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28 May 2007

20th Meeting of the UNAIDS Programme Coordinating Board
Geneva, Switzerland
25-27 June 2007

Provisional agenda item 4.1:

**Report on the progress on follow-up support to countries in their
national target setting towards universal access**

Additional documents for this item: none

Action required at this meeting - the Programme Coordinating Board is requested to:

- i. Request the UNAIDS Secretariat, in collaboration with the Cosponsors, to develop and endorse an accountability and reporting mechanism for UNAIDS to deliver on the recommendations in the Universal Access Assessment Report and present a progress report of its utilization at the June 2008 PCB.
- ii. Request the UNAIDS Secretariat to monitor progress towards the goal of universal access by providing regular assessment of the status of countries' integrated plans and their financing as part of the annual monitoring of the epidemic.

Cost implications for decisions: none

Introduction

1. This report to the UNAIDS Programme Coordinating Board provides a progress overview of the implementation of Universal Access and the lessons learned, with specific focus on progress achieved so far concerning national target-setting and strategic plans and the coordinated actions to address the earlier identified obstacles to universal access.

Background

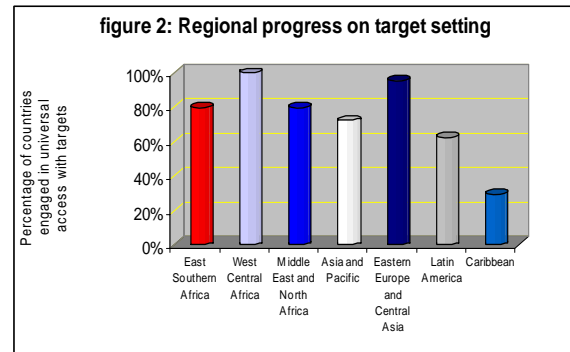
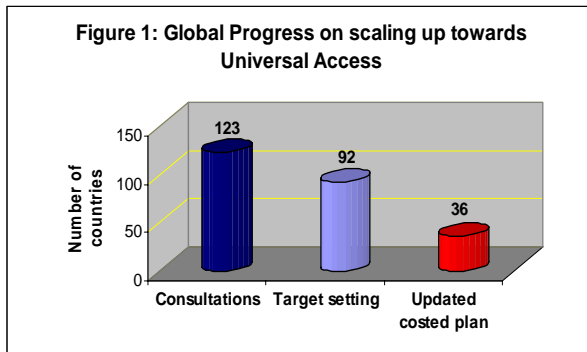
2. At the 2001 UN General Assembly Special Session on HIV/AIDS, UN Member States committed to work towards achieving the 2015 Millennium Development Goals and set global targets accordingly. The 2005 review of achievements towards the UNGASS targets however revealed limited progress and an urgent need for scaling up national responses. Member States thus agreed to move towards universal access to prevention, treatment, care and support by 2010, building on the G8 Gleneagles Communiqué. UNAIDS was requested to assist in facilitating inclusive, country-driven processes aimed to define actions to address obstacles to universal access, and to present the outcomes of these consultations to the 2006 UN General Assembly. Among the commitments made by Member States at the 2006 High-Level Meeting on AIDS, was the setting of ambitious targets in each of the programmatic areas of treatment, prevention and care for 2010, by Member States – through a participatory process.

3. Recent WHO data¹ underscores the real but limited progress: at the end of 2006, coverage of children in need of AIDS treatment was only 15%; around 28% of people in need of antiretroviral treatment were accessing these medicines and an estimated 11% of HIV-infected pregnant women in low- and middle-income countries were receiving antiretrovirals for prevention of mother-to-child transmission of HIV. Universal access aims to address these imbalances, ensuring that the scaling up process builds on existing efforts; is country-owned and country-led, involving partners, in particular civil society; promoting aligning of resources with national priorities; and ensures greater involvement of people living with HIV.

PCB decisions related to Universal Access

4. At its 19th Meeting, the UNAIDS Programme Coordinating Board recognized the need for
- continued follow-up support to countries in their national target setting towards universal access for comprehensive HIV prevention programmes, treatment, care and support, in particular the facilitation of coordinated strategies to overcome identified obstacles to scaling up; further recognized the importance of ensuring that targets are gender disaggregated;
 - requested UNAIDS to report on progress at the June 2007 Programme Coordinating Board meeting. In doing so UNAIDS should access additional data sources, including independent reports from civil society and academic institutions.

