



UNAIDS/PCB(28)/11.10  
10 May 2011

**28<sup>th</sup> Meeting of the UNAIDS Programme Coordinating Board**  
**Geneva, Switzerland**  
**21-23 June 2011**

**UNAIDS 2012-2015 UNIFIED BUDGET, RESULTS AND  
ACCOUNTABILITY FRAMEWORK**

***Part I: Overview***

**Additional documents for this item:**

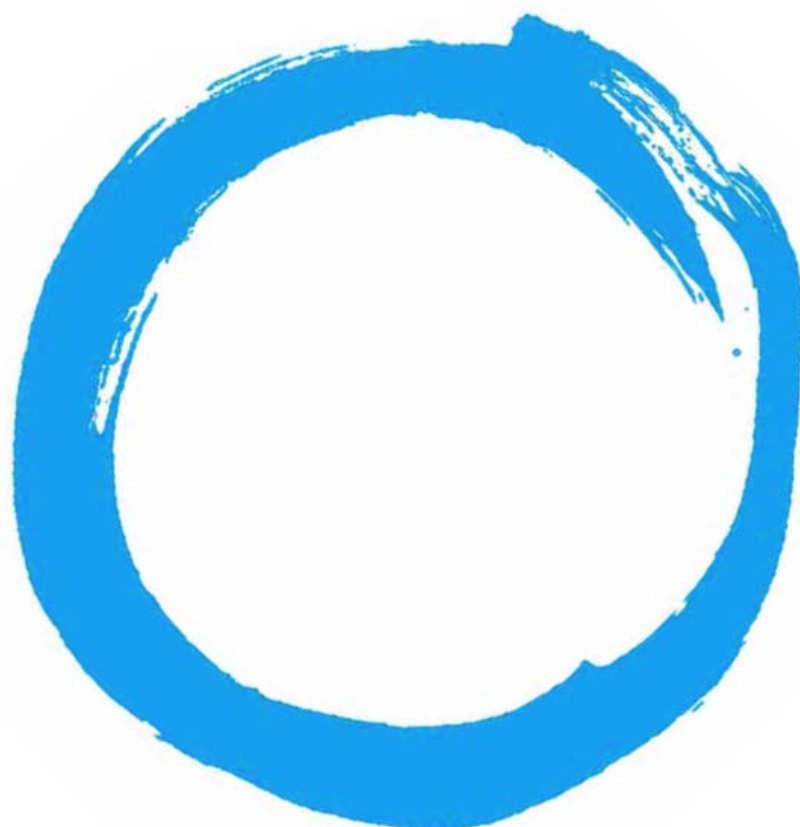
- i. 2012- 2015 Unified Budget, Results and Accountability Framework (UBRAF) Part II (UNAIDS/PCB(28)/11.11)
- ii. Report of the PCB Subcommittee on the preparation of the 2012- 2015 Unified Budget, Results and Accountability Framework (UNAIDS/PCB(28)/11.13)

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

- a. *approve* the 2012- 2015 UBRAF in accordance with the recommendation of the PCB subcommittee on the formulation of the 2012-2015 UBRAF, and taking into account views expressed by the PCB;
- b. *approve* US\$ 485 million as the core budget for 2012-2013 and the proposed allocation between the 10 Cosponsors and the Secretariat;
- c. *request* the UNAIDS Secretariat to report back annually to the Programme Coordinating Board on the implementation of the 2012-2015 UBRAF;
- d. *urge* all constituencies to use UNAIDS 2012-2015 Results and Accountability Framework to meet their reporting needs, and;
- e. *note* the value of the multi-stakeholder consultations and the contributions of the PCB subcommittee in the formulation of the 2012-2015 UBRAF.

**Cost implications for decisions:** US\$ 485 million

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



## ***TRANSLATING UNAIDS 2011-2015 STRATEGY INTO ACTION***

### ***PART I: OVERVIEW***

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## EXECUTIVE SUMMARY

1. The UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) is the successor to the Unified Budget and Workplan (UBW), the Joint Programme's instrument to maximize the coherence, coordination and impact of the UN's response to AIDS by combining the efforts of 10 UN Cosponsors and the UNAIDS Secretariat.
2. The UBRAF remains an instrument to catalyze country level action against AIDS within a broader development context. It is not a mechanism to fund national AIDS programmes, and its role is to leverage, not replace, funding from Cosponsors' own resources and other AIDS programmes. It serves as a framework to maximize the impact of the UNAIDS family at country level which holds the Joint Programme accountable for both programmatic results and value for money.
3. The UBRAF is guided by UNAIDS 2011-2015 Strategy, adopted by the UNAIDS Programme Coordinating Board (PCB) in December 2010. It aims at achieving UNAIDS long term vision of zero new HIV infections, zero AIDS-related deaths, and zero discrimination. The UBRAF is structured around the Strategy, its 10 strategic goals and strategic functions. The UBRAF describes outcomes, outputs and deliverables that the Joint Programme will focus on, the allocation of resources against these, and how progress will be monitored.
4. The UBRAF is an instrument for advancing the UN reform agenda through a unique planning, budgeting and accountability process. It has been developed through a consultative process which involves all Cosponsors and UNAIDS Secretariat as well as a range of other partners and stakeholders. The UBRAF clearly describes the expected results and the value added of UNAIDS, how national partners can continue to count on the Joint Programme for support, and why donors should continue resourcing UNAIDS.
5. Recognizing the need for the UBRAF to be practical and operational, as well as the need to make it a self-standing document linked to UNAIDS Strategy, the UBRAF consists of an overview document and a separate document with more detailed information.
6. The UBRAF itself is structured around three components:
  - A business plan that provides a framework to capture the contributions of the Joint Programme to support the operationalization of UNAIDS 2011-2015 Strategy.
  - A results and accountability framework that will measure the achievements of the Joint Programme and provide a clear link between investments and results.
  - A budget to fund the core contributions of the Cosponsors and Secretariat in 2012-2015 to translate the goals of UNAIDS Strategy into action.

### **Business Plan**

7. The business plan describes the rationale, objectives and expected results of the Joint Programme. For each strategic goal and strategic function, the business plan outlines the expected outcomes of the Joint Programme, i.e., what it aims to achieve, expected outputs and how the Joint Programme will do this. Annual rolling workplans will be developed for the detailed implementation of the UBRAF. The business plan also provides the link to the planning processes and results frameworks of the Cosponsors.

## **Results and Accountability Framework**

8. Outputs and deliverables have been developed to describe:
  - Specific contributions to the achievement of strategic goals and functions
  - Expected level of contribution (global, regional/country level)
  - Accountability of Cosponsors and the Secretariat
9. Indicators will be used to measure progress at three levels: at the level of the overall response to AIDS to determine progress against the strategic goals, at the level of the Joint Programme to measure collective contributions, and at the level of individual Cosponsors and the Secretariat.
10. An annual performance review process will provide the UNAIDS Programme Coordinating Board (PCB) with an overview of the Joint Programme's achievements. An executive dashboard will be used to track progress on each strategic goal and function against key indicators. A mid-term review will be conducted ahead of the 2014-2015 biennium to reorient and revise the 2012-2015 UBRAF, if necessary, at that point. Ultimately the impact of the Joint Programme will be measured by progress at country level.

## **Budget and Resource Allocation**

11. The core budget for 2012-2013 is proposed to remain at the same level as in 2010-2011 and 2008-2009, which represents a decline in real terms. This highlights the continued catalytic and leveraging nature of the UBRAF and efforts to ensure value for money. Keeping the level of the UBRAF flat at a time when supporting universal access to HIV prevention, treatment, care and support – and the achievement of the other MDGs – need to be stepped up, will require doing more with less and working together more effectively to achieve results.
12. Resources from the UBRAF will be allocated to capture the different functions and activities, e.g.:
  - Leadership, advocacy, partnerships, strategic information and normative functions
  - Advisory, technical and implementation support, and capacity building
  - Additional support to countries where the biggest impact can be achieved
  - Central support services of the Secretariat (human resources, finance, IT, etc.)
13. The current biennium saw an increase in the resources allocated to all Cosponsors. This was achieved by decreasing the resources managed by the Secretariat and allocating the corresponding amounts to the Cosponsors. In 2012-2015, as requested by UNAIDS Board, resources are allocated based on epidemic priorities – where and how the greatest impact in the response to the HIV epidemic can be achieved – performance, and the funds that individual Cosponsors raise, rather than past allocations or pro-rata increases. The share of the Secretariat of the core UBRAF remains at the same level as in the current biennium.

## **Next Steps**

14. The 2012-2015 UBRAF is presented to PCB for approval. In the second half of the year, annual rolling workplans will be developed, mechanisms for progress reviews will be put in place, and formats for annual progress reports to the PCB will be finalized.

## **BACKGROUND, VISION, MISSION AND STRATEGY**

15. The future costs that HIV imposes on people, families, communities and countries will be determined by how the HIV response adapts to emerging challenges and new opportunities. Choices will be shaped by finite resources, evolving global priorities and the types of new alliances forged. Success or failure will be determined by how well prevention programmes are focused, how the next phase of treatment is delivered, and the strength of our collective commitment to human rights, gender equality and greater involvement of people living with HIV (GIPA). In this context, the global HIV response finds itself at a critical juncture in which the gains of the past are at risk.
16. The UBRAF presents the framework for UNAIDS to respond to the epidemic between 2012-2015. This initial section describes UNAIDS' unique added value, the changing environment and implications for the AIDS response and lessons learned. It should be read in conjunction with UNAIDS 2011-2015 Strategy.

### **A. UNAIDS UNIQUE ADDED VALUE**

17. UNAIDS draws on the experience and strengths of the 10 cosponsoring organizations and the Secretariat to develop coherent strategies and policies, provide assistance to build country and community capacity, and mobilize political and social support to prevent and respond to AIDS. At country-level, UNAIDS works through Joint Teams and Joint Programmes of Support to foster coordination and multisectoral collaboration for the UN to 'deliver as one'. Through its unique cosponsored structure, UNAIDS has always worked multisectorally – reaching out to all spheres of society, people from all walks of life, and every aspect of global health and development. Moreover, UNAIDS plays an important role at global, regional and country level in promoting an enabling environment to address the key drivers of the epidemic.
18. To strengthen the combined efforts of the Secretariat and the 10 cosponsoring organizations, the Second Independent Evaluation and the PCB called for a review of UNAIDS Division of Labor, following which a new Division of Labor has been developed and agreed. To avoid duplication, Cosponsors outline their contribution and identify clear deliverables to maximize collective results and fully capitalize on the Joint Programme's comparative strength. The Secretariat is tasked to facilitate and promote cooperation and achievement in all Division of Labor areas. As such, the Secretariat's role and responsibilities focus on issues of leadership and advocacy; overall coherence, coordination and partnerships across all areas, and mutual accountability of the UNAIDS family for results. The core principles governing the Division of Labor also focus on national ownership and country priorities as the overarching rubric for harmonization and alignment (in the spirit of the Paris Declaration, the Accra Agenda for Action and the "Three Ones").
19. The Division of Labor captures and consolidates how the UNAIDS family works collectively to take forward the agenda set out in the UNAIDS Strategy for 2011–2015, and deliver results in countries to achieve the Joint Programme's new vision and 10 strategic goals. It leverages respective organizational mandates and resources to collectively and individually deliver results and maximize partnerships.
20. Through its global presence and extensive partnerships, UNAIDS has a unique role to play in the AIDS response by:

- Generating, analyzing and promoting the use of strategic information to guide evidence-based policies and resources allocation;
- Working with countries and donors to ensure that resources for the AIDS response are invested and implemented in the most effective and efficient way, and;
- Advocating for a multi-disciplinary approach and human and gender rights to drive the AIDS response, while promoting country ownership and shared responsibility.

21. Since UNAIDS was established in 1996, the annual budget of the programme has grown four-fold (from US\$60 million to US\$242 million) while global resources for AIDS have seen a fifty-fold increase (from US\$300 million to approximately US\$16 billion in 2010). However, in 2010, it was estimated that approximately US\$24 billion was required to respond comprehensively to the epidemic in low- and middle-income countries, leaving a gap of almost US\$8 billion.

22. Compared to the overall funding for AIDS, UNAIDS budget is modest. Yet UNAIDS core resources have played a catalytic role in mobilizing international and domestic resources for AIDS at the country level, including for civil society as advocates and service providers. This catalytic role in leveraging AIDS funding goes beyond UNAIDS Cosponsors, and extends to major funding organizations like the Global Fund to Fight AIDS, TB and Malaria and bilateral AIDS programmes, such as the US Government PEPFAR.

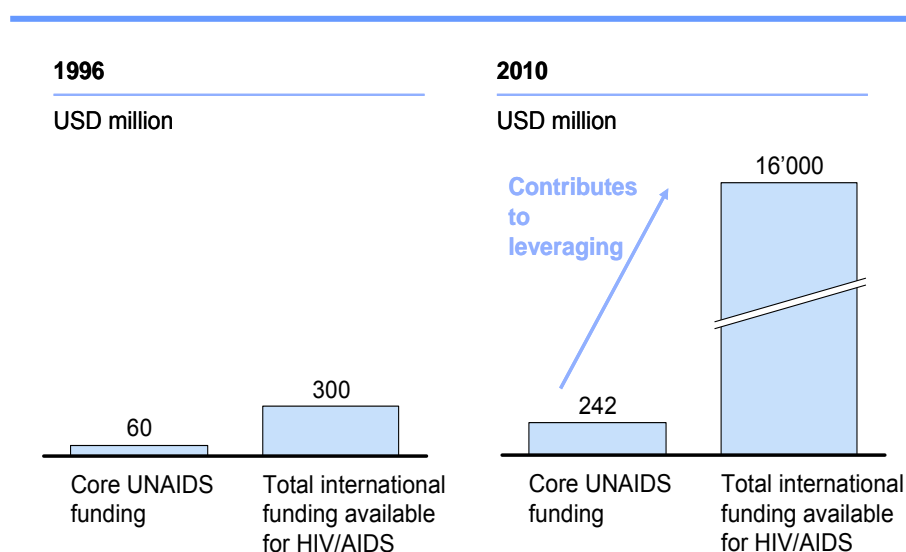


Figure 1: The role of UNAIDS in leveraging funding for HIV/AIDS

23. As the graph above illustrates, the UBRAF is an instrument to catalyze country level action against AIDS within a broader development context. It is not a mechanism to fund national AIDS programmes, and its role is to leverage, not replace, funding from Cosponsors' own resources and other AIDS programmes.



## B. CHANGING ENVIRONMENT AND IMPLICATIONS FOR THE AIDS RESPONSE

24. Three main external factors require a proactive approach from UNAIDS, namely (a) the nature and the changes of the epidemic, (b) economic and social constraints, and (c) the shifting financial and political landscape.
25. **A changing epidemic** – In numerous countries, for example in South Asia and sub-Saharan Africa, new epidemiological patterns have emerged, with older adults in stable, long-term relationships representing a growing proportion of people newly infected. Women make up the majority of those with HIV in sub-Saharan Africa. In Asia, women also account for a growing proportion of HIV infections, rising from 21% in 1990 to 35% in 2009.
26. New infections are increasing again in Eastern Europe and Central Asia, with an estimated 87,000 infections in 2008, more than three times higher than the estimated 26,000 in 2001<sup>1</sup>. With increasing transmission among the sexual partners of people who use drugs, many countries in the region are experiencing a transition from an epidemic that is heavily concentrated among people who inject drugs to one that is increasingly characterized by people who inject drugs being the bridging population for sexual transmission.

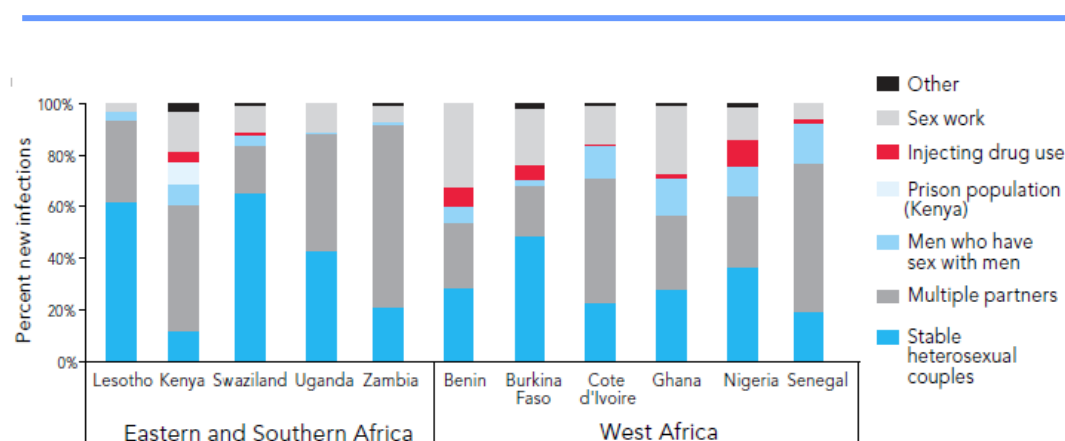


Figure 2: Rate of new infections in selected countries in Eastern and Southern Africa and West Africa

27. Asia's epidemic has been concentrated in specific populations, namely people who inject drugs users, sex workers and their clients, and men who have sex with men. However, the epidemic is steadily expanding into the population as a whole.
28. In the USA, the proportion of new infections among men who have sex with men has been rising since the early 1990s and by 2006 constituted the majority of new HIV infections, a pattern that has also been seen in a number of other western countries.

<sup>1</sup> Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS. Report of the Secretary General. United Nations. 1 April 2010.

29. **Economic and social constraints** – The global AIDS response has been successful in mobilizing funding. However, current economic conditions require maximising the impact and value of available funding. To achieve universal access to prevention, treatment, care and support, total annual investments in the response must reach US\$25 billion, roughly 40% more than total investments in 2008.<sup>2</sup> The enduring global economic difficulties are likely to imperil both the gains achieved thus far, as well as efforts to close coverage gaps at country level. Tackling the epidemic will require fundamental shifts in social norms, putting human rights and gender and civil society at the centre of the response, including people and networks of people living with HIV (PLHIV), sex workers, men who have sex with men, transgender people and people who inject drugs.
30. **Shifting donor financial and political landscape** – Compounding the economic crisis is competition for donor funding across a wide range of development issues, which may result in a shift of resources to other priorities. In order to ensure sustainable financing, there is a need to increase domestic investments and create longer-term certainty regarding commitments to international assistance. Sustainable financing also means engaging large emerging economies to take responsibility not only within their borders, but also in their respective regions.
31. Lastly, there appears to be a financing and policy shift among donors towards favouring countries with a high burden of disease and lower income status. There is a risk that this could have profound effects on key populations that comprise concentrated epidemics in certain countries, if sufficient domestic resources to reach these groups cannot be assured.

## C. LESSONS LEARNED

32. Over many years, UNAIDS has focused on joint planning, coordinated resource mobilisation, collective monitoring and reporting, and many lessons can be learnt from this experience. While there are clearly transaction costs of bringing together 10 UN entities, these have been outweighed by reduced fragmentation, improved coherence, strong unity of purpose and increased effectiveness. In particular at country level, Joint UN Teams on AIDS and Joint Programmes of Support reduce duplication and overlap and increase synergies, thereby implementing UN reform in practice.
33. In all of UNAIDS work, civil society and PLHIV play a key role, and partnerships are a critical element. UNAIDS' support to networks of PLHIV and key populations, and civil society service providers – which includes helping these groups leverage additional funds – has been essential to a successful AIDS response and will be critical in implementing the UBRAF.
34. A budget focused on results accompanied by a performance monitoring framework, regular dialogue with stakeholders and high quality reporting have been important in developing and maintaining the confidence of UNAIDS donors and other partners.
35. A peer review mechanism has been an integral part of the predecessor of the UBRAF, the Unified Budget and Workplan (UBW), and has ensured the identification of gaps, elimination of duplication and enhanced accountability.

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<sup>2</sup> AIDS Outlook 2010. UNAIDS.

36. With resource mobilisation for a unified budget the responsibility of the Executive Director of UNAIDS, multiple and competing fundraising efforts have been avoided. The authority given to the UNAIDS Executive Director to decide on the allocation of resources in line with specific outcomes and outputs approved by the PCB, as well as performance-based release of funds, have provided important flexibility to respond to emerging needs.
37. In 2010, the PCB agreed on a series of recommendations based on the outcomes of the Second Independent Evaluation of the Joint Programme. The evaluation has informed the ongoing development of the UBRAF, the implementation of the Division of Labor and a particular focus on strengthening existing review mechanisms, reporting and accountability based on UNAIDS 2011-2015 Strategy.

#### D. UNAIDS VISION

38. UNAIDS long term vision is aimed at achieving zero new HIV infections, zero AIDS-related deaths and zero discrimination. UNAIDS mission statement highlights the contribution of the Joint Programme and the role UNAIDS needs to play going forward (see box below).

***UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support.***

***Uniting*** the efforts of United Nations System, civil society, national governments, the private sector, global institutions and people living with and most affected by HIV;

***Speaking out*** in solidarity with the people most affected by HIV in defense of human dignity, human rights and gender equality;

***Mobilizing*** political, technical, scientific and financial resources and holding ourselves and others accountable for results;

***Empowering*** agents of change with strategic information and evidence to influence and ensure that resources are targeted where they deliver the greatest impact; and

***Supporting*** inclusive country leadership for sustainable responses that are integral to and integrated with national health and development efforts.

