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30th Meeting of the UNAIDS Programme Coordinating Board
Geneva, Switzerland
5-7 June 2012

UNAIDS performance monitoring report 2010-2011

Additional documents for this item:

- i. Report by the Chair of the Committee of Cosponsoring Organizations (UNAIDS/PCB(30)/12.3)
- ii. Technical supplement: UNAIDS performance monitoring report Selected achievements against indicators (UNAIDS/PCB(30)/CRP1)
- iii. Case Study: Strengthening harm reduction and expanding services coverage for people who inject drugs in Eastern Europe and Central Asia (UNAIDS/PCB(30)/CRP2)
- iv. Case Study: The HIV/AIDS component of Tanzania's UN Development Assistance Plan (UNAIDS/PCB(30)/CRP3)
- v. Financial report and audited financial statements for the 2010-2011 biennium (UNAIDS/PCB(30)/12.6)
- vi. Update on indicators, monitoring and evaluation of the 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) (UNAIDS/PCB(30)/12.9)

Action required at this meeting: The Programme Coordinating Board is invited to *review* and *provide comments* on the report and provide guidance on ways to further strengthen performance monitoring of UNAIDS.

Cost implications: *none*

Overview

1. The UNAIDS performance monitoring report for 2010-2011 provides a summary of key achievements of the Joint Programme against the 2010-2011 Unified Budget and Workplan (UBW). It demonstrates how UNAIDS contributes to progress in the response to AIDS and efforts to achieve UNAIDS vision of “three zeros” - *zero new HIV infections, zero discrimination, and zero AIDS-related deaths.*

Progress towards the “Three Zeros”

Zero new infections

- New HIV infections are now at the lowest levels since their peak. There were 2.7 million new HIV infections in 2010 – a 21% reduction since 1997. Most declines are in young people aged 15-24 as young people are changing their sexual behaviour. However, the number of new HIV infections is continuing to rise in Eastern Europe and Central Asia, Oceania and the Middle East and North Africa


Zero discrimination

- The number of countries, territories or areas that had HIV-related restrictions on entry, stay and residence fell from 63 to 47 between 2008 and December 2011.

Zero AIDS-related deaths

- Globally, fewer people are dying of AIDS-related illnesses. In 2010, there were an estimated 1.8 million deaths – down from a peak of 2.2 million per year in the mid-2000s.
- Nearly half of all people eligible for treatment, 6.6 million of 14.2 million, now have access to it. An estimated 2.5 million AIDS deaths have been averted in low- and middle- income countries since 1995 due to the introduction of antiretroviral therapy. UNAIDS estimates that in 2010 alone, antiretroviral therapy averted 700,000 AIDS-related deaths.
- At the end of 2010, an estimated 34 million people were living with HIV worldwide, up 17% from 2001. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy.

2. To achieve the results of the 2010-2011 UBW, the Cosponsors and the Secretariat have worked together, guided by their mandates and the updated Division of Labour, embracing the “One UN” spirit. The UBW has served as UNAIDS instrument to coordinate the voices of the Cosponsors and the Secretariat, enhance the coherence of the Joint Programme and improve the impact of UNAIDS efforts to support government and non-government organizations achieve progress in the response to AIDS.
3. This report summarizes the achievements of UNAIDS over the last two years at country, regional and global level. Additional information on the key achievements and contributions of the Cosponsors can be found in the report of the Chair of the Committee of Cosponsoring Organizations to the Programme Coordinating Board (UNAIDS/PCB(30)/12.3). Notable achievements in 2010-2011 include:
 - Galvanizing the global AIDS response, culminating in the June 2011 UN High Level Meeting and Political Declaration, and advocating for a new paradigm around shared responsibility, innovative sources of financing, and more predictable and sustainable HIV investments.

- Tracking and measuring progress in the global response (with national progress reports on UNGASS indicators submitted by a record 182 out of 192 member states compared to 153 four years earlier), along with strengthened country capacity to generate and use epidemiological data for alignment of resources with epidemic priorities and improved targeting and efficiency of HIV prevention, treatment and care programmes.
 - Leveraging funding for the AIDS response in countries, including through, for example, UNAIDS Technical Support Facilities which have assisted countries to mobilize US\$1.7 billion in the last three rounds' of applications for the Global Fund.
 - Mobilizing the AIDS response for broad health, development and human rights goals, through the Red Ribbon-Pink Ribbon initiative, the [Agenda for Women and Girls](#), and advocacy for integration of AIDS with other Millennium Development Goals as well as peace and security through Security Council Resolution 1983.
 - Bringing together and building consensus among partners to enhance ownership and sustainability, documenting and disseminating innovative and good practices, and highlighting the importance of involving communities in the AIDS response and scaling up services.
4. The core UBW itself continued to leverage funds across the UNAIDS programme. In addition to the core budget of US\$ 515 million, an additional US\$304 million was mobilized as supplemental UBW at the global and regional level. In addition, US\$ 3.2 billion of country level expenditure was disbursed, bringing the total funding channelled through the UN system last biennium, including World Bank concessional loans and grants, to almost US\$4 billion – almost seven times more than the core UBW itself.
 5. **Part I** of this report presents overall achievements against priority areas in the 2010-2011 UBW and shows how UNAIDS work contributes towards the achievement of the targets established at the High Level Meeting of the UN General Assembly in June 2011.
 6. **Part II** presents achievements under cross-cutting strategies in the UBW to the extent these are not captured in the first part of the report.
 7. **Part III** provides a snapshot of results at country and regional level, selected on the basis of relevance to regional and country contexts, epidemics and challenges, and is included in response to requests for more programmatic information of this type.
 8. **Part IV** presents financial information: budgets and expenditures from the core UBW, but also Cosponsors own resources to present a more comprehensive picture of the work of the UNAIDS family at country level.
 9. To keep the report as concise as possible, while providing readers access to more information, hyperlinks have been included in the electronic version, as well as links to videos (with the  icon)¹. Additional information on the UNAIDS Secretariat and Cosponsors that has formed the basis of this report is available at the [UBW/UBRAF page of the UNAIDS website](#).
 10. The report will be supplemented by two case studies which will be presented to the meeting of 30th Programme Coordinating Board as Conference Room Papers. In addition, a Conference Room Paper has been prepared to present a selection of results against global indicators.

¹ Hyperlinks were functional when this report was published but may change over time.

I. Results against Priority Areas

A. Reduce sexual transmission of HIV, empower men who have sex with men, sex workers and transgender people to protect themselves from HIV and fully access antiretroviral therapy, and empower young people to protect themselves from HIV²

Target: Reduce sexual transmission by 50% by 2015



Overall progress

Globally, the number of new infections per year is declining. In 2010, an estimated 2.7 million people were newly infected with HIV, 15% fewer than the 3.1 million new infections in 2001. Young people aged 15-24 account for 42% of new infections. Here, too, progress is evident. In 21 of 24 countries with HIV prevalence of 1% or greater, statistically significant declines in HIV prevalence among young pregnant women (15-24 years) in the past decade have been documented. In 33 countries, including 22 in sub-Saharan Africa, HIV incidence declined by at least 25% from 2001 to 2009.

Several factors have contributed to declining incidence trends in countries, including safer sex practices, access to and coverage of prevention and treatment services and commodities, and scientific advances in testing, diagnostic and prevention technologies. Many countries in sub-Saharan Africa have started implementing adult male circumcision to prevent female-to-male sexual transmission. Over 550,000 male circumcisions were carried out in nine countries in 2010. The increasing number of PLHIV on treatment is starting to show the effect of 'treatment as prevention' at population level.

Yet more needs to be done to reach zero new infections:

- In 14 countries where HIV prevalence exceeds 2% and where nationally representative data are available, more than 70% of men and women who had high-risk sex in the past year reported not using a condom the last time they had sex.
- According to national universal access reviews, many countries are experiencing interruptions in the supply of condoms, impeding efforts to deliver HIV prevention programmes.
- Evidence from Sub-Saharan Africa shows that increasing proportions of sexual transmission takes place within HIV-discordant married and cohabiting couples, where the uninfected partner might not know of the infected partner's HIV-positive status.
- The high prevalence of HIV among sex workers in Sub-Saharan Africa highlights that unprotected paid sex remains a significant transmission route. In Kenya for example an estimated 14% of new HIV infections were linked to sex work.
- A growing number of HIV infections occur from sexual transmission among men having sex with men, many of whom have female partners.

[WHO/UNAIDS/UNICEF Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access, 2011](#)

[Clearinghouse on male circumcision for HIV prevention](#)

[UNAIDS Guidance Note on HIV and Sex Work \(2009\), including four complementary annexes \(added in 2011\) from the UNAIDS Advisory Group on HIV and Sex Work.](#)

[Securing the future today. Synthesis of Strategic Information on HIV and Young People, UNAIDS 2011](#)
[Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: Recommendations for a public health approach \(WHO, 2011\)](#)

11. The drop in new HIV infections corresponds to some positive trends observed on key behavioural indicators such as increased condom use, delay of sexual debut and

² Priority Areas 1, 6 and 9 in the 2010-2011 Unified Budget and Workplan (UBW).

reduction of multiple concurrent partnerships. Throughout 2010-11, capacity was built with the support of UNFPA to strengthen Sexual Reproductive Health (SRH) and HIV links through a series of global and regional consultations (www.srhshivlinkages.org), and strategic partnerships (e.g. IAWG SRH and HIV Linkages, networks representing PLHIV and key populations). Twenty-three countries carried out assessments of policy, systems, and service delivery, using the Rapid Assessment Tool for SRH & HIV linkages in order to strengthen linkages in national plans. Sixteen reports were prepared and shared summarizing process, findings, lessons learned and recommendations. To assess progress in linking SRH and HIV at the country level, 17 impact assessments were undertaken with the first phase of countries to implement the rapid assessment.

12. Comprehensive Condom Programming (CCP) remains a mainstay of HIV prevention and 86 countries under the Global Condom Initiative have been implementing the standardized '10 Step Strategic Approach to CCP' with UNFPA support. Thirty-eight of these countries drafted National Condom Strategies and developed costed operational plans during the biennium; 10 countries finalized or reviewed National Condom Policies and Strategies. In 2010, 840 million male condoms (of a total 2.8 billion) and 9.8 million female condoms (of a total 18 million) were supplied by UNFPA in low-income countries.

Case study: Using humour to reduce stigma around condoms

The UNFPA-supported Condom Project is breaking down peoples' inhibitions to handle, use and talk about condoms in Burkina Faso, Ethiopia, India, Nigeria and Thailand. Working with local partner organizations, young people make their own 30-second videos about unorthodox uses for condoms, helping to break the ice and get people laughing and talking about condoms. Thousands of people have seen these videos, which have been shown on a range of media from projections on sheets hung from trees to on television in Nigeria and Thailand.

13. By the end of 2011, the World Bank had provided \$5 billion in financing for AIDS (of which \$1.8 billion was in 2010-2011), including 15 years continuous support as the only remaining external financier of Brazil and India's AIDS programs, and a new \$400 million AIDS credit to Nigeria. World Bank AIDS projects predominantly finance prevention activities (with other major global players such as the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund predominantly supporting treatment). The impetus for a focus on prevention is two-fold: firstly, without 'turning off the tap' of new infections, HIV will remain a persistent development challenge in the foreseeable future; secondly, successful prevention requires an understanding of the causes of new infections and the relationship between HIV prevention programs and the reported decline in new annual infections (20% reduction in new HIV infections in the last 10 years).

Challenge: Confirming causality

Confirming causality has been challenging and a weak evidence base for HIV prevention remains. To improve the scale-up of effective HIV prevention programs, prevention evaluations of impact to actually measure the number of infections averted, are therefore critical. In support of and in addition to lending operations, the World Bank finances analytic work to assist countries to better understand HIV epidemic characteristics and plan for effective HIV prevention responses. This entails supporting the design of effectiveness evaluations for HIV prevention with a focus on ensuring that evidence about the population-level effectiveness of these interventions (for HIV prevention) are being collected and analyzed, through proper prospective designs, data analyses and routine linkage of data all along the results chain. During 2010 and 2011, the World Bank initiated impact evaluations and efficiency-effectiveness studies in over 15 countries, including China, India, Kenya, , Nigeria, South Africa, Uganda, Ukraine, Zambia, and Zimbabwe. The India impact evaluation concluded the national AIDS program underpinned by the World Bank had averted 3 million HIV infections.

14. Following conclusive results from scientific trials, the UNAIDS/WHO [Joint Strategic Action Framework](#) was developed to accelerate the scale-up of voluntary medical male circumcision (VMMC) for HIV prevention in Eastern and Southern Africa'. The framework was launched at the ICASA conference in December 2011 and provides guidance to scale up

male circumcision in 13 countries, complementing costing studies undertaken in Tanzania and under development in Botswana. The scale-up of VMMC has been modest in most countries but over 550,000 males in the priority countries were circumcised for HIV prevention by the end of 2010.

15. Progress on Pre-Exposure Prophylaxis (PrEP) is under way following promising results under a collaboration between UNAIDS, Georgetown University and Imperial College in London. A joint workplan for all PrEP activities was developed and activities have begun with WHO receiving planning permission from the WHO Guidelines Review Committee for the development of Rapid Advice on the use of PrEP for men who have sex with men and for sero-discordant couples. Preparations have started for a review of PrEP for sero-discordant couples to be carried out in 2012. An ILO impact study undertaken in 17 countries which implemented the Strategic HIV and AIDS Response in Enterprises showed that condom availability increased by 44.3 per cent and condom use increased by 14.4 per cent between the baseline and impact studies.
16. The June 2011 Political Declaration recognized people who inject drugs, sex workers and men who have sex with men as groups at high risk of HIV transmission and in need of targeted, appropriate responses. In 2011, WHO/UNDP/UNAIDS released [Guidelines on preventing and treating HIV and other sexually transmitted infections among men who have sex with men and transgender people](#), the first public health guidelines to focus on these specific population groups and aimed at policymakers, implementers and medical staff to scale-up access to prevention and treatment.
17. Cities, where it is estimated that as many as 50% of people living with HIV live, present a major opportunity to have a significant impact on reducing new HIV infections and can play a role in realigning national responses to the specific needs of most-at-risk populations. UNDP supported the review, development and/or implementation of municipal action plans to provide increased access to services for MSM and transgender people in Asia³, and for MSM, transgender people and sex workers in Africa, Latin America and Eastern Europe⁴.
18. To further strengthen the evidence base for HIV prevention, systematic reviews were undertaken to inform guidance on HIV and STI interventions for sex workers and their clients. The review of evidence covers violence against sex workers, community empowerment, periodic presumptive treatment and the syndromic management of STI. A values and preferences study was carried out by the Network of Sex Work Projects (NSWP) and brought together experts, researchers, sex workers, WHO, UNFPA, UNDP and the UNAIDS Secretariat.
19. The governments of Argentina, Ecuador, El Salvador, Guatemala, Panama, Paraguay reallocated their budgets to more effectively target prevention following a World Bank study in 2010. As a result of the studies, resource allocations for programmes targeting key affected populations increased nine-fold compared to 2008.
20. A comprehensive analysis of age and sex disaggregated data on epidemiological, behavioural and service indicators for young people and HIV was carried out and

Challenge: Infections in South Africa

An estimated 5 million more South Africans will become HIV infected over the next two decades, roughly doubling the number of PLHIV in the country. In order to prevent this, interventions need to be better targeted, promoted and quality assured. They must be implemented at sufficient scale using the right messaging together with the best technical advice.

³ (Bangkok, Chengdu, Ho Chi Min City, Jakarta, Yangon and Manila)

⁴ (Dar es Salaam, Kampala, Kigali, Lagos, Lusaka, Maputo and Ouagadougou; Georgetown, New Amsterdam, Santo Domingo and Zacatecas and Belgrade)

compiled into a UNICEF-spearheaded report, [Opportunity in Crisis: Preventing HIV from early adolescence to early adulthood](#) by the Joint Programme. The report highlights lessons learned and challenges in responding to the prevention needs from early adolescence to early adulthood and includes current knowledge around adolescents living with HIV. For the first time, country-specific estimates of the number of adolescents living with HIV (male and female) and the number of new HIV infections in young people aged 15-24 years are included.

21. A youth summit co-hosted by the Government of Mali was organized by UNAIDS and rallied more than 150 young people from over 70 countries. An outcome of the summit was an online 'call for action' to mobilize young people around the world to take the lead on the AIDS response and to hold governments accountable for their commitments. In Liberia, one youth activist alone got 20,000 people to endorse the call which was transmitted to the High Level Meeting in June 2011. A month earlier, Archbishop Desmond Tutu symbolically 'passed the baton' to a new generation of young leaders in Robben Island, South Africa.

B. Prevent mothers from dying and babies from becoming infected with HIV⁵

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



Overall progress

In 2005, only 14 per cent of HIV-positive pregnant women in low-and middle-income countries received antiretroviral drugs for prevention of mother-to-child transmission of HIV (PMTCT), while in 2010 that figure had risen to 48 per cent. Improvements were notably also observed in sub-Saharan Africa, the most affected region, reaching 64 per cent of pregnant women living with HIV in Eastern and Southern Africa with ARVs, and 18 per cent in West and Central Africa, up from 18 per cent and 4 per cent in 2005, respectively. As this reflects a shift away from the use of single dose nevirapine these figures are even more impressive. In addition, the 2010 WHO guidelines recommend that women living with HIV should be clinically assessed for treatment eligibility. In 2010, 45% of such women were assessed, down from 51% in 2009.

As access to PMTCT services increased, the annual number of children acquiring HIV infection decreased significantly in the past few years. By 2010 an estimated 390,000 children were newly infected with HIV, 30 per cent fewer than the peak of 560,000 children newly infected annually in 2002 and 2003. New HIV infections in children have virtually stopped in high income countries. Since 1995 over 350,000 new HIV infections among children were averted globally. This trend reflects the steady expansion of services to prevent HIV from being transmitted to infants and to a lesser degree the expansion of access to treatment for children. In 2010, 35% of pregnant women in low- and middle-income countries knew their HIV status, up from 8% in 2005. Increases were observed in almost all regions, with the percentage of pregnant women testing for HIV growing by around 10 per cent or more between 2009 and 2010 in Eastern and Southern Africa; Central Asia and East, South and South-East Asia. During 2010, in 65 low and middle income countries, 28 per cent of infants were reported to have been tested for HIV within the first two months of birth, versus six per cent in 2009.

With improved treatment regimens and strengthened commitment, it now seems feasible by 2015 to eliminate new HIV infections among children and to keep their mothers alive.

[WHO/UNAIDS/UNICEF Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access, 2011](#)

[Global Plan for the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive](#)

⁵ Priority Area 2 in the 2010-2011 Unified Budget and Workplan (UBW).

22. The [Global Plan for the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive](#) (eMTCT) was launched at the High Level Meeting in June 2011, developed by a group of more than 30 countries and 50 community groups, non-governmental and international organizations, convened by UNAIDS and PEPFAR. It helped mobilize additional resources towards elimination, with major commitments from PEPFAR (additional resources US\$75 million in excess of the US\$300 million already provided), foundations and the private sector.

Case study

Twenty five First Ladies joined forces to call for integration of HIV and maternal, newborn and child health programmes, at special event convened by UNAIDS during United Nations High Level Meeting on AIDS. Subsequently, on World AIDS day 2011, 11 of 22 focus countries launched their costed elimination plans for MTCT.

23. The plan's comprehensive approach reinforces the four prongs: preventing new HIV infections, avoiding un-intended pregnancies, preventing MTCT and treatment, care and support for children and women living with HIV. It focuses on 22 most-affected countries where national authorities have been encouraged to establish national platforms for implementation and the development of costed country-driven national plans. Half of the focus countries had launched their national plans by the end of 2011.

24. A global steering group co-chaired by UNAIDS and the US Government was formed to oversee the implementation of the Global Plan, provide normative guidance, monitor and track progress, and coordinate technical assistance. The global steering group is supported by UNICEF and WHO as the co-convenors of the interagency task team that provides normative guidance, monitors and tracks progress and provides and coordinates technical assistance.

Key achievements

In the joint UNFPA/UNAIDS initiative to "better link HIV and sexual and reproductive health in Southern Africa" UNAIDS became a partner of choice for EU Delegations and contributed to the development of EU country strategies for human rights and child rights.

AIDS was positioned in new EU development policies on gender, global health & MDGs as well as in new EU policy frameworks for 2014-2020 on research & public health.

25. More than 25 countries were supported by UNFPA to adapt and implement PMTCT guidelines and strategies to scale up PMTCT and capacity to scale up comprehensive PMTCT was strengthened in over 38 countries. UNICEF supported over 80 countries to scale up their PMTCT and/or paediatric plans and to develop MTCT elimination plans. Eighty per cent of countries in the Latin American and Caribbean regions have demonstrated accelerated progress in the MTCT Elimination Initiative. PMTCT programmes are best integrated with mother-and-child health and nutrition services, which simultaneously prevents HIV transmission and improves health outcomes.

26. Seventeen (77%) of the 22 MTCT elimination priority countries have completed national baseline assessment. Ten countries had costed national plans in place at the end of 2011 and are now moving forward with implementation.

27. '[Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015](#)' was developed in support of the Global Plan and includes a package of services, key entry points, checklists for national implementation, and strategies on Sexual and Reproductive Health and HIV linkages; engaging communities, PLHIV, and men; and eliminating stigma and discrimination. It also covers national capacity to scale up the elimination of MTCT through policies, systems, and services linked to MNCH, and other SRH programmes.

C. Ensure that people living with HIV receive treatment⁶

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



Overall progress

The number of people living with HIV, in low- and middle-income countries and receiving antiretroviral therapy (ART) increased 27% in 2010, reaching more than 6.6 million people. Ten low- and middle-income countries achieved 80% ART coverage and seven countries achieved an estimated coverage between 70% and 79%. While these gains have saved lives, treatment for children has increased, but at an unacceptably low rate, from 21 per cent in 2009 to 23 per cent in 2010. Overall, the number of annual AIDS deaths has declined by approximately 20% from 2005 to 2010. In 2010, access to antiretroviral therapy averted approximately 700,000 deaths in low and middle income countries; over 2.5 million deaths were avoided since its introduction in the mid-1990's.

The overall gains in access to treatment and care are not uniformly shared across all people living with HIV. The estimated global coverage in low and middle income countries is still lower than 50%. Antiretroviral treatment coverage in 2010 continues to be higher for women than men (53% vs. 40%) and also higher for adults than for children (51% vs. 23%). In 2010, people who inject drugs in low and middle income countries from Europe and Central Asia represented 62% of people living with HIV but only 22% of those receiving antiretroviral therapy. National universal access reviews, supported by UNAIDS, identified several challenges to the scale-up of ART and optimization of health outcomes. Interruptions of drug supplies, limited laboratory capacity and inadequate retention of antiretroviral patients in treatment programmes were some of the key challenges with possible implications on treatment outcomes and risk of drug resistance.

