working with the health, trade, and finances and economic planning ministries to enable antiretroviral drugs that are WHO pre-qualification compliant to be produced locally. Already, locally produced antiretroviral drugs have significantly reduced stock-outs in the public health system, increasing the access to antiretroviral therapy for people living with HIV.

161. UNICEF conducted comprehensive needs and resource analysis to support the introduction of a new technology to improve early HIV diagnosis for HIV-exposed infants in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. UNICEF worked with the Colombia University International Centre for AIDS Care and Treatment Programs and the U.S. Centres for Disease Control and Prevention to organize a sub-regional conference under the theme current issues and alternative approaches in HIV diagnosis and monitoring. The event was used to build further consensus on scaling up early infant diagnosis in all Central Asian countries.
162. The role of food and nutrition in HIV treatment and adherence was examined through WFP-supported operational research and food-based pilot programmes. Research included studies on sustainable livelihood strategies to support positive health and nutritional outcomes for people with HIV. The pilot programmes were also used to develop nutritional counselling methodologies. Ghana's national nutritional policy, for instance, will enhance the quality of treatment and patient compliance with treatment schemes.
163. WFP advocacy efforts resulted in nutrition and HIV being included in Ministry of Health workplans in Bolivia, the Dominican Republic, Guatemala and Honduras. Technical support was also provided to develop and validate national norms, protocols, guidance and educational documents.
164. More than 136,000 people were targeted with food and nutrition support from WFP in West and Central Africa, including malnourished clients receiving antiretroviral therapy,

prevention of vertical transmission and tuberculosis treatment, as well as affected household members, orphans and other vulnerable children. The average nutrition recovery rate was 70% but was as high as 91% in Guinea Bissau and as low as 42% in Liberia.

165. The development of the *UNODC-Southern African Development Community Minimum Standards* highlighted access to antiretroviral therapy in closed settings for both prisoners and staff as a minimum service provision. The standards have been approved by the community's ministerial committees for health and justice.
166. Treatment access in closed settings was also promoted in India, where UNODC advocated for HIV/tuberculosis collaborative activities within national AIDS and tuberculosis planning and programmes. Support was provided to prisons in Tihar, India to establish HIV/tuberculosis services linked with the national tuberculosis control programme. In Bangladesh linkages were established for tuberculosis diagnostic and treatment services through non-governmental organizations working with GFATM resources in prison settings.
167. A wide range of technical guidance was produced in 2012. To help increase antiretroviral therapy access and coverage, WHO developed the [consolidated guidelines on the use of antiretrovirals for the treatment and prevention of HIV infection](#) (with follow-up from UNICEF and the Secretariat). This document outlines new clinical guidance for initiating and maintaining HIV care and treatment, and how to operationalize these recommendations, including guidance on integrating HIV service delivery, adherence and retention. WHO also produced programme updates and technical briefs to guide countries in scaling up treatment and prevention of vertical transmission (Option B+).
168. UNAIDS and the Global Network of People Living with HIV (GNP+) elaborated the *Positive Health, Dignity and Prevention Operational Guidelines*, which were developed to provide technical and programmatic support to national stakeholders in developing and adapting policies and services that reach people living with HIV.
169. In the Asia Pacific region, all priority countries were supported to adapt the 2010 revision of WHO guidelines on [antiretroviral therapy for HIV infection in adults and adolescents](#) and [guidance for serodiscordant couples on HIV testing and counselling](#), as well as prevention of vertical transmission, and treatment as prevention programmatic updates. UNDP and UNAIDS produced a brief on [the Potential Impact of Free Trade Agreements on Public Health](#), including access to medicines.
170. WHO contributed to improved rates of coverage in the MENA region by assisting countries to update their treatment guidelines in line with Treatment 2.0 recommendations. WHO also helped train health workers in clinical management of HIV and patient monitoring and retention in Djibouti, Somalia and Sudan, and supported field supervision of HIV testing and treatment service delivery as well as emergency procurement of antiretroviral drugs to Libya and Syria.
171. In Eastern Europe and Central Asia, WHO organized country missions during 2012 to Azerbaijan, Greece, Kazakhstan, Ukraine and Uzbekistan to evaluate national HIV treatment programmes. Technical assistance included development and dissemination of the regional clinical protocols on patient evaluation, management of HIV/hepatitis B co-infection, HIV treatment and care for children, and prevention of vertical transmission. These protocols have been used as a background to revise and adapt national treatment guidelines.

172. Protocols from the U.S. Government's *Expenditure Analysis and HIV Program Efficiency Studies* have been shared and reviewed, and data-sharing agreements for secondary analyses developed. These complementary studies – as well as the Clinton Health Access Initiative's antiretroviral costing work – are providing the foundation for best practices in HIV programme efficiency to be developed.
173. The AIDS 2012 conference provided a platform for the World Bank to provide technical advice and facilitate policymakers' dialogue around issues of financial sustainability of national HIV and AIDS responses in the Latin American region. Participants exchanged challenges and lessons learned, as well as best practices. A PAHO regional meeting on Treatment 2.0 was held in Argentina, with the active participation of civil society organizations, including people living with HIV and key populations. It provided a platform for discussions on key populations' access to treatment, care and support services.

The World Bank provided US\$ 61 million in financing in Latin America as well as technical assistance to strengthen the overall health system; that is, integrating the various duplicative systems into a single streamlined process to ensure continued efficiency and effectiveness of the healthcare supply chain.

### Issues and challenges

174. Although treatment scale-up continues and the target of 15 million people on treatment by 2015 is within sight, the scale-up has been unequal across regions and across populations. For instance, Eastern Europe and Central Asia, and Middle-East and North Africa are not moving at the same pace as other regions, showing low rates of treatment coverage. Numerous factors contribute to this situation, and concerted strategies are required to overcome barriers to health services and lifesaving medicines. Among the main challenges, key populations are not benefiting from treatment opportunities due to stigma and discrimination. Efforts must be continued to promote human rights among the most affected groups and to eliminate stigma from the health sector.
175. Encouraging people to know their HIV status is a fundamental strategy to enrol people living with HIV in treatment earlier, increasing their treatment opportunities and reducing the potential harm of late initiation.
176. Since generic competition has been introduced within the pharmaceutical market, prices for antiretroviral drugs have been reduced considerably. Nevertheless, patients need to shift to second- and third-line regimens, which are much more expensive than first-line drugs. Countries need assistance to improve their capacity to buy at lower prices, including by making full use of the flexibilities included in the WTO Trade Related Intellectual Property Rights (TRIPS) Agreement and avoiding incorporating obligations that go beyond TRIPS.
177. Besides newer drugs, access to cheap and good quality fixed-dose combinations must be enhanced to facilitate adherence to antiretroviral treatment, including developing formulations that are children-friendly; just 28% of eligible children are receiving treatment. Pediatric antiretroviral drugs are not considered an attractive (profitable) market, even for generic companies, which contribute to the lack of options for children to enroll in treatment.

178. Establishing strategies to lower the levels of toxicity and side-effects in current and new treatment regimens is still important to avoid loss to follow-up. For instance, WHO has been recommending phasing out Stavudine (d4T) since 2010 but this process has been extremely slow in many countries, since it is a cheaper drug compared with other medications from the same class. Balancing price, ease of intake, quality and minimizing toxicity and side-effects must be considered when implementing treatment programmes.

### **Future plans**

179. Under the Treatment 2.0 programmatic approach, focus on key populations such as children, adolescents and people who inject drugs, will take place in a more systematic and comprehensive way, to address their specific treatment needs. As necessary, regions and countries will receive local support for adopting Treatment 2.0 principles.

180. The new consolidated WHO antiretroviral guidelines will be launched at the International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention in July 2013, and their adoption will be promoted at regional and particularly country level.

181. The anticipated moves towards a higher Cluster of differentiation 4 (CD4) initiation threshold for adults and adolescents, and antiretroviral drugs for all pregnant women and children under five will inevitably increase numbers of people eligible for antiretroviral therapy, and reflection will be necessary to understand how to best translate the new guidelines into country-level implementation over the long term.



## Prevent people living with HIV from dying of tuberculosis



Target: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

### Selection of significant trends and indicators

*There has been good progress in addressing HIV/tuberculosis co-infection, while the number of countries where TB screening and Isoniazid Preventive Therapy are part of the national health system and plan declined.*

Status	Data
	The percentage of TB/HIV cases on antiretroviral therapy increased from 16% to 23% between 2009 and 2011.
	Number of countries where TB screening and Isoniazid Preventive Therapy are part of the national health system and plan declined from 64% to 48% from 2011–2012

### Achievements

182. The Joint Programme has been actively and collaboratively working to address the challenge of HIV/tuberculosis co-infection. UNICEF's Child TB roadmap of priority interventions for tuberculosis in children includes HIV-positive minimum standards for identifying and managing HIV, tuberculosis and malaria. Together with WHO, UNICEF has produced algorithms to identify the disease among HIV-exposed and infected children.
183. In addition to revising the WHO policy on collaborative HIV/tuberculosis activities, technical support from WHO resulted in the roll-out of the new rapid Xpert® MTB/RIF tuberculosis test in 67 countries and 119 countries tested more than 50% of tuberculosis patients for HIV. WHO and the Secretariat also made concerted efforts to strengthen HIV/tuberculosis co-infection monitoring and evaluation and ensure data harmonization.
184. WHO worked closely with countries to scale up collaborative HIV/tuberculosis activities, with particular emphasis on the high-burden countries. Most notable progress was seen in the African region, especially in South Africa, where the number of people living with HIV who were screened for tuberculosis during their last HIV care visit increased from 2 million in 2010 to 2.7 million in 2011 and the number of people living with HIV on isoniazid preventive therapy almost tripled from 160,000 to 438,000 respectively.
185. The Secretariat drafted a policy brief on tuberculosis in East and Southern Africa and supported the development of the Southern African development community declaration on tuberculosis in the mining sector. In Kenya, Uganda and Zambia, UNODC supported active tuberculosis case-finding in prisons, established screening tools for prisons upon admission and included HIV/tuberculosis collaborative programme in the *UNODC HIV in Prison training curricula*. UNODC advocated for the Zimbabwe Prison Service Strategic Plan as well as the Namibian Correctional Services draft workplace policy to emphasize HIV/tuberculosis collaborative activities. A memorandum of understanding between the Secretariat and the Stop TB Partnership to galvanize advocacy and monitoring and evaluation on TB/HIV-related deaths was signed.

186. Cambodia also saw an impressive increase in the uptake of isoniazid preventive therapy from 500 in 2010 to 1,300 in 2011 after adapting its national isoniazid preventive therapy guidelines in line with WHO global guidance.
187. WFP has given nutritional and technical support to HIV/tuberculosis patients in 10 countries and the International Labour Organization (ILO) has taken a step-by-step approach to integrating tuberculosis into HIV programmes. So far, 14 countries have adopted national HIV workplace policies with a tuberculosis component.

### **Issues and challenges**

188. Despite WHO recommendations that antiretroviral therapy should be started in all tuberculosis patients living with HIV irrespective of CD4 count, only 48% of all co-infected patients received therapy in 2011. The uptake of the “Three I’s for HIV/TB” (intensified tuberculosis screening case-finding, isoniazid preventive therapy and tuberculosis infection control) and earlier access to antiretroviral therapy has also been slow among people living with HIV.
189. Those groups most at risk for HIV/tuberculosis co-infection have poor access to care. There has been limited coordination between HIV and tuberculosis programmes, limited multisectoral collaboration and not enough community engagement. There is an urgent need to scale up collaborative activities in order to avert preventable mortality and to halve the number of tuberculosis-associated HIV deaths by 2015.
190. In addition, programmes need to collaborate more proactively with communities and through multisectoral partnerships to reach those groups most vulnerable to HIV/tuberculosis co-infection: women and children, people who inject drugs, and prisoners. Collaborative HIV/tuberculosis activities should also be incorporated in services that reach key populations, such as maternal child health and prevention of vertical transmission programmes, harm reduction and drug treatment programmes, and prison health services.

### **Future plans**

191. In support of the target to halve tuberculosis-associated HIV deaths, the interagency working group will advocate and provide technical support for the decentralization of antiretroviral therapy to tuberculosis services, the co-location of tuberculosis and HIV services, and integration of HIV/tuberculosis services into services providing care for more vulnerable populations such as women, children, people who inject drugs and prisoners.
192. In order to ensure timely detection and life-saving treatment of HIV-associated tuberculosis, countries will be supported to scale up the “Three I’s for HIV/TB” and early antiretroviral therapy, to make the Xpert® MTB/RIF diagnostic test available at HIV facilities where possible and to provide all co-infected patients with antiretroviral therapy.
193. In its role as secretariat to the TB/HIV Working Group and in collaboration with working group members, WHO will continue to disseminate latest guidance and to facilitate the exchange of best practice and country experience in overcoming the challenges and achieving successful scale-up of collaborative joint HIV/tuberculosis activities.



194. Partnerships between WHO, the UNAIDS Secretariat and other organizations such as the GFATM and PEPFAR, will improve the harmonized recording and reporting of collaborative HIV/tuberculosis activities by HIV stakeholders. This will include expanded reporting of country-level HIV-associated tuberculosis mortality to measure the current status and monitor progress towards the global AIDS targets.



## Social protection and access to care and support

### Selection of significant trends and indicators

*Social protection is a broad theme and many UBRAF indicators were used for the first time. On the positive side, school attendance among orphans and non-orphans increased. A flat-lining of efforts, however, is suggested in the number of countries with a UNAIDS presence providing technical support for HIV-sensitive social protection, which is an area the Joint Programme will need to investigate*

Status	Data
	Median school attendance among orphans and non-orphans aged 10-14 increased from 71% to 79.6% (orphans) and 89% to 92.4% (non-orphans) from 2010 to 2012
	The percentage of countries in which UNAIDS technical support was used to strengthen national capacity to implement and scale up HIV-sensitive social protection and HIV and child sensitive social protection fell from 68% to 22% between 2011 and 2012

### Achievements

195. The Secretariat and Cosponsors have led a process to build evidence and guidance on the impact of social protection on HIV outcomes and on households affected by HIV. They have been at the forefront of efforts to extend universal health coverage, including for households affected by HIV. This led to the development of a *global policy brief on HIV and Social Protection* which was launched in 2012.
196. Scale-up of social protection programmes has occurred in a range of contexts, including China, India, Indonesia, Kenya, Malawi, Nepal, South Africa, Thailand, Ukraine and Zimbabwe. In 2012 in-country social protection lending for HICs reached US\$ 5.9 billion, of which an estimated US\$ 500 million was for HIV-sensitive social protection programmes.
197. These initiatives have strongly contributed to expanding the policy landscape. They have promoted increased access to essential services for people living with HIV and key populations, and an overall expansion in the coverage of people living with HIV including orphans and vulnerable children. They have helped to identify a new fiscal space to contribute to the AIDS response in key countries and evidence on the role of social protection programmes.
198. Social protection programmes have contributed to reaching people living with HIV with critical services to increase the effectiveness of HIV prevention, treatment, care and support interventions. In India, multiple HIV-sensitive social protection programmes in several states, reached over more than 155,000 people by mid-2011 and more than 400,000 recipients by the end of 2012. The Joint Programme initiated extensive work and programmes on conditional cash transfers, to understand if incentive-based approaches can encourage reductions in risky sexual behaviour and promote HIV prevention as well as increase the uptake and adherence to HIV treatment. In Kenya, Lesotho and Malawi cash transfer for orphans and vulnerable children programmes had reached 145,000 households with bi-monthly cash transfers by end of 2012. An additional 10,000 of the poorest households caring for more than 27,000 children in Lesotho were reached with cash transfers, and in

Malawi 125,000 households are covered by cash transfer programmes through to the end of 2016.

