

## **UNAIDS PROGRAMME COORDINATING BOARD**

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### **THIRTY-FOURTH MEETING**

**Date:** 1-3 July 2014

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

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#### **Agenda item 5.1**

**UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework**

**Snapshots: 30+ High Impact Countries**

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**Angola Botswana Brazil Burundi  
Cambodia Cameroon Central  
African Republic Chad China Côte  
d'Ivoire Democratic Republic  
Of The Congo Djibouti Ethiopia  
Ghana Guatemala Haiti India  
Indonesia Islamic Republic Of Iran  
Jamaica Kenya Lesotho Malawi  
Mozambique Myanmar Namibia  
Nigeria Rwanda South Africa South  
Sudan Swaziland United Republic  
Of Tanzania Thailand Uganda  
Ukraine Zambia Zimbabwe**

**SNAPSHOTS**

**30+ High Impact Countries**



Angola Botswana Brazil Burundi  
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**SNAPSHOTS**

**30+ High Impact Countries**



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# Overview

The last decade has witnessed unprecedented gains against HIV. New HIV infections in 2012 were 33% lower than in 2001, AIDS-related deaths declined by 30% from 2005 to 2012, and total funding for HIV-related activities in low- and middle-income countries reached its highest level ever in 2012 (US\$18.9 billion). However, against this backdrop of encouraging success, the AIDS response confronts important challenges. Under WHO's consolidated antiretroviral guidelines, barely one-third of all people eligible for treatment were receiving antiretroviral therapy in 2012. Prevention gains are not universally shared, with little reduction in new infections evident in many parts of the world. In the dozens of countries where HIV treatment scale-up is lagging, minimal progress has been made in preventing AIDS-related deaths. While the world is either on track for or within reach of achieving several of the 10 priority targets from the 2011 High Level Meeting on HIV/AIDS (HLM), most of these targets are unlikely to be met without dramatically strengthened efforts.

Drawing on principles of shared responsibility and global solidarity, all actors in the AIDS response will need to renew their commitment and maximize their strategic impact if the world is to follow through on recent gains to lay the foundation to end the epidemic.

In the face of this historic opportunity and challenge, the 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) aims to optimize UNAIDS' assistance to countries to accelerate long-term progress of the national responses towards the HLM targets. The UBRAF is a unique instrument that strategically combines the efforts of 12 UN system organizations to support the achievement of the goals in the UNAIDS Strategy (2012-2015) and the targets set forth in the 2011 UN General Assembly Political Declaration on HIV/AIDS. The UBRAF includes a four-year planning framework, two-year budget cycles and rolling annual work plans to ensure coherence, coordination, and accountability for results. The UBRAF allocates resources based on epidemic priorities and documented performance, combining core funding with resources that Cosponsors themselves raise.

Towards the vision of zero new HIV infections, zero AIDS-related deaths and zero discrimination, the UNAIDS Strategy expressly calls for accelerated efforts in countries where the leveraging of UN system and other capacities will have the greatest impact. To implement this strategic mandate, UNAIDS is prioritizing joint work in 30+ (38) High Impact Countries that account for 86% of all people living with HIV globally, 88% of all new HIV infections, 93% of new infections among children and 90% of all AIDS-related deaths. In addition to those with the most significant (14) and severe (4) HIV epidemics, High Impact Countries also include the rapidly emerging economies (including the BRICS<sup>1</sup> countries) that will help lead the AIDS response into the future. In addition, the 30+ priority countries include those of compelling geopolitical relevance that also have high levels of infection among risk populations,<sup>2</sup> or other key geopolitical relevance, such as acute humanitarian situations (11 countries).

Across these 30+ countries, UNAIDS has taken steps to intensify assistance, enhance the coherence and coordination of joint efforts, and strengthen the mobilization of financial and technical resources to expedite progress towards national AIDS goals. High Impact Countries also align with the priorities of key funders and global initiatives.

<sup>1</sup> Brazil, Russia, India, China and South Africa.

<sup>2</sup> Out of 25 UNODC target countries for people who inject drugs, 13 are covered by HICs but account for 95% of all new infections from the 25 countries. Respectively, 15 and 21 out of the 38 HICs report men who have sex with men (MSM) and sex work as primary modes of transmission.



They include 30 of the 33 countries prioritized by the United States President's Emergency Plan for AIDS Relief (PEPFAR), as well as 17 out of 23 countries prioritized by the Global Fund<sup>3</sup>, but account for 98-99% of the total new infections in these target countries. The High Impact Countries prioritized by UNAIDS also include all 22 high-burden mother-to-child-transmission countries that have committed to implement the Global Plan on eliminating new infections among children and keeping their mothers alive. Almost half of High Impact Countries are also implementing the global strategy for women's and children's health, integrating HIV interventions into the sexual and reproductive health agenda.

In his annual AIDS progress report to the UN General Assembly, the UN Secretary-General emphasized the importance of combining actions to accelerate progress towards the 2015 HLM targets with efforts to position the response for the post-2015 era. Accelerating concrete progress in the response – and implementing an investment approach to enhance sustainability and efficiency – will help ensure that these countries are ideally poised to leverage opportunities beyond 2015 to end the AIDS epidemic.

## High Impact Country support under the UBRAF, 2012–2013

Signaling high-level commitment to an optimally strategic approach, the UNAIDS Executive Director allocated additional UBRAF resources to the 30+ High Impact Countries. To fully leverage the Joint Programme's capacity to strengthen responses in these priority countries, UNAIDS:

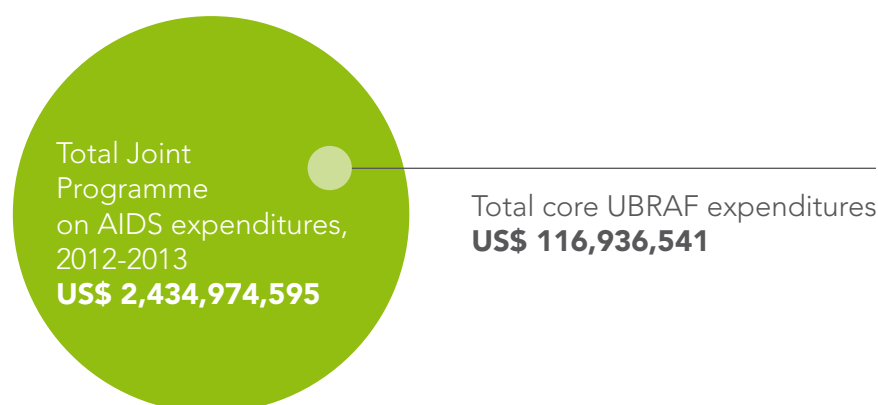
1. deployed additional staff in the 30+ High Impact Countries and the seven UNAIDS Regional Support Teams (RSTs) assisting them. UNAIDS used a mobility exercise and the recruitment of additional national staff to meet these staffing demands;
2. encouraged Cosponsors to intensify action in the 38 High Impact Countries by using additional UBRAF resources, allocated on the basis of identified needs within the Joint Programme of Support and respecting clearly established criteria.

To implement these additional resources, all members of the Joint Programme agreed that funding would be strategically targeted, performance-based, strengthen national ownership, and that accountability would be assured through Joint UN Teams on AIDS. To ensure coherence and coordination and leverage the unique expertise of individual Cosponsors, UNAIDS support in HICs aligns with the UNAIDS Division of Labour.

Each UN Joint Team includes the broad spectrum of skills and expertise offered by UNAIDS to support national priorities. The size of the Joint UN Team varies, depending on national circumstances, ranging from smaller ones in El Salvador to larger ones in Kenya. The Joint Programme's strategies to assist national partners are set forth in the UN Joint Programme of Support.

In 2012-2013, core UBRAF funding in High Impact Countries amounted to US\$116,936,541, including additional UBRAF funding of US\$ 10 million for Cosponsors and US\$ 5 million for the Secretariat. In addition, the UNAIDS family mobilized and expended an additional US\$2,434,974,595.

<sup>3</sup> Together, both PEPFAR and Global Fund account for two-thirds of international assistance in the response to the HIV epidemic and more than 90% of donor HIV funding in the highest-burden and lowest-resourced countries. In mid-2013, an estimated 7.9 million people globally were supported on anti-retroviral therapy (ART) by the two organizations.



Efforts to revolutionize HIV prevention accounted for the bulk of resources (44%) in High Impact Countries, while strategic actions for the next phase of treatment and efforts to advance human rights and gender equality accounted for 27% and 4%, respectively. The remaining 25% supported the UNAIDS Secretariat's strategic functions of ensuring leadership, coherence and mutual accountability across the Joint Programme<sup>4</sup>.

The High Impact Country initiative strongly encouraged Joint UN Teams in High Impact Countries to invest their additional UBRAF resources in a manner that was:

1. **Strategic** – focusing on a limited number of measurable results to accelerate progress towards the HLM targets and three zeroes;
2. **Catalytic** – leveraging the strength of the Joint UN Programme to address critical capacity gaps or bottlenecks in achieving the HLM targets, and/or;
3. **Innovative** – galvanizing political momentum or supporting activities that extend beyond traditional service delivery.

These criteria both reflect and reinforce a key aim of the UBRAF – to shift away from an input-oriented approach to UNAIDS budgeting and work planning towards an approach that is results-based.

## Examples of activities supported with the additional UBRAF funding in High Impact Countries

Adhering to agreed criteria for operationalizing additional UBRAF resources, Joint UN Teams focused on efforts to strengthen the broader response and to expedite progress towards the HLM goals and targets. Joint UN Teams focused funding on: (1) addressing **barriers** or leveraging more resources to reach HLM targets; (2) consult and build consensus on new **prevention approaches and technologies**; (3) redesigning HIV **testing and counselling** approaches; (4) generate **strategic information** to report on the HLM targets and inform the development and adaptation of policies and

<sup>4</sup> Percentages are from global breakdown, this being likely to be indicative of funds distribution within HICs.

programmes; (5) **analyses/assess** the response by stakeholders/institutions, and use of these findings to strengthen national efforts; (6) **build capacity** of national partners in key areas; (7) advocate for **integrated services** and information in **urban hotspots**; (8) support initiatives with **young people**, increasing their capacity for leadership and to exercise their rights to information and services and (9) communication and **advocacy campaigns** to create political momentum regarding key national issues and targets.

## Next steps

The UBRAF seeks to maximize the impact of the UNAIDS family at country level and to hold the Joint Programme accountable for both programmatic results and a value for money. In the 2014-2015 biennium, UNAIDS will continue and intensify its assistance to the 38 High Impact Countries, with closer attention to high-level advocacy and political insight, work planning and monitoring of UN activities, greater availability of UN staff and technical assistance, and an enhanced strategic focus on appropriate investments and partnership development.

## Measuring and reporting impact: Two-page snapshots

The Joint Programme Monitoring System (JPMS) systematically collects results in each of the High Impact Countries, enabling an analysis of how UNAIDS is making a difference in these 38 countries. The country briefs that follow highlight the key achievements in 2012-2013 in each of the High Impact Countries and describe how the UN has contributed to these achievements.

Each of the country snapshots summarizes basic demographic and epidemiological information for the High Impact Country. Basic information is provided regarding the UN response in each High Impact Country, including funding and the programmatic areas in which UNAIDS has focused its support to national partners. For each priority programmatic area, key results and achievements are noted, with text boxes describing how UNAIDS will further support the national response through the Joint Programme.

# Angola

## ANGOLA PROGRESS ON AN ACCELERATED HIV/AIDS RESPONSE TO MEET THE MDGS BY 2015



Total Joint UN  
Programme on  
AIDS expenditures  
**US\$ 21,258,235**

Total core UBRAF expenditures  
**US\$ 1,633,669**

### UN areas of work - prioritization by agencies



**Eliminate new  
HIV infections  
among children**



**Reduce sexual  
transmission**



**Eliminate  
stigma and  
discrimination**



**Close the  
resource gap**

### Country profile (2012 data)

**18,700,000**

Population

**250,000 [210,000 - 300,000]**

Number of people living with HIV

**220,000 [180,000 - 270,000]**

Adults aged 15 and over living with HIV

**130,000 [110,000 - 160,000]**

Women aged 15 and over living with HIV

**13,000 [9,200 - 17,000]**

AIDS-related deaths

**28,000 [21,000 - 36,000]**

New infections

**2.3% [1.9% - 2.8%]**

Adults aged 15-49 prevalence rate

**42% [36% - 51%]**

ART coverage

**17% [14% - 22%]**

PMCT coverage

**Main modes of transmission:**

Multiple heterosexual partners.

# 'WHAT I NEED IS A BUSINESS PLAN WITH TWO CLEAR ACTIONS FOR 2015: TO MAKE SURE NO BABY IS BORN WITH HIV AND EVERY ANGOLAN LIVING WITH HIV HAS ACCESS TO TREATMENT.'

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**José Eduardo dos Santos**

President of Angola

**Empowering women to negotiate safer sex.** Angola's 2011-2014 National Strategic Plan focuses on decreasing sexual transmission by integrating HIV initiatives in all sectors. Engaging women and adolescent girls in projects to reduce vulnerability and develop life skills, including those to delay sexual debut, is part of the strategic approach. The country is empowering women to learn how to negotiate safer sex, with the involvement of schools and communities, and ensuring condoms are freely distributed via health centers, public institutions and NGO networks.

**Delivering ART at municipal and provincial levels.** In Angola, adult antiretroviral therapy (ART) coverage was 48% in 2012. Despite a relatively low HIV prevalence rate at 2%, the epidemic is generalized, with predominance of the female age group of 24-39 years. Consequently, the strategy to prevent vertical transmission has been one of the priorities of the National Response to HIV and AIDS. In this context, the country has redefined its strategies to accelerate the HIV and AIDS Response towards 2015. Counting with the support of the United Nations and partners, the objectives are to reduce new infections in children by keeping their mothers alive and ensuring that 90% of pregnant women who are HIV positive are receiving ART and to ensure that 90% of eligible adults living with HIV have access to ART. The municipal and provincial health services were capacitated to improve access, treatment and monitoring of ARVs. UNDP as the principal recipient of the Global Fund until September 2014, has secured ART funds for 23,151 people living with HIV of the 85,000 eligible and 1,000 pregnant HIV-positive women of the 15,000 estimated to be in need in 2012. The United Nations have been collaborating and supporting civil society organizations,

in particularly PLHIV, in community activities to increase access and adherence to care and ART treatment. Advocacy efforts have been made to strengthen the multi-sectoral approach of the National Commission to fight AIDS and large Epidemics, supported by UNAIDS.

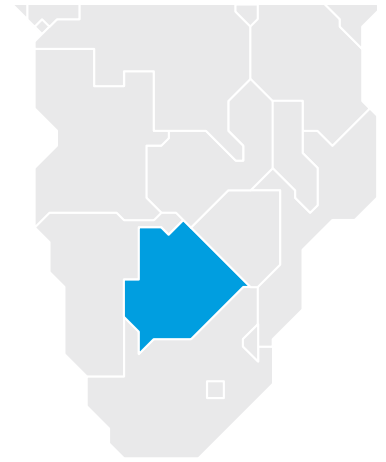
**Better treatment access during pregnancy.** Angola is on UNAIDS' list of 22 priority countries with the highest rate of vertical transmission. With a 9% increase in new HIV infections among children from 2009-2012, prevention of mother-to-child transmission (PMTCT) is a priority for the country. Increasing knowledge about mother-to-child transmission of HIV is relevant as 53% of women in urban areas in 2009 did not know any mode of HIV transmission (INCAPSIDA 2010). Strengthening Option B+ and decentralizing PMTCT activities at the municipal level are two key steps for scaling up mother-to-child transmission services. The United Nations continues to support activities to increase services for sexual and reproductive health, which have been integrated with PMTCT programs since 2007, giving pregnant women better access to diagnosis, treatment and follow up.

## **Accelerating progress to the three zeroes.**

With UN support, Angola's priority is the Accelerated Response towards the 2015 targets of Zero new infections, Zero AIDS-related deaths and Zero stigma and discrimination. This process has two objectives: to eliminate new infections among children by ensuring 90% of pregnant women who are HIV-positive are receiving ART; and to ensure all eligible people living with HIV have access to ART.

# Botswana

## PURSuing A SUSTAINABLE, QUALITY HIV RESPONSE



### Country profile (2012 data)

**2,200,000**

Population

**340,000 [320,000 - 360,000]**

Number of people living with HIV

**330,000 [310,000 - 350,000]**

Adults aged 15 and above living with HIV

**180,000 [170,000 - 190,000]**

Women aged 15 and up living with HIV

**5,700 [5,000 - 6,800]**

AIDS-related deaths

**12,000 [11,000 - 15,000]**

New infections

**23% [21.8% - 24.4%]**

Adults aged 15-49 prevalence rate

**>95% [>95% - >95%]**

ART coverage

**>95% [86% - >95%]**

PMCT coverage

**Epidemic type:** severe/hyper-endemic

**Main modes of transmission:**

heterosexual transmission within stable partnerships.

Total Joint UN  
Programme on  
AIDS expenditures  
**US\$ 49,493,353**

Total core UBRAF expenditures  
**US\$ 2,565,246**

### UN areas of work - prioritization by agencies



**15 million  
accessing  
treatment**



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**Avoid TB  
deaths**

# 'BOTSWANA IS WELL PLACED TO VIRTUALLY ELIMINATE MOTHER-TO-CHILD TRANSMISSION.'

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**Surpassing global target on treatment.** Botswana continues to show exemplary leadership in driving an effective, country-owned AIDS response. It provides antiretroviral drugs to more than 95% of those in need, surpassing the global targets (CD4 350), with most of the resources provided by a committed national government. In 2013, strategic information was generated on several fronts: the fourth round of the Botswana AIDS Impact Study was successfully completed; the impact of treatment scale-up on community-level prevention was being assessed through a Combination Prevention Cohort study; integrated behavioral and serum studies were conducted among key affected populations, such as female sex workers, men who have sex with men and prisoners, with technical support from the UN; and a study on community perspectives on girls' vulnerability to HIV and AIDS was completed with support from PEPFAR. UNHCR and UNAIDS supported a HIV-related behavioral study among refugees, while UNAIDS and UNDP provided technical and financial support for the first round of the stigma index study.

**Comprehensive approaches for getting to zero new infection.** New HIV infections among children have been reduced by 50%. Botswana developed and rolled out effective new testing approaches, including provider-initiated HIV testing and counselling to accelerate treatment scale-up. High-level advocacy by the UN, particularly UNAIDS, along with other partners, has resulted in moves to improve the sustainability of the AIDS response. This includes the strengthening of system efficiency and re-energizing prevention efforts to reach the goal set in the second National Strategic Framework (2010–2016) of zero

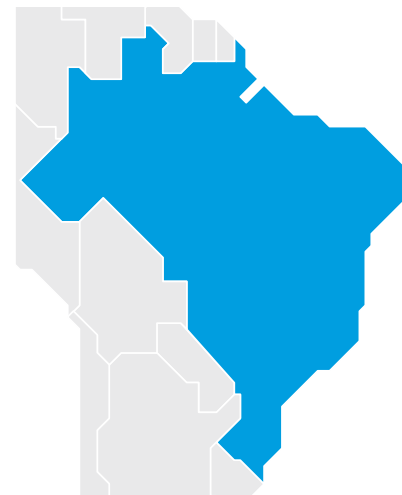
new infections by 2016. HIV prevention among youth through the social media campaign Wise-up was supported by UNICEF.

**Botswana virtually eliminates Mother-to-child transmission.** With more than 95% of HIV positive women receiving antiretroviral treatment to reduce the risk of transmission, the country is achieving its target for HLM 3. UNFPA and UNAIDS have provided technical assistance to integrate HIV and sexual and reproductive health services, including training for health workers and community-based organizations to further improve the efficiency of the health service delivery system.

**Botswana moving towards a sustainable and quality AIDS response.** From 2009–2012, 66% of HIV/AIDS spending was from public resources compared with 32% from external sources and 2% from the private sector. NACA and MoH, with the support from UNAIDS and other partners, are developing an investment case for HIV/ Sexual and reproductive health and HIV/TB integrated services. Such a case is established based on PEPFAR supported studies, efficiency gain exercise across all major HIV programmes and the development of a strategy to counter HIV and TB drug resistance. Prevention, as the ultimate approach for improving sustainability will be rejuvenated, with focus on women, girls and young people.

# Brazil

## DRAWING ON ITS HIV EXPERIENCE AS AN ENGINE FOR INNOVATION



Total Joint UN  
Programme on  
AIDS expenditures  
**US\$ 246,124,730**

Total core UBRAF expenditures  
**US\$ 2,576,701**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**Prevent HIV  
among drug  
users**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**

### Country profile (2012 data)

**198,000,000**

Population

**[530,000 - 660,000]**

Number of people living with HIV

**[520,000 - 650,000]**

Adults aged 15 and over living with HIV

**[160,000 - 190,000]**

Women aged 15 and over living with HIV

**[11,000 - 19,000]**

AIDS-related deaths

**[27,000 - 45,000]**

New infections

**[0.4% - 0.5%]**

Adults aged 15-49 prevalence rate

**[82% - 93%]**

ART coverage

**[...% - ...%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** men who have sex with men, multiple heterosexual partners.

<sup>5</sup> The Brazilian Ministry of Health published an estimate of 718,000 people infected with HIV in 2012 at its 2013 National HIV/AIDS Epidemiological Bulletin. Retrieved May 2, 2014, from [http://www.aids.gov.br/sites/default/files/anexos/publicacao/2013/55559/\\_p\\_boletim\\_2013\\_internet\\_pdf\\_p\\_51315.pdf](http://www.aids.gov.br/sites/default/files/anexos/publicacao/2013/55559/_p_boletim_2013_internet_pdf_p_51315.pdf).



# 'THE UNJT HAS COLLABORATED WITH GOVERNMENT AND CIVIL SOCIETY TO TACKLE DISCRIMINATION AND EMPOWER WOMEN.'

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**Treatment 2015.** Brazil recently regained its leadership role by adopting treatment for all people living with HIV, independent of the CD4 count. In 2012, Brazil had already reached 90% of treatment coverage based on the 2010 WHO guidelines, and now sets itself an ambitious target to bring treatment to all those infected (the Brazilian Ministry of Health estimates that 44% of the 718,000 infected with HIV were receiving treatment in 2012). Brazil's new evidence-based approach is to rapidly scale-up early HIV diagnosis, combination prevention, and treatment as prevention strategies. The United Nations Joint Team (UNJT) is politically supporting the Brazilian Government to achieve treatment for all, which will bring the world a step closer to the goal of reaching 15 million people on treatment by 2015.

**Tackling discrimination.** The UNJT contributed to an enhanced understanding of the intersections between stigma and discrimination (institutional racism, gender-based violence, homophobia, discrimination in the workplace, stigma against people who use illicit drugs) and, vulnerability to HIV infection, and collaborated with civil society to develop strategies to tackle discrimination. In addition, the UNJT supported and mobilized efforts to strengthen sexual education programmes in schools nationwide. Inclusive education favoring indigenous populations, young people and traditional communities has been prioritized. The UNJT developed and implemented initiatives addressing key populations, such as men who have sex with men, transgender people, people who use drugs, people in prison settings, people living with HIV (including those coinfecting with tuberculosis), and people living in remote areas of Brazil. Integrating testing in community campaigns. Brazil has integrated the promotion of HIV testing in community

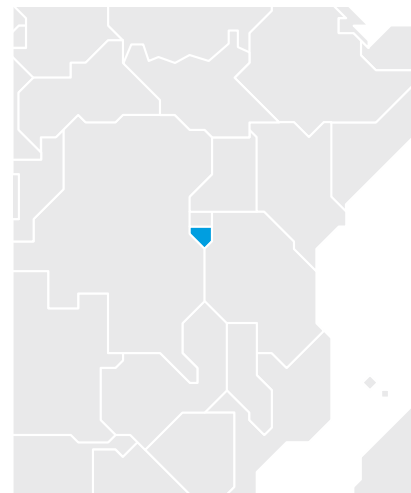
campaigns that provide screening or prevention services for multiple diseases. UN agencies have worked with various partners to focus HIV investments and technical resources in three regions (Amazonas, Bahia and Porto Alegre) improving local capacities to reduce new HIV infections among children and young people, tackle gender-based violence and inequality, develop prevention initiatives in schools, and address human rights in prison settings.