[WHO/UNAIDS/UNICEF Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access, 2011](#)

[Treatment 2.0 framework \(WHO, 2011\)](#)

[Strategic Use for Antiretrovirals in Treatment and Prevention \(WHO, 2011\)](#)

28. In June 2010, the Treatment 2.0 initiative was launched by the UNAIDS Secretariat and WHO. Designed as a radically simplified HIV treatment platform to decrease AIDS-related deaths and benefit HIV prevention efforts, it builds on '3 by 5' and on evidence and experience of the last 10 years.
29. Treatment 2.0 was launched to accelerate access to treatment through better combination treatment regimens, cheaper and simplified diagnostic tools, and a low-cost community-led approach to delivery. UNAIDS' work contributed to dramatic increases in ART coverage in sub-Saharan Africa and the number of people in low- and middle-income countries receiving treatment increased by more than 1.35 million in 2010. Direct technical support on HIV treatment and care was provided to 30 countries through regional workshops in 3 regions and to 10 countries through individual missions and 27 laboratories were accredited for plasma genotyping by the end of 2011. Forty-two different formulations of antiretrovirals were prequalified and 13 diagnostic tests for HIV in areas of serology, CD4 determination, and viral load.

Case study: Ground-breaking results on the HPTN 052 study

Results from the Treatment for Prevention (HPTN 052) trial, showed that if an HIV-positive person adheres to an effective antiretroviral therapy regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%. UNAIDS widely publicized these results from the [HPTN 052 study](#) conducted in Thailand and Africa.

⁶ Priority Area 3 in the 2010-2011 Unified Budget and Workplan (UBW).

30. With the aim of increasing the choice of ARTs and reducing prices, WHO prequalified 42 different formulations of anti-retrovirals during the biennium and a prequalification programme for diagnostics was launched, leading to 13 prequalified diagnostic tests for HIV (in serology, CD4 determination, and viral load). The online [Procurement Supply Management Toolbox](#) was developed by WHO, AMDS and partner organizations and had over 50,000 visitors in 2010.

31. Capacity was built in 42 countries by UNDP on adopting enabling trade and health policies and legislation (e.g. UNDP in partnership with civil society and GTZ supported the East African Community (EAC) on the proliferation of anti-counterfeiting legislation – this resulted in the adoption by the EAC Secretariat of UNDP proposals to amend the draft EAC anti-counterfeiting bill. This will guarantee the continued use of generic medicines in the EAC which account for 90% of all medicines consumed in the region).

Lessons learnt

Many countries could more effectively use TRIPS flexibilities and safeguards to reduce the prices of medicines and increase access to treatment. The [good practice guide](#) and [policy brief](#) produced by UNDP, WHO and the UNAIDS Secretariat in 2010 provide examples of accessible and comprehensive policy tools to support this.

32. An essential part of scaling up treatment includes broader access to HIV Testing and Counselling (HTC). Models such as VCT, Provider Initiated Testing & Counselling (PITC), community-based/household testing, workplace testing and HTC campaigns were assessed for effectiveness in increasing access to testing by different population groups. For example, the AIDS Program of São Paulo in Brazil reported 200,000 people tested in 2010 while the programme in Kenya reported over 1 million people tested. WFP worked with governments and partners in 35 countries to ensure that treatment is accompanied by assessments of nutritional status, education and counselling on nutrition to maintain body weight and health and mitigate side effects, and where necessary provide nutritious food to treat malnutrition. Through HIV workplace programmes, the ILO supports efforts aimed at generating demand for treatment by promoting VCT days. In Ghana and Zimbabwe alone, 27,215 workers undertook VCT.

33. The early identification of infants infected with HIV has been strengthened through the provision of commodities for the dry blood spots and DNA PCR technology in 17 countries, with the support of UNICEF. Innovations are reducing barriers to access, and facilitate the use and enhance quality of services.

D. Prevent people living with HIV from dying of tuberculosis⁷

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



Overall progress

Tuberculosis is a leading cause of death among people living with HIV. Most recent WHO estimates show that there were 1.1 million new TB cases and 360 000 TB deaths among people living with HIV in 2010. However, improvements in scaling up joint TB/HIV services has helped accelerate the decline of TB deaths in people living with HIV and resulted in a 10% reduction between 2009 and 2010.

Efforts to diagnose HIV/Tuberculosis co-infection and to intervene with effective preventive and therapeutic regimens have shown some progress as has access to HIV services for people with tuberculosis. Under new WHO guidelines, everyone with TB and living with HIV should receive anti-retroviral therapy but only 34% of people with TB were tested for HIV in 2010, up from 4% in 2003 to 26% in 2009. Antiretroviral therapy reduces the risk of death among people with tuberculosis and living with HIV but only 46% of co-infected persons received antiretroviral therapy in 2010. Two of the countries with the highest burden of HIV-related TB provided treatment for both diseases for over 50% of people in need.

Efforts to prevent tuberculosis-related deaths among people with HIV have progressed but remains a challenge. The number of people living with HIV screened for TB was equivalent to over half (58%) of the reported number of people enrolled in HIV care worldwide in 2010. Tuberculosis screening in HIV treatment settings remains insufficient. Malnutrition in co-infected individuals jeopardizes the effectiveness of treatment and needs to be better addressed. In 2010, fewer than 1% of people living with HIV received isoniazid preventive therapy. These patterns underscore the urgent need to strengthen collaborative HIV/ tuberculosis efforts.

An epidemiological model produced by the Stop TB Partnership, WHO and UNAIDS showed that it is possible to sharply reduce AIDS deaths worldwide by preventing and treating TB. Results show that one million lives can be saved between now and the end of 2015 by preventing and treating tuberculosis among people living with HIV.

[Tuberculosis and HIV](#)

[WHO HIV/TB Facts 2011](#)

34. In 2010, UNAIDS signed a memorandum of understanding with the Stop TB Partnership. The agreement bound the two organizations together in a common goal: to halve the number of people living with HIV who die from TB by 2015, compared to 2004 levels..

35. The policy on collaborative TB/HIV activities was updated and finalised, following the conduct of systematic reviews and the establishment of guidelines updating the group and a wider peer review process. Guidelines on isoniazid preventive therapy, infection control for TB and intensified case finding were finalised and published. With UNAIDS support, countries have been scaling up the “Three I’s”: Intensified TB case finding, Isoniazid preventive therapy, and Infection control”. North Star Alliance and WHO/ Stop TB along with the National TB Programmes in Kenya and Uganda initiated a pilot

Evaluation

People who inject drugs and prisoners receiving treatment for TB should be provided with treatment for co-occurring conditions (including drug dependence, mental health problems, HCV, HIV and other infections) and psychosocial support. Provision of TB treatment should, however, never be conditional on the treatment of co-occurring conditions.

⁷ Priority Area 4 in the 2010-2011 Unified Budget and Workplan (UBW).

project to test the feasibility of using GeneXpert for the rapid detection of TB in mobile populations along the northern corridor. A regional training/meeting was organised by ILO, Global Business Coalition, UNAIDS Secretariat, WHO and the Global Fund in South Africa, to enhance partnerships between private and public sector institutions; showcase approaches used by businesses to implement TB/HIV workplace programmes (including TB screening and case detection) and build capacity to implement Recommendation No. 200 related to the workplace.

36. A joint policy guide to improve health workers' access to HIV and TB prevention, treatment, care and support was jointly developed by ILO, WHO and the UNAIDS Secretariat, based on a systematic review of research findings. The joint policy guide was officially launched in November 2010 and disseminated to policy makers to inform country plans.
37. Nutritional TB treatment support was provided to patients in 28 countries representing 30 per cent of all food based support in care and treatment. The food was provided as individual and/or household rations, reaching nearly a million beneficiaries in 2010-2011. The evidence related to nutrition and HIV, nutrition and TB, and food insecurity and HIV was reviewed and updated in three background papers published in a supplement of the Food and Nutrition Bulletin in 2010. Food and nutrition support from WFP in conjunction with TB-DOTS was included in the Round 10 Global Fund TB proposals of Djibouti, Lao People's Democratic Republic, Swaziland and Tajikistan; the Djibouti and Swaziland proposals were endorsed.

E. Protect drug users from becoming infected with HIV⁸

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



Overall progress

An estimated 3 million people who inject drugs worldwide (15.9 million) are living with HIV. Eastern Europe and Central Asia, East and South East Asia and Latin America are the regions with the highest number of people who inject drugs living with HIV.

Access to HIV prevention for people who use drugs has increased but not at the required scale. Recent modelling studies showed that achieving high coverage of antiretroviral therapy, opioid substitution therapy (OST) and needle and syringe programmes (NSP) in combination could reduce HIV infections by 50% in 5 years in people who inject drugs. The “Comprehensive package of nine interventions” developed by WHO/UNODC/UNAIDS outlines nine key interventions for national HIV strategies to implement for maximum impact in reducing transmission.

In 2010, median coverage reported for HIV prevention targeting drug users was 32% (ranging from 0% to 64% in 29 countries reporting). The proportion of countries reporting high coverage (as defined by WHO, UNODC and UNAIDS in 2009), varied from 18 to 44 per cent in 82 countries reporting for different services targeting drug users in community settings in 2011, based on UNODC reports. The proportion of countries reporting high coverage for individual services was 28.5% for needle and syringe programmes, 35.3% for opioid substitution therapy, 38.1% for HIV testing and counselling, and 43.9% for antiretroviral therapy.

Globally, coverage for these interventions is still insufficient with only eight out of every hundred people who inject drugs having access to OST, four in one hundred people who inject drugs and are eligible receive ART and half of the countries who report injecting drug use do not have access to Needle and Syringe Programmes.

In 2010, several countries revised national policies to include key elements of harm reduction, such as needle and syringe programmes and opioid substitution therapy. In particular, women who inject drugs are more likely to face violence, greater levels of stigma and often die earlier. Over the biennium, notable progress was achieved in developing gender-responsive HIV programmes for female drug users and female prisoners, in several countries.

[HIV in people who use drugs: The Lancet series \(2010\)](#)

[Women who inject drugs](#)

[HIV in prisons](#)

38. While bringing to light new scientific knowledge, the International AIDS Conference held in Vienna in 2010 drew attention to the growing epidemics in Eastern Europe and Central Asia and highlighted the protection of human rights as a fundamental prerequisite to an effective response to HIV. With technical support from UNAIDS, the Lancet series on people who inject drugs was launched at the Vienna International AIDS Conference in July 2010. Guidance was also produced on the ethical engagement of people who inject drugs in biomedical HIV prevention trials.

Lesson learnt: Country ownership

Ownership from the Government is indispensable for action as is the involvement of people who use drugs – they should be encouraged to participate in the planning, delivery and evaluation of strategies and programs addressing drug use and HIV. Through meaningful involvement of people who use drugs, the effectiveness of the HIV response is enhanced, and programmes will be more appropriate and responsive to the needs of those most affected.

⁸ Priority Area 5 in the 2010-2011 Unified Budget and Workplan (UBW).

39. The fifty-fourth session of the United Nations Commission on Narcotic Drugs (CND) adopted a resolution on achieving zero new infections of HIV in injecting and other drug users. UNODC was requested to continue providing advice and guidance on effective measures to scale up HIV prevention for people who use drugs, and on how to reduce stigma and discrimination.
40. High-level advocacy has generated positive results with the CND and a number of programmatic and policy breakthroughs with respect to HIV and people who inject drugs occurred in several Asian countries. They included among others, a human rights based drug law in Cambodia, the removal of policy barriers in the Philippines, and the initiation of methadone treatment in Lao PDR, needle exchange, and harm reduction task forces.
41. The [Reference Group to the United Nations on HIV and Injecting Drug Use](#) produced the first ever global, regional and country estimates on coverage of HIV services among people who inject drugs in 2010, with support from UNAIDS. In 2011, a landmark reference report on female drug users was published.
42. During the course of the biennium, operational guidelines to monitor and evaluate HIV prevention for people who inject drugs were produced, and technical assistance provided in at least 71 countries. Technical support was provided to establish multisectoral working groups, mobilize additional resources, assess programmatic needs and capacity building, implement, monitor and evaluate evidence-informed comprehensive HIV prevention, treatment and care services for people who inject drugs, in prison settings..
- Challenges**

In spite of high levels of HIV prevalence and risk behaviours, and evidence of effectiveness in such settings, interventions essential to the prevention and treatment of HIV, including NSP, OST and ART, remain unavailable in most prisons and detention centres around the world. Medical services offering treatment for TB, viral hepatitis and sexually transmitted infections are also often unavailable in closed settings.
43. Overall, 1,000 policy makers, managers, technical officers and service providers in Central Asia, South and South East Asia, and Eastern Europe received training and technical support from UNAIDS, including evidence-based policy and programmatic tools, guidelines and best practices. Technical guidelines on comprehensive HIV services for people who inject drugs and prisoners and on their monitoring & evaluation, were translated into local languages and disseminated and used as part of this training.
44. An underground HIV epidemic in Eastern Europe and Central Asia is intensifying at an alarming pace, fuelled by drug use, high-risk sexual behaviour and high levels of social stigma that discourage people from seeking prevention information and treatment. At the Vienna 2010 AIDS Conference UNICEF released a report, [Blame and Banishment](#), highlighting the issues faced by children living with HIV, adolescents engaged in risky behaviour, pregnant women using drugs, and the more than one million children and young people who live or work on the streets of the region. Marginalized young people are exposed on a daily basis to multiple risks, including drug use, commercial sex and other exploitation and abuse, putting them at higher risk of contracting HIV. The trends are especially troubling, as the region is home to 3.7 million people who inject drugs – almost a quarter of the world total and for many, initiation into drug use begins in adolescence.

F. Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS⁹

Target: Eliminate stigma and discrimination against people living with and affected by HIV



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



Overall progress – Punitive laws, stigma and discrimination

Globally, governments cite stigma as the single greatest impediment to accelerated progress in the response. To date, adequate resources have not been allocated to stigma and discrimination reduction programmes. Although many strategies mention human rights, stigma and discrimination, they are not translated into comprehensive, appropriately targeted and funded programmes, according to an analysis of national planning documents.

Key data

- 47 countries, territories and areas had some form of restriction on the entry, stay and residence of people living with HIV (as of November 2011).
- 56 countries have laws that specifically criminalize HIV transmission or exposure.
- About 30% of countries worldwide lack laws that prohibit HIV-related discrimination.
- More than two thirds of countries reported having laws or policies that indirectly or inadvertently reduce service access for vulnerable populations. (2010 UNGASS reporting)
- 27 countries are reported to have compulsory detention for people who use drugs, often without due process or minimum standards of detention or treatment.

The number of countries reporting the existence of laws, regulations or policies protecting people living with HIV from discrimination increased from 87 in 2008 to 124 in 2010. In 2010, 91% of countries addressed stigma and discrimination in their national strategies, and 90% reported anti-stigma activities compared to 39% in 2006.

Efforts to remove punitive laws, policies, practices, stigma and discrimination face considerable challenges. Although the number of countries with HIV discrimination laws in place has increased, fewer than 60% of countries reported having a mechanism to record, document and address instances of discrimination against people living with HIV or key populations at higher risk. While efforts to reduce stigma are increasingly recognized in national strategies, a small minority of countries budget adequately for programmes that address stigma.

A number of countries have reviewed or initiated consultations towards the review of their laws and practices regarding the criminalization of HIV non-disclosure, exposure and transmission. They include Congo, Denmark, Finland, Guinea, Norway, Switzerland, Togo and the United States of America. In September 2011, the parliament of Guyana rejected a motion to criminalize HIV non-disclosure, exposure and transmission on grounds that such measure would undermine the HIV response in the country.

[Making the law work for the HIV response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support](#)

[Information on criminalisation of HIV non- disclosure, exposure and transmission](#)

Overall progress – HIV-related travel restrictions

Between 2010 and 2011, six countries repealed their respective HIV-based travel restrictions (Armenia, China, Fiji, Namibia, Ukraine and USA), and two more (Ecuador and India) issued clarifications that such restrictions were no longer in place. Forty-seven countries, territories and areas continue to have some form of restriction on the entry, stay and residence of people living with HIV.

⁹ Priority Area 7 in the 2010-2011 Unified Budget and Workplan (UBW).

45. The [Global Commission on HIV and the Law](#) was launched in June 2010 to examine the impact of the law on national HIV responses and to catalyze action at country level. Some early results include Fiji not choosing to criminalise HIV transmission and lifting its travel restrictions and the review of patent laws in Moldova and Kyrgyzstan. The Commission is led by UNDP for the Joint Programme, with support also provided by UNICEF, UNFPA and the UNAIDS Secretariat, OHCHR and IPU. The Commission focuses on how laws and law enforcement can support, rather than block, effective HIV responses by increasing awareness and mobilization on these issues. Seven hundred government and civil society stakeholders from 140 countries were engaged in constructive dialogue on creating human rights based legal environments for effective HIV responses. The Commission has held seven dialogues in all regions of the world and focused on four areas: (1) Laws and practices that effectively criminalize those living with HIV and most vulnerable to HIV; (2) Laws and practices that sustain or mitigate violence and discrimination as lived by women; (3) Laws and practices that facilitate or impede HIV-related treatment access; and (4) Issues of law pertaining to children and young people in the context of HIV.

46. 'Snapshots' of the HIV-related legal environment (protective and punitive laws) in countries and regions were developed and incorporated in country UNGASS reporting, in partnership with civil society organizations. Several major media outlets reported these in publications, including [The Economist](#).

Lessons learnt

Parliamentarians are a key target for advocacy on stigma and discrimination; as is work with local NGOs and CBOs with knowledge and representation on the ground. They can identify and involve networks of PLHIV or people affected by HIV. In both cases, on-going relationships and continued negotiations are required rather than a one-time activity.

47. UNAIDS developed a [Policy Framework on Positive Health, Dignity and Prevention](#) with the Global Network of People living with HIV (GNP+) and other partners. It focuses on improving and maintaining the health and well-being of people living with HIV, which, in turn, contributes to the health and well-being of partners, families and communities. This is in direct contrast to previous approaches to 'positive prevention' which could be construed as treating people living with HIV as vectors of transmission. By focusing on the journey experienced by people living with HIV from testing to support, care and treatment, Positive Health, Dignity and Prevention locates the health and social needs and experiences of people living with HIV within a human rights framework.

48. Reports on the [PLHIV Stigma Index](#) (a tool to build evidence and measure the level of stigma experienced by PLHIV within their communities) have been finalized in over 60 countries in collaboration with GNP+ with UNAIDS support. The Index measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV. In the initiative, the process is just as important as the product. It aims to address stigma relating to HIV while also advocating on the key barriers and issues perpetuating stigma - a key obstacle to HIV treatment, prevention, care and support.

Case study: Impact of the Stigma Index in Argentina

The use of the PLHIV Stigma Index has had concrete impact on the access to justice and provision of psychosocial support to PLHIV in Argentina. Examples include:

- Agreements between law faculties and public laws schools were reached to jointly address issues of stigma and discrimination towards PLHIV;
- Capacity building and legal counselling on HIV were installed in different city councils in Buenos Aires;
- Workshops for families and friends were initiated to strengthen the social support network for PLHIV;
- A resolution to eliminate barriers to the adoption of insurance and facilitating access to credit and loans for PLHIV was developed with the Superintendent of Insurance of the Nation.

49. The UNAIDS Advisory Group on HIV and sex work established in 2009 has provided policy advice, technical support and capacity building of sex worker organizations. Four guidance papers were produced for country-level use including one on [The legal and policy environment for sex work, including criminal and other laws affecting sex workers](#).
50. On 14 June 2011, the UN Human Rights Council passed a historic resolution entitled [Resolution on human rights, sexual orientation and gender identity](#). The resolution calls for four actions, including a request to the High Commissioner for Human Rights to commission a worldwide study to document discriminatory laws, practices and acts of violence against individuals based on their sexual orientation and gender identity. Human rights and the law were also in the spotlight at the 5th Francophone Conference on AIDS.
51. In December 2011 the UN Secretary-General declared that homophobic bullying is “a grave violation of human rights and a public health crisis”. The negative consequences of homophobic bullying on the health of LGBTI young people include increased risk of engaging in unsafe sex and greater vulnerability to HIV infection. In December 2011, UNESCO convened the [United Nations’ first-ever international consultation on homophobic bullying in educational institutions](#). It produced striking evidence of the extent of homophobic bullying in educational institutions around the world, as well as international best practice in terms of policies and interventions to prevent and address it.

G. Meet the HIV needs of women and girls and stop sexual and gender-based violence¹⁰

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



Overall progress

HIV is the leading cause of death of women of reproductive age and contributes to at least 20% of maternal deaths. Young women in particular are most vulnerable to HIV, with infection rates twice as high among them as in their male peers. Unfortunately the result is that globally, one young woman, between the age of 15 and 24, is infected with HIV every minute.

Gender-based violence is recognized as an underlying socio-cultural factor in HIV epidemics, in the spread of HIV and in hindering health-seeking behaviour by women and girls. The number of countries reporting policies in place to ensure equal access among women and men to prevention, treatment and support services increased from 111 in 2008 to 144 in 2010. However, in spite of the fact that more countries acknowledge the importance of gender-sensitive responses, few translate this into action. While four out of five national HIV strategies expressly address women and girls, only 46% have dedicated budgets for such activities.

The high prevalence of gender-based violence – affecting up to 70% of women in some countries – continues to undermine effective responses. As of December 2011, 93 countries reported data which show that less than one fifth (18 of 93) of countries have national data on the intersection between gender-based violence and HIV; and 40% (38 of 93) of countries’ health sector policies address gender-based violence. To measure progress on gender equality and HIV, a global indicator on “prevalence of recent intimate partner violence” was added to the existing core indicator set used by countries to report on progress in the AIDS response.

[2010 Global Report chapter on human rights and gender equality](#)

¹⁰ Priority Area 8 in the 2010-2011 Unified Budget and Workplan (UBW).

52. In June 2011, [Resolution 1983](#) was unanimously adopted by the UN Security Council, recognising the deadly link between HIV and violence against women in conflict and post-conflict settings. The resolution calls for increased efforts by Member States to address HIV in peacekeeping missions, while striving to end sexual violence in conflict and post-conflict settings. This was the first Security Council Resolution linking HIV and sexual violence to national and international security and was introduced by an African

Lessons learnt

In several regions, there is still a pronounced tendency to limit “gender” to “women’s issues”, with disregard to inter-gender relations that are at the crux of problems and difficulties which result in negative health outcomes, such as HIV infection and STI. To ensure that national action plans to address gender-based violence and national AIDS plans draw strength and effectiveness from each other, it is necessary to develop stronger links between relevant national agencies (i.e. AIDS authorities) and key civil society organizations, including engaging men and boys.

country. Security Council Members agreed to respect and protect human rights in conflict and postconflict and ruled that the rape of women and girls as a tactic of war will not be tolerated. UNAIDS Secretariat and UNFPA played a central role in supporting the

drafting and facilitating negotiations for the process and worked with the UN Department of Peacekeeping Operations and Member States to integrate HIV prevention and gender-based violence prevention programmes in UN peacekeeping missions.¹¹

53. As of December 2011, over 94 countries had started implementing the [Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV](#), engaging more than 700 civil society organizations, including networks of women living with HIV and women’s rights groups. Globally, governments in 80% of countries (137 of 171) reported including women within multi-sectoral HIV strategies. UN Women has been successfully engaged and committed as a partner to implementing the Agenda and a report on the [gender-sensitivity of AIDS responses](#) was presented by UNAIDS at the 27th PCB meeting.