199. The Economic Policy Research Institute in South Africa was commissioned to review the state of the evidence on HIV and social protection and is working on examining the extent to which HIV-affected households are covered through a range of social protection programmes. Additional efforts have been focused on generating evidence to better understanding of how social protection reduces risk and transmission of HIV and improves HIV treatment uptake and adherence.
200. Research conducted on barriers to access and uptake of social protection schemes for people living with HIV and key populations led to policy shifts in China and Indonesia. The Chinese government issued a national decree prohibiting the denial of health services to people living with HIV, and the Indonesian government committed to ensuring inclusion of coverage of people living with HIV in the universal health scheme which will come into effect in 2014.

The World Bank provided US\$ 1.2 billion in funding for Social Protection in the Africa region, including HIV-sensitive social transfers. This amount is expected to increase as governments and regional bodies, including the African Union Social Protection Forum, continue to support social protection programmes and invest domestic resources in them.

201. The Joint Programme organized a range of events on HIV social protection at the AIDS 2012 conference, including a symposium on HIV and social protection and satellite sessions together with Harvard University on HIV in emergencies and nutrition assessment, counselling and support.
202. A number of regional meetings and initiatives on HIV-sensitive social protection in South East Asia and South Africa were organized, generating commitment to the social protection agenda. Other key initiatives included the establishment of one-stop social protection service centres in Cambodia and Indonesia, to ensure that integrated income, health and employment services effectively reach people living with HIV and key population groups, traditionally excluded by existing social protection programmes.

### **Issues and challenges**

203. Late scale-up of effective treatment programmes in some countries will result in still-rising numbers of AIDS orphans, in Mozambique and Nigeria for example, requiring the need for large scale social protection programmes to meet the needs of this expanding population. Further work on adjusting social protection programs to encourage the uptake of HIV prevention and treatment services is particularly needed to prevent new infections, increase the productivity and resilience of people and communities and reduce the impact of HIV.
204. People in need of social protection programmes such as people living with HIV, sex workers, people who inject drugs and MSM are purposely excluded in social protection programs often due to targeting criteria that assume such populations are reached by other programmes or do not fall within the requirements of existing social protection programmes.

205. The interdependence of social protection, care and support programmes in alleviating poverty with the AIDS response needs to be closely understood for effective programming so that social protection programmes purposely include HIV, and HIV programmes purposely include social protection programmes. Prior work by the Joint Programme indicated the need for joint actions on HIV and social protection in selected countries for tangible results in averting new infections and accelerating progress on access to HIV treatment and adherence to treatment.
206. The labour intensity associated with effective social protection programmes necessarily require deliberate capacity support of ministries of social welfares, finance and other government bodies charged with implementing social protection programmes to enable effective outcomes broadly and HIV outcomes specifically.
207. Evidence-based approaches to social protection, care and support must be reflected in the investment approach to the AIDS response, including support for community- and family-based care and support, palliative care, psychosocial support and economic support.

### **Future plans**

208. Social protection priorities in 2013 include finalizing evidence on the role of social protection in the AIDS response and harmonized support to regions and countries scaling up social protection programmes including the Social Protection Floor.
209. Linking social protection to universal health coverage scale-up and identifying ways to support the GFATM and PEPFAR's new commitment to social protection in the AIDS response are also key priorities for 2013.
210. Other priorities are working with political leaders and regional political institutions such as the AU to increase demand for social protection programmes that include HIV-specific initiatives, (universal health coverage for all including people living with HIV, for example) and impact mitigation efforts for marginalized populations, including people living with HIV and orphans and vulnerable children.
211. Improved monitoring of the social protection, care and support response is planned, including a review of the National Composite Policy Index and existing care and support indicators to ensure they are capturing the policy and programmatic scale-up both nationally and globally.
212. Finally, during 2013, across the Secretariat there will be a series of presentations and events arranged to raise the profile of social protection issues as well as the publication of a guidance note on social protection.

## Myanmar

### MYANMAR FOCUSING ON KEY POPULATIONS

**UN HIV-related expenditure in 2012**  
**US\$ 10,267,132**  
**UBRAF core and non-core**

**Joint UN Team members:** FAO, ILO, Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UNOPS, WFP and **WHO [22 members]**  
**Epidemic type:** concentrated/geopolitical relevance  
**Principal modes of transmission:** MSM, injecting drug use, female sex workers and their clients; low-risk women

Myanmar continues to focus its AIDS response on preventing HIV transmission in key populations at higher risk, especially female sex workers and their partners, MSM and people who inject drugs, while scaling up treatment to reach all those in need to prevent AIDS-related deaths.

The UN provided support for these efforts. Joint work by UNFPA, UNESCO and the WHO has resulted in improved national capacity to deliver HIV and reproductive health services targeting female sex workers, especially younger age groups. UNFPA also contributed to developing and implementing community-based prevention strategies for men who have sex with men and transgender people and advised the government on scaling up access to services. This was achieved after UNDP conducted an extensive review of HIV services for these populations in five cities.

UNODC prompted a review of Myanmar's Drug Law to incorporate harm reduction principles and promote an enabling environment for HIV prevention among people who inject drugs who have the highest infection rates. It partnered with Myanmar's National AIDS Program, the Drug Treatment Centre and the Central Committee on Drug Abuse Control to organize an advocacy event in Kachin State to harmonize harm reduction projects with a local government campaign to suppress drug trafficking amid heightened community concerns about drug activities among people migrating from mining areas. Uptake in opioid substitution therapy was expanded with the support of WHO, UNODC and the Secretariat, who supported the development of new guidelines on methadone therapy and treatment of drug dependence in Myanmar.

By the end of 2011, nearly 40,000 adults and children were receiving antiretroviral treatment in Myanmar, but coverage at 32% remains far too low resulting in a large number of AIDS-related deaths. The main hurdles to better treatment coverage in the public sector are financial constraints and consequently limited availability of antiretrovirals and other commodities, and a shortage of staff at all levels to scale up service delivery. Normative guidance for use of antiretrovirals and PMTCT were revised with the support of WHO to achieve 80% treatment coverage by the end of 2015. Services are being decentralized to increase access to testing and to treatment. HIV and tuberculosis collaborative activities are also expanding to become available in 300 townships from 18 currently. An assessment of antiretroviral treatment services supported by the Secretariat and WHO will inform Myanmar's ambitious treatment scale-up plan. Food assistance was provided by WFP to people living with HIV to promote effective adherence to treatment and to improve treatment outcomes as well as to mitigate the impact of HIV at the individual and household levels.

UNICEF, WHO and UNFPA contributed to strengthening the links between mother and child health and PMCT services in seven pilot sites through capacity building, supplies and logistic support. As a result, HIV testing has increased among antenatal clinic attendees and larger shares of HIV-positive pregnant women are getting prophylaxis to prevent transmission.

Concrete steps to improve strategic information to gain a better understanding of the epidemic and adequately target interventions were taken. Surveillance and population size estimation systems were assessed with the support of the Secretariat and WHO, and a five year system strengthening plan developed. Research is underway on key issues. UNDP is funding a study on the socio-economic impact of HIV and UNFPA a study on violence affecting female sex workers. The results of the research will help strengthening Myanmar's response to HIV and AIDS and accelerating progress to achieve the global AIDS targets.

## E. ADVANCE HUMAN RIGHTS AND GENDER EQUALITY FOR THE AIDS RESPONSE






Target: Eliminate stigma and discrimination, and support enabling legal environments for people living with and affected by HIV



Target: Eliminate HIV-related restrictions on entry, stay and residence by 2015

### **Selection of significant trends and indicators**

Countries report an increasing range of processes and programmes addressing HIV-related stigma, discrimination, support to enabling legal environments, and more national coalitions advocating for them. HIV-related entry, stay and residence restrictions were lifted in three countries, (Republic of Korea, Republic of Moldova and Mongolia), but remain in place in 44 countries, territories and areas.

Status	Data
	National coalitions advocating for removing legal barriers to HIV prevention, treatment, care and support for at least one key population were reported in 62% of countries with a UNAIDS presence.
	The percentage of countries (with UNAIDS presence) reporting legal support services for people living with HIV in the form of : (a) legal aid systems/services for HIV casework and (b) private sector law firms or university-based centres providing free or reduced-cost legal services, increased from 50% to 66% and 45% to 62% respectively from 2010 to 2012
	The number of countries with HIV travel-related restrictions dropped from 48 to 45 from 2011 to 2012

### **Achievements**

218. In 2012, the Joint Programme continued to engage in standard-setting, advocacy and programme support to promote human rights-based and evidence-informed AIDS responses that address HIV-related stigma, discrimination and support enabling legal environments.

#### Addressing HIV-related human rights and enabling legal environments

219. In 2012, the [Global Commission on HIV and the Law](#), led by UNDP and supported by the UNAIDS Secretariat, completed its work (seven regional dialogues between government and affected populations, receipt of over 700 submissions on the impact of the law on HIV, and the input of experts in 18 [working papers](#) and [selected bibliographies](#)) and issued its [report and recommendations](#). Government representatives from Botswana, Ghana, Kenya, Lesotho, Mozambique, Namibia, Nigeria, Seychelles, South Africa, Swaziland, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe made requests to UNDP for support to follow up the recommendations of the Global Commission.

220. Overall, in follow-up to the recommendations of the Global Commission on HIV and the Law, UNDP, in collaboration with Cosponsors, the Secretariat, governments and civil society, supported action on HIV and the legal environment in 73 countries, including 31 high impact countries. UNDP also supported stakeholders to undertake assessments of the legal environment as it relates to the national HIV response in 51 countries, including in 18 high impact countries.
221. Also following up on the recommendations of the Global Commission on HIV and the Law and with UNDP and UNAIDS Secretariat support, Argentina passed a law that recognizes the right of transgender people to change the name and sex written on their identification cards and other official documents without a precondition of a psychiatric diagnosis or surgery. The law also requires public and private medical practitioners to provide free hormone therapy or gender reassignment surgery for those who want it, including those under the age of 18.
222. The UNAIDS Secretariat provided technical and financial support to developing the East African Community HIV and AIDS Prevention and Management Bill 2012. This regional legislation aims to regulate effective responses to HIV across the five East African Community countries (Burundi, Kenya, Rwanda, Uganda and the United Republic of Tanzania). The Bill was adopted by the East African Legislative Assembly in April 2012. With UNDP, UNAIDS and other partner support, Kenya is the first East African Community (EAC) country to have assented to the new EAC HIV Bill, which will become law in EAC countries upon the assent of all the countries in the Community.
223. In 2012, the UNAIDS Secretariat continued to provide support to the Committee on the Protection of the Rights of People Living With HIV (PLHIV) and Those at Risk, Vulnerable to and Affected by HIV of the African Commission on Human and Peoples' Rights, the main human rights body of the African Union. In 2012, the Committee conducted its first country-visit to Kenya. Following continued engagement by UNAIDS, in October 2012, the African Commission on Human and Peoples' Rights adopted its [first general comment](#) which clarifies the provisions of Article 14 of the African Women's Rights Protocol, thereby enhancing women's rights to confidentiality and autonomy in the context of HIV.
224. During 2012, the UNAIDS Secretariat provided official comments to homophobic draft laws that would *inter alia* have a negative impact on national AIDS responses and made interventions when lesbian, gay, bisexual and transgender HIV and human rights defenders were threatened with harm. UNHCR issued [Guidelines on international protection No. 9](#) covering claims to refugee status based on sexual orientation and/or gender identity. UNESCO published two new booklets in its Good Policy and Practice in HIV and Health Education series: [Gender equality, HIV and education](#) and [Education sector responses to homophobic bullying](#), which has also been translated into Spanish. Together with UNDP, UNESCO is supporting a multi-country study, initiated in 2012, on the prevalence of homophobic bullying in Chile, Guatemala and Peru.
225. The Secretariat and UNDP jointly provided policy and advisory support to selected West and Central African countries on HIV-specific law reform and access to HIV services and to justice for people living with HIV and other key populations. In the Economic Community of West African States (ECOWAS), the Secretariat and UNDP provided advisory services to parliamentarians, the High Court of Justice of ECOWAS, members of the judiciary and civil society partners to enhance their engagement in the HIV response. They supported the

establishment of national platforms on HIV, the law and human rights in four countries in the region (Ghana, Liberia, Mali and Senegal) with a view to improve the legal environment for key populations affected by HIV. With the support of the Open Society Initiative for West Africa and Enda Santé, the Secretariat supported the mapping of legal obstacles for achieving universal access for key populations, including women and girls, sex workers, people with disabilities, men who have sex with men and prisoners.

226. UNDP and the Secretariat also strengthened engagement of senior government representatives on national laws and policies relevant to HIV in the Republics of Moldova and Ukraine.

227. UNDP, UNFPA and the Secretariat produced [an analysis of sex work and the law in Asia and the Pacific](#), as well as a regional dialogue on human trafficking, sex work and HIV (UN Regional Team Working Group on HIV and Sex Work). UNFPA and the Secretariat presented a [formal request](#) to the Constitutional Tribunal of Peru to press for an amendment to an article in its penal code that for many years had criminalized consensual sexual activity among young people.

UNICEF, in collaboration with the Eastern European and Central Asian Union of People Living with HIV, trained more than 160 adolescents living with HIV in Belarus, Kazakhstan, Kyrgyzstan, Russia, Ukraine and Uzbekistan to advocate for their rights and to become empowered and knowledgeable about issues of concern to them.

228. Two legal reviews on laws affecting universal access to sexual and reproductive health services were conducted in Belize and Jamaica. Twenty-five judges, lawyers and legal educators from 13 Caribbean countries were trained in ILO standards, including ILO Recommendation No. 200 Concerning HIV and AIDS and the World of Work. UNFPA hosted a universal access advocacy and capacity-building seminar on the impact of structural barriers. It was attended by 45 senior officials from Ministries of Justice, national security, police, education and health from 10 Caribbean countries. Advocacy engagements were executed with the health and education ministries in Belize to advance policy, legislation and protocols to protect populations of young people, sex workers and other key populations.

The Regional Inter Agency Task team on HIV in Humanitarian Setting led by UNHCR and in collaboration with UNICEF and WFP were strongly engaged in advocacy, analysis and training on HIV in humanitarian settings. Efforts were directed towards developing emergency planning for HIV with the inclusion of HIV in emergency preparation and response plans for three countries.

#### Reducing HIV-related stigma and discrimination

229. UNAIDS held a one-day thematic segment on non-discrimination and HIV at its Programme Coordinating Board in December 2012, focusing on the expansion of concrete programmes to reduce HIV-related discrimination in national AIDS responses as well as expanded partnerships with people living with HIV as key resources in the reduction of HIV stigma.

230. To reduce HIV-related stigma and discrimination, UNAIDS has supported the roll-out of the HIV Stigma Index in more than 75 countries, with final reports from more than 40

countries. During 2012, the UNAIDS Secretariat supported the development of an improved indicator by which to measure HIV-related stigma in communities. It also supported the development of an improved tool by which to measure HIV-related stigma in health care settings.

