UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (34)/14.9
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THIRTY-FOURTH MEETING

Date: 1-3 July 2014

Venue: Executive Board Room, WHO, Geneva

Agenda item 5.2

2012–2015 Unified Budget, Results and Accountability Framework

UNAIDS Performance Monitoring Report 2012-2013

Additional documents for this item:

- **Revised Indicator Framework:** *(UNAIDS/PCB (34)/14.10)*
- **Conference Room Paper 4** ***(UNAIDS/PCB (34)/14.CRP4):*** UNAIDS engagement with Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the US President's Emergency Plan for AIDS Relief (PEPFAR)
- **Conference Room Paper 5** ***(UNAIDS/PCB (34)/14.CRP5):*** UNAIDS engagement with civil society

Action required at this meeting – the Programme Coordinating Board is invited to: *Take note* of the report and *request* UNAIDS to continue to look for ways to strengthen performance measurement and reporting.

Cost implications of decisions: None

CONTENTS

ACRONYMS

ATLT	Adolescent HIV Prevention & Treatment Literacy Toolkit
ARV	Antiretroviral
BPU	Bemoni Public Union
BRIC	Brazil, Russia, India and China
CEWG	Cosponsor Evaluation Working Group
CROI	Conference on Retroviruses and Opportunistic Infections
DRC	Democratic Republic of the Congo
ECOSOC	Economic and Social Council
ECOWAS	Economic Community of West African States
eMTCT	Elimination of Mother-To-Child-Transmission
EXD	Executive Director
GFTAM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross National Product
HCLM	High-Level Committee on Management
HCLP	High-Level Committee on Programme
HIC	High Impact Countries
HLM	High Level Meetings
HSRC	Human Science Research Council of South Africa
HTC	HIV Testing and Counselling
IAS	International AIDS Society
IATT	Interagency Task Team
ICASA	International Conference on AIDS and STIs in Africa
ICAAP	International Congress on AIDS in Asia and the Pacific
ICW	International Community of Women with HIV/AIDS
IEC	Information, Education and Communication
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
ISDM	Integrated Service Delivery Meeting
JPMS	Joint Programme of Support
LGBT	Lesbian, Gay, Bisexual and Transgender
LVCT	Liverpool VCT Care and Treatment
MARA	Most at Risk Adolescents
M&E	Monitoring and Evaluation
MERG	Monitoring and Evaluation Reference Group
MDG	Millennium Development Goals
MOPAN	Multilateral Organisation Performance Assessment Network
NASA	National AIDS Spending Assessment
NSP	National Strategic Plans
OHTA	Optimization of HIV Treatment Acceleration
OGAC	Office of the U.S. Global AIDS Coordinator
OST	Opioid Substitution Therapy
PCB	Programme Coordinating Board
PEPFAR	The United States President`s Emergency Plan for AIDS Relief
PID	People who Inject Drugs
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PNG	Papua New Guinea
RMNCH	Reproductive, Maternal, Newborn and Child Health
SADC	Southern African Development Community
SERAT	Sexual Education Review and Assessment Tool
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB-DOTS	Tuberculosis Directly Observed Treatment, short term

TSF	Technical Support Facilities
TRIPS	Treatment-Related Aspects of Intellectual Property
UBRAF	United Budget, Results and Accountability Framework
UNDAF	UN Development Assistance Framework
UNAIDS	UN Joint Programme on AIDS
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision

I. INTRODUCTION

1. The UNAIDS 2012-2013 Performance Monitoring Report summarizes the achievements of the UN Joint Programme on AIDS (UNAIDS)[1] in 2012-2013 at country, regional and global level towards UNAIDS Vision of the "Three Zeros", and outlines key challenges, constraints and lessons learned. The report is a key component of the mid-term review of the 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF), called for by the Programme Coordinating Board (PCB), and complements the main report of the mid-term review as well as other documents which provide additional analyses.

2. The report begins by presenting the main results against the three pillars of UNAIDS 2011-2015 Strategy – efforts to revolutionise prevention of HIV transmission, catalyzing the next phase of treatment, care and support, and advances in human rights and gender equality.

3. Next, leadership, coordination and accountability in the response to AIDS are presented, followed by a section on cross-cutting themes in UNAIDS 2011-2015 Strategy – young people, education for more effective AIDS responses, scaling up HIV workforce policies and programmes, integrating food and nutrition in HIV prevention and care services, and HIV interventions in humanitarian emergencies. Finally, a selection of constraints, challenges and lessons learned are presented as well as key future action planned to address these.