¹ WHO 2006 progress report



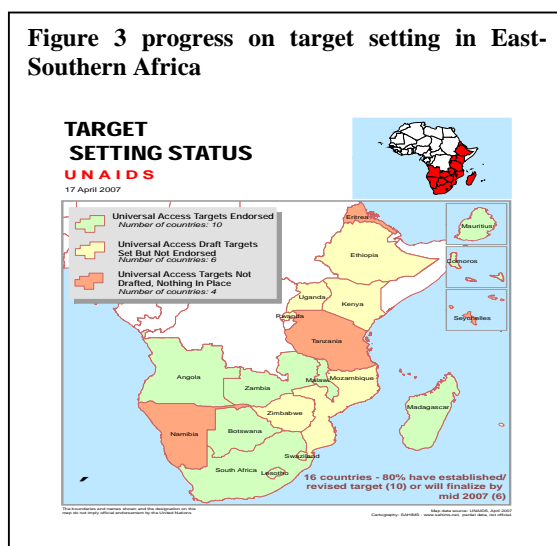
Progress made

Significant progress on target setting

5. Since the UN 2006 High Level Meeting on AIDS, countries have made significant progress in setting national targets moving towards universal access, as well as strategic planning thereby utilizing the UNAIDS recommended outcome indicators. By March 2007, 92 of the 123 countries, that had organized country consultations on obstacles to universal access, had set outcome targets² for universal access, while 36 countries had incorporated these targets into their national strategic plan and costed it accordingly (see figure one).

6. Progress on target setting varies across the regions, as demonstrated in figure two. This can be attributed to differences in the local context, including implementation environment internal conflict, governance, and planning cycles.

7. The map on East-Southern Africa (figure three) illustrates that there is also variation in progress across countries. At the time of the report, governments of ten countries had endorsed the targets on universal access, while five countries were in the process of obtaining government endorsement. The remaining four countries are in the process of setting targets.

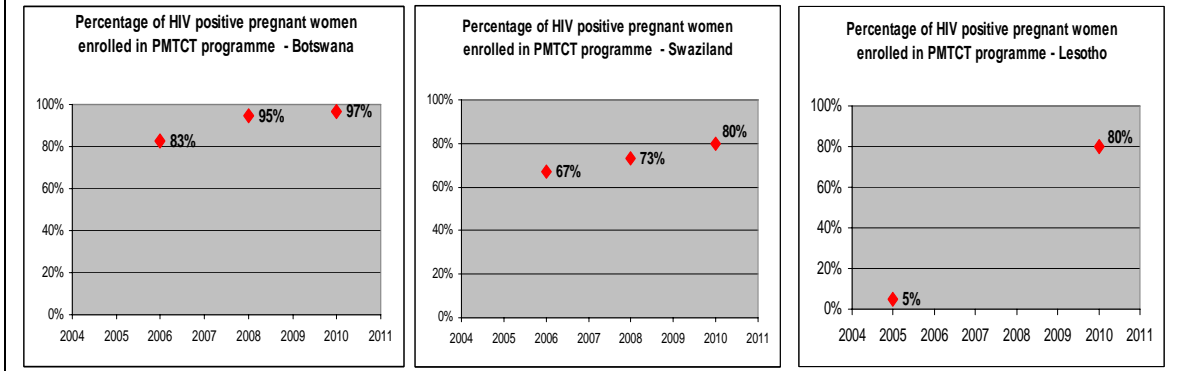


8. Of the 92 countries with targets, 81 countries (87%), have set a target for treatment and a further 84 (94%) set a target for at least one major prevention intervention. Just over half of countries set targets for critical prevention interventions, such as HIV testing, condom availability, and knowledge and behaviour change among young people, with some regions, e.g. Latin America and the Caribbean, scoring less. Almost all regions show a difference in terms of coverage of the different prevention interventions, as discussed below. In general, the targets are only to a limited extent gender disaggregated.

9. Countries highlighted the need for national target setting rather than global processes, given the different local contexts and

² Considerations for countries to set their own national targets for HIV prevention, treatment and care, UNAIDS, (2006)

Figure 4: National coverage and targets set on prevention of mother-to-child transmission of HIV (PMTCT), Botswana, Swaziland, Lesotho