231. UNAIDS has identified seven programmes to support human rights in the context of HIV, both in their own right and as critical enablers under the Investment Framework. The Secretariat released a guidance note, [Key human rights programmes to reduce stigma and discrimination and increase access to justice in national AIDS responses](#), and a user-friendly Human Rights Costing Tool that facilitates cost estimation, funding application and management of such programmes. The Secretariat supported four regional workshops with national HIV planners to integrate these programmes and this tool into national AIDS responses. In support of these programmes and the wider human rights strategic objective in the Global Fund Strategic Plan, UNDP, the Secretariat and WHO worked with the Global Fund develop an implementation plan for human rights issues and programming in the new Funding Model.
232. The UNAIDS Secretariat galvanized, with GBC Health, over 40 global business CEOs to sign a [pledge](#) opposing restrictions on HIV-related entry, stay and residence. It also supported the successful elimination of travel restrictions in the Republic of Korea, the Republic of Moldova and Mongolia.
233. National dialogues convened by ILO resulted in 16 national and 21 sectoral workplace policies on HIV and AIDS being developed.
234. UNESCO collaborated with the Secretariat, PAHO and the NGOs Vivo Positivo and Asosida to develop a Stigma and Discrimination Index and undertake a study on the barriers and the facilitators to access health services for men who have sex with men and transgender people.

UNAIDS has partnered with the Ecumenical Advocacy Alliance, GNP+ and the International network of religious leaders living with or personally affected by HIV and AIDS (INERELA+) to develop and pilot a framework for dialogue between religious leaders and networks of people living with HIV that aims to increase communication and understanding between faith groups, people living with HIV and other key populations.

## Issues and challenges

235. Though many international standards have been set regarding HIV, human rights and the law, there remains the overriding challenge to translate these into reduced stigma and discrimination, protective laws and law enforcement, and increased access to justice at country levels.
236. Anti-discrimination laws that could protect people living with HIV are not sufficiently enforced, and key populations, such as sex workers, people who inject drugs, men who have sex with men and transgender people, continue to be criminalized in many countries, seriously affecting their ability to access HIV commodities and services. Police violence towards key populations is often cited as one of the greatest challenges they face. Ghana, Mozambique, Thailand and Zimbabwe provide examples of positive policing where police become defenders, not violators, of the human rights of key populations in the context of



HIV. Many countries continue to have laws that overtly discriminate against women and increase their vulnerability to HIV.

237. There is a need to strengthen capacity and commitment in national human rights and legal institutions (national human rights institutions, law commissions, judicial academies, labour courts), as well as in UN country teams to take up the difficult human rights and legal issues involved in the AIDS response.
238. The lack of sufficient international and domestic funding for civil society groups working in support of community mobilisation and human rights in the context of HIV, often compounded by legal and policy barriers for key population networks to form and operate, jeopardizes the sustainability of the HIV response in a number of countries. Punitive legal frameworks, policies, practices, stigma and discrimination towards key populations fuel the HIV epidemic and remain a major challenge in effective and rights-based responses to HIV.

### **Future plans**

239. UNDP, in partnership with stakeholders, will continue supporting national dialogues and reviews of legal environments as they related to HIV to catalyse HIV-related law reform and achieve country-level action. UNODC will undertake legal reviews of drug control laws and laws that impact HIV and prisons.
240. The Secretariat will support greater collaboration between the Asia-Pacific and the MENA regions, as well as provide seed-funding to support country-level coalitions, towards the removal of HIV-related restrictions on entry, stay and residence. It will also roll out the Human Rights and HIV Costing Tool to get better indicative funding for programmes to support human rights and act as critical enablers in national responses.
241. The Secretariat, together with GNP+, will continue to support the roll-out of the HIV Stigma Index, with greater attention to building capacity on how to use the evidence to affect policy change.
242. Other tools will be developed, including UNDP's guidance note on *Comprehensive national responses to HIV related stigma*, and the new indicators on stigma in communities and measuring stigma in health-care settings. UNFPA will address stigma as experienced by sex workers, while UNESCO will work to reduce bullying with a focus on homophobia and transphobia in the education sector, measuring the impact of attitudinal stigma with a special focus on young people living with HIV and key populations.
243. UNAIDS Secretariat and UNDP will continue to work closely to support the human rights related issues involved in the roll-out of the Global Fund's New Funding model.

## Ukraine

### VIGOROUS NATIONAL RESPONSE TO REDUCE THE HIV BURDEN

UN HIV-related expenditure in 2012

**US\$ 2,767,084**

**UBRAF core and non-Core**

**Joint UN Team members:** ILO, Secretariat, UNDP, UNFPA, UNICEF and WHO **[20 members]**

**Epidemic type:** concentrated / geo-political relevance

**Principal modes of transmission:** injecting drug use, sex workers and clients, multiple heterosexual partners

Ukraine has the most severe HIV epidemic in Eastern Europe, with an estimated 230,000 people living with HIV. Injecting drug use remains the driving force of the HIV epidemic; prevalence among that key population is 21.5%. But the country is responding vigorously to relieve its HIV burden and drew praise from a UNAIDS Programme Coordinating Board delegation in October 2012 for the strong engagement of civil society. UNODC, in particular, is supporting an integrated approach to drug use and related HIV issues. UNODC led an evaluation on the prison component of the National AIDS Programme, and its recommendations to improve services for people who inject drugs and prisoners will inform the 2014–2018 programme. UNODC also advised the State Drug Control Service on the draft national anti-drug strategy for evidence-informed interventions for HIV prevention among people who inject drugs, and support training for national capacity building, monitoring and evaluation.

Ukraine has sought to increase HIV services to young people, in line with the UN goal to make this population group a major focus of the global response. UNICEF has supported training programmes for delivering friendly, non-discriminatory HIV services to most-at-risk- adolescents, reviewed policies and laws hampering most-at-risk adolescents access to HIV counselling and testing, and strengthened the knowledge base on this group by disseminating its research to the Ministry of Health. UNFPA has supported the training of medical and social service providers in Odessa and Mykolaiv in youth-friendly approaches to delivering HIV and sexually transmitted infections (STI) services; developed 36 short television programmes on preventing HIV/STI; and supported the 'Grow Healthy' curriculum for those aged 14–17 that integrates sexual and reproductive health and HIV/STI education into a broader healthy lifestyles concept.

The UN family has also supported efforts to reduce stigma and discrimination for people living with HIV and key populations. ILO produced a framework to reduce HIV-related stigma and discrimination in the health sector; the UNDP supported the training of 126 prosecutors on HIV legislation and human rights approaches and organized a national dialogue on HIV and the law that contributed to improved national AIDS legislation and related laws; and UNESCO provided educational institutions with a framework for protecting HIV-positive and affected learners and workers from discrimination.

One area where progress could be accelerated is gender equality. A 2012 World Bank study suggests gender can impede access to services, in particular for female injecting drug users, with many HIV and services to people who inject drugs, including drug rehabilitation, testing and for drug dependence, mainly targeted at male users. The Secretariat, UNDP and other UN agencies provided technical support to draft of the HIV and gender strategy to be integrated into the 2014–2018 National AIDS Plan.

## HIV needs of women and girls and gender-based violence



Target: Eliminate gender inequalities and gender-based abuse and violence for women and girls to protect themselves from HIV

### Selection of significant trends and indicators

*More countries have included HIV related gender and women's issues in national strategies and operational plans, but the engagement of women living with HIV in formal planning and review mechanisms and processes decreased. The number of countries with laws against gender-based violence has doubled since 2010, data availability of gender-based violence and HIV has improved, and messaging aimed at the public has increased.*

Status	Data
	Percentage of countries with a policy, law or regulation in place to reduce violence against women and men including sexual assault, increased from 38% to 77% from 2010-2012
	Percentage of countries that have implemented an information education communication strategy on HIV for the general population that includes messaging to fight violence against women increased from 74% to 80% from 2009 to 2011
	Percentage of countries where country-specific data on the links between gender-based violence and HIV is collected and available increased from 16% to 27% from 2010-2012
	Percentage of countries where women living with HIV participate in the formal planning and review mechanism of the national response to HIV fell from 66% to 61% in countries with a UNAIDS presence from 2010 to 2012

244. The UNAIDS Agenda for Women and Girls is the guiding document for UNAIDS' work on women, girls and gender equality. It was developed and is being implemented with the engagement of diverse women's advocates, in particular women living with HIV at global and national levels. A gender scorecard provided a regional analysis of the achievements of countries in implementing the [Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV](#).

245. [The mid-term review of UNAIDS Agenda for Women and Girls](#) found that since the launch of the Agenda in 2011, many countries accelerated action for women, girls, gender equality and HIV, with demonstrated progress in 60% of the 80 countries implementing the agenda, particularly in translating political commitments into scaled-up action, with especially notable progress made in the HICs. The review, which was presented to the Programme Coordinating Board in December 2012, included representatives of communities of women living with HIV and women's rights advocates as part of the reference group that oversaw the process, as well as key respondents that informed the findings of the review.

246. The Programme Coordinating Board took note of the report and appreciated the progress made in implementing the UNAIDS Agenda for Women and Girls by stakeholders, particularly in building political commitment, strengthening the gender sensitivity of AIDS responses and meaningfully engaging women, girls and other stakeholders. The review found that accelerated country efforts resulted in progress in strengthening gender equality within AIDS responses in nearly two thirds of countries. Of the 80 countries that officially

launched the Agenda, all but eight have HIV policies included in the operational planning of gender ministries.

247. Among the countries engaged in implementing the Agenda, 90% initiated action to better understand their epidemic, context and response. Of the UBRAF indicators that had progress data available, 76% of the countries reporting now have a national multisectoral HIV strategy that includes a specific component for women. However, only 38% of the countries reporting also have a budget component for women in their strategy. HIV has been included more often in the operational planning and budgeting of government entities responsible for women's and gender issues.
248. To scale up systematic action to further engender national responses, the Secretariat together with UN, bilateral and civil society partners developed and piloted a comprehensive tool to undertake gender assessments of national AIDS responses, and supported five countries to take forward a gender assessment and ensure the findings are put to use.
249. The UNAIDS [Women Out Loud](#) report explores the impact of HIV on women and the instrumental role women living with the virus are playing to end AIDS. It includes the latest data and commentary from some of the leading advocates on women and HIV, and 30 women living with HIV give their personal insights into how the epidemic is affecting women and on how women are actively working to reduce the spread of HIV and impact of AIDS.
250. With support from the European Community and in collaboration with a wide range of partners, UN Women has been providing support to Cambodia, Jamaica and Papua New Guinea to integrate gender equality and human rights into the governance of the AIDS response. Gender advisors placed by UN Women in Cambodia's national AIDS coordinating body have generated increased political will for gender and human rights, enhanced institutional capacity to mainstream gender in national responses and ensured the inclusion and participation of networks of women living with HIV in national planning and policy processes.
251. Despite the increased inclusion of HIV in operational planning and budgeting of government entities responsible for women's and gender issues, there has been a drop in the participation of networks of women living with HIV in formal planning and review mechanisms in the response to AIDS. However, efforts to achieve meaningful participation continue. Joint UN Teams on AIDS in 57 countries supported the strengthening of national capacity among civil society organizations and networks in promoting gender equality, including engaging men and boys for gender equality.
252. UNDP and UNFPA supported the MenEngage Networks in 11 African countries. An analysis of gender equality in Brazil, Chile and Mexico has strengthened capacity and significantly increased resources for advocacy, including men in promoting gender equality and addressing gender-based violence in national policy. UNDP also supported the leadership capacity of women living with HIV and key populations in Belize, Bolivia, Colombia, Ecuador, Grenada, Guyana, Honduras, Nicaragua, Panama, Peru and Venezuela. UNDP also provided technical assistance to the Bahamas, Belize and Grenada to integrate gender into their national HIV strategies, policies and programmes.

253. An increasing number of countries linked HIV and sexual and reproductive health services: 79% of 80 countries that officially launched the Agenda are now linking HIV and sexual and reproductive health. To support greater integration, the Secretariat and Cosponsors have provided technical assistance to 32 countries to integrate gender into their national HIV strategies, policies and programmes.
254. Four out of five countries that reported through the Global AIDS Response Progress Report (GARPR) had implemented an information, education and communication strategy on HIV for the general population that includes messaging to fight violence against women. In 2012, 11 countries that launched the Agenda initiated messaging to fight violence against women. More than 75% of countries reporting through GARPR have a policy, law or regulation to reduce violence against women and men including sexual assault. This surpasses the 2015 target of 60%.
255. A [regional research project](#) on violence against sex workers was launched in Indonesia, Myanmar, Nepal and Sri Lanka to improve the understanding of the risk and protective factors associated with sex workers' exposure to violence and HIV. The research partners are UNDP, UNFPA, Partners for Prevention, Centre for Advocacy on Stigma and Marginalization and the Asia Pacific Network of Sex Workers. The aim of the research is to inform policy and programmes to prevent violence against sex workers. As a result of UNESCO support and the organization's international consultation on homophobic bullying, Gay and Lesbian Memory in Action and the Centre for Education Rights and Transformation convened a meeting in South Africa on lesbian, gay, bisexual and transgender issues in education. Member States in the region now have guidance to prevent and manage gender-based violence in the Southern African Development Community region as a result of technical guidance provided by UNAIDS. Gender-based violence will also be addressed through the joint UNAIDS and UNFPA regional project on linking sexual and reproductive health and HIV. All countries have included activities to address gender-based violence through linkages in their country 2013 work plans.

In 2012 for the first time in China, as a result of advocacy by UN Women, the GFATM country coordinating mechanism included a seat for women's civil society organizations as a permanent member of the board, and the China Rolling Continuation Channel HIV/AIDS programme allocated special funding for women's civil society organizations to address the needs of women and girls, and gender equality in the context of HIV.

256. Gender-based violence, stigma, and discrimination increase HIV risk and vulnerability among key populations. UNDP, UNFPA, WHO and the Global Network of Sex Work Projects brought together female, male and transgender sex workers to document community-led approaches to addressing gender-based violence. UNHCR, together with UNFPA, addressed violence and stigma among sex workers displaced by conflict along the Ecuador-Colombia border. UNDP, UNFPA, ILO, UNESCO and the Secretariat, with partners, intensified efforts to address homophobia, transphobia and bullying in work places, schools and the community.

### **Issues and challenges**

257. The mid-term review underlined that support for the needs and rights of women and girls is hampered by uneven levels of political will, funding constraints, insufficient coordination,

inadequate involvement of a range of partners, and weak links between programming for women and girls, including those from key populations.

258. Where there is political commitment, more remains to be done to translate this into concrete, sustainable actions, while some issues are considered sensitive (gender-based violence, sexual and reproductive health and rights, sex work, and sexual diversity). Stakeholders, especially women living with HIV, have underscored the lack of commitment and funding as the most significant barriers to the Agenda's implementation.
259. Many stakeholders identified inadequate coordination as a major barrier at all levels. Coordination and collaboration is impeded by insufficient priority given to gender equality, weak relationships among stakeholders, lack of clarity regarding roles and responsibilities, and staff changes within government and the UN.
260. While countries have expanded data collection, only a few countries systematically reviewed their epidemic and response from a gender perspective. There is also a need to strengthen data to better track the relationship between gender equality, gender-based violence and HIV and building capacities to use data to inform programming.
261. South-south knowledge-sharing is also limited, while monitoring and evaluation of the Agenda needs to be strengthened. The lack of strategic information on gender equality and prevention and management of gender-based violence as a critical enabler of an effective AIDS response have resulted in limited funding through mechanisms such as the GFATM.