54. The Joint Programme supported 83 countries in designing, implementing or evaluating prevention, treatment, care and support programmes specifically intended to empower women and girls and on gender-based violence for 37 countries. The Interagency Working Group on Gender Equality (led by UNDP and UNFPA with support from UNICEF, WHO, the UNAIDS Secretariat and UNIFEM) supported 31 countries to integrate a focus/action on Gender-based Violence into their national HIV strategies and plans. For example, Belize has integrated strategies to address gender-based violence in the new national Strategic Plan 2012-2016 and extended the support of emergency responses to victims of sexual violence.

Case study: Together for Girls

The [Together for Girls partnership](#), launched at the Clinton Global Initiative in 2009, focuses on three pillars: conducting and supporting national surveys on the magnitude and impact of violence against children, particularly focused on sexual violence against girls; supporting coordinated programme actions in response to the data; and leading global advocacy and public awareness efforts to draw attention to the problem and promote evidence-based solutions. The partnership brings together UNICEF, UNFPA, WHO, the UNAIDS Secretariat, UN Women, the United States Government and the private sector.

A report launched jointly by seven ministries in Tanzania, civil society and UNAIDS issues of children and violence. It provides new insight into underlying mental, physical, and sexual violence factors as a means to strengthen Tanzania’s national agenda for education, health, justice, social welfare, and police response. Each ministry and civil society committed to undertake specific actions to address areas raised in the report.

¹¹ UNAIDS/PCB(30)/12.11 provides further information on the 1983 resolution and follow-up activities undertaken by main stakeholders.

55. In 2010, 37 countries (of 94), indicated having data on links between gender-based violence and HIV, as reflected in the Scorecard on Gender Equality in National HIV Responses. Programmatic guidance on addressing violence against women in HIV/AIDS programmes and a policy brief on addressing violence against women in HIV testing and counselling programmes were released in 2011. A set of indicators on gender and HIV is being developed for national programmes as part of an inter-agency effort led by UN Women.
56. Produced to inform and support the 2010 MDG summit, [Eight Lives: Stories of Reproductive Health](#) by UNPFA relates the tales of eight women and the many reproductive health issues experienced by them, including HIV and AIDS, and the corresponding stigma associated with these issues. It includes also some key actions that are needed to accelerate progress and ensure that universal access to RH becomes a reality for women and girls worldwide. The publication and some of the individual stories will be featured in the Swedish UN Association quarterly magazine, which reaches over 6,000 members.
57. Ten countries (Ethiopia, India, Kenya, Madagascar, Malawi, Namibia, Rwanda, Swaziland, Tanzania and Zambia) addressed gender equality in their national HIV responses through the UNDP-led interagency initiative '[Universal Access for Women and Girls Now!](#)' Results included a clear gender component and a commitment to address gender-based violence and to gender equality in the HIV response in Zambia; and research results on barriers to accessing HIV services for female sex workers and the wives of migrant men informed the implementation of India's Fourth National AIDS Control Programme.

H. Enhance social protection for people affected by HIV¹²

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



Overall progress – social protection

Members States committed, in the 2011 Political Declaration, to strengthen national social and child protection systems and care and support programmes for children, in particular for the child girl and adolescents affected by HIV, as well as their families and caregivers. Social transfers of food, cash or vouchers, combined with community-based care, help to overcome barriers to service access and treatment adherence. Although social protection has a clear role to play in strengthening the HIV response, intensified collaboration between HIV and social protection experts are needed to ensure that social protection programmes respond to the needs of individuals living with, and households affected by, HIV.

Government partners are showing growing interest in developing HIV sensitive social protection policies which can be inclusive of populations affected by HIV and AIDS and reduce structural inequalities which increase HIV related risk and vulnerability.

Social protection contributes to more equitable health outcomes by reducing structural inequalities that drive the HIV epidemic, such as gender inequalities, as well as helping to overcome barriers to access to treatment. At national level, social protection has been identified as a key contributor to more equitable development outcomes by reducing poverty and social exclusion of households and children affected by the HIV epidemic. As of December 2010, an estimated 16.6 million children had lost one or both parents to AIDS – nearly 15 million of these in sub-Saharan Africa. The number of children orphaned or made vulnerable by HIV appears to have peaked in 2009, primarily due to the expansion of antiretroviral treatment and programmes to prevent new infections among children. However, country reports indicate that most households with children affected by HIV do not receive any form of free assistance. The most effective and non-stigmatizing approach involves situating HIV assistance within broader programmes that address the needs of all vulnerable children.

[HIV - Sensitive Social Protection: What does the evidence say? \(UNAIDS, 2010\)](#)

[HIV and Social Protection Guidance Note \(UNAIDS, 2011\)*](#)

58. Good progress has been made in strengthening the evidence base and guidance on HIV-Sensitive social protection. This includes work on cash transfers and HIV prevention, empirical research on cash transfers and HIV/STI risk and documentation of models of HIV and child sensitive in East and Southern Africa. Much of this evidence has helped to inform [a joint guidance document on social protection](#) prepared by the Social Protection, Care and Support Technical Working Group and includes examples from both the UN and civil society.
59. UNICEF is co-convening with the World Bank in social protection, care and support, and has been playing a lead role in generating evidence and guidance on how social protection programmes can be more responsive to HIV-affected households. In 2010 and 2011, UNICEF supported the development of nationally owned social protection schemes in more than 20 highly HIV-affected countries.

¹² Priority area 10 in the 2010-2011 Unified Budget and Workplan (UBW).

* Requires registration with AIDSspace before accessing this document online.

60. The World Bank completed an assessment of safety nets, poverty and HIV/AIDS in Botswana, Namibia and Swaziland. All three countries have formal and informal safety nets¹³ that are being overwhelmed by high HIV/AIDS prevalence. Prior to the spread of HIV, Botswana and Namibia both had relatively developed formal safety nets while Swaziland had few formal mechanisms to help cushion the poor from the effects of poverty. The rise in HIV prevalence increased adult mortality rates, decreased economic productivity, and created more orphans and vulnerable children. As more and more adults were infected and their conditions worsened, they were unable to provide for themselves or their families. Their rising health care costs placed an even greater strain on household budget. In many countries this led to ad hoc programs targeting those most affected by the epidemic, but often with weak sustainability as they were funded through HIV/AIDS programs and not linked to any on-going social protection programs.

Who is the vulnerable child?

Statistical analysis by UNICEF of DHS and MICS household data was carried out to identify key determinants of child vulnerability in the context of HIV and AIDS. The analysis showed that being a single or double orphan is not consistently a useful predictor of child vulnerability and that poverty intensifies the impact of HIV and AIDS on children's lives. A combination of variables is therefore needed to identify and reach vulnerable children including household wealth, orphanhood and residency patterns. This research received the 2010 IAS/CCABA Prize for Excellence in Research needs of Children Affected by AIDS.

61. Global guidance on children affected by AIDS, [Taking Evidence to Impact](#), was developed by UNICEF with 15 agencies including the US Government, and launched at the Global Partners Forum. It recommends placing great emphasis on child and social protection systems strengthening and HIV sensitive social protection. UNICEF also provided technical support to scale up HIV sensitive social protection in eight countries across East and Southern Africa as well as South Asia.

62. At the 99th Session of the International Labour Conference in 2010, the first [International Labour Standard on HIV and AIDS and the world of work \(Recommendation No. 200\)](#) was adopted by an overwhelming majority of ILO member states. It calls for the design and implementation of national tripartite workplace policies and programmes on HIV and AIDS to be integrated into overall national policies and strategies on HIV and AIDS and on development and social protection. Forty-two countries have developed national tripartite HIV and AIDS workplace policies based on Recommendation No. 200 and the ILO Code of Practice. Extensive training was undertaken to operationalize Recommendation No. 200 in countries and inform country programmes and policies.

Case study: Promoting HIV-sensitive social protection

Eight priority countries (Cambodia, China, India, Indonesia, China, Nepal, Papua New Guinea, Thailand and Vietnam) integrated HIV into national social protection strategy processes with the support of UNDP, UNICEF, ILO and the UNAIDS Secretariat. This work benefited from socio-economic impact assessments conducted by UNDP which provided the evidence-base for policy action and the cornerstone for impact mitigation steps, as well as a mapping of HIV-sensitive social protection programmes by UNICEF.

Following a regional consultation in Cambodia in mid-2011, governments in the region were able to reflect on findings, share experiences and commit to advancing HIV-sensitive social protection. The Prime Minister of India subsequently made explicit calls for HIV-sensitive social protection, particularly in the area of employment. Following the success of this work in the Asia Pacific region, UNDP will be replicating it in Latin America.

¹³ The World Bank defines safety nets as non-contributory transfer programs that are targeted at the poor and vulnerable with the intention of insulating them from economic shocks. Safety nets are intended to work alongside other government programs such as health, education, and social insurance to promote economic growth and lower risk.

I. Enhance integration of AIDS into the broader development agenda¹⁴

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



Overall progress

Realigning responses to strategic priorities

Supporting countries in optimizing their responses through a clearer focus on investment has been embraced by major providers of international development assistance in AIDS. The investment approach is in the forefront of the new strategy being developed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as the HIV prevention strategy recently issued by the US President's Emergency Fund for AIDS Relief. An agenda is emerging which clearly aligns donor interests in value for money with implementing country interests in optimal results.

Assessing and realigning the response and technical assistance

A growing number of countries in all regions have benefited from Modes of transmission (MOT) studies that have estimated new infections by modes of transmission and compared national prevention priorities with epidemiological patterns. By quantifying the gap between epidemiological patterns and national prevention resource allocations, the studies have prompted several countries to start realigning their HIV programmes to address actual needs.

At country level, Joint UN Teams on HIV/AIDS and Joint Programmes of Support provide the basis for UN joint work, resource mobilization, performance assessment and reporting. The UNAIDS Technical support strategy 2011-2015 was developed to increase the impact and sustainability of HIV country responses through quality technical support. Technical Support Facilities in five regions provided 14,700 days of technical assistance in 67 countries, using regional consultants in 85% of all assignments. Assistance was provided to address specific gaps in technical capacity as well as development of national technical support plans.

63. Throughout the biennium, progress was made in a number of areas and at different levels to increase integration of the AIDS response into global health and development agenda.
64. In nine countries, where UNAIDS signed an [IHP+ compact](#), support was provided to integrate the health-related aspects of HIV/AIDS strategic and action plans into national health plans (Burkina Faso, Burundi, DRC, Djibouti, Ethiopia, Mali, Mozambique, Nepal and Nigeria). On-going support was also provided to develop HIV national strategic plans and strengthen health systems (including capacity building and Global Fund proposals). Additionally UNAIDS participated in health sector mutual assessments using national performance assessment frameworks, enabling operational links between the National Health Development Plan and the National AIDS Strategic Plan

Examples of integration

A specific section on AIDS, reflecting UNAIDS' strategic priorities is now included in the revised Cotonou agreement governing relations between the EU and African, Caribbean and Pacific States.

AIDS is better positioned in new EU development policies on gender, global health and the MDGs and EU policy frameworks for 2014-2020 on research and public health.

¹⁴ Captured under the cross-cutting strategies in the 2010-2011 Unified Budget and Workplan (UBW).

65. UNAIDS, PEPFAR, The George W. Bush Institute and a number of other organizations launched the joint [Pink Ribbon Red Ribbon initiative](#) in September 2011 as an innovative partnership to leverage public and private investment in global health to combat cervical and breast cancer. The Pink Ribbon Red Ribbon initiative will expand the availability of vital cervical cancer screening and treatment and breast care education—especially for women most at risk of getting cervical cancer in developing nations because they are HIV-positive.
66. WHO and the UNAIDS Secretariat contributed to the first ever UN General Assembly High-level meeting on Non-Communicable Diseases (NCDs). The support included inputs to the Political Declaration on NCDs, where we helped raise awareness on linkages between NCDs and HIV, and the need to integrate responses for HIV and NCDs. A high-profile side-event was also held with participation of Executive Heads of WHO and UNAIDS, Member States and civil society, to strengthen the synergies between the HIV and NCD responses.

J. Intensify mobilization of resources for the AIDS response¹⁵

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



Overall progress

As a result of unprecedented investment in health, HIV prevalence is falling due to programmes that reduce risk behaviour, more than six million people are receiving life-saving anti-retroviral therapy, millions of orphans have received basic education and health care, and more tolerant and enabling social environments have been established in many countries.

While none of this would have been possible without the strong mobilization of the global community and unprecedented levels of funding, the gap remains between investments needs and resource availability at a time of fiscal constraints.

A sizeable proportion (23%) of all international assistance is available through multi-lateral institutions such as the Global Fund to fight HIV, tuberculosis and malaria, which was the main source of AIDS funding for 52 of its 92 recipient countries. Many low-income countries remain heavily dependent on external financing and resources for the response. In 56 countries, at least 70% of HIV resources are provided by international donors while overall funding from international sources reduced by 10% in 2010 - the first time in a decade.

67. Closing the resource gap in countries has required a multi-faceted approach by UNAIDS to help countries mobilize additional resources, allocate resources most effectively and maximize the use of available resources. Throughout the biennium technical support was provided to countries to mobilize additional funds, including through the Global Fund, and to support their implementation. UNAIDS has contributed to the mobilisation of additional resources for HIV responses by strengthening national capacity to apply for, plan and implement Global Fund grants. Intensive support was provided to countries by UNAIDS for Global Fund's Round 10 proposal development and submission, with a success rate of 69% (for countries with UNAIDS support), compared with the overall proposal success rate of 41%.

¹⁵ Captured under the cross-cutting strategies in the 2010-2011 Unified Budget and Workplan (UBW).

68. The management and governance capacities of Global Fund Country Coordinating Mechanisms (CCM) were strengthened in 27 countries with UNAIDS support throughout the biennium, helping countries navigate the more complex landscape of AIDS financing and coordination. With UNAIDS technical support, financial management and accountability systems in 15 countries were strengthened, including through improved procurement (e.g. Angola), stronger national M&E systems and functions and better processes to transfer funds to civil society organizations (e.g. Ethiopia), ensuring effective use of resources and better reporting to the Global Fund. This focus was critical at this time of grant architecture reform within the Global Fund in order to ensure countries met eligibility requirements for the continuation in services and the provision of essential commodities.
69. While supporting the prioritization and allocation of resources through national planning processes, UNAIDS developed the Unified Budget, Results and Accountability Framework (UBRAF 2012-15), an instrument to leverage funding for AIDS beyond cosponsors and to improve joint planning, performance monitoring, accountability and effectiveness of the Joint programme of support. The UBRAF 2012-15 provides a longer 4-year planning cycle and succeeds the UBW.
70. The [UNAIDS Investment Framework](#) is an approach to support countries in their decision-making for spending on AIDS, focusing on priority areas where cost-effective impact is best achieved. Modelling of the framework's impact shows that its implementation would avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020. The Framework was presented in a policy paper in *The Lancet* (Schwartländer et al) in June 2011, and is based on existing evidence of what works in HIV prevention, treatment, care and support. It is intended to facilitate more focused and strategic use of scarce resources. It was developed by an international group of experts including UNAIDS, Futures Institute, London School of Public Health, University of Washington, International Treatment Preparedness Coalition, Brazilian National AIDS Programme, the Global Fund, PEPFAR, Bill & Melinda Gates Foundation, UNICEF, Ministry of Health South Africa, World Bank, WHO and Antwerp Institute of Tropical Medicine.

II. Cross-cutting strategies

A. Bring AIDS planning and action into national development policy and broader accountability frameworks

71. [Universal access consultations in 117 countries and 7 regions](#) provided an opportunity for stakeholders and constituencies to take stock of progress made, identify obstacles, and decide what needs to be done in order to achieve universal access and the MDGs. Throughout 2010 and 2011, UNAIDS supported the consultations and then convened 32 government and civil society leaders to review progress. The Consensus Statement helped civil society groups develop momentum to position and advocate for the Political High Level Declaration in June 2011, and the process brought country and regional information to the centre of UNAIDS decision-making and reporting.

Evaluation: DoL country assessments

Twenty-one country assessments of progress on the implementation of the Division of Labour (DoL) conducted informed the Bangkok multi-stakeholder consultation in March 2010 on the Second Independent Evaluation. Findings from this and 11 country assessments of Joint Teams informed recommendations to the UN Development Operations Coordination Office (UNDOC) on the future of Joint Teams. Two of these assessments (Nigeria and the Philippines) provided the basis for case studies to inform the PCB in June 2011.

72. At the end of 2011, 69 countries had included world of work components in their national AIDS strategies. The ILO provided workplace input into the National AIDS Strategies of 51 countries, and in 35 of these countries, the principles of [Recommendation No. 200](#) (the first international labour standard on the world of work) are reflected in the newly developed/revised strategies.

73. In 47% of countries with more than 10,000 refugees, and 38% of countries with internally displaced populations, UNHCR's advocacy work led to these populations being included in National HIV Strategic Plans.

Challenge: National AIDS Coordinating Authorities (NACS)

In some countries, NACs are weak and lack proper accountability. For example, membership may not have sufficient civil society representation and be dominated by government representatives who lack expertise. Meetings may be held irregularly. There may also be overlaps between different government mechanisms (e.g. NACs, CCM and NAPs) and few are truly multisectoral. Young people are also seldom represented.

74. Forty-five countries put in place improved strategic and operational plans that are evidence-informed, prioritized, costed, and focused on efficiency and effectiveness. This was as a result of the World Bank-coordinated AIDS Strategy and Action Plan (ASAP) service providing targeted technical support.

B. Optimize UN support for applications to and programme implementation of the Global Fund to Fight AIDS, Tuberculosis and Malaria

75. UNAIDS developed a [resource kit for the development of Global Fund HIV proposals](#), which includes strategic and technical guidance. UNAIDS and partners also developed [Community System Strengthening \(CSS\) guidelines](#) to encourage CSS inclusion in national and regional proposals to the Global Fund.

76. UNDP's partnership with the Global Fund to Fight AIDS, TB and Malaria has helped to develop country capacity to effectively implement large-scale health programmes. In this biennium, UNDP acted as a Global Fund principal recipient in a total of 33 countries, with programme delivery reaching \$727 million. As a principal recipient, UNDP has helped

countries that face unusually difficult circumstances achieve results in spite of the challenges. From 2003-2010, UNDP as principal recipient has supported countries reach 47 million people by prevention services; distribute 403 million condoms; provide HIV counselling and testing to 7 million people; detect and treat 493,000 tuberculosis cases; treat 1.1 million cases of sexually transmitted infections; have 774,000 people currently on antiretroviral treatment; treat 32 million cases of malaria and distribute 14 million bed nets. 84% of the grants managed by UNDP are rated A or B1 by the Global Fund (adequate to exceeding expectation). UNDP has served as a principal recipient in a total of 41 countries between 2003 and 2010. In 14 of these countries, UNDP handed over its role to a national entity, reflecting achievements in capacity development. It is in the process of doing so in another nine countries for at least one grant.

77. Nine countries (Cambodia, Liberia, Sierra Leone, Djibouti, Ethiopia, Ghana, Lao PDR, Swaziland, and Zimbabwe) successfully integrated food and nutrition into Round 10 Global Fund proposals as a result of WFP support. Following this, WFP produced a manual and toolkit in partnership with PEPFAR, FANTA II (the USAID funded Food and Nutrition Technical Assistance Project) and WHO, to help countries to be more successful at integrating food and nutrition in their Global Fund proposals.
- Challenge: Dependency on the Global Fund**
In many countries the Global Fund provides the highest proportion of external funding for national spending on HIV and AIDS, pointing to questions about long-term sustainability; the need to diversify funding portfolios increasing domestic funding; and strengthen implementation and management optimize the use of funds.
78. Global Fund Round 10 proposals from eleven countries (Azerbaijan, Bhutan, Cambodia, Kazakhstan, Kenya, Maldives, Moldova, Nepal, South Africa, Sudan and Zambia) included injecting drug use and prisons received support from UNODC.
79. PMTCT SRH/HIV linkages were reprogrammed in Round 9 Global Fund proposals implementation and included into Round 10 Global Fund proposals development in 18 countries with the support of UNFPA.
80. The inclusion of the world of work component in national AIDS strategies and the presence of world of work and private sector representatives on national coordinating authorities has informed and facilitated resource mobilization efforts in many countries. For the Global Fund Rounds 9 and 10, the ILO provided proposal development support to SADC, Benin, Bosnia and Herzegovina, Burkina Faso, Cameroon, Guinea, India, Mozambique, Sierra Leone, South Africa, Sri Lanka and Ukraine. Approximately \$48 million was mobilized for the world of work.
81. UNICEF supported Thailand and Nepal in their GFATM Round 10 submissions resulting in an allocation of US\$ 42 million and US\$ 57.3million respectively. In Thailand the funds will enhance the systems, capacity and monitoring for protection, care and support for children infected and impacted by HIV/AIDS. Nepal will use the funds not only to establish PMTCT interventions throughout the country, but also address the present gaps in HIV-sensitive social protection for families and children affected by HIV/AIDS. These are the most substantial funding levels leveraged for children affected by AIDS to date in South Asia.

C. Improve country-by-country strategic information generation, analysis and use, including through the mobilization of novel sources

The HIV epidemic and the response

[UNAIDS' Global Report](#) and the process for collecting data has strengthened programmatic approaches by ensuring the validity, internal consistency and comparability across countries and over time, thus building stronger national and evidence-information responses. In November 2010, the Report showed that new HIV infections fell by nearly 20% in the last 10 years, AIDS-related deaths were down by nearly 20% in the last five years, and the number of people living with HIV is stabilizing. As a result at least 56 countries have either stabilized or achieved significant declines in rates of new HIV infections.

82. The availability and quality of global AIDS data reached an unprecedented high as in 2010 more than 182 countries (95%) submitted reports to UNAIDS on the UNGASS targets – which was a UN record for country-level reporting. As part of the universal access review process, UNAIDS country-specific epidemiological fact sheets were developed and made available to the public along with several scientific articles on epidemiological estimates. In October 2011, UNAIDS provided detailed [Global AIDS Response Progress Reporting core indicator guidelines](#) for national governments to monitor progress on the Political Declaration.
83. Thirty-four countries improved their tracking and monitoring of the epidemic by using the Country Response Information System (CRIS), which was evaluated as a success. [AIDSinfo](#) was launched in 2010 to provide easy access to global AIDS data (with approximately 200 visits per day), followed by an iPad application launched for the HLM meeting in June 2011. UNAIDS Secretariat developed both tools.
84. Almost all 116 countries trained by UNAIDS Secretariat in the Estimation and Projection Package (EPP) curve-fitting part of Spectrum instead of the old workbook method went on to use the packages, which contributed to improving the overall quality of HIV estimates. The improved Spectrum model helps estimate new infections, HIV prevalence, service need, and the number of children orphaned due to AIDS.
85. Fifteen countries completed a Modes of Transmission analysis (or Epi Review) in support of their strategic planning, supported by the UNAIDS Secretariat. This analysis helps effective planning and delivery of HIV prevention programs by identifying where new infections are occurring.
86. Methods to estimate the size of key populations at higher risk were shared, in order to

Lessons learnt: The value of evidence

ILO work increasing the access of vulnerable workers to HIV prevention has found that the use of evidence is one of the strongest advocacy tools, particularly in concentrated and low level epidemics.