4. The report presents progress against the global targets established by the 2011 United Nations General Assembly Political Declaration on HIV and AIDS ("global targets"), based on a review of trends and achievements against indicators included in the 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) Part II (UNAIDS/PCB(29)/11.23). Progress against some of the UBRAF indicators, along with short case studies, is presented throughout the narrative. Progress against all the indicators and in relation to the budget of the UBRAF are presented in a separate *Expenditure and indicator* matrix.

5. As the successor to the UNAIDS Unified Budget and Workplan (UBW), the UBRAF is an instrument to maximize the coherence, coordination and impact of the UN's response to AIDS by combining the efforts of 11 UN Cosponsors and the Secretariat to catalyse country-level action against AIDS. The UBRAF is based on the UNAIDS 2011-2015 Strategy, with outcomes, outputs and deliverables cascading from strategic goals and global AIDS targets. It is designed to help the Joint Programme frame, deliver and monitor results at country level. It identifies resources for global action, for High Impact Countries (HICs) and for other countries grouped by region.[2]

6. As part of the UBRAF, 30+ HICs were identified where the AIDS response could have the biggest impact. Cumulatively, the HICs bear the brunt of the HIV burden, accounting for 88% of new infections and 90% of total AIDS deaths among adults. More than half of total UBRAF funds are directed to these countries. In 2012-2013, the first biennium of

[1] Throughout this document 'UNAIDS' refers to the efforts of the UN Joint Programme on HIV/AIDS. When appropriate, reference is also made to the work of individual Cosponsors and UNAIDS Secretariat.
[2] Thirty-eight high impact countries: Angola, Botswana, Brazil, Burundi, Cambodia, Cameroon, Central African Republic, Chad, People's Republic of China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, the Islamic Republic of Iran, Jamaica, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, the Russian Federation, Rwanda, South Africa, South Sudan, Swaziland, United Republic of Tanzania, Thailand, Uganda, Ukraine, Zambia and Zimbabwe.

UBRAF operations, UN system resources to these countries totaled more than US$ 2.4 billion.

7. Supporting the achievement of the global targets within different national contexts is the foundation of UNAIDS work. At the country level, UN Joint Teams on AIDS are responsible for developing and implementing Joint Programmes of Support, which are aligned to national plans on HIV and AIDS. These form the basis of reporting on the UBRAF.

8. At the regional and global level, UNAIDS focuses on catalyzing processes and driving results where global public goods and coherence are most relevant. Mobilizing partners and marshalling support for better treatment and prevention technologies are challenges that are fundamentally global in scale and scope. Similarly, ensuring the broad array of stakeholders is working towards the same specific objectives within a common framework for targeting investments and measuring results necessarily involves a great deal of coordination and leadership at global and regional levels.

9. In the UBRAF, accountability is linked to the achievement of strategic goals and targets and measurement of results and contributions of the Joint Programme against indicators and performance criteria. The measurement of performance has been strengthened as part of the development and implementation of the UBRAF, and reporting has been expanded to include not only indicator-based reporting, but also additional information obtained from Cosponsors' internal results reports and reporting by interagency task teams and working groups. Annual performance reviews are conducted at all levels – global, regional and national – and contribute to the reporting to the Programme Coordinating Board, Cosponsor Boards, the Economic and Social Council and the UN General Assembly.

10. A web-based tool, the Joint Programme Monitoring System (JPMS) was introduced in 2012 and, after refinements were made to enhance performance monitoring, the JPMS is now the backbone of UNAIDS performance reporting. Reporting in the JPMS captures the country, regional and global organizational and thematic levels, with each successive level able to provide complementary reporting. As well as being linked to UNAIDS strategic goals and the global AIDS targets, the JPMS reporting is also linked to country results frameworks, normally the UN Development Assistance Framework (UNDAF).

11. Experience of the JPMS has showed that the UBRAF reporting has led to better planning and articulation of results by the Cosponsors and Secretariat at country and regional level. The quality of reporting has also improved in most of the 108 countries from where a report was produced for 2012-2013. It has also increased transparency, accountability and access to performance information as the system acts as a database. The ability to review results for a particular theme across all parts of the Joint Programme has facilitated reviews and links to global groups such as inter-agency task teams. There is however still scope for improvements in terms of reducing and focusing the amount of information.