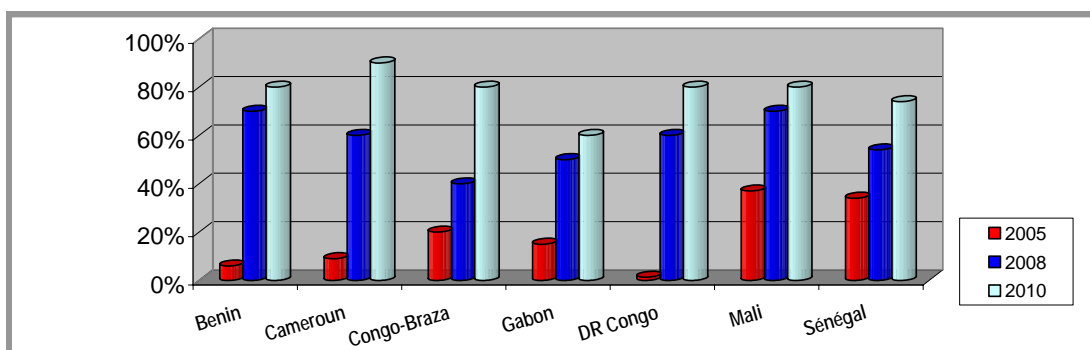
challenges. Figure four, presenting the difference in coverage and targets set by Swaziland, Botswana and Lesotho for prevention of mother-to-child transmission of HIV, underlines this observation. These three middle-income countries, with the highest HIV prevalence rates in the world, have different starting points for their national scale up and have chosen differing rates of scaling up.

10. Countries have gone to great lengths to facilitate national ownership; for example, Seychelles intentionally slowed down its country target setting process to ensure national ownership, involving relevant partners. Other countries, such as Kazakhstan and Morocco, succeeded in harmonizing the universal access targets with already advanced planning processes.

11. Countries have generally made deliberate decisions about the level of the targets, based on a calculated review of current coverage, overcoming identified obstacles and the availability of resources. For example, Morocco undertook a risk analysis to assess the feasibility of their targets. Russia developed a methodology to guide target setting procedures, not only defining the indicators and the level of the targets, but also clarifying the method of calculation, the source and the method of data collection. In other circumstances, countries have set deliberately high ambitious targets, either to catalyze accelerated action, e.g. Lesotho, or to reflect the “equitable access policy” of the concerned country, as was the case in Viet Nam and Kyrgyzstan.

12. Many countries have set ambitious targets to guide their scaling up process, often more than doubling or tripling their baseline coverage, as shown in the graph below on intended scaling up of prevention of mother-to-child transmission in selected countries in West and Central Africa. Swaziland decided to set its treatment target at 60%, based on perceived need, despite a projected feasibility of 38%. Similarly Kazakhstan, committed to contain the concentrated nature of their HIV epidemic, aims for 50% adherence to safe injecting behaviours by 2010; a highly ambitious target given the cultural stereotypes and the generally difficult to reach populations.

Figure 5: Coverage and targets for PMTCT, selected countries, West Central Africa



Text box 1: Universal Access targets an integral part of the macro economic framework: Mauritania

Recognizing the importance of undertaking scaling up towards universal access within the national development framework, the Government of Mauritania used the newly set universal access targets in their Strategic Plan, to guide the AIDS component in the Medium Term Expenditure Framework (MTEF). With technical support from UNAIDS, the country estimated annual costs per HIV thematic area, based on the targets. The National AIDS Commission was thus able to 1) Forecast financial resources needed to achieve objectives of National Strategic Plan; 2) Estimate additional budgets needed for the scaling up, taking into account the overall budget development of the country and the support provided by donors; 3) Allocate provisionally available funds.

Learning from this experience, national managers and stakeholders realized that the MTEF was a powerful tool to negotiate with state and non-state stakeholders. Linking the national strategic plan with the MTEF was also helped in mobilizing domestic resources behind the national HIV response. The financial justifications are expected to be equally useful during negotiations with donors for additional resources. Finally, stakeholders recognized the opportunity of increased mutual accountability by integrating the monitoring of expenditures into national monitoring and evaluation framework.

Moving on: developing "costed national AIDS plans"

13. Review of the scaling-up processes shows that countries utilized different approaches to integrate targets into the broader national AIDS strategy. Many countries, as is the case in many parts of Eastern Europe and Central Asia, have undertaken target setting as part of the development of the new national HIV Strategic Plan. Other countries, such as Malawi, have incorporated the newly set targets into their existing national strategic plan and updated it accordingly. In other cases, demonstrated in Ghana and Swaziland, target setting occurred just after their strategic planning cycle had been completed, and they consequently chose to incorporate the targets during the next review of the existing plan. Many countries across West and Central Africa, have utilized the Annual Action Plan pending revision or development of their Strategic Plans, as a way to immediately act on the targets set and the identified obstacles.