### **Future plans**

262. In accordance with recommendations of the mid-term review and the 31st Programme Coordinating Board decision points, a number of strategic priorities will be translated into a time-bound action plan for the 2013-2015 period. These include increased political commitment through high-level advocacy and strengthening links to movements beyond the HIV and gender equality fields.
263. Coordinated country support will be advanced using a comprehensive package of complementary tools to support countries to undertake gender transformative programming. There will be efforts to ensure that strategic investment approaches are gender transformative, and the evidence base and normative guidance on gender equality and HIV, including gender-based violence and HIV, will be strengthened.
264. The linkages between HIV and sexual and reproductive health, in particular for young women and girls, and between gender-based violence and HIV, will be strengthened and country-level action to address violence against sex workers will be enhanced.
265. The engagement of women and girls, in particular those living with HIV and from key populations, will be heightened through increased access to strategic information and resources, and UNAIDS will continue to advocate to remove discriminatory laws, and reduce stigma and discrimination against women living with and affected by HIV.

## F. STRATEGIC FUNCTIONS

### Leadership and advocacy








Target: Close the global AIDS resource gap and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries



Target: Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

### **Selection of significant trends and indicators**

*Countries where national leadership publically engages in the AIDS response have increased. HIV is integrated into the development plans of all countries with a UNAIDS presence, while the number of countries where the multisectoral strategy is costed and budgeted has also increased. However, there is a decrease in financial support to civil society for HIV activities as well as a decrease in the involvement of civil society in HIV-related national planning and budgeting processes.*

Status	Data
	Percentage of countries where the country leadership (government ministers) publicly engages in AIDS response increased from 72% to 96% in countries with a UNAIDS presence and from 82% to 97% among HICs from 2009 to 2011
	Percentage of countries with a UNAIDS presence where HIV is integrated into the general development plan increased from 96% to 100% from 2009 to 2011
	Percentage of countries where multisectoral HIV strategies include education, health, labour, transport, military/police, women and young people (seven sectors) increased from 58% to 62% in countries with a UNAIDS presence and from 76% to 84% among HICs from 2010 to 2012. In the same period, countries whose multisectoral strategies have a budget for their activities rose from 31% to 34% in countries with a UNAIDS presence and from 53% to 61% among HICs
	Percentage of countries where civil society has adequate financial support to implement its HIV activities decreased from 19% to 16% but increased among HICs from 13% to 21% from 2010 to 2012
	Percentage of countries with a UNAIDS presence where civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan fell from 70% to 56% from 2010 to 2012

## **Achievements**

### Leadership and advocacy to unite efforts

271. In 2012, UNAIDS continued to spearhead political advocacy to secure global, regional and national leadership in the AIDS response in pursuing the vision of "Getting to Zero", reinforcing national ownership and promoting sustainable funding for AIDS responses worldwide. UNAIDS' strategic leadership transformed the three zeros into high-level, time-bound strategic commitments at the global, regional and country levels.

272. “Getting to Zero” and the 10 global AIDS targets from the UN 2011 Political Declaration have shaped the global discourse around HIV among political bodies, decision makers, activists and civil society. At country level, “Getting to Zero” has been used to inspire and guide the development of comprehensive HIV plans and specific results-based interventions. More than 20 countries have developed and are implementing new or revised national strategic plans that set priorities and targets specifically reflecting UNAIDS’ three zeros and the global AIDS targets, with a further 36 countries in the process of doing so.
273. The global AIDS targets and elimination commitments are now embedded in the HIV strategies of the 11 Cosponsors, and are also reflected in a renewed division of labour, and in the Joint Programme work plans. UNAIDS is supporting countries and national authorities to undertake a mid-term review of progress towards the global AIDS targets in 2013.
274. In embracing the global AIDS targets, countries committed to monitor and report on progress and challenges encountered in their national AIDS responses. In 2012, 186 countries (96% of United Nations Member States) submitted comprehensive reports on progress in their national AIDS response. The high response rate reflects global commitment to the response to AIDS. The analysis of the country reports was published in the 2012 [Global Report](#).
275. In Africa, the leadership of UNAIDS contributed to the AU Heads of State adopting a “Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria Response in Africa” in July 2012. Developed with the direct support of UNAIDS, the AU Roadmap offers a set of practical and African-owned solutions, which are structured around three strategic pillars - health governance, diversified financing and access to medicines - to enhance sustainable responses to AIDS, tuberculosis and malaria. The Roadmap also sets up an accountability structure embedded in NEPAD to monitor progress in the region, as well as revitalizing AIDS Watch Africa.
276. The Joint Programme and the UN Department of Peacekeeping Operations forged strong working partnerships at country level to advance the implementation of the UN Security Council Resolution 1983. High level dialogue resulted in leaders agreeing to jointly convene a stocktaking AIDS and security summit to review progress and agree on core action points to sustain political leadership and greater accountability. Collaboration with the G8 was initiated to tackle sexual violence in conflict. As part of this new initiative, the G8 has adopted a declaration of commitment and pledged US\$ 35 million to support the work. The UK has set up a specialist team of experts to investigate allegations of sexual violence, gather evidence and help build the capabilities in collaboration with UN missions and local civil society.
277. Additionally, best practice case studies were published targeting the six largest peace keeping missions (Côte d’Ivoire (UNOCI), the Democratic Republic of Congo (MONUSCO), Haiti (MINUSTAH), Lebanon (UNIFIL), Sudan (UNAMID), and South Sudan (UNMISS)). The case studies capture best programmes underway in the priority areas of sexual and gender-based violence, [integration of HIV in demobilization, disarmament and integration of HIV in security sector reform initiatives](#)
278. The Asia and Pacific High-level Intergovernmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS in February 2012, co-convened government representatives from national health, justice, law enforcement, social development and drug control agencies from 30 UN Economic and Social Commission for Asia and the Pacific (ESCAP) Member States, UN and civil society organizations, including people living with HIV and representatives of key populations. A framework was endorsed to fast-track



regional action on AIDS towards achieving global AIDS targets and commitments by 2015. Further, the ASEAN Cities Getting to Zero Project has been developed, involving 13 cities.

279. High-level advocacy and leadership work with the Central American Ministries of Health Council resulted in a statement that commands Central American countries to align national plans with the global AIDS targets.
280. The engagement of the Joint Programme in the 2012 International AIDS Conference resulted in bringing forward the latest thinking and developments in the global AIDS response alongside a reinforced vision for ending the epidemic. Throughout the conference, the Secretariat emphasized the enormous progress made in the past decade and the challenges ahead, highlighted the critical role of the US leadership in ending the epidemic, and reiterated UNAIDS' call for a new compact of shared responsibility and global solidarity. It underlined the need to focus attention on the Political Declaration commitments and on smart investments based on evidence, science and human rights. The UNAIDS vision and strategic direction of 'Getting to Zero' was used in titles or descriptions at conference sessions, conference hubs, and abstracts.

#### Strategically positioning AIDS in the post-2015 agenda

281. In 2012, UNAIDS led efforts on positioning AIDS in the post-2015 agenda and integrating the AIDS response with broader health and development goals. The catalyst for debate was initiated through UNAIDS' active engagement in the Rio+20 UN Conference on Sustainable Development which illustrated the opportunities to contribute lessons and strategies from the AIDS movement to the challenges of sustainable development, and for AIDS decision-makers to learn from other sector.
282. During 2012, a Joint Programme paper was prepared on [UNAIDS and post-2015 AIDS, health and human rights: toward the end of AIDS in the post-2015 development era](#) as a contribution to the Post-2015 Global Thematic Consultation on Health. UNAIDS supported consultations on post-2015 in 40 countries. UNAIDS put forward five focus areas for establishing a new global health agenda: new architecture for global health to focus on country ownership and joint leadership; new voices from emerging countries and innovative partnerships; new delivery approaches that can reach billions, while focusing on quality and impact; innovation through information technology, emerging partners and low-cost solutions; and human rights and gender equality at the centre of the movement.
283. Subsequently, in December 2012, responding to the calls from country partners and civil society, UNAIDS and the *Lancet* announced the establishment of [The UNAIDS and Lancet Commission: from AIDS to sustainable health](#), which will explore the future of AIDS, health and global development post 2015. It will be co-chaired by Malawi's president, Ms. Joyce Banda, AUC chairperson Dr. Nkosazana Dlamini-Zuma and London School of Hygiene and Tropical Medicine director Dr. Peter Piot. Seeking to create a space for systematic analysis, the Commission will have the opportunity to reflect on evidence and make recommendations. Building on continuing consultations, the recommendations will help inform the efforts of the UN Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda and contribute to the deliberations of Member States. The Commission comprises prominent individuals from public life, as well as current and emerging youth leaders. They bring expertise from various fields and/or a deep understanding of the AIDS response, as well as commitment and vision for the future sustainable development agenda. Particularly strong leadership will be sought from low- and middle-income countries in the hope of fostering a

more balanced, relevant debate at the global level. The findings of the Commission will be published in a special issue of the *Lancet* in the first quarter of 2014.

Broadening its advocacy outreach, the UNAIDS [Goodwill Ambassador](#) programme worked with more than a dozen public figures from the world of the arts, entertainment, sport and other fields to strengthen awareness on AIDS. Nobel Peace Prize laureate and a member of Myanmar's parliament, Daw Aung San Suu Kyi, was appointed as a Global Advocate for Zero Discrimination in November 2012 and four new UN Special Envoys for HIV/AIDS were appointed in 2012.

#### Championing the elimination of new infections among children and keeping their mother alive

284. On the specific target on elimination of mother-to-child transmission of HIV, UNAIDS has joined with PEPFAR, the private sector and civil society to facilitate the rapid scale-up of national PMTCT programmes in more than 80 countries. The Joint Programme has made a huge difference in the areas of policy, guidelines and tool development, capacity development, expanded access to HIV testing and counselling, efficient procurement of antiretroviral drugs and other essential commodities, and monitoring and evaluating progress.
285. With evidence and support from UNAIDS, transformed PMTCT service delivery is being adopted in Namibia, Rwanda, Uganda and the United Republic of Tanzania, with other countries considering it (Democratic Republic of the Congo, Kenya, Zambia). In 2011, 100,000 fewer children acquired HIV infection than in 2009. This represents a 24% drop since 2009 and a 43% decline since 2003, which represents more progress in two years than in the previous six. In countries with generalized epidemics, such as Burundi, Kenya, Namibia, South Africa, Togo and Zambia, the number of children newly infected declined by 40–59% from 2009 to 2011.
286. UNAIDS launched the '[Believe it. Do it](#)' campaign in May 2012 to focus attention and action on the global goal of ending new HIV infections among children by 2015 and ensuring mothers living with HIV remain healthy.
287. At the AIDS 2012 conference, UNAIDS and OGAC launched a progress report on the Global Plan with key leaders from countries and the business sector, emphasising the need for a focused approach in priority countries for future scale-up. UNICEF and WHO co-hosted a leadership forum on innovation in eliminating new HIV infections in children, while a joint UNFPA, WHO and the Secretariat session focused on extending the investment approach to family planning and maternal and child health as a way to highlight the benefits of integrated approaches to service delivery.

## Closing the resource gap<sup>6</sup>

288. During 2012, UNAIDS continued its advocacy on shared responsibility with partners, which includes countries taking responsibility for diversifying funding sources and increasing domestic financing to ensure financial sustainability. The circumstances of countries most affected by AIDS have changed in the last decade and for the first time, in 2011, domestic AIDS investments exceeded international investments in low and middle-income countries. The governments of Brazil, India and China have committed to ensuring that at least 90% of their national response is financed domestically.
289. More countries are rising to the challenge of filling the AIDS investment gap and sustaining the response by identifying domestic sources of funding. Innovative financing is playing a central role in increasing domestic investments in the AIDS response – for example, Rwanda and Uganda charge levies on mobile phone use to generate funds for HIV programmes. A flagship report, [Together we will end AIDS](#), published to coincide with the AIDS 2012 conference, included chapters on value for money and financing of AIDS responses.
290. The investment approach promoted by UNAIDS is influencing the overwhelming majority of over US\$ 7 billion in resources flowing through the GFATM and PEPFAR annually. It has been fully recommended and endorsed by the GFATM in the development of its new funding model, and informs GFATM guidance to countries for the development of applications. PEPFAR guidance to its coordinators includes the directive to support the investment approach at the country level. Leading civil society networks are supportive of and engaged with the investment approach, which is viewed as “transformative”. With the support of UNAIDS, countries from all regions are moving forward with an investment approach, ranging from identifying new domestic resources to developing full investment cases.
291. Tools related to the investment approach have been developed such as [Investing for results. Results for people: a people-centred investment tool towards ending AIDS](#) as well as [Efficient and Sustainable HIV Responses](#), a set of eight case studies. These documents assist countries to make decisions about how to allocate resources in the AIDS response to yield the best return on their investments while preserving equity and protection for vulnerable populations.
292. Furthering the development of investment cases, in support of its financing operations, the World Bank initiated four types of analysis to assist 25 countries improve the efficiency and effectiveness of AIDS responses including allocative efficiency analysis, programme efficiency analyses, effectiveness studies and sustainability of financing studies. UNDP with the support of a UNAIDS task team developed guidance related to critical enablers and synergies with other sectors entitled [Understanding and Acting on Critical Enablers and Development Synergies for Strategic Investment](#).

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<sup>6</sup> In June 2011, at the UN High Level Meeting on AIDS in New York, the UN General Assembly adopted the Political Declaration on HIV and AIDS, and Member States agreed to increase funding towards an annual target of US\$ 22–24 billion by 2015 to intensify and accelerate efforts towards ending the HIV epidemic. Between 2000 and 2008, funding for AIDS increased by billions of US dollars each year, due largely to dedicated financing mechanisms such as the GFATM, and PEPFAR. However, since 2008, international financing for AIDS has stagnated, and in 2011, there was still an estimated US\$ 7 billion shortfall from reaching the global target of US\$ 24 billion by 2015.

293. The East and Southern Africa regional Joint Team undertook a mapping exercise to identify countries that were eligible for the Transitional Funding Mechanism with current GFATM grants facing programme disruption until April 2014. WHO provided technical assistance with regard to GFATM grants in Kenya, Mozambique, Namibia, South Africa, South Sudan, United Republic of Tanzania and Zambia.

#### Strengthening HIV integration

294. AIDS programmes can no longer be implemented in isolation. During 2012, efforts to eliminate parallel systems for HIV-related services and to strengthen integration of the AIDS response in global health and development were intensified. New tools and processes have been introduced to enable countries identify cost drivers and create incentives to eliminate parallel systems, in particular by addressing the overall design of AIDS responses, the potential efficiency gains in the delivery of responses, and the fiscal and other considerations required to sustain responses.

295. Many conditions that create the underlying vulnerabilities that drive the HIV epidemic remain: gender inequality; income disparities; unemployment; stigmatized and criminalized sexual behaviours and drug use; and the impact of urbanization and globalization. These will need to be addressed as part of national development programmes if we want to achieve zero new HIV infections.<sup>[2]</sup>

296. To eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, UBRAF core funds were used to leverage financing and ensure that resources were targeted to achieve maximum impact. Tools and processes which have been developed enable countries to more clearly identify cost drivers and create incentives to eliminate parallel systems, in particular by addressing the overall design of AIDS responses, the potential efficiency gains in the delivery of responses, and the fiscal and other considerations required to sustain responses.

297. The UNAIDS and UNFPA HIV/sexual and reproductive health linkages project showed results at the system and service levels in all countries involved (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia, Zimbabwe). Financial and technical support contributed to the review of national policies, strategies, protocols and guidelines. The reviews received a positive response and suggested that it is an opportune time to integrate linkages of the two programmes in core policy documents.