## E. UNAIDS 2011-2015 STRATEGY

39. UNAIDS Strategy for 2011-2015 was adopted by the PCB in December 2010. It includes three strategic directions and 10 corresponding strategic goals to support UNAIDS long term vision of “*getting-to-zero*”. The achievement of those 10 strategic goals is further underpinned by three strategic functions – see figure below.

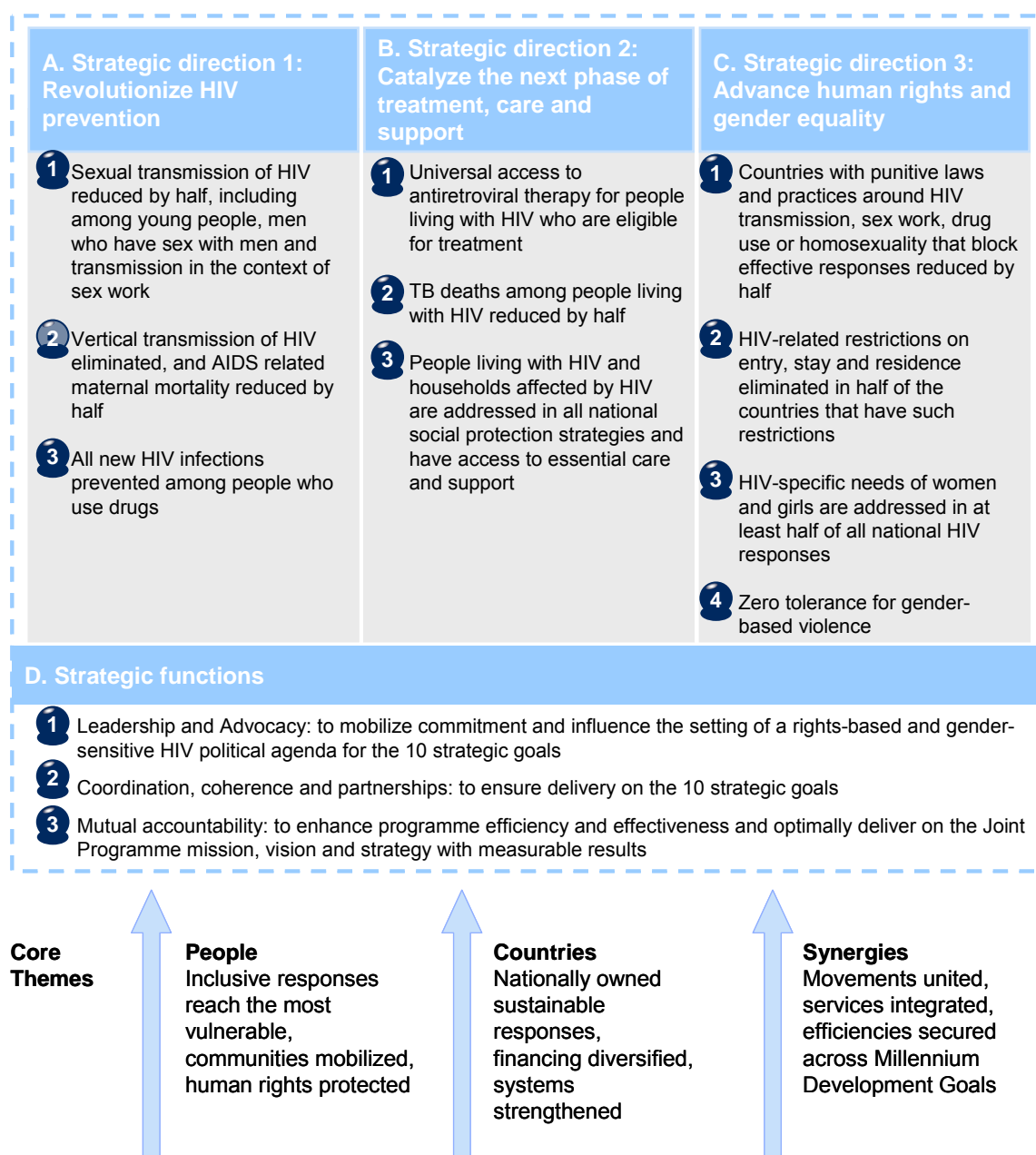


Figure 3: People, countries and synergies – core themes underpinning UNAIDS strategic directions and functions

40. Accountability through shared ownership is a guiding principle that must steer UNAIDS collective effort on three core themes across the three strategic directions: people, the primacy of countries and the pursuit of synergies.

- Effective HIV responses must be led and owned by people living with and affected by the epidemic to ensure a rights-based, sustainable response and to hold national and global partners to account.
  - To sustain people-centred responses requires country ownership, and countries' ability to lead, manage and establish accountability systems for their response.
  - To achieve multiplier effects across MDGs requires strategic investments and ensuring synergies between HIV-related and broader health and human development efforts. By situating the AIDS response within the broader development agenda and integrating AIDS with other health, development and human rights efforts, progress can be accelerated in areas such as maternal and child health, sexual and reproductive health, gender violence and inequality, and universal education, including comprehensive sexuality education.
41. Effective partnerships are critical to successful and sustainable HIV responses. New kinds of partnerships are needed to reach the broader development and human rights areas, increase south-south collaboration, ensure the centrality of country ownership and engage emerging economies. The UNAIDS strategy calls for political alliances that link HIV movements with movements seeking justice through social change.
42. New partnerships should leverage financial and other resources for alliances and networks (particularly those of key populations, such as sex workers, men who have sex with men and people who inject drugs), promote the full involvement of people infected and affected by HIV, and develop stronger connections with young people (with specific focus on those most at risk), women's movements, parliamentarians, media, etc. This approach includes more strategic partnerships with civil society, the private sector, universities, think-tanks and implementers, to ensure that these continue to serve as an engine of innovation—from treatment advances to logistics and applications of new social media, and in finding solutions to specific obstacles that hold back progress in the response to the epidemic.
43. UNAIDS 2011-2015 Strategy aims to:
- Redouble political commitment to sustain and accelerate gains and an ambitious set of targets
  - Ensure diversified, predictable and sustainable financing in the context of flat-lining of resources
  - Ensure that countries are at the centre of the response, by strengthening country ownership and mechanisms of mutual accountability for resources and results
  - Promote the meaningful participation of PLHIV, women, affected and vulnerable groups
  - Maximize efficiencies by reducing unit costs, implementing and scaling up innovative delivery systems, utilising new information technologies and best business practices, and integrating HIV and primary health care services
  - Recalibrate the technical support market for enhanced transparency and strengthening of lasting national institutions
44. Given the changing nature of the epidemic and the need for greater focus, UNAIDS will not only have to concentrate its efforts programmatically, but also consider how to

provide support to selected countries with focused and tailored support to have the greatest impact on the epidemic.<sup>3</sup>

45. By intensifying efforts in 20 countries (see box below) UNAIDS can:

- Focus on almost 75% of all new HIV infections globally
- Address more than 75% of the gap between need and actual coverage of ART
- Cover over 75% of the global gap in prevention of vertical transmission and 95% of the global burden of HIV-associated TB

<ul style="list-style-type: none"> <li>▪ Brazil</li> <li>▪ Cambodia</li> <li>▪ Cameroon</li> <li>▪ China</li> <li>▪ Democratic Republic of the Congo</li> <li>▪ Ethiopia</li> <li>▪ India</li> <li>▪ Kenya</li> <li>▪ Malawi</li> <li>▪ Mozambique</li> <li>▪ Myanmar</li> <li>▪ Nigeria</li> <li>▪ Russian Federation</li> <li>▪ South Africa</li> <li>▪ Thailand</li> <li>▪ Uganda</li> <li>▪ Ukraine</li> <li>▪ United Republic of Tanzania</li> <li>▪ Zambia</li> <li>▪ Zimbabwe</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Would address</b> <ul style="list-style-type: none"> <li>– Over 70% of new global HIV infections</li> <li>– Over 80% of the global gap in ART for eligible adults</li> <li>– Over 75% of the global gap in prevention of vertical transmission</li> <li>– Over 95% of the global burden of HIV-associated TB</li> <li>– Major HIV epidemics driven by injecting drug use (over half of the 20 low- and middle-income countries estimated to have more than 100 000 people who inject drugs and an estimated HIV prevalence among them exceeding 10%)</li> <li>– Laws that affect the HIV response, including laws that restrict travel for people living with HIV (14 of these countries have 3 or more such laws)</li> </ul> </li> <li>▪ <b>Would boost aid effectiveness</b> <ul style="list-style-type: none"> <li>– Enhance the implementation of more than US\$ 5.1 billion in active HIV grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria</li> <li>– Leverage funding from the United States President's Emergency Plan for AIDS Relief (more than US\$ 7.4 billion for 2007–2009)</li> </ul> </li> <li>▪ <b>Would engage</b> <ul style="list-style-type: none"> <li>– All five BRICS countries (Brazil, Russian Federation, India, China, South Africa)</li> </ul> </li> </ul> <p style="font-size: small; margin-top: 10px;">* These countries meet three of the following five criteria according to independent data sources: (1) &gt;1% of the people newly infected with HIV globally; (2) &gt;1% of the global gap in antiretroviral therapy for adults (CD4 count &gt;350/ml); (3) &gt;1% of the global burden of HIV-associated TB; (4) estimated to have more than 100 000 people who inject drugs and an estimated HIV prevalence among them exceeding 10%; and (5) the presence of laws that impede universal access for marginalized groups, including sex workers; men who have sex with men; transgender people; and people who inject drugs.</p>
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Figure 4: Focus countries where a major impact on the epidemic can be achieved

46. The HIV epidemic has also reached catastrophic proportions in some smaller countries such as Botswana, Lesotho, Namibia and Swaziland and some countries in the Caribbean. Due to their small population size, such countries contribute little to the global burden of disease, but investing in strengthened HIV responses is critical to their very survival. They too must be given priority for support.

47. By focusing on 20+ priority countries, UNAIDS will maximize its impact. In many of these countries UNAIDS will not be increasing its own funding, nor necessarily advocating for increased international funding specifically for these countries. Rather, UNAIDS will focus on building commitment, mobilising domestic resources and/or financing from large regional partners, and supporting efforts to increase the efficiency and impact of HIV responses.

48. Maintaining a functioning UN Joint Team on AIDS and implementing UN Country Team-endorsed Joint Programmes of Support on AIDS are essential elements of UNAIDS work in all countries. In keeping with the principles of UN reform, Joint

<sup>3</sup> UNAIDS 2011-2015 Strategy

Programmes of Support need to be reviewed annually with government, donors and key partners as the basis for mutual accountability. UNAIDS support in all AIDS-affected countries will include, but not be limited to, an essential package of support to inform country AIDS plans and responses through strategic information, effective planning and implementation support. Tools and resources will be made available at country level to enable UNAIDS to support the achievement of the UNAIDS Strategy and its 10 strategic goals.

# MAIN COMPONENTS OF THE UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK

## 1. INTRODUCTION

### A. KEY CHANGES COMPARED TO THE PAST

49. The UBRAF is comprised of three main components:

- A business plan
- A results and accountability framework
- A budget

50. As a tool to translate the UNAIDS 2011-2015 Strategy into concrete action for the Joint Programme, the UBRAF demonstrates clear linkages to the UNAIDS 2011-2015 Strategy and the accountability of the Joint Programme vis-à-vis the goals in the Strategy. The UBRAF is aligned to strategic goals as well as regional, country and epidemiological priorities which have been identified based on country inputs and regional consultations spearheaded by the Secretariat with full engagement of the Cosponsors and other partners.

51. As an approach, the UBRAF is fundamentally different from its predecessor (the UBW). The UBRAF is:

- Guided by UNAIDS Vision, Mission and Strategy, clearly aligned with the three strategic directions and the corresponding 10 strategic goals;
- Designed based on a four-year planning cycle, biennial budget cycles and one-year revolving workplans with broad stakeholder reviews of performance;
- Intended to capture global, regional and country level priorities and resources and describe UNAIDS role as catalytic force for the AIDS response;
- Country focused and leveraging UN system (and other organizations) capacities with a focus on countries where the greatest impact on the epidemic can be made;
- A results framework (building on 2009-2011 outcome framework and business cases), rather than a work plan.
- The UBRAF includes a logical framework of expected results and contributions of the Cosponsors and the Secretariat, with resource allocations based on epidemic priorities, performance and funds that Cosponsors themselves raise (not entitlements or pro-rata increases), and clear performance criteria.

### B. BUSINESS PLAN, RESULTS AND ACCOUNTABILITY FRAMEWORK AND BUDGET

52. The business plan, results and accountability framework, and resource allocation and budget are interrelated and mutually reinforcing components of the UBRAF. This section describes both their function in supporting the achievement of the goals in the Strategy and the sequence for developing them.

53. The figure below summarizes the different elements of the UBRAF and their link to the strategic directions and functions.



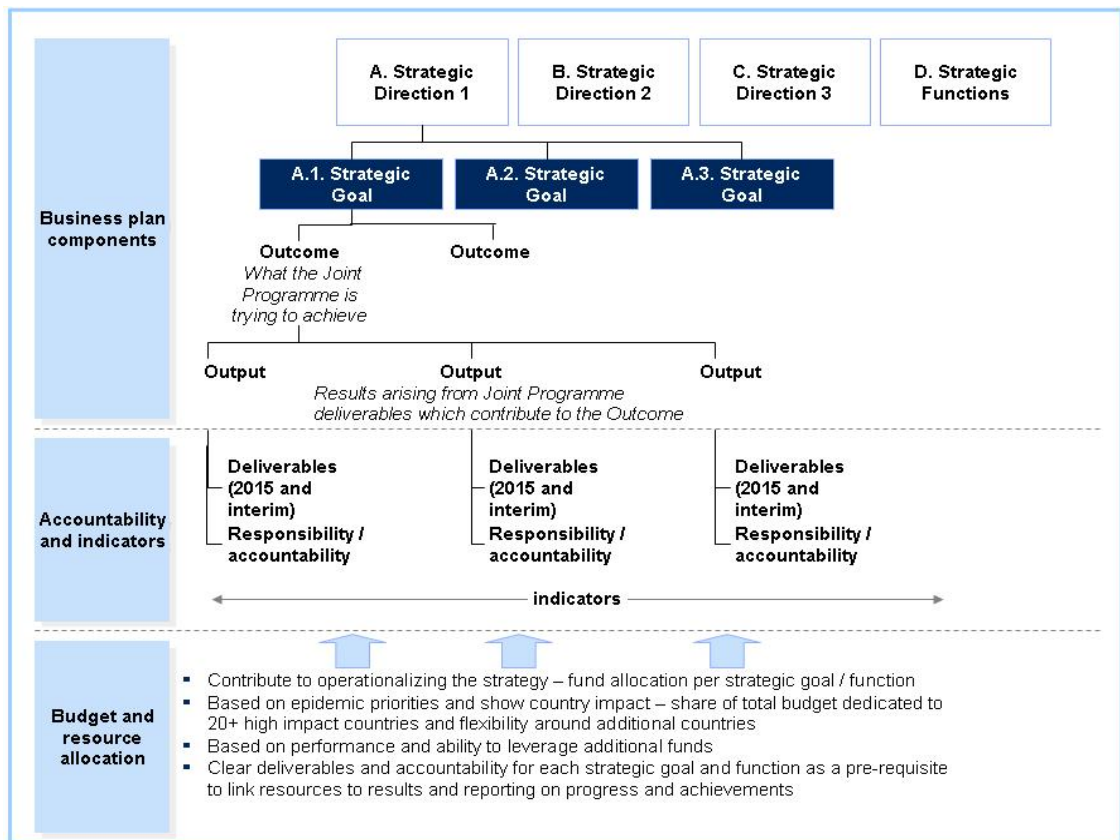


Figure 5: The elements of UBRAF and their link to the strategic directions and functions

54. The UBRAF links all elements of the business plan, the results and accountability framework and the budget to produce a chain of results to support the achievement of UNAIDS 2011-2015 Strategy. The figure below summarizes the business plan, results and accountability framework, and budget, and the links between them.

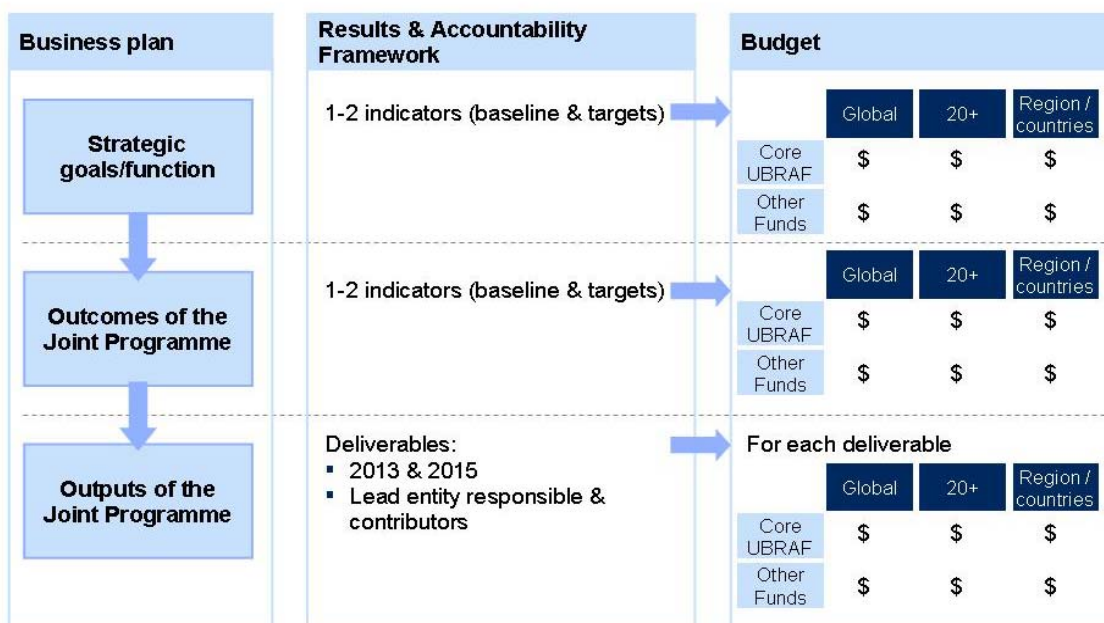


Figure 6: Links between the different elements of the UBRAF

55. Each of these business plan elements (strategic goals, outcomes and outputs) are reflected in the results and accountability framework, which provides for three levels of progress monitoring: 1) approximately one or two key indicators for each strategic goal to track progress in the overall response; 2) approximately one or two key indicators for the collective work of the UNAIDS Joint Programme at the outcome level; and 3) indicators for each of the Cosponsors (by linkage to their own corporate results frameworks and workplans) and the Secretariat to complement outcome level indicators. Success will be determined in particular by progress in countries.
56. These three levels are complementary and provide a comparative view of the impact the Joint Programme has on the strategic goals and functions through the specific deliverables that will contribute to those goals.
57. The budget allocation will be linked to each of the three levels of the business plan and the results and accountability framework. For each strategic goal and function, specific deliverables for each of the outputs will be identified and resource needs defined, from either core UBRAF or other AIDS resources the Cosponsors raise themselves.

## 2. BUSINESS PLAN

58. The business plan clearly links strategic directions with corresponding strategic goals / functions and in turn with outcomes and respective outputs.



Figure 7: The results-based structure of the UBRAF Business Plan

*The following pages present the main elements of the business plan, focusing on what the Joint Programme aims to achieve and how it plans to achieve expected outcomes. The achievement of strategic goals is supported by – and at times dependent on – strategic functions, which should be kept in mind while reviewing the outputs and outcomes.*

*At the end of each section, priorities and examples of outputs at regional level are presented. These were identified through consultations in each region and complement the outcomes and outputs presented by strategic goal and strategic function.*

*Gaps and needs related to different strategic goals and functions, indicators, benchmarks, targets and specific deliverables are included in Part II of the UBRAF.*

## A. REVOLUTIONIZE HIV PREVENTION

59. More than 7,000 people are newly infected with HIV every day. A revolution in prevention politics, policies and practices is critically needed. To achieve universal access to HIV prevention, treatment, care and support, prevention spending ought to constitute approximately 45% of the global resource needs for the HIV response based on UNAIDS' estimates. In reality, funding for HIV prevention has become the smallest part of the HIV budgets of many countries. In 2007, countries spent on average only 21% of HIV-related resources on prevention efforts.
60. Revolutionizing HIV prevention is a complex challenge that requires the Joint Programme to work to further intensify prevention efforts. This will also require support to the creation of protective social and legal environments that enable access to HIV programmes – demonstrating how linked this strategic direction is with the third strategic direction. UNAIDS will invigorate a combination prevention revolution to achieve our bold vision of *zero new infections* by focusing on the following three strategic goals.