Evaluation: Sector-specific indicators

A UNESCO M&E rapid assessment pointed to the need for core HIV and AIDS indicators that are relevant to the education sector and are collected directly through ministries of education. In response, the UNAIDS IATT on Education developed a set of core indicators for which field testing started. This is improving national capacities for collecting, entering and analysing data and developing sustainable M&E systems to measure the impact of HIV on the education sector.

prioritize programmes with the greatest impact in preventing new infections, with 60 countries through five regional workshops organized by UNAIDS. The Joint Programme developed related guidelines on this and on second-generation surveillance. UNFPA and UNDP supported data generation, mapping, assessments and size estimations of sex workers and men who have sex with men in 26 countries.

87. UNAIDS' planning up to 2015 was more focused on epidemic priorities and impact at country level, which will lead to better information, effective implementation, monitoring and reporting in the Joint Programme. A highly consultative process led to the development of the Unified Budget, Results and Accountability Framework (UBRAF) 2012-2015 ([Part I](#) and [Part II](#)).

Lessons learnt: Use and exchange of strategic information

Regular information exchange with country offices, collaboration with partners, and financial support of donors is helpful for strengthening the Strategic Information systems. However, often due to lack of trained human resources at country level, promoting the use of strategic information for common planning by all partners still remains a challenge.

88. UNHCR's Health Information System became operational in over 40 countries and is used by all humanitarian partners. It monitors health services provided to some 1.5 million camp-based refugees, improving the health status of people of concern through evidence-based policy formulation, improved management of reproductive health and HIV programmes and, ultimately, direct actions that improve refugee health.
89. UNICEF with the London School of Hygiene and Tropical Medicine built capacity of over 80 national researchers who conducted 23 quantitative and qualitative research studies to understand the risk profiles of most-at-risk adolescents in 7 Central and Eastern European countries. The "Research Toolkit on Most-at-Risk Adolescents" contains tools and protocols developed to guide the data collection and data analysis. The training and Toolkit facilitated a better analysis of the risk profiles and situation of HIV among adolescents and young people.

D. Access and realign the management of technical assistance programmes

90. The revised [UNAIDS Division of Labour](#) (DoL) consolidated UNAIDS support to countries in 15 areas of work. Each area is led by one or two convening agencies according to the organizational mandate and comparative technical expertise of the Secretariat and Cosponsors. As such the DoL optimises UN technical support contributions for impactful and effective results while ensuring mutual accountability.
91. The UNAIDS Technical Support Strategy sets out guidance for countries to efficiently implement and achieve their nationally defined HIV goals and targets. Following on from its PCB approval in December 2010, results include:
- More evidence-based and human rights-sensitive National Strategic Plans. The World Bank with UNAIDS has guided strategic planning processes in 43 countries, and conducted peer reviews of 21 draft strategies.
 - Twenty-two countries developed national technical support and capacity development plans.
 - Improved capacity of countries in all regions to mobilize resources, including but not limited to, the preparation of proposals for the Global Fund; grant signing; unblocking implementation bottlenecks, capacity building in programme and financial management, and monitoring and evaluation.
 - Resolving grant implementation challenges in 27 countries through engaging the UNAIDS Technical Support Facilities via 40 different technical support assignments.

92. [A paper on progress on UNAIDS technical support](#) was presented to the PCB in December 2011, and an update has been prepared for the 30th PCB (UNAIDS/PCB(30)12.10).

E. Develop shared messages for sustained political commitment, leadership development and advocacy

93. The vision of 'zero new HIV infections, zero discrimination and zero AIDS-related deaths' spearheaded by UNAIDS in 2010 has led to far-reaching change - as illustrated by the success of the 2011 General Assembly High Level Meeting on AIDS and the Political Declaration on HIV/AIDS. It became a rallying call for leaders in governments, in the private sector, amongst activists and resounded across the world on World AIDS Day 2011 from Premier Wen to President Obama to President Woldegiorgis and to the heart of national responses.
94. [UNAIDS 2011-2015 Strategy](#) was adopted by a large number of countries as the framework for own national HIV strategy, the case for example for all ten Member States of ASEAN, China, India and several Pacific Island Countries in the Asia Pacific region.


Political Declaration on HIV/AIDS

An historic resolution, the [2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS](#), was ratified by the General Assembly Special Session on HIV/AIDS from 8-10 June 2011. The High Level Meeting (HLM) brought together more than 3,000 participants (including 32 Heads of State, Government and Vice Presidents as well as representatives from UN agencies, civil society and non-governmental organizations, permanent missions and the private sector) to take stock of and chart the future of the global AIDS response:

- The UN Declaration is the first to recognize key populations – men who have sex with men, people who inject drugs and sex workers are disproportionately affected by the HIV epidemic.
- Overall there were 34 events organized or co-hosted by UNAIDS during the five-day HLM period, contributing to collaboration across the Joint Programme in areas ranging from advocacy and awareness raising to launches of major initiatives, and demonstrating the energy and commitment of partners in the AIDS response. This included 25 First Ladies joining forces to call for integration of HIV and maternal, newborn and child health.
- From the cover of *The Economist* to more than 5,000 news articles published in over 150 countries, the media attention and public resonance of the HLM was considerable. This High Level Meeting demonstrated to the world that after 30 years, AIDS remains high on the global political agenda.


95. UNAIDS ensured inclusion of HIV in various sporting events, including the FIFA World Cup, Winter Olympic Games, Youth Olympic Games and Cricket World Cup. This helped to strengthen and increase commitment to the HIV response, notably among Presidents and First Ladies hosting the events.

'One day on earth'

On 11 November 2011, UNAIDS teamed up with the global initiative, ["One Day on Earth"](#)  to film the many faces of the HIV response. More than 50 UNAIDS field offices in all parts of the globe participated in the project.

96. A wide range of advocates, including Special Envoys and Goodwill Ambassadors, worked with UNAIDS to raise HIV and AIDS issues with millions of people. For example, Brazilian footballer Ronaldinho promoted AIDS awareness through sport; HRH Crown Princess of Norway, Mette-Marit, helped highlight the needs of young people; 'JYJ', the Republic of Korean band, broadcast an HIV stigma and discrimination to more than a million fans, an issue also addressed by Malian kora player Toumani Diabaté; MTV star James Chau presented a health commercial that was aired on CCTV to millions of viewers in China; a 'Red Ribbon United Team' including former professional football stars, played an inaugural charity


match against a team of prominent Russian politicians, business leaders and former international sports stars; actress Naomi Watts visited India to increase support for PMTCT; and singer Annie Lennox visited Washington DC to increase awareness on women and AIDS.

97. The [UNAIDS High Level Commission on Prevention](#), with 15 world renowned leaders, was established in 2010 to reinvigorate the HIV prevention agenda. In their message from the meeting on Robben Island (May 2011 )

2010 International AIDS Conference, Vienna

Policies and guidance were disseminated during the conference. Five satellite sessions convened by UNAIDS focused on: a human rights based approach to prevention; eMTCT; HIV prevention and health systems; HIV and young people; and combination prevention. The [CONDOMIZE! Campaign](#) distributed 1 million condoms in 100 hours.

The Red Ribbon Award and community dialogue space hosted at the Conference provided capacity-building and financial support to 25 community-based organizations from 20 countries, and created platforms for best practice exchange and engagement with global and regional policymaking.

Commissioners called on Member States participating in the High Level Meeting on AIDS to commit to a global HIV prevention revolution, and to guide the future global HIV response with strong commitments, bold actions and ambitious targets to ensure every effort is made to stop new HIV infections. Around World AIDS Day 2010, thousands of online conversations took place on Twitter and Facebook (with the keyword hashtag #PreventionRevolution ) trending in cities worldwide), with awareness videos created for the initiatives receiving over 100,000 views on YouTube alone.

Developments in relation to BRICS countries

UNAIDS engagement with BRICS countries contributed to many achievements, including taking a larger role in the governance and financing of the global AIDS response. In June 2011, the first meeting of BRICS health ministers in Beijing articulated a new agenda for South-South cooperation to expedite innovation for health technologies.

- Brazilian President Luiz Inácio Lula da Silva was awarded the 2010 “UNAIDS Award for Leadership” in recognition of his contribution to social and economic development as well as the AIDS response (including building partnerships and encouraging south-south cooperation).
- The Russian Federation convened a high level forum on MDG-6 in October 2011, which launched a new MDG-6 Action Plan with an emphasis on financing and regional partnerships. The inputs including a [joint statement](#) of the three international Co-chairs of the meeting – UNAIDS Secretariat, World Bank, and the Global Fund – was critical in shaping the Action Plan.
- In July 2011 India, to ensure availability of generic antiretroviral drugs, announced that it would reject any efforts to include “data exclusivity” clauses in bilateral trade agreements. It has also passed guidelines on new health insurance coverage for HIV patients.
- In December 2011, China pledged to fill its HIV resource gap.
- There were considerable policy shifts in South Africa’s approach to the epidemic, for example in increasing public spending on AIDS by 22% in 2010 compared to 2009 and through the launch of a national HIV testing campaign in April 2010.
- Botswana, Kenya, Lesotho and Namibia and South Africa are now contributing a combined total of more than US\$ 2 billion per year to their domestic AIDS responses, providing examples of national ownership.

98. Three million stamps in 2011 alone raised global awareness of HIV, along with posters and workplace programmes. The [HIV prevention campaign with ILO, UNI Global Union and the Universal Postal Union](#) led to the issuance of more than 30 different national postage stamps to mark the discovery of HIV in 1981 and 30 years of the world living with the virus and AIDS.

The private sector

Working with the Joint Programme, the sector has helped generate new financial resources for the Global Plan on eMTCT and wider outreach on issues of human rights and prevention. Other examples include:


- Through a global Partnership with Standard Bank, thousands of people were encouraged to be tested for HIV in Ghana, Nigeria, South Africa and Uganda on World AIDS Day, through support to national testing and counselling.
- Sir Richard Branson, CEO of Virgin Atlantic, tweeted “Be an Activist” on behalf of UNAIDS 2011 World AIDS Campaign, reaching millions of his “followers”. At the same time, the UNAIDS Secretariat teamed up with the Body Shop and world-renowned photographer Rankin to launch an international HIV solidarity campaign.
- On the margin of the MDG Summit in 2010, UNAIDS participated in the UN Private Sector Forum chaired by the UN Secretary General in presence of over 150 Chief Executive Officers, 60 Heads of State and Government and Heads of UN agencies which identified concrete actions the private sector could undertake to help close MDG implementation gaps over the next five years.

99. In June 2011, UNAIDS published [OUTLOOK 30](#) which reviewed 30 years of AIDS and looked forward to the AIDS response in the future.
100. During a visit to UNAIDS Secretariat in Geneva, UN Secretary-General Ban Ki-moon reaffirmed his commitment to the AIDS agenda and encouraged staff to work even harder to ‘remove the hidden obstacles’ within the AIDS response. The Secretary-General also highlighted the importance of doing more to prevent HIV infections and pledged to be an activist in this issue. He emphasized the need for countries to remove discriminative laws that restrict the free movement and travel of people living with HIV.

F. Broaden and strengthen engagement with communities, civil society and networks of people living with HIV at all levels of the response

101. [A guidance document for the Joint Programme’s work with civil society](#) was developed in 2011, following the finalization of the Joint Programme’s Partnership directions as part of the UNAIDS Strategy. This focuses around a new paradigm for partnerships, emphasizing solidarity and shared responsibility.
102. In March 2010, the Secretariat convened the first meeting of its kind bringing together some 40 Baha’i, Buddhist, Christian, Hindu, Jewish, Muslim, and Sikh leaders who committed to strengthen efforts to respond to HIV, and pledged for holistic prevention, a prioritized response and universal respect for all people living with or affected by HIV. The Secretariat also supported the convening of 400 leaders from a range of religions in India to support a robust policy dialogue on addressing stigma.
- Lessons learnt: Working with local partners**
To work effectively to address stigma and discrimination, it is important to work with local NGOs and community based organisations as they often have the best knowledge and representation on the ground, and are best placed to identify and involve networks of people living with HIV or affected by HIV.
103. Forging strategic partnerships with Civil Society Organizations (CSOs) has increased the uptake of the ILO Recommendation No. 200 and strengthened the traction and

visibility of workplace programmes. ILO trained 250 CSOs and networks of PLHIV in 27 countries in knowledge building on the provisions of the Recommendation and potential national entry points.

104. A total of 5,267 policy makers from Ministries of Labour, 4,425 employers' representatives and 18,335 workers' representatives from 40 countries received training on HIV and AIDS issues using ILO materials. An example is the course titled "HIV/AIDS and the world of work – A prevention and social protection perspective", which was designed for policy makers and conducted in 2010 and 2011 in collaboration with WHO, UNICEF, WFP, GNP+, HelpAge, FAO, the Global Fund and the UNAIDS Secretariat.
105. Leadership capacity development of networks and associations of women living with HIV was undertaken in 52 countries across six regions, supported by UNDP. The participants designed breakthrough initiatives and many of these initiatives are being implemented at the national level. These initiatives include amongst others strategic advocacy and setting up micro-credit schemes and income-generating projects. After the pilot phase, these programmes were taken over by national authorities in several countries.
106. Young people most affected by HIV in 19 countries developed initiatives in advocacy, peer-based services and community mobilization, receiving grants from the HIV Young Leaders Fund supported by UNFPA.
107. Six International HIV/AIDS Alliance Hubs, supported by UNAIDS, provided 4,100 days of technical support to community-based organizations. The Secretariat also provided direct funding support jointly with GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit) to the civil society-led global initiative Civil Society Action Team (CSAT), which is hosted by the International Council of AIDS Service Organisations (ICASO). Through regional hubs, CSAT coordinates, brokers and advocates for technical support to civil society organizations that are implementing or seeking grants from the Global Fund.
108. The *Stigma Fuels HIV* campaign was launched by UN Cares and UN Plus in June 2011 and reached thousands of UN employees in more than 70 countries (broadcast by many offices including Ethiopia  and UNAIDS HQ) involving more than 15 different UN entities, drawing on pro-bono work by global advertising firm *Saatchi & Saatchi*. In 2010, UN Cares received a special commendation in the context of the UN 21 Awards from the UN Secretary General. Training-of-trainer workshops were undertaken to renew the capacity of country-level UN Cares teams to implement the 10 Minimum Standards throughout all UN organizations and duty stations.

Evaluation: health insurance of HIV-positive UN staff
UN Plus conducted a survey regarding health insurance status of HIV-positive staff in more than 10 duty stations, and undertook a health insurance study in the context of HIV and other chronic diseases. The study was completed at the end of 2011 and during 2012 it will be used as an important advocacy tool to improve the health insurance schemes within the UN system in the context of HIV/AIDS and other chronic diseases.

III. Results in regions and countries

109. This part presents results at regional and country level. This is the first time that these have had such an emphasis in UBW reporting, which responds to PCB requests for focus at country level¹⁶. Within each region, results have been selected under two (and three for Eastern and Southern Africa) relevant Principal Outcomes. Overall, the amount of text by Principal Outcome and by region is proportionate to the UBW expenditure.

A. Asia and the Pacific


Expected Outcome: Human rights based and gender responsive policies and approaches to reduce stigma and discrimination are strengthened, including as appropriate focused efforts on sex work, drug use, incarceration and sexual diversity

Expected Output: Human rights based policies and programmes are coordinated and promoted in all settings, and vulnerability to HIV reduced through an enabling legal environment and access to justice for those affected

110. A number of policy developments in the region around people who use drugs were facilitated by UNODC and UNAIDS Secretariat. A joint advocacy strategy was developed to support the repeal of compulsory detention centres for people who use drugs, and representatives from ten countries in Asia were convened to share strategies and drive a policy dialogue. In Cambodia, a new human rights based drug law which includes HIV prevention, treatment and care for people who use drugs was drafted and reviewed in collaboration with WHO and the UN High Commissioner for Human Rights and other key stakeholders.
111. UNODC also contributed to various other regional and country initiatives for people who use drugs. The high-level East Asia and the Pacific Regional Task Force has provided a platform to facilitate policy development and advocacy. In Indonesia, for example, Members of Parliament were sensitized and trained to be able to better respond to the needs of drug users and other key populations. In Myanmar, recommendations for legal reviews affecting people who use drugs were produced and disseminated; in Lao PDR, needle and syringe programs and methadone maintenance treatment were piloted in two provinces.
112. UNDP/APCOM conducted a research study in 20 Asian countries on increasing access to health and HIV services for MSM and transgender people, which was featured in an editorial in the Lancet. Recommendations from the study were adopted by the Asia Pacific Forum of National Human Rights Institutions. The results of the study and the technical consultations related to the study received considerable policy attention from Governments, Judiciary and Parliamentarians and academia in the region. For instance, in Papua New Guinea the Ministries of Community Development and the Ministry of Justice called for a review of punitive laws relating to same sex practices and sex work.
113. Four countries (Kiribati, Solomon Islands, Tuvalu and Vanuatu) drafted cabinet papers for HIV legislation to ensure protection of the rights of PLHIV, with UNAIDS support.

¹⁶ e.g. Decisions 5.2 (23rd PCB); 4.7 (25th); 10.3 (26th)

Expected Output: Stigma, discrimination and other key social determinants of vulnerability addressed in HIV policies and programmes

114. A year-long exhibition on “Healthy Sexuality: The Story of Love”  was organized by the National Science Museum of Thailand and supported by UNESCO, reaching over one million adolescents with information on relationships, pregnancy and childbirth, contraception, safe sex and sexual violence. All materials in the exhibition were developed and/or vetted by Thai youth. A [website](#) promoted learning beyond the exhibition and a scaled-down exhibition will tour Thailand for another two years.
115. [YouthLEAD](#) is an initiative supporting youth leaders to create a culture of pluralism and inspire adults through their example, with a network of focal points in over 15 countries, and was established with the support of UNICEF, UNFPA and Seven Sisters (the Coalition of Asia Pacific Regional networks on HIV/AIDS). It successfully participated in multiple high-level policy events, including the Asia Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support. The Consultation resolution included wording on removing restrictions for young key affected populations YKAP accessing HIV prevention services such as age restrictions and mandatory parental consent.
116. HIV prevention needs and peer education of MSM and transgender people in Asia and the Pacific were strengthened by the UN and national partners. In Thailand, 300 HIV prevention packages were produced for MSM and transgender people for use by peer educators and outreach workers in 30 provinces across Thailand. In Bangladesh, a video was developed with the Bandhu Society for MSM interventions. Over 500 people were trained in peer education efforts. In Cambodia, UNESCO supported the establishment of the first Five Year Strategic Plan of the National MSM Network.
117. In partnership with USAID, UNDP contributed to the design of local responses to HIV among men who have sex with men and transgender persons in 6 cities of Southeast Asia. A technical consultation in Hong Kong on the initiatives undertaken in Bangkok, Chengdu, Ho Chi Min City, Jakarta, Manila and Yangon brought together more than 150 government, community and regional partners and led to six city-level draft action plans aimed at improving the quality and scope of existing prevention and health-based services.

Expected Output: Gender inequality, gender-based violence and discrimination against women and girls are more effectively addressed, including through the engagement of men and boys

118. India's National AIDS Control Organization incorporated different and more cost-effective female service delivery models into its national operational and costing guidelines for working with people who inject drugs. This followed work by UNODC which identified the most cost effective and technically sound female service delivery model after work in the country (in Manipur, Meghalaya, Mizoram and Nagaland).
119. Bangladesh, Cambodia, Myanmar, Nepal and Viet Nam implemented and scaled-up the ‘Creating Connections’ curriculum supported by UNICEF which targets adolescent girls and mothers of adolescents, promoting sexuality and reproductive health education and sensitively challenging social norms of silence on sexuality, as part of a broader HIV prevention strategy. Following a regional training of trainers in March 2011 organised by UNICEF, UNFPA, UNESCO and the University of Melbourne for representatives from the countries, the training was replicated at national level including implementing the curriculum nationally; integrating components into

adolescent, girls and mothers clubs; and commissioning boys' programmes in ethnic minority communities.

120. A National Dialogue in Papua New Guinea linked to the Global Commission on HIV and the Law provided a forum for PLHIV and key affected populations to discuss the serious human rights violations they face in the country with policy makers. Subsequent dialogue gave impetus to the movement in PNG to reserve 22 seats in parliament for women, which the UN has been advocating for the last few years. This was passed by parliament in November 2011.
121. In Afghanistan, over 1,000 women who use drugs, and over 300 spouses of male drug users, received comprehensive HIV prevention and treatment services by UNODC. Advocacy and training provided around the interventions (in three districts and two prisons) were well accepted by the government and communities, strengthening the gender-sensitivity of services and helping to establish new service delivery sites for women.

Case study: Female drug use in Pakistan

Comprehensive HIV services for vulnerable women and girls who use drugs are generally not gender responsive, which deters many of them from accessing services that they need. For example, women may be prevented from accessing services if they are pregnant, HIV-positive or if they have children. There may also be barriers to accessing services as a result of household responsibilities, lack of family support, social networks and/or financial constraints. In cases where there is a lack of privacy and confidentiality, this may create fear of being identified and stigmatized.

A UNODC project in Pakistan is improving equitable access to HIV/AIDS prevention and care services for women. The project in itself is an innovation, as the first ever effort in the country to address HIV prevention, treatment and care for highly vulnerable women and girls.

More than 1,600 women who use drugs and spouses of male drug users in 11 cities, and 1,400 women inmates in nine prisons, have received services under the project consisting of comprehensive HIV prevention/treatment services including VCT, Hepatitis B and C diagnosis, reproductive health care, STI prevention, diagnosis and syndrome management, and pregnancy testing, psychosocial counselling, basic health care and hygiene services.

A UNODC study arising from the project, [Female Drug Use in Pakistan: Mapping Estimates, Ethnographic Results & Behavioural Assessment](#), confirmed the need to address the HIV-related concerns of women who use drugs. The capacity of service providers to deliver gender-specific services has been significantly enhanced, and the work has informed work developing targeted interventions within specific geographical settings.

Expected Output: Human rights of most-at-risk populations are promoted and protected, including equitable access to services

122. A workshop in the Maldives on Opioid Substitution Therapy (OST) organized by the World Bank brought together over 50 policymakers, programme implementers, researchers and drug user representatives. It identified critical factors contributing to effective and sustainable OST programmes, and country teams committed to a 100 day action/results agenda.
123. United Arab Emirates has started discussions among various Asian embassies in Abu Dhabi to support migrants' rights to health, and 13 labour sending countries were better prepared to discuss health issues of migrant workers in the 2011 Colombo Process Ministerial Consultation. This has arisen as a result of a series of regional dialogues organised by the UNDP Regional

Analysis: Funding for key populations

Mobilising adequate resources to fund programmes for key populations remains a challenge. Analysis of Global Fund Round 8 Phase 1 funding shows that out of USD 903 million allocated to HIV budgets, key populations were specifically allocated 8.8% (USD 79 million) – broken down by MSM, (2.1%, USD 19 million), sex workers (3.2%, USD 29 million) and people who inject drugs (3.5%, USD 31 million).