298. With UNAIDS technical support, South Africa launched an integrated five-year strategy addressing HIV, tuberculosis and sexually transmitted infections in 2012, while in Malawi the number of facilities providing integrated services rose from zero to 20. Additional results from the sites indicate increased uptake of antiretroviral therapy, increased utilization of family planning services, reduced workload and better patient flow, and increased male involvement in antenatal care.

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<sup>[2]</sup> Global Commission on HIV and the Law. *HIV and the law: risks, rights and health*. New York, United Nations Development Programme, 2012 (<http://www.hivlawcommission.org/index.php/report> , accessed 19 February 2013).

299. UNFPA supported maternal and child health systems in the integration of prevention of vertical transmission into sexual and reproductive health services in 15 countries (Benin, Burundi, Cameroon, Central African Republic, Chad, Republic of Congo, Cote d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Guinea Bissau, Guinea Conakry, Liberia and Nigeria). In several countries, UNFPA provided technical support and advocacy contributing to the development of comprehensive prevention of vertical transmission plans and capacity development for integrated service delivery.
300. WHO's consolidated antiretroviral treatment guidelines for 2013 address service delivery and operational issues that aim to increase efficiency and effectiveness of HIV programmes, including integration of HIV care and treatment with opioid substitution therapy, maternal child health and tuberculosis care; task-shifting for HIV care and treatment; and a methodology and tool for rapid assessment of the degree of integration of HIV programmes. WHO has also initiated normative processes to increase the efficiency and effectiveness of HIV programmes. These include HIV service delivery guidelines to assist high-burden countries assess how task-shifting, appropriate integration with other clinical services and decentralization are contributing to efficiency gains and sustainability, and a methodology and tool to rapidly assess the integration of HIV programmes into existing health information systems and how this has increased positive synergies.
301. Some countries are integrating aspects of HIV programming with other health services to consolidate service provision and reduce costs. Jamaica has integrated HIV and sexual and reproductive health services. Zimbabwe, with the support of UNFPA and bilateral partners, has developed a large integrated programme supporting sexual and reproductive health and an HIV combination prevention strategy based on the investment approach. WHO's Global Health Sector Strategy 2011-2015 calls for a focus on key investment areas to achieve the greatest impact in the AIDS response, and promotes the efficiency of HIV programmes through integrating and decentralizing services. The South-East Asia Regional Office (SEARO) has adapted the global health sector strategy as the Regional Health Sector Strategy for 2011–2015, taking into consideration the regional context, specificities and priorities in addressing the HIV epidemic.
302. On behalf of the Interagency Working Group on Women, Girls, Gender Equality and HIV, UNDP has led a process to develop a "roadmap" for integrating gender into national HIV strategies and plans. The tool "On Course" will assist governments, civil society and other HIV actors to make clear, concerted, cost effective and sustainable efforts to address multi-dimensional gender and human rights issues in their national HIV efforts and support increased capacity to achieve gender equality results.
303. The Secretariat has developed, piloted and launched a Human Rights Costing tool that is designed to capture unit costs, plan and budget for the key programmes to support human rights in national AIDS responses committed to by governments in the 2011 Political Declaration on HIV/AIDS. In 2011-2012, the Secretariat convened, with the participation of national stakeholders, regional meetings on integrating such programmes into national strategic plans in Asia Pacific, Eastern and Southern Africa, and the Middle East and North Africa regions.
304. UNHCR will continue to support the relevance of integrating humanitarian population concerns when countries use the investment approach to assess gaps and tailor their interventions when programming GFATM grants and other resources.

## Issues and challenges

305. UNAIDS has been advocating for a shift away from the paradigm of AIDS 'exceptionalism' and stand-alone architecture, thereby taking AIDS out of isolation and towards a broader multisectoral health, development, human rights and social justice agenda. Despite significant progress in achieving many linkages programmatically there is still room for progress.
306. Although the increase in domestic investments has helped to narrow the AIDS resource gap, robust and reliable donor support will remain crucial in achieving the global AIDS targets, given the large shortfall in global funding for HIV. By 2015, the estimated annual gap will be US\$ seven billion. While there have been encouraging developments in the shared responsibility agenda in sub-Saharan Africa, more work is needed in other regions.
307. Competing priorities, vertical programming, limited workforce, and unpredictable funding are among the key factors constraining movement towards informed integration of services and programmes to eliminate parallel systems. There is a clear deficit in the available metrics to support the target to eliminate parallel systems.
308. Monitoring and accountability challenges remain because of different accountability frameworks/funding streams, poor access to data, and difficulties in tracking downstream progress.

## Future plans

309. Further steps will be taken towards the operationalization of the shared responsibility and global solidarity agenda and the financing component of the AU Roadmap through defining global fair-share principles, addressing methodological issues and supporting countries in developing HIV financing compacts with key donors to ensure sustainability of HIV financing. Beyond 'Know your epidemic, know your response', for AIDS responses to make an impact in reducing new infections and sustain funding for treatment and care programmes, it will be vital for countries to also know their effectiveness, efficiency and return on investment.
310. UNAIDS will continue working with women's groups to address the positioning of gender equality in high-level political agendas such as the Global Power Women Network, UNAIDS and Lancet Commission, the Commission on the Status on Women and also regional bodies.
311. Work will be done to develop specific guidance on how governments, together with communities, the private sector and funders can further integrate programmes or services. There will also be a focus on high-level advocacy to develop the discourse and highlight the crucial role that integrating systems and programmes will play in achieving programme scale-up.
312. The entire programme effectiveness agenda will require increased attention in 2013. Immediate priorities include support for the national reviews of the 10 global AIDS targets in countries, and putting the Economics Reference Group into operation.
313. UNAIDS' work through the Joint UN Teams and Joint Programmes of Support, in the context of the Resident Coordinator System, will remain a priority to promote relevant, coherent and effective UN action to support national priorities and to improve linkages between operational and normative activities.

314. The Secretariat will continue to leverage the experience of the Joint Programme in implementing intergovernmental mandates, from the Programme Coordinating Board and the General Assembly, to the Security Council and the United Nations Economic and Social Council (ECOSOC). UNAIDS will continue to participate in interagency mechanisms, such as the Chief Executive Board for Coordination, High-Level Committee on Management, High-Level Committee on Programmes and the United Nations Development Group (UNDG), with emphasis on achieving the global AIDS targets, responding to the recommendations of the Quadrennial Comprehensive Policy Review (QCPR), and supporting the development of the second generation of Delivering as One.

**Jamaica**  
**FOCUSING ON UNIVERSAL ACCESS**

**UN HIV-related expenditure in 2012**  
**US\$ 1,269,018**  
**UBRAF core and non-core**

**Joint UN Team members:** ILO, Secretariat, UN Women, UNDP, UNESCO, UNFPA, UNICEF and WHO [**13 members**]  
**Epidemic type:** concentrated/geopolitical relevance  
**Principal modes of transmission:** sex workers and their clients, men having sex with men, multiple heterosexual partners

In Jamaica, the Government is leading the AIDS response with increased focus on creating an enabling environment. It has embraced the investment approach and is engaged in the sustainability of the response. The HIV epidemic in Jamaica is closely tied to poverty, developmental and sociocultural issues. Legal barriers, cultural and religious beliefs, and high levels of homophobia are major determinants of risk and vulnerability, especially for MSM, commercial sex workers, the homeless and adolescents. Thus, while the response has maintained an upward trend in treatment coverage, and sustained a solid achievement in PMTCT, HIV prevention continues to face significant challenges due to prevailing legal framework and social determinant of risk and vulnerability.

With a reduction in sexual transmission is a priority, the Secretariat and Cosponsors have advocated for the revision of the legal framework and the national HIV policy to specifically address populations at higher risk of HIV transmission and vulnerable groups such as adolescents. To this end, joint technical and financial support were provided to the Government and resulted in the development and implementation of strategies, tools and strategic information. These include: MSM Strategy, Human Rights Costing Tool, Gender Assessment Tool, Assessment of the Legal Framework, Modes of Transmission analyses and the HIV Stigma Index. This, along with public opinion has led the Government to embrace a human rights and gender- based response. Thus, the National Strategic Plan (2012–2017), which was developed with the support of UNAIDS, focuses on scaling up strategies to establish a comprehensive programme of treatment, care and prevention services that is evidence-based and addresses the special needs of key populations.

Through joint actions, the UN achieved a remarkable impact on the national AIDS response in key strategic areas. The generation of a body of strategic information has propelled an evidence-based approach to planning, which is showcased in the national strategic plan. The UN Joint Team has initiated and maintained a presence in the building of a national and multisectoral movement in favour of the elimination of mother-to-child transmission, generating a renewed sense of shared responsibility by enlisting new partners in the response, including faith-based organizations, and leading political advocacy, human rights and gender equality.





How Jamaica finances its AIDS response remains a cause for concern. The country relies heavily on external sources, and although domestic funding trends are increasing, the average annual funding gap is estimated at US\$ nine million. Any further shortfalls (external financing is expected to significantly reduce in the next two years) will have serious implications for delivering HIV services. With this in mind, the UN is collaborating with the Government on a future sustainability plan and investment framework for its HIV programme. This strategic move included a financial sustainability study of Jamaica's HIV programme, jointly supported by the World Bank and the Secretariat, which emphasized the need for efficient, effective prevention programmes, particularly for key populations.



## Coordination, coherence and partnerships

### **Selection of significant trends and indicators**

*Mechanisms for promoting multistakeholder interaction to implement HIV strategies and programmes exist in nearly all countries with a UNAIDS presence. Increasing attention is being given to the regular coordination of strategic information, though there is a slight fall in the number of countries using key strategic information tools. On the positive side, civil society access to technical support is increasing.*

Status	Data
	Percentage of countries with a UNAIDS presence with a mechanism to promote stakeholder interaction between government, civil society organizations and private sector to implement HIV strategies/programmes increased from 91% to 99% from 2010 to 2012
	Percentage of countries where a national M&E committee or technical working group meets regularly to coordinate strategic information/M&E increased from 37% to 84% in countries with a UNAIDS presence and 29% to 95% in HICs from 2009 to 2011
	Percentage of countries where civil society accessed adequate technical support rose from 26% to 36% in Countries with a UNAIDS presence and from 21% to 39% among HICs from 2010 to 2012
	Percentage of countries with a UNAIDS presence reported having used Modes of Transmission fell from 65% to 49%, a NASA from 76% to 66% and AIDSinfo from 64% to 59% from 2012-2011

### **Achievements**

315. UNAIDS focuses on strategically complementing the efforts and capacities of national governments and civil society and technical partners to organize and manage results. In all countries where UNAIDS is present, it coordinates efforts across the range of stakeholders to provide strategic, policy and technical support to stakeholders in developing and implementing rights-based and evidence-informed national AIDS responses.

#### Support to multisectoral national strategies and investment approaches

316. National governments and their funding partners are all interested in ensuring greater returns on investment. Following the global consensus meetings on national strategies in Nairobi (June 2012) and on coordination at the country level in Washington DC (July 2012), draft guidance on national strategies and implementation for results was developed. The draft guidance emphasizes the principles of, and builds on, previous planning practices and contains new investment thinking for framing national AIDS strategies. The new guidance developed by the Secretariat, the World Bank, WHO, UNDP and other partners is expected to be finalized during 2013 and made available to some 40 countries which will embark on developing new national strategic plans or undertake a mid-term review of their existing national strategic plans.

317. WHO's Department of HIV developed tools for strategic planning and programme review to assist countries to develop sound strategic and operational plans. The department has also contributed to development of wider health sector planning tools such as the Joint Assessment of National Strategies tool and the OneHealth costing tool.

318. The Investment Framework was introduced in 2011 as a conceptual approach to improving the impact of HIV funding. This approach is about leveraging more sustainable sources of funding for AIDS, and requires all stakeholders to think differently and more innovatively about how the various elements that make up an effective and efficient AIDS response are planned and prioritized. *(Refer to paragraphs 288 to 292 for further examples of broader application of the approach.)*
319. In Morocco, for example, investment analysis showed that while key populations account for two thirds of new HIV infections, less than one third of prevention expenditures were directed to these populations. Morocco's new National Strategic Plan for 2012–2016 has significantly shifted its priorities, allocating over 60% of AIDS resources to prevention efforts for key populations.
320. WHO supported Iraq to develop its first ever National Strategic Plan with the prioritization of ensuring access to interventions by key populations at higher risk. Similarly, Saudi Arabia's first National Strategic Plan was developed, emphasizing the generation of strategic information on the epidemic situation in key populations at higher risk.
321. In West and Central Africa, regionally specific guidelines for developing evidence-based national AIDS strategies were developed by the World Bank and the UNAIDS Regional Support Team for West and Central Africa. The guidelines include practical guidance, methodology, and approaches for developing results-based national strategic plans on AIDS, responding to the specific epidemic dynamics of the region's countries.
322. UNAIDS produced a policy brief on social health insurance and HIV services in low and middle income countries. Currently under review by experts at WHO and the World Bank, the policy brief highlights the fact that HIV services are often not sufficiently included in the benefit packages of existing social health insurance, and promotes the inclusion of key HIV services in social health insurance where financially feasible.
323. The UNAIDS Economics Reference Group, co-convened by the World Bank and the Secretariat, was established in 2012 to provide countries with policy and normative guidance for strategic AIDS investments along with the advancement of the research agenda in AIDS economics and harmonization of research methodologies and tools. The body will comprise three technical working groups focusing on costing, efficiencies and sustainability of HIV financing respectively and its work plan for the first three years is supported by the Bill & Melinda Gates Foundation.
324. Strategic realignments in Benin, Burkina Faso, Cote d'Ivoire and Ghana have resulted in increased programmatic focus and concomitant resource allocation shifts. In South Africa, support was provided for the National Strategic Plan and NASA, including a joint annual programme review of plan reports and development of nine costed, multisectoral provincial operational plans.
325. In Cambodia, progress has been accompanied by a reliance on external donor resources, with the Government contributing only 4% of total AIDS expenditures. In a series of consultations supported by UNAIDS, Cambodia has developed "Cambodia 3.0", a new national strategy built on increased domestic investment within a focused investment approach to reach the global AIDS targets and eliminate new HIV infections.

326. The UNAIDS strategy and vision was imbedded in the regional HIV strategic plans of the West African regional economic entity and the Central African economic regional entity, in a key reference document in the Arab AIDS Strategy, in the Pan Caribbean Partnership against HIV and AIDS.

#### Building strategic alliances

327. The AUC and NEPAD, with the support of UNAIDS, undertook a review of available data to assess the degree to which commitments made by the AU and the G8 from 2001 to date, have been implemented. Findings of this review were validated by officials of the AUC, NEPAD and UNAIDS, as well as by technical experts from the Stop TB Partnership, the Roll Back Malaria (RBM) partnership, African Leaders Malaria Alliance (ALMA), the GFATM, the GAVI Alliance, and AIDS Accountability International. The report will be officially launched and submitted to African Heads of States and Government for consideration and adoption during the 50th anniversary celebrations of the AU in May 2013, in Addis Ababa, Ethiopia. It will also be presented at the upcoming G8-Africa Outreach Summit.