**Empowering women.** Brazil has shown exceptional leadership in promoting global health while drawing on its domestic experience with HIV as an engine for innovation. Brazil, in cooperation with UN agencies, has championed technical collaboration on HIV, particularly with Lusophone countries in Africa. As a result, the UNJT in Brazil supported the creation of a network of women living with HIV in these countries, developing their leadership, and strengthening local responses to HIV.

**Making better use of resources.** The UNJT has demonstrated the benefits of working in partnership with governments and communities to make better use of resources. The UN Integrated Plan on HIV/AIDS is a unique partnership in the Amazon Region, the State of Bahia and the city of Porto Alegre, which brought together the UNJT with the federal, state and municipal governments, and civil society. The Integrated Plan contributes to the challenging goal of responding to regional inequalities, creates local synergies, and culminates in culturally-appropriate and successful interventions. For the following biennium, the Integrated Plan will be strengthened and expanded with focus on 'ZeroDiscrimination'.

# Burundi

## PUTTING WOMEN AND YOUNG PEOPLE AT THE HEART OF RESPONSE



Total core UBRAF expenditures  
**US\$ 1,404,500**

### UN areas of work - prioritization by agencies



### Country profile (2012 data)

**10,800,000**

Population

**89,000 [75,000 - 110,000]**

Number of people living with HIV

**72,000 [60,000 - 88,000]**

Adults aged 15 and over living with HIV

**43,000 [36,000 - 53,000]**

Women aged 15 and over living with HIV

**4,800 [3,600 - 6,300]**

AIDS-related deaths

**4,600 [2,400 - 7,500]**

New infections

**1.3% [1.0% - 1.5%]**

Adults aged 15-49 prevalence rate

**58% [51% - 67%]**

ART coverage

**54% [41% - 69%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** sex workers and their clients, men who have sex with men.

# 'COMMITTED TO ELIMINATING NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND KEEPING THEIR MOTHERS ALIVE.'

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## **Long-term prevention with medical male circumcision for the very young.**

In the area of sexual transmission and prevention, the UN supported the national HIV response with a focus on young people. UNFPA helped revise and implement the strategic plan for reproductive health to take account of prevention of mother-to-child transmission (PMTCT) and the specific needs of young people. UNFPA also collaborated with UNESCO and UNICEF to support the Burundian Association for Family Welfare evaluate youth-friendly HIV services at health-care centres, while UNICEF supported an integrated minimum package of HIV-sensitive services, including health care, education and birth registration for about 10 000 orphans and vulnerable children. The report of the study "Know your epidemic/Know your response" identifies areas where Burundi, with UN support, can improve, including scaling up male circumcision, which remains at 20–25%. The report suggests the relatively low HIV prevalence and cultural issues preventing widespread adult uptake may make it more efficient to develop a neonatal programme, combined with information and communication initiatives for adults as a 'long-term insurance' against surges of HIV epidemics.

**Targeting breastfeeding mothers.** As one of 22 countries committed to implementing the Global Plan towards eliminating new HIV infections among children by 2015 and keeping their mothers alive, Burundi has put women and young people at the heart of its HIV response, almost halving the number of new infections among children between 2009–2011. Since 2009, Burundi has also doubled the coverage of antiretroviral prophylaxis for pregnant women living with HIV to 54%. Additional coverage is needed during pregnancy, especially during breastfeeding when most children newly infected with HIV acquire it. With antiretroviral therapy (ART) for children remaining low (21%), the national response must be redoubled in the coming years. Burundi is integrating

efforts to eliminate mother to child transmission (eMTCT) into its reproductive health programme. In 2012, UN agencies supported a revised eMTCT plan, as well as a budgeted plan to scale up PMTCT services, while WHO updated training modules and tools for PMTCT data collection.

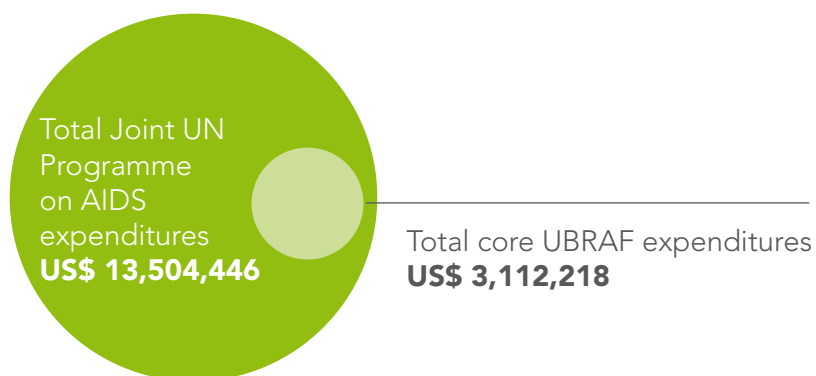
**Commitment to reduce financial dependency.** While still very dependent on international sources for its HIV response with only 4.3% of the HIV response coming from the Government's budget, the Government has committed to increasing domestic investment in health from 8% in 2011 to 15% in 2015. The UN has engaged the Ministry of Finance and Economic Planning in a discussion on innovative sources of funding in order to increase the sustainability of the HIV response. Additionally, the major financial institutions in Burundi (banks and insurance companies) have agreed to contribute 3% of their annual net benefits to underfinanced sectors such as the health sector and the HIV response.

## **Legal reform to protect the most vulnerable.**

Burundi has acted to improve the rights of people affected by HIV. In 2012, UNAIDS and UNDP funded a workshop, with the Office of the High Commissioner for Human Rights, where parliamentarians, lawyers, representatives of the justice and health ministries, civil society and human rights advocates created a framework for legal reform to protect vulnerable populations, encourage the judiciary to uphold international conventions and to share information on human rights and HIV. More needs to be done through UN action and advocacy in a country that has increased the penalties for those convicted of acts of homosexuality and where traditional practices contribute to transmission.

# Cambodia

## GEARING UP TO ELIMINATE NEW HIV INFECTIONS BY 2020



### UN areas of work - prioritization by agencies



### Country profile (2012 data)

**15,300,000**

Population

**76,000 [59,000 - 120,000]**

Number of people living with HIV

**71,000 [51,000 - 130,000]**

Adults aged 15 and over living with HIV

**39,000 [26,000 - 76,000]**

Women aged 15 and over living with HIV

**2,700 [1,900 - 4,700]**

AIDS-related deaths

**1,400 [<1,000 - 2,900]**

New infections

**0.8% [0.5% - 1.5%]**

Adults aged 15-49 prevalence rate

**84% [63% - >95%]**

ART coverage

**... [... - ...]**

PMCT coverage

**Epidemic type:** concentrated  
**Main modes of transmission:** sex workers and their clients, sexual transmission within stable couples.

# 'FOCUS ON UNREACHED KEY AFFECTED POPULATIONS INCLUDING THROUGH INNOVATION IS KEY TO ELIMINATE NEW HIV INFECTIONS.'

---

## H. E. Ieng Mouly

Senior Minister and Chair of the National AIDS Authority and  
Dr. MeanChhi Vun, Director, National Center for HIV/AIDS,  
Dermatology and STD

**Sustained leadership for results.** Cambodia continues to build on its achievements on AIDS, which have already been recognized with a Millennium Development Goals prize for excellence in 2010 for progress towards goal 6. Strong leadership by the Government, in partnership with civil society and UN agencies, led to a decline in HIV prevalence from 1.7% of adults aged 15–49 in 1998 to 0.8% in 2012. Cambodia also achieved the universal access target for treatment, with more than 80% of adults and children in need receiving treatment.

**Boosting outreach and services to key populations.** Adult HIV incidence declined by more than 50% between 2001 and 2012. Further to the NSPIII, the Government, supported by WHO, the UNAIDS Secretariat, UNICEF and other partners, adopted the “Cambodia 3.0” framework to eliminate new HIV infections by 2020. This ambitious framework includes new approaches for improving outreach for prevention among key affected populations (entertainment/sex workers, men who have sex with men, intravenous drug users, transgender people and prisoners). Such approaches include community-led testing, eliminating mother-to-child transmission of HIV, further increasing treatment access and improving care and support for people living with HIV. WHO, UNAIDS Secretariat and UNODC are assisting efforts to expand the harm reduction programme for people who inject drugs. UNAIDS has also contributed to other key achievements in the national multisectoral HIV response by providing advocacy and guidance for developing policies to scale up targeted programmes

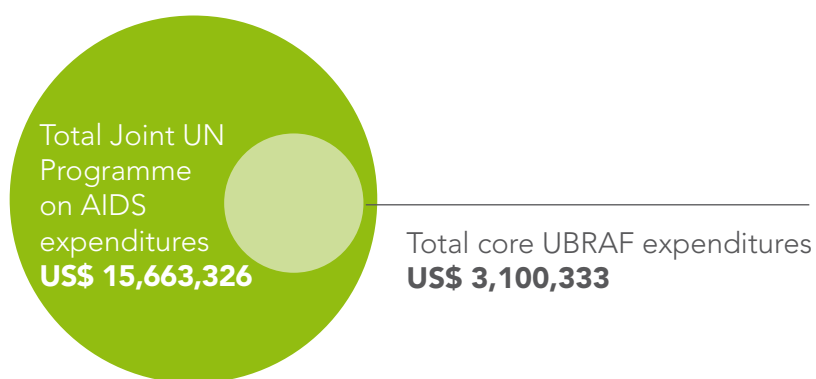
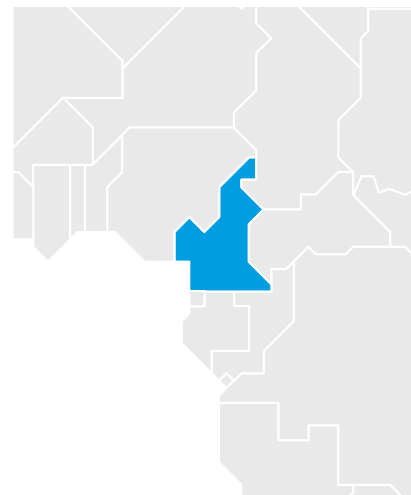
and introduce new technology for combination prevention. Further building strategic information and resource mobilization were also a key area of UNAIDS investment to strengthen the national response.

Empowering people living with HIV and key affected populations. The UN also supported Cambodia’s capacity building efforts on various fronts for affected communities: human rights, advocacy, promoting increased access to key health and social services and a more enabling environment through a legal framework review and Police-Community-Partnership Initiative. Policy breakthroughs achieved with UNAIDS support include: school sexuality and HIV education curriculum (UNESCO, UNFPA); the Good Food Toolkit (WFP); the pilot scheme Better Health and Safety for Entertainment Establishments (ILO); increased capacity on TRIPS (UNDP, UNAIDS Secretariat, WHO); access to social services (UNICEF, WFP); a HIV-sensitive social protection review (UNDP, WFP, ILO, UNAIDS, UNICEF); and increased evidence, planning and resources for addressing HIV-related gender and gender-based violence issues (UN Women, UNAIDS Secretariat, UNFPA, UNDP, ILO).

**Building for further achievements.** With its clear vision, high-level commitment, financial resources (more than US\$70 million was mobilized due to UNAIDS support for 2014/2015) and the support of other partners, Cambodia is well advanced on the path to achieving the UN’s 2011 Political Declaration targets and the three zeros by 2015.

# Cameroon

## INTEGRATING RESPONSE IN HEALTH AND DEVELOPMENT EFFORTS



### UN areas of work - prioritization by agencies



### Country profile (2012 data)

**22,100,000**

Population

**600,000 [550,000 - 660,000]**

Number of people living with HIV

**540,000 [500,000 - 590,000]**

Adults aged 15 and over living with HIV

**310,000 [290,000 - 340,000]**

Women aged 15 and over living with HIV

**35,000 [30,000 - 40,000]**

AIDS-related deaths

**45,000 [38,000 - 53,000]**

New infections

**4.5% [4.1% - 4.9%]**

Adults aged 15-49 prevalence rate

**45% [41% - 48%]**

ART coverage

**64% [56% - 73%]**

PMCT coverage

**Epidemic type:** Generalized/High burden

**Main modes of transmission:** Sex workers and their clients, men who have sex with men, multiple heterosexual partners.

# 'UN ADVOCACY HAS IMPROVED AWARENESS OF LINKS BETWEEN HIV RESPONSES AND MDG AGENDA.'

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**First success for reducing new infections among children.** Though the country still has more work to do to achieve the UNAIDS target of zero new infections among children by 2015, mother-to-child transmission has fallen from 29% in 2009 (baseline) to 24% in 2011, according to UNICEF. In another major advance, prevention of mother-to-child transmission services are being integrated into antenatal, delivery and postnatal care settings, and other sexual and reproductive health services. To this end, the Joint UN Team on AIDS has helped strengthen community-based interventions for family planning. PMTCT policy and programmes are also being expanded, including antiretroviral therapy for eligible women, and in the areas of sexual and reproductive health, primary prevention and nutritional support. Under the National Strategic Plan, almost all health districts are equipped to provide PMTCT services.

**Women and girls have better access to treatment services.** Cameroon has identified the need to eliminate parallel systems for HIV-related services and to further integrate the HIV response in health and development efforts. Regular consultations between health partners have resulted in information exchange, a rational allocation of resources and the integration of services. Integrating antiretroviral therapy, PMTCT and TB treatments has enhanced access to treatments for women and girls regardless of the point of contact. The HIV-related needs of women and girls have been specifically addressed in the Cameroon UN Joint Plan on AIDS 2012–2013. In 2012, UNDP initiated a

programme to educate, sensitize and train local leaders and women's groups in poorer regions on gender-based violence in the context of HIV. The programme aims to prevent practices that expose women and girls to HIV.

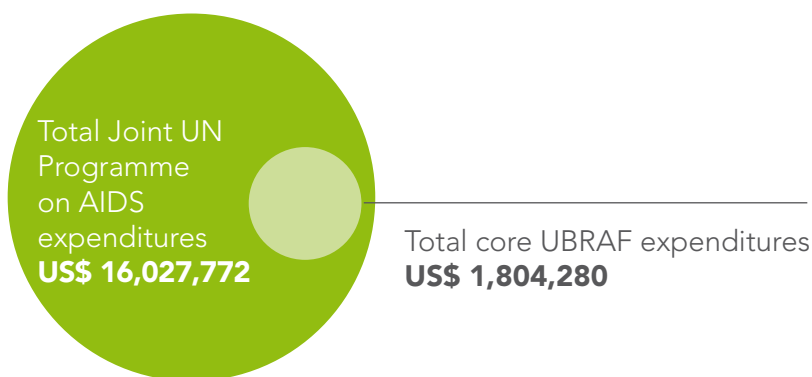
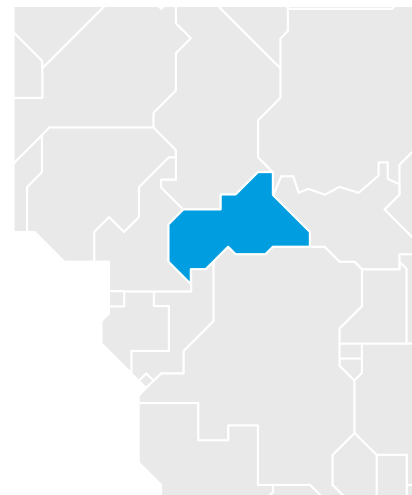
Scaling up treatment coverage and attracting pregnant women in hospital. Efforts are needed to scale up treatment programmes and coverage as about 50% of the people in need of antiretroviral treatment do not access them. With health districts at almost maximum PMTCT coverage, the challenge is to reach women who do not give birth in hospital, particularly those in rural communities.

## **Translating Human rights awareness into actions.**

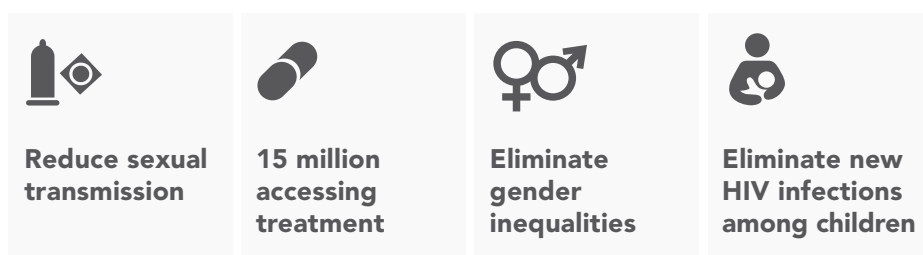
Reducing stigma and discrimination is crucial to the national HIV programme. In Cameroon, the rights to health of key populations, such as men who have sex with men and sex workers have lacked effectiveness. Although UN advocacy has improved awareness of links between HIV responses, the broader MDG agenda and human rights and gender, the Stigma index data compiled with the support of UN staff has enabled an action plan to reduce discrimination and guide judges, lawyers and associations on human rights related to HIV. Next steps will be moving from data to action and focus stakeholders on mobilizing resources to achieve zero discrimination by 2015.

# Central African Republic

## CONFRONTING ADVERSITY IN HIV RESPONSE



### UN areas of work - prioritization by agencies



### Country profile (2012 data)

**4,576,000**

Population

**130,000 [100,000 - 150,000]**

Number of people living with HIV

**110,000 [75,000 - 120,000]**

Adults aged 15 and over living with HIV

**62,000 [44,000 - 67,000]**

Women aged 15 and over living with HIV

**10,000 [7,500 - 13,000]**

AIDS-related deaths

**8,200 [2,000 - 10,000]**

New infections

**4.6% [3.2% - 5.0%]**

Adults aged 15-49 prevalence rate

**22% [21% - 26%]**

ART coverage

**48% [41% - 74%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** multiple heterosexual partnerships



# 'THE GOVERNMENT HAS MADE ELIMINATING GENDER INEQUALITIES A PRIORITY.'

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**Encouraging initial reduction of mother-to-child transmission.** The Government's commitment to scaling up prevention interventions even in a difficult context is evidenced by its willingness to dedicate funds from the national budget to the HIV response, and to work closely with international partners, including UNAIDS. Prevention of mother-to-child transmission (PMTCT) services were scaled up, from 62 in 2006 to 107 in 2010 (89% of target), with a 2010–2013 roadmap to accelerate implementation. Mother-to-child transmission was reduced by half in 50% of the sites. The UN has helped advance the scope, scale and effectiveness of the country's HIV response. The UN Joint Support Programme identified eliminating vertical transmission as a key target and this has been made a priority in the National Strategic Plan 2012–2016. National PMTCT guidelines were revised in 2010, according to WHO recommendations.

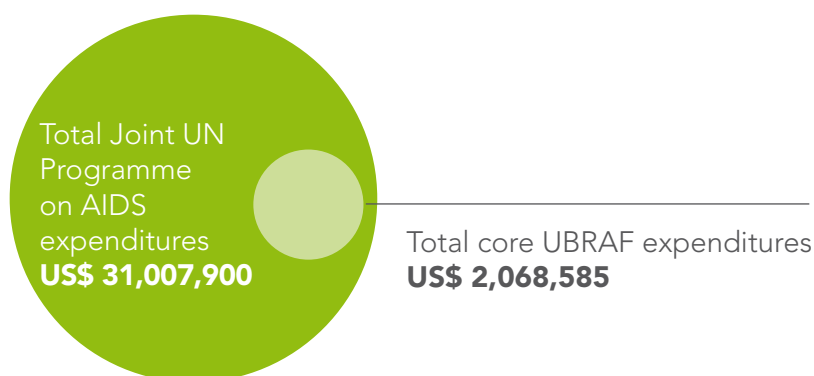
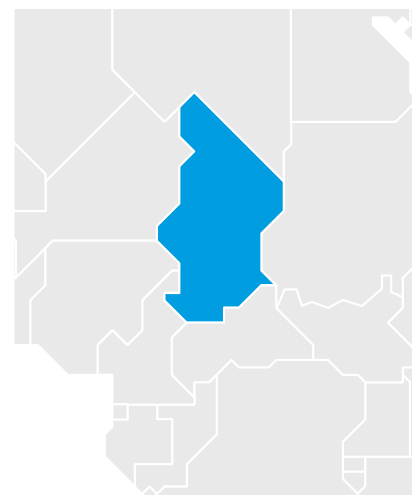
**Alleviating service bottlenecks.** The Government decided to increase access to treatment for all by integrating services. UNICEF has helped develop an operational plan to alleviate service bottlenecks and a capacity-building plan for PMTCT services in 51 health facilities. UNICEF, UNFPA and WHO helped devise plans to integrate PMTCT services with those for sexual and reproductive health. Scaling up access to HIV services has, however, proven difficult. Some programmes, including those funded by the Global Fund, have been suspended, and bottlenecks have hindered the implementation of plans.

**Strategic actions for women and girls.** Political and economic turmoil has exacerbated gender imbalances, and although the country experienced a degree of stability between 2008 and 2013, the sociocultural environment is not favorable to change, meaning women remain at higher risk of HIV because of sexual violence. In line with the 2011 UN Political Declaration on HIV and AIDS, the Government has made the elimination of gender inequalities a priority; strategic actions for women and girls have been incorporated into national, provincial and local plans. With technical support from UNAIDS and WHO, a budgeted operational plan for accelerated action for gender equality in the HIV response has been developed, though funding has not yet been made available.

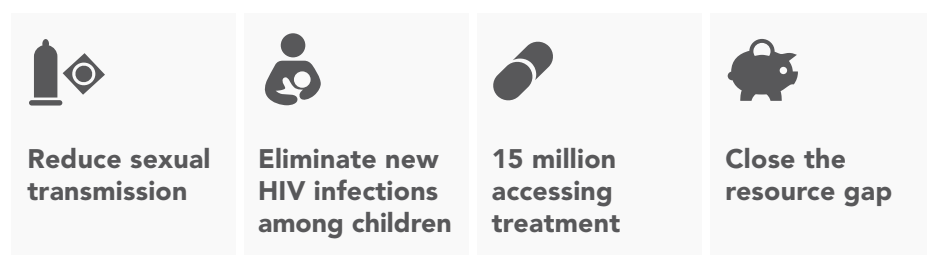
**Domestic resources to be reinforced by external partners.** The response to HIV is a government priority, along with a commitment to increase the health budget from the current 4% to 8% by 2015. But with only US\$ 1.9 million of the US\$ 15.7 million spent in total on the response coming from the public purse, reliable donor support remains crucial. The UN and partner institutions such as the World Bank will continue supporting the Government to strengthen the country coordinating mechanism for strategically monitoring grants and mobilize funds.

# Chad

## ENGAGING ALL LEVELS OF SOCIETY IN THE RESPONSE



### UN areas of work - prioritization by agencies



### Country profile (2012 data)

**13,400,000**

Population

**210,000 [180,000 - 270,000]**

Number of people living with HIV

**180,000 [150,000 - 220,000]**

Adults aged 15 and over living with HIV

**100,000 [88,000 - 130,000]**

Women aged 15 and over living with HIV

**14,000 [12,000 - 19,000]**

AIDS-related deaths

**16,000 [12,000 - 21,000]**

New infections

**2.7% [2.3% - 3.4%]**

Adults aged 15-49 prevalence rate

**40% [35% - 48%]**

ART coverage

**14% [11% - 18%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** sex workers and their clients, multiple heterosexual partners.