14. Some countries have also set targets as part of broader development frameworks, thereby not only giving the targets more prominence but also assuring that in due course, appropriate resources would be allocated or mobilized for implementation. In Burundi, HIV/AIDS has been mainstreamed into the Poverty Reduction Strategy Paper, while Mauritania offers a good example of using the targets to guide the AIDS component within the Medium Term Expenditure Framework. Cambodia meanwhile, committed to achieving universal access as part of the broader objective of meeting the Millennium Development Goals. In Somalia, universal access targets have been conceptualised as the mid-point in achieving the Millennium Development Goal six to halt and reverse the spread of HIV by 2015.

15. Recognizing that costed national AIDS plans are prerequisite to successful scaling-up, a total of thirty-six countries have already moved ahead and defined the actions and the costs needed to accomplish their targets. Countries have adopted various resource mobilization strategies to fund these plans, ranging from utilization of the 7th Round of the Global Fund, donor round tables, to an increase in domestic funding. For example, Swaziland, Kenya, Botswana and Comoros plan a doubling or even tripling the 2005-6 national allocations of funds to HIV/AIDS by 2010. Romania plans to domestically fund more than half of the projected total resource requirements for scaling up. Kenya is considering the application of a tax levy and the expansion of the hospital insurance fund to include the provision of ARVs.

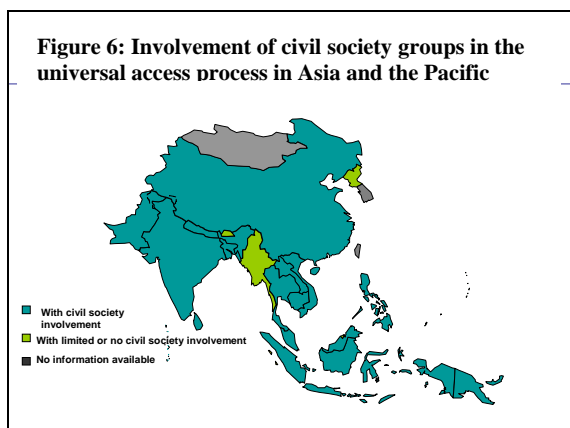
16. Many of these countries are however left with a considerable funding gap, ranging from 31 million USD out of a reported need of 53.7 million USD in Kazakhstan, to 282 million USD out of a total need of 541 million USD for the strategic plan in Ghana. Few countries have managed to mobilize adequate additional resources so far, mainly using the big funding initiatives in terms of Global Fund, the World Bank MAP, and PEPFAR, where present.

17. Several countries are defining strategies for scaling up. Ethiopia is currently operationalizing task shifting and undertaking training of 50,000 lower cadre health workers in support of scaling up. Kenya demonstrated that decentralized action is an effective strategy to scaling up. Within the Rapid Results Initiative, districts were asked setting targets to be achieved in 100 days, resulted in a rapid increase in the number of people on antiretroviral treatment, underlining that scaling up is possible, when national commitment is put into action.

Increasing civil society participation

18. Almost all countries have confirmed the involvement of civil society throughout the target setting processes, as illustrated by figure 6 below, showing civil society involvement in Asia and the Pacific. Many countries undertook special efforts to ensure greater involvement of civil society. This was for example the case in Malawi, where a number of civil society organizations got together and established a coalition, which enabled wider involvement of civil society in the target setting process as well as increased discussion on the ambitiousness of targets.

19. Country reports testify to the value brought by such partnerships. In many cases the scaling-up process has led to increased dialogue between civil society and governments. For example, civil society groups in Russia established dialogue on indicators, specifically



addressing concerns of populations at higher risk. The country-level target setting process also enabled the involvement of partners otherwise sidelined and excluded from decision-making such as sex workers, people who inject drugs and people living with HIV themselves. For example, in Cambodia, participation of the network of people injecting drugs in the target setting process supported the setting of more ambitious targets, in response to their concerns.

Coordinated UN action to address obstacles to scaling up

20. The 19th Programme Coordinating Board (PCB), requested UNAIDS to provide a progress report on the facilitation of coordinated strategies to overcome identified obstacles to scaling up, during its next meeting in June 2007. Earlier, at the request of the UN General Assembly, the UNAIDS Secretariat and Cosponsors facilitated country-led consultations to develop practical strategies for moving towards universal access. Through this process, obstacles to scaling up towards universal access were analyzed and actions defined to overcome them.

21. The UNAIDS Assessment Report³, summarizing the recommendations of these consultations, served as a critical input into the 2006 UN High Level meeting and became the basis of the 2006 Political Declaration, endorsed by all UN Member States.

³ UN General Assembly document A/60/737, Towards universal access: assessment by the Joint United Nations Programme on HIV/AIDS on scaling up HIV prevention, treatment, care and support.