Programme on the health challenges for Asian labour migrants, jointly with IOM, the Secretariat, ILO, WHO and JUNIMA.

Expected Outcome: Coverage and sustainability of programmes for HIV prevention, treatment, care and support are increased and address the vulnerability and impact associated with sex work, drug use, incarceration and sex between men

Expected Output: Evidence-informed policies and practices, and improved coordination and harmonization of approaches for HIV prevention, treatment and care for injecting drug users, sex workers, men who have sex with men and transgender people

124. In China, the needle and syringe exchange programme in Chengdu City of Sichuan Province was presented to national authorities to illustrate good practice examples to support scaling up of services, supported by UNODC.
125. The Joint Programme organized the first-ever [regional consultation in Asia on HIV and sex work](#) in Pattaya in October 2010, bringing together some 150 participants from eight countries in the region (including Ministers, health officials, police, sex workers and NGOs working on sex work) and calling for greater emphasis on ensuring universal access to HIV prevention, treatment, care and support services for sex workers. In collaboration with the Asia-Pacific Network of Sex Workers (APNSW), participants shared strategies and developed national action plans. Actions arising from the recommendations of the Consultation include: an analysis of the needs and opportunities to promote sex work as work and safer sex work environments (ILO led), guidance on priority interventions to strengthen health sector responses to sex work (WHO led), draft report on enabling legal policy and human rights environments (UNDP and UNFPA), and regional research on violence against sex workers (UNFPA and UNDP).
126. Pakistan held a National Consultation on HIV and Sex Work in 2008 and representatives participated in the Pattaya conference. The culmination of both events that were supported by UNFPA resulted in increased collaboration between the government, bilateral agencies, the sex worker community, and NGOs and has resulted in the scaling up of services for sex workers based on the agreed minimum service package, providing greater geographical coverage, reaching a greater number of sex workers with an enhanced range of services.
127. UNHCR and the Malaysia AIDS Council conducted an assessment on risks and vulnerabilities associated with sex work among refugees in Kuala Lumpur, and a similar assessment was conducted in Bangladesh. HIV prevention services for sex workers significantly improved through peer education and self-support groups.
128. Eight countries (Indonesia, Iran, Mongolia, Nepal, Sri Lanka, Thailand, Timor-Leste and Viet Nam) have developed and implemented programmes for most at risk young people with support from the Joint Programme. For example, UNFPA organized a

Case study: Expanding access to ARVs

Government discussions in India on compulsory licensing, a key TRIPS flexibility, were informed by a [UNDP report](#) on the continued role of India as a supplier of affordable medicines five years after having complied with the TRIPS agreement. Given that India supplies 80% of Africa's HIV medicines, this could also significantly impact access to medicines in Africa. UNDP and the UNAIDS Secretariat organized a roundtable with the Indian generic manufacturing industry on the importance of India retaining its policy in domestic legislation, which would allow it to continue to provide ARVs to the rest of the world. The follow-up roundtable examined the implications of India's compliance with the TRIPS agreement since 2005, as analyzed in the UNDP report. These efforts are expected to lead to increased policy coherence between India and several LMIC countries that import pharmaceuticals, with the aim to sustain and increase access to affordable treatment.

short e-course capacity building training for 122 policy makers and programmers in the region on programming for most at risk young people in low and concentrated epidemics.

Expected Output: HIV prevention, treatment, care and support services scaled up with, by and for those engaged in injecting drug use, sex between men, sex work, and including those in prisons and other at risk settings

129. UNDP partnered with Humanist Institute for Cooperation and community based organizations to formulate and submit a successful USD 12.5 million multi-country Global Fund Round 10 proposal on HIV among men who have sex with men in Southeast Asia (including Indonesia, Malaysia, the Philippines and Timor Leste).
130. A regional strategy for South-East Asia and the Western Pacific to halt and reverse the epidemic among people who inject drugs in Asia was developed and published by WHO with regional partners.

Case study: Supporting initiatives involving sex workers

UNFPA has supported various countries in the region. For example:

- In India, this involved review and support of the Self-Regulatory Boards, which are sex worker-led mechanisms to identify and address victims of human trafficking for the purposes of sexual exploitation and the commercial sexual exploitation of children. Sex workers and local officials agree to a human rights based course of action for those who have been trafficked and police reports in West Bengal indicate that over 80% of trafficking cases in the state of West Bengal are currently identified by DMSC Self-Regulatory Boards.
- In Bangladesh, work with the District AIDS Committee led to the establishment of a 'Local Partnership Forum on HIV and Sex Work'. This created a platform for technical and financial support for brothel-based interventions promoting the human and sexual rights of sex workers.
- Funds were provided in the Philippines for mapping and profiling sex workers. The information identified in the report, 'Sex work in the time of HIV: Risk and vulnerabilities in the Philippines' was used to input into the 5th AIDS Medium-Term Plan.

131. The knowledge, attitudes and healthy behaviour of over 60,000 members of mobile populations and 538 female sex workers in Mongolia and China were increased to prevent HIV/STI. In partnership with the Red Cross Societies of Mongolia and China, UNFPA supported a 'Cross border HIV prevention project' for young female sex workers aged 18-25 and their potential clients (mobile traders and truck drivers who had regularly crossed the border since 2009). The project used innovative approaches such as the internet and mobile phones, and involvement of entertainment establishment owners, and led to increased capacity of local Red Cross societies to deliver and sustain scaled-up HIV prevention.

B. Caribbean

Expected Outcome: Human resources and systems of government and civil society enhanced to develop, implement and scale up evidence informed comprehensive HIV responses improving accountability

Expected Output: Capacity of national AIDS authorities to lead and coordinate an inclusive and broad based multisectoral response on AIDS is strengthened

132. A regional study supported by UNDP assessed the impact of the financial crisis on national AIDS responses (in collaboration with the United Nations Commission for Latin America and the Caribbean) in five countries (Dominican Republic, El Salvador, Guatemala, Jamaica and Panama).

Expected Output: National AIDS Strategies and Action Plans are costed, inclusive, multisectoral, sustainable, prioritized and informed by scientific evidence, reflecting social and epidemiological data

133. The Caribbean HIV and Sex Work Technical Working Group was established to enhance and mobilize the response through improved coordination and exchange, and led to the Georgetown Declaration on HIV and Sex Work, facilitated by UNFPA. Broad participation in the Group includes health ministers, national AIDS programmes, parliamentarians, civil society, multilaterals and bilaterals. Two regional meetings developed a roadmap for 2012-2013. Two other meetings developed the capacity of 28 sex workers from 7 countries to advocate for strengthened access to health services, and brought 52 programme managers from 11 countries together to help address the SRH and rights of sex workers.

134. UNDP provided technical (document analysis and review) and financial assistance to two networks of women living with HIV (ICW Latina and CRN+ in the Caribbean) to map and assess progress on gender equality, human rights and on HIV/AIDS Millennium Development Goals (3, 5 and 6) from the perspective of women living with HIV.

Expected Output: National human resource planning, training, compensation, and retention measures in all sectors relevant to the response are improved

135. The [AIDS Act No. 135-11 adopted on 7 June 2011](#) in the Dominican Republic explicitly referenced Recommendation (No. 200) concerning HIV and AIDS and the World of Work.

136. Latin America and the Caribbean Network of Uniformed Services received a USD 55 million grant from the Global Fund (the first Global Fund grant that covers uniformed personnel at a regional level). Support came through the platform of the Uniformed Services Task Force on HIV and uniformed services (a global coordination mechanism co-chaired by UNAIDS Secretariat and the US Department of Defence).

Expected Output: Sustainable programmes to mitigate the socio-economic impact of AIDS are developed and implemented through strengthened capacity of country partners

137. Recommendations on sexuality education were prepared for CARICOM Ministers of Education and a Health and Family Life Education (HFLE) teacher training manual was updated in the region to take account of good practices in school health which include sexuality education, following regional meetings of HFLE Focal Points across the Caribbean facilitated by UNESCO and the World Bank.

Expected Output: National systems for procurement and supply management, and legislation to facilitate access to quality affordable HIV medicines, diagnostics, condoms, and other essential HIV commodities are strengthened

138. Procurement and financial management capacity was developed in AIDS projects in Barbados and Jamaica, through World Bank fiduciary management training through workshops and on-the-job training.

Case study: Haiti

The delivery of HIV prevention and treatment services was restored to Haiti, a year after its devastating earthquake. Before the earthquake, UNAIDS estimated that 68 000 people were living with HIV in the three departments that were later impacted by the tremor—57% of the national total of 120 000. With the support of the Joint Programme, within three months of the January 2010 earthquake, 80% of people on HIV treatment in these departments were able to access their antiretroviral drugs again.

Ninety-two thousand HIV positive beneficiaries were reached by WFP in its post-earthquake response in Haiti, providing both a safety net as well as a Food by Prescription activity. UNCHR supported GBV prevention.

UNDP, as Global Fund principal recipient, helped mainstream HIV and health related initiatives into different phases of early recovery (including cash-for-work and gender based violence programmes) to ensure that people living with HIV and other vulnerable groups including sex workers, MSM and youth were able to access life-saving HIV services.

The HIV prevention needs of MSM living in Haiti are being addressed through the implementation of a sexual diversity programme. These were developed following recommendations arising from an extensive consultation which engaged networks of MSM, PLHIV and other civil society groups including international NGO (funded by Programme Acceleration Funds and coordinated by UNFPA), and the inputs of a technical working group which held a workshop on the eve of the 2011 International Day Against Homophobia.

Haiti's national HIV/AIDS Post Disaster Emergency Mid-Term Plan was developed with support from AIDS Strategy and Action Plan (ASAP), which participated in a rapid needs assessment and the support helped Haiti to forge a strategic working relationship with local and international partners and help focus on results.

Expected Outcome: Human rights based and gender responsive policies and approaches to reduce stigma and discrimination are strengthened, including as appropriate focused efforts on sex work, drug use, incarceration and sexual diversity

Expected Output: Human rights based policies and programmes are coordinated and promoted in all settings, and vulnerability to HIV reduced through an enabling legal environment and access to justice for those affected

139. The Joint Programme supported the region to develop a number of laws. The Prime Minister and Leader of the Opposition in Jamaica signed a declaration committing them to address stigma and discrimination and to draft an HIV Law. Draft HIV laws were developed in the Dominican Republic, Guyana and Haiti. UNICEF supported the government's revisions to voluntary counselling and testing (VCCT) policies for adolescents less than 16 years of age.

Expected Output: Gender inequality, gender-based violence and discrimination against women and girls are more effectively addressed, including through the engagement of men and boys

140. The UNAIDS Agenda for Women and Girls was launched in Barbados, the Bahamas, Dominican Republic, Guyana, Haiti, Jamaica and Trinidad and Tobago, and the Joint Programme helped strengthen national women's commissions to lead gender responses in Belize, Dominican Republic, Haiti and Trinidad and Tobago.

Expected Output: Human rights of most-at-risk populations are promoted and protected, including equitable access to services

141. UNICEF facilitated a regional training for national decision makers from Barbados, Guyana, Jamaica, St. Kitts & Nevis and Suriname which built capacity on needs and rights of adolescents from key affected populations through better focus on HIV, Health, and Social Harms. The course was based on the 2011 training for the Asia-Pacific region (UNICEF, UNFPA and the University of Melbourne).

C. Eastern Europe and Central Asia

Expected Outcome: Human resources and systems of government and civil society enhanced to develop, implement and scale up evidence informed comprehensive HIV responses improving accountability

Expected Output: Capacity of national AIDS authorities to lead and coordinate an inclusive and broad based multisectoral response on AIDS is strengthened

142. The International Forum on MDG-6 was hosted in Moscow from 10-12 October to foster a strategic discussion on progress towards the Millennium Development Goal 6 in Eastern Europe and Central Asia. The Forum was organized and prepared with the Ministry of Foreign Affairs, Ministry of Finance of the Russian Federation and NGO Infoshare with support from UNAIDS. An Action Plan adopted to enhance Development Cooperation in the region was adopted following the Forum, with a pledge to increase the engagement of women's organizations and partners. The Forum also endorsed marketing communications to achieve behavioural objectives in health, particularly in the area of HIV and AIDS response. A network of COMBI specialists for HIV in the region was formed and local communications strategies were drafted with support from WHO.
143. The [5th Inter-parliamentary Conference of Central Asian countries](#) was organized jointly with the World Bank, UNODC and the Secretariat in Baku in June 2010 and attended by over 70 participants including members of parliaments and senior officials from Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. The countries agreed on a [Resolution](#) requesting legislative actions to eliminate stigmatization and discrimination of drug users and prison inmates regarding access to HIV services.

Country results following the 5th Inter-parliamentary Conference of Central Asian countries:

In Azerbaijan, a new HIV law was endorsed including provisions to improve access to HIV prevention, treatment and care for people who inject drugs and prisoners;

In Kazakhstan, a programme to develop alternatives to incarceration for drug using offenders who had committed non-violent crimes was endorsed;

In Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, the issues of stigma and discrimination have been included into teaching modules developed for health care service providers and for students of schools of medicine and law schools as well as at the institutes training social workers (Azerbaijan, Kazakhstan, Kyrgyzstan);

In Uzbekistan, opioid antagonists (naloxone and naltrexone) were made available for overdose prevention and relapse prevention.

144. A regional prevention education conference in Almaty, April 2011, organised by UNESCO, UNFPA, UNICEF, ILO, the UNAIDS Secretariat and GIZ, achieved a major breakthrough in advocacy for sexuality education: the [Resolution](#) acknowledged sexuality education as integral to prevention education and key to achievement of the three zeros. A regional action plan was developed to scale up prevention education, with Armenia and Ukraine pioneering its implementation. Obligatory health education (with HIV prevention and sexuality education components) has been introduced and plans established to strengthen capacities for its sustainable delivery.

Expected Output: National AIDS Strategies and Action Plans are costed, inclusive, multi-sectoral, sustainable, prioritized and informed by scientific evidence, reflecting social and epidemiological data

145. A national Strategy and Operational Plan on the Suppression of Narcotic Drug Misuse was developed by the Ministry of Security for Bosnia & Herzegovina with support from UNICEF. The plan provides a legal framework for NGOs for harm reduction services to drug users, including adolescents over 15, without coming into conflict with the law. Operational research was conducted in four countries (Bosnia, Moldova, Serbia and Ukraine) with support from UNICEF to generate better evidence on young injecting

drug users. The inclusion in national behavioural surveillance studies of information related to initiation into injecting drug use led to a better understanding of the age and circumstances surrounding initiation into drug injection. The [findings](#) also strengthened the development of programmes designed to reduce initiation into injection and risky injection practices.

146. National AIDS Spending Assessments were carried out in Belarus and Tajikistan during the biennium with Secretariat assistance to support the development of prioritized National AIDS Strategies and costed national Action Plans.

Expected Output: National strategic information and accountability systems, including one agreed monitoring and evaluation framework for HIV, are developed and implemented

147. Three knowledge hubs were supported by WHO in updating curricula, incorporating changes in the latest WHO/UNAIDS guidelines, and maintaining and updating the Hub's training database. The [Regional Knowledge Hub for Care and Treatment of HIV/AIDS](#) in Russia continued training on sexual reproductive health, clinical mentoring and Training of Trainers on the case management data base and paediatric ART. The [Knowledge Hub for surveillance](#) in Croatia, serves as a regional resource on HIV/AIDS surveillance issues (in particular on second generation HIV surveillance) by establishing a cadre of consultants, facilitating direct technical assistance missions, training health professionals and adapting tools and guidelines. It has pursued its work on training, technical assistance, research and networking. The [Harm Reduction Knowledge Hub](#) in Lithuania has gathered a pool of trainers and consultants and developed training tools to help countries implement evidence-based harm reduction and advocacy training on oral substitution therapy for injection drug users, harm reduction training in prisons and gender training for Harm reduction service providers. Joint efforts also supported [data triangulation in Estonia, Moldova and Ukraine](#).

Universal Access in the EECA:

As part of the process of strengthening national capacity towards Universal Access, up to 90 specialists were trained in key countries of the EECA region to generate quality data and improve the use of strategic information in the development of the National AIDS Action Plans, HIV M&E systems, UA targeting and advocacy. Trainings were carried out on (1) modes of transmission studies; (2) population size estimation methods; (3) HIV related data triangulation; and (4) projection methodologies.

UA consultations were conducted and targets set in all countries with assistance from the UNAIDS and Regional Support Teams, resulting in 100% UA reporting.

148. The national M&E system on HIV/AIDS in Kazakhstan was jointly reviewed and assessed by UNAIDS and the CDC resulting in a plan of action agreed on to strengthen the system. In Ukraine, capacity for M&E was strengthened by developing a strategy and action plan for One National M&E system, drafting the Cabinet of Ministries of Ukraine Decree and National M&E Plan, identifying strategies and guidelines to develop regional M&E systems, building capacity in national institutions for the analysis and use of strategic information and conducting a national AIDS Expenditures Study.

Expected Output: Community systems strengthened through capacity building and inclusion of people living with HIV, most-at-risk, affected and vulnerable groups in national responses

149. Seven countries (Albania, Bosnia & Herzegovina, Moldova, Montenegro, Romania, Serbia and Ukraine) included 'Most At Risk Adolescents' as a target group in their National AIDS Strategies and/or operational plans, following twenty-three studies and capacity building for 80 national researchers to better understand the risk profile of the group. UNICEF provided support for this work, as well as advocacy and technical support in the Russian Federation and Ukraine to reduce the abandonment and institutionalization of children born to HIV infected mothers. This has included working

with civil society organizations and government social services and child protection systems to ensure that child care reforms take into account the needs of children living with HIV.

Expected Output: Sustainable programmes to mitigate the socio-economic impact of AIDS are developed and implemented through strengthened capacity of country partners

150. Moldova, Serbia and Ukraine reviewed the structure of health and social welfare systems to provide more comprehensive services following advocacy from UNICEF. For example in Moldova work with government and civil society partners linked health and social services through development of a referral system aimed at addressing the needs of vulnerable children/adolescents and their families. The system employs 'social assistants' as case managers to monitor and evaluate the progress of intervention plans intended to facilitate children/family members' access to social assistance, health, education, the criminal justice system and civil society organizations.
151. Five countries in the region (Belarus, Kazakhstan, Kyrgyzstan, Moldova and Ukraine) were better able to plan for a sustainable AIDS response and mitigate the negative impact of intellectual property on treatment through UNDP input. This was done in particular through assisting countries to incorporate public health flexibilities in the WTO TRIPS agreement in national intellectual property rights legislation and to utilize them to reduce the prices of essential medicines.

Expected Output: National systems for procurement and supply management, and legislation to facilitate access to quality affordable HIV medicines, diagnostics, condoms, and other essential HIV commodities are strengthened

152. A Computerized Logistics Management Information Systems (LMIS) Assessment was conducted in Tajikistan and Uzbekistan. Tajikistan has strengthened RHCS systems including management, storage, LMIS, supply chains, resulting in increased distribution, efficiency and reduced costs. The Ministry of Health has earmarked funds for maintaining RHCS and begun to allocate funds for commodities – included within the SWAp Comprehensive Health Strategy to 2020.

Expected Outcome: Coverage and sustainability of programmes for HIV prevention, treatment, care and support are increased and address the vulnerability and impact associated with sex work, drug use, incarceration and sex between men

Expected Output: Evidence-informed policies and practices, and improved coordination and harmonization of approaches for HIV prevention, treatment and care for injecting drug users, sex workers, men who have sex with men and transgender people

153. Regional data on reported newly diagnosed cases related to people who inject drugs for 2008 suggest that infection rates are still generally falling in the European Union, following the peak in 2001–02, which was attributed to outbreaks in Estonia, Latvia and Lithuania. Of the four countries reporting the highest rates of newly diagnosed infections (Estonia, Latvia, Lithuania, Portugal), all continued to show a downward trend, with a marked decline in the Baltic States, in particular, Estonia and Latvia, where UNODC has implemented large HIV/AIDS programme activities since 2006. In Estonia, a decrease was observed from 86 cases per million in 2007 to 27 per million in 2008 (34% reduction); and in Latvia from 62 cases per million in 2007 to 44 per million in 2008 (69% reduction) (Source: [EMCDDA annual report, 2010](#)).

Expected Output: HIV prevention, treatment, care and support services scaled up with, by and for those engaging in injecting drug use, sex between men, sex work, and including those in prisons and other at risk settings

154. An international seminar on drug addiction treatment in Kyiv, Ukraine (July 2010), cosponsored by UNODC, established collaboration between research institutions from the United States, Ukraine and Central Asian countries for enhancing the role of OST in Eastern Europe and Central Asia.

D. Eastern and Southern Africa

Expected Outcome: Human resources and systems of government and civil society enhanced to develop, implement and scale up evidence informed comprehensive HIV responses improving accountability

Expected Output: Capacity of national AIDS authorities to lead and coordinate an inclusive and broad based multisectoral response on AIDS is strengthened

155. DRC, Zambia and Lesotho and Malawi completed AIDS Sector institutional assessments with inputs from UNDP, the World Bank and the Secretariat that enabled the countries to understand the institutional strengths and limitations as well challenges to effective and efficient coordination of the AIDS response at the national and sub national levels. In turn, findings of the assessments informed policy decisions such as restructuring of National AIDS Councils or redefining the role of key sector ministries in the coordination of the AIDS response.
156. More than 750 country partners benefited from 27 targeted capacity-building exercises to strengthen Global Fund grant proposal and implementation processes. These were organized by the TSF Southern Africa and Eastern Africa, with support from the Secretariat, which developed training modules for country and regional workshops on grant consolidation, in line with emerging requirements by the Global Fund.

Expected Output: National AIDS Strategies and Action Plans are costed, inclusive, multisectoral, sustainable, prioritized and informed by scientific evidence, reflecting social and epidemiological data

157. Botswana, Lesotho, Malawi, South Africa, Uganda and Zambia have produced action plans for addressing short term country specific HIV and gender gaps in Environmental Impact Assessment regulations, resulting in increased collaboration between NACs, Ministries of Health and Environment in these countries. In all countries, the links between gender, HIV vulnerability and large infrastructure projects are being identified and better understood. In collaboration with SADC, UNDP worked with these countries (and Mozambique and Namibia) to address these issues, with the knowledge that large “capital projects” can increase HIV susceptibility, partly through their impact on labour migration.
158. Food and nutrition stakeholders in seven selected countries (Kenya, Malawi, Mozambique, Rwanda, Swaziland, Zambia and Zimbabwe) familiarized themselves with routine patient information systems to identify opportunities for greater integration of nutrition indicators and comprehensive information management. The exercise, led by WFP in collaboration with WHO, the Secretariat and the expert organization HISP, has built momentum in aligning data systems among national counterparts, thus allowing for enhanced programme management and evidence building around nutrition intervention effectiveness.