# 'WITH THE SUPPORT OF UN AGENCIES, SIGNIFICANT EFFORTS ARE UNDER WAY TO ELIMINATE THE TRANSMISSION OF HIV FROM MOTHER TO CHILD.'

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**Eliminate new HIV infections among children.** Chad is working with the support of the UN to increase its previously low coverage of services for the prevention of mother-to-child transmission (PMTCT). The number of PMTCT sites across the country increased from 93 in 2009 to 140 in 2011 but coverage remained low (14%). However, 304 new UNICEF-supported PMTCT sites established during 2012 helped increase PMTCT coverage from 12% in 2012 to 43% at the end of 2013 (463 sites). With the support of UN agencies significant efforts are under way to eliminate the transmission of HIV from mother-to-child (eMTCT) at national and decentralized levels. The Joint UN Regional Team on AIDS mission in Chad in November 2012 developed e-MTCT microplans for 36 districts in the 10 priority regions, with implementation starting in 2013. To involve all social strata of the country in eMTCT, advocacy sessions were organized for parliamentarians in 2013 as well as social mobilization campaigns targeting community and religious leaders. Parliamentarians and community leaders have committed to work for eMTCT; in six regions religious leaders have agreed to promote PMTCT services and reproductive health in their communities. A national eMTCT plan was launched by the prime minister in May 2012 with the presence of the UNAIDS Executive Director.

**Removing bottlenecks to treatment.** In 2013, UNAIDS and UNICEF advocacy with the Ministry of Public Health led to task shifting for prescribing antiretroviral medicines for PMTCT and to addressing

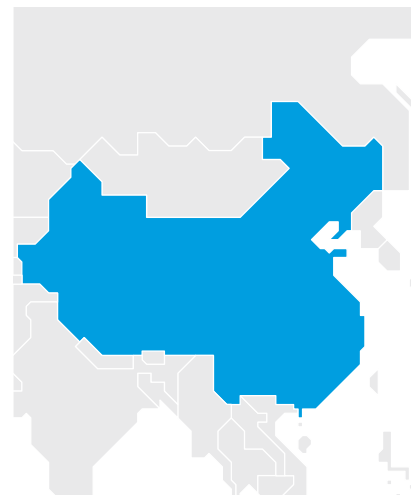
one of the bottlenecks to treatment, namely the lack of coordination between PMTCT and maternal and reproductive health programmes. The UN has helped launch integration activities for HIV and reproductive health. The percentage of pregnant women who received ARV for PMTCT reached 14% to 18.1% between 2012 and 2013.

**Encouraging civil society to lead response.** The UN has supported efforts to address persistent stigma and discrimination in a country where HIV laws have been ineffective in protecting people who live with HIV (PLHIV). It has helped restructure the network of PLHIV, for example, encouraging a strengthened role for civil society and the community in the response, while UNAIDS is supporting administrative, traditional and religious authorities to popularize law 19, which protects PLHIV. Organizations of key populations, such as men who have sex with men and injecting drug users, have also been engaged as partners to advance universal access to HIV prevention and treatment care in major municipalities, but more can be done to protect and empower these groups.

**Promoting workplace rights for PLHIV.** Looking forward, Chad has also taken a frontline approach to promoting the rights of people living with HIV in the workplace, recognizing it is the most effective setting to protect workers and ensure a safe and supportive environment for people affected by HIV.

# China

## LEADING THE WAY ON TREATMENT AS PREVENTION



### Country profile (2012 data)

**1,350,378,000**

Population

**780,000 [620,000 - 940,000]**

Number of adults and children living with HIV

**771,000 [610,000 - 930,000]**

Adults aged 15 and up living with HIV

**230,600 [173,800 - 285,100]**

Women aged 15 and up living with HIV

**28,000 [25,000 - 31,000]**

Deaths due to AIDS

**48,000 [41,000 - 54,000]**

New infections

**<0.1% [<0.1% - 0.1%]**

Adults aged 15-49 prevalence rate

**87.3% among registered PLHIV eligible for ART**

ART coverage

**79.6% among registered HIV positive pregnant women**

PMCT coverage

**Epidemic type:** High burden country

**Modes of transmission:** Sex workers and their clients, men who have sex with men.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 41,028,129**

Total core UBRAF expenditures  
**US\$ 4,119,336**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate  
gender  
inequalities**



**Eliminate  
stigma and  
discrimination**



**Eliminate new  
HIV infections  
among children**

# 'STRENGTHEN LEGAL AND SCIENTIFIC PREVENTION AND CONTROL OF HIV/AIDS.'

## Xi Jinping

President of China

### Renewed efforts against sexual transmission

**of HIV.** China is leading the way on treatment as prevention in its HIV/AIDS strategies and has stepped up efforts in response to emerging issues. National prevalence remains low but the epidemic is severe in some areas. Sexual transmission has become the primary transmission mode and infections among men who have sex with men (MSM) are increasing. The proportion of sexual transmission cases rose from 33.1% in 2006 to 76.3% in 2011, and for homosexual transmission from 2.5% in 2006 to 13.7% in 2011. UN agencies, especially UNAIDS, WHO, UNDP and UNICEF, have supported efforts to improve coverage of services, particularly among key populations, such as MSM, sex workers and people who inject drugs, as well as scaling up access to antiretroviral medicines. The China Action Plan to Prevent and Control HIV/AIDS (2011–2015) builds on the achievements of the previous five-year plan, setting ambitious targets on prevention and control, and increasing access to affordable medicines via domestic production.

### Evidence on gender and HIV is guiding the response.

China has been slow to emphasize gender in its AIDS response but awareness is improving. As part of implementing the UN/RCC (China Global Fund Rolling Continuation Programme) 2011–2012, a gender and HIV work plan was produced with input from UNAIDS, UN Women, ILO, WHO and UNDP. National guidelines are being developed following a study on intimate partner transmission by UNAIDS and UN Women.

**Instigating HIV-related law reform.** In 2013, UN agencies (ILO, UNESCO and UNAIDS), jointly

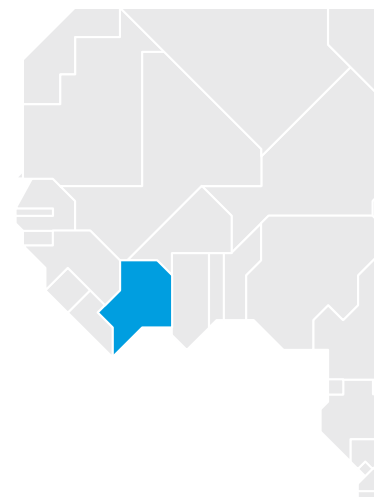
advocated for removal of discriminatory clauses in a provincial regulation that prohibit people living with HIV from becoming teachers. Similar advocacy efforts led to China's Ministry of Commerce indicating it would review proposed regulations prohibiting people living with HIV from accessing public bathing facilities. UNDP, ILO and UNAIDS contributed to efforts towards HIV-related law reform, facilitating a debate through the Red Ribbon Forum that explored the closure of compulsory drug detoxification centres, interaction between HIV and the law, and discrimination in healthcare settings.

### More partnerships to address prevention challenges.

Continued advocacy to uphold the human rights of key affected populations remains a priority, along with mobilizing resources for civil society organizations to ensure the sustainable delivery of services to under-served key affected populations, including detainees. UN agencies, including UNAIDS, are committed to supporting the scale-up of treatment as prevention among key affected populations, and rolling out prevention of mother-to-child transmission services. China is helping, with UNAIDS support, to bring new perspectives and solutions to global challenges posed by the HIV epidemic. Looking forward, support among UN agencies and international partners to the portfolio of China in the world, with a focus on China-Africa health collaboration is growing.

# Côte d'Ivoire

## EMBRACING THE VISION OF ZERO NEW INFECTIONS IN CHILDREN



Total core UBRAF expenditures  
**US\$ 2,507,473**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**15 million  
accessing  
treatment**



**Close the  
resource gap**

### Country profile (2012 data)

**19,772,257**

Population

**450,000 [390,000 - 530,000]**

Number of people living with HIV

**390,000 [340,000 - 450,000]**

Adults aged 15 and over living with HIV

**220,000 [190,000 - 260,000]**

Women aged 15 and over living with HIV

**31,000 [26,000 - 38,000]**

AIDS-related deaths

**30,000 [22,000 - 39,000]**

New infections

**3.7% (ref. EDS-MICS 2011-2012)**

Adults aged 15-49 prevalence rate

**49% [44% - 55%]**

ART coverage

**68% [55% - 84%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** multiple  
heterosexual partners.

# 'OUR FIRST DUTY AS RESPONSIBLE PARENTS AND CITIZENS IS TO PRESERVE A BRIGHTER FUTURE FOR GENERATIONS TO COME.'

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## **Mrs Dominique NOUVIAN OUATTARA**

First Lady of Côte d'Ivoire

**Revitalizing maternity centers.** Côte d'Ivoire has embraced the vision of zero new HIV infections in children. By the end of 2013, 62% of HIV-positive pregnant women were able to access services that prevent transmission from mother to child. The coverage of HIV prevention and treatment services for women and children increased between 2009 and 2013 up to 59% for pregnant women accessing antiretroviral medicines. Notable progress has been made in revitalizing maternity centers, and the country is providing free health services to all pregnant women during delivery. HIV is being integrated into sexual and reproductive health programmes, and community involvement is growing in health management and family planning. This is quite an achievement in a country with one of the highest HIV prevalence rates in West Africa, and a post-election crisis in 2010–2011 that slowed interventions.

**Commendable social protection.** The country, with support and training from the Joint UN Team on AIDS (JUNTA), has taken a commendable approach to social protection by providing technical and financial assistance to develop a national plan. UNAIDS and UNDP, in collaboration with development partners, have helped develop the network of women living with HIV to enhance the implementation of the UNAIDS Agenda for Women and Girls. The Joint UN Team has also provided support to develop the national strategy against gender-based violence to be adopted by the government.

**Tangible results at community level.** A national plan for eliminating mother-to-child transmission has been

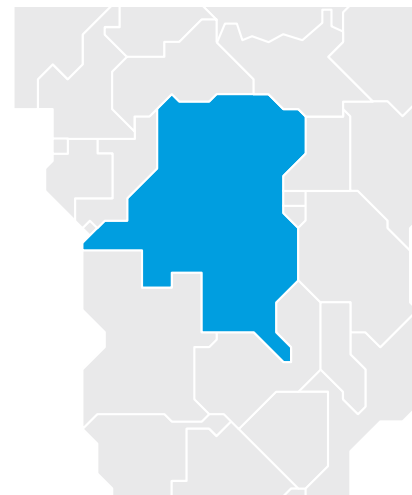
developed and launched with technical and financial support from the UNAIDS Secretariat, UNFPA and UNICEF. Resources to implement the plan have been mobilized through the UN system, the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR). With UNFPA and UNICEF backing and commensurate with Côte d'Ivoire's decentralized system, a multisectoral approach to HIV, maternal and child health has been integrated with prevention of mother-to-child transmission, giving tangible results at community level.

### **Workplace policies to secure PLHIV rights.**

Promoting the workplace rights of people living with HIV is a priority. The response of the private sector has been weak and access to prevention services for all workers living with HIV/AIDS continue to be problematic. UNAIDS and the ILO are helping revise the 2006 national HIV/AIDS workplace policy. It is crucial that the UNAIDS Agenda for Women and Girls is launched at the country level. The draft law on HIV has been reviewed with the support of UNAIDS and Cosponsors and approved by the Government; the National Assembly is scheduled to adopt it in 2015. Scaling up access to services for highly vulnerable populations and people living with HIV, such as men who have sex with men, sex workers, injecting drug users and prison populations in an environment free of discrimination and stigma, is critical to the response.

# DR Congo

## INCREASING DOMESTIC RESOURCES AMID HUMANITARIAN CHALLENGE



Total core UBRAF expenditures  
**US\$ 4,531,111**

### UN areas of work - prioritization by agencies



### Country profile (2012 data)

**77,000,000**

Population

**480,000 [440,000 - 530,000]**

Number of people living with HIV

**390,000 [360,000 - 430,000]**

Adults aged 15 and above living with HIV

**230,000 [210,000 - 260,000]**

Women aged 15 and over living with HIV

**32,000 [29,000 - 36,000]**

AIDS-related deaths

**34,000 [30,000 - 40,000]**

New infections

**1.1% [1.0% - 1.2%]**

Adults aged 15-49 prevalence rate

**31% [29% - 34%]**

ART coverage

**13% [11% - 15%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** sex workers and their clients, men who have sex with men, multiple heterosexual partners.



# 'THE GOVERNMENT HAS IDENTIFIED THE NEED FOR MORE MATERNITY HOSPITALS OFFERING PMTCT SERVICES.'

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**Addressing barriers to discussing sexuality.** Early sexual intercourse and lack of HIV knowledge are known to increase the risk of infection, which is particularly relevant to the Democratic Republic of Congo, where 13.5% of young people have sexual intercourse before the age of 15, and only 16.6% correctly describe how to prevent HIV transmission through sexual intercourse. The country has identified sexual transmission of HIV among those aged 15–24 for focused intervention through multiple programmes, particularly in education systems. Such programmes also aim to address the cultural barriers to discussing sexuality. The 2014–2017 strategic plan, developed with technical and financial support from UNAIDS, UNICEF and UNDP, targets reducing risky sexual behaviors among vulnerable groups as one of its key strategies.

## **Tackling sexual gender-based violence.**

Sexual and gender-based violence remain key drivers of the spread of HIV in the country. A series of UN advocacy activities and trainings in various constituencies and regions have been implemented to enhance awareness and make available evidence-based information for further strategic and policy changes. These activities have included support for the International Centre for Migration, Health and Development (ICMHD), developing a national knowledge, attitude and practice (KAP) policy, and providing training tools for preventing HIV and sexual gender-based violence. The UN Organization Stabilization Mission in the Democratic Republic of Congo (MONUSCO) and UNFPA have collaborated with the Government in developing a humanitarian action plan for the North and South Kivu provinces. The UN has also assisted in efforts to sensitize senior armed

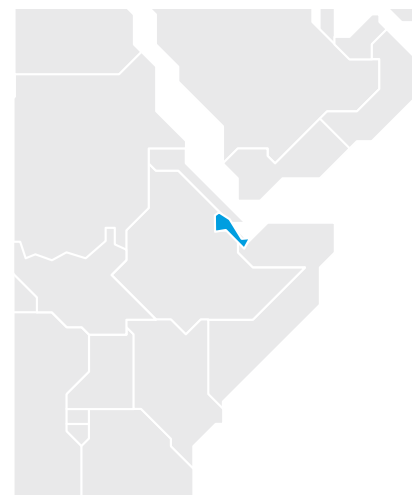
forces personnel to sexual gender-based violence, a process that has also reached inmates and prison staff in the cities and towns of Kinshasa, Bukavu, Kalemie, Kongolo and Manono.

**Increasing domestic investment in response.** The Democratic Republic of Congo has prioritized vertical transmission. A plan to eliminate new HIV infections among children by 2017, developed with UNAIDS, UNICEF, WHO and UNFPA, was launched in October 2012. The Government has identified the need for more maternity hospitals offering prevention of mother-to-child transmission (PMTCT) services, a regular supply of drugs and tests, and community involvement in the response. Financial gaps in AIDS spending have been assessed and domestic investment increased from 3% to 10% to expand PMTCT interventions. Improving reproductive health and integrating HIV care into family planning services are further priorities. To this end, UNFPA has already helped build capacity in integrated maternity services, and with the support of UNICEF and WHO, Option B+ is being implemented in Katanga in four health zones.

**Humanitarian challenges stretch resources.** The Government is increasing domestic resources for its HIV response, an admirable approach amid continuing humanitarian challenges and political unrest. Beside strategic and technical changes for a more cost effective AIDS response, the UN system will continue supporting the Government to mobilize domestic resources from public and private sectors.

# Djibouti

## TARGETING MIGRANTS AND MOBILE POPULATIONS



### Country profile (2012 data)

**915,000**

Population

**7,700 [6,200 - 9,400]**

Number of people living with HIV

**6,500 [5,200 - 8,000]**

Adults aged 15 and above living with HIV

**3,700 [3,000 - 4,700]**

Women aged 15 and up living with HIV

**<1,000 [<1,000 - 1,000]**

**Deaths due to AIDS**

AIDS-related deaths

**<500 [<200 - <1,000]**

New infections

**1.15% [0.92% - 1.46%]**

Adults aged 15-49 prevalence rate

**31% [26% - 38%]**

ART coverage

**20% [15% - 26%]**

PMCT coverage

**Epidemic type:** generalized

**Main modes of transmission:** sex workers and their clients, heterosexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 6,303,162**

Total core UBRAF expenditures  
**US\$ 857,893**

### UN areas of work - prioritization by agencies



**15 million  
accessing  
treatment**



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**Eliminate  
gender  
inequalities**

# 'DRIVERS, DOCK WORKERS, SHIP CREWS AND SEX WORKERS LIVING AROUND DJIBOUTI'S PORTS ARE VULNERABLE TO HIV.'

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**Stabilizing HIV rates among young people.** Djibouti's location near busy shipping lanes along the Red Sea and Indian Ocean means large numbers of migrants and mobile populations, including truck drivers, dock workers, ship crews and sex workers, living around its ports can be particularly vulnerable to HIV due to poverty, social exclusion, separation from families and communities, loneliness, fear and marginalization. Recognizing this, the Government has sought to address HIV transmission among these high-risk groups, in close collaboration with UNAIDS and other UN partners. The 2012–2016 National Strategic Plan aims to improve access to comprehensive HIV services and care for refugees and migrating populations. The UN Refugee Agency (UNHCR) and the UN Children's Fund (UNICEF) provide medical and social care in refugee camps for victims of gender-based violence and vulnerable children, including those orphaned by HIV, and educate young refugees in HIV prevention and awareness. UNICEF, along with the UN Population Fund and partners from the education sector, have helped adolescents and young adults access social services, including voluntary counselling and testing, and to improve their psychosocial skills to protect them against drugs and HIV infection. These efforts have helped stabilize HIV rates among young people and reverse the upwards 2008 trend.

**Nutritional advice to HIV-positive mothers.** UNICEF and WHO have supported the Ministry of Health in coordinating decentralized services for preventing

mother-to-child HIV transmission (PMTCT) by training health service providers in voluntary counselling and testing and in advising HIV-positive mothers on feeding and nutrition.

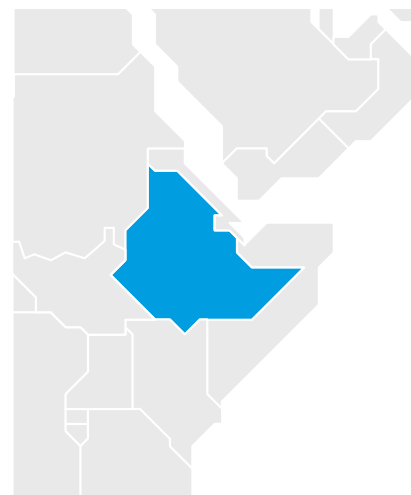
**Easing access to HIV testing and treatment.** The UN worked with other vulnerable populations in 2012, strengthening, for example, the capacity of the Sister to Sister sex-worker network to participate in the response by conducting HIV awareness sessions in the capital, Djibouti city, and bringing together network leaders with nursing staff to ease access to HIV testing and treatment for sexually transmitted infections, including HIV.

## **HIV needs of young people create challenges.**

Challenges remain for the UN and its partners in meeting the HIV needs of adolescents and young adults, who represent more than 50% of Djibouti's population and are the most affected by HIV; prevalence among 15–34 year-olds is 6% compared with 1.2% in the general population. Efforts will be made to reach out-of-school adolescents as, despite laws making attendance compulsory until age 16, 59% of 13–18 year-olds are not enrolled in school. Current socio-economic conditions expose them to the risk of khat, alcohol and drug consumption as well as to sexually transmitted infections, including HIV.

# Ethiopia

## EMPHASIS ON WOMEN AND CHILDREN YIELDS STRONG RESULTS



### Country profile (2012 data)

**85,200,000**

Population

**760,000 [690,000 - 840,000]**

Number of people living with HIV

**590,000 [540,000 - 660,000]**

Adults aged 15 and above living with HIV

**380,000 [340,000 - 420,000]**

Women aged 15 and up living with HIV

**47,000 [40,000 - 56,000]**

AIDS-related deaths

**20,000 [14,000 - 29,000]**

New infections

**1.3% [1.2% - 1.5%]**

Adults aged 15-49 prevalence rate

**60% [55% - 65%]**

ART coverage

**41% [35% - 49%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** sex workers and their clients, sexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN Programme on AIDS expenditures  
**US\$ 104,672,724**

Total core UBRAF expenditures  
**US\$ 4,104,447**

### UN areas of work - prioritization by agencies



**Reduce sexual transmission**



**15 million accessing treatment**



**Eliminate new HIV infections among children**



**Eliminate stigma and discrimination**

# THE STRATEGIC HIV PLAN HAS BEEN TAILORED TO THE NEEDS OF WOMEN AND GIRLS.

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## **Adolescents leading progress on incidence reduction through a rights-based programme.**

Ethiopia has made strong progress in scaling up HIV prevention services for key populations, including young people, refugees, sex workers and prisoners. Adult HIV incidence declined by 90% between 2001 and 2012. The rights-based adolescent programme implemented by UNICEF and UNFPA in 25 target districts in Addis Ababa, Afar, Amhara, Oromia and the Southern Nations, Nationalities and Peoples' Region (SNNPR) provided 134,000 young people with direct HIV and sexual reproductive health information. UNHCR, with support from UNICEF, UNFPA and WHO, has supported a comprehensive HIV prevention programme in refugee settings. UNFPA supported training for peer learning for female sex workers, while UNODC collaborated with prison management to educate inmates and staff on HIV prevention in prison settings. After several years of UN advocacy, the Government of Ethiopia agreed to develop a comprehensive condom strategy for female and male condoms. A strategy, using the Comprehensive Condom Programming Framework developed by UNFPA, was completed in the first quarter of 2013.

## **Addressing gender barriers to HIV services helps reduce new infections among women.**

Prevalence of new infections among pregnant women aged 15–24 has declined from 5.6% in 2005 to 2.6% in 2011. With increasing PMTCT coverage, at 41% now, new HIV infections among children have been substantially reduced; however the percentage of children receiving HIV treatment remains low - at less than 25% in 2012 – particularly for children above five years old. As part of the UNAIDS Agenda for Women and Girls, a multi-disciplinary taskforce has been established at the Federal Ministry of Health to advise on gender

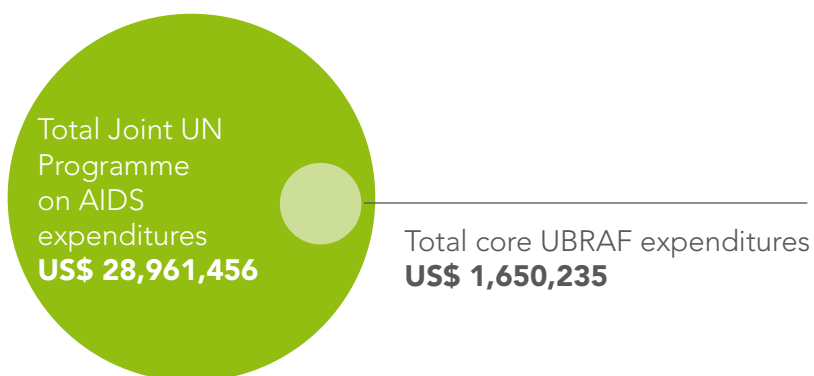
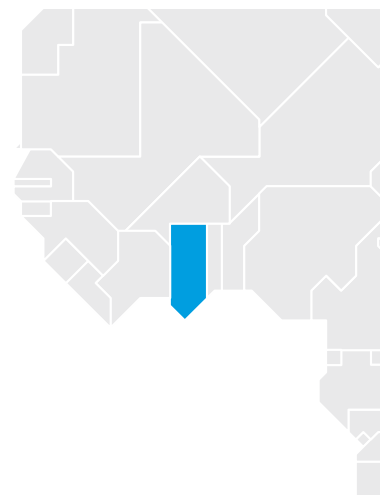
and health, a result of high-level UN advocacy and an assessment of gender barriers to HIV services. Members of the National Network of Positive Women in Ethiopia were supported to become strong advocates, particularly for increased access to prevention of mother-to-child transmission (PMTCT), antenatal care and family planning, and for the rights of HIV positive women. As a result, the strategic HIV plan and biannual action framework was tailored to fit the needs of women and girls, reflecting global and regional commitments to scale up such action. Strategies developed for advancing the integration of HIV into the wider maternal, newborn and child health platform and the national elimination of mother-to-child transmission strategic framework resulted in the adoption of PMTCT option B+ of the WHO 2013 combined guidelines.