Text box 2: Recommendations for reaching Universal Access, as per consultations*

1. Setting and supporting national priorities

No credible, costed, evidence-informed, inclusive and sustainable national AIDS plan should go unfunded

2. Predictable and sustainable financing

Meet AIDS funding needs through greater domestic and international spending, and enable countries to have access to predictable and long-term financial resources.

3. Strengthening human resources and systems

Adopt large-scale measures to strengthen human resources to provide HIV prevention, treatment, care and support, and to enable health, education and social systems to mount an effective AIDS response.

4. Affordable commodities

Remove major barriers—in pricing, tariffs and trade, regulatory policy, and research and development—to speed up access to affordable quality HIV prevention commodities, medicines and diagnostics.

5. Stigma, discrimination, gender and human rights

Protect and promote the AIDS-related human rights of people living with HIV, women and children, and people in vulnerable groups, and ensure that they are centrally involved in all aspects of the response.

6. Accountability

Every country should set in 2006 ambitious AIDS targets reflecting the urgent need to massively scale up HIV prevention, treatment, care and support and move as close as possible to universal access by 2010.

***Towards universal access: assessment by the Joint United Nations Programme on HIV/AIDS on scaling up HIV prevention, treatment, care and support, UNAIDS 2006**

22. A first major step towards a joint approach to address these obstacles to scaling up was the development of the 2007-2010 Strategic Framework⁴ by UNAIDS, undertaken at the request of the PCB. The Framework seeks to support countries to move towards universal access and to facilitate follow-up to the High Level Meeting in a coordinated manner and clarifies the Cosponsors' areas of responsibility for universal access, in line with the Division of Labour.

23. UNAIDS also defined its 2008-2009 Unified Budget and Workplan (UBW) in support of scaling up towards universal access. The UBW specifically focuses on the provision of more effective country support, including: i) support for the development and implementation of national action plans that incorporate targets on universal access; ii) technical support to overcome implementation bottlenecks and improve effectiveness of resources; and iii) civil society engagement, in particular meaningful involvement of people living with HIV.

24. In the meantime, the UNAIDS Secretariat and its Cosponsors --in response to the country level obstacles—have further expanded their country support, including:

- development of evidence-informed practical approaches to scale up prevention (UNAIDS)
- technical assistance for countries for the development and costing of national strategic plans to guide scaling up (World Bank)
- facilitating resource mobilization efforts through the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (UNAIDS)

⁴ UNAIDS, Follow-up to the 2006 Political Declaration on HIV/AIDS, 2007-2010 Strategic Framework for UNAIDS support to countries' efforts to move towards universal access. UNAIDS, Geneva, 2007.

- development and implementation of strategies for addressing the human resource crisis in the health sector (WHO)
- agreement with major funding partners to better coordinate technical support, to make the money work (the UNAIDS Secretariat and WHO)
- support to countries on incorporating HIV and AIDS in poverty reduction strategies (UNDP)

25. While the 2006 Political Declaration contains several recommendations –adopted by UN Member States— to address country-level obstacles to universal access, the UNAIDS Assessment Report provides valuable guidance on the operational actions to be taken. In order to accelerate these actions, UNAIDS is developing an accountability framework, supported by a monitoring tool. The monitoring tool, meant for the UNAIDS Cosponsors and the Secretariat, aims to better coordinate the global actions to be taken. In addition, it strives to advance accountability for results within UNAIDS, in particular at the country level, in accordance with the UNAIDS Division of Labour.

Challenges and lessons learnt

Obstacles to target setting

26. Various factors have impacted upon the progress made in setting ambitious national targets. Firstly, many of the identified obstacles to scaling-up do not only impact on the current pace of scaling up, but have also affected the ability of countries to actually set ambitious targets. For example, the unpredictability of funds had a strong bearing on the target setting process in Cameroon, while the human resource crisis impacted on the level of the targets set in Burkina Faso. Swaziland and Madagascar reported that their health systems capacity was a major constraining factor for setting more ambitious targets. Other countries, e.g. Russia, have legal frameworks in place that prohibit the setting of targets for specific interventions, such as condom use by sex workers and substitution treatment for injecting drug users.

27. Secondly, lack of baseline data and information on the size of most-at-risk populations presented a major challenge to countries in setting targets. In Madagascar, detailed information on the number of people in need of AIDS treatment is lacking, as prevailing stigma and discrimination obstruct people from easily accessing treatment. As a result, the country deliberately set a modest treatment target. Several countries, especially those with concentrated epidemics, have recognized the need to better estimate the number of people at higher risk of HIV infection and have planned surveys accordingly.