<b>1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Reduced sexual transmission through evidenced-informed combination prevention policies and programmes prioritized to specific localities, contexts and populations including young people, men who have sex with men, sex workers and transgender people</b>	<p>Strengthened capacity of young people, youth-led organizations, key service providers and partners to develop, implement, monitor and evaluate HIV prevention programmes targeting young people in school and in community settings including through comprehensive sexuality education, HIV testing and risk reduction counselling, and comprehensive condom programming.</p> <p>New and emerging HIV prevention technologies and approaches (including male circumcision, microbicides, PREP, HIV vaccines) supported and included in the scale up of combination prevention if they continue to show effectiveness in trials.</p>

	<p>For men who have sex with men, sex workers and transgender people, major municipalities have:</p> <ul style="list-style-type: none"> <li>- Informed vocal and capable organizations engaged as partners to advance universal access to HIV prevention, treatment, care and support.</li> <li>- at least one comprehensive HIV programme that provides non-judgemental, non-stigmatizing and relevant services.</li> <li>- at least one robust rights-based programme to inform them about their rights; receive reporting about human rights violations; and ensure positive and appropriate responses from relevant administrative and judicial authorities.</li> </ul> <p>Strengthened capacity to plan, implement and evaluate combination prevention programmes that meet the needs of individuals and communities.</p>
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<b>2. Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<p><b>1. In countries with the greatest number of HIV-positive pregnant women, (a) Universal access coverage achieved; (b) Antiretroviral drugs provided to pregnant women living with HIV; (c) Unmet need for family planning reduced; (d) HIV incidence reduced among women of reproductive age</b></p>	<p>Global plan and monitoring framework for eliminating new HIV infections among children and for keeping their mothers alive implemented.</p> <p>Maternal and child health systems and services strengthened, including antenatal care and deliveries by skilled attendants, and PMTCT integrated with sexual and reproductive health.</p> <p>Implementation of PMTCT in marginalized populations improved, including rural and urban areas, areas of low HIV prevalence and concentrated epidemic settings.</p> <p>Reliable information and monitoring systems established, and external donor support and technical assistance mobilized.</p>
<p><b>2. In low and concentrated epidemic settings, (a) Testing of pregnant women increased; (b) Access of pregnant women to ARVs increased; (c) Unmet need for family planning reduced; (d) HIV incidence reduced among women of reproductive age</b></p>	<p>PMTCT service delivery decentralized and integrated into routine antenatal, delivery and postnatal care settings and other sexual and reproductive health services (e.g. family planning, management of sexually transmitted disease).</p> <p>Pediatric HIV treatment and care integrated into existing child health services and treatment programmes to address the needs of exposed and infected children.</p> <p>PMTCT policy and programmes expanded, including antiretrovirals (prophylaxis and treatment for eligible women), family planning and primary prevention, including nutritional support.</p>

<b>3. All new HIV infections prevented among people who use drugs</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<p><b>1. Strengthened regulations, policies and legislative reforms, which are evidence-based and human rights focused, and support harm reduction and drug dependence treatment services for people who use drugs</b></p>	<p>Review and adaptation of national legislation and policies concerning narcotic drugs, criminal justice, prison management and HIV have been facilitated.</p> <p>Evidence base developed which supports public health oriented policies and comprehensive HIV prevention, treatment and care services including drug dependence treatment for people who use drugs, and those living in prisons and other closed settings.</p>
<p><b>2.</b></p> <ul style="list-style-type: none"> <li><b>a. Expanded needle and syringe programmes to regularly reach people who inject drugs</b></li> <li><b>b. Expanded opioid substitution therapy to regularly reach people who inject opioids</b></li> <li><b>c. Increased coverage of other evidence based drug dependence treatment services among people who use opioids and/or use stimulant drugs</b></li> <li><b>d. Doubled the number of people who use drugs and living with HIV who have access to timely and uninterrupted antiretroviral therapy</b></li> </ul>	<p>Provision of HIV prevention, treatment, care and support services including drug dependence treatment, as per UN guidance, for people who use drugs including those living in prisons and other closed settings.</p>

*Based on priorities identified at regional level, examples of joint outputs include:*

- *Asia and the Pacific* – High-quality strategic information available on key affected populations (including most-at-risk young people) to inform programming and budgeting in all countries.
- *Caribbean* – HIV surveillance systems strengthened, with Modes of Transmission studies completed in 10 countries and data available on HIV in men who have sex with men and other key populations at risk in 12 countries.
- *Eastern Europe and Central Asia* – Adopt and implement the comprehensive package for HIV prevention among people who inject drugs in 6 countries in the region including in prisons where required.
- *Latin America* – Referral and counter-referral networks at hospital and community levels implemented, to ensure appropriate support to HIV+ pregnant women.
- *Middle East/Northern Africa* - Strategic information informs planning and targeted prevention programming for men who have sex with men, partners of people who use drugs, young people and in the context of sex work.
- *West and Central Africa* - Capacity built to implement and scale up integrated community-based reproductive, MNCH, PMTCT and prevention services.

## B. CATALYZE TREATMENT, CARE AND SUPPORT

61. An estimated 1.8 million people died from AIDS-related causes in 2009. Access to treatment for all who need it can come about through simpler, more affordable and more effective drug regimens and delivery systems. Greater links between antiretroviral therapy services, treatment for co-infections and opportunistic infections and primary health, maternal and child health, TB and sexual and reproductive health services will further reduce costs and improve efficiencies. Enhanced capacity for rapid registration will increase access to medicines, as will countries' abilities to make use of TRIPS flexibilities. Alternative mechanisms that could increase access to more effective drug regimens for children and adults such as pooled procurement must be promoted. The increased involvement of communities, PLHIV and key populations in strategies, service design and delivery, adherence and provision of care and support will also make a big difference. Nutritional support and social protection services must be strengthened for people living with and affected by HIV, including orphans and vulnerable children, through the use of social and cash transfers and the expansion social insurance schemes. To reach the vision of *zero AIDS-related deaths* UNAIDS will focus on the following three strategic goals:

<b>1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Increased delivery and access to timely and uninterrupted treatment, care and support for people living with HIV</b>	<p>Global guidance adapted and implemented to achieve the five pillars of Treatment 2.0, including support for strategic information that measures effectiveness and impact, with particular focus on countries with high prevalence and low ART coverage.</p> <p>Drug regimens optimized, with minimal toxicities, high barriers to resistance, limited drug interactions and fixed dose combinations or easy-to-use paediatric formulations</p>

	<p>(Pillar 1).</p> <p>Promotion and expansion in the use of point-of-care and other simplified platforms for diagnosis and treatment monitoring (Pillar 2 of Treatment 2.0) (e.g. rapid diagnosis, point-of-care CD4 and viral load testing, and tests for related conditions).</p>
<p><b>2. Increased Access to and availability of affordable HIV-related commodities</b></p>	<p>National legislative, procurement and other systems strengthened to make use of TRIPS flexibilities, pooled procurement and local production and cost-reduction and financial sustainability plans for drugs, diagnostics and non-commodity costs developed (Pillar 3 of Treatment 2.0).</p> <p>Service delivery decentralized and integrated with prevention and other health programmes to increase access to and quality and sustainability of treatment (Pillar 4 of Treatment 2.0).</p> <p>Demand for treatment increased by mobilising communities (Pillar 5 of Treatment 2.0), promoting policies and engaging them in strategies, service design and delivery, adherence and provision of care and support including nutritional support and ensuring human rights of all affected communities (esp. key populations).</p>
<p><b>3. Equitable access to treatment, care and support for key populations is ensured and monitored by countries to inform policy and programme implementation</b></p>	<p>Policies and programmes address equitable access to treatment, care and support for children, women and men, with a particular focus on key populations.</p> <p>Country-specific strategic information generated to monitor access for key populations by documenting barriers to be addressed.</p>

2. TB deaths among people living with HIV (PLHIV) reduced by half	
Outcomes: what the Joint Programme aims to achieve	Outputs: results which the Joint Programme contributes to
<p><b>1. More people living with HIV diagnosed and receiving TB treatment</b></p>	<p>Country systems strengthened and HIV/TB collaborative activities implemented to reduce the burden of TB and HIV for people living with HIV (including the three I's for HIV/TB and earlier treatment to prevent TB transmission, morbidity and mortality).</p>
<p><b>2. Burden of TB among people living with HIV reduced</b></p>	<p>Access to ART to prevent TB for all PLHIV who are eligible, and for all TB patients irrespective of CD4 count.</p>
<p><b>3. Knowledge of HIV status among TB patients increased and burden of HIV reduced</b></p>	<p>HIV testing and counselling for TB patients expanded; HIV prevention, treatment and care services provided by TB programmes; more HIV-positive TB patients on antiretroviral therapy and co-trimoxazole preventive therapy; and HIV care and support, including nutrition, for TB patients living with HIV improved.</p>

<b>3. PLHIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Increased access to HIV-sensitive social transfers (cash, food, in-kind) by vulnerable people and households affected by HIV and AIDS</b>	<p>HIV sensitive social transfers are incorporated into national social protection policies and programmes (cash, food, in-kind).</p> <p>Evidence based guidance developed in relation to HIV sensitive social transfers.</p> <p>Advocacy and communications strategy addressing investments in HIV sensitive social protection is developed.</p>
<b>2. National social protection plans and social health insurance schemes incorporate access to HIV prevention, treatment and care</b>	<p>National social protection, social health insurance or other health financing strategies reviewed and revised to ensure increased access to HIV prevention, treatment care and support.</p> <p>Innovative ways to finance HIV related health care promoted.</p> <p>Advocacy strategy for progressive and sustainable HIV financing is developed.</p>
<b>3. People and households affected by HIV have increased access to care, protection and support</b>	<p>National HIV/AIDS strategies are reviewed and incorporate a comprehensive response to care, protection and support, including for key populations.</p> <p>Strengthened national care and support systems (both government and non-governments).</p>

*Based on priorities identified at regional level, examples of joint outputs include:*

- *Eastern and Southern Africa* – Comprehensive HIV treatment policies and guidelines revised, updated and implemented, in line with evidence and the most up to date WHO guidance.
- *Eastern and Southern Africa, Western/Central Africa, Caribbean, Latin America* – Development of financial sustainability plans, drug price negotiating strategies and capacity for the use of TRIPS flexibility for treatment and diagnosis supported.
- *Eastern and Southern Africa* – Nutritional and food support services integrated into treatment programmes for vulnerable TB patients, including those living with HIV.
- *Western/Central Africa* – Functional community/home based care systems established in 11 countries.
- *Asia and the Pacific* – Barriers to social protection for HIV-affected households assessed and addressed by governments; care and support integrated in future GFATM proposals.
- *Asia and the Pacific* – Inclusion of HIV and AIDS coverage under social insurance schemes for formal sector workers advocated.
- *Latin America* – Impact of HIV on households and social protection measures available to AIDS-affected households, assessed and used to improve social protection.



## C. ADVANCE HUMAN RIGHTS AND GENDER EQUALITY

62. Social and legal environments that fail to protect against stigma and discrimination or to facilitate access to HIV programmes continue to block universal access. Countries must make greater efforts: to realize and protect HIV-related human rights, including the rights of women and girls; to implement protective legal environments for people living with HIV and vulnerable groups; and to ensure HIV coverage for the most underserved and vulnerable communities. People living with and vulnerable to HIV should know their HIV-related rights and be supported to mobilize around them. Much greater investment should be made to address the intersections between susceptibility to HIV transmission gender inequality and gender-based violence.
63. UNAIDS seeks to advance progress towards the vision of *zero discrimination* by focusing on four strategic goals.

<b>1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Inappropriate criminalization of HIV transmission and legal barriers to HIV service utilization reversed, including attention to specific needs of young people and women</b>	Movements for HIV related law reform are catalyzed and/or supported. Proposals for law reform or removal of legal/regulatory barriers are approved.
<b>2. Stigma and discrimination reduced and access to justice increased for people living with HIV and other key populations in all countries</b>	Key populations act as change agents in all countries and in relevant global forums and processes. Evidence on stigma and discrimination and its impact is developed, updated and used to inform programmes and policies in countries. Access to legal services and legal literacy increased, especially for key populations, especially on laws and practices which impede universal access to HIV and health services for key populations including women.
<b>2. HIV-related restrictions on entry, stay and residence eliminated in half of all national HIV responses</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Parliamentarians and governments in an increasing number of countries with discriminatory HIV-related travel restrictions are actively considering proposals for reform</b>	National coalitions for relevant law and regulation reform are created including attention to HIV related services for migrants.

<b>3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<p><b>1. HIV strategies and programmes are gender-transformative and appropriately linked with broader country action on gender equality, sexual and reproductive and maternal and child health, and human rights</b></p>	<p>Strategic actions for women and girls are incorporated into national AIDS strategic plans, with appropriate budgets for implementation, monitoring and evaluation.</p> <p>Strategic actions on HIV are incorporated into national gender plans, sexual and reproductive and maternal and child health plans, and women's human rights action frameworks, with appropriate budgets for implementation, monitoring and evaluation.</p> <p>Social movements that address HIV-specific needs of women and girls catalyzed and strengthened.</p>

<b>4. Zero tolerance for gender-based violence (GBV)</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<p><b>1. National responses integrate GBV and HIV at the policy, programme and services level, including actions and resources that address and prevent both pandemics in an integrated manner</b></p>	<p>Evidence on GBV/HIV linkages is collected and shared with all countries reviewing or developing national HIV strategies and the range of actors linking GBV and HIV is increased.</p> <p>Range of actors linking GBV and HIV is increased.</p> <p>Evidence on GBV/HIV linkages is collected and shared with all countries reviewing or developing national HIV strategies or GBV strategies.</p>
<p><b>2. Countries are implementing a comprehensive set of actions to address and prevent violence against women and girls</b></p>	<p>Strategies, policies, services, and resource allocation programming within hyper-endemic countries account for HIV prevention, treatment, care and support, gender equality and gender-based violence.</p> <p>Crisis/post-crisis countries significantly affected by HIV integrate GBV and HIV into conflict prevention, resolution and recovery efforts.</p>

*Based on priorities identified at regional level, examples of joint outputs include:*

- *Latin America* – Legislation and policies addressing stigma and discrimination reviewed and adapted in 3 to 4 countries.
- *Middle East/Northern Africa* – HIV related restrictions on entry, stay and residence of PLHIV are removed and mandatory HIV testing replaced by voluntary confidential testing.
- *Middle East/Northern Africa* – Social protection policies revised and strengthened to ensure that they are responsive to the needs of women and girls.
- *Eastern and Southern Africa* – Countries supported to ensure that gender, sexual reproductive health and HIV are integrated and incorporated in all key legal, policy and institutional frameworks.
- *Western/Central Africa* – Women’s and girls’ rights and gender equality mainstreamed in national development frameworks, including new national and sector strategic plans.

#### **D. LEADERSHIP, COORDINATION AND ACCOUNTABILITY**

64. The primary mandate of the Joint Programme is to deliver against the UNAIDS 2011-2015 Strategy along the three strategic directions. The UNAIDS Secretariat will take responsibility for ensuring the effective functioning of the Division of Labor, with special focus on issues of leadership, overall coherence and coordination across all the areas and mutual accountability of the UNAIDS family for results. The Secretariat is also responsible for ensuring that key support services are provided at country and regional level to support the delivery of programmatic results.
65. Achieving the goals of the UNAIDS 2011-2015 Strategy will demand continued effectiveness in the three strategic functions of leadership, coordination and mutual accountability.
66. **Leadership and advocacy**: providing clear vision, efficient direction and strong advocacy are prerequisites for appropriate global and national responses, political commitment at all levels and multi-sectoral strategies to improve and scale-up HIV prevention, treatment and equality.
67. **Coordination, coherence and partnerships**: the AIDS response requires collective action and continued partnership development with key development partners as well as civil society organisations, PLHIV and private sector. Strong coordination of diverse partners is crucial to ensuring efficiency, effectiveness, and country-owned responses to achieve the Strategy.
68. **Mutual accountability**: developing mechanisms to ensure accountability and deliver value for money is critical to success, especially across a large complex partnership. The UBRAF is designed to drive systems that reinforce the direct link between investments and results and to clearly demonstrate country-level achievements, and holds the Joint Programme accountable for deliverables directly linked to achieving the three strategic directions.

<b>1. Leadership and advocacy</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Positive and measurable movement on key issues and drivers of the epidemic</b>	<p>Programmes/resources/strategies to work with PLHIV in terms of positive health, dignity and prevention are expanded.</p> <p>Capacities to work with key populations are strengthened.</p> <p>Support provided to civil society to further enable leadership and advocacy efforts.</p>
<b>2. Effectiveness in national HIV responses</b>	<p>Countries are using "Know Your Epidemic - Know Your Response" analysis to re-prioritize the national response and reallocate resources.</p> <p>Inter-governmental and inter-agency organizations, multilateral institutions and funding mechanisms, and civil society are active and committed in the implementation of the UNAIDS 2011-2015 Strategy.</p>
<b>3. Renewed and expanded political commitment to the HIV response</b>	<p>Presence of transformative leadership and commitment for a sustainable AIDS response including at national and local levels and among key populations.</p> <p>Advocacy to secure commitment, effective partnerships and investment of national resources to advance gender equality and rights-based AIDS responses.</p>
<b>4. Inclusion of AIDS into global health, human rights, gender, and development agendas</b>	<p>Links between HIV responses and the broader MDG agenda are visible, and show cost-effectiveness.</p>

<b>2. Coordination, coherence and partnerships</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. Technical, political and financial partnerships and programmes accelerate social change</b>	<p>National capacity, systems and institutions are strengthened to address a new phase of prevention, treatment, care and support programmes.</p> <p>Strategic alliances and partnerships are established and well defined for quality diagnostics and treatment, and elimination of new child infections.</p>
<b>2. AIDS responses are country-owned, human rights-based, gender responsive, appropriate, coordinated and sustainable</b>	<p>Community data and approaches have influenced the design, implementation and decision making of HIV policies and plans.</p> <p>National Strategic planning and programme tools implemented with inclusion of civil society.</p> <p>Skills built to address gender, GIPA and human rights</p>

	aspects of HIV epidemic.
<b>3. Implementation of evidence-informed, prioritized, costed national strategic and operational plans which are aligned to other sectoral plans and development processes to achieve Universal Access targets</b>	<p>National HIV strategies and programmes are aligned and integrated into broader health and development planning and programmes.</p> <p>Strategic information tools and processes further refined, shared and utilized for decision making.</p>
<b>4. Technical and policy support are demand driven and cost effective</b>	Technical support provided, including through civil society technical support providers, to strengthen community systems and provide HIV-related services.

<b>3. Mutual accountability</b>	
<b>Outcomes: what the Joint Programme aims to achieve</b>	<b>Outputs: results which the Joint Programme contributes to</b>
<b>1. UNAIDS delivers value for money, managing high impact operations that link human and financial resources to results and demonstrate improved efficiency, effectiveness and outreach</b>	<p>Mutual accountability frameworks, including UBRAF, and systems for delivery of UNAIDS Vision, Mission and Strategy developed</p> <p>UNAIDS Division of Labor is systematically operationalized and monitored at global, regional and country levels.</p> <p>HIV and AIDS corporate results frameworks, both across UNAIDS and among other stakeholders in the response to AIDS, are increasingly synchronized and aligned.</p>
<b>2. Effective and efficient management is provided in support of the Joint Programme</b>	<p>The UBRAF is managed, monitored and reported in a transparent way to meet the needs of different stakeholders.</p> <p>UNAIDS support services and resources are developed, deployed and implemented for maximum efficiency and impact.</p>

*Examples of joint work at regional level include:*

1. Regional and intergovernmental organizations are strengthened and innovative regional partnerships (on key HIV-related issues) are established in regions to support the implementation and monitoring of national and regional responses to AIDS
2. Regional UN forums (i.e. technical arms of Regional Directors' Teams, Joint UN Regional Teams on AIDS) are established or strengthened to support development and implementation of Joint Programmes of Support at country level

*Examples of joint work at country level include:*

1. Broker new partnerships and establish mechanisms providing direct access to and engagement with high-level national political actors with a view to promoting transformative leadership for a sustainable AIDS response (country policy and context analysis, political intelligence briefs)
2. Convene multi-sectoral forums for the engagement and coordination of all partners and stakeholders on HIV, including government, civil society, private sector, PLHIV and donors (stakeholder mapping and analysis, institutional reviews, harmonization and alignment tools)
3. Generate, analyze and use strategic information to promote issues around knowing your epidemic and context, gender, human rights, and most at risk populations in national programming (situation analysis, modes of transmission study/synthesis report, epidemic projections, cost effectiveness analysis)
4. Develop evidence-informed, prioritized, results-based, costed and multi-sectoral national strategic and operational plans that are nationally owned, and integrated with broader health sector and national development plans (third generation NSP guidance and tools, costing, technical support and capacity development planning tools)
5. Undertake annual and mid-term reviews of national strategic and operational plans to identify gaps and best practices, and generate in-depth analysis to ensure value for money and improve results-based planning and implementation (programme evaluation, implementation analysis, efficiency/impact studies)
6. Successfully mobilize Global Fund resources, national government budgets and other alternative domestic financing for HIV (national AIDS spending assessment, costing, financial gap analysis, resource mobilization, dual track financing and community system strengthening)
7. Maintain a functioning UN Joint Team on AIDS and implement a UNCT-endorsed Joint Programme of Support on AIDS, reviewed annually with government, donors and key partners) as the basis for mutual accountability for implementation of UN reform on UNAIDS vision, mission and strategy (revised joint team guidance and tools, joint programme and UNAIDS country office performance assessments)
8. Promote an enabling environment for movement on sensitive issues in the AIDS response through the strengthening of national social protection legislations, policies and plans that ensure HIV sensitivity (stigma index, gender audit, legal audit)
9. Build the capacity of UN Plus (UN system-wide group of staff members living with HIV) with a view to increasing visibility and membership, especially at country level, in order to address HIV related stigma and discrimination within the UN, and to assist UN Plus members in effectively addressing issues of concern to staff living with HIV and contributing to HIV programming and policies across the UN system.