**Sharp increases in HIV treatment coverage.** Major investments in HIV testing programmes and community-centre treatment led to sharp increases in HIV treatment coverage (reaching 60% by 2012), while the estimated HIV incidence rate fell by 90% from 2001 to 2011, partly due to better HIV treatment. The country has made strong progress in expanding access to HIV treatment but the momentum must continue to tap significant unused capacity to reach those who have yet to obtain therapy.

**More evidence for key populations.** The UN and its partners must continue to assist the Government in efforts to increase the evidence base to inform prevention programming and interventions, and to bridge the knowledge gap in combination prevention, especially for key populations.

# Ghana

## SCALING UP ITS HIV RESPONSE ON SEVERAL FRONTS



### UN areas of work - prioritization by agencies

			
Reduce sexual transmission	Eliminate gender inequalities	Eliminate new HIV infections among children	Eliminate stigma and discrimination

### Country profile (2012 data)

**26,900,000**

Population

**240,000 [200,000 - 270,000]**

Number of people living with HIV

**210,000 [180,000 - 240,000]**

Adults aged 15 and above living with HIV

**120,000 [100,000 - 140,000]**

Women aged 15 and over living with HIV

**12,000 [8,900 - 15,000]**

AIDS-related deaths

**8,000 [4,500 - 12,000]**

New infections

**1.4% [1.2% - 1.6%]**

Adults aged 15-49 prevalence rate

**58% [52% - 65%]**

ART coverage

**95% [77% - 95%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** multiple heterosexual partners.

# 'I COMMIT TO ENSURING NO CHILD IS BORN HIV-POSITIVE, NO CHILD DIES FROM THE DISEASE AND NO CHILD IS ORPHANED BECAUSE OF HIV.'

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## Lordina Mahama

First Lady of Ghana

New HIV infections in children cut by 76% since 2009. Ghana has scaled up its HIV response on several fronts, particularly around the elimination of mother-to-child transmission (eMTCT). Ghana has tripled its coverage of antiretroviral medicines for pregnant women living with HIV, resulting in a 76% reduction in new infections among children, the highest observed among the countries with a high burden of pregnant women living with HIV. A stakeholder group was established to coordinate the scaling up of services for prevention of mother-to-child transmission (PMTCT) and Early Infant Diagnosis and Pediatric ART services in 14 focus regions.

Increasing young people's knowledge of HIV. Ghana has also endeavored to increase young people's knowledge of HIV. The Ministry of Education HIV and AIDS Policy and Sectoral Plan 2011–2015 has been aligned to the National Strategic Plan 2011–2015 and a framework to address sexuality and HIV education was developed. The HIV Alert School Programme, with input from UNESCO, UNAIDS, UNFPA and UNICEF, has increased its coverage, while the UNJT Youth Cluster will continue to support integrating sexuality education in informal and formal learning. A coordinated advocacy effort in 2013, under 'Protect the Goal Campaign', has reached out nationwide to promote safe sex practices among the young people with three messages: 'use condom', 'know your HIV status', and 'reduce sex partners'. The campaign is getting endorsement from celebrities, media, civic and cultural leaders, as well as a wide spectrum of the society.

Reducing the funding gap and promoting alternative policies for increased access to treatment. UN advocacy and technical support has enhanced government efforts to build a more sustainable response, including committing US\$ 100 million for the period of the National Strategic Plan 2011–2015, an increase from less than US\$ 1 million per annum to US\$ 20 million per annum (though a 40% funding gap persists). Challenges remain such as the

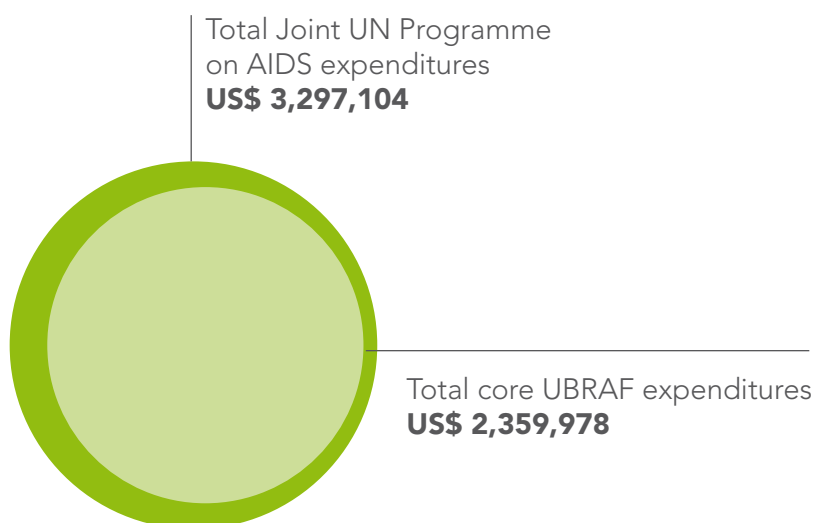
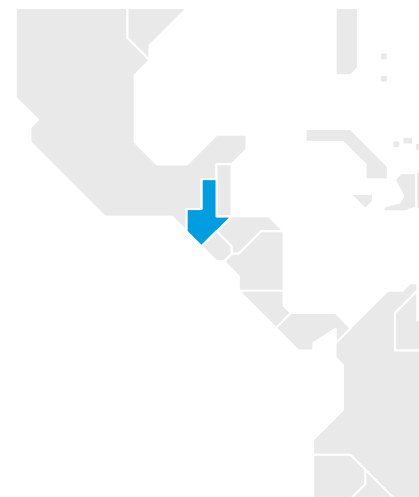
timely release of funds and the sustained fiscal crisis in the economy. UNAIDS, UNDP, WHO and UNFPA took the initiative together with UNIDO and the UN-RC to support the government to adopt the Business Plan of the Pharmaceutical Plan for Africa (PMPA) in enhancing its capacity to locally manufacture pharmaceutical products and support the manufacturers to work towards WHO prequalification status.

New funding mechanism and retargeting. Resources are needed to sustain workable interventions and maintain the gains made in the national response to HIV and AIDS. UNAIDS will continue to support Ghana in the process for applying for funds from the Global Fund under the new funding mechanism, assist the Country Coordination Mechanism to align the concept note to the National Strategic Plan 2011–2015 and facilitate dialogue on new HIV targets to be adopted by Ghana.

**Supporting dialogue on human rights.** Stigma and discrimination towards people living with HIV (PLHIV) and key populations, including men who have sex with men, female sex workers and people who inject drugs, persist in Ghana. Criminalizing these groups' activities hinders access to services, while lack of knowledge among law enforcers and the judiciary mean their human rights continue to be violated. But progress is being made. The UNJT Stigma Cluster Group will continue to support dialogue on human rights and HIV, the Heart-to-Heart initiative and to reduce widespread stigma and discrimination. A national consultation on human rights and HIV has been organized by UNDP, UNAIDS, the Ghana AIDS Commission. The most-at-risk populations strategy 2011–2015 seeks to strengthen services to those groups, while the draft national gender policy includes HIV/AIDS.

# Guatemala

## ENGAGING YOUNG PEOPLE IN THE NATIONAL AIDS RESPONSE



### UN areas of work - prioritization by agencies



**Eliminate  
stigma and  
discrimination**



**Eliminate new  
HIV infections  
among children**



**Reduce sexual  
transmission**



**Eliminate  
gender  
inequalities**

### Country profile (2012 data)

**15,600,000**

Population

**58,000 [36,000 - 130,000]**

Number of people living with HIV

**53,000 [33,000 - 120,000]**

Adults aged 15 and above living with HIV

**20,000 [12,000 - 44,000]**

Women aged 15 and up living with HIV

**3,400 [1,800 - 7,100]**

AIDS-related deaths

**3,000 [1,000 - 15,000]**

New infections

**0.7% [0.4% - 1.5%]**

Adults aged 15-49 prevalence rate

**51% [37% - 87%]**

ART Coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** Concentrated

**Modes of transmission:** men who have  
sex with men.



# UNAIDS HAS PROVIDED TECHNICAL, ADVOCACY AND FINANCIAL SUPPORT TO SEVERAL INITIATIVES ON THE HUMAN RIGHTS OF POPULATIONS THAT ARE MOST AT RISK.

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## **Overcoming obstacles to health and legal services.**

In Guatemala, populations that are the most affected by the HIV epidemic face high levels of stigma and discrimination and frequent violation of their human rights, posing obstacles to accessing health and legal services. To address this situation, UNAIDS has provided technical, advocacy and financial support to several initiatives on human rights of the most at risk populations. Such support has helped increase the capacity of the Legal Network and Observatory on HIV/AIDS, update national HIV legislation and public policy, and develop a mechanism in order to monitor and litigate complaints on human rights violations. A legal aid centre has been established in Guatemala City where lawyers provide pro-bono services. A draft of a national gender identity law and an advocacy strategy were developed in 2013, supported by UNAIDS Secretariat, UNFPA, UNDP and an organization of transgender persons.

**Providing free rapid HIV testing and counselling.** In partnership with the AIDS Health Care Foundation, the nongovernmental organization “Acción para una vida saludable”<sup>6</sup> and the health department in Petén province, UNAIDS developed a project framed by the treatment 2.0 strategy (pillar 5), which provides free rapid HIV testing and referral of positive cases, as well as training for 20 people living with HIV to promote the initiative. Poor access to antenatal care, resistance to HIV testing and a scarcity of test kits are among the reasons that causing Guatemala to have the highest rate of vertical transmission of HIV in Latin America: 15% of children born to mothers diagnosed as HIV-positive in 2013 are HIV-positive themselves. The UN Joint Team on AIDS has worked closely with the Ministry of Health to elaborate a national strategy for eliminating vertical transmission

of HIV and congenital syphilis that was launched in October 2013. Technical and financial support to improve capacity for implementing the strategy was also provided. Though achieving the 2015 target of zero new infections among children will be a challenge, including prevention of mother to child transmission (PMTCT) services in budgetary frameworks and expanding services to all health centres, providing this service are important steps forward.

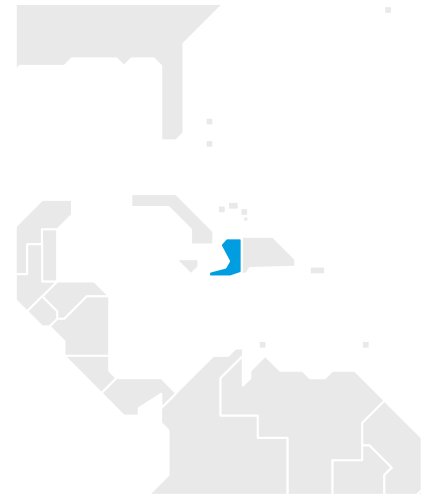
**Eliminating gender inequalities.** A national action framework on HIV and gender-based violence among women and girls is being implemented through multi-sector working groups and with support from UN Women, UNESCO and UNDP. The UN Secretary-General’s UNITE to End Violence against Women campaign has also been launched in the country.

**Progressing through a youth focus.** Guatemala is making strong progress in engaging adolescents and young people in the design and implementation of more effective programmes on youth and HIV. UNAIDS Secretariat, UNICEF and UNESCO are committed to continue the support for initiatives such as First National Consultation on Youth and HIV, inspired by the global initiative CrowdOutAIDS. The consultation involved youth from different ethnic backgrounds and geographic areas. Seven recommendations with 34 specific actions to improve HIV programmes were defined. Going forward, the UN will work to help ensure these recommendations and actions are implemented.

<sup>6</sup> Action for a healthy life

# Haiti

## VULNERABLE POPULATIONS AT THE CENTRE OF AIDS RESPONSE



### Country profile (2012 data)

**10,900,000**

Population

**150,000 [130,000 - 160,000]**

Number of people living with HIV

**130,000 [120,000 - 150,000]**

Adults aged 15 and over living with HIV

**78,000 [70,000 - 88,000]**

Women aged 15 and up living with HIV

**7,500 [6,200 - 8,900]**

AIDS-related deaths

**8,500 [6,900 - 11,000]**

New infections

**2.1% [1.9% - 2.3%]**

Adults aged 15-49 prevalence rate

**60% [55% - 65%]**

ART Coverage

**>95% [85% - 95%]**

PMCT coverage

**Epidemic type:** Generalized

**Modes of transmission:** Sex workers and their clients, men who have sex with men, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 54,284,990**

Total core UBRAF expenditures  
**US\$ 2,352,312**

### UN areas of work - Prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate  
stigma and  
discrimination**



**Eliminate new  
HIV infections  
among children**

# IN HAITI THERE IS GROWING AWARENESS OF THE HARMFUL EFFECTS THAT DISCRIMINATION HAS ON HIV PREVENTION.

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**Moving towards an AIDS free Generation.** Haiti has put people most vulnerable at the centre of its AIDS response. With UN support, the country has worked hard to reach populations at a high risk of HIV infection with prevention and treatment services. Interventions have been hampered by political upheaval, natural disaster and medical emergencies, and following the earthquake in 2010, which caused severe setbacks in service delivery and access, there is evidence of a steady recovery. More and more pregnant women use services to prevent HIV infection in their unborn children. With the support of UNAIDS and partners in the UN system, a national strategic plan on the elimination of mother to child transmission has been adopted and the Ministry of Health and the First Lady took the lead in an HIV prevention campaign to ensure that more pregnant women access HIV testing and treatment services. UN partners have worked closely with the Government to revise PMTCT guidelines and advocated for the adoption of the B+ option.

## **Adapting the post-earthquake priorities.**

With UNAIDS support, the Government has developed the National Multisectoral HIV Strategic Plan 2008–2012, revised and extended to 2018. The Ministry of Education's operational plan, developed with UNESCO, includes HIV prevention and school health, while WHO, UNICEF and UNFPA have supported strategies to educate coordinators in reproductive health departments on issues affecting young people. Haiti is strengthening capacities to work with key populations, especially sex workers and their clients as well as men who have sex with men, of which an estimated 8% and 18% are living with HIV, respectively. New priorities for the post-earthquake period, while remaining within the national

strategic plan framework, have been adopted to ensure continuing prevention, diagnostic care and treatment, and rehabilitation for vulnerable populations. UNFPA provided technical and financial assistance to SEROVie Foundation, which won the Red Ribbon award for its work with Haiti's sexual minorities. It also supported the Ministry of Health's condom programme. UNDP helped 2,400 sex workers and 8,600 MSM enrol in HIV prevention programmes.

## **Mobilizing LGBT community in the response.**

In Haiti, there is growing awareness of the harmful effects that discrimination has on HIV prevention. UNAIDS Secretariat is advocating for a prominent human rights agenda, mobilizing the lesbian, gay, bisexual and transgender (LGBT) community, for example, and supporting its integration into the response. UNESCO is developing materials on HIV and human rights for community leaders, and UNFPA works with members of the Joint UN Team on AIDS to validate UNESCO teaching material, promoting human rights and gender equality.

**Re-energizing prevention will be vital.** Moving into the post-emergency period, continued UN support for the National Multisectoral HIV Strategic Plan (PSNM 2018) will be vital in order to define norms for youth and adolescent services, integrate LGBT interventions and interventions for women and girls, strengthen coordination for eMTCT and build the capacity of people living with HIV to help lead the AIDS response.

# India

## ON TRACK TO ELIMINATE NEW PAEDIATRIC HIV INFECTIONS



### Country profile (2012 data)

**1,220,000,000**

Population

**2,100,000 [1,700,000 - 2,600,000]**

Number of people living with HIV

**1,900,000 [1,600,000 - 2,400,000]**

Adults aged 15 and over living with HIV

**750,000 [610,000 - 940,000]**

Women aged 15 and up living with HIV

**140,000 [100,000 - 170,000]**

AIDS-related deaths

**130,000 [80,000 - 230,000]**

New infections

**0.27% [0.22% - 0.33%]**

Adults aged 15-49 prevalence rate

**50% [43% - 56%]**

ART Coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** Generalized

**Modes of transmission:** Sex workers and their clients, men who have sex with men, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 559,866,968**

Total core UBRAF expenditures  
**US\$ 3,135,213**

### UN areas of work - Prioritization by agencies



**Prevent  
HIV among  
drug users**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**



**Eliminate  
stigma and  
discrimination**

# HIV INCIDENCE HAS DECLINED MORE THAN 50% BETWEEN 2001 AND 2011, PARTICULARLY IN SOUTHERN STATES.

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**Interventions for key populations.** HIV prevention via reduced sexual transmission among key populations has been central to the AIDS response in India: these include female sex workers, men who have sex with men, transgender people, internal migrants, mobile populations as well as people who inject drugs. These interventions, adapted and scaled-up over time, have yielded positive results with HIV incidence declining more than 50% between 2001 and 2011 particularly in southern states where the epidemic was concentrated and programs were substantially rolled out. However, recent data indicates that the epidemic is increasing in some states in North East and North India, mostly driven by injecting drug use and unprotected sexual contacts. The Government is planning further scale up of preventive interventions across populations, with focus on specific states and districts for key populations. Injecting drug use remains a major mode of HIV transmission, and UNODC, UNAIDS Secretariat and other partners are working with Government, civil society and community organizations to scale-up effective interventions for people who use drugs.

**Merging services in antenatal clinics.** India has unequivocally committed to ending vertical transmission, although eliminating new paediatric HIV infections by 2015 remains a challenge. A comprehensive set of actions are being implemented in 2014 to put India on track to meet this target. These include steps for strengthening convergence of Prevention of Parent-to-Child Transmission (PPTCT) in urban and rural health care services for achieving enhanced antenatal care uptake, increased HIV counselling and testing, and greater availability and accessibility to PPTCT across the country. The UN assisted the development of national guidelines for PPTCT based on the more efficacious multi-drug regimen. India has now universally adopted and rolled-out the Option B+ strategy as single-dose Nevirapine is in the process of being phased out. Following advocacy and guidance from WHO, UNICEF, UNAIDS Secretariat and other partners, the Ministry of Health and Family Welfare is now integrating PPTCT into maternal and child health. To this effect, India formulated and formally

launched a national strategy specifying a time based implementation plan for scale-up of effective multi-drug regimens for PPTCT across the country, and updated operational guidelines for implementation of this new policy in January 2014. The aim is securing 100% coverage by end 2014.

**Building an enabling environment for the HIV response is critical.** Numerous national and state level initiatives for social protection of people living with HIV and their families as well as of key populations have been taken up with the support of UNDP and other UN Agencies in their respective sector focus (ILO, UNODC, etc.). Mechanisms are also in place for facilitating service uptake under the national AIDS program, with an increased focus on risk and vulnerability among women. This is coupled with efforts for mainstreaming HIV into various ministries and departments at national and state level. In addition, there is a renewed thrust to push a comprehensive HIV Bill for adoption by Parliament which will secure essential rights of people living with HIV and address stigma and discrimination.

**Focused response in India to sustain gains and scale up for populations in need.** Changes in the geographic profile of the epidemic requires a focused response for North and North East India, while scaling up services for key populations will be critical to sustaining gains. Service uptake among women must be increased, specifically for those who are facing diverse risks, living with HIV or pregnant. India needs to continue its efforts to provide quality generic Antiretroviral (ARV) drugs for both its population and globally, and to establish free universal access to health. Going forward, UNAIDS and partners will advocate for a simplified Treatment 2.0 framework with countries. For this to succeed, the Trade-Related aspects of Intellectual Property Rights (TRIPS) flexibilities will continue to play an important role.

# Indonesia

## INTENSIFYING EFFORTS TO PREVENT SEXUAL TRANSMISSION



### Country profile (2012 data)

**241,000,000**

Population

**610,000 [390,000 - 940,000]**

Number of people living with HIV

**590,000 [380,000 - 910,000]**

Adults aged 15 and over living with HIV

**230,000 [150,000 - 370,000]**

Women aged 15 and over living with HIV

**27,000 [16,000 - 42,000]**

AIDS-related deaths

**76,000 [47,000 - 150,000]**

New infections

**0.4% [0.3% - 0.7%]**

Adults aged 15-49 prevalence rate

**17% [12% - 24%]**

ART Coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** sex workers and their clients, men who have sex with men, heterosexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN Programme on AIDS expenditures  
**US\$ 19,856,666**

Total core UBRAF expenditures  
**US\$ 3,000,065**

### UN areas of work - Prioritization by agencies



**Reduce sexual transmission**



**Prevent HIV among drug users**



**15 million accessing treatment**



**Eliminate new HIV infections among children**

# 'WE NEED TO ACT BOLDLY AND LEVERAGE ON THE SCIENCE, WHICH IS TELLING US TREATMENT CAN ALSO SERVE AS PREVENTION.'

---

## Ms Nafsiah Mboi

Minister of Health

**Taking bold steps to accelerate response.** Faced with an increasing epidemic, the Minister of Health has taken bold steps to accelerate the response by intensifying efforts to prevent sexual transmission. Substantial progress has been made through innovative responses focusing on preventing HIV transmission among those people most at risk, including the country's large floating domestic workforce, mostly men aged 15–50 who engage in high-risk sex. The new structural approach seeks to empower sex workers, involve local stakeholders and promote partnerships with health services across Indonesia.

### **Scaling up needle and syringe exchange.**

Indonesia's epidemic is concentrated in key populations at high risk of HIV infection, including sex workers and their clients, injecting drug users, men who have sex with men and transgender people. The UN system has supported an accelerated prevention response by helping improve the quality and coverage of services, such as needle and syringe exchange. The UN led advocacy and capacity building, organizing a seminar on the right to health for drug users. With UN assistance, discrimination documentation has also been improved, which will help the National AIDS Commission monitor complaints and ensure laws are more effectively applied. UNAIDS advocacy has helped generate better coordination and education among government and law enforcements bodies.

**Removing barriers to services for key groups.** The country is striving to scale up testing and treatment programmes, initiating continuum of care at district level and increasing access to antiretroviral treatment

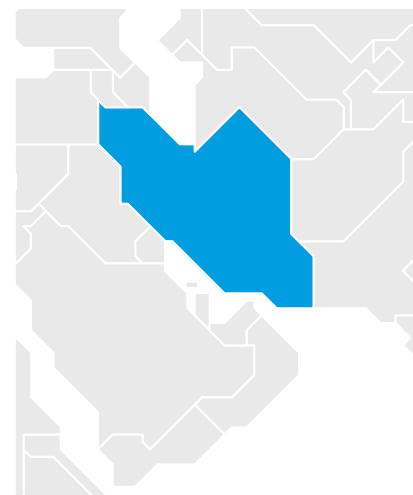
by engaging communities to design and roll out the programmes. Strong national leadership has been demonstrated with the launch of the Strategic Use of ARV campaign and the removal of policies that hamper access to services for people living with HIV and other key populations. Legal impediments remain, however, including laws that prohibit sex work and those that stipulate only married couples can access sexual and reproductive services. The UN Joint Team is focusing its support on programmes for key populations that need to be accelerated and linked to the strategic use of ARV.