28. Thirdly, some partners have expressed concerns about the feasibility of the ambitious targets and the robustness of the underlying process, such as the development of (updated) national plans, costing of these plans and resource mobilization strategies. There is indeed a delicate balance between ambitious and feasible targets and it demands careful consideration of all relevant factors within a given national context to ensure joint action for reaching these targets.

Text box 3: comparing the political and operational recommendations:

2006 UN Political Declaration:

UN Member States pledge to provide the highest level of commitment to ensuring that costed, inclusive, sustainable, credible and evidence-based national HIV/AIDS plans are funded and implemented with transparency.

2006 UNAIDS Assessment Report:

The UNAIDS Secretariat, UNDP and the World Bank will facilitate a participatory process to provide criteria for the development and oversight of prioritized, costed, aligned and evidence-informed national AIDS plans (December 2006)

29. Interestingly, country reports also indicate that the target setting and follow-up were perceived as a rational approach to planning, relatively new to national programmes. In many instances, it helped countries justify their proposal submitted to the Global Fund. In addition, target setting is expected to contribute to more results-based management.

Prevention lagging behind

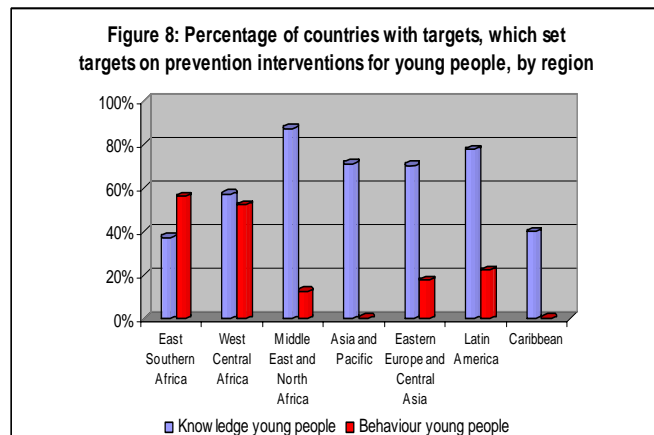
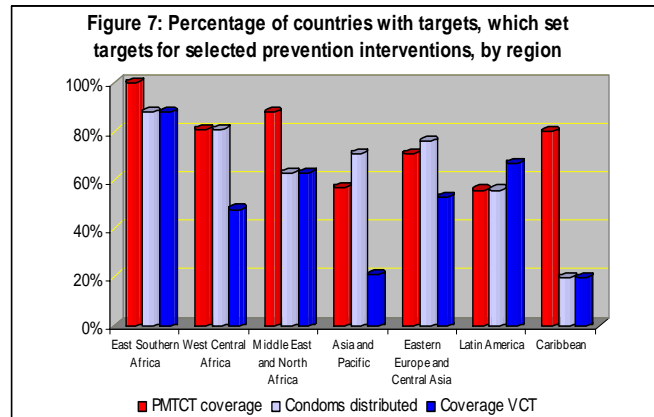
30. A renewed emphasis on HIV prevention is critically needed. In 2006, the number of people on antiretroviral therapy in low- and middle-income countries increased from 1.3 million to about 2 million people, while 4.3 million new HIV infections occurred—the vast majority in low- and middle-income countries. Analysis of the targets confirms that more needs to be done on scaling up prevention, in particular in ensuring a comprehensive approach that accommodates the different but complementary elements of prevention.

31. As shown by figure seven, regions face different challenges in drawing together the various prevention interventions to provide a comprehensive response. Even for well-established interventions—such as distribution of condoms, prevention of mother to child transmission of HIV, and HIV testing and counseling—there is great variation in the percentage of countries with targets covering these three interventions.

32. Figure eight, comparing the targets set for correct knowledge among young people with the targets set for behaviour change among young people, further illustrates that there is still much to be done to establish comprehensive prevention programmes. In only a few regions, prevention programmes on correct knowledge and behaviour change among young people go hand in hand.

Limited indication of harmonization and alignment

33. While the consultative processes have generally proven to be helpful for consensus building on obstacles and targets, country reports do not indicate that the scaling-up process has resulted in better harmonization and alignment. Very few country reports indicate deliberate action by government and partners to jointly work towards achieving universal access targets, on the basis of the national action plan. Moreover, progress on harmonizing targets for the different initiatives, such as the Global Fund, and bilaterally supported projects, with the universal access targets, has been limited. Several countries were confronted with partners later questioning the sustainability of the ambitious targets and plans, often resulting in a down-scaling of their targets and illustrating perhaps a lack of consensus building during the earlier stages of the process.