### 3. RESULTS AND ACCOUNTABILITY FRAMEWORK

#### A. OVERVIEW

69. By having a four-year planning cycle (instead of two years) UNAIDS is for the first time able to plan for concrete achievements over a timeframe that allows for measurable impact (i.e., 2012-2015). The results and accountability framework demonstrates the link between investments in actions and progress against strategic goals, particularly at the country level.
70. The PCB has identified a number of parameters and principles to guide UNAIDS performance monitoring and reporting:
- Measure progress against UNAIDS Strategy
  - Report annually to the Board
  - Focus on results at country level
  - Demonstrate links between investments and results
  - Identify contributions of each Cosponsor and the Secretariat
  - Align performance monitoring with Cosponsors' corporate results frameworks
71. The results and accountability framework comprises three main elements:
- 1. Indicators at three levels** (with associated baseline and targets)
    - Indicators for each strategic goal – to track progress of the global response
    - Indicators for each outcome – to measure the collective achievements of the Joint Programme
    - Indicators linked to Cosponsor corporate results frameworks and effectiveness of the Secretariat – to assess performance of the Cosponsors and the Secretariat
  - 2. Deliverables** – concrete results related to strategic goals and functions, linked to the outputs of the Cosponsors and Secretariat.
  - 3. Review process** – performance assessment to measure progress and achievements with a particular focus on results at country level.
72. Indicators as well as baselines and targets identified are included in Part II of the UBRAF.

#### B. RESULTS AND ACCOUNTABILITY FRAMEWORK

##### 1. Indicators

73. Indicators will measure results against the strategic goals and functions at three levels:
- a) the macro level, i.e., progress in specific areas of the response to AIDS;
  - b) the level of the Joint Programme, i.e., the collective contribution of UNAIDS, and;
  - c) the level of individual Cosponsors and the Secretariat.
74. As far as possible, baselines and targets to measure progress on an annual or biannual basis have been identified to track progress against outcomes, goals and strategic directions.
75. A set of high-level indicators has been selected for each strategic goal (see Part II). Where possible, this list of indicators has been drawn from the principal global AIDS

indicators (UNGASS) and has been supplemented by indicators from the corporate results frameworks of Cosponsors.

76. Indicators in the UBRAF have been assessed by the Cosponsor Evaluation Working Group and aligned with other UN initiatives, global AIDS and MDG indicators. They are the same as and/or complement indicators used by key partners such as the Global Fund to Fight AIDS, TB and Malaria and PEPFAR, the United States President's Emergency Plan for AIDS Relief. These indicators serve to measure the achievements and mutual accountability of the Joint Programme. For Cosponsors, in-depth reporting of achievements will principally be using their own organizational indicators and reporting processes.
77. The targets and scope of the UBRAF indicators will be developed and refined further prior to the start of the implementation of the UBRAF and included in the regular reporting to the PCB on UBRAF implementation. All indicators will be reviewed as part of the annual reviews of progress in order to make sure that the indicators are robust, appropriate and remain relevant. The full engagement of external stakeholders, in particular national governments and civil society as well as UN Country Teams and UN Joint Teams on AIDS in the annual review process, is key. Monitoring and evaluation guidance will be developed to assist implementation and measurement across the Joint Programme, with links to Cosponsor corporate results frameworks.

## 2. Deliverables

78. For each strategic goal and function, specific deliverables have been identified to reflect inputs from global, regional and country level. These deliverables describe:
- Accountability of the Cosponsors and the Secretariat for specific results
  - Expected level of contribution (global, region/country, 20+ high-impact countries)
  - Contribution to outputs and strategic goals or functions
79. The deliverables will be reviewed and changed as necessary, principally in 2013 during the development of the budget for 2014-2015.

## 3. Review process

80. The annual performance review process aims to provide the Committee of Cosponsors Organizations (CCO) and PCB with a clear and simple overview of progress and achievements against UNAIDS 2011-2015 Strategy. An executive dashboard (illustrated below) will be used to present progress against each strategic goal and function using key indicators as described above.



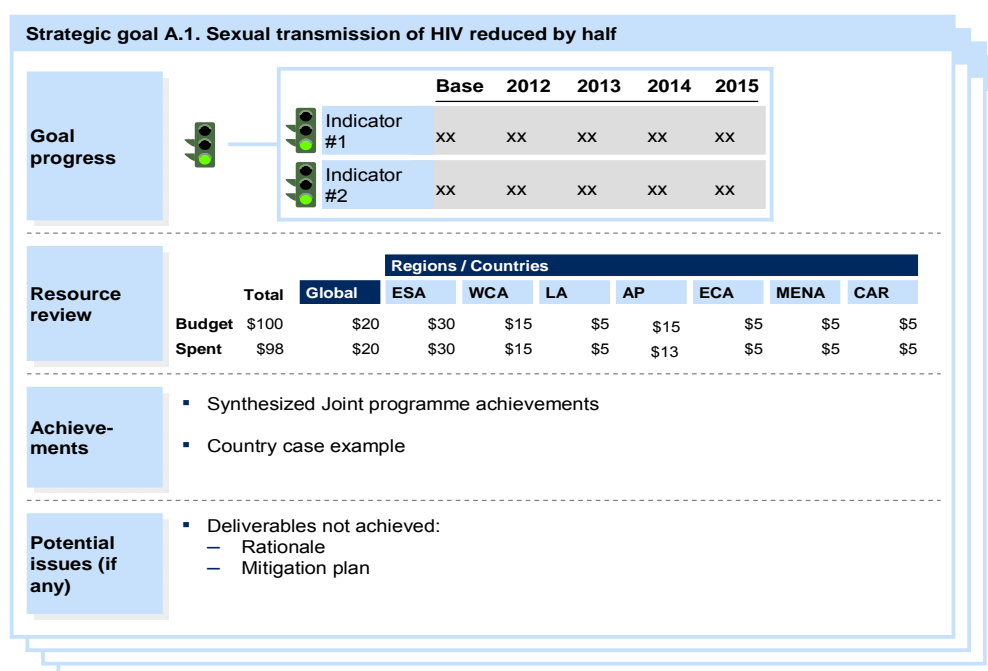


Figure 8: Example of an executive dashboard to present progress against strategic goals and functions

81. The annual review will also identify resources budgeted and spent by the Joint Programme for each goal / function, a summary of joint achievements, and country or regional case studies. Importantly, the review will identify goals where progress is not being achieved as expected. In such cases, the CCO and PCB will be presented with an analysis of progress on lower-level indicators, deliverables and reasons for delays and proposed mitigation plans will be developed, recognizing that the causes may lie outside the scope of the Joint Programme.
82. In addition to the annual review process, a biennial review will involve an assessment of Cosponsor and Secretariat achievements by strategic goal / function, and provide the basis for the next core budget allocation.
83. The performance assessment of Cosponsors and the Secretariat will primarily be based on indicators and achievement of UBRAF deliverables. This reinforces the need for Cosponsors and the Secretariat to build specific deliverables and associated allocation of resources demonstrating:
- Role in driving technical, normative and advocacy work at global and regional levels in thematic areas where such work is a clear priority and influences country responses and impacts on policies, programmes and outcomes;
  - Relevance and scope of technical expertise and core functions to address epidemic priorities, including capacity, strategic partnerships and influence in priority areas and in specific countries (e.g., harm reduction in countries vulnerable to growing IDU-driven epidemic), and;
  - Role in supporting implementation of evidence-informed AIDS strategies in particular countries while meeting standards with regard to quality and cost-effectiveness.

84. The way in which Cosponsors and the Secretariat allocate their core UBRAF resources to deliverables should also demonstrate the specific impact each Cosponsor and the Secretariat can achieve at global, regional and country level.
85. As part of the review process, and to complement the main performance measurement mechanism (i.e., achievement of UBRAF deliverables), the amount of funds leveraged and the financial utilisation of funds will also be reviewed.

## **4. BUDGET AND RESOURCE ALLOCATION**

86. The 2012-2015 UBRAF represents a new direction in resource planning, management and reporting to capture (i) UNAIDS global agenda, (ii) key roles and responsibilities at regional level, (iii) promoting the AIDS response at country level through UN reform in action, and (iv) a focus on 20+ countries where a major impact on the epidemic can be made. The budget also captures the management functions, i.e., central support services of UNAIDS Secretariat. To the extent possible, the formulation of the UBRAF has been aligned with planning and budget processes of the Cosponsors.

### **A. SCOPE, LEVEL AND STRUCTURE**

#### **1. Scope of the budget**

87. The UBRAF is designed as a catalytic instrument to support national AIDS programmes. It is a vehicle to translate UNAIDS 2011-2015 Strategy into action and galvanize action towards universal access to HIV prevention, treatment care and support in countries in accordance with UNAIDS Mission Statement (see p.11). Intended to catalyze country-level action against AIDS, the UBRAF mobilizes and leverages funding from Cosponsors' own resources and other AIDS programmes which are essential to achieve the goals in UNAIDS 2011-2015 Strategy.
88. Since its establishment, UNAIDS budget has primarily covered the activities of the UNAIDS Secretariat. This is based on the founding ECOSOC Resolution 1994/24 which stipulates that "The co-sponsors will contribute to the resource needs of the programme" and that "Funding for country-level activities will be obtained primarily through the existing fund-raising mechanisms of the co-sponsors. These funds will be channelled through the disbursement mechanisms and procedures of each organization."
89. To provide a comprehensive view of the UN system funding for AIDS, the UBRAF includes two categories of funding: core funds which UNAIDS Secretariat traditionally raises as well as other AIDS-specific funds that the Cosponsors themselves raise. In total, the core UBRAF will represent approximately 12 per cent of the total amount of funding estimated to be managed by UNAIDS Cosponsors and Secretariat in 2012-2013 for AIDS-specific activities, as shown in the graph below.

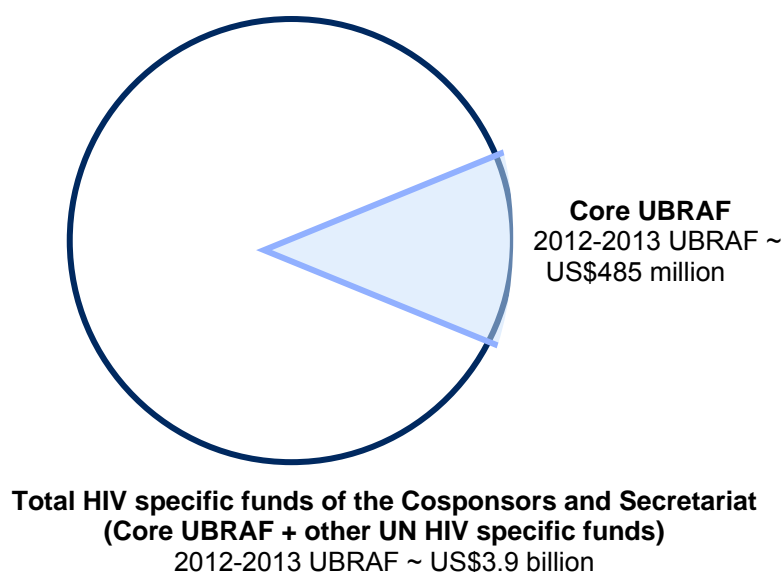


Figure 9: The two categories of funding in the UBRAF: core funds and other AIDS funds

## 2. Level of the budget

90. Given the current resource environment and despite the growth in the Joint Programme and its priorities, the core budget of the UBRAF is proposed to remain at the same level over the next two years – approximately US\$485 million – as in the previous two biennia (2008-2009 and 2010-2011). Holding the core budget to zero nominal growth over six years means a decrease in real terms as there is no re-costing to take into account inflation and a weakening of the US dollar, the currency of the budget against other currencies in which expenditures occur, in particular the Swiss franc.
91. In the past, the Secretariat has also raised extra-budgetary funds amounting to approximately US\$65 million per biennium for country level activities and key areas of work which were not captured in the UBW. To provide similar support as in the past, it is proposed to maintain a flexible level of non-core funding throughout the 2012-2013 biennium with a transition over the lifetime of the UBRAF to integrate these funds and related activities into the core budget of the Secretariat. These resources will be used to support the achievement of the goals in UNAIDS Strategy, and this process will lead to more comprehensive resource planning and management, increased transparency and accountability.

## 3. Structure

92. Based on guidance by the PCB, the PCB subcommittee and feedback from stakeholders, the UBRAF has been formulated to show UNAIDS contribution to the 2011-2015 Strategy. The resources of the Joint Programme are shown against the strategic directions and functions, and reflected in two 2-year budget cycles (2012-2013 and 2014-2015) that will be reviewed annually.

93. The specific structure of the budget comprises:
- Two main budget categories, 'Secretariat' and 'Cosponsors', broken down further to show the resources for each Cosponsor;
  - Two types of funding, 'core' and 'other AIDS' funds, with the latter representing the AIDS funds that the Cosponsors themselves mobilize at country, regional and global levels;
  - Two main levels of funding, 'global' and 'regional/country level', with a further breakdown by region and focus on 20+ high impact countries and other countries;
  - Two cost categories for the Secretariat budget, 'development activities' and 'management functions', i.e., central support services, to enhance transparency and accountability.

## B. RESOURCE ALLOCATION

94. The budget development and resource allocation is an iterative two-step process, which includes:
- Estimation of resource needs and allocation of resources
  - Detailed definition of resources and associated deliverables
95. The figure below illustrates how these two steps fit into the four year planning cycle and the overall results and accountability framework.

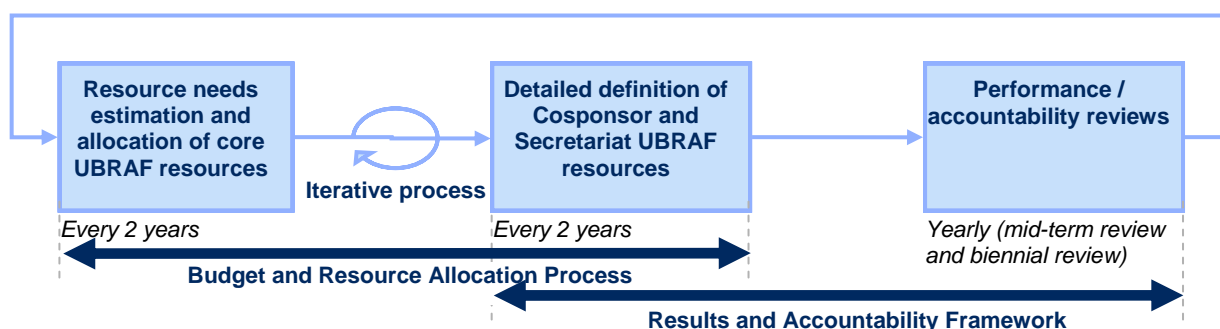


Figure 10: The two-step process of budget development and resource allocation

### 1. Estimation and allocation of resources

96. Based on the outcomes, outputs and deliverables identified as part of the UBRAF process, the Cosponsors and Secretariat have estimated resource needs from the core UBRAF and identified the other resource for AIDS that they expect to mobilize in the next two years.
97. The allocation of the core resources has been guided by the decisions, recommendations and conclusions of the 25<sup>th</sup> and 26<sup>th</sup> meetings of the PCB according to which:

*“the decisions of the Executive Director on the allocation of money between the 11 organisations (ten Cosponsors and Secretariat) are based on epidemic priorities and the comparative advantages of the UN” and*

*“the allocation of [UBW] funding raised through the Secretariat should no longer be based on entitlement and pro-rata increases, but on epidemic priorities, the performance of the Cosponsors, and the funds that individual Cosponsors raise”.*

98. The specific criteria used in determining the allocation of resources are included below:
- A. *Overall quality of UBRAF submission*
    - Relevance of proposals to the achievement of the goals in the Strategy
    - Clarity of normative, technical, advisory, advocacy and/or capacity building role
    - Specificity and measurability of deliverables in proposals
  - B. *Country focus*
    - Centrality of countries and focus on results at country level
    - Consideration of regional priorities and support to 20+ high impact countries
    - Presence and capacity to support implementation in countries
  - C. *Commitment*
    - Mobilisation and leveraging of resources for the AIDS response
    - Engagement in the joint response to AIDS, partnerships and past performance
    - Mainstreaming of AIDS internally and integration of AIDS with other MDGs

## 2. Allocation of global, regional and country level resources

99. While activities take place at global, regional and country level, ultimately any action of UNAIDS must translate into results at country level. The allocation of resources between the global and regional/country level takes this into account to ensure maximum return on investments. Currently, 60 per cent of core resources in the UBW (approximately US\$485 million per biennium) are spent at the regional and country level, with the balance spent at global level.
100. Over the next two biennia, the aim is to increase the amount of core UBRAF resources spent at regional and country level to 70 per cent to maximize the impact of all Cosponsor and Secretariat resources dedicated to the AIDS response:

	Prevention	Treatment care and support	Human rights and gender	Leadership, co-ordination and accountability	Allocation of budget
Global level	Advocacy, normative functions, policy development, partnerships				40% → 30%
Regional level	Capacity building, advisory, technical & implementation support				60% → 70%
High impact countries	20+ countries Additional support through joint teams and joint programmes				
All countries	Essential package of support, tools and resources				

Figure 11: Current and target allocation of core UBRAF resources

101. For countries, the allocation of UBRAF resources will be based on epidemic priorities, needs, the potential impact of funding as well as issues such as the role of civil society in service provision, particularly in the areas of care and support. Specific criteria to determine the allocation of the UNAIDS Secretariat resources at country level are shown below:
- *Criteria 1: HIV severity score, a composite of variables, which includes HIV incidence, prevalence, number of people living with HIV and Human Development Index;*
  - *Criteria 2: Number of staff in a country office, to ensure resources are directed where they can be best leveraged;*
  - *Criteria 3: Country income classification based on World Bank ranking, to provide an indication of how much and to what level financial help may be needed;*
  - *Criteria 4: Adjustment factor based on concentrated epidemics, to take into account specific epidemics patterns (e.g., IDU) while the overall prevalence could be low, and;*
  - *Criteria 5: Availability of other HIV funds (PEPFAR, Global Fund, in-country-resources), to capture the catalytic and leveraging nature of UBRAF resources.*
102. Additionally, funding will be provided to UN Joint Teams on AIDS and Joint Programmes of Support to intensify action in specific high impact countries. It should be noted that in a number of these countries UNAIDS will not be increasing its own funding, or advocating for increased international funding, but rather advocating for increased national commitment and mobilisation of domestic resources.

### 3. Detailed definition of core UBRAF resources

103. The vast majority of the core resources in the 2012-2015 UBRAF are for what can be defined as *development activities*. These contribute to the effective delivery of results, and include (i) actions with budgets linked to specific activities, which contribute to the achievement of the strategic goals in the UBRAF, and (ii) activities of a normative, policy-advisory, technical and implementation nature that are needed for the achievement of the objectives of the Joint Programme and the outputs in the UBRAF.
104. For the Secretariat, development activities include global level work as well as the work of seven regional support teams and 85 country offices, which account for approximately four fifths of the Secretariat budget.
105. In addition to the development activities, the UBRAF includes *management functions*, i.e., *central support services* of the Secretariat, which are necessary for the smooth functioning of the Joint Programme to ensure effective delivery of results. The programme support costs or administrative overhead charged by Cosponsors for the core UBRAF resources they receive through UNAIDS Secretariat range from 5 to 13 per cent.
106. The central support services include human resources management, budget, finance, information and communication technology, and administrative services, as well as office running costs. Particular attention is given to strengthening cost-effectiveness and efficiency of support and services to ensure that resources are allocated where they can have greatest impact.

107. A key component in the area of human resources management is the alignment of the Secretariat staffing at global, regional, and country levels with UNAIDS vision, mission and Strategy for 2011-2015. Work is underway on a comprehensive review to develop a workforce strategy that ensures optimal deployment of staff and expertise at all levels, reduced operating costs, and strengthened country focus. This strategy, which will be reported on to the PCB at its 29<sup>th</sup> meeting, will be integral to the implementation of the 2012-2015 UBRAF to ensure the Secretariat remains 'fit for purpose' to deliver on the goals in the Strategy.
108. In the area of budget and finance, the role of the Secretariat is to manage not only the funding for the Secretariat, but also the resources raised for and transferred to the Cosponsors, which represent approximately one third of the core UBRAF. This entails joint resource planning – i.e., the development of the UBRAF – as well as the monitoring and reporting to the PCB on the implementation of all (core and non-core) resources managed by the Cosponsors and the Secretariat to ensure accountability.
109. Increasing the effectiveness and efficiency of the Joint Programme also includes continued investments in information and communication technology, which are captured under the central support services. This includes tools for strategic information and knowledge management to (i) track the state of the epidemic, the response, actors involved, and provide relevant, near real-time information for decision making; (ii) monitor the work of the Joint Programme as well as (iii) support integration of UNAIDS HIV-specific data collection efforts with those of other UN agencies at country level to avoid duplication of processes and efforts.
110. As mentioned earlier, partnerships are key to support the implementation of UNAIDS Strategy, and better IT tools are needed to strengthen support to partnerships at global, regional and country level. With an increased focus on people and communities, in particular youth, additional efforts are needed to harness social media and other communication technologies to be able to drive social change and engagement in the AIDS response. This approach also requires upgrading of existing information systems, communication tools and processes, which has budgetary implications which need to be taken into consideration.