**Showing leadership beyond its borders.** With UN support, Indonesia is building a strong national response while also taking a leading role in regional and worldwide efforts to stem the epidemic. As chair of the 2011 South East Asian Nations (ASEAN) summit, it pushed for the regional bloc to commit to the UNAIDS three zeros vision (zero new HIV infections, zero discrimination and zero AIDS-related deaths), prompting all 10 members to emphasize financial sustainability, national ownership and strong leadership. To coincide with the panel's meeting in March 2013, Indonesia collaborated with UNAIDS and other UN agencies to host a forum that focused on ways to pursue the Millennium Development Goals.

**Taking an active part in developing the post-2015 global agenda.** Going forward, Indonesia was appointed by the UN Secretary-General Ban Ki-Moon to co-chair a high-level panel tasked with setting development priorities beyond 2015.

# Iran

## HARM REDUCTION AMONG DRUG USERS AT HEART OF AIDS RESPONSE



### Country profile (2012 data)<sup>7</sup>

**74,100,000**

Population

**71,000 [53,000 - 100,000]**

Number of people living with HIV

**70,000 [52,000 - 100,000]**

Adults aged 15 and over living with HIV

**19,000 [13,000 - 30,000]**

Women aged 15 and over living with HIV

**4,600 [3,200 - 6,400]**

AIDS-related deaths

**11,000 [7,400 - 20,000]**

New infections

**0.2% [0.1% - 0.2%]**

Adults aged 15-49 prevalence rate

**13% [10% - 17%]**

ART Coverage

**.... [...% - ...%]**

PMCT coverage

**Epidemic type:** Concentrated

**Modes of transmission:** Injecting drug use, spouses of people at high risk of HIV/AIDS.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 12,726,736**

Total core UBRAF expenditures  
**US\$ 1,156,278**

### UN areas of work - Prioritization by agencies



**Prevent HIV  
among drug  
users**



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**15 million  
accessing  
treatment**

<sup>7</sup> All figures are estimates



# IRAN'S CONTRIBUTION TO HARM REDUCTION WAS AGAIN RECOGNIZED IN 2012 WHEN AN IRANIAN NON-GOVERNMENTAL ORGANIZATION WON A RED RIBBON AWARD.

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**Red Ribbon Award for harm reduction work.** The Government of Iran has put harm reduction for people who inject drugs at the top of its HIV agenda, making it a key plank of the third national strategic plan (2010–2014) developed in partnership with UNAIDS and other stakeholders. Measures have slowed infections but shared injecting equipment continues to fuel the epidemic. The prevalence of HIV stands at 15% among people who inject drugs, though figures vary between provinces, and the greatest number of new HIV infections are among injecting drug users and their spouses. The UN has supported this harm reduction strategy by providing guidelines and tools to enhance HIV services, including drug dependence treatment, and helping to document Iran's best practices. Needle and syringe programmes have been intensified with UN/Global Fund assistance and by August 2011, 421 centres had delivered 6,022,834 free needles during the previous year, with a further 2,460,150 needle-syringes distributed in 2012. Iran's contribution to harm reduction was recognized in 2012 when an Iranian nongovernmental organization won a Red Ribbon Award.

**Enabling people living with HIV to integrate in the community.** Iran has identified the increasing role of sexual transmission in the spread of HIV, and its links with drug use. Sexual intercourse, frequently unprotected, among people who inject drugs, and other high-risk sexual practices, have been observed among young people using amphetamine-type stimulants. With technical assistance from the Joint UN Team on AIDS, the Government is working to reduce high-risk sexual practices, reflected in changes to national strategic plan priorities. Free condoms are

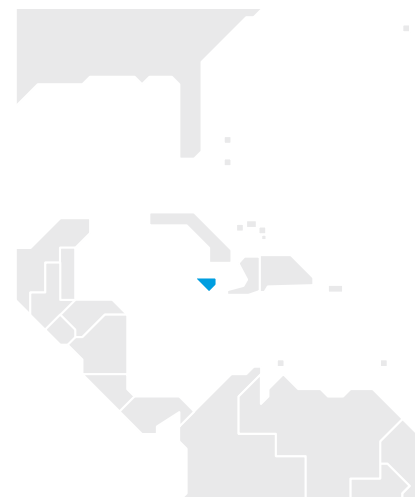
provided at various locations, including counselling centres and prison conjugal visit rooms. A study funded by the UNAIDS Country Office in Iran found that increasing condom use in people who inject drugs from 30% to 90%, could cut new HIV cases for their sex partners by 93%. UNAIDS has helped scale up prevention and care programmes for vulnerable women, among whom prevalence of HIV has reached 4.5%, with most not using condoms consistently. Within a Government-agreed framework, UNFPA and UNODC conducted culturally sensitive education among relevant populations on reproductive health and preventing HIV/STIs. UNAIDS Secretariat, UNDP and the Global Fund have helped the Ministry of Health establish 15 Positive Clubs, serving 4,500 people living with or affected by HIV, creating an enabling platform for the meaningful reintegration into the community.

**eMTCT programme in 15 provinces.** The country recognizes the need to accelerate progress towards the UN 2011 Political Declaration goals on preventing mother to child transmission and treatment. The National AIDS Programme has used UN inputs to develop a policy on eliminating mother to child transmission (eMTCT). In 2014, phase one of this programme will be implemented in 15 provinces.

**Constantly evaluating HIV services.** In order to improve quality and coverage, HIV services, including testing and counselling, will be constantly evaluated by the National AIDS Programme, with help from UNAIDS.

# Jamaica

## EMBRACING THE INVESTMENT APPROACH, ENGAGING PARTNERS



### Country profile (2012 data)

**2,800,000**

Population

**28,000 [23,000 - 34,000]**

Number of people living with HIV

**28,000 [23,000 - 33,000]**

Adults aged 15 and over living with HIV

**9,300 [7,800 - 11,000]**

Women aged 15 and over living with HIV

**1,300 [<1,000 - 1,800]**

AIDS-related deaths

**1,400 [<1,000 - 2,000]**

New infections

**1.7% [1.4% - 2.0%]**

Adults aged 15-49 prevalence rate

**69% [61% - 78%]**

ART Coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** concentrated

**Main modes of transmission:** sex workers and their clients, men who have sex with men, multiple heterosexual partners.

Total Joint UN Programme on AIDS expenditures  
**US\$ 7,632,185**

Total core UBRAF expenditures  
**US\$ 1,867,839**

### UN areas of work - Prioritization by agencies



**Reduce sexual transmission**



**Eliminate stigma and discrimination**



**Eliminate new HIV infections among children**



**Eliminate gender inequalities**

<sup>7</sup> All figures are estimates

# 'EVERYONE HAS A ROLE TO PLAY IN ACHIEVING ZERO DISCRIMINATION INCLUDING DISCRIMINATION ON THE GROUNDS OF SEXUAL ORIENTATION.'

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**Hon Dr Fenton FERGUSON**  
Minister of Health

**Taking an evidence-based approach.** The HIV epidemic in Jamaica is closely tied to poverty and developmental and sociocultural issues. Legal barriers, cultural and religious beliefs and high levels of homophobia are key determinants of risk and vulnerability, especially for adolescents, men who have sex with men (MSM), sex workers and the homeless. To address this, technical and financial support from UNAIDS generated a body of strategic information that has driven an evidence-based approach to planning as showcased in the National Strategic Plan (2013–2017). The plan focuses on establishing a comprehensive programme of treatment, care and prevention services that is evidence-based and addresses the needs of key populations. Strategic information was derived from the human rights costing tool, the gender assessment tool, an assessment of the legal framework, modes of transmission analyses, the PLHIV stigma index, National AIDS Spending Assessment, and financial sustainability study. This resulted in the development of a MSM Strategy and the Ministry of Education's guidelines for school personnel to assess and refer students needing sexual and reproductive health services. The Government is continuing to foster an enabling environment for universal access to HIV-related services, embracing the investment approach and engaging partners in sustainable actions. While the response has maintained an upward trend in treatment coverage, with solid gains in prevention of mother-to-child-transmission services, prevention remains a challenge.

**Engaging civil society via 'mentor moms'.** UNAIDS support has focused on helping to reduce mother-to-child-transmission of HIV, from 10% in 2006 to less than 2% in 2012. The Government has requested leadership in this area from the UN, which has ensured a multidisciplinary

approach. Civil society participates via a 'mentor mom' programme which aims to increase adherence to treatment and improve care and support.

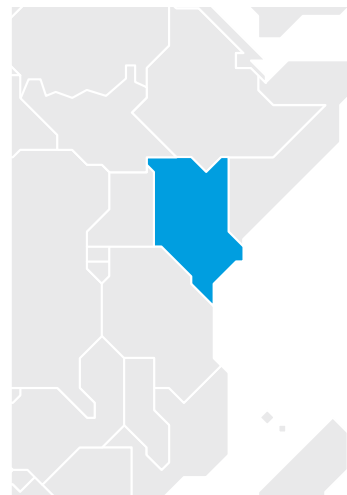
**Giving young people access to SRH services.** Key ministries, including education and youth, have increased their focus on amending laws and increasing young people's access to sexual and reproductive health services. UNAIDS Cosponsors and the Secretariat supported the Government by advocating for human rights, including sexual and reproductive health services for adolescents. Laws are being reviewed and the national HIV policy is being revised to address populations at higher risk of HIV transmission and vulnerable groups, such as adolescents and men who have sex with men, to reduce stigma and discrimination. UNAIDS collaborated with the Ministries of Health and Justice to engage parliamentarians, faith-based leaders, academia and civil society in identifying laws that hinder universal access to services in the Justice for All and Human Rights movement.

## **Critical need to reduce the funding gap.**

Jamaica relies heavily on external income. Although domestic funding trends are increasing, the average annual funding gap is estimated at US\$ 9 million. External funds are expected to fall significantly in the next two years therefore the UNAIDS Secretariat is supporting the development of a sustainability plan using an investment approach. A financial sustainability study that emphasizes the need for a more effective prevention programme for key populations provides a basis for the plan.

# Kenya

## MOBILIZING NEW SOURCES OF DOMESTIC FINANCING



### Country profile (2012 data)

**43,000,000**

Population

**1,600,000 [1,600,000 - 1,700,000]**

Number of people living with HIV

**1,400,000 [1,400,000 - 1,500,000]**

Adults aged 15 and over living with HIV

**820,000 [790,000 - 860,000]**

Women aged 15 and over living with HIV

**57,000 [51,000 - 65,000]**

AIDS-related deaths

**98,000 [91,000 - 110,000]**

New infections

**6.1% [5.9% - 6.3%]**

Adults aged 15-49 prevalence rate

**73% [69% - 77%]**

ART Coverage

**53% [47% - 60%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** men who have sex with men, heterosexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 152,137,367**

Total core UBRAF expenditures  
**US\$ 4,248,814**

### UN areas of work - Prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**



**Prevent HIV  
among drug  
users**

<sup>7</sup> All figures are estimates

# 'USER FEES FOR DELIVERY IN PUBLIC FACILITIES HAVE BEEN WAIVED.'

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**Placing women and adolescents at the centre of the response.** National Stakeholders and the Government of Kenya have developed a National HIV Prevention Revolution Strategy. This strategy developed over the course of a two year period – revolutionized prevention by mobilized key constituency groups to make HIV Prevention “everyone’s business”. It recognizes that progress on HIV prevention cannot be made without structural interventions that address the vulnerability of women and girls and improve gender equality and eliminate stigma and discrimination. The strategy rolls out high-impact combination prevention policies based on geographic area and the nature of the epidemic in the general population, key populations and young people. UNAIDS was the key partner of support for the First Lady’s advocacy campaign on the elimination of mother to child transmission and reduction of maternal and child mortality which saw 30,000 Kenyans run a half marathon in support. Free maternity services at health centers. New HIV infections among children have decreased but coverage of antiretroviral prophylaxis for pregnant women living with HIV fell by 20% between 2011–2012 due to disruptions in the health system. However, by Presidential Decree, Kenya has launched an initiative to provide free maternity services at all public health centers. User fees for delivery in all public dispensaries have also been waived. UNICEF, UNFPA, UN Women, WHO and the UNAIDS Secretariat successfully advocated for a ministerial commitment to Option B+ (lifetime antiretroviral therapy for all HIV-infected pregnant women).

**Preventing HIV among drug users.** Kenya is moving towards effective interventions for key populations. A comprehensive HIV prevention package for persons who use drugs, plus a national treatment protocol for substance use disorders and standard operating procedures for needles and syringes and for opioid

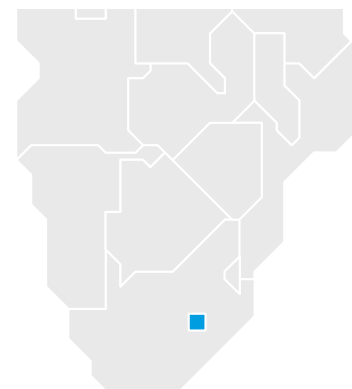
substitution therapy have been developed with the support of UNODC and UNJT. A community antidrug coalition for Kenya (CADKE) was established by National Authority for Campaign against Alcohol and Drug Abuse (NACADA) to minimize drug use as part of HIV prevention. Ensuring financial sustainability of the AIDS response.

**Kenya has sought to mobilize new sources of HIV financing, particularly domestic ones.** The UN is working with the Government to reduce its proportion of external funding from 80%, and in 2012 the cabinet approved a memo on additional and sustainable financing for HIV and AIDS and priority non-communicable diseases prevention and care. Under a proposal to establish a Trust Fund for HIV and non-communicable diseases, the Government would contribute 0.5%–1% of its annual ordinary tax revenue to the fund, which would also receive contributions from partners and the private sector. The UN also supported the review of the country’s Global Fund architecture that recommended long-lasting reforms. This resulted in approval of grants totaling US\$ 549 million to date and an additional US\$ 66 million for HIV and TB programmes in 2013. With support from the World Bank and PEPFAR, an efficiency review of HIV services delivery was completed leading to significant policy shifts and cost savings.

**Strategic planning and delivery.** The new United Nations Development Assistance Framework positions the response to HIV at outcome level allowing for a strategic and strong human rights and gender focused platform for continued UN engagement. It provides the basis of support for the new Kenyan National Strategic Plan on AIDS currently under development.

# Lesotho

## MEDICAL MALE CIRCUMCISION YIELDS IMPRESSIVE RESULTS



### Country profile (2012 data)

**1,916,000**

Population

**360,000 [340,000 - 380,000]**

Number of people living with HIV

**320,000 [300,000 - 340,000]**

Adults aged 15 and over living with HIV

**190,000 [180,000 - 200,000]**

Women aged 15 and over living with HIV

**15,000 [14,000 - 17,000]**

AIDS-related deaths

**23.1% [21.7% - 24.7%]**

Adults aged 15-49 prevalence rate

**26,000 [23,000 - 30,000]**

New HIV infections

**54% [52% - 57%]**

ART coverage

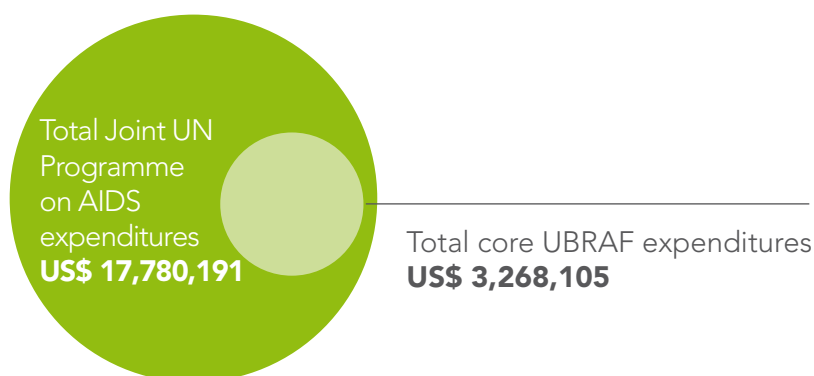
**58% [52% - 64%]**

PMCT coverage

**Epidemic type:** severe/hyperendemic

**Main modes of transmission:**

heterosexual transmission within stable partnerships, multiple heterosexual partners.



### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**



**Eliminate  
gender  
inequalities**

# 'THE UN HAS SUPPORTED THE ACHIEVEMENT OF 60% COVERAGE FOR ADULT ANTIRETROVIRAL THERAPY.'

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**Medical male circumcision increases fivefold.** Lesotho has shown consistent political leadership in its HIV response. Despite many challenges – the HIV prevalence rate for adults remained at 23% in 2011 – the country, with assistance from the UN family, has maintained efforts to strengthen its national response. Prevention activities have been prioritized in the National HIV and AIDS Strategic Plan 2011/12–2015/16 (NSP), particularly the scale-up of facility-based medical male circumcision, which WHO says reduces the risk of female-to-male sexual transmission of HIV by about 60%. WHO, UNAIDS and UNICEF supported the Ministry of Health and Jhpiego (a health organization affiliated with The Johns Hopkins University) in establishing four government sites for male circumcision, and roll-out to all hospitals is in progress. The number of medical male circumcisions increased fivefold from 10,000 to 50,000 by the end of 2013. Commensurate with moves to decentralize health-care delivery, the partnership has piloted a programme that links the hospital service to lower level health centres for follow up appointments. The WHO/UNAIDS approach to introducing neonatal circumcision has also been adopted. Other effective prevention strategies, such as condom promotion and HIV testing and counselling, have reduced new infections from 28,000 to 25,000 in 2013. Meanwhile the number of people who tested for HIV and received results remains stable at about 310,000.

**Pioneering nurse-driven ART delivery.** Demonstrating it has the capacity for innovation and rapid progress, Lesotho has been one of the pioneers of nurse-driven antiretroviral delivery programmes as well as integrated

services for mother–baby pairs in maternal, newborn and child health settings. With UN support, the country has prepared a comprehensive, costed plan and is rolling out Option B+. These measures can serve as the foundation for expanding services in the country, where 58% of pregnant women living with HIV are effectively receiving antiretroviral therapy.

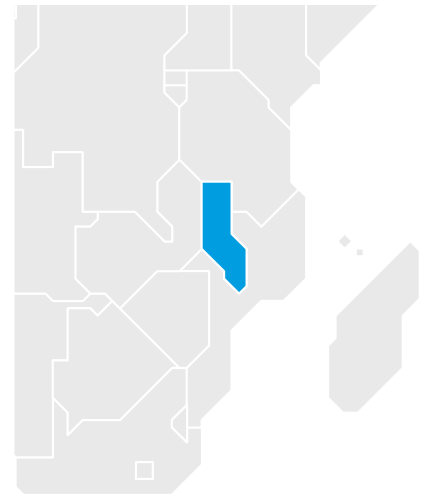
**Cash transfers encourage safe behaviours.** The UN has helped achieve 60% coverage for adult antiretroviral therapy (ART) in Lesotho. This was achieved through: a pilot scheme to integrate sexual and reproductive health and HIV services in three districts; revising ART guidelines in line with WHO recommendations; and revising the 2011/12–2015/16 NSP using investment thinking. New strategies, including social cash transfers that create incentives for safer behaviours, have helped reduce young people's HIV vulnerability. A randomized study in Lesotho found that a programme of financial incentives reduced the probability of acquiring HIV by 25% over two years.

## **UN advocates for decentralized response.**

Going forward, it is essential the UN continue to provide comprehensive support so that the National AIDS council can be quickly re-established to coordinate the national response. Decentralizing policy is a key factor of the Government's commitment to reorganizing the structure of the response, backed by high-level advocacy from UNAIDS.

# Malawi

## SIMPLIFIED ART TREATMENT FOR LIFE FOR ALL PREGNANT WOMEN



### Country profile (2012 data)

**17,600,000**

Population

**1,100,000 [1,100,000 - 1,200,000]**

Number of people living with HIV

**950,000 [900,000 - 1,000,000]**

Adults aged 15 and over living with HIV

**560,000 [520,000 - 590,000]**

Women aged 15 and above living with HIV

**46,000 [40,000 - 52,000]**

AIDS-related deaths

**66,000 [58,000 - 76,000]**

New infections

**10.8% [10.2% - 11.4%]**

Adults aged 15-49 prevalence rate

**69% [66% - 73%]**

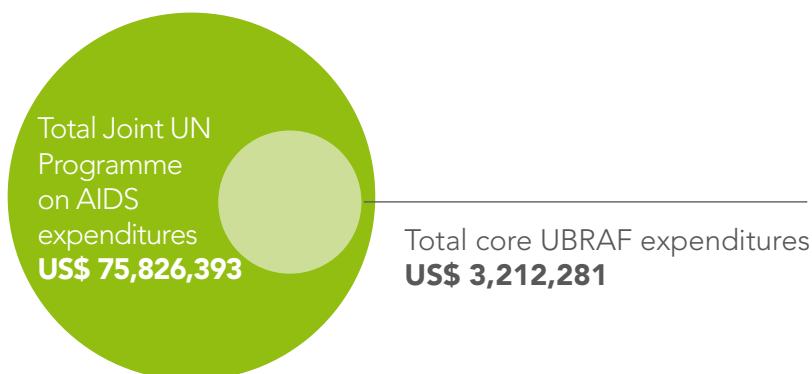
ART coverage

**60% [54% - 67%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** sex workers and their clients, heterosexual transmission within stable partnerships, multiple heterosexual partners.



### UN areas of work - prioritization by agencies



**Reduce sexual transmission**



**Eliminate stigma and discrimination**



**Eliminate new HIV infections among children**



**15 million accessing treatment**



# 'COMMITTED TO MOBILIZING DOMESTIC RESOURCES AND ENSURING EFFICIENT USE OF EXTERNAL FUNDS.'

**Joyce BANDA**

President of Malawi

**Test and treat approach a huge success.** The Government has made significant progress in tackling the HIV epidemic, with the latest model for eliminating mother-to-child transmission (eMTCT). Malawi blazed the way in 2011, offering lifelong simplified treatment for all pregnant and breastfeeding women (Option B+) using a voluntary provider-initiated 'test and treat approach', regardless of preconditions. Children under five are also prioritized in this way. Malawi became a global leader, with a 748% increase in the number of pregnant women receiving antiretroviral therapy over a 15-month period in 2011–2012. Malawi is accelerating training and recruitment of health professionals, expanding infrastructure for maternal, newborn and child health services, and increasing basic emergency obstetric and neonatal care to WHO standards. It is also strengthening partnerships with private institutions to sustain success. The UN has been working with the Government to implement the 2012 national plan that seeks to eliminate mother to child transmission of HIV by 2015, while SMS technology has helped halve the turnaround for early infant diagnosis to 20 days.

**Avoiding stock outs key to maintaining gains.** The UN, with Global Fund assistance, set up a supply chain to complement the Government-managed procurement system. UNAIDS is working with local partners to prioritize cost-effective interventions.