328. In regard to the implementation of the AU Roadmap for Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria, UNAIDS supported the AUC and NEPAD to develop a practical guide which aims to assist member countries of the AU, African regional bodies and the AUC to implement the Roadmap. Its purpose is to provide practical ideas for how to take the agreed Roadmap agenda forward in order to achieve rapid results, in both reducing the burden of these three diseases and in developing mechanisms to sustain national and regional programmes for the three diseases<sup>[1]</sup>. Cosponsors particularly, WHO, ILO, UNDP and the World Bank, and other key stakeholders such as the GFATM, RBM, UNIDO and ALMA provided useful comments and inputs. The report will be reviewed, endorsed and officially launched during 2013.

329. Following the adoption of the AU Pharmaceutical Manufacturing Plan for Africa (PMPA), in 2012, the AUC and other partners elaborated a business plan for PMPA, which was subsequently endorsed by the Assembly of Heads of State and Government. The business plan seeks to develop strong, independent and predictable national regulatory authorities, build regulatory capacity, increase and enhance competition, reduce demand uncertainty, strengthen forecasting capacity, increase investments in the development of needed medicines, and provide time-limited, easily understood and accessible incentives to accelerate progress towards pharmaceutical self-sufficiency in Africa. UNAIDS, together with AU major partners including UNIDO and WHO, has been involved in initial discussions to establish a central consortium that would assist the AUC in the implementation of this business plan.

330. UNAIDS was instrumental in the establishment of the “West African Health Organization (WAHO) local drug production working group” which aims to advise the WAHO to implement several critical activities related to efforts to ensure availability to quality and affordable drugs in the West African region. An ECOWAS Charter on Public Private Partnership for Local Pharmaceutical Production of antiretrovirals and other Essential Medicines has been developed and was submitted to Health Ministers for endorsement in April 2013. The Charter references the Pharmaceutical Manufacturing Plan for Africa as well as the AU Roadmap.

331. In July 2012, 60 Ministers of Finance and Health were engaged on the issue of leveraging the AIDS Response for Sustainable Health Financing (Harmonization for Health in Africa

(HHA) Initiative) in partnership with the AU, the Economic Commission for Africa and the African Development Bank.

332. In 2012, UNAIDS supported BRICS countries to advance the shared responsibility and global solidarity agenda by advocating for BRICS countries to increase their level of domestic investment in AIDS and encouraging the countries to increase development cooperation to low income countries and facilitate directing aid to priority areas. UNAIDS supported the BRICS to champion the strategic investment approach and maximize the value of resources, and a partnership was established with China, the AU, NEPAD and Regional Economic and Social Commission for Africa on China/Africa health cooperation.
333. The Joint Programme and partners invested in improving strategic information and documenting community-led and community engaged approaches to better shape national responses. In the Asia-Pacific, UNDP, the Secretariat, the Asia Pacific Coalition on Male Sexual Health and national partners developed MSM Country Snapshots. The 2010 Asia Pacific Regional Consultation on Sex Work continues to shape results including case studies on sex worker-led programmes.
334. A process has been launched by UNESCO and the Secretariat to mobilize political commitment to make good quality HIV and sexuality education, sexual and reproductive health and youth-friendly services available to young people in 21 countries in Eastern and Southern Africa. Fourteen countries are now applying the Sexuality Education Analysis and Review Tool (SERAT), developed within the West and Central Africa region with technical support from UNESCO, to assist the education sector in improving the planning, design, monitoring and evaluation of HIV and AIDS curricula.
335. In partnership with the Southern African Development Community and Member States, UNDP successfully engaged policy makers and other key stakeholders in integrating HIV and gender into environmental impact assessments for capital projects in the region. For example, this includes a wide variety of actions in South Africa, with the development of national AIDS Mainstreaming Guidelines for over 1.2 million public-sector workers (and for 40,000 workers in Lesotho); the integration of HIV and gender in Free State University (similarly for universities in Botswana and Makarere, Uganda); and integration of HIV and gender into environmental impact assessments processes into the 2013 operation plans nationally and for all nine provincial departments.
336. A prioritized joint regional HIV plan and budget was developed by the UNAIDS Cosponsor Regional Group in Latin America for better and coherent implementation of the UBRAF. Specific partnerships among Cosponsor agencies were established to better address and support HICs' joint programmes of support.
337. UNAIDS was central to brokering and launching of the Robert Carr Civil Society Network Fund, to provide core funding to ensure the long term survival of critical civil society networks, in particular for global and regional networks of people living with HIV and key populations. Twenty four civil society networks were awarded funding during the first year of the Fund's operation.

#### Generating and using strategic information

338. UNAIDS continued to support focused efforts in the domain of strategic information that enables the response to AIDS to be more effective in addressing the dynamics of the epidemic and its underlying factors. In addition to the roll out of the Stigma Indexes and Modes of Transmission studies which inform and guide programme managers, NASA were

supported in more than 15 countries. Gender assessments have been conducted in six countries (Bolivia, Djibouti, Jamaica, Liberia, Rwanda and Tajikistan). In 2012, 32 countries reported that a population size estimation study had been conducted.

339. The Caribbean Men Internet Survey on behaviours and practices of internet-using adult MSM was completed in June 2012, with UNAIDS support, representing the largest such survey in the Caribbean, with 3,567 respondents. The findings will be used to support decision-making processes, policy and programmes to improve Caribbean interventions and quality of life for MSM.
340. The World Bank and the Secretariat promoted national-level stock-taking in the form of Know Your Epidemic Know Your Response analyses in order to support strategic and HIV investment decisions at country level, most recently in Burundi, Mozambique, South Africa, South Sudan and Zimbabwe. These analyses have proven to contribute critically to the countries' on-going efforts to understand the state of the HIV epidemic.
341. UNAIDS strategic information support in South Africa has contributed to an increasingly sophisticated body of evidence and analysis which guides South Africa's strategic planning, its resource allocation plans, and investment dialogues. This allows the country to avoid a fragmented approach of small and diffuse efforts, and to concentrate on high-value, high-impact and scalable initiatives that address the main dynamics of the epidemic.
342. At the request of the several governments in West and Central Africa, UNAIDS assisted in the exercise to understand the 15- to 20-year fiscal space implications of HIV and AIDS programming, produced guidelines for developing results-based national AIDS strategies, with particular focus on ensuring that results are set in coherence with the broader national development plans.
343. Seventeen countries in Central America were supported to analyse and use new strategic information for high level advocacy, sustainable cost-effective HIV strategies and policies development, focusing on key populations and favourable environments. A regional systematic review of available quality surveillance data and case reporting for Latin America was undertaken alongside with the sustainability analysis using modes of transmission and NASA data.
344. The EMRO carried out the annual review of HIV surveillance information and development of HIV surveillance systems in the region and shared it with Member States and UN partners. EMRO supported a HIV data triangulation exercise in Morocco and the findings have been used to re-orient sub-national strategic plan objectives.

#### Provision of technical support

345. During 2012, technical support offered by UNAIDS continued to be a focus to ensure targeted assistance to countries on accessing and managing external investments in the AIDS response.
346. UNAIDS provided technical contributions to 19 grants under review, yielding funding decisions worth US\$ 1.9 billion for their HIV portfolio. As highlighted in the new *GFATM Strategy 2012-2016*, "The United Nations partners, especially WHO and UNAIDS, have a special role in this regard in providing the necessary norms, standards and evidence to enable more strategic investment."

347. In addition, the TSFs assisted unblocking of GFATM grant implementation challenges in over 30 countries through more than 70 technical support assignments. External reviews of the TSFs completed in 2012 found the TSFs to be effective, relevant and able to offer value for money in response to growing demand for their services. As part of an on-going drive to obtain the best possible value for money the TSFs were consolidated from five to three in 2012: the TSF Eastern and Southern Africa, the TSF West and Central Africa and the TSF Asia Pacific.
348. The West and Central Africa Joint UN Regional Team on AIDS has been revived with more collaborating partners, from bilateral and multilateral agencies and civil society. The Economic Community of West African States is now a full-member of the Regional Team coordination group, which allows the support of all partners to the implementation of the Economic Community of West African States AIDS plan. Within the team, three working groups are addressing issues of technical support, procurement and supply chain management and efficient use of resources.
349. The UNAIDS Regional Support Team and UNDP has supported the establishment of a Francophone focal point for the Policy and Law Programme of African Men for Sexual Health and Rights, which will boost strategies for access to HIV-related services and human rights for the lesbian, gay, bisexual and transgender community.
350. UNAIDS has provided technical and financial support to the development of the East African Community HIV and AIDS Prevention and Management Bill 2012. This regional legislation aims to regulate effective responses to HIV across all of the five East African Community countries (Burundi, Kenya, Rwanda, Uganda and the United Republic of Tanzania). The Bill was adopted by the East African Legislative Assembly in April 2012.
351. Workers' organizations from 12 Caribbean countries received technical support from the ILO. This work combined with ILO's technical support to other countries in the region, ensured that workplace responses in the region were all consistent with the global human rights tools and provisions as they relate to the workplace. UNDP provided technical assistance to the Bahamas, Belize and Grenada to integrate gender into their national HIV strategies, policies and programmes. With support from the European Community, and in collaboration with a wide range of partners, UN Women has been supporting Jamaica in using the same approach that integrates gender equality and human rights into the governance of the AIDS response.
352. The UNICEF, UNAIDS, ADB (Asian Development Bank) HIV and AIDS Data Hub responded to regional and country needs by generating and disseminating strategic information. The [web portal](#) remains the only regional site of its kind, with a large repository of HIV data and its synthesis into strategic information on 26 countries in Asia-Pacific. The offline regional database has 96,000 data points for 1,500 indicators on HIV vulnerability, risk behaviours, and prevalence, national response and socio-economic impact, and there were 48,000 unique visitors in 2012.

The UN Joint Team in Zambia developed a stakeholder and service electronic mapping system for the National AIDS Council, and launched the e-mapping tool to all districts. The tool informs planning and programming at decentralized levels, and also proved useful in mapping stakeholders and services provided, enhancing sub-national response teams' capacity to coordinate stakeholders and identify response gaps.

353. Supporting capacity development of community-led organizations of sex workers, MSM and transgender people has resulted in stronger engagement of key populations. UNFPA supported the Global Network of Sex Work Projects to strengthen the African Sex Workers Alliance and the Sex Worker's Rights Advocacy Network (SWAN) in the Eastern Europe and Central Asia region. UNHCR supported sex work organizations in humanitarian settings and UNDP led the establishment of the Eurasian Coalition on Male Health. With the UNAIDS Regional Support Team from EECA, UNDP supported strengthening advocacy activities of African Men Sexual Health and Rights. ILO supported lesbian, gay, bisexual and transgender organizations in the workplace. UNFPA, UNODC, ILO, WHO and the Secretariat contributed to the International AIDS Conference Hub: the Sex Worker Freedom Festival. This extraordinary conference demonstrated the efficacy of investing in community-led approaches. UNESCO spearheaded NewGen Asia developing the capacity of young key populations as youth leaders

### **Issues and challenges**

354. There is need for a shift of attention from planning to implementation, drawing attention to making planning processes lighter and more strategic while focusing resources on achieving results and doing more with less.

355. Promoting effective use of strategic information tools, such as Modes of Transmission studies, is critical for countries' on-going efforts to understand the state of the HIV epidemic.

356. UNAIDS anticipates that the demand for technical support will continue to grow and there is recognition of the need for better coordination of technical support globally which has led to the establishment of a coordination group of GFATM grant implementation technical support providers which included UNAIDS, the U.S Government, GIZ BACKUP Initiative, the French 5% Initiative and the GFATM.

### **Future plans**

357. There will be a continued shift towards strategic investment thinking, to improve understanding that resources for HIV are investments in national well-being, not costs. The content and package of interventions will focus on programme activities and critical enablers that are based on science and proof of results, while maintaining a rights-based approach that guarantees that the needs of all affected populations are addressed.

358. Increased advocacy is planned for better targeted and less generic interventions to focus on affected population groups and geographical areas. Increasing use of domestic resources will be encouraged to enhance country ownership and mutual accountability, while encouraging continued international investments in the spirit of shared responsibility and global solidarity, as well as financing by new partners.

359. The Modules for the new guidance "National AIDS Strategies and Implementation for Results" will be fully harmonized with the Investment Framework tools and support provided to some 40 countries which will develop new national strategic plans or undertake a mid-term review of their existing national strategic plans during 2013.

360. Further steps will be taken towards the operationalization of the shared responsibility and global solidarity agenda and the financing component of the AU Roadmap through defining global fair-share principles, addressing methodological issues and supporting countries in developing HIV financing compacts with key donors to ensure sustainability of HIV financing.




361. A number of strategic information products are in the pipeline, including a unit cost repository, a policy brief on social health insurance and a publication on return on investment. Country support will be continued, in particular through the development of up to 20 investment cases and related sustainable HIV financing plans, in collaboration with the World Bank. The World Bank and the Secretariat will jointly develop 11 country investment cases by the end of 2013.
362. A new Monitoring and Evaluation Reference Group (MERG) has been established which has set global priorities for the coming years which will now need to be addressed. An initial work plan has been drafted. There has been close collaboration with the GFATM on monitoring and evaluation, while collaboration with the World Bank and PEPFAR needs to be further strengthened. Tools and approaches for measurement of costs and benefits of HIV interventions and expenditure tracking will be harmonized between main stakeholders.
363. The Joint Programme will continue to work with BRICS on the above areas, and support BRICS countries as they engage in south south cooperation and technology transfer to low and middle income countries in health and development – particularly in Africa – in areas such as access to medicines and commodities, research and new technologies and local production.
364. In 2013, requests to the TSF continue to grow in a range of technical areas from supporting the development of evidence, to planning programmes, implementing and monitoring and evaluation. UNAIDS anticipates that the demand for support will continue to grow. Work is currently underway to look at closer engagement with other providers including plans to establish a virtual steering group on technical support.



## Mutual accountability

### Selection of significant trends and indicators

*Financial implementation of core UBRAF funds in 2012 was close to the maximum of 50%. Reporting in the JPMS was encouraging and provides a good baseline for reporting over the remaining three years of the UBRAF. However, annual multi-stakeholder reviews of Joint Programmes of Support at country level need to be emphasized more for the 2013 reporting period.*

Status	Data
	Overall core budget implementation of the UBRAF in 2012 was 47.2%
	95% of HICs reported financial information in the JPMS for at least two UBRAF outputs by at least two organizations, and 42% of HICs provided financial information for at least 75% of UBRAF outputs by at least 75% of Joint Team members.
	Percentage of countries with a UNAIDS presence conducting a (UBRAF) annual multi-stakeholder review of the Joint Programme of Support fell from 48 to 38% from 2011 to 2012

## Achievements

### Ensuring strategic use of resource and cost effective delivery of results

365. The Secretariat has implemented a strategic realignment to: ensure alignment of human and financial resources with evolving corporate priorities and optimal deployment of expertise to achieve the global AIDS 2015 targets; continue strengthening country focus; and lower overall operating costs and maximize value for money. As part of the strategic realignment, a range of cost savings and efficiency measures have been implemented that have reduced overall expenditures by 13 per cent in 2012 compared to 2011. Savings have been realized in such areas as staff travel, printing and communication.

366. As part of the strategic realignment, several positions at headquarters were abolished and some 50 positions were re-profiled, primarily in the field, to better respond to programme priorities and provide the most effective technical and operational support. The revised positions focus on: policy and strategy; global outreach and advocacy; strategic interventions; rights, gender and community mobilization; strategic information; youth and social organization; and sustainable financing. At Headquarters, the realignment boosted the Secretariat's core functions and refocused programmatic support around the achievement of the global AIDS targets. Structurally, Headquarters operates with fewer but larger teams, resulting in a flatter, more flexible and agile configuration responsive to emerging needs.