### **C. BREAKDOWN OF THE BUDGET**

111. In accordance with the decisions, recommendation and conclusions of the PCB, the 2012-2015 UBRAF is split in two 2-year budget cycles. Accordingly the figures included in the tables and graphs below as well as the detailed presentation of the budget are for the period 2012-2013.
112. As explained earlier, the UBRAF reflects both core resources as well as the funds that Cosponsors themselves raise for HIV specific activities, which are referred to as 'non-core' or 'other AIDS funds'. The table below shows the core UBRAF as well as the non-core funds Cosponsors and the Secretariat are expected to mobilize in the next biennium:



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

Funding Type	Estimated Resources	%
Core funds	484,820,000	12%
Other AIDS funds	3,403,911,000	88%
<b>Grand Total</b>	<b>3,888,731,000</b>	<b>100%</b>

113. The funds for AIDS that the Cosponsors and Secretariat expect to mobilize in the next biennium – US\$ 3.4 billion over and above the core UBRAF – are HIV-specific and do not include funding in which HIV is mainstreamed, or funds which are supportive of HIV responses more generally, and indirectly advance work on AIDS.

114. The sections below present the allocation of core UBRAF and non-core funds by:

1. Strategic direction and function
2. Global level, high impact countries and other countries
3. Cosponsors
4. Secretariat

#### 1. Funding for strategic directions and functions

115. The tables below show breakdown of the core UBRAF resources by strategic direction and strategic function.

**Table 2: Core budget allocation by strategic direction (in US\$)**

Strategic Direction	Core Resources	%
Prevention	82,225,700	53%
Treatment, Care and Support	46,484,500	30%
Human Rights and Gender	26,297,300	17%
<b>Grand Total</b>	<b>155,007,500</b>	<b>100%</b>

116. In accordance with the Division of Labor, the Cosponsors have primarily budgeted their funds against the strategic goals and directions, whereas the Secretariat resources are budgeted against the strategic functions – even though these also contribute to the achievement of the strategic goals.

**Table 3: Core budget allocation by strategic function (in US\$)**

Strategic Functions	Core Resources	%
Leadership and advocacy	131,870,800	40%
Coordination, coherence and partnerships	104,738,200	32%
Mutual accountability	93,203,500	28%
<b>Grand Total</b>	<b>329,812,500</b>	<b>100%</b>

117. It is important to keep in mind that the core UBRAF only represents a partial and therefore incomplete view of the work of UNAIDS Cosponsors and Secretariat. To fully understand the catalytic and leveraging role of the core UBRAF, the other AIDS-related resources of the Cosponsors (and Secretariat) also need to be taken into account. The chart below presents the total funding of the Cosponsors and

Secretariat for AIDS by strategic direction and function, with more than 50 per cent of all estimated resources going towards HIV prevention.

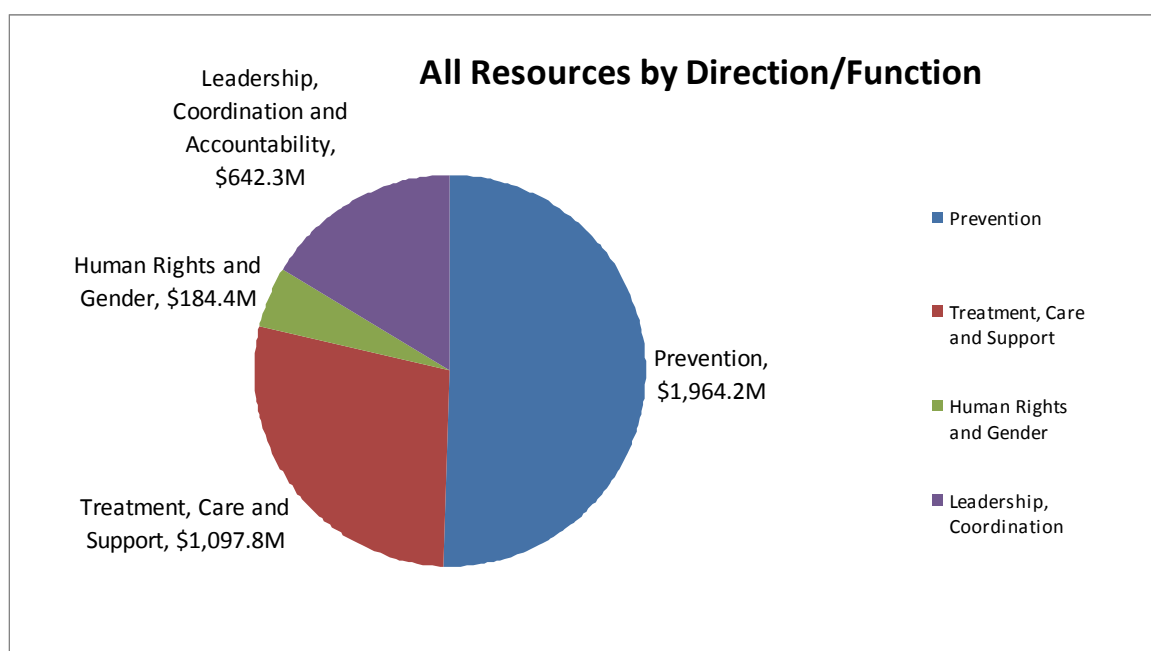


Figure 12: Core and non-core funds by strategic direction and function (in US\$ millions)

118. The apparent lower share of funding for human rights and gender compared to the other strategic directions and functions can be explained by the fact that the work of the Secretariat in these areas is captured under leadership, coordination and accountability, and that human rights and gender are also mainstreamed and included in the budgets for prevention, treatment, care and support.

## 2. Funding for global level action, high-impact countries and other countries

119. The table below presents the breakdown of the core UBRAF funds for global level activities, high impact countries and all other countries in 2012-2013.

Table 4: Core budget for global level, high impact countries and other countries (in US\$)

Funding Level	Core Resources	%
Global level	192,393,700	40%
20+ high impact countries	98,942,900	20%
All other countries	193,483,400	40%
<b>Grand Total</b>	<b>484,820,000</b>	<b>100%</b>

120. While, as stated above, the aim is to reach a target of 30% over the next two biennia, approximately 40% of all core UBRAF resources are currently allocated for global leadership, advocacy, normative functions and policy development. However, when all Cosponsor and Secretariat resources are considered, a much smaller share, approximately 7 per cent goes towards global level activities as shown in the chart below:

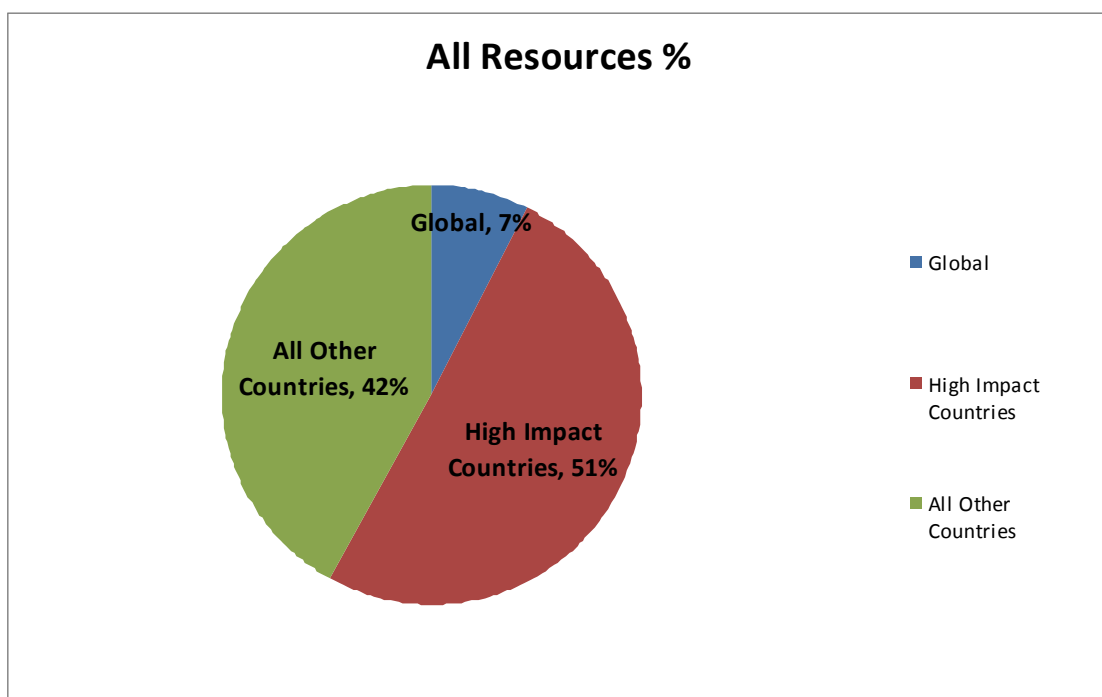


Figure 13: Total funding for global level, high impact countries and other countries (%)

121. The proportion of funding for high impact countries is to a large extent influenced by the US\$1.8 billion of World Bank loans and grants.
122. Table 5 shows resources broken down by global level action, high impact countries and all other countries.

Table 5: Total budget by global level, high impact countries and other countries (in US\$)

Cosponsor	Global	20+ High Impact Countries	AP (All other)	CAR (All other)	EECA (All other)	ESA (All other)	LA (All other)	MENA (All other)	WCA (All other)	TOTAL
UNHCR	7,903,400	5,403,800	2,168,700	221,200	546,100	4,262,900	705,200	1,389,200	3,699,500	26,300,000
UNICEF	13,476,200	226,386,100	25,587,700	8,689,300	12,464,400	42,239,500	10,026,800	8,756,400	29,333,600	376,960,000
WFP	6,071,800	166,303,100	8,705,000	162,600	162,600	43,823,100	8,705,100	0	33,216,700	267,150,000
UNDP	16,062,200	272,766,300	22,580,800	10,720,700	23,728,400	124,766,800	4,893,800	64,424,700	23,256,300	563,200,000
UNFPA	12,122,800	15,132,300	19,675,900	5,140,500	10,262,700	26,898,500	7,815,800	6,227,000	15,284,500	118,560,000
UNODC	5,613,000	19,753,000	8,312,200	1,879,100	7,903,600	4,324,300	3,826,300	6,906,500	3,278,000	61,796,000
ILO	7,682,400	7,748,200	3,346,800	1,859,400	2,053,400	5,593,800	2,231,100	1,487,900	2,797,000	34,800,000
UNESCO	9,066,100	19,635,800	2,625,600	291,300	1,430,800	2,643,400	1,662,400	982,300	1,907,300	40,245,000
WHO	62,739,500	69,832,600	26,828,600	0	14,059,100	10,447,000	8,129,600	12,797,100	16,566,500	221,400,000
WB	1,400,000	1,086,959,900	213,892,400	21,029,600	12,436,000	170,992,500	29,901,200	3,389,600	272,998,800	1,813,000,000
Secretariat	146,620,000	70,300,000	23,522,000	13,798,200	10,457,800	31,147,100	11,176,000	13,361,200	44,937,700	365,320,000
Grand Total	288,757,400	1,960,221,100	357,245,700	63,791,900	95,504,900	467,138,900	89,073,300	119,721,900	447,275,900	3,888,731,000

### 3. Funding by Cosponsor

123. Table 6 below shows the core allocations for the Cosponsors for 2012-2013. Allocations for the two last biennia are included for comparison.

**Table 6: Breakdown of the core budget by Cosponsor (in US\$)**

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

\* Amounts reflect the Cosponsors' core allocations without Programme Acceleration Funds or other Interagency Funds.

The table below shows the 2012-2013 core UBRAF allocations as well as other HIV specific funds of the Cosponsors and Secretariat.

**Table 7: Breakdown of the core budget and all non-core funds of Cosponsors (in US\$)**

Organization	2012-2013 Core UBRAF	2012-2013 Other AIDS funds	Total
UNHCR	9,800,000	16,500,000	26,300,000
UNICEF	24,000,000	352,960,000	376,960,000
WFP	9,800,000	257,350,000	267,150,000
UNDP	17,200,000	546,000,000	563,200,000
UNFPA	21,000,000	97,560,000	118,560,000
UNODC	11,500,000	50,296,000	61,796,000
ILO	9,800,000	25,000,000	34,800,000
UNESCO	12,400,000	27,845,000	40,245,000
WHO	35,000,000	186,400,000	221,400,000
World Bank	14,000,000	1,799,000,000	1,813,000,000
Secretariat	320,320,000	45,000,000	365,320,000
<b>Grand Total</b>	<b>484,820,000</b>	<b>3,403,911,000</b>	<b>3,888,731,000</b>

124. Budgeted amounts included for Cosponsors' other AIDS funds are best estimates by Cosponsors taking into account their most recent level of regular budgets and voluntary fundraising. These budget estimates are subject to change as Cosponsors formulate their individual workplans, refine and approve their own budgets, and mobilize funds. All resources shown are 'HIV-specific' and do not include mainstreamed HIV funds, or funds which are supportive of HIV responses more generally, and indirectly advance work on AIDS.

125. Additional notes:

- i) The estimated other AIDS resources for UNDP include Global Fund-related HIV funds (approximately \$450 million) as well as other HIV-specific funding (approximately \$96 million).
- ii) The IDA and IBRD financing by the World Bank captured in the other funds of approximately US\$1.8 billion is HIV-specific loans and grants.
- iii) Figures included for other funds by UNICEF do not include the cost of approximately 131 full time equivalent staff at headquarters, regional offices and country offices paid for from UNICEF own resources.
- iv) The amount for WFP reflects the total food costs, including cash transfers and vouchers when applicable, plus the implementation cost. These activities fall under WFP's HIV/TB specific development, protracted relief or emergency operations.
- v) WHO support for the WHO/UNAIDS Vaccine Initiative is included in the UBRAF, but as the majority of activities by definition are of global nature, the funds will not be subject to a 30/70 split between global and regional or country level activities.
- vi) The amount for the Secretariat includes US\$30 million for activities of the Cosponsors and the Secretariat in the context of intensified action in high impact countries through UN Joint Teams and Joint Programmes of Support.

126. As noted earlier, the core UBRAF plays a key role in catalyzing and influencing a significant amount of 'Other AIDS' funds raised by Cosponsors to support country and community action on HIV. Data from WFP, UNDP and UNICEF from last year show that about 22% of their combined 'Other AIDS' funding (approximately \$106 million) was channelled through national NGOs; about 14% (\$67 million) through international NGOs; and about 28% (\$133 million) through governments. The remaining 35% was used for a variety of other purposes, in particular for purchasing commodities for HIV treatment, condoms and food assistance. See figure 8 below.

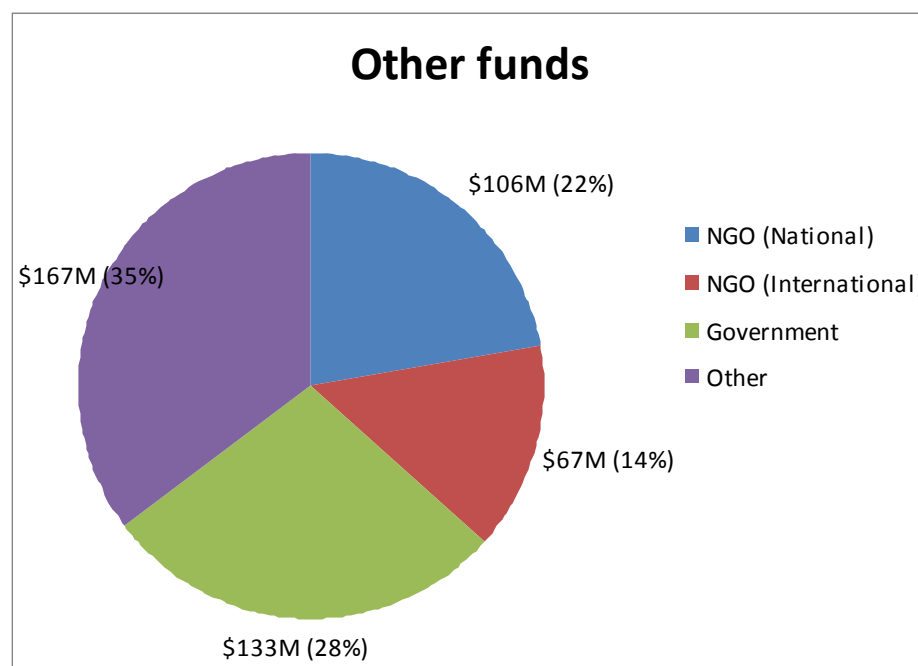


Figure 14: Breakdown of WFP, UNICEF and UNDP non-core funds in 2010 (in US\$ millions and as % of total)

#### 4. Secretariat Budget

127. The current biennium saw an increase in the core budgets of all Cosponsors. This was achieved by decreasing the budgets managed by the Secretariat and allocating the corresponding amounts to the Cosponsors. In 2012-2013, as requested by UNAIDS Board, core resources have been allocated based on epidemic priorities – where and how the greatest impact in the response to the HIV epidemic can be achieved – performance, and the funds that individual Cosponsors raise, rather than past allocations or pro-rata increases. The share of the Secretariat of the core UBRAF remains at the same level as in the current biennium.

128. While the work of the Secretariat contributes – and indeed is essential – to the successful implementation of UNAIDS Strategy and the achievement of all strategic goals, the budget of the Secretariat has, in accordance with the Division of Labor, been constructed around the strategic functions of leadership, coordination and accountability. As described earlier, the Secretariat budget can be broken into programmatic or development activities, and management functions or central support services. The breakdown of the Secretariat core budget is shown in the chart below.

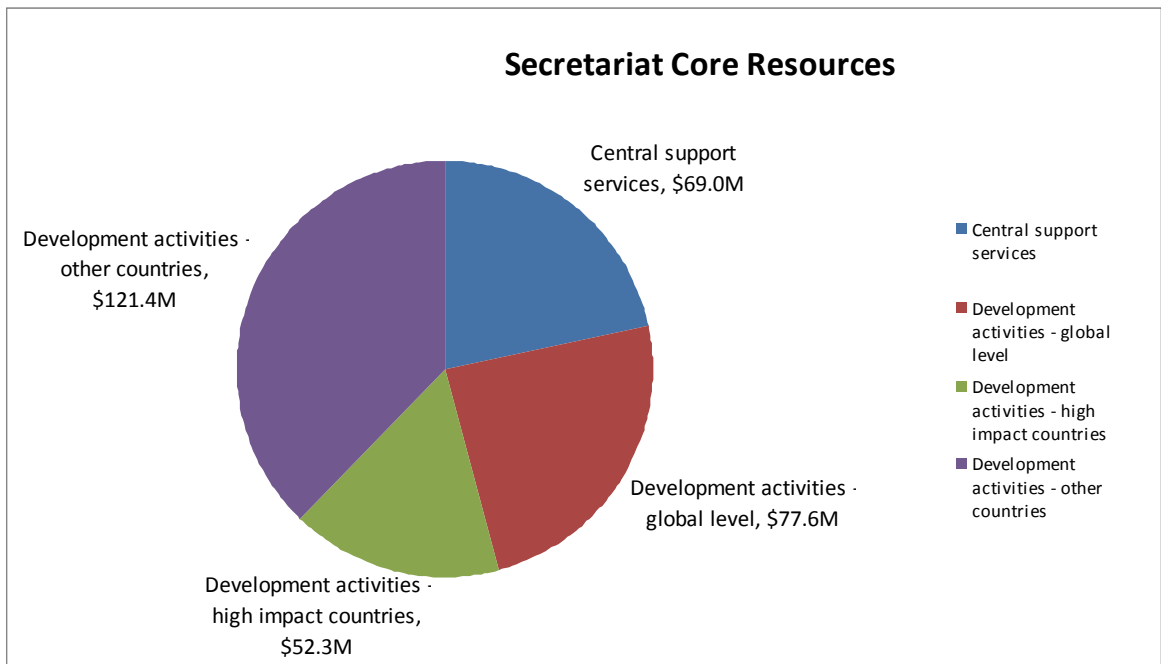


Figure 15: Breakdown of Secretariat core budget (in US\$ million)

**A detailed presentation of the budget is included in Part II of the UBRAF.**

## 5. OVERVIEW OF WORK IN REGIONS

The following pages present an overview of regional priorities and results that correspond to the 10 strategic goals of the UNAIDS Strategy. These priorities were developed through consultations within each region. They represent how the Joint Programme aims to achieve its goals in each region. Importantly, not all 10 strategic goals have been identified for each region, but rather, goals are prioritised based on the nature of the epidemic in the different regions.






### A. ASIA AND PACIFIC

#### Regional HIV epidemic and challenges

129. Most epidemics are still concentrated, with highest prevalence found in people who inject drugs, female sex workers and men who have sex with men. Typically epidemics in Asia start with HIV spreading rapidly and explosively among people who inject drugs when sharing of needles is widespread. Data show that people who inject drugs buy and sell sex and this seeds HIV among sex workers and their clients, and accelerate the spread of HIV among these larger populations. Thus responses in the Asia-Pacific region have to focus solidly on key populations, to sustain and further progress.
130. Progress on Universal Access to high impact prevention has remained slow or unstable in many countries, in particular among men who have sex with men, people who inject drugs, indirect sex workers, and clients. Policy and legal barriers at the national and local level in many countries continue to thwart the expansion of prevention services for key populations and spending on prevention for this population is inadequate. Flat-lining funding is partly due to insufficient domestic contributions from most lower and middle income countries in the region, and recent global financial developments threaten continued access to affordable drugs, the scale up of ART, prevention of vertical transmission, TB and Hepatitis B and C coverage.