Expected Output: National strategic information and accountability systems, including one agreed monitoring and evaluation framework for HIV, are developed and implemented

159. M&E Advisers and national counterparts in all ESA countries were trained by the UNAIDS Secretariat on the new EPP/Spectrum software and updated country and epidemiological data.

Evaluation

95% of countries in the region reported using national M&E assessments to determine HIV M&E priorities in 2010, a much higher percentage than in other low and middle income countries. However, only 60% of countries reported having a centralized HIV M&E database, and only 75% were producing annual HIV M&E reports. UNGASS reporting had generally good feedback, but was not used as the national AIDS report by the majority of countries in the region.

Expected Output: Community systems strengthened through capacity building and inclusion of people living with HIV, most-at-risk, affected and vulnerable groups in national responses

160. To encourage and support effective and quality involvement of African civil society in the HIV response at the national level, and to formalize a longstanding partnership, the UNAIDS Secretariat signed a memorandum of understanding with the African Council of AIDS Service Organizations in December 2010.

Case study: Sex work and HIV in Namibia

Sex workers are named in Namibia's National Strategic Plan framework for HIV/AIDS 2010/1-14/5 as a priority population, with one result being that African Sex Worker Alliance Namibia brought voices of sex workers to the global agenda. UNFPA and the UNAIDS Secretariat were involved with several initiatives around sex work in the country, including support to two sex worker-led networks. The process for community assessment was especially innovative and built upon principles of meaningful partnership and community ownership, and is a demonstration of the importance of catalytic funds.

161. Civil society participants in Africa fed into the 2010-2011 Universal Access consultations and national policy making. As part of this the UNAIDS Secretariat with support from partners, including UNICEF, convened 35 civil society participants from several countries, in African inter-governmental organizations (AU, SADC, ECOWAS, African Commission on Human and People's Rights and its Committee on the Rights of PLHIV and Key Populations).

Expected Output: National human resource planning, training, compensation, and retention measures in all sectors relevant to the response are improved

162. The ESA Knowledge Hubs Network supported by WHO provided on-going technical support to countries to decentralize learning activities; to build the management capacity of District health Management Teams in support of ART, care & prevention; and develop and use training modules of managers on HIV ART monitoring tools.

Expected Output: Sustainable programmes to mitigate the socio-economic impact of AIDS are developed and implemented through strengthened capacity of country partners

163. In Malawi alone, 28,138 cash grants were made to households including 67,887 children affected by AIDS as part of a UNICEF-supported [Children and AIDS Regional Initiative](#). This is based on research on government-funded social protection schemes which demonstrated that such grants helped to reach marginalized and excluded children, increase primary school attendance and help reduce persisting inequality. UNICEF also facilitated mapping and diagnostics of child protection, care and support systems for children in 15 countries in sub-Saharan Africa.

164. UNDP, the UNAIDS Secretariat, the World Bank developed a partnership with SADC to initiate conversations on options for sustaining AIDS programmes in the context of dwindling external funding with all 13 SADC member states. This led to the drafting of

a Regional Follow up Action Plan which has high level commitment from member states and from SADC.

Expected Output: National systems for procurement and supply management, and legislation to facilitate access to quality affordable HIV medicines, diagnostics, condoms, and other essential HIV commodities are strengthened

165. UNFPA mobilized over \$240 million for the Global Programme for Reproductive Health Commodity Security (GRHCS) in 56 countries, providing contraceptives including condoms and essential life-saving medicines to avert stock outs and shortfalls. Fourteen of 20 countries in Eastern and Southern Africa funded by GPRHCS have an RHCS Strategic Plan that is being implemented, and 17 countries have an RHCS budget line. All countries have a coordination mechanism.
166. The East African Community (EAC) amended a draft anti-counterfeiting bill in a public health sensitive fashion, guaranteeing the continued use of generic medicines that account for 90% of the total consumed in the region, as a result of a partnership with UNDP, GTZ and civil society.
167. The fragmentation of supply chain operations programmes was reduced through the creation of comprehensive systems approaches to ensure access to the 1,200-2,500 products managed by health sector service delivery systems. The World Bank provided technical assistance for this in a number of countries, including the development of a USD 100 million Kenya Health Sector Project (with USD 55 million to support commodities and supply chain management for the public sector) as well as the development of a USD 36 million Mozambique Health Commodity Security Project.
168. UNICEF supported Malawi, Swaziland, Zambia, Rwanda, Tanzania, Lesotho, Zimbabwe, Uganda were supported through UNITAID planning and implementation to improve procurement and supply management as well as ensure effective coordination to reduce duplication and wastage and stock outs of PMTCT related drugs and commodities

Expected Outcome: National capacities for scaling-up HIV prevention, treatment, care and support are enhanced.

Expected Output: Prevention of sexual transmission of HIV and STI strengthened including through sexual and reproductive health policy, programmes and service linkage

169. UNFPA supported a wide range of integrated health services including male circumcision. Zimbabwe developed an integrated model on CCP/MC/PMTCT¹⁷ community services utilized by partners nationwide. As of July 2011, 31,000 men had been circumcised. In Malawi, there was a 21% increase in uptake of male circumcision. Rwanda developed an operational plan for male circumcision aligned with the National HIV Strategic Plan 2009-2012.

Lessons learnt: Sexuality Education

Evidence from UNESCO's [International Technical Guidance on Sexuality Education](#) has been instrumental in attracting greater engagement from decision makers on the issue. Some ongoing political and community resistance to addressing sexuality for young people within a school environment has prompted the development of new approaches to advocacy and evidence utilisation, linking HIV risk to other SRH issues such as unintended pregnancy, and focusing on engaging stakeholders in dialogue about the need for school-based education.

A situational analysis in Kenya highlighted the challenges in implementing life skills lessons, the need for teacher training, dedicated space in the curricula and institutional support for a non-examined subject.

¹⁷ Comprehensive Condom Programming / Male Circumcision / Prevention of Mother to Child Transmission of HIV

170. In Uganda, UNHCR supported the promotion of a nation-wide campaign on male circumcision and the scaling up to refugee settlements.
171. Lesotho, Swaziland, South Africa, Uganda and Zambia incorporated lessons learned into their curriculum reviews and Zimbabwe developed a sexuality education policy. These are the initial outcomes from a capacity building workshop for 70 Curriculum Development Specialists from the Ministries of Education and UN Staff responsible for young people from ten SADC Countries (Botswana, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, Zambia and Zimbabwe) organized by UNFPA, UNICEF and UNESCO. The workshop helped countries to design and implement effective sexuality education and HIV prevention among young people in educational settings.

Expected Output: Comprehensive programmes for the prevention of mother-to-child transmission scaled up

172. The Joint Programme has played a central role supporting work around the Global Plan in many countries. In Burundi, Comoros, Tanzania and Uganda, national PMTCT policies were developed. In Rwanda new WHO guidelines on PMTCT were adopted and are being implemented. In Kenya, review of the National PMTCT policy is underway to strengthen Prongs 1 and 2, advocating also for re-integration of family planning. In Ethiopia, the National PMTCT Training package was revised and is now addressing Prong I and II. Malawi developed a national plan on virtual eMTCT. In Namibia, PMTCT Prongs 1 and 2 have been fully incorporated in the review of PMTCT and efforts are underway to integrate it in the eMTCT plan. Technical assistance for the development of eMTCT plans in 12 countries was provided by UNICEF (including six costed plans in Burundi, Ethiopia, Kenya, Lesotho, Swaziland, Tanzania and Uganda).

Expected Output: Interventions for the prevention of HIV transmission within health care and occupational settings (including blood safety, safe injection practices, universal precautions; occupational health standards, PEP) scaled up

173. Countries in the region were kept informed by WHO of developing science with respect to the PrEP through regional consultations in Johannesburg and Nairobi, and country consultations in Zambia and Zimbabwe.
174. In November 2010, the ILO, WHO and the UNAIDS Secretariat launched a Joint Policy Guide to improve health workers' access to HIV and TB prevention, treatment, care and support services. ILO technical guidance helped to anchor human resource (for health) strategies into national AIDS strategies in 20 countries including Botswana, Ethiopia and Tanzania.

Expected Output: Comprehensive HIV-related treatment and care services scaled up

175. RapidSMS (telephone messaging) is being implemented in Kenya, Lesotho, Malawi, South Africa, Uganda and Zambia to strengthen the follow-up for infants on treatment and the continuum of care with support from UNICEF. In Zambia Project Mwana improved broader maternal, newborn and child health (MNCH) continuum of care, including HIV/PMTCT with specific attention to infant-feeding. To date, more than 3,000 infant HIV test results have been relayed using Short Message Service (SMS) rapid technology, with a reduced turnaround time of about 50 per cent. Access to paediatric ART is also being improved by strengthening service integration within maternal and child health services for children living with HIV; promising results were reported in Kenya, Lesotho, Malawi, Swaziland and Uganda.

176. Commonalities in nutritional rehabilitation principles between maternal and child health programmes and HIV- and TB-related services increasingly call for convergence in strategy, protocol and service delivery mechanisms. As a result of consultations with partners, WFP refocused its programmes in Djibouti, Ethiopia, Lesotho and Zimbabwe so that food and nutrition services were increasingly integrated with the health sector's care and treatment programmes.

Expected Output: Equitable access and uptake of HIV testing and counselling ensuring confidentiality, informed consent, counselling and appropriate referrals

177. Routine provider-initiated testing and counselling (PITC) for children was introduced in MCH, paediatric wards and nutrition centres in the majority of priority focus countries in the region by UNICEF. HIV-related interventions have been introduced in child health days (CHDs). Immunization clinics in the majority of countries in the region rolled out early infant diagnosis.

Expected Output: Scaled up and harmonised joint HIV/TB planning, training, procurement and delivery of HIV/TB services

178. Male circumcision and TB trainings were provided by ILO to peer educators in Swaziland as part of comprehensive training package which covered structural, behavioural and biomedical approaches to HIV and TB. In South Africa, the ILO provided technical input during the development and launch of the national strategic plan on HIV/AIDS, TB and STIs (2012-2016). In Namibia, the ILO inputted into the development, reviews and implementation of the National Tripartite Framework on HIV/AIDS and TB. In Kenya and Botswana, 287 TB suspects from enterprises were referred to public health facilities by peer educators as part of the strategy aimed at increasing TB case finding.

Expected Outcome: Increased coverage and sustainability of programmes including to address the vulnerability of, and impact on women and girls, young people, children, populations affected by humanitarian crisis and mobile populations

Expected Output: Protection, care and support for children affected by AIDS are provided

179. Evidence-informed strategic national plans for the protection, care and support of vulnerable children were supported by UNICEF in 13 countries, initiated through mapping of the child protection systems. UNICEF worked closely with USG/PEPFAR to support social welfare systems strengthening, and has been able to leverage funding for this work in a number of countries including Malawi, Swaziland and Uganda. A 'Challenge Fund' initiated by UNICEF catalyzed responses to children affected by AIDS in different ways, for example to assess national social protection systems (Namibia) and support innovative community case management models (Mozambique).

Expected Output: Policies, programmes and services for young people, particularly those most at risk, are implemented

180. UNHCR supported a regional initiative on sex work in humanitarian settings in East Africa. Intervention involved partners and Ministries of Health to address the special health and protection needs of sex-workers, adolescents involved in survival sex and sexual exploitation and Men Having Sex with Men. Assessments and programmes were developed and/or strengthened in key countries, with in particular training and support of multifunctional teams in three countries (Ethiopia, Kenya, and Uganda) where HIV, Sexual and Reproductive Health (SRH) services for sex workers have significantly improved, communities have been sensitized, and peer-led networks

developed. UNHCR Kampala implemented the initiative in urban and refugee settlements, which was replicated in different sites to ensure that sex workers have access to all health services, reduce their vulnerability to HIV and profit of alternative livelihood activities.

Case study: Adolescents living with HIV (ALHIV)

Eastern and Southern Africa has an estimated 54% of the 2.7 million young people living with HIV. UNICEF, UNFPA and WHO has worked with eight key countries (Botswana, Lesotho, Malawi, Namibia, Rwanda, Swaziland, Uganda and Zimbabwe) to help improve health service provision for ALHIV; identifying challenges in finding care and keeping them alive, healthy and productive; and identifying priority areas for improved service delivery ranging from early diagnosis to sexual and reproductive health and prevention support.

Following a regional consultation, country teams were equipped to train trainers in prevention, treatment, care and support for ALHIV and develop country plans to ensure effective transfer of knowledge and mobilization.

Namibia has developed a communications strategy on ALHIV and also, along with Zimbabwe, held a national stakeholder consultation to improve planning and health services. This links into two global processes to ensure systematic guidance, coordination and greater impact: WHO is developing guidance on testing and services for ALHIV; and UNICEF is reviewing field lessons on service delivery to provide a practical resource on addressing diagnosis, disclosure, ART initiation, adherence support, primary care and transition in ALHIV.

In the education sector, UNESCO has identified separate lessons. Responses have largely focused on HIV prevention or awareness, with little attention paid to the existence, needs and desires of young people living with HIV. The barriers they face in schools are linked to high levels of stigma and discrimination experienced from staff and other students, and pressure around disclosure. For many young people living with HIV in school, balancing treatment and other medical needs adds a huge amount of stress to their lives.

181. In Tanzania, Behaviour Change Communication (BCC) guidelines for HIV prevention for young people were drafted following UNFPA support to enhance the capacity of government and non-government partners in this area.

Expected Output: HIV transmission and impact on women and girls are reduced through gender responsive service delivery and access to commodities

182. Ethiopia conducted a large-scale girls-outreach programme which reached more than 1.14 million girls with UNFPA support. In addition, more than 1,600 vulnerable women including female sex workers were able to benefit from and took part in the income generating schemes that included training them on life skills aiming at reducing their vulnerability, enhancing their negotiation power and preventing new infections.
183. Research facilitated by UNICEF in Malawi (the 'Sisters to Sisters') initiative demonstrated that peer-led sexuality education training for adolescent girls led to significantly improved knowledge, attitudes and reported behaviours - with reported condom use at last sex increasing from 55% to 81%.
184. Global Fund Round 10 grants incorporating gender were made to Eritrea, Kenya, South Africa and Zambia, with UNAIDS Secretariat support.

Expected Output: HIV policies and programmes implemented for populations affected by humanitarian crisis

185. National mechanisms to coordinate HIV responses in emergencies were established in Ethiopia, Kenya, Malawi, Mozambique and Zimbabwe. Disaster management policies inclusive of HIV in Kenya and Namibia were reviewed, strengthened and supported. This was as a result of technical support from the UNAIDS Secretariat and UNHCR to these and six other priority countries (Guatemala, Haiti, Ivory Coast, Liberia, Libya and South Sudan) to address HIV in emergency settings.

Case study: North Star Alliance

[North Star Alliance](#) works in partnerships with others to build networks of roadside health clinics at transport 'hotspots' in Africa so that mobile workers and related communities have sustainable access to high quality health and safety services. It was founded by WFP and TNT (the express distribution company), in consortium with partner organizations and is a sub-recipient of a major SADC Global Fund Grant to address HIV at 32 cross-border locations throughout southern Africa.

At the end of 2011, North Star was operating 23 Roadside Wellness Centres that provide health services and HIV prevention to long distance truck drivers, sex workers and community members in 10 countries. In 2011, a total of 268,405 people had visited the clinics, 8,120 STIs had been treated and 39,740 HIV tests were done. So far seven SADC member states have signed MOUs with SADC to provide mobile cross-border health services.

WFP Kenya supported three Roadside Wellness Centres along the northern corridor, with contributions from DFID through the Joint Programme. The Government of Kenya considers the clinic in Mlolongo to be a model approach and is supporting the combination prevention and treatment for HIV and a range of both communicable and chronic diseases.

In Zimbabwe, WFP and North Star Alliance supported a series of HIV prevention workshops led by Art for AIDS International that combined fact-based information, stigma-reduction techniques, group activities and the creation of individual art collages. The original signed art created by truck drivers, sex workers and youth was reproduced and prints will be sold to benefit girl-friendly activities.

E. Latin America

Expected Outcome: Strategic information strengthened and available to support knowing your epidemic, guiding and evidence informed response and improving accountability

Expected Output: HIV monitoring and evaluation approaches and systems are better coordinated and harmonized

186. Eight countries (Argentina, Chile, Colombia, El Salvador, Guatemala, Nicaragua, Uruguay and Venezuela) completed cost evidence based and results focused national strategic plans applying ASAP methodology. The ASAP exercise conducted with a participatory process which included civil society, key populations and PLHIV, allowed countries to "know their epidemic" and provided tools for development of GFATM proposals (Rounds 8, 9 and 10).

Expected Output: Reliable and timely data, information and analyses on global, regional and national trends are available and used, and the estimation of global and country HIV resource needs and tracking of financial flows are improved

187. Complementing the ASAP exercise, new data on Modes of Transmission of HIV was generated in El Salvador, Guatemala and Panama and with preparations undertaken for this in Brazil and Mexico. Thirteen National AIDS Spending Assessments were conducted in the region, which will contribute to more efficient resources allocation and new NSP and human rights strategy development.

Lessons learnt: The value and complexity of obtaining good data

Experience in many countries in the region points to the importance of reliable data and evidence to underpin the national AIDS response as well as research and evaluation agendas. Conversely, a lack of effective data has held back the response in certain countries. For example, weaknesses in HIV information systems in Peru mean that efforts are still needed to strengthen the evidence base and avoid underreporting of HIV cases.

There are also multiple challenges obtaining data, including limited availability of human resources and funding. Strengthening the timely dissemination and use of available strategic information is also a challenge.

188. Better availability and use of strategic information on the epidemic contributed to communication and advocacy efforts, enhancing knowledge on the epidemic and response among leaders from governments, civil society, and key populations in the

region. through the dissemination of four regional analyses. These included a review of the HIV epidemic for the 2010 ECLAC MDG progress report; a consolidated analysis of UNGASS 2010 country reports; a universal access report and road map; and a report on lessons learned and recommendations for population size estimates for key populations.

189. Progress on gender equality and human rights in the region was presented at the MDG summit in 2010. The underlying analysis and mapping was done by two networks of women living with HIV who received technical and financial assistance from UNDP, and subsequently supported the design and implementation of interagency country-level interventions in ten countries in the region.
190. The study [Food Insecurity and Nutritional Barriers to Antiretroviral Therapy: Lessons from Latin America and the Caribbean](#) by WFP was published in May 2011, indicating that food insecurity and undernutrition are closely linked to quality of life, health status and access and adherence to antiretroviral therapy in the region.
191. Brazil, Colombia and Peru completed the UNAIDS Inter-Agency Task Team (IATT) on Education Global Progress Survey in 2011, which was undertaken in its second instalment in approximately 40 countries around the world and is coordinated by UNESCO. In each country, ministers and civil society representatives developed consensus to identify strengths, weaknesses and trends in the national HIV response. The Brazil review included a review of health education in four states.

Expected Output: Biomedical, socio-economic, behavioural, operational research and evaluation agendas developed and promoted to scale up of the response

192. National HIV allocations to key affected populations in six countries (Argentina, Ecuador, El Salvador, Guatemala, Panama and Paraguay) increased nine-fold from 2008 to 2010. In 2010, USD 27 million was allocated to men who have sex with men and USD 10 million to sex workers, up from USD 1.1 million and USD 1.8 million respectively in 2008. Significant increases were also allocated to campaigns aimed at prisoners and people who inject drugs. These increases followed a World Bank study on allocative efficiency after which several governments reallocated funds to prevention and scale-up.
193. An HIV prevalence study in Chile supported by the UNAIDS Secretariat provided information about exposure and risk management for the first time in the country's response to AIDS.

Challenges: Having a strong and stable Ministry of Health (MoH)

UNAIDS offices in many countries – including Argentina, Ecuador, Guatemala, Honduras, Paraguay, Peru and Uruguay – reported challenges around the MoH and associated institutions.

For example, in Ecuador, Peru and Uruguay, gaps in leadership, managerial and technical capacity occurred during periods when MoH were restructured or decentralized (or simply had a high turnover of staff). In Ecuador and Peru this led to frequent deficits in the delivery of ARTs. Services to PLHIV were also affected in Guatemala during natural disasters when the MoH was forced to suspend activities to concentrate on solving the crisis. In Argentina, the formulation of public policy in the MoH is challenging due to the country's federal nature.

Furthermore, given that the MoH is often expected to manage the HIV and AIDS programme in a country, weak leadership and capacity may lead to a low priority being given to a multisectoral response.

Expected Outcome: National capacities for scaling- up HIV prevention, treatment, care and support are enhanced

Expected Output: Prevention of sexual transmission of HIV and STI strengthened including through sexual and reproductive health policy, programmes and service linkage

194. HIV prevention was integrated in SRH services in Colombia and Ecuador through an 'Integra' initiative supported by UNFPA. UNFPA also helped to identify and share best practices on the expansion of counselling and testing at the sub-regional level.
195. In Venezuela, UNHCR initiated a joint program with UNFPA and the UNAIDS Secretariat to fund an education and awareness-raising project on issues of sexual and reproductive health, sexual and gender-based violence, and HIV/AIDS throughout the border region. The programme targeted vulnerable youth and adolescents in communities with a significant presence of 'persons of concern' to UNHCR.

Expected Output: Comprehensive programmes for the prevention of mother-to-child transmission scaled up

196. There were appreciable increases of HIV testing of pregnant women in Bolivia and Peru. With support from UNICEF, ministries of health trained community health workers and midwives to carry out rapid tests in places lacking lab facilities. UNICEF also supported Honduras to develop mobile laboratory teams to perform HIV testing, and provided oversight and technical support in all three countries to scale-up good practices and share lessons learned.

Expected Output: Interventions for the prevention of HIV transmission within health care and occupational settings (including blood safety, safe injection practices, universal precautions; occupational health standards, PEP) scaled up

197. Three virtual training modules (on gender, human rights & SRH; masculinity; and project design) were introduced in 33 projects with armed and police forces in thirteen countries. Examples of follow-up included reaching 1,118 uniformed services personnel in Paraguay, and providing 1,950 dignity kits to people affected by natural disasters in Honduras and Panama. The modules were developed by the Latin America Faculty of Social Sciences with support from UNFPA.
198. Recommendation No. 200 on HIV and AIDS and the World of Work was referred to in court cases in Brazil where workers living with HIV were discriminated against on the basis of their HIV status, following tailored ILO training programmes to legal personnel. The courts ordered that they be reinstated and compensated for lost wages and benefits.

Expected Output: Comprehensive HIV-related treatment and care services scaled up

199. Nicaragua and Honduras scaled up work on HIV prevention, voluntary testing and counseling and treatment in prisons, as a result of UNODC support. El Salvador started a process of reform of its penitentiary system and Honduras, Nicaragua and Panama started reforms following UNODC assessments and a [study \(in Spanish\) on HIV and prisons in the four countries](#).