### Strengthening Joint Programme accountability and governance mechanisms

367. A peer review process more robust than anything undertaken previously was implemented at the beginning of the second year of the biennium (2013), involving Cosponsors and the Secretariat in a two-stage evaluation of (1) progress and performance in the first year of the current biennium and (2) the workplan and budget for the next biennium. This provided an opportunity to review results as well as areas where progress was not developing as expected, and ensure there will be focus on key areas in

the 2014/15 budget development related documents for discussion at the June 2013 Programme Coordinating Board, as well as to ensure epidemic priorities are best addressed in future work. Concomitantly, a multi-stakeholder consultation was organized on 4 March, 2013 in Geneva with over 70 participants (Permanent Missions, Observers, Programme Coordinating Board NGO Delegation and Global Coordinators) to take stock of lessons learned so far in the implementation of the UBRAF and to reflect these in the development of the 2014-15 budget.

368. The importance attached by the Programme Coordinating Board to the mutual accountability of the Secretariat and Cosponsors to enhance programmatic efficiency and effectiveness has been a key priority of the Secretariat, facilitating coordination and ensuring coherence across all areas of the Division of Labour in order to maximize synergies.
369. The UBRAF, fully operationalized in 2012, has improved accountability by presenting a detailed overview of Cosponsor and Secretariat results against the strategic goals and functions. Performance is measured using indicators at impact, outcome and output levels, and supplemented by case studies and in-depth assessments. The launch of the [JPMS](#) tool in 2012 has enabled for the first time Joint Programme reporting at country level to be collected in a uniform way, subsequently informing regional and global reporting.
370. The adoption of the International Public Sector Accounting Standards (IPSAS) in 2012 has improved the quality, comparability and credibility of UNAIDS' financial reporting. UNAIDS received a clean audit opinion on its 2012 financial statements, which for the first year were presented IPSAS compliant.
371. In 2012, two fruitful Programme Coordinating Boards were held and included several important developments for the Joint Programme, such as UN Women joining as the 11th Cosponsor and discussions on the Post-2015 development agenda, gender sensitivities of AIDS responses, strategic investment approaches, and stigma and discrimination. The Programme Coordinating Board thematic sessions continue to showcase the Board's ability to bring together diverse groups of stakeholders to discuss often complex issues in an environment that respects varying views.

### **Issues and challenges**

372. Prioritizing investments, actions and results in support of the UNAIDS vision and the global AIDS targets remains an on-going challenge. Considerable effort is being invested to support culture change towards stronger cost consciousness, value for money, results-based budgeting and management, and accountability for results.
373. The UBRAF has been successfully operationalized and there is clear progress in terms of results-based planning and reporting. While a noticeable improvement over its predecessor (the UBW), the UBRAF is a complex instrument and ways of reducing complexity should be considered in 2014-15 while retaining the original framework.

### **Future plans**

374. In 2013, the strategic realignment will continue its focus on supporting countries to deliver more results at the country level, including strengthening capacity in HICs. Additional country focus initiatives include creating multi-country offices and placing greater reliance on National Officers. Other Secretariat-wide priority actions include the

2013 Mobility exercise, the Secretariat Gender Action Plan and the Performance and Learning Management Project, as well as publication of new human resources policies. The implementation of the IT strategy and governance framework, including the deployment of new information technologies and applications, will help promote collaborative working and enhance knowledge management and communication throughout the organization.

375. Efforts will continue to strengthen cost and value consciousness across the Joint Programme to optimize the use of resources and to balance the budget. Another priority for the Secretariat will be taking the lead in mobilizing resources for the core budget.
376. Strengthening support for governance will remain an area of focus and include enhancing inter-sessional work with regional groups and individual Board members, continued implementation of measures to enhance strategic support to the Programme Coordinating Board, such as through multi-stakeholder processes, the use of case studies in reporting and Programme Coordinating Board field visits; and building synergies and closer ties to the governance structures of Cosponsors and other key partners, such as the GFATM and UNITAID.
377. The UBRAF has already improved transparency and accountability by enhancing results-based planning and the preparing of joint reports. In 2014-2015, reducing the complexity in the management of the UBRAF and reporting will be explored and the JMPS will be refined to improve how UBRAF results and performance are reported and information used across the Joint Programme.
378. The UBRAF is a model of joint accountability that meets a number of the QCPR requirements such as strengthened joint work, joint organization of work and specific goals and more transparency. Further steps will be taken towards its operationalization. The Secretariat is supporting the development of a detailed common action plan for the UN system by UNDG on the implementation of the QCPR.

**Cameroon****REDUCING STIGMA AND DISCRIMINATION CRUCIAL TO NATIONAL HIV PROGRAMMES**

**UN HIV-related expenditure in 2012**  
**US\$ 3,355,452**  
**UBRAF core and non-core**

**Joint UN Team members:** ILO, Secretariat, UN Women, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, WFP, WHO and World Bank [20 members]

**Epidemic type:** high burden

**Principal modes of transmission:** sex workers and their clients, men having sex with men, multiple heterosexual partners

Cameroon has shown the way in Africa in decentralizing its AIDS response. Under the National Strategic Plan, drafted with UNAIDS' participation, almost all health districts are equipped to provide PMTCT services. PMTCT services are being integrated into antenatal, delivery and postnatal care settings, and other sexual and reproductive health services. Though the country has much to do to achieve zero new infections among children by 2015, mother-to-child transmission has fallen from 29% in 2009 (baseline) to 24% in 2011, according to UNICEF. With health districts at almost maximum PMTCT coverage, the challenge is to reach women who do not give birth in hospital, particularly those in rural and marginalized communities. To this end, the Joint UN Team on AIDS has helped strengthen community-based interventions for family planning. PMTCT policy and programmes are also being expanded, including antiretroviral therapy for eligible women, sexual and reproductive health, primary prevention and nutritional support.

Cameroon has identified the need to eliminate parallel systems for HIV-related services and to further integrate the AIDS response in health and development efforts. The HIV-related needs of women and girls have been specifically addressed in the Cameroon UN Joint Plan on AIDS 2012–2013. The regular consultations between health partners have facilitated the exchange of information, the rational allocation of resources and the integration of services; integrating antiretroviral therapy, PMTCT and tuberculosis treatments has enhanced access to treatments for women and girls regardless of the point of contact. In 2012, UNDP initiated a programme to educate, sensitize and train local leaders and women's groups in the poorer provinces on gender-based violence in the context of HIV; such programmes will facilitate specific actions to prevent practices that expose women and girls to HIV.

Reducing stigma and discrimination is crucial to national HIV programmes but measures in Cameroon to uphold the right to health of key populations, such as MSM and sex workers, have lacked effectiveness. Limited human rights knowledge and finances for expanding nationwide promotion interventions have exacerbated the problem. However, UN advocacy has improved awareness of the links between AIDS responses and the broader MDG agenda, and human rights and gender were taken into account in the UNDAF 2013–2017 and the Joint Plan 2013. HIV Stigma Index data compiled with the support of UN staff has enabled an action plan to reduce discrimination and guide judges, lawyers and associations on human rights related to HIV. Moving from data to action will be a challenge but it will help focus stakeholders on mobilizing resources to achieve zero discrimination by 2015.

## G. CROSS-CUTTING THEMES

388. Cross cutting themes are issues from the UNAIDS division of labour areas that are not directly represented or explicitly captured in the strategic goals of the UNAIDS 2011-2015 strategy or the global AIDS targets. The themes are:
- i. young people;
  - ii. education for more effective AIDS responses;
  - iii. scaling up HIV workforce policies and programmes;
  - iv. integrating food and nutrition in HIV prevention and care services and,
  - v. HIV interventions in humanitarian emergencies.

### Young people

#### Achievements

389. In 2012, the Joint Programme focused heavily on the inclusion of young people and HIV/sexual and reproductive health in the global response; implementing the Secretary-General's System-Wide Action Plan on Youth was a major thrust of these efforts. Other key youth initiatives included a set of youth-defined recommendations to guide UNAIDS' work on HIV and young people until the end of 2015. The recommendations derived from the input of more than 5000 young people from 79 countries who participated in CrowdOutAIDS, an innovative youth-led web-based crowdsourcing project initiated by the Secretariat.
390. Hundreds of youth leaders gathered for the Third Pan-African Youth Leadership Summit, a three-day meeting organized by the West African Youth Leadership Network for the United Nations in cooperation with UNAIDS. The focus was on how young people can contribute to the post-2015 development agenda and reach the UNAIDS.
391. Coordinated support through the Asia-Pacific IATT on Young People from Key Populations increased the capacity of youth-led regional networks, such as Youth LEAD, Youth Voices Count and the HIV Young Leaders Fund, and helped engage more young people in regional and national-level policy and programming. It also improved understanding of the availability and gaps in strategic information, and the dynamics of the epidemic among young people from key populations. It informed policymaking and programming at country level and improved the capacity of policymakers to understand the needs of young people from key populations.
392. UNICEF, UNFPA and the Secretariat organized the first meeting of young people living with HIV, with 25 participants from nearly all of the Latin America region's countries. The key outcome was to create a Regional Network of Young People Living with HIV in Latin American countries, and the meeting assisted in defining the network's mission, objectives and structure and elected a six-member management team. UNICEF supported programmes in Brazil and Jamaica to provide thousands of adolescent girls and young women with HIV testing and counselling and comprehensive treatment and care. In Jamaica, work with networks of adolescents living with HIV has intensified efforts to lower the age of consent and/or parental consent to eliminate obstacles to services and treatment.
393. Twelve UNFPA country offices in Eastern and Southern Africa reported enhanced youth-sensitive comprehensive condom programming. Mozambique, Uganda and the United Republic of Tanzania revived their condom committees/taskforces. Support for promoting condoms for young people and for building skills among government officials, non-governmental service providers and peer educators was provided in Ethiopia,

Lesotho, Malawi and Swaziland. A prevention pack was developed in Ethiopia to support outreach to young people out of school, while in Djibouti and Iran, there was progress in developing national prevention programmes for adolescents and scaling up adolescent-friendly HIV services.

394. UNICEF and the Futures Institute conducted modelling studies to demonstrate the impact and cost of investment approaches that target adolescents. The studies supported advocacy for strategic shifts in programming for adolescents towards increased investment in high-impact interventions.
395. Key publications in this area included new education-sector guidance published by UNESCO and GNP+ on young people living with HIV, while UNFPA published [Marrying too young: end child marriage](#), summarizing data and evidence from 40 countries and identifying hot spots with the largest proportions and numbers of girls at highest risk.
396. In Cameroon, Central African Republic, the Democratic Republic of the Congo and Nigeria, progress was made in using quality data on knowledge, risks, vulnerability, and service utilization when devising programmes for young people. Uganda drafted a school health policy promoting sexuality education.

### Issues and challenges

397. National governments, partners and youth-led organizations lack capacity to develop, implement and assess prevention and care programmes for adolescents. Interagency coordination and upstream leveraging with donors and national systems remain difficult. Much interagency work fails to integrate sexuality education efforts, life skills and many prevention services.
398. In the Asia-Pacific, the Middle East North Africa and Eastern Europe and Central Asia regions, challenges arise in the work targeting young people from key populations; limited information on these young people make it difficult to design effective programmes. The dominating generalized epidemic agenda limits the available resources for high-impact interventions needed for young people in key populations. Policy and legal barriers also prevent services from reaching these young people, and condom costs are a constraint.

### Future plans

399. Global-level support will be provided to analyse bottlenecks on adolescents and youth services, and for a global action framework on adolescents and HIV. There will also be increased support for scaling up adolescent/youth HIV testing and counselling, treatment and care, including access to sexual and reproductive health services.
400. Guidance for government self-assessment of consent policies and for programming and policymaking for key populations and minors will be developed.
401. Comprehensive sexuality education will be scaled up as will condom programming for dual protection.

## Ensure high-quality education for a more effective AIDS response

### Achievements

402. The Inter-Agency Task Team on Education (UNICEF, UNFPA, ILO, UNESCO, WHO), developed a series of communication tools to advocate to the health and education sectors for policies and programmes supporting HIV education. The team administered the Global Progress Survey of the education sector response to HIV, including 39 country situational reports, trend analyses and a publication detailing analysis and recommendations.
403. UNESCO developed a sexuality education review and analysis tool and is using it in 14 countries. UNICEF completed a Global Life Skills Education Evaluation that reviewed documentation from 40 countries and provided detailed recommendations.
404. UNESCO provided technical support to education ministries in 75 countries to strengthen the education sector's response to AIDS, and more than 20,000 education staff were trained.
405. UNESCO and UNICEF trained and supported education management information system staff in Jamaica, Namibia, South Africa, the United Republic of Tanzania, Viet Nam and Zambia to use and analyse HIV-sensitive indicators, while UNESCO, UNICEF and UNFPA trained 105 curriculum developers from 17 countries in designing effective comprehensive sexuality education curricula. In total, UNFPA has worked with 38 ministries of education curriculum developers.
406. Regionally, UNESCO mobilized US\$ 7.2 million to intensively scale up comprehensive sexuality education in six focus countries in Eastern and Southern Africa and to support efforts in a further 10 countries in the region. UNFPA trained young people in HIV prevention in 13 countries, reaching about 3.2 million people in the region. UNESCO also published a review of policies and strategies to implement and scale up sexuality education in Asia and the Pacific.
407. As part of education-sector efforts to address harmful gender norms that drive the HIV epidemic in the Caribbean, UNESCO, UNICEF, the University of the West Indies and the Caribbean Community Regional Working Group on Health and Family Life Education helped deliver comprehensive sexuality education by developing the capacity of teachers and increasing access to teaching and learning resources. ILO also trained 28 peer educators from 12 Caribbean countries in HIV programming, and UNFPA provided technical support to the education and health ministries to deliver sexual and reproductive health curricula in Barbados and Jamaica.
408. Advances in online education programmes were another key achievement in 2012. Web-based, youth-led advocacy and awareness-raising campaigns on HIV, stigma and sexual and reproductive health reached more than four million young people in Eastern Europe and Central Asia. They were referred to two interactive web platforms designed for adolescents seeking HIV/sexual and reproductive health information and services. Educational institutions in Central Asia and Ukraine were equipped with training materials (e-courses, student books) and given technical guidance to improve the quality and scale up of HIV and sexual and reproductive health education being integrated into health and life skills courses and subjects.

409. UNDP, partnering with the International Development Law Organization (IDLO), developed and launched an e-course on HIV and the law, targeting a broad audience of stakeholders, including government officials. This was the first virtual training in this field to be carried out in the Russian language.
410. The UNESCO e-course Building teachers' knowledge on HIV was widely disseminated among teacher training institutions across the EECA region. The course was incorporated into other training courses and used also to train peer-educators.

### **Issues and challenges**

411. The role of HIV education as a critical enabler is not well understood by some partners in the AIDS response, and a more careful analysis is required of how the education sector contributes to the response in different epidemiological settings. The communications and advocacy tools developed by the Inter-Agency Task Team on Education will help to address this challenge.
412. Promoting comprehensive HIV and sexuality education is often challenging because some essential topics, including condoms, safer sex and sexual diversity, are often excluded from school curricula in many countries, and many teachers have not developed the necessary knowledge and skills on these issues.
413. There are still conservative elements that politicize education and resist comprehensive sexuality education, saying sex education encourages promiscuity, despite strong evidence to the contrary.
414. Programming on HIV and sexuality education in the regions and countries needs to be aligned with policy and curriculum review cycles to facilitate country ownership. It is critical to explain education's dual contribution in the AIDS response: that health education addressing HIV and sexual reproductive health contributes to the basic programmes of the AIDS response; and that general education is a short- and long-term protective factor.