Asia and the Pacific		
Bangladesh, Cambodia, China, Indonesia (Papua), India, Maldives , Mongolia, Myanmar, Nepal, Papua New Guinea, Philippines, Thailand, Viet Nam		
Strategic goal	Priority	Joint outputs
<b>A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work</b>	✓	<ol style="list-style-type: none"> <li>1. High-quality strategic information available for all affected populations (including young people most at risk) to inform programming and budgeting in all countries.</li> <li>2. Capacity within organizations and networks of key populations to engage meaningfully in decision-making at all levels and to address stigma and rights violations is strengthened.</li> <li>3. Coverage of quality HIV prevention and sexual and reproductive health services for vulnerable groups and their partners scaled up.</li> <li>4. Male and female condom programmes scaled up (including lubricants) with emphasis on key populations and affected.</li> <li>5. Capacity of the UN, government and civil society built on ways to integrate HIV prevention for young key affected populations (15-24) in national AIDS programmes.</li> </ol>



Asia and the Pacific		
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>		<ol style="list-style-type: none"> <li>1. National strategies to eliminate paediatric HIV using new prevention of vertical transmission guidelines and conceptual framework implemented with Joint UN technical assistance.</li> <li>2. Integration of HIV and MNCH, sexual reproductive health, nutrition and community services improved and collaboration strengthened.</li> <li>3. Testing, treatment and monitoring of MTCT risk increased, including better access to diagnostics and ART.</li> <li>4. MNCH sector capacity for implementation decision-making and resources mobilisation strengthened (including use of ICT).</li> <li>5. Primary prevention strengthened by expanding couples' counselling and engagement of partners of pregnant women at higher risk of HIV.</li> </ol>
<b>A.3. All new HIV infections prevented among people who use drugs</b>		<ol style="list-style-type: none"> <li>1. Evidence-informed HIV prevention, treatment and care for people who use drugs reflected in national strategies, policies and legislation in all countries.</li> <li>2. Expansion and progress on national and regional harm reduction strategies 2010-2015 monitored and assessed at mid-term..</li> <li>3. HIV prevention expanded among ATS and non-injecting drug users, including prevention and management of overdose and Hepatitis B and C.</li> <li>4. Strategic information on drug use, HIV and Hepatitis C available and used by HIV programme.</li> <li>5. Drugs and HIV interventions under different ministries or agencies harmonized and coordinated to reduce overlaps and increase synergies and efficiency.</li> </ol>
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>		<ol style="list-style-type: none"> <li>1. Treatment coverage and care in resource-constrained settings scaled-up.</li> <li>2. Treatment 2.0 rolled out in all countries in the region.</li> <li>3. Uptake of HIV testing and counselling increased and increased referral to care services ensured.</li> <li>4. Structural barriers and obstacles to HIV treatment service access identified and removed.</li> </ol>
<b>B.2. TB deaths among people living with HIV reduced by half</b>		
<b>B.3. People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</b>		<ol style="list-style-type: none"> <li>1. HIV-sensitive social protection for affected children, young-people and adults including legal rights, right to health, education and livelihoods instituted and implemented.</li> <li>2. Evidence informed social protection measures for AIDS-affected households in high-burden countries implemented.</li> <li>3. Access to social protection for HIV-affected households and funding increased with removal of barriers by governments and care and support integrated in GFATM proposals.</li> <li>4. HIV and AIDS coverage included in social insurance schemes for formal sector workers in the region..</li> </ol>
<b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>		<ol style="list-style-type: none"> <li>1. Punitive and discriminatory laws and regulations reformed and misuse of existing laws reduced in the region.</li> <li>2. TRIPS flexibility and similar approaches used effectively by countries in the region, to improve access to affordable drugs and diagnostics.</li> <li>3. Selective enforcement and misuse of existing laws and regulations reduced by engaging with law enforcement agencies.</li> <li>4. Legal reforms to punitive laws and regulations carried out as a result of advocacy by ASEAN, SAARC, PIF and human rights bodies.</li> <li>5. Legal redress and reporting mechanisms on the impact of punitive laws and regulations and human rights violations fully utilised by civil society and community groups.</li> </ol>




Asia and the Pacific		
<b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b>		
<b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>		
<b>C.4. Zero tolerance for gender-based violence</b>		
<b>Strategic Functions</b>	<b>Priority</b>	<b>Joint outputs</b>
<b>D1. Leadership and Advocacy</b>	✓	<ol style="list-style-type: none"> <li>1. Agenda and political and other leadership focus on key populations and systems strengthening for Treatment 2.0 and leadership of women affected by HIV</li> <li>2. Strategic information targeted programmatic responses strengthened and utilized in all countries in the region to improve and expand programmes</li> </ol>
<b>D2. Coordination, Coherence and Partnerships</b>	✓	<ol style="list-style-type: none"> <li>1. Effective and coherent UN system action in support of community action and leadership strengthens national responses</li> <li>2. Effective and flexible partnerships between civil society, UN system and governments enhanced and sustained to achieve UA and MDGs.</li> <li>3. Country responses guided by new national strategic plans that are appropriately targeted and prioritized, with costed operational plans.</li> <li>4. National AIDS agenda and strategic processes improved through partnerships, synergies and technical support mechanisms (including TSF).</li> <li>5. Social protection mechanisms developed in national plans to address gaps in UA for key affected populations.</li> <li>6. Technical support mechanisms in the region more effectively support appropriate national HIV responses.</li> <li>7. X number of country KAPs networks established in the region through exchange of knowledge and good practice between communities.</li> <li>8. Access and adherence to treatment improved and sustained through partnerships outside the HIV response and increased resources.</li> <li>9. Civil Society Organisations involved in health sector based services and ensuring links between health sector and community based services for ART, TB and PMTCT.</li> </ol>
<b>D3. Mutual accountability</b>	✓	<ol style="list-style-type: none"> <li>1. Mutual accountability of the UN Joint Programme in the HIV response improved in the region.</li> <li>2. Mutual accountability framework for the regional Joint Programme developed and implemented based on agreed work plan.</li> <li>3. Achievements and progress monitored and reported on by national AIDS programmes (e.g. UA and MDG processes).</li> </ol>

## B. CARIBBEAN

### Regional HIV epidemic and challenges

131. The Caribbean has the second highest HIV prevalence after sub-Saharan Africa with about 1% of the adult population infected. Adult prevalence varies between countries from 0.1% in Cuba to 3% in the Bahamas, Haiti and the Dominican Republic account for close to 70% of PLHIV in the Caribbean. The HIV epidemic is diverse in terms of its magnitude and its intensity between countries, within countries, and between population groups. It affects all Caribbean people but continues to disproportionately affect key populations. Women and girls are increasingly vulnerable to HIV infection due to prevalent gender inequalities. The dimension of the epidemic among the Caribbean transgender population remains unknown.
132. The region is confronted with a number of challenges which include limited use of strategic information for planning especially among key populations, lack of access to HIV services by key populations, human rights issues including stigma and discrimination that limit access to health care services, lack of addressing gender issues and the ongoing vulnerability of the region to natural disasters. The sustainability of AIDS programmes is also a challenge given that a high percentage of HIV expenditure is externally funded. The region is now seeing external funding to support the HIV response fall at a time when Caribbean governments are facing severe fiscal challenges.

Caribbean		
Barbados and Eastern Caribbean States, Bahamas, Belize, Cuba, Dominican Republic, Guyana, Haiti, Jamaica, Surinam, Trinidad and Tobago		
Strategic goal	Priority	Joint outputs
<b>A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work</b>	✓	<ol style="list-style-type: none"> <li>HIV surveillance systems strengthened, with Modes of Transmission studies completed and data available on HIV among men who have sex with men and other vulnerable groups in 10 countries.</li> <li>HIV prevention programmes for men who have sex with men developed and implemented in 10 countries, at local levels, and at regional level.</li> <li>Evidence-informed policies, school- and non-school-based programmes and services scaled up, and commodities supplied in 12 countries.</li> <li>HIV prevention programmes for male and female sex workers in place in 10 countries in the region by 2015.</li> <li>HIV prevention programmes for prison settings and people who use drugs developed and implemented in 10 countries.</li> <li>HIV prevention in the workplace implemented in government and the private sector in at least 6 OECS countries.</li> </ol>
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>	✓	<ol style="list-style-type: none"> <li>Strategy and operational plan to implement the MTCT Elimination Initiative developed and implemented by 2015.</li> <li>Capacity of staff in Mother and Child Health (MCH) and newborn services built in the early detection, care and treatment of HIV and syphilis in pregnant women, their partners and children.</li> <li>Capacity of staff in Mother and Neonate Child Health (MNCH) built to provide quality services to HIV-exposed infants, including early diagnosis as per protocol; Capacity built in the community to provide care and support to children affected.</li> <li>Regional mechanism for certification of, or registration established and functioning with regional reporting system and database for MTCT of HIV and other STIs by 2013.</li> <li>Capacity built to develop, implement and maintain effective M&amp;E systems with core dataset defined for MTCT of HIV, syphilis and other STIs.</li> </ol>

Caribbean		
<b>A.3. All new HIV infections prevented among people who use drugs</b>		
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>		<ol style="list-style-type: none"> <li>1. Comprehensive plans to scale up care and treatment incorporated in national plans and implemented in all countries by 2015.</li> <li>2. Financial sustainability plans in place in all countries by 2013 (including drug price negotiation strategies and capacity building on the use of TRIPS flexibilities).</li> <li>3. Health sector and civil society capacity strengthened to scale up testing and counselling linked to care and treatment, emphasizing most vulnerable and at risk populations.</li> <li>4. Capacity built in national HIV programme services and staff to provide positive prevention for PLHIV, including adherence to treatment.</li> </ol>
<b>B.2. TB deaths among people living with HIV reduced by half</b>		
<b>B.3. People living with HIV and households affected by HIV addressed in all social protection strategies and have access to essential care and support</b>		
<b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>		<ol style="list-style-type: none"> <li>1. Punitive laws that address issues related to adolescents, homosexuality, sexual orientation, sex work, drug use and HIV status analysed to inform law and policy reform in all countries</li> <li>2. High level advocacy plans developed and implemented in 6 countries and at regional level.</li> <li>3. Communication strategy to foster social change and discussion implemented in 11 countries and at regional level by 2015.</li> <li>4. Social change in support of non-discriminatory policy and legal environment spearheaded by civil society organizations of employers and workers, PLHIV, faith-based community and other key stakeholders.</li> <li>5. Access to human rights desks and legal aid services ensured and promoted for vulnerable groups, such as migrants, people affected by displacement and emergencies in at least 6 countries</li> </ol>
<b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b>		
<b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>		<ol style="list-style-type: none"> <li>1. Evidence-informed interventions, addressing women and girls' vulnerability to HIV implemented, especially in the workplace in at least 6 countries.</li> <li>2. Capacity strengthened in existing civil society mechanisms in at least 6 countries, including family planning associations and employers' and workers' organizations to address HIV among women and girls.</li> <li>3. Gender-Based Violence, HIV and SRH services integrated into Ministries of Health, gender affairs services and PANCAP.</li> <li>4. Access to HIV prevention, care and treatment for women and girls increased in at least 6 countries by addressing bottlenecks and obstacles identified through operational research.</li> <li>5. HIV prevention for women and girls in conflict, post conflict, and displacement setting implemented in at least 6 countries.</li> </ol>

Caribbean		
<b>C.4. Zero tolerance for gender-based violence</b>		
<b>Strategic Functions</b>	<b>Priority</b>	<b>Joint outputs</b>
<b>D1. Leadership and Advocacy</b>	✓	<ol style="list-style-type: none"> <li>1. HIV response in the region strengthened by including sensitive issues on the HIV agenda and creating enabling environments for the response (e.g. Caribbean Advisory Group, Prevention Revolution Group, etc.)</li> <li>2. Regional HIV strategic information produced for different audience to make informed decisions on the HIV response.</li> <li>3. Two regional and 4 national dialogues on HIV financing with countries and studies on sustainable financing conducted in 5 countries.</li> <li>4. Six countries undertake modes of transmission studies by 2013.</li> <li>5. All countries supported to integrate HIV into broader health and development processes by 2013.</li> <li>6. Countries supported to develop evidence-based costed strategic and operational plans and to conduct reviews by 2014.</li> <li>7. Technical support on communication and strategic information provided to PANCAP to coordinate the AIDS response.</li> </ol>
<b>D2. Coordination, Coherence and Partnerships</b>	✓	<ol style="list-style-type: none"> <li>1. Joint UN teams on AIDS provided with technical support and training in all countries to implement Joint UN programmes of support aligned to NSPs in all countries by 2014</li> <li>2. Regional Caribbean cosponsor group strengthened to implement a coordinated plan addressing priority objectives for implementation.</li> <li>3. Network of "new" women and youth leaders developed to deliver on priority targets by 2013.</li> <li>4. Technical groups harmonized to reduce duplication and inefficiency and develop operational plans to address priority goals.</li> </ol>
<b>D3. Mutual accountability</b>	✓	<ol style="list-style-type: none"> <li>1. New Division of Labor adapted and implemented at regional and country levels by 2015.</li> <li>2. Regional and country level commitment tracked to improve delivery of results.</li> <li>3. All countries in the region supported to carry out annual reviews of Joint Programmes of Support.</li> <li>4. Greater programme effectiveness of UCOs documented in programme performance and result-based work planning and reporting (using the UCO programme assessment)</li> </ol>

## C. EASTERN AND SOUTHERN AFRICA

### Regional HIV epidemic and challenges


133. The Eastern and Southern Africa region is the epicentre of the global HIV epidemic, accounting for 48% of the global HIV burden (5.4% of the global population). HIV prevalence among adults is above 10% in nine of the 20 countries in the region and exceeds 15% in four of them. Every day, 3,200 people are newly infected and 2,400 die of AIDS.

134. Southern Africa was home to 34% of people living with HIV in 2009 and 40% of all adult women with HIV. 31% of new HIV infections and 34% of all AIDS-related deaths occurred in these 10 countries. While the burden of HIV infections and AIDS-related deaths remain high, they are declining. HIV prevalence among young people fell by at least 25% in recent years (in 9 of the 20 countries) and AIDS-related deaths fell by 20% between 2003 and 2009.

135. The primary mode of HIV transmission in the region remains heterosexual transmission with extensive mother-to-child transmission. Recent evidence however show new infections in some countries occurring among men who have sex with men and people who inject drugs as well as high HIV prevalence among sex workers and their clients.
136. Progress in scaling up ART has resulted in achieving treatment coverage of 41% in 2009 compared to 36% global average for the low and middle income countries (based on the 2010 WHO guidelines). In 2009, 3.2 million people in need of ART in the region were initiated on treatment, a more than 12-fold increase in 5 years and 33% increase in 2009 alone. While progress is significant, it remains fragile.
137. In spite of signs of stabilization and even decline, the HIV epidemic continues to outpace the response in Eastern and Southern Africa. For every two people initiated on treatment, an estimated three become newly infected. HIV continues to weigh heavily on maternal and child mortality in some countries. Only four countries in the region<sup>4</sup> have reached the target of providing 80% of pregnant women in need with ART to reduce mother-to-child transmission of HIV. The HIV epidemic in the region is flanked by an equally ferocious TB epidemic but most HIV/TB co-infected people are not receiving ARV treatment in high burden countries.
138. Significant challenges to the AIDS response and efforts to expand access to life-saving HIV prevention, treatment, care and support include HIV-related stigma and discrimination and criminalization of key populations, namely men who have sex with men and sex workers. Few countries in the region significantly cover AIDS spending from domestic resources and a majority remain heavily dependent on external assistance for their AIDS responses. Over-dependence on external donors and underinvestment of domestic resources undermine the sustainability of the AIDS response.

Eastern and Southern Africa		
Angola, Botswana, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe		
Strategic goal	Priority	Joint outputs
A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work	✓	<ol style="list-style-type: none"> <li>1. Data and evidence on HIV prevention combination strategies generated and used for discordant couples, youth, key populations in selected geographic areas (including mobile populations, sex workers, men who have sex with men and people who inject drugs) and the general population.</li> <li>2. Coverage of evidence-informed, combination HIV prevention programmes strengthened.</li> <li>3. Lessons learnt, best practice and timely information related to prevention of sexual transmission of HIV among targeted audiences (<i>stated above</i>) available and used by national partners to coordinate, implement and evaluate programmes.</li> <li>4. Data and evidence on supportive laws, policies, programmes and resources to prevent sexual transmission of HIV, including in prisons, hotspots and humanitarian settings used more effectively by countries.</li> <li>5. HIV prevention scaled up by improving effective integration of SRH and HIV services in all countries.</li> </ol>


<sup>4</sup> Botswana, Namibia, Swaziland and South Africa

Eastern and Southern Africa		
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>		<ol style="list-style-type: none"> <li>1. All HIV positive pregnant women and their infants receive effective combination ARV prophylaxis.</li> <li>2. All HIV positive pregnant women eligible for treatment provided with antiretroviral therapy and their HIV-exposed children followed-up and provided with care including infant feeding counselling and support.</li> <li>3. Comprehensive package of family planning services available to all women.</li> <li>4. Basic package of SRH and HIV services available for all women of reproductive age including HIV positive women.</li> </ol>
<b>A.3. All new HIV infections prevented among people who use drugs</b>		<ol style="list-style-type: none"> <li>1. Regulations and policies supporting harm reduction in the context of injecting drug use and non-injecting stimulant use implemented in 6-8 countries, including in prisons.</li> <li>2. Comprehensive package for HIV prevention among people who inject drugs<sup>5</sup>, adopted and implemented by 6 countries in the region including in prisons as required.</li> <li>3. Needle and syringe programmes reach 40% of people who inject drugs, opioid substitution therapy covers 10% of people who use drugs and those living with HIV receive antiretroviral therapy.</li> <li>4. Information and skills to promote healthy life choices and prevent both drug use and HIV among young people mainstreamed in the education sector in 6-8 countries.</li> <li>5. Coverage of harm reduction programmes improved in 6-8 countries by addressing the needs of young people who inject drugs and/or are living with HIV as a result of drug use.</li> <li>6. HIV prevention programmes for people who use drugs, including in prison settings expanded across the region</li> </ol>
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>		<ol style="list-style-type: none"> <li>1. Antiretroviral therapy provided to all people living with HIV in need of treatment.</li> <li>2. Comprehensive HIV treatment policies and guidelines updated, adapted for the region and implement based on evidence and the most up to date WHO guidance.</li> <li>3. Quality HIV treatment programmes in the public and private sectors implemented incorporating national patient monitoring, pharmaco-vigilance, HIV drug resistance monitoring and prevention, nutritional status monitoring and regular programme reviews.</li> <li>4. Decentralized comprehensive high quality HIV care and treatment services provided down to the primary health care level, including provider-initiated HIV testing and counselling and nutritional support, all linked to TB, prevention of vertical transmission, SRH and other preventive and care services in the public, private, NGO and FBO sectors.</li> <li>5. Increased availability and affordability of ART through appropriate use of TRIPS flexibilities, south-south technical cooperation, resource mobilization and capacity building, in close collaboration with regional institutions.</li> </ol>
<b>B.2. TB deaths among people living with HIV reduced by half</b>		<ol style="list-style-type: none"> <li>1. Antiretroviral therapy provided to all TB patients co-infected with HIV in the public (including prisons) and private health sector regardless of CD4 count.</li> <li>2. TB screening provided in the in the public (including prisons) and private sectors, for all people living with HIV; Isoniazid preventive therapy provided to those without active TB.</li> <li>3. Integrated and comprehensive quality treatment and care services provided to PLHIV and TB patients, including those in prisons.</li> <li>4. Nutritional and food support services integrate into treatment programmes for vulnerable TB patients, including those living with HIV in all countries.</li> </ol>

<sup>5</sup> The comprehensive package refers to The 2009 WHO, UNODC and UNAIDS technical guide for countries which outlines nine key interventions against which countries should set targets for universal access to HIV prevention, treatment and care for people who inject drugs.