Inadequate pace

34. While recognizing the significant progress made by countries –in terms of consultations, target setting and planning– the question is whether the pace of progress is sufficient to reach the set targets by 2010. At present, 88% (123) of the low- and middle-income countries have engaged in universal access, 75% (92) of those engaged set targets and only 39% (36) have already integrated the targets into costed plans, allowing acceleration of the national response.

35. A quick review of the plans shows that content and costing are of uneven quality. Many fall short in terms of comprehensiveness --in particular prevention efforts, multi-sectoriality and addressing obstacles. For example, the solid national plans of Zambia and Malawi only address some of the identified obstacles. The plans also provide little recognition of interventions addressing gender-inequalities, nor on promoting integrated delivery of HIV services with areas such as tuberculosis and reproductive health. Costing is hampered by inconsistent use of unit-costs and insufficient incomplete inclusion and quantities of interventions.

36. The development of costed plans is critical for mobilizing additional resources. However, with a few exceptions, countries have so far failed to raise supplementary resources through such plans. The slow progress in mobilizing additional resources does not only reflect the difficulties that many countries have experienced in producing quality plans, but also to some extent the limited commitment on the side of donors to funds these plans.

37. 2010 estimates from the Clinton Foundation, based on linear scaling-up, indicate that only 4.5 million people out of the total number of 9 million, in need of AIDS treatment, will be reached. The current progress on plans and the lack of additional funding may indeed pose a serious threat to universal access. As for now, few countries will initiate acceleration of the national response in 2007 and reach 50% of their 2010 targets – as per the UNAIDS Assessment Report – in 2008.

Uneven partnership with civil society

38. Although progress has been made towards greater involvement of civil society in the national responses, many challenges remain. One key issue is that civil society involvement has not resulted in broad engagement of the different civil society groups and up to the community level. Reports from countries also show that involvement in targeting does not necessarily guarantee involvement in other critical process areas, such as planning, policy dialogue or discussions on resource allocation.

Text box 4: Civil Society Involvement in Latin America

Latin American civil society is organized into eight regional networks representing the most vulnerable groups, including men who have sex with men, sex workers, transsexuals, intravenous drug users, and HIV positive men and women. Through the Horizontal Technical Cooperation Group, an initiative established by national AIDS programmes in Latin America to better coordinate the regional AIDS response, civil society has been fully involved in the consultations on Universal Access and target-setting. Regional networks however have less access to national universal access consultations and policy discussions.

Country-based civil society participated in the national consultations, organized by 18 countries in the region. Despite the fact that civil society would greatly contribute to better understanding national epidemics and outreach to populations at higher risk, civil society was not called upon when planning and policy-making was undertaken.

Networks therefore call upon the need for a more democratic framework for establishing policies and action plans for AIDS at the national level.

39. It appears that governments do not fully appreciate the importance and role of civil society. In many cases, civil society organizations are tolerated as implementing partners, providing services to difficult-to-reach populations, rather than seen as an equal partner, contributing to the national response. As a result, the potential of civil society organizations is underutilized and the services provided tend to be in parallel to mainstream interventions, rather than harmonized with national plans.

40. Related to the above is the observation that civil society is less frequently recipient of available public funds, to support their provision of services, in particular to populations at higher risk of HIV infection. Romania, already ahead of other countries, has legally recognized civil society as a critical partner in the national response. This has however not yet been translated in adequate access to public funds, to support civil society in undertaken priority interventions, e.g. prevention.

Country-level obstacles insufficiently addressed

41. Despite the fact that the Strategic Framework underlines the need for a sustained strategic response, and the UNAIDS Assessment Report provides valuable guidance on operational actions, few systematic efforts have been made so far to address the country-level obstacles and systems issues through global action. For example, the increasing costs of treatment, being a life-long commitment, underline the need for more sustainable commitments and affordable commodities.

42. Furthermore, only a few plans, such as those from Zambia and Burkina Faso, include actions to overcome some of the identified obstacles to scaling-up, raising the question of how scaling up can be achieved while these obstacles remain unaddressed. Failure to address the obstacles will not only affect the goal of universal access, but will also hamper the process of scaling-up, as was well-demonstrated during the target setting.

Next steps for UNAIDS

43. Several actions are needed to support countries with scaling up towards universal access. These will be undertaken in partnership with international funding mechanisms, such as the Global Fund and PEPFAR.