200. The PAHO Blueprint for the [Provision of Comprehensive Care to Gay Men and Other Men Who Have Sex With Men in Latin America and the Caribbean](#) was launched in 2010 and provides an important framework for the provision of health services and to strengthen access and quality to treatment.

Expected Output: Equitable access and uptake of HIV testing and counselling ensuring confidentiality, informed consent, counselling and appropriate referrals

201. Brazil's National AIDS Program offered rapid testing during the seven days of the 'Rock in Rio' festival that brought together about one million people. Support from the

Joint Programme included technical inputs to data analysis, management and planning.

202. Rapid testing and immediate results has allowed effective referrals to clinics in Bolivia and Peru through trained community health workers and midwives who carry out rapid tests in places lacking lab facilities. As a result of joint efforts between the ministries of health and UNICEF, significant increases of HIV testing of pregnant women in these countries have taken place.

F. Middle East and North Africa

Expected Outcome: Strategic information strengthened and available to support knowing your epidemic, guiding and evidence informed response and improving accountability

Expected Output: HIV monitoring and evaluation approaches and systems are better coordinated and harmonized

203. Iran, Morocco and Tunisia refocused their national strategic plans to address HIV more effectively following support from UNAIDS. In total in the region, Modes of Transmission (MoT) studies were completed for Djibouti, Iran, Morocco and Tunisia. Morocco and Yemen finalized studies on MSM and Morocco did another study on people who inject drugs. Seventeen countries provided HIV estimates and projections (through UNGASS) and 13 undertook National AIDS Spending Assessments (NASAs).

Challenges and opportunities: the changing political and social tapestry of the region

There is much hope in the region following the 'Arab Spring' but significant challenges exist in the transitional period for many countries as HIV and AIDS services may be disrupted or not high on the agenda. Stigma and discrimination is high in some countries which means that key populations have been denied services. Work with the League of Arab States (LAS) has helped in part to address this.

Expected Output: Reliable and timely data, information and analyses on global, regional and national trends are available and used, and the estimation of global and country HIV resource needs and tracking of financial flows are improved

204. The first comprehensive strategic assessment of HIV across different population groups was produced by WHO, the World Bank and the UNAIDS Secretariat in 2010, [Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa: Time For Strategic Action](#). It highlights the need to focus policy efforts in MENA among risk groups, rather than the general population where HIV transmission is very limited, as well as drawing attention to the need to develop robust surveillance systems to monitor HIV spread among priority populations. The report represents a valuable source of epidemiological information and situational analysis made available to governments for strategic HIV-related decision and policy making by Ministries of Health. It was disseminated at [a high-level meeting in Dubai in June 2011](#) and resulted in a declaration advocating policies and practices enhancing the HIV response and countering stigma and discrimination.
205. HIV surveillance was strengthened in Afghanistan, Iran, Libya, Morocco, Oman, Pakistan, Somalia, Sudan, Syria and Yemen following technical support and capacity building by WHO.

Expected Output: Biomedical, socio-economic, behavioural, operational research and evaluation agendas developed and promoted to scale up of the response

206. Operational research on the Situation and Needs of Children Affected By AIDS was conducted by UNICEF in Djibouti, Lebanon, Morocco, Oman and Sudan; on key affected populations in Oman; Knowledge, Attitude, Behaviour and Practices studies in Iran, Lebanon and Occupied Palestinian territory; as well as PMTCT in Djibouti, Lebanon, Morocco and Oman.

Expected Outcome: Increased coverage and sustainability of programmes including to address the vulnerability of, and impact on women and girls, young people, children, populations affected by humanitarian crisis and mobile populations

Expected Output: Protection, care and support for children affected by AIDS are provided

207. Programming for most at risk adolescents (MARA) has improved in at least 6 countries in the region through mappings, studies, services and other interventions. During a workshop in the region, UNICEF convened representatives from 14 countries including from national AIDS programmes, civil society and the League of Arab States, the World Bank and other UN partners to build capacity on HIV prevention and programming for MARA.

Expected Output: Policies, programmes and services for young people, particularly those most at risk, are implemented

208. Four thousand religious leaders were trained, and over 100,000 reached on HIV awareness, as part of the Religious Leaders Initiative on HIV organized by UNDP (in 31 countries in total). In Egypt and Libya initiatives included sensitization sessions during sermons, outreach with Muslim students and partnerships with NGOs for women to provide awareness raising sessions for female prisoners.
209. In Lebanon, 72% (185) of school health educators were trained with UNESCO support to deliver good quality life-skills based HIV and AIDS education at school level, using interactive teaching and learning approaches. Copies of a training manual to support school health educators in the delivery of classroom and extra-curricular activities will be distributed to all public secondary schools.
210. A comprehensive multimedia advocacy and educational project supported by UNFPA, [Youth in Arab States: Changing the World for the Better](#), highlighted the efforts of the Y-PEER Global Youth Network to achieve the MDGs, including MDG 6.

Expected Output: HIV policies and programmes implemented for populations affected by humanitarian crisis

211. Refugees were included in the 2010-2012 Strategic and Operational Youth Action Plan on HIV/AIDS in Lebanon, following advocacy by UNHCR with the National AIDS Programme, which now delivers youth friendly reproductive health services including HIV/AIDS. UNHCR also collaborated with UNFPA on awareness raising events under the Y-PEER programme, targeting high school Iraqi refugees.

Lessons learnt: Preparedness for crisis

It was important that UNAIDS was ready to demonstrate leadership to address vulnerability linked to AIDS in humanitarian crisis situations such as Libya, Syria and Yemen, as well as during the Food emergency in the horn of Africa in Somalia and Sudan.

Expected Output: Equitable access to comprehensive HIV prevention, treatment and care services through the workplace and for mobile populations

212. Djibouti had a successful Round 10 Global Fund grant, which integrates a WFP role in delivering integrated food and nutrition activities (including targeting 13,500 refugees

from neighbouring countries). A separate WFP evaluation of the nutritional and food security status contributed to the development of the National Strategic Plan in the country.

213. Studies on the legislative framework of HIV and AIDS and the World of Work were completed in Jordan and Lebanon with ILO support, identifying a number of articles in the labour codes requiring amendments.

G. West and Central Africa

Expected Outcome: Human resources and systems of government and civil society enhanced to develop, implement and scale up evidence informed comprehensive HIV responses improving accountability

Expected Output: Capacity of national AIDS authorities to lead and coordinate an inclusive and broad based multisectoral response on AIDS is strengthened

214. An interagency HIV assessment of internally displaced people in western Côte d'Ivoire in 2011 helped to identify where ART, PMTCT and nutritional support had been disrupted and target the response. It was coordinated by UNHCR with participation from other UN agencies, the ministries of Health and Social Affairs, NGOs and PLHIV.
215. In Cote d'Ivoire UNICEF supported a vulnerability analysis that brings together information on HIV prevalence, the age range most impacted, vulnerability factors, sexual risk behaviours, health care systems and enabling environment factors such as family support, sexual violence and the sexual exploitation taking place in schools. This information is being used to update national HIV prevention strategies and identify other data gaps.

Expected Output: National AIDS Strategies and Action Plans are costed, inclusive, multisectoral, sustainable, prioritized and informed by scientific evidence, reflecting social and epidemiological data

216. The Republic of Congo is reviewing its Social Protection Policy with regards to the needs of PLHIV, using a study on social vulnerability led by WFP with the Support of the UNAIDS Secretariat. The study found that if people find that they are HIV positive, many may relocate away from their usual support networks, lose their employments opportunities and struggle to care for children.

217. Governments in Benin, Côte d'Ivoire, Ghana and Niger analyzed the epidemic, alignment to national priorities and proven cost-effective interventions with World Bank support. This followed capacity building of government staff in three countries, with links built between the six eastern African countries in IGAD

Challenges: Stigma and discrimination and capacity of civil society

Stigma and discrimination remain a barrier in many countries in the region to scaling up services for key populations and PLHIV. Coordination and institutional managerial capacities of civil society were strengthened in the areas of resource mobilization, advocacy and community systems by the UNAIDS family.

(Intergovernmental Authority on Development) with a view to optimize cross-country collaboration and harmonize policy and programme efforts across borders. Collaboration with the UNAIDS also helped develop the Regional Strategic Plan on AIDS of ECOWAS, which was endorsed by the governments of the concerned countries.

218. UNICEF, in collaboration with UNFPA, UNAIDS and other partners, supported the development of National Strategies and Plans for HIV prevention among young people

and marginalized people in the region. For example: (1) Nigeria revised the national prevention plan (NPP) that promotes combination prevention and articulates a standard 'minimum' prevention package; (2) CAR finalized its HIV Sectoral Plan for Youth based on the findings from the youth vulnerability study; (3) The Gambia National Youth Policy 2009-2018 was approved by the cabinet; (4) the HIV prevention plan in young people developed in Mali (2010-2012) has laid the ground for more youth-friendly strategies; and (5) The HIV and AIDS Policy and Strategic Plan for the Education Sector were developed in Liberia in collaboration with partners.

219. Government teams from 12 countries participated in a training on results-based strategic planning (six modules) to guide the development of prioritized national plans on AIDS (part of a joint initiative of ASAP/World Bank, the regional office of the Secretariat and the French government). The modules, which guide the optimization of resource allocation and utilization, were launched during the ICASA conference in 2011. By end of 2011, five countries (Côte d'Ivoire, Ghana, Mauritania, Senegal and Sierra Leone) had developed their NSP using a result-based approach.

Expected Output: Community systems strengthened through capacity building and inclusion of people living with HIV, most-at-risk, affected and vulnerable groups in national responses

220. A national strategy on management of gender-based violence was developed in Côte d'Ivoire. The Joint Programme supported civil society groups to provide innovative care services to survivors of sexual violence including referral to HIV services, which led to the development of the strategy. UNFPA supported a technical gender/HIV review in the country which helped identify grave violations of human rights and provided recommendations to the government to address the problem.
221. An early warning and alert system was launched in Senegal to address human rights violations of PLHIV and key populations. This was in response to a study published by UNDP, John Hopkins School of Public Health and Enda Santé (a Senegalese and development NGO) which researched the impact of the criminalization of men who have sex with men on their access to HIV and health services.
222. The number of violations of human rights among sex workers in Ghana fell following a UNFPA study and programmatic support on the subject. The study concluded that frequent violations occurred and training and advocacy was needed to ensure human rights protection for sex workers. Sensitization sessions were held with senior and mid-level police officers to raise awareness on the issue and how to deal with perpetrators. The capacity of sex workers to report violations was also strengthened.
223. Five countries (Benin, Chad, Côte d'Ivoire DRC and Togo) integrated the concept of Positive Health, Dignity and Prevention in their national strategic plan following a regional consultation on organized by the UNAIDS Secretariat with UNDP, UNFPA and UNESCO.

Expected Output: National human resource planning, training, compensation, and retention measures in all sectors relevant to the response are improved

224. In Ghana, working through 20 trade associations allowed the ILO to reach 44,000 informal economy workers with HIV prevention, treatment, care and support services. The promotion of voluntary counselling and testing led to 13,808 workers in the informal economy taking an HIV test.
225. A distance-learning programme for teachers and teacher trainers on HIV and AIDS using DVDs and radio programmes was developed with support from UNESCO in

Cameroon, CAR, Chad, Republic of Congo, Equatorial Guinea and Gabon to reach teachers in some of the most remote parts of the countries. Working with the national governments, 98 national pedagogic experts were trained. In Cameroon alone, 5,100 teachers were reached in 241 schools.

Expected Output: National systems for procurement and supply management, and legislation to facilitate access to quality affordable HIV medicines, diagnostics, condoms, and other essential HIV commodities are strengthened

226. Supply chains for HIV commodities were strengthened in Cameroon, CAR, Côte d'Ivoire and Nigeria following technical support provided by UNICEF, including training national staff on forecasting and quantification for UNITAID commodities. In Cameroon a procurement supply management coordination mechanism for treatment was established with UNICEF as the reference and the lead in the management and procurement for PMTCT and paediatric HIV care, treatment and support commodities.

Case study: Improving municipal capacity to address epidemics amongst key populations in Lagos, Nigeria

Expanding and operationalizing HIV policies from the national to district and municipal levels is a challenge but vital to ensure populations are reached. Two large local government areas (Shomolu and Ikeja) in Lagos, whose Chairmen became committed to provide leadership and resources to implement the first Lagos Action Plan for key populations, provide an example.

An estimated 190,000 people (5.1%) are HIV positive in Lagos State with much higher prevalence rates among sex workers (23.5% if brothel-based, and 12.9% otherwise) and men who have sex with men (24.5%). These high estimates led to the prioritization of key populations in the State AIDS Strategic Plan in 2009. AIDS co-coordinating structures operate in Lagos's 20 local government areas.

UNDP and UNFPA worked with the Shomolu and Ikeja local authorities to review research and service needs, with particular attention to men who have sex with men and sex workers. The assessment revealed the complexity of addressing HIV epidemics in the city, with low prioritization of these groups and the absence of their engagement with AIDS policy makers. The assessment also revealed various examples of rights violations; men who have sex with men and sex workers' rights were frequently violated especially when they reveal their sexual orientation or when they are found to engage in sex work. These violations are fuelled by punitive laws and stigma and discriminatory practices which limit their access to HIV and legal services.

Through an open dialogue process involving all stakeholders, municipal authorities were engaged and informed about NGO-led efforts to improve service coverage for key populations in the city. The process has created a beneficial impetus among city officials and some elected politicians. Over 2012 to 2013, advances in implementation of the action plan in its three priority pillars are anticipated: empowered local leadership and communities; scaled up treatment, care and support services for key populations; and strengthened access to justice and rights-based programming. City stakeholders are in agreement that efforts at the municipal level can complement larger state and national efforts in the response to the AIDS epidemic in Nigeria. Future UN country team efforts will focus on the critical importance of working with local government in other Nigerian cities.

227. National capacity in procurement and supply chain management for RH commodities including condoms was strengthened in Benin, Burundi and DRC through UNFPA training in logistics management information systems.
228. In Togo (2010) and Burundi (2011), imminent stock-outs of antiretroviral drugs were averted when the regional joint UN team organized a situation analysis and emergency technical support plan that identified a short-term source for the drugs, as well as a longer-term plan to address procurement and supply management challenges. Joint missions (UNHCR, UNICEF, UNDP, WHO, the UNAIDS Secretariat as well as others such as USAID and the Global Fund) contributed to resolving management issues related to Global Fund implementation and access to treatment (e.g. Mauritania, CAR and the Abidjan-Lagos Transport Corridor project).

229. DRC, Ghana, Ethiopia, Nigeria and Sierra Leone received technical assistance from the World Bank to address procurement reforms, medicines financing and supply chains. This included participation in south-to-south regional learning exchanges to improve capacity and knowledge, with a high degree of participation from Kenya, Mozambique and South Africa.

Expected Outcome: National capacities for scaling-up HIV prevention, treatment, care and support are enhanced

Expected Output: Prevention of sexual transmission of HIV and STI strengthened including through sexual and reproductive health policy, programmes and service linkage

230. Eighteen countries received training from UNFPA on understanding SRH and HIV linkages, reprogramming Global Fund Round 9 grants around PMTCT, and ensuring Round 10 proposals were developed to accommodate integrated linkages on SRH and HIV/AIDS. Additionally reproductive health integration plans were completed in Guinea Bissau, Mali, Senegal and Togo.

231. Ministries of education in Cape Verde, DRC, Guinea-Bissau and Senegal reviewed and evaluated the integration of sexuality education in policies and school and teacher training curricula with the support of UNESCO. The Sexuality Education Review and Analysis Tool allows an easy identification of needs based on the epidemiological context, and the corresponding gaps in policies and programmes, with a particular focus on human rights and gender. The analysis has informed plans in all countries for advocacy and technical support.

Expected Output: Interventions for the prevention of HIV transmission within health care and occupational settings (including blood safety, safe injection practices, universal precautions; occupational health standards, PEP) scaled up

232. UNFPA provided technical support in a number of contexts. In DRC, 4,000 people worked in uniformed personnel services received integrated VCT and family planning. In Gambia, 53 facilities have PEP and more than 43,117 persons received an HIV test, results and post-test counselling; PMTCT and VCT are integrated in over 75% of MCH services where 15,953 pregnant women received VCT and know their results; and family planning is being integrated into ART sites.

Expected Output: Comprehensive HIV-related treatment and care services scaled up

233. Thirteen countries received support from UNICEF to adapt and adopt national paediatric treatment guidelines in line with the latest WHO guidelines. UNICEF was also at the forefront introducing innovations such as early infant diagnosis using the Dried Blood Spot technology, point-of-care diagnosis including CD4, development and bundling of diagnostic commodities and medicines, and developing programming tools.

234. Eleven countries (Burkina Faso, Central African Republic, Cote d'Ivoire, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger and Sierra Leone) implemented nutrition programmes in support of ART with the help of WFP. Regular M&E results and anecdotal evidence from implementing partners have shown that, in general, nutrition support enhances treatment success and better nutritional status reduces mortality risk especially in the first months of the initiation of treatment.

Expected Output: Equitable access and uptake of HIV testing and counselling ensuring confidentiality, informed consent, counselling and appropriate referrals

235. Reproductive, maternal and child health services were successfully integrated in 13 Global Fund proposals that focused on PMTCT, with the support of UNICEF. This was complemented by the production of regional training modules on accelerated child survival that include PMTCT and paediatric HIV care which will be used to build the capacity of health workers at all levels.

Expected Output: Scaled up and harmonised joint HIV/TB planning, training, procurement and delivery of HIV/TB services

236. In an effort to integrate food assistance and nutritional support in HIV/TB programmes, technical assistance and training were provided by WFP in Ghana, Guinea and Sierra Leone. In Guinea 60 health sector staff members were trained in M&E. The training module included indicators for food/nutrition programmes for PLHIV and TB, collection of data, and M&E forms.
237. Over 150 prisoners and prison guards were trained on HIV, TB and joint HIV/TB management in all 9 prisons in Benin by UNODC.
238. **The Programme Coordinating Board is invited to review and provide comments on the report and provide guidance on ways to further strengthen performance monitoring of UNAIDS.**

IV. FINANCIAL INFORMATION

The end of biennium reports for the period 1 January 2010 - 31 December 2011 are presented in the following tables and charts:

- Expenditure by organization against budget for core UBW, supplemental and Cosponsors own global/regional resources
- Expenditure by principal outcome for core UBW, supplemental and Cosponsors own global/regional resources
- Expenditure by organization against own country level resources
- Expenditure by organization on priority areas
- Expenditure by organization on crosscutting strategies
- Expenditure summary
- Charts

Table 1: 2010-2011 UBW expenditure by organisation

Agency	Core			Supplemental			Cosponsor Global and Regional Resources			Total Unified Budget and Workplan Resources		
	Budget ¹⁸	Expenditure	% Implementation	Budget	Expenditure	% Expenditure vs commitment	Budget	Expenditure	% Expenditure vs commitment	Budget	Expenditure	% Implementation
UNHCR	8,854,145	8,854,145	100.00%	8,600,000	7,960,678	92.57%	5,800,000	12,716,056	219.24%	23,254,145	29,530,879	126.99%
UNICEF	24,996,473	24,627,152	98.52%	3,019,253	14,030,895	464.71%	877,769	3,567,854	406.47%	28,893,495	42,225,901	146.14%
WFP	8,865,034	8,738,000	98.57%	9,906,000	24,608,178	248.42%	8,632,000	4,896,866	56.73%	27,403,034	38,243,044	139.56%
UNDP	17,734,713	17,734,713	100.00%	6,000,000	5,338,186	88.97%	20,000,000	24,738,419	123.69%	43,734,713	47,811,318	109.32%
UNFPA ¹⁹	21,891,289	21,665,187	98.97%	29,250,000	23,053,188	78.81%	28,590,000	20,233,890	70.77%	79,731,289	64,952,265	81.46%
UNODC	11,968,404	12,206,377	101.99%	4,050,000	5,746,762	141.90%	1,095,000	8,992,900	821.27%	17,113,404	26,946,039	157.46%
ILO	11,428,404	11,427,328	99.99%	4,800,000	5,639,442	117.49%	6,500,000	4,710,477	72.47%	22,728,404	21,777,247	95.82%
UNESCO	12,836,366	12,454,197	97.02%	12,500,000	11,927,967	95.42%	11,500,000	7,835,028	68.13%	36,836,366	32,217,192	87.46%
WHO	33,272,915	32,676,970	98.21%	85,310,000	87,428,982	102.48%	21,140,000	13,993,299	66.19%	139,722,915	134,099,251	95.98%
World Bank	16,066,213	15,841,000	98.60%	9,020,000	5,410,360	59.98%	15,150,000	12,598,400	83.16%	40,236,213	33,849,760	84.13%
Secretariat ²⁰	217,400,000	210,370,351	96.77%	0	0		0	0		217,400,000	210,370,351	96.77%
Interagency ²¹	131,950,000	133,226,393	100.97%	0	0		0	0		131,950,000	133,226,393	100.97%
TOTAL	517,263,956	509,821,812	98.56%	172,455,253	191,144,638	110.84%	119,284,769	114,283,189	95.81%	809,003,978	815,249,640	100.77%

¹⁸ Cosponsor 2010-2011 allocations were revised and reprogrammed following the midterm review and include interagency fund for technical support.

¹⁹ Expenditures include components of SRH and gender programmes

²⁰ The Executive Director's proposal for an increase of US\$30 million in the 2010-2011 UBW Core budget was approved by the PCB in December 2011

²¹ Interagency allocation does not include the US\$4.5 million technical support funds, which were transferred to Cosponsors' core allocation.