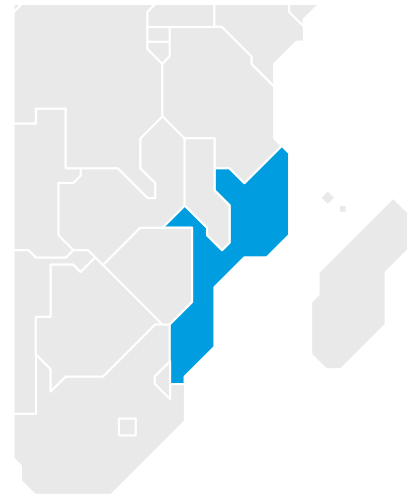
**Engaging interest groups in draft HIV bill.** There is no specific law that deals with HIV issues but the Government is committed to addressing human rights, reflected in its growth and development strategy, the National HIV and AIDS Strategic Plan 2011–2016 and the

National HIV and AIDS policy, which is aligned with other legislation prohibiting the practice of discrimination. The UN helped draft the national HIV and AIDS Bill, providing information on best practices to address the criminalization of HIV, mandatory and compulsory testing for key and vulnerable populations. The findings of the Legal Environment Assessment (LEA) and the Stigma Index study supported by the UN were used in the draft. Interest groups must be engaged to support the Bill and to ensure its passage through parliament towards the end of 2014.

**Reaching out to the private sector.** The UN continues to engage key stakeholders to ensure the new prevention strategy targets key populations, including sex workers and truck drivers. The fiscal squeeze threatens the sustainability of the HIV response. Dependency on donor funds reduces Government control and exposes the HIV programme to external pressure. In addition, public finance management weaknesses threaten donor aid. In 2013, the misuse of public funds led to budgetary support by major donors being suspended, putting a huge strain on the provision of services. Government, with support from Donors, is working towards resolving these weaknesses in order to restore donor confidence and support. Dialogue between the Government and the private sector to introduce taxes to raise resources for the HIV response commenced in 2013 but need to be intensified if the resource gap is to be reduced.

# Mozambique

## MASSIVE INCREASE IN PEOPLE ON ANTIRETROVIRAL THERAPY



### Country profile (2012 data)

**25,000,000**

Population

**1,600,000 [1,400,000 - 1,800,000]**

Number of people living with HIV

**1,400,000 [1,200,000 - 1,600,000]**

Adults aged 15 and over living with HIV

**810,000 [730,000 - 930,000]**

Women aged 15 and over living with HIV

**77,000 [65,000 - 93,000]**

AIDS-related deaths

**120,000 [97,000 - 150,000]**

New infections

**11.1% [9.9% - 12.9%]**

Adults aged 15-49 prevalence rate

**45% [41% - 50%]**

ART coverage

**86% [74% - >95%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:**

heterosexual transmission with stable partnerships, multiple sexual partnerships and key populations.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 80,621,311**

Total core UBRAF expenditures  
**US\$ 3,946,017**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate  
gender  
inequalities**



**Eliminate  
stigma and  
discrimination**

# 'THE COUNTRY IS IN THE FOREFRONT OF THE USE OF NEW DIAGNOSTIC TOOLS SUCH AS POINT-OF-CARE DEVICES.'

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**Mobile technology is helping retain patients.** In Mozambique, the biggest gain in the HIV response has been a 101% increase in the number of people on antiretroviral therapy in 2012. The country is in the forefront of the use of diagnostic tools, such as point-of-care devices for CD4 readings being studied for viral load monitoring. Likewise, mobile technology is helping to retain patients. The UN Joint Team has helped decentralize HIV services, integrating them with other health programmes to further improve access and treatment, specifically in the four most affected provinces of Maputo Cidade, Maputo province, Gaza and Inhambane. Progress has been less satisfactory in the scale-up of voluntary medical male circumcision (VMMC) and focused efforts are needed to achieve the number of circumcisions for maximum public health impact. UNAIDS and WHO are helping a working group expand VMMC as a preventive technology, with a plan to target two million men by 2015.

**Social protection for the most needy.** Another positive development has been in social protection, with people living with HIV (PLHIV) and households affected by HIV addressed in all national strategies. The UN Joint Team's working group on prevention of mother-to-child transmission (PMTCT) helped provide nutritional support to malnourished pregnant and lactating women and their infants through the Nutritional Rehabilitation Programme, while UNICEF led several initiatives on pediatric care and treatment, within the UNJT treatment working group. Although social services received only a small part of the state budget in 2011, social protection programmes absorbed almost half, showing funding is going to the people who need it the most.

**Increasing ART for breastfeeding mothers.** There has been progress in HIV prevention and treatment services for women and children, with a concerted effort to end vertical transmission. Sites offering HIV services increased from eight in 2002, to more than 1,000 in 2010, and as a result the number of pregnant women receiving testing also increased, from 12% in 2005 to 87% in 2010. Much still needs to be done, and PMTCT guidelines have again been revised. Further reductions in HIV incidence are possible if the coverage of antiretroviral medicines is increased during the breastfeeding period, and Mozambique has begun providing lifelong antiretroviral therapy for pregnant women living with HIV (Option B+). The Joint Team's PMTCT working group, led by UNICEF and WHO, has supported the integration of PMTCT in the HIV accelerated plan, revising elimination of mother-to-child transmission targets and prioritizing universal access to antiretroviral therapy during pregnancy.

**Planning for natural disasters.** Flooding in Gaza province in early 2013 left more than 12 000 people at risk of losing access to HIV treatment. Through partnerships between Government departments, the National AIDS Commission, NonGovernmental Organizations and United Nations agencies, routine services were restored. Contingency plans for an adequate response in future emergencies will be prepared and training sessions are already being carried out in the two provinces with the highest risk of natural disasters and a high HIV burden.

# Myanmar

## FOCUSING ON PREVENTING HIV IN HIGHER RISK POPULATIONS



### Country profile (2012 data)

**49,300,000**

Population

**200,000 [170,000 - 220,000]**

Number of people living with HIV

**190,000 [160,000 - 210,000]**

Adults aged 15 and over living with HIV

**63,000 [55,000 - 71,000]**

Women aged 15 and over living with HIV

**12,000 [9,700 - 14,000]**

AIDS-related deaths

**7,100 [5,700 - 8,900]**

New infections

**0.6% [0.5% - 0.6%]**

Adults aged 15-49 prevalence rate

**48% [42% - 52%]**

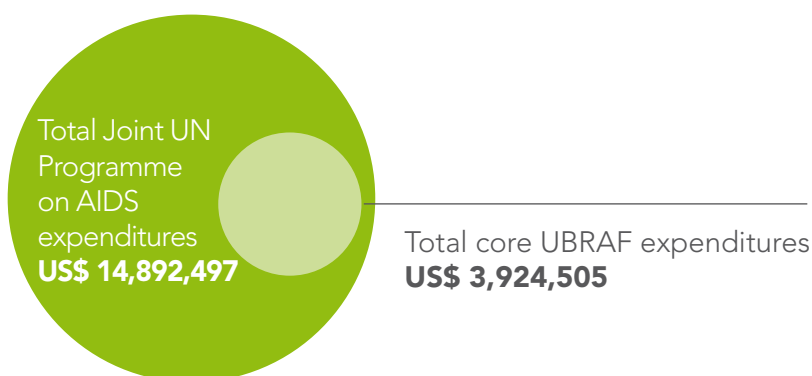
ART coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** Concentrated/  
geopolitical relevance

**Modes of transmission:** men who have  
sex with men, injecting drug use, sex  
workers and their clients.



### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate  
gender  
inequalities**



**Avoid TB  
deaths**

# UNAIDS HAS HELPED INCREASE THE NATIONAL CAPACITY TO DELIVER HIV AND REPRODUCTIVE HEALTH SERVICES THAT TARGET FEMALE SEX WORKERS.

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## **Young people are better informed about HIV.**

Myanmar continues to focus its AIDS response on preventing HIV transmission in key populations at a higher risk: female sex workers and their partners, men who have sex with men (MSM) and injecting drug users (IDUs), while scaling up treatment to reach all those in need. The Joint UN Team on AIDS, particularly through the work of UNFPA, UNESCO and WHO, has helped increase the national capacity to deliver HIV and reproductive health services that target female sex workers. Myanmar is decentralizing and integrating HIV testing and counselling into wider health services to foster early detection. It is also increasing coverage of services for preventing new HIV infections among children and expanding treatment services. UNFPA helped implement community-based prevention strategies for MSM and transgender persons and advised the Government on scaling up access to services. This was achieved after UNDP reviewed HIV services for these populations in five cities. Young people are becoming better informed about HIV via education, outreach and media programmes. UNFPA helped set up two hotlines for youth to access information on adolescent reproductive health and HIV.

**UN supports ambitious treatment scale-up.** By the end of 2012, nearly 53,700 adults and children were receiving antiretroviral therapy (ART) in Myanmar but coverage remains low at 48%. The main hurdles to better treatment coverage in the public sector are financial constraints and, consequently, limited availability of antiretroviral medicines and other commodities, as well as shortage of staff to scale

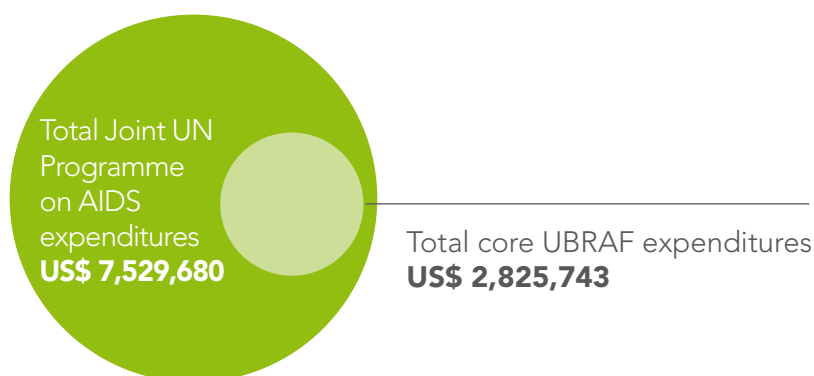
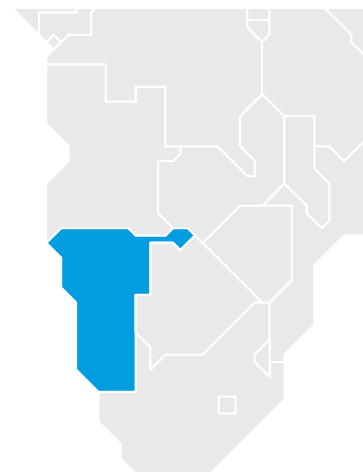
up service delivery. Guidance for using antiretroviral treatment and on prevention of mother-to-child transmission (PMTCT) was revised with the help of WHO to achieve 80% treatment coverage by the end of 2015. An assessment of ART services supported by UNAIDS Secretariat and WHO will inform Myanmar's ambitious treatment scale-up plan. UNICEF, WHO and UNFPA helped strengthen links between mother and child health and PMTCT services in seven pilot sites. As a result, HIV testing has increased at antenatal clinics and more HIV-positive pregnant women are receiving prophylaxis to prevent transmission.

**Health staff receives ART instruction.** UNICEF and WHO provide financial and technical support to the National AIDS Programme for scaling up ART for adults and children and to decentralize ART provision. The capacity of states and regional ART training teams has been increased; health staffs at 30 decentralized ART sites have received instruction. Food assistance was provided by the WFP to people living with HIV to promote adherence to treatment, improve outcomes and mitigate the impact on individuals and households.

**Strong collaboration on HIV and TB.** Going forward, a stronger collaboration is envisaged between the national tuberculosis (TB) and AIDS programmes, ensuring all co-infected people receive antiretroviral therapy and all people living with HIV are screened for TB by 2015.

# Namibia

## INNOVATIVE APPROACH BRINGS REWARDS



### UN areas of work - prioritization by agencies



**Reduce sexual transmission**



**15 million accessing treatment**



**Eliminate stigma and discrimination**



**Eliminate new HIV infections among children**

### Country profile (2012 data)

**2,140,000**

Population

**220,000 [190,000 - 250,000]**

Number of people living with HIV

**200,000 [180,000 - 230,000]**

Adults aged 15 and above living with HIV

**120,000 [100,000 - 130,000]**

Women aged 15 and up living with HIV

**5,000 [3,400 - 7,100]**

AIDS-related deaths

**10,000 [8,000 - 13,000]**

New infections

**13.3% [11.4% - 15.2%]**

Adults aged 15-49 prevalence rate

**78% [69% - 86%]**

ART coverage (according to 2013 eligibility criteria of 500 CD4)

**94% [78% - >95%]**

PMCT coverage

**Epidemic type:** severe/hyper-endemic

**Main modes of transmission:** sex

workers and their clients, heterosexual transmission within stable partnerships, multiple heterosexual partners.

# 'WE MUST SYSTEMATICALLY INTENSIFY OUR INTERVENTIONS AT POLICY AND SERVICE DELIVERY LEVELS.'

## **H.E. Hifikepunye Pohamba**

President of Namibia

### **Combination prevention helps reduce HIV incidence.**

Namibia's efforts to prevent HIV transmission resulted in more than 50% reduction of HIV incidence between 2001 and 2012. This was achieved through various strategies, including scaling up HIV prevention services for young people and key populations, including sex workers, and innovative approaches such as mobile clinics. The UN is supporting the delivery of comprehensive sexuality education in the education sector to scale up HIV prevention and affirm the ESA Ministerial Commitment. Namibia has already met its goal of providing antiretroviral medicines to 94% of women who are eligible – to prevent mother-to-child HIV transmission – resulting in a 50% reduction of new HIV infection among children and less than 4% transmission from mother to child.

**Integrating sexual and reproductive health.** The UN Joint Team provided technical assistance to develop the EMTCT Strategy for 2012–16, including the monitoring and evaluation components, integrating sexual and reproductive health and ensuring links with communities. Two prevention challenges require further UN advocacy efforts, however: declining support for socio-behavioural HIV prevention programmes, and prevention through VMMC. The UN is supporting stronger linkages of SRHR and HIV in national health and development plans, policies and guidelines, improved uptake and delivery of quality integrated services for HIV and SRHR.

### **Namibia is exceeding the global treatment target.**

The Namibia antiretroviral treatment programme has been a flagship of its response. It achieved the 2010 universal access target in 2009, and its achievements continue to be exemplary; based on the previous eligibility criteria of 350 CD4, 90% of people eligible for antiretroviral treatment, were receiving it by December 2013 with paediatric ART coverage of 70%. Trends indicate Namibia will achieve the ambitious target of

95% antiretroviral coverage among adults by 2015/16 (350 CD4 count criteria). Integration of HIV and TB services has led to a 50% reduction in TB-related deaths among co-infected people living with HIV. Authorities have joined with UNAIDS, UNDP and Pharm Access Foundation to provide HIV prevention and primary health care services to previously under-served informal settlements in Windhoek. The government recently launched the new treatment guidelines based on the 2013 WHO recommendations and the UN is supporting the development of operational plans. Namibia currently has a high geographic and uptake coverage of HIV counselling and testing through the implementation of mixed service delivery models for HIV testing and counselling (HTC). Efforts are underway to scale up provider-initiated testing and counselling (PITC) and HTC access for key populations, adolescents and couples testing in collaboration with civil society.

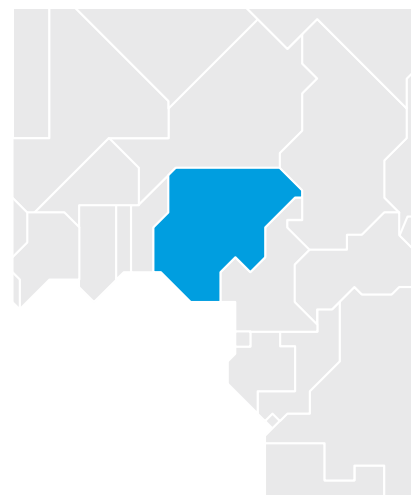
### **More domestic resources especially for prevention.**

Namibia is expected to assume additional responsibility for funding its response from domestic resources, given its status as an upper-middle income country. Domestic funding for HIV and AIDS increased from about 50% to 60% by 2012, but the amount spent on prevention services (11% of the overall HIV /AIDS budget) lags behind the 50% target by 2013. As part of its drive for self-sufficiency, the country plans to develop an HIV Investment Case and Sustainability Strategy.

**Addressing gaps in the response.** Going forward, the UN will provide advocacy and technical assistance to address gaps in the response, including HIV-related stigma and the challenging legal environment that hampers access to services by MSM and sex workers. The revised NSF has prioritized HIV among young people and key populations.

# Nigeria

## INCREASE ACCESS TO ART AND PMTCT TO REDUCE NEW INFECTIONS



### Country profile (2012 data)

**185,000,000**

Population

**3,400,000 [3,100,000 - 3,800,000]**

Number of people living with HIV

**3,000,000 [2,700,000 - 3,300,000]**

Adults aged 15 and above living with HIV

**1,700,000 [1,500,000 - 1,900,000]**

Women aged 15 and over living with HIV

**240,000 [210,000 - 280,000]**

AIDS-related deaths

**260,000 [210,000 - 310,000]**

New infections

**3.1% [2.8% - 3.5%]**

Adults aged 15-49 prevalence rate

**32% [29% - 35%]**

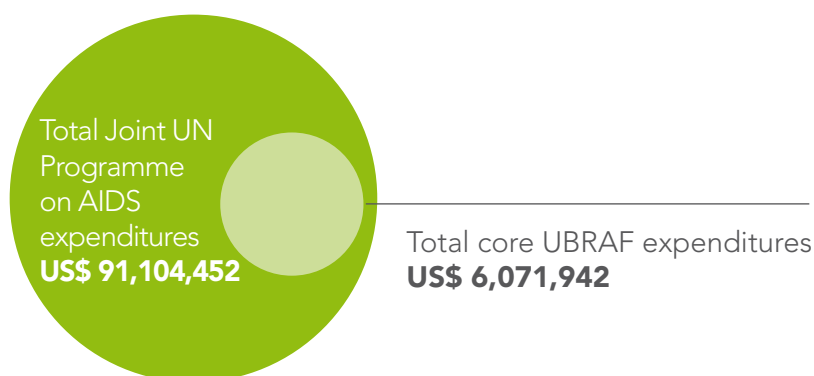
ART coverage

**17% [15% - 19%]**

PMTCT coverage

**Epidemic type:** High burden

**Modes of transmission:** multiple heterosexual partners, heterosexual transmission within stable partnerships, sex workers.



### UN areas of work - prioritization by agencies



**Eliminate new HIV infections among children**



**15 million accessing treatment**



**Close the resource gap**



**Reduce sexual transmission**



# THE JOINT PROGRAMME OF SUPPORT ON AIDS HAS BEEN A POWERFUL TOOL IN MOBILIZING RESOURCES, HELPING NIGERIA STRENGTHEN ITS COMMITMENT TO FUND THE NATIONAL AIDS RESPONSE.

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## **Women on antiretroviral therapy are up by 45%.**

Nigeria is one of the countries showing a steady decline in HIV incidence, with more than a 50% reduction between 2001 and 2012. Although access to antiretroviral therapy (ART) is still limited for most people living with HIV, increased efforts have been made through prevention activities, particularly for pregnant women. While only 1,120,178 (16.9%) were tested for HIV in 2011, this is an improvement compared to 2010, when 907,387 women were tested. Women receiving ART rose by 45%, with a decrease in the proportion taking single-dose nevirapine and an increase (from 25.2% to 33.2%) in those taking the more effective maternal triple antiretrovirals therapy (Option B).

**President sets ambitious prevention targets.** The President's Comprehensive Response Plan, which increases to 50% the domestic contribution to total HIV expenditure, is being rolled out at federal and state levels. Its objective is to test 80 million Nigerians for HIV, provide ART to 90% of the people living with HIV in need, reach 90% coverage of PMTCT, as well as 500,000 in most-at-risk populations and 40 million young people with combination prevention by 2015.

**Prioritizing the reduction of new infections among children.** Eliminating new HIV infections in children and keeping mothers alive is a priority in Nigeria, which carries about one third of the global burden of new infections among children. The UN, coordinating and financing its activities through the Joint UN team on AIDS and the Joint Programme of Support on AIDS, has been at the forefront of these efforts, working hand-in-hand with the Government and making progress in policy-setting and technical support. The UN, in supporting the reprogramming of the Global Fund Round 9 proposals to scale up Nigeria's prevention of mother-to-child treatment (PMTCT) response, has helped expand and improve services through planning, resource mobilization

and capacity building. As a result, PMTCT services have been decentralized into routine antenatal, delivery and postnatal care settings, and other sexual and reproductive health services.

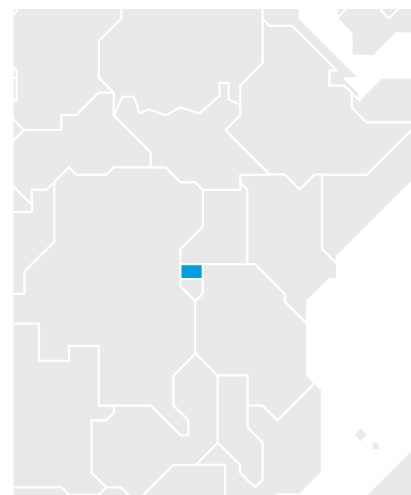
**UN advocates for increased national funding.** Scaling up PMTCT, in particular, has been enhanced by applying the UNAIDS Unified Budget Results and Accountability Framework (UBRAF). Funds from the UBRAF were catalytic resources, and advocacy efforts with the Government will be maintained to increase national funding. The Joint Programme of Support on AIDS has been a powerful tool in mobilizing and allocating resources, helping Nigeria strengthen its commitment to fund the national AIDS response. In 2010 the proportion of domestic funding for HIV/AIDS rose to 45.5% of total funding from all sources, a sevenfold increase. Progress in engaging community-based organizations (CBOs) has been more problematic. The UNAIDS' booklet on best practices in Africa confirms that CBOs can be powerful partners supporting access to HIV care, particularly for groups missed by mainstream services. The need for further investment in CBOs, particularly in rural areas, has been identified, and the World Bank is examining the impact of CBO engagement on HIV/AIDS-related outcomes.

## **President sets ambitious prevention targets.**

The President's Comprehensive Response Plan, which increases to 50% the domestic contribution to total HIV expenditure, is being rolled out at federal and state levels. Its objective is to test 80 million Nigerians for HIV, provide ART to 90% of the people living with HIV in need, reach 90% coverage of PMTCT, as well as 500,000 in most-at-risk populations and 40 million young people with combination prevention by 2015.

# Rwanda

## INTEGRATING HIV RESPONSE INTO THE WIDER HEALTH SERVICE



### Country profile (2012 data)

**11,002,631**

Population

**210,000 [190,000 - 230,000]**

Number of people living with HIV

**180,000 [160,000 - 200,000]**

Adults aged 15 and over living with HIV

**100,000 [95,000 - 120,000]**

Women aged 15 and over living with HIV

**5,600 [4,200 - 7,500]**

AIDS-related deaths

**7,800 [5,800 - 11,000]**

New infections

**2.9% [2.6% - 3.2%]**

Adults aged 15-49 prevalence rate

**87% [81% - 94%]**

ART coverage

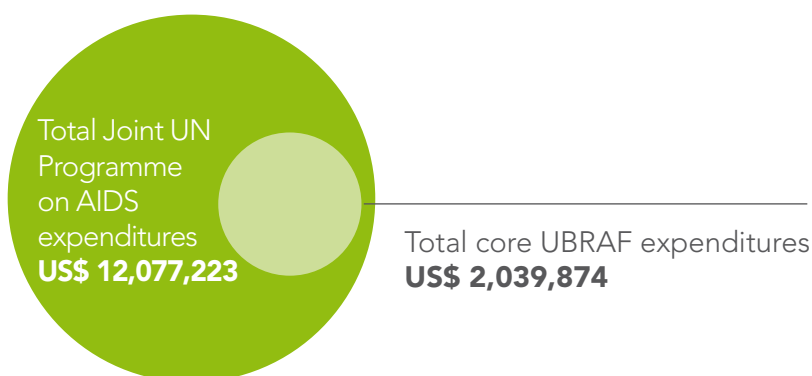
**92%**

PMCT coverage

**Epidemic type:** generalized and concentrated (mixed epidemic)

**Main modes of transmission:**

heterosexual transmission within stable partnerships, sex workers and their clients, men who have sex with men.



### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**



**Eliminate  
gender  
inequalities**

# 'OUR RESPONSIBILITY IS TO RISE TO THE CHALLENGE AND COMBINE ALL OUR RESOURCES IN THE DRIVE TO UNIVERSAL ACCESS TO HIV SERVICES.'

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**Dr Agnes BINAGWAHO**

Rwanda Minister of Health

**More visits to the doctors, more vaccinations.** Rwanda is integrating its HIV prevention, treatment and care services within wider health services. Integrating HIV care has led to an increase in the use of general health services. More pregnant women have visited doctors, more children have been vaccinated, and more people have received reproductive health services as well as HIV treatment and nutrition support. The UN has supported this integration, helping to incorporate former National AIDS Commission structures into district health management teams. The UN has provided strategic information and basic commodities such as condoms, via peers and information, education and communication. Mobile services and outreach activities for hard-to-reach populations, such as female sex workers and men who have sex with men, have been established to enhance prevention and treatment coverage. Another UN contribution has been in male circumcision. The launch of the PrePex device at the end of 2013 has led to an increase in male circumcision.

**Promoting male involvement in eMTCT.** Rwanda has also scaled up services for the prevention of mother-to-child transmission of HIV (PMTCT) nationwide and strengthened the capacity of health-care providers to provide comprehensive services. Virtually all women receive their test results and the proportion of HIV-exposed infants receiving antiretroviral (ART) prophylaxis doubled, up to 98% in some areas, in June 2013. In May 2011, Rwanda's first lady, Jeannette Kagame, launched the country's national elimination of mother-to-child transmission (eMTCT) initiative, leading to the development of a National Strategic Plan for eMTCT released in 2012 with the support of the UN and other

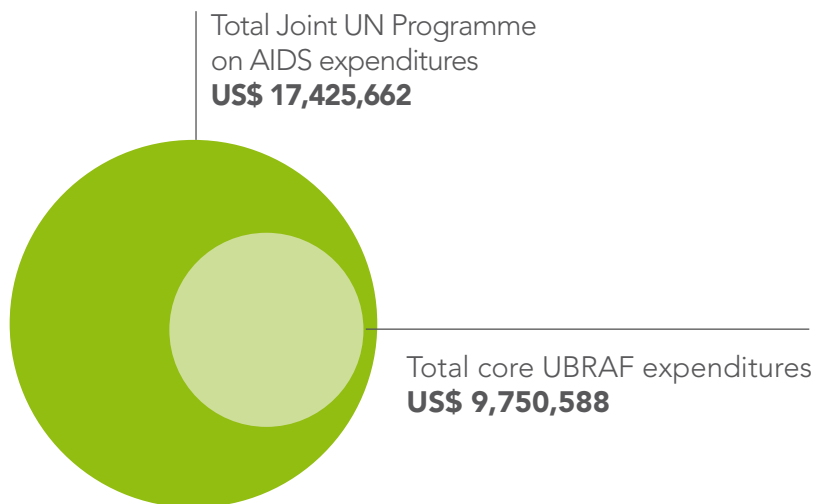
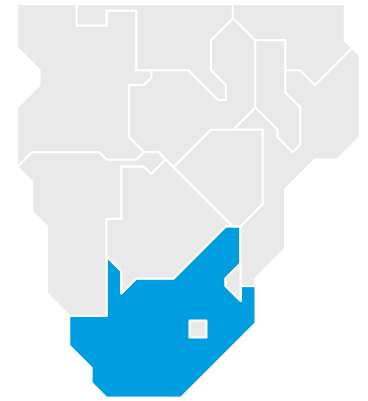
partners. The percentage of HIV-positive pregnant women receiving ART for PMTCT is 92% and the transmission of HIV from mother-to-child is down to 1.8% in June 2013, for HIV-exposed infants by 18 months of age. Rwanda is internationally recognized for its leadership in male involvement in eMTCT; the proportion of pregnant women attending antenatal care whose male partner was also tested was 85%.

**On track to achieve universal ART access.** In 2013, it was estimated that the ART coverage of adults needing therapy and receiving it was 93%, compared with 63% in 2009. The country is on track to achieve universal access to lifesaving ART for those in need by 2015. Rwanda has prioritized early ART, provided free of charge to those who are eligible in line with WHO guidelines, also shifting ART services to nurses. Big gains against HIV have been reported: more than a two thirds decline in deaths and a 50%+ reduction in incidence. The country is pioneering scaling up HIV testing and treatment for people with tuberculosis.

**UN supports an investment approach.** Despite progress, the HIV response faces several challenges, including heavy dependence on external resources. Domestic contributions amount to only 10% of the external funding. Going forward, to ensure an efficient, effective and sustainable financial response to HIV, the UN Joint Team has prioritized future support to the Government in taking an investment approach based on improved strategic information.

# South Africa

## MASSIVE TREATMENT SCALE-UP YIELDS IMPRESSIVE RESULTS



### UN areas of work - prioritization by agencies



**Reduce sexual transmission**



**Eliminate gender inequalities**



**Eliminate stigma and discrimination**



**Eliminate new HIV infections among children**

### Country profile (2012 data)

**52,600,000**

Population

**6,100,000 [5,800,000 - 6,400,000]**

Number of people living with HIV

**5,700,000 [5,500,000 - 6,000,000]**

Adults aged 15 and above living with HIV

**3,400,000 [3,200,000 - 3,600,000]**

Women aged 15 and up living with HIV

**240,000 [220,000 - 270,000]**

AIDS-related deaths

**370,000 [340,000 - 420,000]**

New infections

**17.9% [17.3% - 18.4%]**

Adults aged 15-49 prevalence rate

**80% [77% - 84%]**

ART coverage

**83% [75% - 90%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:**

heterosexual transmission within stable partnerships, multiple heterosexual partners.

# 'THE HIV AND AIDS TURNAROUND IS ONE OF THE BIGGEST ACHIEVEMENTS OF THIS ADMINISTRATION AND WE ARE USED AS A MODEL COUNTRY BY UNAIDS.'

## President Jacob Zuma

South Africa State of the Nation Address to Parliament,  
February 2014

**Strong leadership, better understanding of the epidemic, greater response.** South Africa continues to be the country most profoundly affected by HIV. Bold leadership in South Africa has resulted in a strong and effective national response. The Government is making unprecedented public sector investments in HIV (US\$ 1.9 billion in 2013, representing a 500% increase since 2009). Over the last biennium, South Africa tested and counselled more than 20 million people for HIV, screened nine million for TB and extended free antiretroviral therapy (on a revolutionary one pill a day treatment) to more than two million people, thus increasing life expectancy from 56 to 60 years. Major campaigns are underway to promote adult male medical circumcision. The United Nations Joint Team on AIDS (UNJT) has helped develop the National Strategic Plan on HIV 2012-2016 and strengthen the capacity of government, the private sector and civil society to coordinate evidence-based HIV prevention programmes. Policies developed as part of this support include the Sex Worker National Strategy and the National Operational Guidelines for prevention, treatment, care and support programmes for Key Populations. The UNJT is also contributing to the national HIV Investment Case study to support public sector investment.

**Getting closer to zero new infant infections.** In 2012, only 2.7% of the babies of women living with HIV were HIV positive at eight weeks, compared to 8% in 2008. Each year, health services in South Africa are enabling 240,000 pregnant women living with HIV access to treatment to keep their babies HIV-negative. In 2012, the UN supported policies to increase universal access to free antiretroviral therapy, targeting all HIV-positive

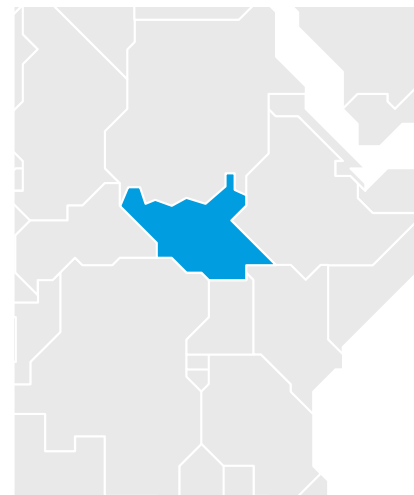
pregnant women and infants born to HIV-positive mothers. It also facilitated the establishment of the Women Living with HIV Think Tank to enhance the ability of women living with HIV to exercise leadership in developing policies.

**Focusing on gender equality.** The UNJT continues to support the South African government in addressing the structural drivers of HIV, including gender inequality and gender based violence, which make women and girls vulnerable to HIV. In 2013, the UNJT and partners launched the 'We Will Speak Out' Campaign committing FBO leadership to eliminating sexual violence. Technical support and funding was provided to, among others, the Treatment Action Campaign, Her Rights Initiative and the Positive Women's Network to further advocate for the health and rights of women, and girls.

**Advocacy for Human Rights.** The UNJT continues to support the Government's realization of human rights of key populations. Laws such as the criminalization of sex work are barriers for accessing to services. The UNJT also produced issue papers on hate crimes and stigma and discrimination to guide the work of the AIDS Council's Human Rights Technical Task Team (HRTTT). Going forward, the UNJT is supporting the South Africa National AIDS Council (SANAC) in undertaking research on stigma, and developing a more comprehensive community-based approach to reducing stigma due to HIV.

# South Sudan

## NOTABLE SUCCESS IN ADDRESSING THE GENERALIZED HIV EPIDEMIC



### Country profile (2012 data)

**9,200,000**

Population

**150,000 [100,000 - 230,000]**

Number of people living with HIV

**140,000 [88,000 - 200,000]**

Adults aged 15 and over living with HIV

**78,000 [51,000 - 120,000]**

Women aged 15 and over living with HIV

**13,000 [8,400 - 20,000]**

AIDS-related deaths

**15,000 [7,500 - 23,000]**

New infections

**2.7% [1.8% - 4.0%]**

Adults aged 15-49 prevalence rate

**8% [6% - 12%]**

ART coverage

**13% [8% - 21%]**

PMCT coverage

**Epidemic type:** generalized/  
geographical relevance

**Main modes of transmission:** Sex  
workers and their clients, multiple  
heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 83,431,792**

Total core UBRAF expenditures  
**US\$ 2,518,060**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**15 million  
accessing  
treatment**



**Eliminate  
gender  
inequalities**

# 'THE UN FAMILY IS HELPING TO PROVIDE THOUSANDS OF PEOPLE IN SOUTH SUDAN WITH LIFE-SAVING HIV TREATMENT.'

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**Bold response produces tangible results.** As the world's newest nation, declaring independence in 2011, South Sudan faces many challenges, not least in its HIV response. The Government is trying to scale up prevention and treatment services in a country impoverished by more than 20 years of civil war. A lack of basic services and infrastructure, a depressed economy, nascent governance and legal systems, and a returning population of refugees forced to flee the conflict add to the burden. Despite these challenges, South Sudan has achieved some notable successes in addressing its generalized HIV epidemic, which has an estimated prevalence of 2.7%. In 2012, the UN family, including the UNDP, WHO and other agencies, supported the Southern Sudan AIDS Commission, the Ministry of Health and nongovernmental organizations in providing about 4,376 people in South Sudan with life-saving HIV treatment and therefore averting numerous deaths.

**Services expanded for key populations.** Evidence-informed HIV combination prevention programmes and services have been initiated with a focus on key populations (sex workers, uniformed forces, boda boda or motorcycle taxi drivers, men who have sex with men, young people and truckers) and vulnerable groups including women, girls and populations of humanitarian concern (refugees, internally displaced populations and returnees). There are now 92 (75 functional) sites providing PMTCT, 133 offering HIV testing and counselling, 22 providing antiretroviral therapy (ART) and 36 antenatal clinics doing biannual sentinel surveillance.

**Scaling up ART benefits women and children.** Women and the young, in particular, have benefited from the scale-up in services. In 2012, UNDP completed the construction of antenatal clinics in Terekeka, Lainya, Morobo, Kajo-Keji, Nzara, Maridi, Pochalla and Wau,

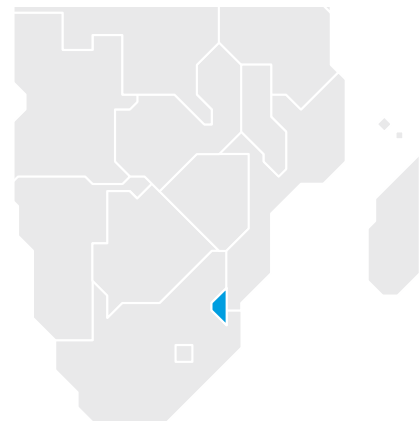
while UNICEF outreach helped provide 15 873 young people with HIV testing and counselling. UNDP, WHO and UNICEF through the Global Fund grant supported efforts to procure antiretroviral drugs, including Nevirapine, for the 22 centres providing ART and, by 2012, 30,652 pregnant women had been put on counseling and testing for PMTCT with 1,000 being provided with antiretroviral for PMTCT. WHO has also supported the scale-up of ART, updating HIV care and patient monitoring and operational tools and protocols, and providing clinical mentoring and supervision for ART delivery. Continued support in this area is crucial as only about 11% of adults and 1% of children living with HIV in South Sudan receive ART.

**UN support crucial for expanding PMTCT.** Despite a rapid increase in PMTCT services, they are reaching only a fraction of the pregnant women who could benefit from them. Coverage is hampered by limited access to antenatal care and a low level of knowledge. Only 15% of women understand mother-to-child transmission of HIV, while research indicates less than 10% of South Sudan's population has comprehensive knowledge of effective HIV prevention methods. Poor tracking systems and outreach for the 81% of pregnant women who deliver at home further hinders the scale-up of PMTCT services. It is crucial that the UN continues to support efforts to extend coverage if South Sudan is to achieve elimination of vertical transmission.

**Expanding treatment for women.** Going forward, the UN will rally for an increase of ART benefits as well as scaling of PMTCT services. This can be done through strategic and technical guidance as well provision of mobilising funding.

# Swaziland

## TAKING RADICAL STEPS TO REDUCE NEW HIV INFECTIONS



### Country profile (2012 data)

**1,300,000**

Population

**210,000 [200,000 - 230,000]**

Number of people living with HIV

**190,000 [180,000 - 200,000]**

Adults aged 15 and over living with HIV

**110,000 [100,000 - 120,000]**

Women aged 15 and over living with HIV

**5,500 [4,800 - 6,300]**

AIDS-related deaths

**12,000 [9,800 - 14,000]**

New infections

**26.5% [24.6% - 28.3%]**

Adults aged 15-49 prevalence rate

**82% [78% - 86%]**

ART coverage

**83% [75% - 92%]**

PMCT coverage

**Epidemic type:** severe/hyperendemic

**Main modes of transmission:**

heterosexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 26,326,685**

Total core UBRAF expenditures  
**US\$ 2,528,340**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**



**Prevent HIV  
among drug  
users**



# SWAZILAND SECURED PRICES BELOW THE BENCHMARK FOR 93% OF ITS ANTIRETROVIRAL MEDICINES.

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**Safety net for vulnerable children.** One of Africa's smallest countries, Swaziland has the world's highest percentage of people living with HIV (PLHIV); more than a quarter of those aged 15-49 are living with the virus. The country has taken radical steps to reduce new HIV infections and scale up access to treatment, making young people the focus of its response. To mitigate the impact of HIV in households, the UN supported Neighborhoods Care Points (NCPs), a safety net for vulnerable children offering holistic care. The UN in 2012 supported NCP efforts to keep vulnerable young people in school and provide two nutritious meals to 39,330 children. UN provided training featuring an HIV prevention toolkit to 184 youth-led organizations. UNICEF, UNFPA, WHO and UNAIDS are collaborating on reproductive health services, targeting young people at cultural events such as the annual Reed Dance, the UN helped provide 100,000 young girls with information on HIV prevention. The UN provided the Public Sector HIV and AIDS Coordinating Committee with information to improve monitoring and evaluation, and the Swaziland Business Coalition on HIV and AIDS with HIV testing and counselling for timber and sugar workers via mobile clinics. The UN helped Baylor College of Medicine conduct follow-ups via mobile phones and home visits on 800 HIV-positive children receiving antiretroviral therapy, resulting in increased treatment adherence.

**Striving to halt the march of twin epidemics.** An estimated 16 000 Swazis develop life-threatening tuberculosis (TB) annually and more than three quarters of people who have TB are also living with HIV. But with the support of the UN family, the country is striving to halt both epidemics. In 2012, the UN supported TB

screening among PLHIV at 30 sites, with 711 confirmed TB cases detected from January–June. The UN is assisting the National TB Control Programmes (NTCP) to develop a community-based patient support system for drug-susceptible and drug-resistant TB cases through the Global Drug Facility and Green Light Committee mechanisms. UN technical assistance to the NTCP to quantify first- and second-line anti-TB drugs contributed to low stockouts of both medicines. The UN has developed national guidelines for isoniazid preventive therapy, which reduces TB incidence in HIV patients, though procurement and supply constraints remain.

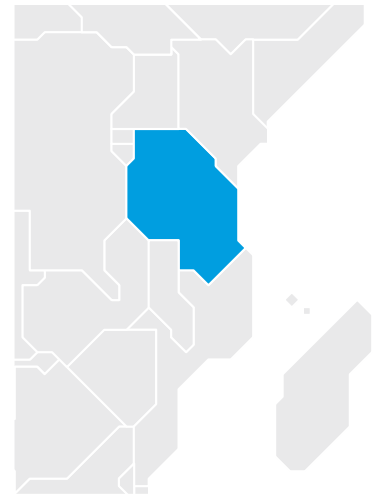
## **Big savings in procuring antiretroviral drugs.**

Swaziland revised its antiretroviral medicines procurement tender process, saving US\$ 12 million between January 2010–March 2012. In addition to benchmarking prices and improving forecasting, Swaziland incorporated historical information about supplier performance into the evaluation criteria. Swaziland secured prices below the benchmark for 93% of its antiretroviral medicines, resulting in a 27% price decrease between January 2010–March 2011 compared with 2009 tender prices. The reductions amounted to savings of almost US\$ 5 million, which is being invested in HIV treatment services.

**Integrating services saves millions.** Going forward, to realize US\$ 31 million in efficiency gains up to 2018, Swaziland is further integrating services for preventing new HIV infections in children into maternal/child health facilities.

# Tanzania

## MOUNTING A DETERMINED RESPONSE TO THE HIV EPIDEMIC



### Country profile (2012 data)

**44,928,923**

Population

**1,500,000 [1,300,000 - 1,600,000]**

Number of people living with HIV

**1,200,000 [1,100,000 - 1,400,000]**

Adults aged 15 and above living with HIV

**730,000 [660,000 - 810,000]**

Women aged 15 and up living with HIV

**80,000 [69,000 - 94,000]**

AIDS-related deaths

**83,000 [69,000 - 100,000]**

New infections

**5.1% [4.6% - 5.7%]**

Adults aged 15-49 prevalence rate

**61% [56% - 67%]**

ART coverage

**77% [66% - 89%]**

PMCT coverage

**Epidemic type:** high burden

**Modes of transmission:** sex workers and their clients, heterosexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 63,187,668**

Total core UBRAF expenditures  
**US\$ 3,299,532**

### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**Eliminate  
stigma and  
discrimination**



**15 million  
accessing  
treatment**

# 'WE MUST WORK TOGETHER TO ENSURE MOTHER-TO-CHILD TRANSMISSION OF HIV BECOMES A THING OF THE PAST.'

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## Mama Salma KIKWETE

First Lady of Tanzania

**Progress in medical male circumcision.** Tanzania has mounted a determined response to the challenges posed by the HIV epidemic. Voluntary Medical Male Circumcision (VMMC) scale-up is focused in 12 regions with high HIV prevalence and low male circumcision rates. As of mid-March 2014, 900,439 males were circumcised, with a target of 2,102,252 males circumcised by 2017. The UN Joint Team has supported a local non-governmental organization, to promote VMMC among young people in the Makete district. The scale-up of VMMC has been facilitated by task-shifting to nurses thereby reducing demands on doctors.

**Mother-to-child transmission a key priority.** Strong leadership has resulted in a significant expansion of services to eliminate mother-to-child-transmission (eMTCT). HIV counselling and testing sites have increased to 2,137, with 96% of reproductive and child health services offering prevention of mother-to-child transmission (PMTCT) services. The UN Joint Team facilitated alignment of the Tanzania PMTCT programme to global eMTCT targets. UN advocacy and training were crucial in launching the national eMTCT plan in 2012, and in the country adopting Option B+ for PMTCT and rolling it out in phases from September 2013. With UN support, bottlenecks in pediatric HIV treatment have been identified and will be addressed to accelerate scale-up of pediatric care and antiretroviral treatment.

Addressing gender inequality. The Government is working to improve gender equality and empower women, important in a country where stigma and discrimination are drivers of the epidemic. Through UN system support, Tanzania mainland and Zanzibar have developed gender operational plans for HIV that address gender discrimination, inequalities and gender-

based violence, with activities to address gender in HIV at national, regional and district level. Aligned with the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV, the plans seek equal access for women, men, boys and girls in HIV prevention, treatment, care, support and mitigation activities within communities and workplaces. In addition, UNICEF has supported TACAIDS to develop a National Programming Framework for Adolescent Girls, to reduce the vulnerability of adolescent girls to HIV, violence and unintended pregnancies.

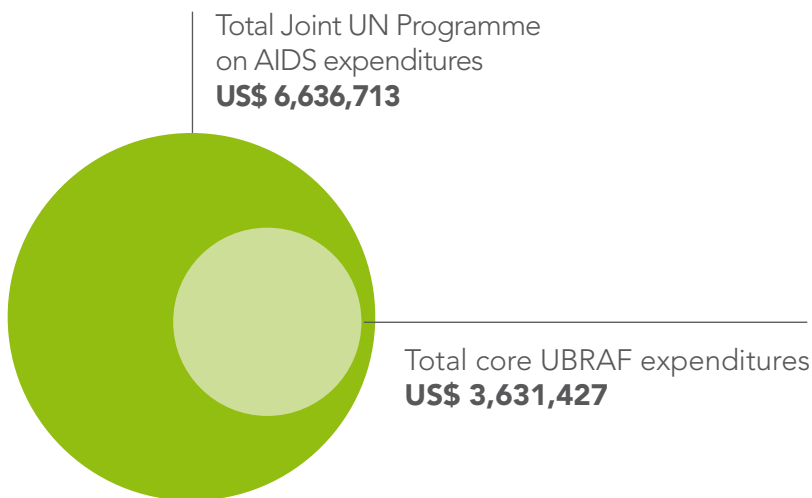
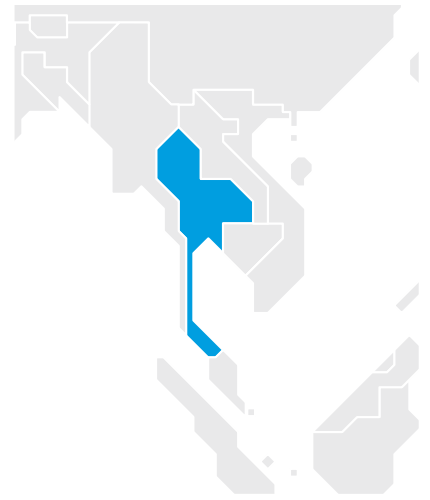
**Scale up of antiretroviral therapy.** A total of 512,555 (including 38,848 children below 15 years) eligible people living with HIV are currently on treatment. The 2013 Consolidated WHO HIV guidelines have been fully adapted through UN Joint Team support.