### **Future plans**

415. In 2013, the Joint Programme will expand the evidence base and continue building countries' capacities to plan, programme, implement, and scale up comprehensive HIV and sexuality education programmes.
416. Under UNESCO' leadership, a 21-country report will inform an Eastern and Southern Africa Ministerial Commitment, to be developed and signed by education and health leaders in late 2013. UNFPA, UNICEF and other Cosponsors will provide technical and/or financial support. UNESCO will adapt the SERAT tool for civil society organizations (CSERAT) to use and produce an analysis on the sexuality education needs and challenges for young people in seven countries in West and Central Africa.
417. Continued country support will be provided to integrate HIV-sensitive indicators in national education management information systems. UNFPA will co-chair the Secretary-General's Sector-Wide Action Plan on Youth, finalizing the workplan and implementing activities. UNHCR will continue providing education, awareness and life-skills training to children in and out of school, with or without parents, from HIV-positive and HIV-negative families in all refugee operations.



## Scale up HIV workforce policies and programmes

### Achievements

418. At the global level, ILO worked with UNICEF, WHO, the Secretariat, GBCHealth and GNP+ to organize a global training course, 'HIV and AIDS and the world of work: a prevention and social protection perspective'. National HIV and social protection experts participated which contributed to developing a network of knowledgeable experts at the country level who are at the forefront of efforts to implement HIV policies and ensure people affected by HIV have access to social protection.
419. At the regional level, ILO worked closely with IOM, WHO, the Southern African Development Community, the World Bank and other national partners to develop the community's guidelines on TB, HIV and Silicosis. The guidelines will be signed by the Council of Ministers (including health and labour) before being put into operation in the 15 countries in the region where the HIV burden is highest.
420. Working with national governments and sectoral institutions, employers, workers and their organizations, ILO provided technical support to review and/or develop codes of practice on HIV and the world of work, workplace policies and programmes in several countries, including Malawi, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe. Following tripartite capacity-building exercises by ILO, six Caribbean countries began developing or revising national workplace policies. These countries also signalled their intention to implement workplace programmes with participating agencies from the public and private sectors.
421. Private sector mobilization programmes include an ILO initiative in Guyana involving 15 companies and more than 23,000 workers. Thirteen of the companies had developed HIV workplace policies, and the other two had drafted policies. ILO also mobilized the private sector in Jordan and Lebanon, building consensus for workplace initiatives to provide young men and women with comprehensive HIV information.
422. With ILO technical and financial support, Armenia, Azerbaijan, Kazakhstan, Russia, Tajikistan and Ukraine developed national tripartite workplace strategies on HIV prevention in the workplace. ILO supported ministries of labour, and employers' and workers' organizations to design these workplace strategies, and ultimately, in the national responses to HIV in their countries. Targeted interventions in Russia and Tajikistan to involve law and law enforcement authorities will serve as models for other countries to consider.
423. ILO provided training, tools and technical guidance to world of work actors in 20 countries on HIV/tuberculosis workplace programmes and policies.
424. UN Plus, the HIV-positive UN staff group, conducted a study with UN Cares, the UN system-wide workplace programme on HIV, on the UNICEF-Van Breda Health and Wellness Programme. UN Plus also collaborated with the International Planned Parenthood Federation (IPPF+) and the Red Cross Red Crescent Network of People Living with HIV (RCRC+), workplace-based networks of people living with HIV, at the AIDS 2012 conference to raise awareness of HIV-related issues in the workplace, particularly stigma and discrimination.

## Issues and challenges

425. There are still relatively high levels of HIV-related stigma and discrimination in employment. In some countries, there is a perception that HIV workplace programmes are not as important as other health interventions in responding to the epidemic. This leads to workplace programmes being deprioritized when countries have to ration limited financial resources.
426. In many countries with concentrated epidemics, a better understanding of how HIV workplace programmes reach out to key populations is required to enhance their appeal.
427. Programmes that adequately reach vulnerable mobile and migrant workers have been limited in scope and coverage. Mobile workers and migrant workers should have access to all the HIV services they require whether in the sending, transit or receiving countries. This is often not the case.
428. More robust evidence on how HIV workplace programmes contribute to national HIV targets is needed to strengthen advocacy for such programmes.

## Future plans

429. Generating strategic information that demonstrates the link between HIV workplace programmes and national HIV prevention, treatment and human rights targets and how such programmes address the specific needs of key populations, including lesbian, gay, bisexual and transgender people and mobile/migrant workers, is a key priority for 2013.
430. Multicountry studies on how HIV workplace programmes best achieve good outcomes will be completed and the findings disseminated across the HICs. Generating information on global estimates of HIV incidence among working populations and highlighting the impact of HIV on the workforce will serve as a global guide to countries and inform the working populations they prioritize.
431. The scale-up of basic programmes drawing on investment approaches through HIV workplace programmes will be accelerated and there will be a stronger focus on reducing stigma and discrimination within the workplace, as this is the first step towards reducing stigma within communities. Workplace programmes addressing the needs of migrant and mobile workers should also focus on ensuring social protection for these groups.

## Integrate food and nutrition within the AIDS response

### Achievements

432. Food and nutrition was firmly placed on the AIDS response agenda in 2012. Prior to the AIDS 2012 conference, UNICEF, WFP, WHO and the Secretariat jointly organized a one-day meeting on food and nutrition in the AIDS response. The meeting brought together UN partners to discuss how food and nutrition have evolved from treatment mitigation to enablers of treatment and how they increasingly contribute to adherence and retention in care. A subsequent stakeholder meeting of UN agencies, academia and civil society created an IATT on Food and Nutrition to improve partner collaboration and promote the food and nutrition policy agenda within the AIDS response. Three sub-working groups were set up on resource mobilization and advocacy, research and programmes.

433. Several publications also promoted food and nutrition as critical enablers in the AIDS response. *Adherence and food and nutrition in the context of HIV and TB*, which many task team members worked on in 2012 for publication in 2013, will describe the barriers that prevent people living with HIV from accessing treatment and care services, and adhering to treatment, as well as the role of food and nutrition interventions in overcoming these barriers. UNHCR published *an introduction to cash-based interventions in UNHCR operations* to encourage a proactive approach to using and scaling up such programmes.
434. A paper on paediatric HIV and nutrition, *Integration of nutritional support with paediatric HIV care in developing countries*, was published, and a long-term research partnership between WFP and the University of California in San Francisco will lead to the publication of four joint articles between 2013 and 2014 on HIV, food insecurity and nutrition.
435. Using UBRAF funds, a tripartite partnership between the Thai Red Cross AIDS Research Centre, Albion Street Centre and WFP established the Asia Pacific Collaborating Centre on HIV Nutrition. It will train health professionals in HIV and nutrition, conduct research, engage policymakers and support WFP country offices and governments in selected countries to integrate food and nutrition into GFATM proposals. The first training session was held in early 2012.
436. WFP technical support and assistance was provided to 18 countries in the West and Central Africa region to integrate food and nutrition within the AIDS response. As a result, 137,000 people living with HIV and affected household members were targeted with food and nutrition support through antiretroviral therapy, tuberculosis and prevention of vertical transmission, as well as through programmes for orphans and other children made vulnerable by AIDS.

### Issues and challenges

437. Competing priorities mean food and nutrition support is often one of the first interventions to be deprioritized. Many organizations working on food and nutrition interventions for people living with HIV were severely hampered by the cancellation of the GFATM Round 11, which affected country stakeholders' access to resources in 2011.
438. Refugees are rarely integrated into national HIV food and nutrition strategies, and refugee people living with HIV do not generally benefit from any specific food and nutrition support except through the collaboration with WFP and UNHCR.
439. Food and nutrition stakeholders have struggled to contribute to the evidence base, despite having large HIV programmes that could help generate new evidence.

### Future plans

440. The IATT on Food, Nutrition and HIV priority areas are programme implementation, including service supply; supporting people living with HIV overcome barriers to accessing those services; research; and resource mobilization. Countries will be supported to undertake situation analyses to determine needs and identify programmatic and coverage gaps, and to build capacities to plan, fund, implement and evaluate their food and nutrition support programmes.

441. Team members will also increase their efforts to strengthen the capacity of country stakeholders to work with partners to access GFATM allocations.
442. Implementers will expand cash and voucher interventions to enable malnourished people living with HIV to obtain their food closer to home. This will also strengthen local economies and decrease operational administrative costs.

## Address HIV in humanitarian emergencies

### Achievements

443. At the global level, UNHCR and WFP worked with key sectors and humanitarian cluster leads to integrate HIV interventions into multiple areas of the humanitarian response, including protection, health, food security, shelter and education. UNICEF and the Secretariat also commissioned work on HIV and adolescents in emergencies to recommend how to improve responses to that group's needs.
444. At the regional level, UNHCR chairs the Inter-Agency Working Group on Gender-Based Violence and HIV in emergencies in which Cosponsors and NGOs also participate. In the Eastern and Southern Africa region, the working group supported countries to mainstream HIV in national contingency plans and to include populations of humanitarian concern in HIV strategies.
445. The IATT on HIV in Emergencies developed a [website](#) that is a resource for country and regional programmes. Organized according to three themes – key populations at higher risk, other populations of concern and prevention, treatment, care and support – the website's content will be the basis to further develop a technical assistance strategy.
446. The UN Inter-Agency Working Group on Disarmament, Demobilization and Reintegration developed a resource package to integrate gender and HIV. In partnership with the International Rescue Committee, UNHCR, UNICEF, UNFPA, and WHO, the Working Group created a multilevel system for collecting gender-based violence incident data in humanitarian settings. The system, known as GBVIMS (Gender-Based Violence Information Management System), is already considered in the health and psychosocial sectors as a model for best practice in managing such data.
447. Training was another key achievement in 2012. UNICEF worked with the Women's Refugee Commission to develop a training tool to assist communities to respond to sexual violence in humanitarian settings. It will train community health workers on how to refer those who have experienced sexual violence and to provide care when referrals are not possible. The project aims to advance and implement approaches to primary prevention of gender-based violence, especially sexual violence against women and girls affected by conflict and disaster. The continuing project will develop evidence-based best practices.
448. UNFPA also supported the training of 2,700 service providers and programme managers in the Minimum Initial Service Package on Reproductive Health, and country-level training has been provided to scale up the Inter-Agency Standing Committee guidelines on HIV in emergencies. Kenya and South Sudan, in particular, benefited from this support. All new refugee influxes during the year had UNHCR-led HIV programmes in line with the Inter-Agency Standing Committee guidelines.

449. In Latin America, the Regional Inter Agency Task team on HIV in Humanitarian Settings, led by UNHCR and WFP and with technical support from the Secretariat, engaged in project coordination, advocacy, analysis and training on HIV in humanitarian settings. This included developing emergency planning for HIV; preparing and disseminating material and tools on HIV for humanitarian settings; advocacy to raise awareness of the need to include HIV in the humanitarian response; and disseminating the new version of the Inter-Agency Standing Committee Guidelines for Addressing HIV in Humanitarian Settings.

### **Issues and challenges**

450. HIV is rarely perceived as a priority during emergencies, particularly at the onset, yet the large number of new emergencies in 2012 and the resulting commitment by agencies to respond slowed down some of the broader plans of the Inter-Agency Task Team. Coordinating the team requires dedicated resources that are being stretched by increased discrimination against migrants, asylum seekers and refugees at a time when the global financial crisis has reduced funding for emergency responses.

451. Existing monitoring systems and data on addressing HIV in emergencies are limited.

### **Future plans**

452. UNHCR and WFP will engage humanitarian clusters on their experiences using HIV guidance notes and build on successful sex work programmes, integrating gender-based violence into HIV interventions and work with people who inject drugs in humanitarian settings. A more cohesive approach to working with other key populations in emergency settings will be developed and there will be continued advocacy for appropriate HIV interventions to be included in contingency plans for conflict-prone regions and at the onset of emergencies.

453. UNFPA will continue advocacy and technical support (including training) for implementing the Minimum Initial Service Package on Reproductive Health in all acute emergency crises.

454. Access to antiretroviral therapy for displaced populations and economic migrants will be scaled up through UNAIDS-led global outreach and special initiatives. UNHCR will consult on this subject, with a wider stakeholder consultation to follow.

[Annex follows]

**Annex 1: Total expenditure in 2012 at global level, by high impact and other countries (US\$)**

Agency	Global	30+ HICs	AP	CAR	EECA	ESA	LA	MENA	WCA	TOTAL
<b>UNHCR</b>	2 893 500	5 548 000	2 108 600	149 000	152 200	2 913 500	526 100	489 900	1 740 600	<b>16 521 400</b>
<b>UNICEF</b>	6,279,500	48,693,000	9,533,700	1,241,200	2,136,800	21,102,100	1,579,700	1,917,500	10,020,400	102,503,900
<b>WFP</b>	1 008 200	193 557 800	127 300	17 700	17 700	461 300	203 100	37 900	302 500	<b>195 733 500</b>
<b>UNDP</b>	3,142,400	121,237,800	5,297,400	5,366,600	26,917,900	30,177,200	2,600,400	14,251,400	10,486,700	219,477,800
<b>UNFPA</b>	18 566 500	40 452 800	1 140 000	736 400	4 323 400	3 250 800	8 168 100	4 766 400	3 452 300	<b>84 856 700</b>
<b>UNODC</b>	1 663 800	8 289 000	2 811 600	71 700	1 966 400	770 500	365 300	2 025 500	311 300	<b>18 275 100</b>
<b>UN Women</b>	611 000	5 108 300	271 700	79 300	14 800	-	-	-	559 200	<b>6 644 300</b>
<b>ILO</b>	4 587 500	7 101 100	491 200	513 100	359 000	341 200	335 900	347 100	605 400	<b>14 681 500</b>
<b>UNESCO</b>	2 185 200	5 059 600	821 200	367 000	672 200	1 162 700	546 300	385 200	1 101 700	<b>12 301 100</b>
<b>WHO</b>	45 163 100	29 203 100	15 093 500	852 100	4 446 400	4 702 500	1 702 500	13 016 900	3 412 500	<b>117 592 600</b>
<b>World Bank</b>	10 534 400	1 498 974 100	251 666 000	24 915 800	20 580 600	388 916 900	35 561 300	2 033 100	267 922 400	<b>2 501 104 600</b>
<b>Secretariat</b>	88 663 600	42 039 100	12 518 800	3 442 200	5 151 500	7 265 900	5 888 200	5 003 900	11 758 800	<b>181 732 000</b>
<b>Grand Total</b>	<b>185,298,700</b>	<b>2,005,263,700</b>	<b>301,881,000</b>	<b>37,752,100</b>	<b>66,738,900</b>	<b>461,064,600</b>	<b>57,476,900</b>	<b>44,274,800</b>	<b>311,673,800</b>	<b>3,471,424,500</b>

<sup>[1]</sup> 31<sup>st</sup> PCB in December 2012 under the report of the Executive Director decided to: “Note with appreciation the leadership of the African Union in developing its Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria and encourages UNAIDS, including its Cosponsors, and key stakeholders, to support African countries, in accordance with national priorities, with strong attention to evidence and human rights, to implement, as appropriate the African Union Roadmap to help achieve the 2011 UN General Assembly HLM on AIDS targets and inform the Post-2015 UN development agenda”

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