Table 2: 2010-2011 UBW expenditure by Principal Outcome

Principal Outcome	Core			Supplemental			Global/Regional Resources			Total 2010-2011 UBW Resources		
	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation	Budget	Expenditure	% Implementation
PO1: Leadership and Resource Mobilization	74,147,662	77,978,656	105.67%	6,275,000	6,012,248	95.81%	3,205,000	3,192,558	99.61%	83,627,662	87,183,462	104.25%
PO2: Strategic Information	37,626,448	43,412,817	115.93%	13,585,244	13,552,210	99.76%	6,877,463	5,265,906	76.57%	58,089,155	62,230,934	107.13%
PO3: Human resources in government and civil society	102,659,869	112,568,950	110.17%	52,765,166	53,562,879	101.51%	31,751,817	23,819,504	75.02%	187,176,852	189,951,332	101.48%
PO4: Human rights and gender	19,745,869	20,793,486	105.81%	8,081,218	8,355,806	103.40%	11,643,612	12,201,608	104.79%	39,470,699	41,350,901	104.76%
PO5: National capacities for scaled-up HIV prevention	48,735,360	40,567,344	83.64%	46,121,458	70,316,978	152.46%	21,862,034	16,135,578	73.81%	116,718,852	127,019,900	108.83%
PO6: Most-at-risk populations	15,201,082	14,665,185	96.93%	16,100,000	14,811,568	92.00%	6,950,000	10,223,665	147.10%	38,251,082	39,700,418	103.79%
PO7: Women and girls, young people, children and population of humanitarian concern	38,074,396	27,862,411	73.53%	23,370,167	19,914,812	85.21%	19,769,843	26,847,568	135.80%	81,214,406	74,624,791	91.89%
PO8: Coordination, alignment and harmonization	181,073,270	171,972,962	95.43%	6,157,000	4,618,137	75.01%	17,225,000	16,596,802	96.35%	204,455,270	193,187,901	94.49%
TOTAL	517,263,956	509,821,812	98.56%	172,455,253	191,144,638	110.84%	119,284,769	114,283,189	95.81%	809,003,978	815,249,640	100.77%

Table 3: 2010-2011 country-level expenditures by region²²

Agency	Asia Pacific	Europe and Central Asia	East and Southern Africa	West and Central Africa	Latin America	Caribbean	Middle East and North Africa	TOTAL EXPENDITURE	Country Level Resources (Projected)	% Expenditure vs. Projected country-level resources
UNHCR	-	-	2,534,391	-	100,000	-	400,000	3,034,391	11,500,000	26.39%
UNICEF	48,706,344	9,256,856	168,178,300	46,704,207	8,214,298	3,866,796	15,425,245	300,352,046	309,077,023	97.18%
WFP ²³	11,626,938	900,000	132,355,080	63,562,573	831,323	224,000	9,345,451	218,845,366	216,309,000	101.17%
UNDP ²⁴	33,431,852	55,933,041	212,006,176	98,448,966	13,645,933	17,247,576	69,286,456	500,000,000	300,000,000	166.67%
UNFPA ²⁵	13,038,194	8,396,452	71,132,479	3,389,723	16,265,956	2,251,281	8,585,885	123,059,970	100,000,000	123.06%
UNODC	9,877,589	10,272,310	4,054,775	97,500	16,415,038	-	2,942,573	43,659,785	45,150,000	96.70%
ILO	869,873	154,008	5,207,981	1,699,168	829,831	307,692	-	9,068,553	11,700,000	77.51%
UNESCO	442,982	6,360	131,858	1,335,488	18,229,045	-	56,465	20,202,198	28,500,000	70.88%
WHO	42,267,863	5,538,187	22,816,235	11,408,117	2,298,601	1,149,300	20,603,472	106,081,774	127,549,000	83.17%
World Bank	522,510,000	29,900,000	429,520,000	673,125,400	109,200,000	17,000,000	17,900,000	1,799,155,400	599,940,000	299.89%
Secretariat	16,336,243	2,852,356	17,883,051	8,609,457	4,308,778	1,787,075	2,088,204	53,865,165	40,000,000	134.66%
TOTAL	699,107,877	123,209,570	1,065,820,326	908,380,600	190,338,802	43,833,720	146,633,753	3,177,324,648	1,789,725,023	177.53%

²² Country level resources in this table are additional to, and formally considered to be outside, the UBW.

²³ WFP country-level expenditures include estimated food cost.

²⁴ UNDP estimated country level HIV expenditure for the biennium includes standalone HIV projects only and HIV programmes funded by the Global Fund.

²⁵ UNFPA country-level expenditures include components of SRH and gender programmes.

Table 4: 2010-2011 UBW expenditure by Priority Area

Agency	PRIORITY AREAS										TOTAL
	Sexual transmission	PMTCT	PLHIV treatment	HIV/TB	PUD	MSM, Transgender, Sex workers	Punitive Laws	Women & Girls	Young people	Social protection	
	1	2	3	4	5	6	7	8	9	10	
UNHCR	2,400,000	4,158,176	4,800,000	750,000	700,000	1,550,000	1,590,000	3,872,113	2,000,000	2,207,000	24,027,289
UNICEF	4,305,422	5,277,523	6,043,535	417,305	426,171	-	140,706	1,011,787	6,974,491	9,892,138	34,489,079
WFP	1,027,757	887,589	26,045,550	5,697,500	-	-	-	218,010	-	2,518,638	36,395,044
UNDP	3,464,308	-	994,282	-	360,465	7,758,479	5,719,206	9,471,103	-	2,360,934	30,128,777
UNFPA	8,765,048	8,488,922	56,217	-	149,824	6,237,187	742,827	8,653,968	11,813,372	44,900	64,952,265
UNODC	2,371,890	-	2,699,183	302,118	11,639,482	-	4,144,271	3,150,627	1,020,692	1,617,777	26,946,039
ILO	2,395,497	-	1,851,066	2,068,838	-	-	2,831,042	2,068,838	1,415,521	2,613,270	15,244,073
UNESCO	5,202,724	-	829,121	-	448,550	678,698	1,569,590	1,480,844	9,612,934	1,381,173	21,203,634
WHO	8,046,839	14,748,267	41,578,714	14,750,034	5,360,440	6,700,550	6,700,550	670,053	1,340,110	670,053	100,565,610
World Bank	15,016,660	-	-	-	1,391,250	1,484,250	-	-	-	6,087,400	23,979,560
Secretariat	11,717,629	8,625,184	6,374,222	7,005,333	8,940,740	6,731,851	12,033,184	9,403,555	13,421,628	6,921,185	91,174,510
Interagency	8,713,006	6,981,063	7,500,646	6,981,063	6,434,835	3,463,886	7,154,257	6,981,063	7,420,710	3,517,177	65,147,706
TOTAL	93,426,780	49,166,724	98,772,536	37,972,191	35,851,758	34,604,901	42,625,634	46,981,960	55,019,457	39,831,645	
TOTAL EXPENDITURE ON PRIORITY AREAS											534,253,585
Percentage of all UBW expenditure on Priority Areas											65.53%

Table 5: 2010-2011 UBW expenditure report by crosscutting strategy²⁶

Agency	Crosscutting Strategies						TOTAL
	AIDS planning	Global Fund	Strategic information	Technical Assistance	Leadership & Advocacy	Civil society partnerships	
	1	2	3	4	5	6	
UNHCR	400,000	45,000	820,000	3,913,590	165,000	160,000	5,503,590
UNICEF	1,572,153	1,787,201	4,126,863	-	-	250,605	7,736,822
WFP	300,000	392,000	410,000	420,000	203,000	123,000	1,848,000
UNDP	4,637,677	10,645,543	-	-	-	2,399,321	17,682,541
UNFPA	-	-	-	-	-	-	-
UNODC	-	-	-	-	-	-	-
ILO	1,524,407	1,742,180	1,306,635	653,317	435,545	871,090	6,533,174
UNESCO	4,228,354	187,298	1,459,290	1,196,210	2,291,910	1,650,497	11,013,558
WHO	6,704,964	5,369,268	9,385,181	1,348,938	4,020,326	6,704,965	33,533,641
World Bank	-	-	9,870,200	-	-	-	9,870,200
Secretariat	28,105,479	11,023,406	26,738,072	16,429,924	12,180,443	24,718,516	119,195,841
Interagency	5,089,248	12,416,700	9,645,591	32,440,627	3,264,047	5,222,475	68,078,687
TOTAL	52,562,282	43,608,596	63,761,831	56,402,606	22,560,271	42,100,468	
TOTAL EXPENDITURE ON CROSSCUTTING STRATEGIES							280,996,054
Percentage of all UBW expenditure on Crosscutting strategies							34.47%

²⁶ Table 4 plus Table 5 represents all UBW expenditure. Cosponsors with no expenditure in Table 5 assigned expenditure under the Priority Areas in Table 4.

Table 6: 2010-2011 Expenditure summary (UBW and country-level)

Agency	Total 2010-2011 Budget	2010-2011 Expenditure				
		Core	Supplemental	Global and Regional Expenditure	Country level expenditure	TOTAL
UNHCR	34,754,145	8,854,145	7,960,678	12,716,056	3,034,391	32,565,270
UNICEF	337,970,518	24,627,152	14,030,895	3,567,854	300,352,046	342,577,947
WFP	243,712,034	8,738,000	24,608,178	4,896,866	218,845,366	257,088,410
UNDP	343,734,713	17,734,713	5,338,186	24,738,419	500,000,000	547,811,318
UNFPA	179,731,289	21,665,187	23,053,188	20,233,890	123,059,970	188,012,235
UNODC	62,263,404	12,206,377	5,746,762	8,992,900	43,659,785	70,605,824
ILO	34,428,404	11,427,328	5,639,442	4,710,477	9,068,553	30,845,800
UNESCO	65,336,366	12,454,197	11,927,967	7,835,028	20,202,198	52,419,390
WHO	267,271,915	32,676,970	87,428,982	13,993,299	106,081,774	240,181,025
World Bank	640,176,213	15,841,000	5,410,360	12,598,400	1,799,155,400	1,833,005,160
Secretariat	257,400,000	210,370,351	0	0	53,865,165	264,235,516
Interagency	131,950,000	133,226,393	0	0		133,226,393
TOTAL	2,598,729,001	509,821,812	191,144,638	114,283,189	3,177,324,648	3,992,574,288

Chart 1

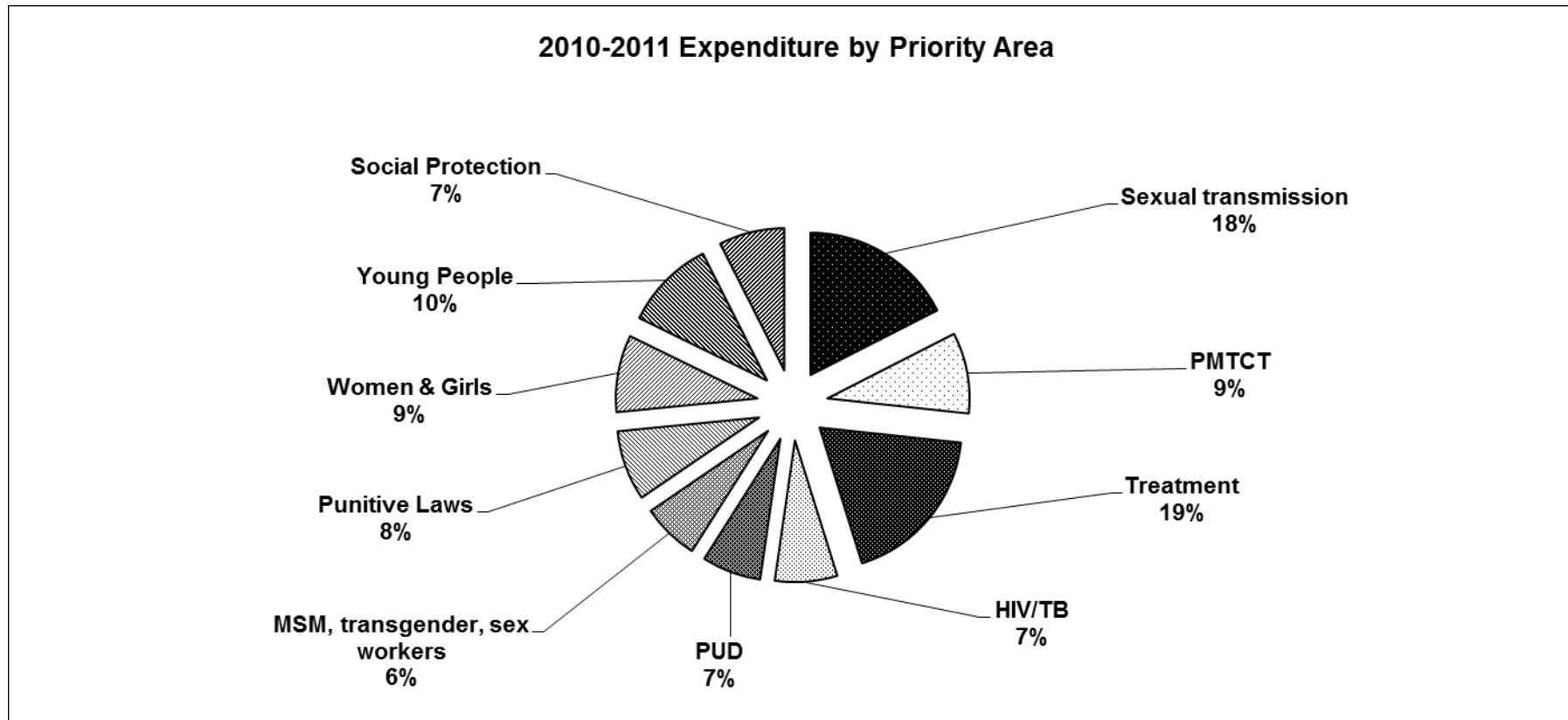


Chart 2

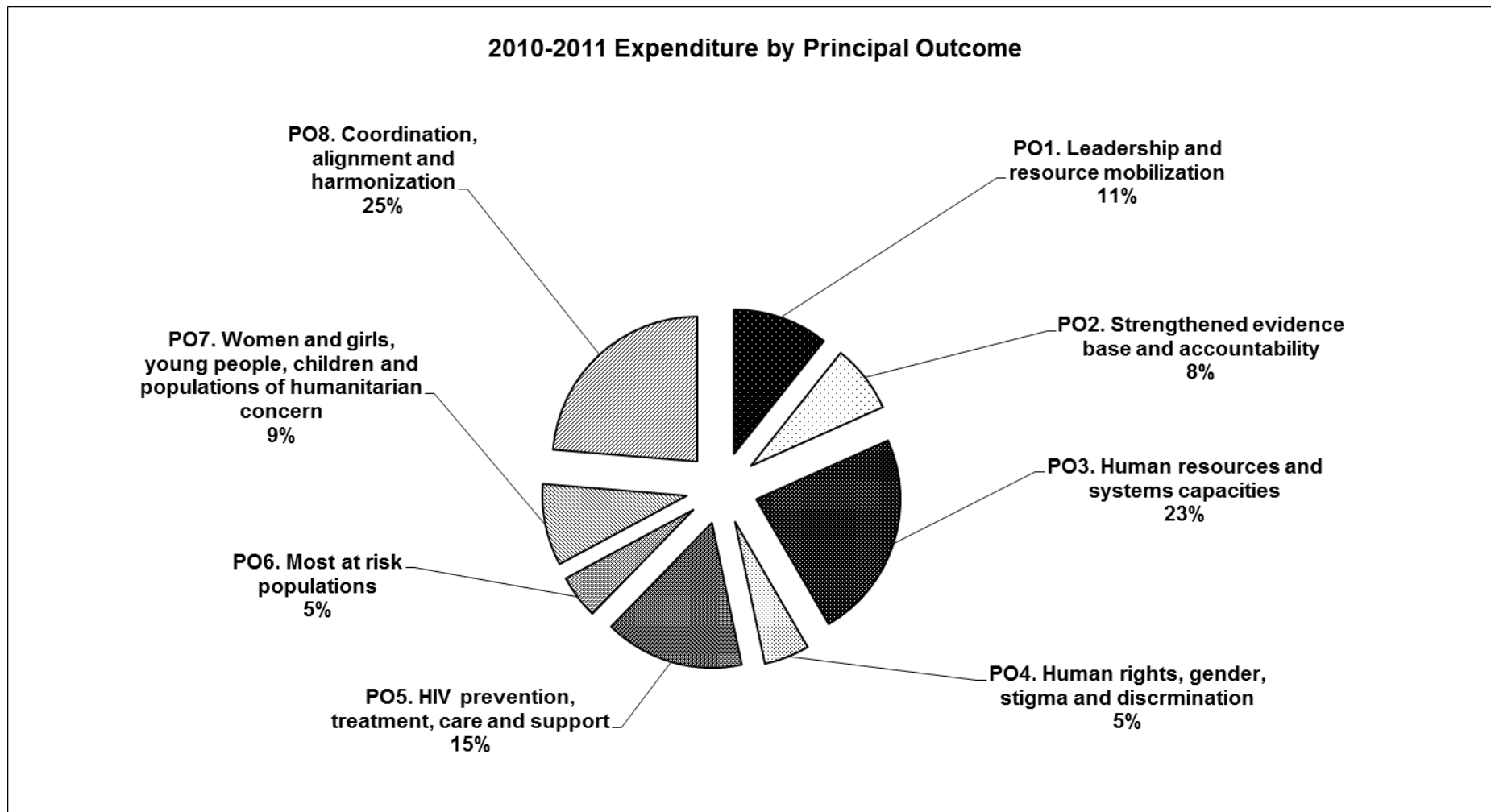
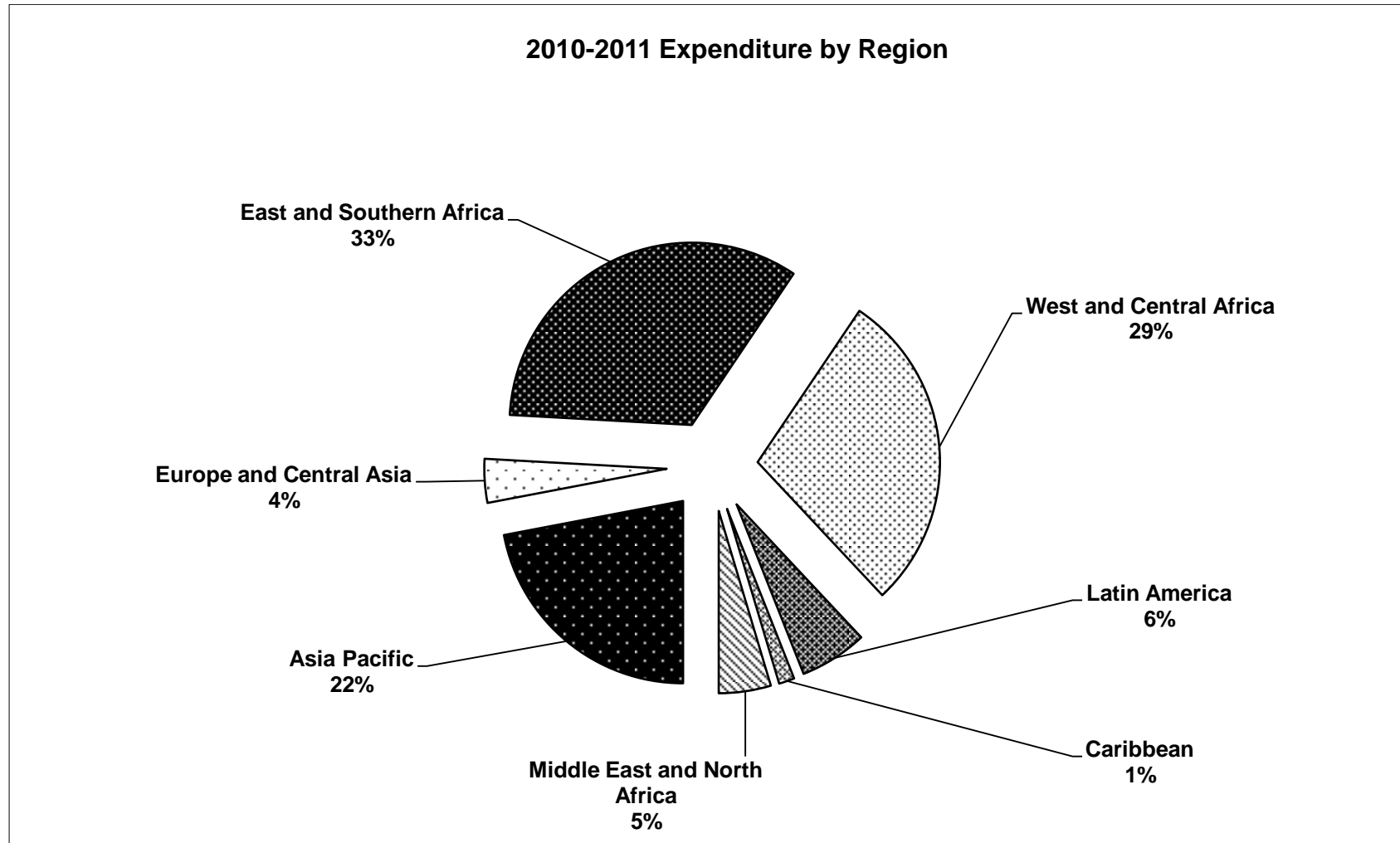


Chart 3



ABBREVIATIONS

APCOM	Asia Pacific Coalition on Male Sexual Health
ALHIV	Adolescents Living with HIV
ART	Antiretroviral Therapy
ASAP	AIDs Strategy Action plan
AU	African Union
BRICS	Brazil, Russia, India, China and South Africa
CBOs	Community-based organizations
CCABA	Coalition on Children Affected by AIDS
CCM	Country Coordinating Mechanisms
CCO	Committee of Cosponsoring Organizations
CCP	Comprehensive Condom Programming
CDC	Centre for Disease Control and Prevention
CD4	Cluster of Differentiation 4 (a type of lymphocyte or white blood cell)
CND	United Nations Commission on Narcotic Drugs
CRIS	Country Response Information System
CRN +	Caribbean Regional Network of People Living with HIV
CSATs	Civil Society Action Team
CSOs	Civil Society Organizations
CSS	Community System Strengthening
DHS	Demographic and Health Surveys
DoL	Division of Labour
EAC	East African Community
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ECLAC	Economic Commission for Latin America and the Caribbean
ECOWAS	Economic Community of West African States
EECA	Eastern Europe and Central Asia
eMTCT	Elimination of Mother to Child Transmission
EPP	Estimation and Projection Package
FANTA	Food and Nutrition Technical Assistance Project
GFATM	Global Fund to Fight, AIDS TB and Malaria
GNP+	Global Network of People Living with HIV
GTZ	German technical cooperation
GVB	Gender-based violence
HCV	Hepatitis C virus
HFLE	Health and Family Life Education
HLM	High Level Meeting
HPTN	HIV Preventions Trial Network
HTC	HIV Testing and Counselling
IAS	International AIDS Society
IAWG	Interagency Working Group
ICASA	International Conference on AIDS and STIs in Africa
ICASO	International Council of AIDS Service Organizations
ICW	International Community of Women Living with HIV
ILO	International Labour Organization
IOM	International Office for Migration
IPT	Isoniazid preventive therapy
IPU	Inter-Parliamentary Union
JUNIMA	Joint Initiative on Mobility and HIV/AIDS
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey

MNCH	Maternal Newborn and Child Health
MSM	Men having sex with men
MOT	Modes of Transmission
MOU	Memorandum of Understanding
NACs	National AIDS Coordinating Authorities
NAPs	National AIDS Programmes
NASA	National AIDS Spending Assessment
NGOs	Nongovernmental organizations
NSP	Needle and syringe programme
NSPs	National Strategic Plans
NSWP	Network of Sex Work Projects
OHCHR	Office of the High Commissioner for Human Rights
OST	Opioid substitution therapy
PAHO	Pan American Health Organization
PCB	Programme Coordinating Board
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider- initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
RHCS	Reproductive Health Commodity Security
SADC	South African Development Community
SRH	Sexual and Reproductive Health
SWAps	Sector Wide Approach Programmes
STI	Sexually transmitted infections
TRIPS	Trade Related Aspects of Intellectual Property Rights
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDOC	United Nations Development Operations Coordination Office
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
UBRAF	UNAIDS Budget, Results and Accountability Framework
UBW	Unified Budget and Workplan
VCT	Voluntary Counselling and Testing
VMMC	Voluntary medical male circumcision
WFP	World Food Programme
WHO	World Health Organization