### Promoting condom use among the young.

Reducing risky sexual behavior of young people remains a challenge, given low condom use and low risk perception among those aged 15–24. Participation by the UN Joint Team partners within national dialogue structures and sustained advocacy has helped prioritize this key population for policy and strategy, along with UN support to evidence-based interventions such as to increase HIV testing and counselling and condom use among young people and other young key populations. But coordination and funding for prevention programmes, particularly behavioral and structural interventions, remain a challenge and continued UN support remains critical to improve the future situation.

# Thailand

## SCALING UP SERVICES FOR VULNERABLE GROUPS



### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate  
stigma and  
discrimination**



**Prevent HIV  
among drug  
users**



**15 million  
accessing  
treatment**

### Country profile (2012 data)

**67,600,000**

Population

**440,000 [400,000 - 480,000]**

Number of people living with HIV

**430,000 [390,000 - 470,000]**

Adults aged 15 and above living with HIV

**200,000 [180,000 - 210,000]**

Women aged 15 and up living with HIV

**21,000 [18,000 - 24,000]**

AIDS-related deaths

**8,800 [5,500 - 24,000]**

New infections

**1.1% [1.0% - 1.2%]**

Adults aged 15-49 prevalence rate

**76% [71% - 80%]**

ART coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** concentrated

**Main modes of transmission:** sexual,  
heterosexual sex, men who have sex with  
men.

# 'THAILAND, WITH UN SUPPORT, HAS TAKEN POSITIVE STEPS TO ADDRESS STIGMA AND DISCRIMINATION, AND ENSURE HUMAN RIGHTS IN HIV.'

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**Tailoring prevention to key populations to further reduce transmission.** Thailand has acknowledged in its new National AIDS Strategy 2012–2016 that continued progress towards becoming one of the first countries in Asia to end its AIDS epidemic will depend heavily on scaling up prevention, care and treatment services for key populations: men who have sex with men, sex workers, people who inject drugs, for whom HIV incidence and prevalence is significantly higher than in the general population, as well as vulnerable groups of migrants and youth. The UN continues to support Thailand in targeting these key populations, primarily through strategy and policy guidance, participatory programme design and management, capacity development and strategic information. Advocacy and technical support from the UN Joint Team, for example, has helped Thailand redesign its prevention programmes from “information delivery” to high-impact “service delivery”. Pre-exposure prophylaxis and treatment as prevention, HIV counselling and testing, and early treatment and retention in services are all part of this redesigned approach. The UN has supported Thailand advance towards equitable access to prevention, treatment and care, with particular focus on reaching key affected and marginalized populations, including young key affected populations.

**Advocating for drug law reform.** In April 2012, the UN Country Team (UNCT) jointly organized, with the Ministry of Justice, a seminar to discuss effective approaches to drug-dependence treatment and harm reduction. The UN supports the Ministry in implementing the seminar’s recommendations for legal and policy changes and assists with implementing

comprehensive harm reduction demonstration sites. The UN Country Team and the UN Joint Team continue to advocate for changes to Thai laws on compulsory treatment and those that criminalize people who use drugs.

**Monitoring stigma and discrimination.** Thailand, with UN support, has also taken positive steps to measure and address stigma and discrimination, and ensure human rights for HIV. As a result of continuous UN support and advocacy, Thailand’s National AIDS Committee has established a subcommittee to monitor and address these issues. The UN cooperated with the subcommittee and the justice and health ministries to train police officers on HIV and human rights.

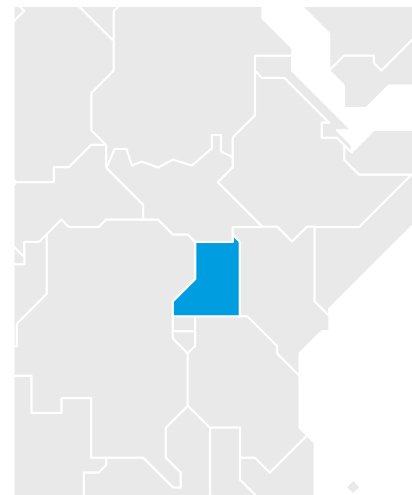
## **Adapting and sustaining the response.**

Several challenges will need to be addressed as Thailand pursues its vision of zero infections, zero AIDS-related deaths, and zero stigma and discrimination: among them, the demographic and the epidemic changes, the need for greater integration of the HIV responses by different sectors, and the demands of rapid decentralization that is hindered by weaker capacity and lower resources at the subnational level. These challenges will require the UN family to redouble its efforts to provide evidence-based technical support and harness its convening powers to maintain stakeholder commitment and consolidate action on key priorities.

# Uganda

## PREVENTION STRATEGIES

### THE CORNERSTONE OF RESPONSE



#### Country profile (2012 data)

**38,600,000**

Population

**1,500,000 [1,400,000 - 1,800,000]**

Number of people living with HIV

**1,400,000 [1,200,000 - 1,600,000]**

Adults aged 15 and above living with HIV

**780,000 [690,000 - 900,000]**

Women aged 15 and up living with HIV

**63,000 [52,000 - 81,000]**

AIDS-related deaths

**140,000 [110,000 - 170,000]**

New infections

**7.2% [6.4% - 8.4%]**

Adults aged 15-49 prevalence rate

**64% [58% - 73%]**

ART coverage

**72% [62% - 86%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** heterosexual transmission within stable partnerships, multiple heterosexual partners.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 77,853,641**

Total core UBRAF expenditures  
**US\$ 3,620,104**

#### UN areas of work - prioritization by agencies



**Reduce sexual  
transmission**



**15 million  
accessing  
treatment**



**Eliminate  
gender  
inequalities**



**Eliminate new  
HIV infections  
among children**

# 'HIGH-LEVEL ADVOCACY HAS RESULTED IN THE PRESIDENT RECOMMITTING TO THE RESPONSE.'

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**Expanding services for most-at-risk groups.** The UN has supported Uganda's pledge to scale-up circumcision in the formal health sector and among district health systems. Cumulatively, about 1,200,000 men were circumcised by September 2013 and Uganda hopes to reach the 4.2 million male circumcision target by 2016. Capacity for programming and service delivery to most at risk population groups (MARPs) has been expanded by training 300 health workers. The UN has also helped deliver services to about 5,000 sex workers and 800 men who have sex with men annually since 2011. Other UN-assisted policy and planning frameworks include: the National MARPs Programming Framework; an approved reproductive health/HIV linkages and integration strategy; an action plan for sexual and reproductive health/HIV in sex-work settings; and a school health policy.

**Strengthen HIV monitoring and evaluation.** After dramatically reducing HIV prevalence following a comprehensive prevention campaign in the 1990s, there are signs the number of people living with HIV (PLHIV) in Uganda may be rising. Experts believe complacency and the normalization of AIDS may be increasing risky behavior. Uganda has made prevention the cornerstone of its response, linking sexual and reproductive health (SRH) and HIV, and focusing on reducing HIV incidence by 30% by 2015. The UN Joint Team's input is crucial to this prevention response and to efforts to strengthen HIV monitoring and evaluation systems, evident in requests for technical support from all government sectors and key nongovernmental partners.

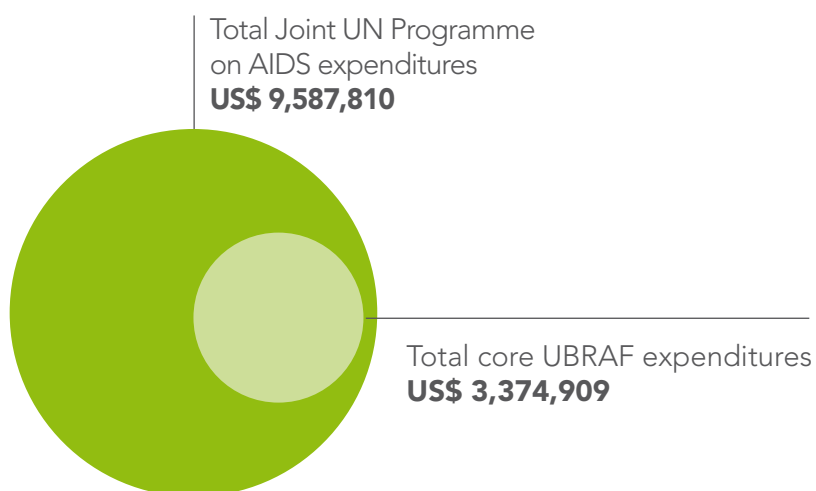
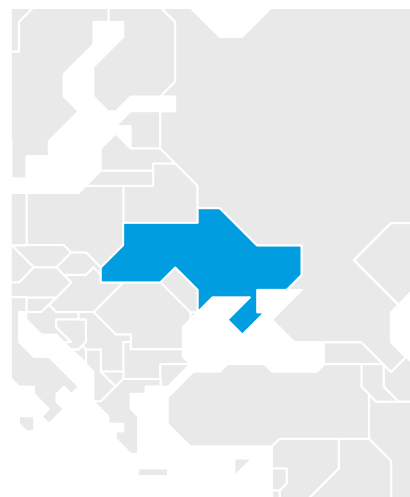
**Rolling out national eMTCT plan.** Uganda has invested in scale-up to eliminate mother-to-child transmission

(eMTCT). The UN's high-level advocacy on vertical transmission has targeted political leadership, and as a result, the president has recommitted himself to the HIV/AIDS response. Uganda has the fourth highest number of women needing prevention of mother-to-child transmission (PMTCT) services. However, 72% currently receive these services compared with a 61% average among the 22 highest-burden countries. With the support of the Joint UN Team on AIDS, which provided strategic information, tools, guidance and operational research, a national eMTCT plan incorporating Option B+ was rolled out. Uganda's progress towards eliminating new HIV infections among children can be further advanced if it increases the uptake of ARV medicines during breastfeeding, reduces the number of new HIV infections among women, as well as improving access to family planning services. The UN is also advocating for improved access to treatment, care and support for HIV positive persons and/or those affected by HIV. The NSP, revised with UN support, aims to improve the life of PLHIV by mitigating the health effects of HIV/AIDS, improving access to services for PLHIV, children and other vulnerable populations, and ensuring equitable and timely service delivery, all by 2015. In 2013, 194,000 patients were on antiretroviral therapy, above the annual target of 110,000.

**Encouraging religious and cultural leaders for changes.** Going forward, The UN is encouraging faith and cultural institutions to identify factors that foster social change, and working with the National Forum of PLHIV Network in Uganda to implement the PLHIV stigma index.

# Ukraine

## NOBODY LEFT BEHIND: TOWARDS AN AIDS FREE GENERATION



### UN areas of work - Prioritization by agencies



**Prevent HIV among drug users**



**15 million accessing treatment**



**Reduce sexual transmission**



**Eliminate gender inequalities**

### Country profile (2012 data)

**45,600,000**

Population

**230,000 [190,000 - 270,000]**

Number of people living with HIV

**230,000 [190,000 - 260,000]**

Adults aged 15 and over living with HIV

**95,000 [80,000 - 110,000]**

Women aged 15 and over living with HIV

**18,000 [15,000 - 22,000]**

AIDS-related deaths

**11,000 [7,500 - 15,000]**

New infections

**0.9% [0.7% - 1.0%]**

Adults aged 15-49 prevalence rate

**41% [36% - 46%]**

ART Coverage

**...% [...% - ...%]**

PMCT coverage

**Epidemic type:** concentrated

**Modes of transmission:** injecting drug use, heterosexual sex.



# 'GREATER FOCUS ON EFFECTIVE INTERVENTIONS AND DOMESTIC INVESTMENT IN THE AIDS RESPONSE IN UKRAINE.'

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**Targeting people who inject drugs.** Injecting drug use remains the driving force of the HIV epidemic, although prevalence among people who inject drugs has fallen from 32.7% in 2007 to 19.7% in 2013. The number of opioid substitution therapy (OST) patients increased from 160 in 2006 to 8,614 by the end of 2013. The UNAIDS Secretariat, UNICEF and WHO supported the Government through policy and strategic guidance including: an innovative and comprehensive model of HIV prevention, care and support for young female sex workers, people who inject drugs and other vulnerable youth; an elimination of mother-to-child transmission (eMTCT) strategy focused on pregnant women who inject drugs; and capacity building for public health staff and nongovernmental organizations to provide integrated care services for people who inject drugs and to implement OST. UNODC helped develop and implement an OST strategy that led to prison medical services being reorganized.

**Striving for universal coverage for ART.** Antiretroviral therapy (ART) coverage increased from 26% in 2011 to 41% in 2012, and Ukraine is attempting to further increase coverage by continuing to decentralize services. New ART sites have been opened, with 145 now offering ART to 55,734 people. WHO recommendations for the early treatment of HIV-positive individuals through a fixed combination of antiretroviral regimens, and for increased accessibility of simplified, community-centred diagnostic approaches have been acted on. UNAIDS promoted the 2013 WHO recommendation to start treatment for HIV-positive pregnant women when their CD4 count shows fewer than 500 cells/mm<sup>3</sup>, and advocated for the treatment as prevention and rapid testing strategies to the Ministry of Health. The World Bank and UNAIDS conducted a HIV programme efficiency study, which focused on the national strategic plan, OST and ART in

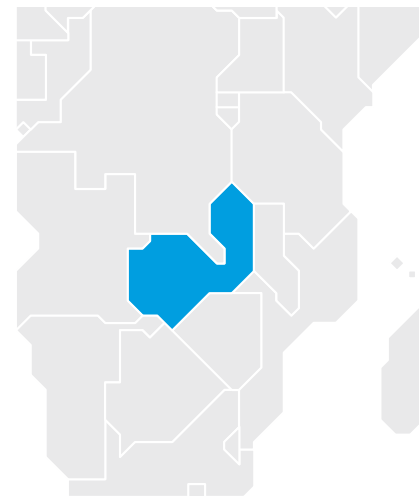
three regions of Ukraine and provided evidence on several efficiency gaps created by high levels of ART regimens. Based on data collected, the study recommended fixed-dose regimens and joint procurement mechanisms be considered.

**Virtual elimination of mother-to-child transmission to be sustained.** HIV prevalence for pregnant women decreased from 0.52% in 2007 to 0.47% in 2011, while the rate of HIV transmission from mother-to-child decreased from 27.8% in 2001 to 3.7% in 2011. This success was achieved by integrating the prevention of mother-to-child transmission (PMTCT) programme into standard maternal and paediatric health amenities and by building capacities, processes that were started in 2001. UNICEF advocacy and technical assistance for a new national clinical guideline/protocol on ART for children with HIV or AIDS and for situation assessment on early infant diagnosis of HIV generated evidence for strategic changes that increased diagnosis and treatment for more than 4,000 children born to HIV-positive mothers. WHO supported the PMTCT protocols ensuring ART scale-up for eligible women, including provider-initiated testing and counselling principles, and a new national ART clinical guideline for children with HIV or AIDS.

**Aiming for 100% state funding for ART.** Despite commendable growth in domestic investment in the HIV response (tenfold between 2005 and 2010), Ukraine remains 50% dependent on external financing, though the Government does fund 87% of ART services. UN advocacy and technical assistance will be necessary to ensure further reductions in drug costs and to optimize procurement.

# Zambia

## ACCELERATING SCALE UP OF MALE CIRCUMCISION



### Country profile (2012 data)

**14,400,000**

Population

**1,100 000 [1,000 000 - 1,200 000]**

Number of people living with HIV

**950,000 [900,000 - 1,000,000]**

Adults aged 15 and above living with HIV

**490,000 [460,000 - 530,000]**

Women aged 15 and up living with HIV

**30,000 [26,000 - 36,000]**

AIDS-related deaths

**56,000 [49,000 - 64,000]**

New infections

**12.7% [11.9% - 13.7%]**

Adults aged 15-49 prevalence rate

**79% [76% - 84%]**

ART Coverage

**95% [87% - 95%]**

PMCT coverage

**Epidemic type:** Generalised (high burden)

**Modes of transmission:** heterosexual transmission within stable partnerships, multiple concurrent heterosexual partnerships.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 79,695,214**

Total core UBRAF expenditures  
**US\$ 4,051,627**

### UN areas of work - Prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate new  
HIV infections  
among children**



**Eliminate  
gender  
inequalities**



**Eliminate  
stigma and  
discrimination**

# WITH UN SUPPORT, A NATIONAL STRATEGY AND OPERATIONAL PLAN ON VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) HAVE BEEN ACCELERATED.

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## **Creating awareness on the benefits of circumcision.**

One of the major achievements in Zambia's response to the epidemic has been the scale-up of male circumcision. Most new HIV infections occur in adults whose partners have had casual heterosexual sex (37%). Against this background, the Government has put HIV prevention strategies at the core of its response. Under the 2011–2015 National AIDS Strategic Framework (NASF), a national VMMC strategy and operational plans on voluntary medical male circumcision (VMMC) have been developed and accelerated. The strategy has set a target of circumcising 80% of sexually active adult men by 2015. Traditional leaders have been fully engaged to create awareness and champion VMMC. In 2013 alone, 294,466 VMMCs were performed out of which 59.9% were adults. In all these achievements the UN Joint Team on AIDS has been a key stakeholder technically through normative guidance and to some extent, financially.

**Option B+ for HIV positive pregnant women.** In 2012, through continued advocacy by the UN Joint Team on AIDS and other stakeholders, the Ministry of Health reaffirmed the Government's commitment to the virtual elimination of mother-to-child transmission by adopting Option B+. PMTCT services have been integrated into antenatal care and other sexual and reproductive health services. In 2012, 88% of HIV positive pregnant women received efficacious antiretroviral medicines to reduce mother-to-child transmission of HIV compared to 58% in 2009. As a result, Zambia registered a 51% reduction in new HIV infections among infants. Although the emphasis here is on prong 3, it is worth noting that Zambia approach to PMTCT is holistic and focuses on all four prongs.

## **Improving legal environment through evidence.**

According to the Zambian Constitution, same sex relationships, injecting drug use and sex work are

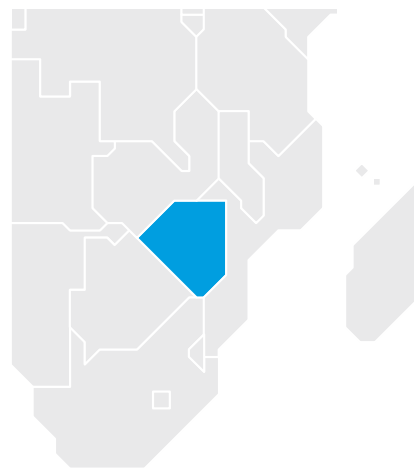
illegal. Such legal impediments obstruct effective HIV prevention and treatment by limiting access to services for these groups. The Joint UN Team on AIDS has advocated for a public health approach for key populations through support of a study tour to Kenya in 2012 to learn how Kenya is implementing programmes for key populations under similar legal environment. UN advocacy led to an evidence-informed revision of the NASF with re-definition of key populations including PLHIV, Women and adolescents, prisoners and the migrant population.

Committing to comprehensive sexuality education. Zambia is one of 20 countries in Eastern and Southern Africa that affirmed a landmark commitment to accelerate access to comprehensive sexuality education and health services for young people in the region. The historic ESA commitment was endorsed at the 2013 ICASA Conference and has time-bound actions and targets that were agreed upon by member states. The commitment process was led by UNAIDS and UNESCO.

**Tracking gender equality.** With support from the UN Joint Team on AIDS, the gender scorecard has been implemented in three of the ten provinces – Copperbelt, Southern and Western. Plans are afoot to roll out to the remaining seven provinces. Successful roll out of the gender score card will allow Zambia to track progress on gender equality in the HIV response. This process and other data-driven studies such as the national AIDS spending assessment, modes of transmission analysis and GOALS impact modelling have been undertaken in 2013 to inform the Zambia Investment Case. The UN Joint Team continues to assist in the efforts to ensure the revised NASF focuses on high impact interventions including key populations.

# Zimbabwe

## INTEGRATING HIV WITHIN THE BROADER HEALTH & DEVELOPMENT FRAMEWORK



### Country profile (2012 data)

**13,060,000**

Population

**1,400,000 [1,300,000 - 1,500,000]**

Number of people living with HIV

**1,200,000 [1,100,000 - 1,300,000]**

Adults aged 15 and over living with HIV

**700,000 [660,000 - 740,000]**

Women aged 15 and over living with HIV

**39,000 [34,000 - 45,000]**

AIDS-related deaths

**69,000 [59,000 - 79,000]**

New infections

**14.7% [13.8% - 15.6%]**

Adults aged 15-49 prevalence rate

**79% [75% - 83%]**

ART Coverage

**82% [72% - 91%]**

PMCT coverage

**Epidemic type:** high burden

**Main modes of transmission:** heterosexual transmission within stable partnerships.

Total Joint UN  
Programme  
on AIDS  
expenditures  
**US\$ 207,048,800**

Total core UBRAF expenditures  
**US\$ 3,910,723**

### UN areas of work - Prioritization by agencies



**Reduce sexual  
transmission**



**Eliminate  
gender  
inequalities**



**15 million  
accessing  
treatment**



**Eliminate new  
HIV infections  
among children**

# 'A HIGHLY PRIORITIZED RESPONSE, RAPIDLY SCALING UP TREATMENT AND CONTINUING TO BRING NEW INFECTIONS DOWN.'

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**Rolling out lifelong ART for pregnant women.** The prevention of mother-to-child transmission (PMTCT) programme has been a pillar of the HIV response in Zimbabwe, contributing significantly to the 50% reduction in new infections over the past decade. Antiretroviral therapy (ART) and PMTCT services have been integrated within the broader framework of reproductive health services, and decentralized and expanded across the country. The UN supported the Government through joint interventions to achieve 93% uptake in PMTCT services using the most efficacious regimen, a decrease in vertical transmission (from 22% to 9%) and the phase out of single-dose Nevirapine. A concerted effort to increase coverage of antiretroviral medicines during breastfeeding will further reduce new HIV infections among children. Zimbabwe has committed to rolling out lifelong ART for pregnant women living with HIV (Option B+), which will accelerate progress towards eliminating mother-to-child transmission of HIV (eMTCT). The percentage of children receiving HIV treatment has doubled and the number of pregnant women living with HIV receiving ART for their own health has increased from 25% in 2009 to 43% in 2013.

**Strong dialogue between stakeholders.** The epidemic has been reversed faster than in any other country in southern and eastern Africa, helped by behaviour change, with people having fewer sexual partners, and high condom distribution. In 2013 there were 66,000 new HIV infections, the lowest since the mid-1980s. UNAIDS enjoys strong dialogue with the multisectoral National AIDS Council which oversees the national response, as well as with the Health Ministry, parliament, representatives of people living with HIV and key populations, and development partners, such as the Global Fund.

**Innovative ways to finance HIV responses.** The Government has taken a proactive and vigorous approach to tackling its HIV resource gap despite the economic challenges facing the country. Funding remains well short of the country's needs but with UN support Zimbabwe has carefully prioritized its response and innovative domestic tax levy for AIDS has leveraged international finance. In 2012, donors contributed 76% to treatment programmes with a significant domestic portion from the National AIDS Trust Fund which collects a 3% levy from all taxable income. Investments in Zimbabwe grew from US\$ 150 million in 2011 to US\$ 260 million in 2013, with total HIV funding projected to average US\$ 293 million annually in 2014–2016.

**Inclusive and gender-transformative HIV programming.** UNAIDS has supported the country's HIV response in applying principles of non-discrimination, inclusion and a focus on the most marginalized. Public health approaches are being employed to overcome barriers to access to HIV services for key populations. Progressive implementation of the UNAIDS Scorecard on Gender Equality in National HIV Responses is bolstered by the commitment of the Government of Zimbabwe to elevating standards of living for women, but it suffers from scarce funding. Consequently, despite the strong backing of the new 2013 constitution for women's rights and equality, there is limited space for making it work for HIV-affected women and girls. Going forward, the UN Joint Team will also prioritize stigma and discrimination, having already helped launch an HIV stigma index.