Text box 5: Sustainability of universal access to anti-retrovirals: experiences of Brazil

Brazil provides AIDS treatment to an estimated 165,000 people, including newborns exposed to the HIV virus and those encountering occupational injuries. Being one of the first countries in the world to ensure free access to antiretroviral (ARV) drugs, Brazil has many lessons to share about scaling up towards universal access.

Between 1997 and 2004, Brazil succeeded in a nearly 5 times reduction in the average costs of ARVs, through different strategies, such as local drug production and price negotiations with pharmaceutical companies.

Nevertheless, the ARV drug budget has continued to increase: in 2004, the country spent a total of US\$ 260 million on the procurement of ARVs, of which about 80% was for imported drugs. At the end of 2005, the required funding for ARVs amounted to about 400 million. And it is anticipated that in 2008 US\$ 525 million will be required to treat a total of 215,000 patients, estimated to be in need of ARVs.

The significant increase in the budget, and the high cost of second line and third line treatment, has lately resulted in a debate about sustainability of the free access policy, considering all available options to maintain a human rights approach to universal access.

44. In the first place, UNAIDS will continue to support the remaining low and middle-income countries in finalizing their consultation and target setting process, as a matter of urgency. All countries will be supported with the development and costing of credible plans, in line with agreed criteria.

45. Secondly, advocacy for additional funding at global, regional and country level will be stepped up, thereby involving all relevant partners. Countries will also be supported with their national resource mobilization efforts, including identification of alternative sources of domestic funding.

46. Thirdly, countries will be supported – through intensified technical assistance in accordance with nationally identified technical support needs – to utilize available funds and absorb additional funds well, by systematically addressing immediate and more complex long-term obstacles to scaling up, including human capacity building and systems strengthening.

47. Fourthly, UNAIDS will continue to advocate for broad partnerships, in particular with donors, civil society and other stakeholders, to ensure greater harmonization and alignment of partners efforts, creation of demand for services, and increased mutual accountability between state and non-state actors.

48. Finally, UNAIDS will monitor and evaluate the progress made towards universal access, involving different partners and applying different approaches, including the promotion of joint annual reviews and mid-term reviews.

Recommendations

49. Based on the above, UNAIDS request the PCB for input and endorsement of the following broad actions:

- The UNAIDS Secretariat, in collaboration with the Cosponsors, to develop and endorse an accountability and reporting mechanism for UNAIDS to deliver on the recommendations in the Universal Access Assessment Report⁵ and present a progress report of its utilization at the June 2008 PCB.
- Request the UNAIDS Secretariat to monitor progress towards the goal of universal access by providing regular assessment of the status of countries' integrated plans and their financing as part of the annual monitoring of the epidemic

⁵ * The Universal Access Assessment Report was presented to the UN Secretary General for review at the 2006 UN High Level Meeting on AIDS and served as the basis for the Political Declaration.

Annex A⁶

TREATMENT

- **Core Indicator 1:**
Percentage of women, men and children with advanced HIV infection (i.e. who meet eligibility criteria) who are receiving antiretroviral combination therapy

- **Recommended Indicator:**

Percentage of adults and children on ART who are still alive 12 months after initiation of antire

CARE AND SUPPORT

- **Core Indicator 2:**
Percentage of OVC (boy/girl) aged under 18 living in households whose household have received a basic external support package* (in caring for the child) (The support package could include food, education, health care, family/home and/or community support.)troviral therapy

PREVENTION

- **Core Indicator 3:**
Percentage of HIV positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to child HIV transmission
- **Core Indicator 4:**
Percentage of general population or “most at risk” populations who received an HIV test in the past 12 months and were informed of the results⁷
- **Core Indicator 5:**
Number of condoms distributed annually by public and private sector
- **Core Indicator 6**
Percentage of young men and women aged 15 to 24 who have had sex before age 15

Recommended Indicators:

Coverage of targeted prevention programmes in low prevalence countries⁸

Percentage of young people (15-24) or “at risk” group who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions (male/female)⁹

NATIONAL COMMITMENT

- **Core Indicator 7:**
Amount of national funds disbursed by governments in low and middle income countries
- **Recommended Indicator:**
Implementation of the Three Ones (according to UNAIDS check list, including the involvement of civil society and other stakeholders)

⁶ UNAIDS (2006) *Considerations for countries to set their own national targets for HIV prevention, treatment and care*

⁷ This target should cover testing in health facilities and in other locations.

⁸ In concentrated epidemics, this indicator should be considered as “Core.”

⁹ Knowledge encompasses an understanding about the role of delaying sex, reducing partners, and use of condoms in preventing sexual transmission of HIV.