Eastern and Southern Africa		
<b>B.3. People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</b>	✓	<ol style="list-style-type: none"> <li>1. HIV sensitive, child-sensitive and coherent social protection systems and policies informed by evidence and implemented.</li> <li>2. National strategies effectively include provision for better targeted social safety net programmes for PLHIV and enhance access to prevention, treatment, care and support.</li> <li>3. Effective national social protection legislation, policies, plans and programmes that ensure greater HIV sensitivity in place in all countries of the region.</li> </ol>
<b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>	✓	<ol style="list-style-type: none"> <li>1. Punitive and discriminatory laws, policies and practices assessed, reviewed and reformed, to facilitate access to HIV prevention, treatment, care and support.</li> <li>2. Access to justice improved and stigma and discrimination reduced (<i>by building civil society and private sector's capacity to protect and promote rights-based approaches to HIV, and address HIV-related stigma and discrimination among key populations.</i>)</li> <li>3. Stigma and discrimination reduced in the public and private sector (<i>by training service providers on HIV and human rights of key populations (PLHIV, men who have sex with men, sex workers, people who use drugs, women and children).</i>)</li> <li>4. Rights-based approach to HIV integrated in national HIV and AIDS policies and development plans, global fund and other proposals by all countries.</li> <li>5. HIV laws that protect human rights in the context of HIV and AIDS formulated and enforced by labour court judges and human rights bodies in half the countries in the region.</li> </ol>
<b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b>		
<b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>	✓	<ol style="list-style-type: none"> <li>1. Gender considerations, SRH and HIV integrated and incorporated in key legal, policy and institutional frameworks in all countries.</li> <li>2. Comprehensive, good quality, sexual and reproductive health information and services provided for women and girls (including those made more vulnerable by displacement as a result of humanitarian crises and confinement in prisons).</li> <li>3. Disaggregated data and evidence on the specific needs of women and girls in the context of HIV interventions generated, analyzed and utilized in all countries.</li> <li>4. Comprehensive, multi-sectoral programmes addressing Gender-Based Violence and mitigating its impact developed and implemented.</li> <li>5. Gender-responsive programming improved by mobilising men and boys.</li> </ol>
<b>C.4. Zero tolerance for gender-based violence</b>	✓	Goal 9 Outputs are also linked to Goal 10.
<b>Strategic functions</b>	<b>Priority</b>	<b>Joint outputs</b>
<b>D1. Leadership and Advocacy</b>	✓	<ol style="list-style-type: none"> <li>1. Countries in the region undertake the Modes of Transmission and Know Your Epidemic/Response studies and use them for strategic planning.</li> <li>2. All countries in the region carry out and institutionalize National AIDS Spending Assessments (NASAs).</li> </ol>
<b>D2. Coordination, Coherence and Partnerships</b>	✓	<ol style="list-style-type: none"> <li>1. Countries' HIV responses are outlined in evidence-informed, prioritized and costed national strategic and operational plans.</li> </ol>



Eastern and Southern Africa		
<b>D3. Mutual accountability</b>		<ol style="list-style-type: none"> <li>1. Countries to mobilize resources from key bilateral and multilateral institutions (such as the Global Fund).</li> <li>2. Countries address the growing importance of work around HIV financing sustainability.</li> </ol>


## D. LATIN AMERICA

### Regional HIV epidemic and challenges

139. At first glance, statistics show that the AIDS epidemic in Latin America is under control. The prevalence of HIV throughout the region is stable at a relatively low 0.4%. Most people living with HIV seem to be able to get the treatment they need: 51% according to the latest WHO/UNAIDS data. Universal access to treatment (80% of all people in need receiving it) is almost a reality in Brazil, Chile, Costa Rica, Mexico and Uruguay as reported by the National AIDS programmes. In 2009 Costa Rica reported zero cases of mother-to-child transmission.
140. But there is a dire disparity in these numbers. HIV prevalence among men who have sex with men, male sex workers and transgendered people is as high as 20.3%, 19.3% and 34% respectively in some countries. Although treatment appears to be widely available, it is not reaching key populations. Stigma and discrimination, hate crimes, gender-based violence, persistent homo/lesbo/trans-phobia fuel the Latin American epidemic and often result in avoidable deaths and disabilities.
141. While the epidemic seems stable, modes of HIV transmission are changing. In Peru, heterosexual transmission accounts for 43% of new infections, modifying the ratio of infections between men and women.
142. The political will to confront HIV and move towards universal access has been shown in many instances: investments in the HIV response are mainly funded by domestic resources (95% - both public and private). However most resources are allocated to treatment, not prevention and few resources are directed to most vulnerable and key populations.
143. Until every Latin American is able to access services without fearing reprisal or violence, access in the region will not be universal. The status of women and girls must be improved, prevention programmes must target key populations, including youth within these groups, and human rights of all, must be protected. These and other social determinants of the AIDS epidemic cannot be overlooked.

Latin America		
Argentina, Bolivia, Brazil, Costa Rica, Chile, Colombia, El Salvador, Ecuador, Guatemala, Honduras, México, Nicaragua, Panamá, Paraguay Perú, Uruguay, Venezuela		
Strategic goal	Priority	Joint outputs
<b>A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work</b>	✓	<ol style="list-style-type: none"> <li>1. HIV prevention and sexual/reproductive health policies, programmes and services for young people developed, implemented, monitored and evaluated for diverse settings, including emergencies and workplaces in at least 10 countries by 2013.</li> <li>2. Capacity of national partners for research, design and implementation of effective HIV prevention strengthened, including in emergencies, conflict, and displacement settings</li> <li>3. Comprehensive sexuality education and HIV prevention programmes in school and vocational education settings designed, adapted, implemented, monitored and evaluated in at least 8 countries.</li> <li>4. Comprehensive municipal-level HIV programmes in place for men who have sex with men, sex workers, and transgender people in at least 12 countries by the end of 2013 (including municipal/ regional organizations/ networks of men who have sex with men, sex workers (and their clients), and transgender people).</li> <li>5. Capacity built in health services, NGOs and CBOs in 10 countries to design, implement, monitor and evaluate emerging HIV/STI prevention and sexual/reproductive health policies, programmes and services by the end of 2013.</li> </ol>
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>	✓	<ol style="list-style-type: none"> <li>1. Prevention of vertical transmission/ syphilis elimination and antenatal coverage and follow-up of HIV positive mothers and children expanded in at least 10 countries by the end of 2013 (by effectively integrating MCH/HIV service into country policies and programme strategies).</li> <li>2. Capacity of staff in the health sector built for early diagnosis of HIV-exposed children and of community members to provide care and support for these children.</li> <li>3. Referral systems and networks at hospital and community levels implemented to ensure appropriate management of HIV+ pregnant women.</li> <li>4. Progress on the reduction of MTCT and syphilis elimination monitored and reported on in all countries.</li> </ol>
<b>A.3. All new HIV infections prevented among people who use drugs</b>	✓	<ol style="list-style-type: none"> <li>1. HIV prevalence, behavioural risks, social determinants and service uptake by injecting/non-injecting drug users and prisoners monitored and used for strategic and programme planning in at least 10 countries of the region by 2014.</li> <li>2. LAC observatory on HIV and prisons fully operational across the region by 2014.</li> <li>3. Capacity built on comprehensive HIV prevention, treatment/care and support in injecting/non-injecting drug treatment centres and prisons in 10 countries by 2013.</li> <li>4. Strategy and tools for advocacy developed and utilised; capacity built on human rights-based and gender-sensitive drug policies and penitentiary health policies.</li> <li>5. Country strategies for harm and demand reduction integrated into national HIV strategies and plans and rolled out by 2015.</li> </ol>
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>	✓	<ol style="list-style-type: none"> <li>1. Access to HIV testing for vulnerable groups and number of status-aware HIV+ individuals increased by implementing Inter-sectoral strategies to reach vulnerable populations in prisons, mobile populations and internally displaced persons.</li> <li>2. Access to treatment ensured and rights of PLHIV protected (including prisoners, migrants, highly mobile workers and internally displaced persons).</li> <li>3. Increased and sustainable access to treatment ensured for PLHIV</li> <li>4. TRIPS flexibility used by countries to lower the price of drugs and diagnostics.</li> <li>5. Treatment 2.0 approach rolled out in 10 priority countries.</li> </ol>
<b>B.2. TB deaths among people living with HIV reduced by half</b>		
<b>B.3. People living with HIV and households affected by HIV addressed in all social protection strategies and have access to</b>	✓	<ol style="list-style-type: none"> <li>1. Social protection policies in health, employment, education and legal sectors reviewed in at least six countries and amended to include appropriate provisions for people living with and affected by HIV.</li> <li>2. HIV-sensitive social protection advocated for AIDS-affected adults and children, forcibly displaced groups and those affected by humanitarian crises and emergencies.</li> <li>3. Access to health, education, nutrition, work and legal protection ensured for AIDS affected adults and children, forcibly displaced groups and those affected by</li> </ol>


Latin America		
<b>essential care and support</b>		humanitarian emergencies 4. Impact of HIV on households and social protection measures available to AIDS-affected households assessed in at least five countries to improve relevance and application of social protection activities
<b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>	✓	1. Legislation and policies addressing stigma and discrimination reviewed and adapted in 3-4 countries. 2. Non-discriminatory/punitive HIV policies and/or programmes in place in 5-6 Latin America countries. 3. Access to legal services for vulnerable groups promoted or reinforced in 5-6 countries. 4. Programmes addressing the specific legal needs of key populations increased in 5-6 countries. 5. Gender violence, harassment, gender equality and MDGs/human development policies implemented in 10 countries.
<b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b>		
<b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>	✓	1. Implementation of existing public policies and accomplishment policies/programmes addressing the needs and rights of women and girls assessed every year, in 1-2 countries. 2. National capacities to prevent and respond to, gender-based violence to women and girls strengthened in at least 3-4 countries. 3. Promotion of combination prevention approaches specifically targeting women and girls supported in 5 countries (including promotion and access to female condoms). 4. Efficient, friendly and free of charge mechanisms in place to provide access to justice for women and girls in 1-2 countries, per year. 5. Increased access to comprehensive, evidence-based youth friendly, and culturally appropriate sexual and reproductive health services for women in 2-3 countries. 6. HIV and AIDS -related needs of women and girls in forced displacement and humanitarian crisis situations addressed by 2-3 countries.
<b>C.4. Zero tolerance for gender-based violence</b>		
<b>Strategic functions</b>	<b>Priority</b>	<b>Key Joint Programme outputs</b>
<b>D1. Leadership and Advocacy</b>	✓	1. Capacity leadership and visibility enhanced for increased participation of most affected populations, civil society and governments in the AIDS response, based on the GIPA principle. 2. Increased synergies and efficiencies in UN support to national responses in the region, through improved UN Joint Programming on AIDS, an effective Division of Labor, and UNAIDS leadership.
<b>D2. Coordination, Coherence and Partnerships</b>	✓	1. Performance on implementing bilateral and multilateral grants to scale up UA to HIV prevention, treatment, care and support increased at country and regional level. 2. Coordinated technical support to the region contributes to improved performance on programme implementation and grant utilisation.






Latin America		
D3. Mutual accountability		1. Accountability mechanisms for UNAIDS Cosponsors and Secretariat in the region established.





## E. MIDDLE EAST AND NORTH AFRICA

### Regional HIV epidemic and challenges

144. Over 460,000 people are estimated to be living with HIV in the Middle East and North Africa (MENA). Based on the 2010 Global Report on AIDS Epidemic, the MENA region has the steepest rise in new infections worldwide. Since 2005, newly available strategic information indicates that several countries in the region including Egypt, Morocco and Tunisia demonstrate signs of concentrated epidemics. This is in addition to epidemics already established in Djibouti, Iran, Libya, Somalia and Sudan.
145. While access to treatment has improved, the coverage remains unacceptably low (14% based on previous WHO guidelines, and 6% based on the guidelines requesting initiation of treatment at a CD4 count of 350). The impact of stigma and discrimination in dissuading people from seeking testing and care appears to be the major obstacle to treatment access in the region. UNAIDS is instrumental in addressing political reticence to expand coverage and to achieve better linkages between prevention, treatment, care and support for all population groups.
146. Since the beginning of 2011, the MENA region has been going through profound political, social and structural changes, which imply a review of priorities at country and regional level. As a consequence, governments and the Joint Programme may have to adjust their interventions and their priority areas in the short- and medium term to meet with new national requirements, which may affect the implementation of HIV activities. UNAIDS investment for the next 2-4 years will therefore be critical to prevent and minimise any potential vacuum of HIV resources.

MENA		
Algeria, Bahrain, Djibouti, Egypt, Iraq, Iran, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, Yemen		
Strategic goal	Priority	Joint outputs
A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work		<ol style="list-style-type: none"> <li>1. Strategic information in MENA informs planning and targeted prevention for MSM, partners of IDU, young people and in the context of sex work in 5 priority countries. Prevention services packages for key populations and coverage increased by 25% in 6 countries.</li> <li>2. Policies and guidance developed to support all stakeholders in the implementation of HIV programmes in at least 10 countries.</li> <li>3. Demand for, availability of, and access to quality services (SRH/HIV) and commodities for young people, especially for key populations, increased by 15% in 9 countries</li> <li>4. Comprehensive HIV education provided to young people in and out of school in 9 countries.</li> </ol>

MENA		
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>		<ol style="list-style-type: none"> <li>1. Global framework on elimination of new paediatric HIV infections adapted and endorsed by MENA countries by 2012(emphasizing all prevention of vertical transmission 4 prongs).</li> <li>2. Availability and uptake of quality services for PMTCT increased by 25% in seven most affected countries.</li> <li>3. Integration of HIV services with sexual and reproductive health services strengthened.</li> <li>4. Integration of HIV services with sexual and reproductive health services implemented in eight countries</li> </ol>
<b>A.3. All new HIV infections prevented among people who use drugs</b>		<ol style="list-style-type: none"> <li>1. Laws and/or regulations and/or policies in place that protect the human rights of people who use drugs and support their involvement in HIV programmes in 10 countries.</li> <li>2. Comprehensive package of services, including harm reduction, for people who inject drugs adapted to the regional context and implemented in five countries (with tailored provisions for women who use drugs)</li> </ol>
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>		<ol style="list-style-type: none"> <li>1. Access to and utilisation of voluntary HIV testing and counselling services as an entry point for HIV prevention and care increased by 100 percent of current level for different groups in the 7 most affected countries by 2015.</li> <li>2. Access to affordable HIV-related commodities including ARV and diagnostics improved in at least 3 of the countries most affected.</li> <li>3. Uninterrupted quality HIV treatment and care services at all levels of the health system in all settings increased by 100% in the 7 countries most affected, by 2015</li> <li>4. Social protection policies and systems against stigmatisation and discrimination against PLHIV adopted to facilitate access to treatment and prevention in 3 countries.</li> </ol>
<b>B.2. TB deaths among people living with HIV reduced by half</b>		
<b>B.3. PLHIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</b>		
<b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>		<ol style="list-style-type: none"> <li>1. Laws, policies and practices of 10 countries are protective of the Rights of PLHIV, including in the workplace, key populations, and other groups.</li> <li>2. HIV-related access to justice and legal services is expanded for PLHIV and groups at higher risk in 5 countries.</li> <li>3. Strengthened Capacities of religious leaders, media, healthcare workers and employers are reducing stigma and discrimination in 4 countries</li> </ol>
<b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b>		<ol style="list-style-type: none"> <li>1. HIV related restrictions on entry, stay and residence of PLHIV are removed and mandatory HIV testing replaced by voluntary confidential testing in 3 countries of the region imposing such restrictions</li> </ol>

MENA		
<b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>		<ol style="list-style-type: none"> <li>1. Evidence on the specific needs and vulnerabilities of women and girls in the context of HIV collected/generated and analyzed and reflected in HIV national strategic plans (both qualitative and quantitative) in five countries.</li> <li>2. Key actions from the Agenda for Women and Girls incorporated in NSPs on HIV and other relevant plans and policies in 10 countries.</li> <li>3. Awareness raised and action taken to eliminate violence against women and girls in the context of HIV with the effective engagement of men and boys in promoting gender equality in 5 countries.</li> <li>4. Social protection policies revised and strengthened to ensure that they are responsive to the needs of women and girls in the context of HIV (and humanitarian situations) in two countries of the region.</li> </ol>
<b>C.4. Zero tolerance for gender-based violence</b>		<i>See output C3.3</i>
Strategic Functions	Priority	Joint outputs
<b>D1. Leadership and Advocacy</b>		<ol style="list-style-type: none"> <li>1. Political leadership and commitment generated in half of the countries in the region lead to an increase of domestic resources on AIDS.</li> <li>2. Strategic information and intelligence on countries influences high-level decision-making and prioritisation of work for all countries and at regional level.</li> <li>3. Strategic plans in place and programmes implemented in 15 countries.</li> <li>4. Integration of HIV programmes and services with other health and development programmes advocated for and supported in 2 countries.</li> <li>5. Access to justice increased, and stigma and discrimination reduced, through region-wide advocacy campaign and partnerships.</li> <li>6. Agenda for Women and Girls is fully supported and implemented in half of the national AIDS responses in MENA by 2015.</li> </ol>
<b>D2. Coordination, Coherence and Partnerships</b>		<ol style="list-style-type: none"> <li>1. National capacity, systems and institutions strengthened in at least 10 countries to address the new phase of prevention, treatment and care programmes. Key populations at higher risk of infection and PLHIV are involved in the design and decision making processes of regional and national AIDS strategies such as CCM in half of the countries.</li> <li>2. Funding channelled to civil society HIV service delivery providers and for community systems strengthening through GFATM and other funding streams is increased in at least five countries.</li> <li>3. A minimum of four countries increase the effectiveness and efficiency of existing grants and mobilise required resources for a sustainable AIDS response.</li> </ol>
<b>D3. Mutual accountability</b>		<ol style="list-style-type: none"> <li>1. Systems and tools developed at global level are implemented and achieve greater programme effectiveness of the Secretariat in the areas of programme performance, results-based work planning and reporting and resources deployment in half of the countries and at regional level.</li> <li>2. New UNAIDS Division of Labour for implementing the Strategy systematically operationalised and monitored at regional level and in countries with more than three agencies with HIV/AIDS capacities at country level.</li> <li>3. Systematic reviews of Joint Programmes of Support on AIDS conducted.</li> <li>4. Innovative systems and tools established to collect, manage and disseminate evidence on key areas of the epidemic and the response to inform decision making at country and regional levels.</li> <li>5. Strategic analyses produced to inform programme improvement with a special view on increased effectiveness, efficiency and sustainability in the AIDS response.</li> </ol>

## F. WEST AND CENTRAL AFRICA

### Regional HIV epidemic and challenges

147. West and Central Africa has been heavily affected by HIV and AIDS. Most countries in the region have generalized epidemics, with adult HIV prevalence exceeding 1%. Three countries reported HIV prevalence equal to or exceeding the continental average for sub-Saharan Africa (5.0%)<sup>6</sup>, national prevalence in WCA remains considerably lower than in Eastern and Southern Africa. Recent epidemic trends show signs of progress, as new infections have either stabilized or begun to decline in most countries in the region. Between 2001 and 2009, HIV incidence fell by more than 25% in 10 countries in the region and stabilized in seven countries<sup>7</sup>.
148. However, women, girls and young people continue to be disproportionately affected by the epidemic. Women account for 58% of people living with HIV in Ghana and for 69% in Chad and HIV infections are especially high among adolescent girls and young women.
149. While evidence on HIV prevalence in key marginalized populations is still limited, studies indicate that sex workers, people who inject drugs and men who have sex with men experience levels of HIV infection several times higher than the general population. UNAIDS commissioned modes-of-transmission analyses in Nigeria and Senegal, which found that men who have sex with men account for a considerable share of new infections.
150. As in other parts of the world, young people continue to be heavily affected by the epidemic. In many countries in West and Central Africa, early sexual debut contributes to the spread of HIV. In Nigeria, for example, 49.7% of females report sexual debut before age 15. In Mali, young girls are more than four times more likely to have early sexual debut than young men.
151. National AIDS strategies and coordinating mechanisms are in place to guide and strengthen country responses to HIV in the West and Central Africa region. Universal access has been embraced resulting in the development of country-specific targets for service coverage.
152. While knowledge of HIV status has increased in many countries, they are still substantially lower than in higher-prevalence countries of Eastern and Southern Africa. The coverage of services to prevent mother-to-child transmission (23% in 2009) remains inadequate more than a decade after the emergence of effective tools to reduce the risk of HIV infection in newborns. Prevention efforts among key populations need to be intensified.
153. Overall treatment coverage increased by 33%, resulting in 25% in 2009; treatment for children however is still significantly lower (12%) than for adults (27%), highlighting the urgent need to improve early diagnosis of HIV infection in children and deliver appropriate care. Late diagnosis of HIV infection, interruptions in drug supplies and discontinuity of care have contributed to sub-optimal medical outcomes, underscoring the need for action to improve service quality. Treatment

<sup>6</sup> Cameroon (5.3%), Equatorial Guinea (5.0%), and Gabon (5.2%).

<sup>7</sup> HIV incidence fell in Burkina Faso, Central African Republic, Congo, Côte d'Ivoire, Gabon, Guinea, Guinea-Bissau, Mali, Sierra Leone and Togo and stabilised in Benin, Cameroon, DRC, Ghana, Niger, Nigeria and Senegal.

coverage for individuals co-infected with HIV and TB has increased but service for co-infected patients remains extremely low in many countries. Access to nutritional support and comprehensive care and treatment for HIV-related opportunistic infections will also require additional efforts.

154. Funding for the AIDS response remains inadequate in the region. While many countries remain highly dependent on international assistance, some countries have demonstrated leadership in mobilizing new domestic resources for AIDS.

