PROGRAMME COORDINATING BOARD

UNAIDS/PCB(32)/13.8
Issue date: 20 May 2013

THIRTY-SECOND MEETING

Date: 25-27 June 2013

Venue: Executive Board Room, WHO, Geneva

Agenda item 4.3

UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework

Budget for 2014-2015

Additional documents for this item:

i. 2014-2015 Results, Accountability and Budget Matrix (UNAIDS/PCB(32)/13.9)

ii. 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF Part I) (UNAIDS/PCB(28)/11.10)

iii. 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF Part II) (UNAIDS/PCB(29)/11.23)

iv. 2012 Performance monitoring report (UNAIDS/PCB(32)/13.5)

v. Financial report and audited financial statements for the year ended31 December 2012 (UNAIDS/PCB(32)/13.6)

vi. Interim financial management update for the 2012–2013 biennium for the period 1 January 2012 to 31 March 2013 (UNAIDS/PCB(32)/13.7)

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

a. *approve* US$ 485 million as the core budget for 2014-2015 and the proposed allocation between the 11 Cosponsors and the Secretariat;

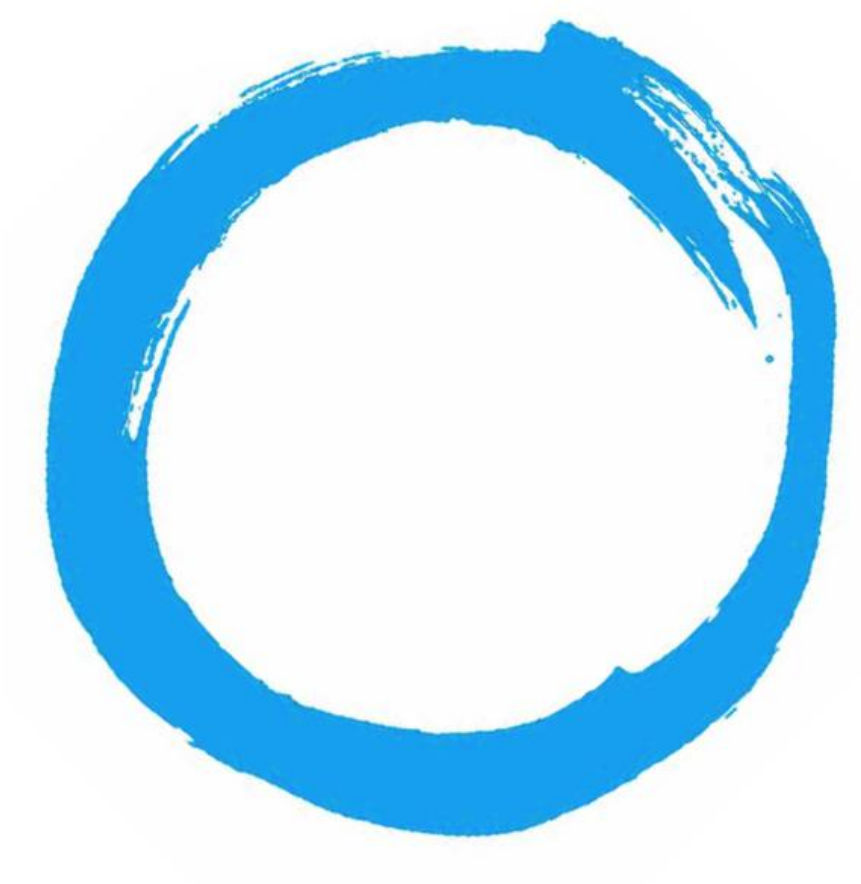
b. *endorse* the continued simplification and refinement of the indicators, with the support of UNAIDS Monitoring and Evaluation Reference Group, and;

c. *remind* all constituencies to use UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework to meet their reporting needs.

Cost implications of decisions:

US$ 485 million.

UNAIDS 2012-2015 UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK (UBRAF)



TRANSLATING
UNAIDS 2011-2015 STRATEGY
INTO ACTION

UNAIDS BUDGET FOR 2014-2015

UNAIDS

I. INTRODUCTION

1. The 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) is UNAIDS operational instrument to support the achievement of the goals of UNAIDS Strategy and the targets of the 2011 UN General Assembly Declaration on HIV and AIDS. At its 32nd meeting in June 2013, the Programme Coordinating Board (PCB) will consider progress in the first year of implementing UNAIDS 2012-2015 UBRAF and will be asked to approve the budget for the second biennium of the UBRAF (2014-2015).

2. The UBRAF was developed through a consultative process (across the Joint Programme and among member states and civil society) and approved by the Programme Coordinating Board in 2011.[1] The UBRAF is a unique operational instrument that brings together the efforts of twelve UN system organizations to deal with a specific issue – AIDS – ensuring coherence and coordination in planning and implementation, and accountability for results. It includes a four-year planning framework, two-year budget cycles and rolling annual workplans.

3. The UBRAF incorporates three components:
   - a business plan to capture the contributions of the Joint Programme to support the achievement of the goals of UNAIDS Strategy and the global AIDS targets;
   - a results and accountability framework to measure the achievements of the Joint Programme and provide a clear link between investments and results;
   - a budget to fund the core contributions of the Cosponsors and Secretariat in 2012-2013 as well as 2014-2015 to translate the goals of UNAIDS Strategy into action.

4. The UBRAF moves beyond its predecessor, the Unified Budget Workplan (UBW), in several respects. Specifically it:
   - provides a clearer representation of UNAIDS contribution to the AIDS response;
   - sets out expected results at country level over a longer (four-year) period;
   - presents more detailed budgets which show investments of UNAIDS resources;
   - strengthens accountability and enables direct reporting by countries and regions;
   - tracks performance against improved indicators with benchmarks and targets.

5. The development of the budget for 2014-2015 takes into account progress against goals, targets and lessons learned – which are described in the 2012 performance monitoring report (UNAIDS/PCB(29)/13.5) – as well as guidance from the PCB and recommendations of external reviews to strengthen organizational effectiveness, efficiency and relevance.

6. Most notable is the recent assessment by the Multilateral Organization Performance Assessment Network (MOPAN), a network of 17 donor countries with a common interest in assessing the organisational effectiveness of the major multilateral organisations they fund.

7. Overall, the 2012 MOPAN assessment of UNAIDS was very positive.[2] The main areas of strength noted are:
   - The UN Joint Programme on HIV/AIDS is highly valued by its direct partners and the Cosponsors;

[1] See Unified Budget, Results and Accountability Framework approved in June 2011 and a further refined Results, Accountability and Budget Matrix endorsed by the PCB in December 2011.

[2] Multilateral Organization Performance Assessment Network (MOPAN): see Volume 1, Volume 2, and UNAIDS response.

- The UNAIDS Secretariat is valued for its technical expertise, evidence-based advocacy, and influence in policy setting;
- UNAIDS' highly consultative approach is crucial to the achievement of its mandate and its 'Getting to Zero' vision, and;
- UNAIDS' effectiveness in building partnerships is highly valued and recognised by stakeholders as one of its strengths.

8. The assessment also noted a number of challenges, in particular the need to ensure:
   - Plans and strategies have targets, baselines and clear milestones
   - Results represent those for which UNAIDS is responsible or accountable
   - Performance information is used to adjust programming and budgets
   - Sufficient evaluation coverage of programming activities

9. In 2011, the development of the 2012-2015 UBRAF was guided by a PCB sub-committee, which presented its recommendations to the PCB in June 2011.[3] As recommended by the PCB sub-committee, the development of UNAIDS budget for 2014-2015 included a multi-stakeholder consultation held in Geneva on March 4 2013. 70 participants (permanent missions, NGO delegates, Cosponsors and UNAIDS Secretariat) attended the consultation to take stock of lessons learned in the implementation of the UBRAF and to reflect these in the 2014-2015 budget.