West and Central Africa		
Benin, Burkina-Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of Congo, Gabon, Ghana, Liberia, Mali, Nigeria, Senegal, Sierra Leone, Togo		
Strategic goal	Priority	Joint outputs
<b>A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work</b>	✓	<ol style="list-style-type: none"> <li>1. HIV prevention and reproductive health services targeting vulnerable and key populations scaled up.</li> <li>2. Governments' commitment and support and CSOs and youth leadership involvement in HIV prevention among vulnerable and key populations increased.</li> <li>3. National monitoring, evaluation, reporting systems provide regular monitoring and evaluation data to inform HIV programming and monitor progress towards Universal Access.</li> <li>4. Rapid assessments on HIV risk and vulnerability carried out in all countries experiencing humanitarian crises and used in HIV programmes.</li> <li>5. Prevention and treatment of STI and HIV improved in all programmes/ services working with men who have sex with men, people who inject drugs, and transgender settings disseminated and used.</li> </ol>
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>	✓	<ol style="list-style-type: none"> <li>1. Comprehensive programmes to eliminate of mother-to-child transmission scaled up in all countries.</li> <li>2. Quality management information system in place and used to monitor programme implementation.</li> <li>3. Procurement and supply management system for prevention of vertical transmission/MNCH strengthened.</li> <li>4. Health and planning staff capacity built in all countries to establish, implement scale up integrated community-based reproductive, MNCH, and prevention of vertical transmission.</li> <li>5. Capacity strengthened in all countries to operationalize follow up, referral, treatment and reproductive health services for HIV positive pregnant women and adolescents.</li> </ol>
<b>A.3. All new HIV infections prevented among people who use drugs</b>		
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>	✓	<ol style="list-style-type: none"> <li>1. TRIPS flexibility used by governments to negotiate drug prices, increase access to commodities and improve national procurement and supply management systems.</li> <li>2. Early diagnosis of HIV in adults, adolescents and infants strengthened and increased.</li> <li>3. Follow-up and referral system for TB/HIV established to ensure continuum of care and community outreach for HIV-infected pregnant women, children, adolescents and other PLHIV.</li> <li>4. Access to care and support increased, capacity of communities and systems to address structural and socio-cultural barriers and to provide care and support strengthened.</li> <li>5. Food and nutrition support programmes for PLHIV under ART treatment (HIV/TB, prevention of vertical transmission+) integrated into programmes, implemented and scaled up.</li> </ol>



West and Central Africa		
<b>B.2. TB deaths among people living with HIV reduced by half</b>		
<b>B.3. People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</b>	✓	<ol style="list-style-type: none"> <li>1. HIV-sensitive social protection systems (plans, strategies, budgets) developed and implemented.</li> <li>2. HIV sensitive social protection priorities integrated in national planning and development instruments and budgets.</li> <li>3. Evidence on social protection measures generated to inform advocacy, policy development, and programmes through operational research and documentation.</li> <li>4. Comprehensive social protection measures ensure access to prevention, treatment, care and support and reduce vulnerabilities of PLHIV.</li> <li>5. Community and/or home based care systems established and functional in 11 countries.</li> </ol>
<b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b>	✓	<ol style="list-style-type: none"> <li>1. Punitive laws, discriminatory regulations and practices removed and enabling legal environment created by training and engaging judicial and law enforcement agencies.</li> <li>2. Punitive and discriminatory laws, policies and practices in all spheres of society removed by actively engaging regional and national bodies and key stakeholders.</li> <li>3. Capacity and engagement of parliamentarians strengthened on law reform and removing punitive and discriminatory laws.</li> <li>4. Human rights-based approach, GIPA and gender and equity in HIV programming for vulnerable groups effectively integrated through increased governments, UNCTs and civil society capacity.</li> <li>5. Access to legal aid services improved for people living with HIV, vulnerable groups and key populations.</li> </ol>
<b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b>		
<b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b>	✓	<ol style="list-style-type: none"> <li>1. Women's and girls' rights and gender equality mainstreamed in national development frameworks, including new national and sector strategic plans.</li> <li>2. Advocacy and partnerships with key regional and national leaders and/or networks for women and girls and gender equality strengthened.</li> <li>3. Gender equality, elimination of gender-based violence and transformation of social gender norms promoted by effectively engaging men and boys.</li> <li>4. Women's and girls' rights and gender equality mainstreamed in national programmes, informed by research on women, girls and masculinity carried out in the region.</li> </ol>
<b>C.4. Zero tolerance for gender-based violence</b>		
<b>Strategic functions</b>	<b>Priority</b>	<b>Joint outputs</b>
<b>D1. Leadership and Advocacy</b>	✓	<ol style="list-style-type: none"> <li>1. Political commitment and leadership among government, civil society, non-state partners, private sector, labour and regional stakeholders galvanized to ensure inclusive, multisectoral and sustainable AIDS responses.</li> <li>2. Regional agenda for an effective, comprehensive AIDS response clearly defined and supported by regional policies and standards.</li> <li>3. Leadership and capacity of people living with HIV and groups of people living with HIV, civil society and community-based organizations to meaningfully engage in AIDS responses strengthened at all levels.</li> <li>4. Leadership by the UN system on AIDS coordinated and harmonized, with capacity and AIDS competence strengthened at regional and country levels.</li> </ol>

West and Central Africa		
<b>D2. Coordination, Coherence and Partnerships</b>	✓	<ol style="list-style-type: none"> <li>1. Regional technical assistance support to national responses coordinated.</li> <li>2. Leadership support provided to AU, RECs, Intergovernmental organizations and other regional partners in support to the implementation and monitoring of national and regional responses.</li> <li>3. Capacities of government, civil society and partners strengthened to coordinate approaches and implement policies, and effective and sustainable multisectoral HIV and AIDS programmes.</li> </ol>
<b>D3. Mutual accountability</b>	✓	<ol style="list-style-type: none"> <li>1. Mechanism for joint national reviews developed to coordinate and strengthen accountability and oversight of national responses.</li> <li>2. NACs and other coordination mechanisms effectively mobilized for an optimal use of financial resources to scale up programmes.</li> <li>3. Regional commitment to support national response is adequately monitored and evaluated.</li> </ol>



## G. EASTERN EUROPE AND CENTRAL ASIA

### Regional HIV epidemic and challenges

155. In most countries, the epidemic is concentrated with injecting drug use remaining a key driver of HIV transmission. However, sexual transmission has increased and has become the main mode of transmission in a number of countries in recent years. High levels of HIV prevalence are found in key populations such as drug users, sex workers and men who have sex with men. HIV prevalence is also high among prison populations, where the risk of TB/HIV is particularly high. Migrants moving from low to high prevalence countries in the region are also at particular risk of HIV infection. Prevention programmes such as targeted outreach and harm reduction targeting key populations are insufficient and need to be scaled up in the region to prevent a further spread of the epidemic.
156. Progress on Universal Access has remained slow in most countries, with insufficient access to prevention, in particular for men who have sex with men and people who inject drugs. Access to treatment remains low and insufficient to meet needs. Addressing HIV/TB co-infection and hepatitis B and C remain major challenges. Good progress has been made towards the elimination of mother-to-child transmission with significantly increased coverage of HIV testing. Travel restrictions, policy and legal barriers continue to limit access to prevention and treatment for key populations, notably harm reduction and oral substitution. National funding for HIV prevention in key populations remains insufficient and political commitment requires renewed mobilization.

Eastern Europe and Central Asia		
Albania, Armenia, Azerbaijan, Belarus, Bosnia & Herzegovina, Croatia, Estonia, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Romania, Russian Federation, Serbia, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan		
Strategic goal	Priority	Joint outputs
<b>A.1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work</b>	✓	<ol style="list-style-type: none"> <li>1. Strategic information on the epidemic, including vulnerable and key populations and young people available in all countries to inform and monitor programming and budgeting.</li> <li>2. Essential services for key populations reflected in national plans and implemented: <ul style="list-style-type: none"> <li>- Comprehensive package for men who have sex with me and transgender people in 15 priority countries;</li> <li>- Comprehensive package for sex workers;</li> <li>- HIV prevention in prisons in at least 10 countries, including Russia and Ukraine;</li> <li>- Condom programming expanded with a focus on non-exclusive sex partners and key populations in Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Ukraine and Uzbekistan.</li> </ul> </li> <li>3. HIV and STI prevention incorporated in all national strategies and programmes for young people and adolescents implemented in 10 countries</li> <li>4. Comprehensive programme of HIV and sexuality education including behaviour impact communication for adolescents and young people implemented in 8 countries.</li> <li>5. Positive health, dignity and prevention programmes scaled up in all countries in the region.</li> <li>6. All national HIV strategies specifically address the needs of women and girls and include programmes to reduce women's vulnerability to HIV transmission, notably towards female partners of people who use drugs and men who have sex with men.</li> </ol>
<b>A.2. Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half</b>	✓	<ol style="list-style-type: none"> <li>1. Strategies to eliminate mother-to-child transmission developed, scaled up and monitored in 10 countries of the region, especially among key populations.</li> <li>2. HIV, MCH and sexual health and reproductive health services integrated, providing ARV prophylaxis and increased access for key populations in 10 countries.</li> <li>3. PMTCT protocols updated and services to pregnant women improved, including prophylaxis guidelines, infant feeding, and confidentiality of services.</li> <li>4. Social follow-up and support to families of infected children in place in all countries.</li> </ol>
<b>A.3. All new HIV infections prevented among people who use drugs</b>	✓	<ol style="list-style-type: none"> <li>1. Evidence-based prevention, treatment and care of people who use drugs reflected in national policies and strategies across the region and legislative barriers to prevention and treatment removed.</li> <li>2. Strategic information available in 12 countries on patterns of drug use and barriers to access/provision of health and social services for drug using populations, disaggregated by sex and age, used for evidence-based policies and programmes.</li> <li>3. Programmes targeting people who use drugs implemented and monitored including: <ul style="list-style-type: none"> <li>- Community outreach, HIV testing and basic health for people who inject drugs in 15 countries;</li> <li>- Community-based prevention targeting people who uses drugs in 8 countries, including prevention of overdose;</li> <li>- Integration between HIV, drug dependence and NGO services to improve the quality of drug treatment and rehabilitation in 10 countries;</li> <li>- Primary prevention of drug use and drug injection implemented and monitored in 10 countries, including linkages with harm reduction.</li> </ul> </li> <li>4. Access to harm reduction increased in at least 10 countries with the development of a comprehensive package for people who use drugs.</li> </ol>
<b>B.1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment</b>	✓	<ol style="list-style-type: none"> <li>1. Increased ART coverage, timely initiation of treatment, revised guidelines implemented and support mechanisms in place for patient retention and adherence in all countries.</li> <li>2. Access to treatment for drug users significantly increased in 6 countries.</li> <li>3. Cost-effectiveness of ARV treatment improved through implementation of TRIPS flexibilities and supply chain management (and cover twice the patients currently treated with similar resources).</li> <li>4. More people know their HIV status and access early treatment through increased provision of information and VCT with focus on key populations and young people (incl. under age).</li> <li>5. Early detection of treatment resistance in place and access to second line drugs improved in all countries.</li> </ol>

<p><b>B.2. TB deaths among people living with HIV reduced by half</b></p>	<p style="text-align: center;">✓</p>	<ol style="list-style-type: none"> <li>1. In all countries, programmes in place to ensure every person diagnosed with TB is tested for HIV and accesses ARV without delay if found positive.</li> <li>2. New technologies for active TB diagnosis among people living with HIV introduced and scaled up in 8 countries of the region.</li> <li>3. Training programmes in place to improve the capacity of health care workers to deal with TB and HIV.</li> <li>4. Programmes to address the issue HIV/TB co-infection in prison settings implemented and monitored in 10 countries.</li> </ol>
<p><b>B.3. People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</b></p>		
<p><b>C.1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</b></p>	<p style="text-align: center;">✓</p>	<ol style="list-style-type: none"> <li>1. Advocacy plans on HIV and human rights developed and implemented in the region.</li> <li>2. Legal and policy obstacles to effective health and social protection/support by key populations assessed and reviewed.</li> <li>3. Legal/policy barriers preventing civil society from working with key populations removed and law enforcement agencies sensitized to cooperation with civil society.</li> <li>4. Systems in place to provide legal aid for people affected by HIV.</li> <li>5. Mechanisms in place in all countries to strengthen leadership and networks of organizations of people living with HIV civil society organizations and community systems in providing of HIV prevention, care and support</li> </ol>
<p><b>C.2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</b></p>		
<p><b>C.3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</b></p>		
<p><b>C.4. Zero tolerance for gender-based violence</b></p>		
<p><b>Strategic goal</b></p>	<p><b>Priority</b></p>	<p><b>Joint outputs</b></p>
<p><b>D1. Leadership and Advocacy</b></p>	<p style="text-align: center;">✓</p>	<ol style="list-style-type: none"> <li>1. Communication plans developed including different media to mobilize opinion leaders and the public on HIV prevention, treatment and care, international experience and practices.</li> <li>2. Strategic information produced and used to inform decision-making processes and improve prioritization and resource allocation in countries (including modes of transmission, epidemiological analysis, and cost effectiveness studies)</li> <li>3. Data collection systems further harmonized to report on global and regional HIV initiatives and commitments; harmonised monitoring, evaluation and reporting systems advocated for in line with European best practice.</li> <li>4. Regional participation in Treatment 2.0, HIV vaccine development, new tests and POC technologies, research and development for HIV prevention and treatment secured by means of advocacy and mechanisms of regional cooperation.</li> <li>5. New donor countries in the region contribute to maximise impact of cooperation and alignment with best international practice.</li> <li>6. HIV programmes and services integrated with other health programmes, notably MCH,</li> </ol>

		<p>SRH, TB and chronic care, in at least two countries.</p> <p>7. Civil society participation in policy development, HIV programme monitoring and financing advocated for and secured in all countries.</p>
<p><b>D2. Coordination, Coherence and Partnerships</b></p>		<ol style="list-style-type: none"> <li>1. Partnership mechanisms between government, civil society and the UN system established towards Universal Access and other MDGs by 2015.</li> <li>2. National capacity, regulatory systems, social contracting approaches and institutions strengthened in 15 countries to implement effective and inclusive prevention, treatment and care programmes.</li> <li>3. Coherent and effective support provided to countries to 1) finalise national strategic plans to 2015, 2) increase funding and effectiveness of Global Fund grants and 3) support domestic resource-mobilisation and cost-effectiveness for countries losing eligibility to grant funding.</li> <li>4. Coherent and regional approach to HIV and migration developed with access to prevention, "portability" of treatment and better access to health care and third party payment mechanisms.</li> <li>5. Technical support to countries to address epidemic priorities in the region, especially strengthening civil society capacity, notably people living with HIV and key populations.</li> <li>6. Partnerships with the private sector foster opportunities for better access to prevention, treatment and care and mobilize technology transfers for improved effectiveness.</li> </ol>
<p><b>D3. Mutual accountability</b></p>		<ol style="list-style-type: none"> <li>1. Capacity of the UN system at country and regional level monitored with gaps documented to ensure adequate support programmes (i.e. staffing and other resources).</li> <li>2. Synergies between Resident Coordinators and Secretariat developed to enhance the quality of the UN response at country level and optimize cost-effectiveness of coordination.</li> <li>3. Strategic analyses conducted jointly on important aspects of the epidemic in the region to increase effectiveness of the UN support to the response.</li> <li>4. Efficiency of UNAIDS in results-based planning, coherence of joint programmes of support and joint performance monitoring and reporting increased in all countries of the region, drawing on the Division of Labor, including annual reviews of joint programmes of support.</li> </ol>

## **ABBREVIATIONS**

ART – Anti-Retroviral Treatment

BRICS – Brazil, Russia, India, China and South Africa

CCO – Committee of Cosponsoring Organizations

GNP+ – Global Network of People living with HIV

GIPA – Greater Involvement of People living with HIV

ILO – International Labour Organization

MDGs – Millennium Development Goals

MSM – Men having Sex with Men

NGO – Non-Government Organisation

PCB – UNAIDS Programme Coordinating Board

PLHIV – People Living with HIV

PMTCT – Prevention of Mother To Child Transmission

SIE – Second Independent Evaluation

TB – Tuberculosis

TRIPS – Trade Related Aspects of Intellectual Property Rights

UBRAF – Unified Budget, Results and Accountability Framework

UBW – Unified Budget and Workplan

UNAIDS – United Nations Joint Programme on HIV/AIDS

UNDP – United Nations Development Programme

UNESCO – United Nations Educational, Scientific and Cultural Organization

UNFPA – United Nations Population Fund

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

WB – World Bank

WFP – World Food Programme

WHO – World Health Organization

## TERMINOLOGY AND DEFINITIONS

Term	Definition	Source
Combination prevention	Combination prevention has the following features: tailored to national and local needs and contexts; includes a combination of biomedical, behavioral and structural elements – to reduce both the immediate risks and the underlying vulnerabilities; developed with the full engagement of affected communities, promoting human rights and gender equality; operates synergistically, consistently over time, on multiples levels – individual, family and society; invests in decentralized and community responses and enhances coordination and management; and flexible and based on continuous learning – it can adapt to changing epidemic patterns and can rapidly adjust and deploy new tools and innovations.	UNAIDS 2011-2015 Strategy: end note 28
Comprehensive education programmes	Defined as including five components consisting of: 1) quality education; 2) content, curriculum and learning materials; 3) educator training and support; 4) policy, management and systems; and 5) approaches and entry points.	EDUCAIDS Framework for Action (UNESCO, June 2008)
Gender-based violence	<p>Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many — but not all — forms of GBV are illegal and criminal acts in national laws and policies. Around the world, GBV has a greater impact on women and girls than on men and boys. The term “gender-based violence” is often used interchangeably with the term “violence against women.” The term “gender-based violence” highlights the gender dimension of these types of acts; in other words, the relationship between females’ subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence. The nature and extent of specific types of GBV vary across cultures, countries, and regions. Examples include:</p> <ul style="list-style-type: none"> <li>– Sexual violence, including sexual exploitation/abuse and forced prostitution</li> <li>– Domestic violence</li> <li>– Trafficking</li> <li>– Forced/early marriage</li> <li>– Harmful traditional practices such as female genital mutilation, honour killings, widow</li> </ul>	Inter-Agency Standing Committee (IASC) Guidelines for Gender-Based Interventions in Humanitarian Settings (IASC, 2005): pp.7-8

Term	Definition	Source
	inheritance, and others.	
Harm reduction	Refers to policies, programmes and approaches that seek to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. For people who inject drugs, in relation to HIV, it is a comprehensive package of nine elements, as elaborated in the WHO/UNODC/UNAIDS Technical Guide: needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for people who inject drugs and their sexual partners; targeted information, education and communication for people who inject drugs and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; and, prevention, diagnosis and treatment of tuberculosis.	UNAIDS Terminology Guidelines 2011, UNAIDS 2011-2015 Strategy: end note 38, and WHO/UNODC/UNAIDS: <i>“Technical Guide for countries to set targets for Universal Access to HIV prevention, treatment and care for injecting drug users”</i> 2009
Key populations	Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.	UNAIDS 2011-2015 Strategy: end note 41
Men who have sex with men	Men who have sex with other men, regardless of whether or not they have sex with women or have a personal or social identity associated with that behaviour, such as being “gay” or “bisexual”.	UNAIDS 2011-2015 Strategy: end note 6
People affected by HIV	Encompasses family members and dependents who maybe involved in care giving or otherwise affected by the HIV-positive status of a person living with HIV.	UNAIDS Terminology Guidelines 2011
Positive Health, Dignity and Prevention	<ul style="list-style-type: none"> <li>– Increasing access to, and understanding of, evidence-informed, human rights-based public health policies and programmes that support individuals living with HIV in making choices that address their needs and allow them to live healthy lives;</li> <li>– Scaling up and supporting existing HIV testing, care, support, treatment and prevention programmes that are community-owned and</li> </ul>	UNAIDS 2011-2015 Strategy: end note 39



Term	Definition	Source
	<p>led;</p> <ul style="list-style-type: none"> <li>– Scaling up and supporting literacy programmes in health, treatment and prevention and ensuring that human rights and legal literacy are promoted and implemented;</li> <li>– Ensuring that undiagnosed and diagnosed people living with HIV, along with their partners and communities, and including in HIV prevention programmes that highlight shared responsibility, regardless of known or perceived HIV status, and have options rather than restrictions to be empowered to protect themselves and their partner(s);</li> <li>– Scaling up and supporting social capital programmes that focus on community-drive, sustainable responses to HIV by investing in community development, networking, capacity-building and resources for organization and networks of people living with HIV.</li> </ul>	
Sex workers	Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating.	UNAIDS 2011-2015 Strategy: end note 8
Transgender	In broad terms transgender comprises individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term <i>transgender people</i> describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another.	UNAIDS 2011-2015 Strategy: end note 36
Vertical transmission	HIV transmission from mother to child during pregnancy, childbearing or breastfeeding.	UNAIDS 2011-2015 Strategy: end note 19
Vulnerable groups	Populations which are subject to societal pressures or social circumstance that may make them more vulnerable to exposure to infections, including HIV, such as, populations affected by humanitarian situations, refugees, internally displaced persons and migrants, informal-economy workers, people experiencing hunger, poor nutrition and food insecurity, people with disabilities, and orphaned and vulnerable children.	UNAIDS Terminology Guidelines 2011 and UNAIDS Outcome Framework 2009-2011

**Results Based Management definitions (from the UNAIDS Monitoring and Evaluation Working Group, MERG)**

Term	Definition
Goal	A broad statement of a desired, usually longer-term, outcome of a programme or intervention.
Outcome	Short-term and medium-term effect of a programme or intervention, such as change in knowledge, attitudes, beliefs, and/or behaviours.
Output	The direct results or products of a programme, intervention or a set of activities.
Deliverable (activity)	Actions taken or efforts through which inputs such as funds, technical assistance and other types of resources are mobilized to produce specific outputs.
Indicator	A quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention.

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