10. The multi-stakeholder consultation on UNAIDS 2014-2015 budget provided an opportunity to consider the extent to which the UBRAF has enhanced coordination and coherence in planning and implementation, and increased accountability. Lessons learned in implementing the UBRAF, feedback received at the consultation and written comments from PCB members and observers have been reflected in the 2014-2015 budget. Advice has also been sought from UNAIDS Monitoring and Evaluation Reference Group (MERG) to further strengthen monitoring and evaluation of the UBRAF.

11. The development of the new budget has been guided by key requirements and principles of the Quadrennial Comprehensive Policy Review (QCPR). These include a focus on specific goals, results-based planning and budgeting, strengthened joint work, improved effectiveness and more transparency. In particular, the development of the new budget reflects the need for enhanced system-wide coherence and strengthened accountability for results and impact as well as QCPR calls for on-going efforts to streamline and harmonize procedures and lower transaction costs.

12. The UNAIDS budget for 2014-2015 is presented on a zero growth basis, which represents a decrease in real terms. Holding the core budget to zero nominal growth over eight years (since 2008) means a considerable decrease in real terms as there is no re-costing to take into account inflation or increases in costs which directly impact the level of expenditures.

13. The 2014-2015 budget largely mirrors that of 2012-2013 with refinements made to reflect programmatic priorities, however, without significant changes in the allocation of core resources. The core budget represents the essential needs of the Joint Programme to support the achievement of the strategic goals and targets in the UBRAF. The core budget is intended to cover the full budgetary needs of the UNAIDS Secretariat and to provide catalytic funding for the AIDS work of 11 Cosponsors. The UBRAF therefore reflects the concept of a "critical mass" of core funding for the UN system response to AIDS through UNAIDS called for in the QCPR.

[3] See http://www.unaids.org/en/aboutunaids/unaidsprogrammecoordinatingboard/pcbsubcommittee/ PCB Subcommittee

II. LESSONS LEARNED IN THE IMPLEMENTATION OF THE UBRAF

14. Implementation of the UBRAF began in 2012 and distinct progress in terms of results-based planning and reporting can be seen. In its first year of implementation, UBRAF reporting has provided the Joint Programme with a clearer understanding of results in countries, and thus increased accountability for results at country level. The UBRAF by definition is a complex instrument by bringing together the efforts of 12 UN system entities at global, regional and country level into one single document. While retaining the original framework, ways of reducing the reporting burden and simplifying the management for development results need to be considered in 2014-2015.

15. A Joint Programme Monitoring System (JPMS), a web-based reporting tool, was developed by the UNAIDS Secretariat in consultation with Cosponsors to improve tracking and measurement of results and reporting to the PCB. The system is designed as an internal monitoring tool which allows for generation of a considerable amount of structured programme information, more than at any other time in the history of UNAIDS, which can be shared across all levels of the Joint Programme. The voice of the Joint Programme at the country and regional levels has also been strengthened.

16. The JPMS needs to be further enhanced in order to make the best use of the significant amount of information it has generated, and strengthen reporting on financial expenditure at the country level. Key challenges going forward will be to further strengthen the analysis and utilization of information generated through the reporting. Ensuring complementarity between Cosponsors' own systems and the JPMS will also require further attention.

17. UNAIDS Cosponsors and Secretariat have gained considerable experience from the development and implementation of the UBRAF over the past two years, and the opportunity exists to use it to strengthen coordination and coherence in planning, implementation and reporting by and among members of UNAIDS, and to enhance impact at the country level. Increased attention is needed in order to utilize the UBRAF more fully as a resource planning and management tool, particularly at country level with UN country teams, and with other stakeholders to fully tap into potential synergies, leverage more resources for the AIDS response and enhance the attainment of development results. On-going efforts to further align planning and reporting against the UBRAF and the Global AIDS targets should also continue.

18. As part of efforts to strengthen monitoring and evaluation of the UBRAF, UNAIDS Monitoring and Evaluation Reference Group (MERG) was requested to provide independent advise on the UBRAF results and indicator framework. The MERG recommended a considerable simplification of the indicator set and improvements in the quality of the indicators, stronger links between resources, results and indicators, and other ways to complement information that can be obtained from the UBRAF indicators, which by definition will always be limited in some respects, in order to describe the achievements of the Joint Programme.

19. The UBRAF multi-stakeholder consultation on 4 March 2013 took stock of lessons learned so far following the first year of implementation of the UBRAF in 2012 and collected feedback on priorities for the 2014-2015 budget. The consultation provided an opportunity to reflect on the extent to which the UBRAF has enhanced coordination and coherence and increased accountability. Participants in the consultation recognized that while it was still too early to make a full assessment, the lessons learned thus far can be used to inform plans and priorities for the Joint Programme to be as effective as possible in the 2014-2015 biennium, and to ensure AIDS is well positioned in the post-2015

period. The midterm review of the 2012-2015 UBRAF which is scheduled to be conducted after two years of implementation provides an opportunity to carry out a comprehensive assessment.

20. The implementation of the UBRAF has coincided with the Quadrennial Comprehensive Policy Review (QCPR) and UNAIDS will be well placed to offer concrete experience in the implementation of the QCPR, particularly with respect to joint programming (working through Joint Teams in the context of the Resident Coordinator system, with regional UN Development Group teams and UN Country Teams); working with a broad range of partners; evidence and rights-based approaches; national ownership; shared responsibility and global solidarity; focus on youth and vulnerable groups and links to humanitarian and peace keeping work through follow-up to Security Council Resolutions 1308 and 1983.

III. OVERALL CONTEXT OF THE AIDS RESPONSE

21. UNAIDS budget for 2014-2015 has been developed within the overall context of the AIDS response, in which the deadline for achieving the Millennium Development Goals (MDGs) and the visionary targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS is now less than three years away. Thanks to extraordinary research breakthroughs and advances achieved through concerted global action, a clear opportunity now exists to lay the groundwork for the end of the AIDS epidemic.

22. Over the last years, significant progress has been made towards the 2015 targets of the Political Declaration on HIV and AIDS. Globally, essential HIV services are reaching more people than ever, the annual number of new HIV infections continues to decline, and AIDS-related deaths are also falling. After the launch of the Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, the number of new HIV infections among children has steadily decreased. A record eight million people were receiving anti-retroviral therapy at the end of 2011. Stakeholders from all parts of the world have recognized the AIDS response as a shared responsibility, illustrated by the substantial new financial resources invested in HIV-related activities by low- and middle-income countries. Africa has enhanced its leadership and ownership of the international development agenda, adopting a visionary African Union Roadmap on Shared Responsibility and Global Solidarity for the response to AIDS, tuberculosis and malaria in Africa, and Asian health ministers have joined together in a common endeavour to address the HIV-related needs of women.

23. Although the gains achieved are genuine, AIDS is far from over. AIDS remains the leading cause of death among women aged 15-49 years worldwide, the leading cause of life years lost in Southern and Eastern Africa, the third leading cause of death in Eastern Europe, and the sixth leading cause of death worldwide. As of December 2011, an estimated 17 million children in the world had lost one or both parents due to AIDS. Treatment is not yet reaching all of those who need it most – in particular children, of whom only 28% of those in need receive treatment, and key populations at increased risk of HIV infection. In many countries adolescents and young people have limited access to HIV services, and stigma and discrimination are still rife.

24. To expand the response to AIDS further will require overcoming social, legal and economic barriers and reaching more and more marginalized people, including people who use drugs, sex workers, men who have sex with men, transgender people and prisoners. It will also require continuous and innovative efforts to improve efficiencies

and lower diagnostic and drug prices, particularly second and third line drugs which are under patent protection.

25. To sustain and build on previous gains – and to address the continuing challenge posed by the epidemic – the entire global community must renew its commitment to the AIDS response and have the political will to revise and adapt approaches to seize new opportunities as they emerge. Mobilizing the substantial additional funding that will be needed to end AIDS will require shared responsibility leading to increased investments by low- and middle-income countries as well as international donors. HIV-related expenditure must become more strategic and focused on investments that have the greatest impact and on the populations that need services the most – supported by critical enablers in the areas of human rights, gender equality and community mobilization to support and sustain the civil society engagement and action that has carried the AIDS response for so many years.

26. In addition, synergies between HIV-specific interventions and broader development initiatives, such as social protection programmes, must be captured, alleviating the social, legal and economic conditions that increase HIV vulnerability, mitigating the impact of HIV and reinforcing the long-term capacity of countries to lead and sustain their national responses.

27. An integrated approach to health promotion and care delivery is vital, and the AIDS response should both advance and benefit from the broader global push for universal health coverage. Engagement of political leaders must be coupled with an intensified effort to generate and sustain grassroots support for the AIDS response. At the same time as efforts are taken to strengthen the overall AIDS response, renewed commitment is needed to address persistent gender inequalities and the under-prioritization of essential services for key populations at higher risk of HIV infection. Above all, gains cannot be accelerated or sustained without recognition of AIDS as a shared global responsibility, requiring reinvigorated commitment, international solidarity and strategic action in 2014-2015 and beyond in the post-2015 period.

28. The AIDS response has a unique place as one of the most significant social movements of recent decades. It has provided the world with a new reference point as to what can be accomplished through global partnership. The cross-sectoral nature of HIV has had a profound impact on global health, development and human rights approaches, and by focusing on AIDS, countries have realized multiple effects across the other MDGs and broader development issues. This approach, with communities most affected and individuals most at risk at the centre of efforts, must be the basis for future action.

IV. OVERVIEW OF PLANS AND PRIORITIES

An Unfinished Agenda

29. The Millennium Development Goals (MDGs) demonstrate the power of the United Nations to focus the world on a shared agenda and deliver real and meaningful results for people and countries. Continued progress in the response to AIDS should inspire and ignite bold ambition and determination for transformation, while further breakthroughs in innovation, science and technology and other fields may yield unprecedented results. The end of the AIDS epidemic can be a shared triumph of the post-2015 era, for which the basis needs to be laid in the next two years, and one the UN Joint Programme on AIDS can play a critical role in.

30. UNAIDS 2011-2015 Strategy has a vision of zero new HIV infections, zero AIDS-related deaths, and zero discrimination, and goals based on three strategic pillars/directions (Revolutionize HIV prevention; Catalyze the next phase of treatment, care and support; and Advance human rights and gender equality for the HIV response) described below. These three strategic directions present an interdependent approach to respond to AIDS that is based on country and community ownership, inclusiveness, protection of human rights, and gender equality, transformative partnerships, shared responsibility, accountability for results, evidence and strategic investments to ensure resources are used as efficiently and effectively as possible.

Strategic Direction 1: Revolutionize HIV prevention

Progress

31. The latest global data show that HIV incidence has fallen by 50% or more in 25 countries between 2001 and 2011, more than half of which are in sub-Saharan Africa where the majority of the new HIV infections occur. Prevalence in young people aged 15 to 24 fell by 25% for young men and 29% for young women from 2001 to 2011, driven by significant declines in all regions except Eastern Europe and Central Asia where prevalence rose. The number of countries reporting epidemiological data on sex workers significantly increased between 2006 and 2012 reflecting greater official recognition of the HIV-related needs of this population.

32. According to the UNAIDS 2012 Global Report, the number of new HIV infections among children declined from 560,000 [510,000 – 650,000] in 2003 to 330,000 [280,000 – 390,000] in 2011, a 43% decline in nine years. Some countries, e.g. Burundi, Kenya, Namibia, South Africa, Togo and Zambia, have achieved at least a 40% reduction since 2009. There has been scale-up of more effective regimens to stop new infections in children and keep mothers alive.

33. Early experience with simplification of treatment options for women, including ensuring that antiretroviral therapy is offered to pregnant women and initiated for the sake of their own health has shown that treatment coverage can increase, including for women with more advanced disease.

34. Nearly 10% of global HIV infections are due to unsafe injecting drug use, increasing to nearly 30% if sub-Saharan Africa is excluded. Unsafe injecting in Eastern Europe and Central Asia is of particular concern and while access to HIV prevention services for people who inject drugs has increased it is not at the required scale to impact on the HIV epidemic.

Constraints and challenges

35. Almost 40% of all new adult HIV infections in 2011 occurred in young people and three fifths of these are among young women. HIV also continues to impact particular population groups disproportionately. Female sex workers, men who have sex with men and people who inject drugs are respectively, 14 times, 19 times and 22 times more likely to acquire HIV than others, including in high burden countries. Information about HIV among transgender communities is limited, but available data indicate very high levels of HIV prevalence.

36. Resources for the AIDS response can and need to be allocated more efficiently. For instance, infection rates among sex workers, men who have sex with men and

transgender people exceed 40% in many countries but only approximately 4% of global funding for programme activities is used to reach them.

37. While treatment among pregnant women living with HIV has reached 30% it remains well below the overall adult coverage level of 54%. HIV related issues are still not consistently recognized as important to meeting the goals and targets in maternal health and family planning, and coordination in planning and implementation is limited.

38. An estimated 3 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 inadequate programming. Access to HIV services among female drug users remains very low compared to their male counterparts.

39. Legal, social and political barriers are major challenges to expanded combination prevention, treatment and care programmes, while stigma, discrimination and policies are still major barriers that hinder key populations' access to evidence-based HIV prevention and treatment services.

Future action

40. Effectively reducing HIV transmission requires accelerating scale-up of basic programmatic activities that evidence shows are highly effective in preventing HIV. These include stopping new HIV infections in children and keeping women living with HIV alive, maximizing the prevention benefit of treatment and combination prevention approaches including condom programming and condom demand strategies, voluntary medical male circumcision, behaviour change programmes and integrated programmes for key populations.

41. In addition, there is a need to direct sufficient funding and support towards creation of enabling environments and ways to enable basic programmes to work. Such critical enablers include legal reform, stigma reduction, legal services, rights literacy, sensitization of police, training of health care workers in non-discrimination, reduction of violence against women and harmful gender norms, and community system strengthening.

42. Full engagement with communities and key populations is important, as well as the need to have improved data to help identify and overcome implementation bottlenecks and achieve greater integration. The Joint Programme will continue to support countries applying investment approaches to national AIDS responses.

43. To increases access to services and reduce stigma and discrimination, elements such as an integrated package for sex workers, men who have sex with men, and transgender people will be prioritized in countries where epidemics are growing among these populations.

44. Focusing on young people – including those born with HIV, who have unique needs – will be vital, and include scale-up of adolescent and youth access to HIV testing and counselling, sexual and reproductive health services, voluntary medical male circumcision, social behaviour change communication, male and female condoms and gender sensitive comprehensive sexuality education. Meeting the needs of young key populations will also be accelerated.

45. Achieving the goal of eliminating new HIV infections among children requires strengthening local capacity to decentralize management and service provision; support

to implement new Consolidated Antiretroviral Therapy Guidelines and other key guidelines (such as those related to infant feeding); and continued support to countries to strengthen linkages between maternal and neonatal child health, sexual and reproductive health, and HIV with an emphasis on meeting the family planning and other sexual and reproductive (SRH) needs of women living with HIV. Emphasis should be given to the full implementation of the Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

46. In order to achieve maximum impact, national HIV strategies should include implementation of all the nine interventions outlined in the WHO/UNODC/UNAIDS comprehensive package for people who inject drugs. In countries with injecting drug use, implementation of opioid substitution therapy, and needle and syringe programmes in prisons, should be a priority. Intensified technical support and community systems strengthening for civil society organizations representing people who use drugs and people in prisons to meaningfully participate in national AIDS strategies, policy elaboration and service delivery is also critical.

Strategic Direction 2: Catalyze the next phase of treatment, care and support

Progress

47. At the end of 2011, antiretroviral therapy was available to an estimated 8 million people in low- and middle-income countries – where ART coverage remains higher for women (68%) than for men (47%). Almost half of tuberculosis patients living with HIV received antiretroviral therapy. Scientific evidence has shown that providing ART has important prevention benefits – giving ART to people earlier in their disease progression not only drastically reduces the risk of TB disease and mortality but it also helps limit HIV transmission.

48. Universal access to treatment is already within reach for several countries. The target of reaching 15 million people on ART, and reducing TB deaths among people living with HIV by 50%, by 2015 is within reach, but renewed efforts are critical to achieving this goal.

49. Following the unprecedented increase of people initiating treatment, there has been an acceleration of social protection efforts and growing recognition of the importance of health service integration, reinforcement of community systems for service delivery with strong links to health systems, and community mobilization. Such initiatives can directly mitigate the social and economic impacts of the HIV epidemic on the most vulnerable households and key populations, care-givers and vulnerable children.

Constraints and challenges

50. Despite progress to date, many of the more than 7 million people who need treatment still face obstacles to treatment, including lack of availability, stigma, discrimination, punitive and coercive policies and laws, and ignorance. At the same time, more than half the people living with HIV are unaware of their HIV status, and many who know their status cannot safely access treatment. Among children under 15 years of age only 28% of those in need of treatment are reached and some of the key populations most severely affected by HIV are also criminalized, which has the effect of driving those most in need of support away from services.

51. Meeting the considerable challenge of reaching the 7 or more million people eligible for ART requires country implementation of global guidance on ART use, accelerated implementation of the 'Treatment 2.0' principles to optimize and simplify treatment and diagnostics, service delivery adaptation, and mobilization of community support for scale up, as well as dedicated and rights-based efforts to reach the most marginalized. Multilateral and bilateral trade agreements are eroding flexibilities in the agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).

52. Increasing access to affordable HIV related products, including monitoring tools, continues to be a challenge and there is still a need to ensure more coordination among procurement agencies, governments, financial mechanisms and pharmaceutical companies. Results will only be achieved by a combination of efforts, ensuring that delivery mechanisms are in place to provide the best quality of care.

Future action

53. The emphasis in 2014-2015 will be to find innovative and efficient ways to deliver HIV treatment and care and support to more people. This will take greater efforts to address the barriers to treatment both within and outside the health system, including those related to gender inequality and gender-based violence. Scale-up must be accompanied by efforts to ensure high quality of care, integration of HIV care with other health and community services – in particular tuberculosis, maternal child health, sexual and reproductive health, and opioid substitution therapy services – and support for demand creation, antiretroviral therapy adherence and programme retention.

54. There is a need for sustained political commitment to HIV in the context of a broadening view on health and development, as well as increased funding including through mobilization of domestic resources in countries. UNAIDS also needs to help identify solutions, and more broadly and as part of investment approaches, facilitate closer dialogue at country level between ministries of health, labour, social welfare, justice, gender, social development, planning and finance to identify the ways in which comprehensive social protection, care and support can contribute to HIV outcomes.

55. The role of UNAIDS will include driving advocacy for sustained political and financial commitment; developing new normative guidance and providing in-country policy support on the strategic use of antiretroviral therapy for HIV treatment; supporting countries adopt innovative early infant diagnosis and HIV testing and counselling services and positioning paediatric HIV treatment and care within child survival and the Treatment 2.0 framework; renewed efforts to scale up early testing and quality treatment and care for HIV/tuberculosis co-infection.

Strategic Direction 3: Human rights and gender equality for the HIV response

Progress

56. Stigma, inequality - particularly gender inequality - and exclusion continue to drive the HIV epidemic, as do legal environments that do not protect against HIV-related discrimination and criminalize populations at risk. The Joint Programme has worked to improve social, legal and policy environments for HIV that governments have committed to in the 2011 Political Declaration on HIV and AIDS. These are being included in the new funding model for the Global Fund to Fight AIDS, Tuberculosis and Malaria along

with programmes to support gender equality, reduce violence against women and strengthen community systems.[4]

57. Thematic days at UNAIDS Programme Coordinating Board on enabling legal environments and on non-discrimination have highlighted the need to urgently take forward more political and programmatic initiatives to address these issues. The independent Global Commission on HIV and the Law, supported by the Joint Programme, examined the impact of law on HIV responses and the work of the Commission has been used to catalyze country-level action to protect human rights, decrease stigma and discrimination and improve the social and legal environment for HIV in over 80 countries.[5]

58. UNAIDS has also supported the development of improved tools to measure stigma in communities and in health care settings and the implementation of the People Living with HIV Stigma Index in over 60 countries. There have been continuous efforts to get HIV-related restrictions on entry, stay and residence lifted, with eight countries having removed these restrictions since 2010.

59. Since the launch of UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV in 2010, almost 100 countries have operationalized the Agenda. At the global, regional and country level, the Joint Programme has worked together to strengthen efforts to intensify and scale up action for women, girls and gender equality in the context of national strategy and planning processes. Nearly all countries now include women-focused initiatives in their national AIDS strategies. Two-thirds of all countries are now linking HIV and sexual and reproductive health (SRH). Responding to a call for gender-transformative HIV responses, UNAIDS has developed a set of tools, including a gender roadmap for advocacy; a gender assessment tool for reviewing the epidemic, context and response, and; a compendium of indicators.[6]

Constraints and challenges

60. Stigma and discrimination are still major drivers of the AIDS epidemic and very common across settings. Despite evidence showing that laws and policies based on evidence and grounded in human rights lead to better health outcomes, more than 60 countries specifically criminalize HIV transmission. Seventy eight countries criminalize same-sex sexual activity. More than 100 countries criminalize some aspect of sex work and 127 countries lack legislation outlawing marital rape.

61. Punitive laws, policies and practices continue to surface, particularly in Eastern Europe and Central Asia and sub-Saharan Africa. Forty-four countries continue to implement HIV-related restrictions on entry, stay and residence. These punitive approaches including those against men who have sex with men, transgender people, sex workers and people who use drugs jeopardize results in reaching the targets in the 2011 Political

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[4] Legal environment (law, law enforcement, access to justice) reviews and related advocacy, legislative review/reform and related advocacy, national dialogues and action planning on HIV and the law, judicial sensitisation, parliamentarian sensitisation, access to justice; law enforcement and legal services, media and religious leader sensitisation, anti-stigma and anti-discrimination.

[5] A map indicating recent activity on the implementation of the Commission's findings and recommendations is available at: http://www.hivlawcommission.org/index.php/recent-developments/recent-developments-map

[6] http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121206_FinalReport_Mid_Term%20Review_UNAIDS_Agenda_for_Women_and_Girls.pdf.

Declaration on HIV and AIDS and continue as barriers for rolling out sufficient programmes by people and institutions engaged in these activities.

62. The interactions between gender inequality, gender diversity and the HIV epidemic are complex, often not adequately understood and remain highly sensitive and controversial. This has resulted in uneven political commitment and HIV not being consistently prioritized in the plans and budgets of ministries of gender and women's affairs. At the same time, civil society organizations involved in gender equality, and sexual and reproductive rights, including networks of women living with HIV and representing key populations, face continued resource constraints. Responding to the differential needs of women and men as well as the dynamics of unequal power relations between men and women remains a challenge in implementation of HIV programmes.

Future action

63. The priority for 2014-2015 is to continue to build and sustain the momentum generated at the country and community levels to achieve transformational change for people living with HIV, and those at greatest risk. The Joint Programme will continue to follow up on the recommendations of the Global Commission on HIV and the Law in collaboration with stakeholders including governments, other UN partners and civil society for a coordinated, efficient, and effective HIV response that is supported by an enabling social, legal and policy environments.

64. Putting human rights and gender equality at the centre of the HIV response, along with those communities most affected, requires a major shift in coverage, content and resourcing of HIV programmes. All countries applying investment approaches in the coming years need to ensure basic programme areas are addressed using gender sensitive strategies, and incorporate action on the critical enablers that address issues of gender equality, human rights, community mobilization and protective laws through concrete and sufficiently resourced programmes.

65. Implementing the Agenda for Women and Girls remains a priority, including supporting stronger collection, analysis and use of sex- and age-disaggregated data to inform programmes. Particular focus will be given to support countries move towards resourced gender transformative HIV responses; rolling out an integrated package of tools to support gender transformative assessments, planning, implementation and evaluation. While strengthening engagement of women and girls in these processes, close collaboration will be sought with partners to increase effectiveness and efficiency in fortifying linkages between gender and HIV work.

66. While there have been notable achievements in attaining the health related MDGs, it is essential that the cross-cutting issues of human rights and gender equality remain front and centre in the AIDS response to consolidate progress made to date. The importance of addressing inequalities features prominently in the post-2015 discussions and provide a real opportunity to leverage AIDS responses for the benefit of broader health and development objectives.

Cross-cutting Strategic Functions

Progress

67. With the Global AIDS targets as guideposts and to ensure the sustainability of the AIDS response, UNAIDS Secretariat has continued to play a leadership and advocacy role to mobilize and sustain political commitment, increase and enhance country ownership and capacity, domestic and international investments, coordination, coherence, partnerships and accountability at all levels to ensure maximum impact of resources. This included support to over 30 countries move forward their work with investment approaches.

68. In 2012, UNAIDS Secretariat has implemented a strategic realignment to ensure that financial and human resources are aligned with UNAIDS vision, to enable the Secretariat to deliver on its strategic role, while maximizing value for money.

69. As part of the strategic realignment, a range of cost savings and efficiency measures have been implemented, which have reduced overall expenditures by 13 per cent in 2012 compared to 2011 (see UNAIDS/PCB(32)/13.7).

70. The importance attached by PCB to the mutual accountability of UNAIDS 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 the synergy between the strategic directions. With UN Women joining as the eleventh Cosponsor, UNAIDS has expanded its range of competence and reinforced its approach to gender equality.

Constraints and challenges

71. Notwithstanding successes in increasing domestic investments, there is still a shortfall in global funding for HIV; by 2015, the estimated annual gap could be $7 billion.

72. Globally and at national level, the Joint Programme continues to challenge itself to identify its most appropriate niche within the wider development architecture. At all levels, the UN budget on AIDS is very small compared to that of governments and other stakeholders, and in a changing environment the UN has to constantly demonstrate its value-added contribution as well as value for money.

73. As part of this, UNAIDS work in generating strategic information, including coordinating the Global AIDS Response Progress Reporting (GARPR) and analysis of the global HIV epidemic, helps countries to ‘know their epidemic’ and thus provide vital country-specific, regional and global information on the epidemic and responses to it. Reacting to this in a timely way – helping countries and stakeholders both construct and adapt their responses to HIV to changing and complex epidemic situations – remains a priority which is at the heart of the Joint Programme’s work.

74. Prioritizing investments, actions and results in support of UNAIDS vision remains an on-going challenge. Considerable work will be required to support a culture change towards stronger cost consciousness, value for money, results-based budgeting and management, and accountability for results at global, regional, national and sub-national levels.

Future action

75. In the area of leadership and advocacy, UNAIDS will continue to unite stakeholders in the response; mobilize political, technical, scientific and financial resources; empower change through innovation, community mobilization and utilizing strategic information and evidence to guide the AIDS response and resource allocation for maximum impact. The shared responsibility and global solidarity agenda is central to UNAIDS as it signals an important shift to innovative approaches and partnerships where diverse investments, sustainable solutions and greater accountability are indispensable.

76. A central pillar of UNAIDS work will be to advocate and support countries, including the 30+ high-impact countries, to maximize impact and cost-efficiency to reach the global AIDS targets. There will be a particular focus on stopping new infections in children, increasing access to HIV treatment, community mobilization, key populations, gender equality and human rights.

77. Shaping the AIDS response in the post-2015 era will be a key priority, recognizing that AIDS remains a formidable development challenge and that the end of the AIDS epidemic can be a shared triumph. Supporting transformative leadership will be emphasized to galvanize young people's involvement in reaching the global AIDS targets. UNAIDS will also remain focused on broader UN initiatives such as security and AIDS through the implementation of Security Council Resolutions 1308 and 1983.

78. UNAIDS leads in coordination, coherence and partnerships by providing strategic information about epidemic and response trends, including analyses of where programme gaps exist. Better reporting on the global AIDS response and guidance on the collection and use of strategic information will continue to play an essential role in guiding HIV programme planning, implementation and monitoring and evaluation at all levels. UNAIDS will continue to support countries apply investment approaches in the development of proposals and implementation of programmes supported by the Global Fund, PEPFAR and others. UNAIDS will also support development of national HIV strategies that are underpinned by investment thinking.

79. UNAIDS Cosponsors and Secretariat will work to ensure that national responses are inclusive of civil society, putting networks of people with HIV, young people and key populations at the centre of the response. UNAIDS Secretariat will continue to support the mutual accountability to enhance programme efficiency and effectiveness and strengthen results-based management, enhance existing accountability frameworks for reporting, monitoring and evaluation. Ensuring UNAIDS will be effectively working as part of the Resident Coordinator system will be a particular priority.

80. 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 Joint Programme Monitoring System (JPMS) will be refined to improve how UBRAF results and the performance of UNAIDS are reported and information used across UNAIDS.

81. Strengthening support for governance will remain key, as will ensuring strategic use of resources and cost-effective delivery of results through the continued implementation of the strategic realignment of the Secretariat. Capacity will be bolstered in high-impact countries, while staffing will be consolidated in other areas. The deployment of new information technologies and applications will help promote collaborative working and enhance knowledge management and communication throughout the organization. Another priority for the Secretariat will be to lead the mobilization of resources for the core budget.

V. BUDGET AND RESOURCE ALLOCATION

Level, Scope and Structure of the Budget

82. As part of a four-year planning framework, the budget proposed for 2014-2015 mirrors UNAIDS budget for the 2012-2013 biennium in terms of scope, level and structure. In the current resource environment, the core budget is proposed to remain at its current level – US$485 million over the next two years. Holding the core budget to zero nominal growth over eight years (from 2008 through 2015) means a considerable decrease in real terms as there is no re-costing to take into account inflation or increases in costs which impact the level of expenditures.

83. As the UBRAF aims at providing a comprehensive view of all UN system resources for AIDS, the budget includes two categories of funding: core funds which UNAIDS Secretariat traditionally raises as well as other AIDS-related funds that the Cosponsors themselves raise. The core resources of the UBRAF are intended to be catalytic, mobilize and leverage funding from Cosponsors' own resources – not replace these – and maximize the impact of Cosponsors' own funding as well as resources from the Global Fund, bilateral programmes, such as PEPFAR, and other in-country resources to support national programmes.

84. In total, the UNAIDS core budget in 2014-2015 represents approximately 11 per cent of the total funding estimated to be managed by UNAIDS Cosponsors and Secretariat in for AIDS-related activities next biennium, as shown in the graph below. The estimated total spending by UNAIDS Cosponsors and Secretariat on AIDS is expected to be US$4.3 billion in 2014-2015.

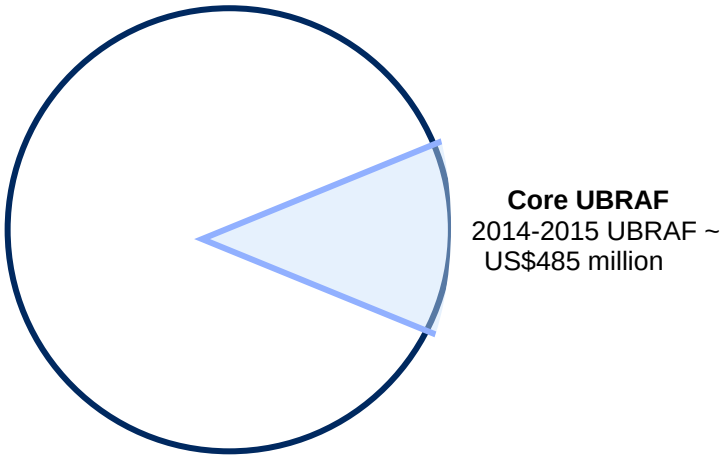

Figure 1: Categories of funding in the UBRAF: core funds and other AIDS funds

85. The budget remains structured to capture (i) UNAIDS global agenda, (ii) key roles and functions at regional level, (iii) joint and individual action at country level, and (iv) a focus on 30+ countries where a major impact on the epidemic can be made.

86. The budget comprises:
    - Two main budget categories: ‘Secretariat’ and ‘Cosponsors’, broken down further to show the resources for each Cosponsor;
    - Two types of funding: ‘core’ and ‘other AIDS’ funds, with the latter representing the AIDS funds that the Cosponsors mobilize at country, regional and global levels;
    - Two main levels of funding: ‘global’ and ‘regional/country level’, with a further breakdown by region and focus on 30+ high impact countries and other countries;

87. The vast majority of the core resources in the 2012-2015 UBRAF are for what can be defined as development activities. These include actions with budgets linked to specific activities, which contribute to the achievement of the strategic goals in the UBRAF as well as activities of a normative, policy-advisory, technical and supportive nature that are needed to achieve the outputs and outcomes in the UBRAF and the Global AIDS targets.

Resource Allocation

88. Resources in the UBRAF are allocated against outcomes and outputs which support the achievement of the goals in UNAIDS Strategy and the Global AIDS targets. The allocation of core UBRAF resources continues to be guided by the decisions, recommendations and conclusions of the 25th and 26th meetings of the PCB: epidemic priorities, the comparative advantages of the UN and the performance of the Cosponsors.

89. The criteria used in the current biennium to allocate the resources between UNAIDS Cosponsors and the Secretariat remain unchanged and have been used as a basis to determine allocations for the 2014-2015 biennium and any possible reallocation of funds in the second year of the 2014-2015 biennium (see UBRAF p.101).

90. The allocation of the UBRAF resources reflects a move towards more strategic investment of resources in 30+ high impact countries. These include, among others, the 22 countries which together account for more than 90 per cent of all children living with HIV. Only through a particular focus on these countries can the target of achieving a 90 per cent reduction in the number of children newly infected with HIV be reached. In the implementation of the UBRAF itself, investment approaches will be used to support the achievement of progress in the response to AIDS.

91. While activities take place at global, regional and country level, ultimately any action of UNAIDS must translate into results at country level. The allocation of resources between the global and regional/country level takes this into account to ensure maximum return on investments. Currently, an average of 60 per cent of core resources are spent at the regional and country level and it is proposed to increase this percentage over the course of the biennium (see below).

Figure 2: Target allocation of core UBRAF resources

Breakdown of the Budget

92. The UBRAF includes core resources as well as funds that Cosponsors themselves raise for HIV specific activities, which are referred to as 'non-core' or 'other AIDS funds'. The table below shows the core UBRAF as well as the non-core funds the Cosponsors and UNAIDS Secretariat are expected to mobilize in 2014-2015.

Table 1: Overview of UNAIDS Cosponsor and Secretariat funding for AIDS (US$)

Funding Type	Estimated Resources	Percentage
Core funds	484,820,000	11%
Other AIDS funds	3,832,820,000	89%
Grand Total	**4,317,640,000**	**100%**

93. The funds that the Cosponsors and Secretariat expect to mobilize in 2014-2015 – US$ 3.8 billion over and above the core UBRAF – are HIV-specific or HIV-focused, where funding in a measurable way contributes to results in the UBRAF. The amounts do not include funding in which HIV is mainstreamed, or funds which are supportive of HIV responses more generally and indirectly advance work on AIDS.[7]

94. Table 2 shows the breakdown of the core budget for global level activities, support to 30+ high impact countries and all other countries.

7 For the World Bank, where appropriate, estimates are made of the proportion of health system, social protection or other funds that directly contribute to the achievement of UBRAF results. Funds to support the achievement of broader development goals, whilst supportive of the AIDS response, are not included.

Table 2: Core budget for global level, high impact countries and other countries (US$)

Funding level	Core Resources*	Percentage*
Global level	201,410,000	41%
30+ High Impact Countries	125,405,000	26%
Other countries	158,005,000	33%
Grand Total	**484,820,000**	**100%**

95. In total, slightly more than 40% of core UBRAF resources are currently allocated for global leadership, advocacy, normative functions and policy development with the aim to reduce this progressively over course of the biennium. However, when all Cosponsor and Secretariat resources are considered, a much smaller share, less than 10 per cent goes towards global level activities as shown in the chart below.

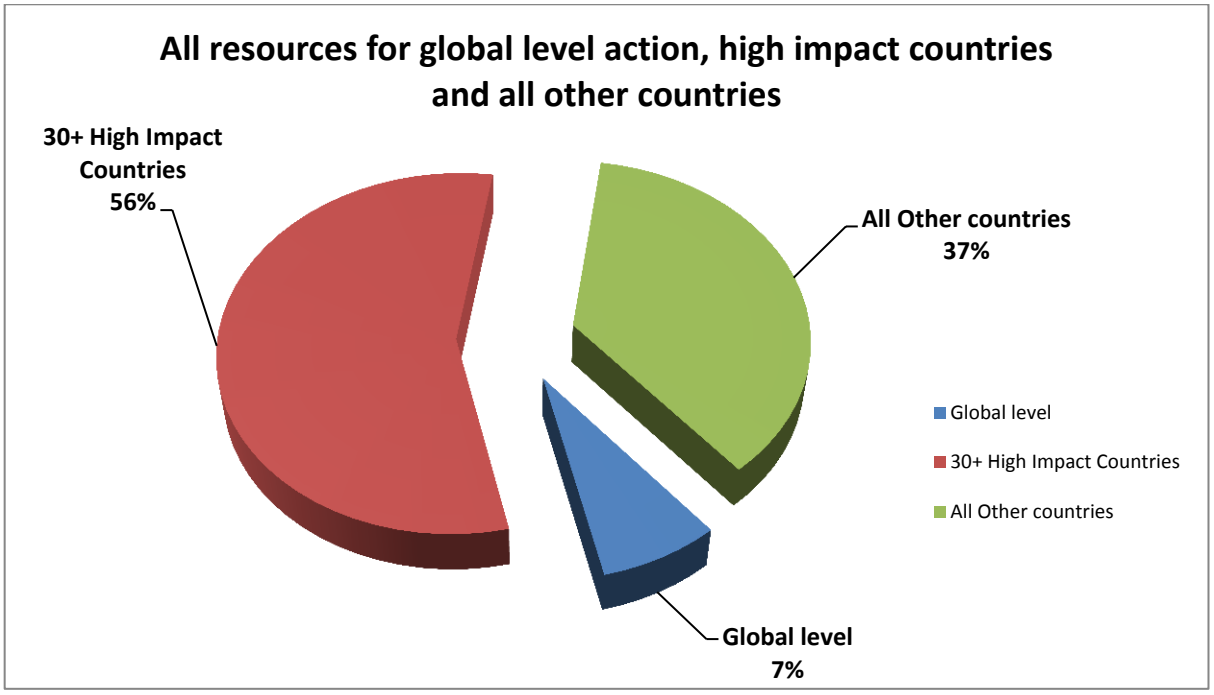

Figure 3: Total funding for global level, high impact countries and other countries (%)

96. A detailed presentation of the budget is included in the Results, Accountability and Budget Matrix of the UBRAF (UNAIDS/PCB(32)/13.9). An overview of the allocation of core UBRAF for 2014-2015 by strategic direction and function is presented below followed by an overview of the resources of UNAIDS Secretariat and Cosponsors.

Funding for Strategic Directions and Functions

97. Tables 3 and 4 below show the breakdown of the core UBRAF resources by strategic direction and function. The budget for 2014-2015 largely mirrors the budget for 2012-2013 with small adjustments made to reflect programmatic priorities and feedback from the PCB. This includes e.g., a slight increase in the funding allocated for human rights and gender which represents 23 per cent in 2014-2015 compared to 17 per cent in 2012-2013 (see table 3 below).

Table 3: Core budget allocation by strategic direction (US$)

Strategic Direction	Core Resources	Percentage
Prevention	79,102,000	48%
Treatment, Care and Support	47,539,000	29%
Human Rights and Gender	37,885,000	23%
Grand Total	**164,526,000**	**100%**

Table 4: Core budget allocation by strategic function (US$)

Strategic Function	Core Resources	Percentage
Leadership and Advocacy	131,642,000	41%
Coordination, Coherence and Partnerships	105,118,000	33%
Mutual Accountability	83,534,000	26%
Grand Total	**320,294,000**	**100%**

Allocation of the Core Budget

98. Initially, the core budget of UNAIDS only covered the activities of UNAIDS Secretariat. This was based on the founding resolution of UNAIDS (ECOSOC 1994/24) according to which “The co-sponsors will contribute to the resource needs of the programme” and “Funding for country-level activities will be obtained primarily through the existing fund-raising mechanisms of the co-sponsors.”

99. Over time, allocations have been made in UNAIDS budget for the Cosponsors to support their mobilization of funds and leveraging of their own resources. While the core budget of UNAIDS has remained constant in nominal terms since 2008, the share of the Cosponsors of the budget has increased every biennium. This has been achieved by decreasing the budget managed by UNAIDS Secretariat and allocating the corresponding amounts to the Cosponsors.[8] .

100. An increase in the budget of the Cosponsors is also proposed in 2014-2015 for UN Women to be able to participate as a full member of the Joint Programme and to provide a modest upward adjustment for the Cosponsors whose core budget was reduced in 2012-2013 and who have shown renewed commitment and strong performance under new leadership.

101. The core budget of the Secretariat has, in accordance with the Division of Labour, been constructed around its strategic functions. Approximately four fifths of the core budget of the Secretariat is allocated for development activities – leadership, advocacy, coordination, coherence and partnerships and accountability at global level as well as in regions and countries. The UBRAF also includes central support services of the Secretariat, which are necessary for the smooth functioning of the Joint Programme and to ensure effective delivery of results.

[8] In addition to the core budget, a window to provide earmarked funding through UNAIDS Secretariat exists for contributions which are over and above the core funding to support the achievement of the Global AIDS targets.

102. Central support services account for approximately 20 per cent of the total core budget of UNAIDS Secretariat and include human resources management, planning, budget, finance, audit, reporting, information and communication technology, resource mobilisation and administrative services as well as office running costs. Support to the Resident Coordinator function, which will double for UNAIDS under the new cost sharing formula, is also budgeted here along with security costs and other jointly funded activities of the UN system.

103. As indicated earlier, UNAIDS Secretariat implemented a strategic realignment in 2012 to ensure that its financial and human resources are aligned with UNAIDS vision and the Secretariat can deliver on its strategic role, while maximizing value for money. As part of the strategic realignment, a range of cost savings and efficiency measures have been implemented, which have reduced overall expenditures by 13 per cent in 2012 compared to 2011 (see UNAIDS/PCB(32)/13.7).

104. The breakdown of the Secretariat core budget is shown in the chart below:

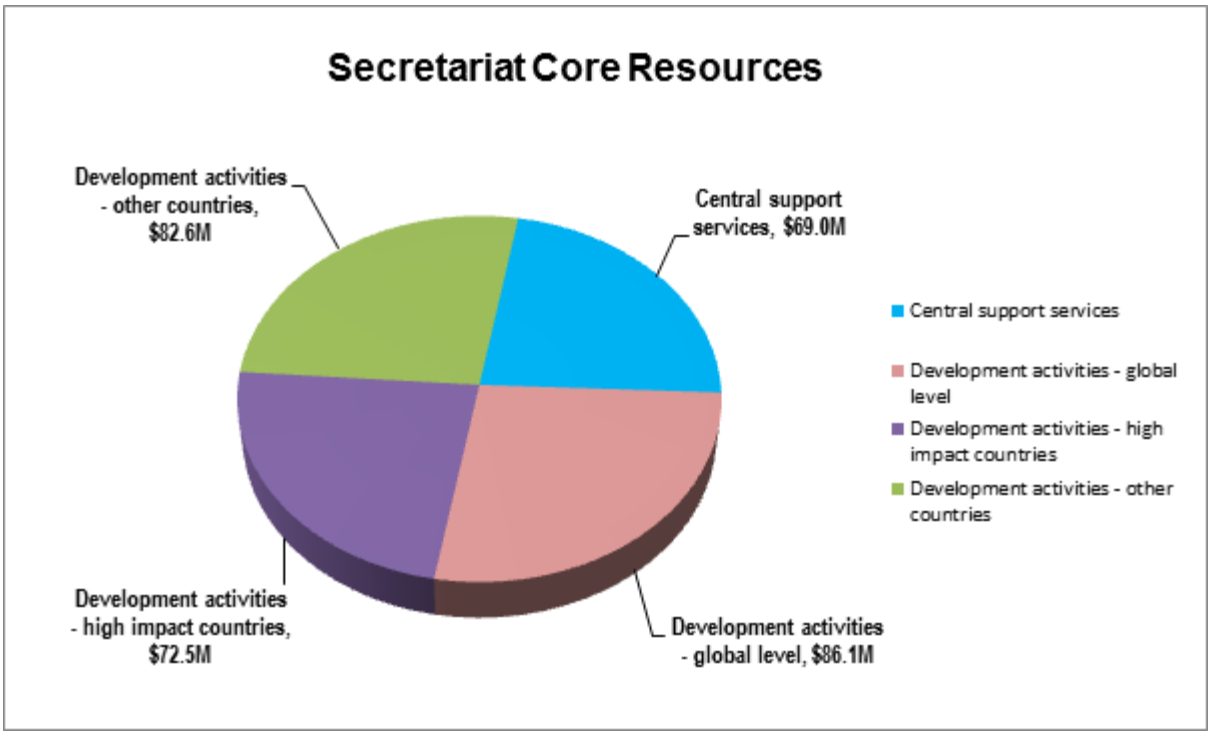

Figure 4: Breakdown of Secretariat core budget (in US$ million)

105. Table 5 below shows the core allocations for the Cosponsors in 2014-2015. The current biennium (2012-2013) and the two previous biennia are included for comparison. Amounts for 2008-2009 and 2010-2011 reflect core allocations without Programme Acceleration or other Interagency Funds.

Table 5: Breakdown of the core budget by Cosponsor (in US$)

Cosponsor	2008-2009 approved core budget	2010-2011 approved core budget	2012-2013 approved core budget	2014-2015 proposed core budget	2014-2015 % share
UNHCR	6,400,000	8,500,000	9,800,000	9,800,000	6%
UNICEF	20,800,000	23,950,000	24,000,000	24,000,000	14%
WFP	7,000,000	8,500,000	9,800,000	9,800,000	6%
UNDP	13,760,000	17,010,000	17,200,000	17,200,000	9%
UNFPA	18,200,000	20,975,000	21,000,000	21,000,000	12%
UNODC	9,500,000	11,475,000	11,500,000	11,500,000	7%
UN Women	-	-	-	7,600,000	4%
ILO	9,500,000	10,950,000	9,800,000	10,900,000	6%
UNESCO	10,600,000	12,300,000	12,400,000	12,400,000	7%
WHO	26,500,000	31,900,000	35,000,000	35,000,000	20%
World Bank	12,410,000	15,410,000	14,000,000	15,400,000	9%
Total Cosponsors	**134,670,000**	**160,970,000**	**164,500,000**	**174,600,000**	**100%**

Overview of all UN Funds on AIDS

106. Table 6 below shows the 2014-2015 core UBRAF allocations and other HIV-related funds of the Cosponsors and Secretariat.

Table 6: Breakdown of the core budget and all non-core funds (US$)

ORGANIZATION	2014-2015 Core UBRAF	2014-2015 Other AIDS Funds	Total
UNHCR	9,800,000	16,500,000	26,300,000
UNICEF	24,000,000	198,000,000	222,000,000
WFP	9,800,000	197,153,000	206,953,000
UNDP	17,200,000	520,000,000	537,200,000
UNFPA	21,000,000	106,106,000	127,106,000
UNODC	11,500,000	29,076,000	40,576,000
UN Women	7,600,000	26,704,000	34,304,000
ILO	10,900,000	17,126,000	28,026,000
UNESCO	12,400,000	13,850,000	26,250,000
WHO	35,000,000	169,029,000	204,029,000
World Bank	15,400,000	2,494,276,000	2,509,676,000
Secretariat	310,220,000	45,000,000	355,220,000
Grand Total	**484,820,000**	**3,832,820,000**	**4,317,640,000**

107. Budgeted amounts included for Cosponsors' other AIDS funds are best estimates by Cosponsors taking into account their most recent level of regular budgets and voluntary fundraising. These estimates are subject to change as Cosponsors refine and approve their own budgets, formulate their individual workplans, and mobilize funds.

108. The funds for AIDS that the Cosponsors and Secretariat expect to mobilize in the next biennium – US$ 3.8 billion over and above the core UBRAF – are HIV-specific or HIV-focused, where funding in a measurable way contributes to results in the UBRAF. The amounts do not include funding in which HIV is mainstreamed, or funds which are supportive of HIV responses more generally and indirectly advance work on AIDS. The overall total and the proportion of funding for high impact countries is to a large extent influenced by the US$2.5 billion of World Bank loans and grants counted as part of the total UN resources on AIDS.[9]

109. Tables 6 and 7 below show the 2014-2015 core UBRAF allocations and other HIV-related funds of the Cosponsors and Secretariat as well as the total budget broken down by global level, high impact countries, and other countries. Overall, the estimated total UN resources for AIDS in 2014-2015 are expected to match or even exceed slightly the resources projected to be available for 2012-2013, with increased funding estimated for Eastern Europe and Central Asia, Middle East and North Africa as well as West and Central Africa.

Table 7: Total budget by global level, high impact countries, other countries (US$)

Cosponsor	Global	High Impact Countries	AP (All other)	CAR (All other)	EECA (All other)	ESA (All other)	LA (All other)	MENA (All other	WCA (All other)	TOTAL
UNHCR	7,179,000	4,906,000	2,103,000	221,000	458,000	4,766,000	547,000	1,722,000	4,398,000	**26,300,000**
UNICEF	10,443,000	119,539,000	29,282,000	4,908,000	7,062,000	23,672,000	5,705,000	4,975,000	16,414,000	**222,000,000**
WFP	2,786,000	162,260,000	2,170,000	18,000	4,727,000	13,022,000	3,366,000	9,847,000	8,757,000	**206,953,000**
UNDP	14,880,000	369,154,000	20,462,000	9,715,000	41,428,000	27,920,000	4,465,000	29,036,000	20,140,000	**537,200,000**
UNFPA	27,644,000	56,819,000	2,332,000	1,511,000	7,609,000	6,592,000	11,528,000	6,908,000	6,163,000	**127,106,000**
UNODC	5,072,000	9,390,000	7,105,000	400,000	6,498,000	3,482,000	1,200,000	5,445,000	1,984,000	**40,576,000**
UN Women	3,304,000	15,553,000	4,257,000	3,158,000	1,314,000	2,200,000	1,347,000	1,159,000	2,012,000	**34,304,000**
ILO	9,668,000	11,670,000	1,250,000	596,000	637,000	765,000	627,000	1,827,000	986,000	**28,026,000**
UNESCO	4,039,000	13,991,000	1,241,000	230,000	1,248,000	2,925,000	619,000	171,000	1,786,000	**26,250,000**
WHO	57,484,000	64,220,000	24,036,000	2,414,000	13,270,000	9,922,000	5,044,000	11,701,000	15,938,000	**204,029,000**
World Bank	11,335,000	1,503,624,000	252,256,000	25,056,000	20,866,000	390,102,000	35,697,000	2,181,000	268,559,000	**2,509,676,000**
Secretariat	170,700,000	83,640,000	24,270,000	6,500,000	9,840,000	14,650,000	9,500,000	12,430,000	23,690,000	**355,220,000**
GRAND TOTAL	**324,534,000**	**2,414,766,000**	**370,364,000**	**54,727,000**	**114,957,000**	**500,018,000**	**79,645,000**	**87,402,000**	**370,827,000**	**4,317,640,000**

9 For the World Bank, where appropriate, estimates are made of the proportion of health system, social protection or other funds that directly contribute to the achievement of UBRAF results. Funds to support the achievement of broader development goals, whilst supportive of the AIDS response, are not included.

VI. PERFORMANCE MEASUREMENT, RISK MANAGEMENT AND ACCOUNTABILITY

110. A detailed presentation of UNAIDS 2014-2015 budget is included in the Results, Accountability and Budget Matrix of the UBRAF (UNAIDS/PCB(32)/13.9), which will serve as a basis for monitoring the implementation of UNAIDS budget in 2014-2015. The overall approach to performance measurement and reporting remains unchanged. This is described in the 2012-2015 UBRAF (UNAIDS/PCB(28)/11.10) and a subsequent update prepared for the June 2012 Board meeting (UNAIDS/PCB(30)/12.9).

111. Lessons already learned from monitoring and reporting on the UBRAF and recommendations of UNAIDS Monitoring and Evaluation Reference Group (MERG) will be drawn upon to further improve performance measurement and reporting to the Board. Particular attention will be given to expanding thematic and programmatic evaluations and clustering and simplifying indicators which form the basis for reporting. Key performance indicators will be used to track and improve internal efficiency and effectiveness.

112. An Enterprise Risk Management strategy (ERM) is under development to enable the identification, assessment, mitigation and management of risk as described in the financial management update prepared for the Board (UNAIDS/PCB(32)/13.7). The ERM is being developed to optimize the effectiveness and results of the Joint Programme through the most efficient management of resources to achieve the goals in UNAIDS Strategy. The ERM, which is expected to be in place by the end of 2013, will help UNAIDS deal with uncertainty and associated risks in order to minimize any negative impact on programme implementation and prevent any loss of resources.

113. Together with the existing internal control framework, the enterprise risk management strategy will assist UNAIDS understand and address the broad spectrum of risks facing the organization, and communicate with various stakeholders how risks are managed or mitigated.

114. UNAIDS operations will continue to be audited by an internal and external auditor and the reports of the auditors will be made available to the Programme Coordinating Board as part of UNAIDS commitment to accountability, transparency and publishing data in an open, electronic format in accordance with the standards of the International Aid Transparency Initiative. Policies and procedures dealing with fraud and corruption are continuously reviewed to ensure alignment with evolving best practices related to risk management and information disclosure.

DECISIONS

115. The Programme Coordinating Board is requested to:

- approve US$ 485 million as the core budget for 2014-2015 and the proposed allocation between the 11 Cosponsors and the Secretariat;
- endorse the continued simplification and refinement of the indicators, with the support of UNAIDS Monitoring and Evaluation Reference Group, and;
- remind all constituencies to use UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework to meet their reporting needs.

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