12. A peer review by Cosponsors and the Secretariat, more robust than any previous similar undertaking, took place in March 2013 and March 2014. The review evaluated progress and performance and provided the opportunity to assess results and areas where additional efforts are needed and ensure epidemic priorities are addressed and lessons learned are considered in future work.

13. Two global multi-stakeholder consultations were held in Geneva on 4 March 2013 and 27 March 2014 – each with more than 70 participants, including representatives of member states and civil society in addition to Cosponsors and Secretariat staff – to take

stock of the lessons learned in implementing the UBRAF, to reflect these in the development of the 2014-2015 budget, and consider inputs into the mid-term review of the UBRAF.

14. The 2012-2013 performance monitoring report presents a summary of information collected primarily through the JPMS. The report presents results at outcome and output levels and describes the contributions of UNAIDS Cosponsors and Secretariat to the AIDS response. Thematic reports available online provide more detailed information.

II. PROGRESS TOWARDS THE "THREE ZEROS" AND POLITICAL DECLARATION TARGETS

15. Under the UBRAF, UNAIDS has oriented its work to maximize progress towards achievement of the 10 targets set forth in the 2011 UN General Assembly Political Declaration on HIV and AIDS. In its efforts to accelerate gains towards the 10 targets, UNAIDS has prioritized action not only in individual thematic areas but also on cross-cutting areas and overarching strategic functions.

A. Revolutionize HIV prevention

16. The long-term decline in annual new HIV infections continued in 2012-2013, with the estimated number of new infections in 2012 33% lower than the number in 2001. Through advocacy, normative guidance, technical support, commodity procurement, partnership cultivation and other activities, UNAIDS helped sustain and strengthen prevention gains in the 2012-2013 biennium.

UNAIDS achievements and contributions

i. *Reduce sexual transmission*

17. By 2012, at least 26 low- and middle-income countries had reached the global goal of reducing HIV incidence by an estimated 50% (from a 2001 baseline). HIV prevalence among young people also continued to decline, although the epidemic's burden in this population remains considerable, with young people aged 15-24 accounting for an estimated 42% of new infections among adults. Towards the global target of reducing sexual HIV transmission by 50% by 2015, the Joint Programme achieved results in three key areas.

18. *Young people*. With the aim of strengthening the scale-up and quality of prevention services for young people, UNAIDS issued new guidelines to reduce sexual transmission among young people. WHO issued guidelines on HIV testing, counselling and care for adolescents.

19. UNAIDS worked to generate strategic information to strengthen HIV responses for young people. The Sixth Stocktaking Report on Children and AIDS, published by UNICEF in December 2013, shows 10-19 year-olds are the only age group within which AIDS-related deaths have increased in the past seven years. Modeling done by UNICEF in partnership with the Futures Institute showed that two million new HIV infections could be averted by 2020 through scale up of high-impact HIV interventions, engagement and empowerment of youth-led organizations, action to address legislation and policy to enable delivery and uptake of the interventions by adolescents, and successful leverage of key sectors to invest in actions to reduce vulnerability of adolescents. Studies in Lesotho, Malawi and Tanzania sponsored by the World Bank documented the

effectiveness of cash transfer programmes in reducing HIV incidence and risk behaviours among young people.

20. Focused efforts were undertaken to expand access to comprehensive sexuality education for young people. The number of countries with an HIV policy in the education sector increased by an estimated 30% in 2012-2013. UNESCO and UNFPA supported the scale-up of sexuality education for young people through work with ministries of education, ministries of health and other stakeholders in 115 countries, using their complementary comparative advantages for work with in- and out-of-school young people. UNESCO, UNFPA and UNICEF supported efforts in dozens of countries in multiple regions to improve sexuality education, including peer review and revision of curricula and support for countries to incorporate HIV prevention (including for key populations) in life skills education. UNESCO has also mobilized dedicated programming resources to scale up sexuality education in Lesotho, Malawi, Mozambique, Tanzania, Uganda and Zambia amongst others.

> UNICEF supported the development and implementation of a free, SMS platform for HIV counselling for adolescents in Zambia. Innovative approaches such as interactive counseling and education on HIV and STIs through SMS (free-of-charge and confidential) is particularly relevant in the countries where the mobile phone penetration is high where youth and young adults represent a high percentage of all mobile phone users. It also enables real-time monitoring of the utilisation, availability and quality of adolescent and youth friendly HIV services.

21. *Key populations*. UNAIDS generated extensive normative guidance to strengthen efforts to improve access to HIV services among key populations. These include guidance on HIV/STI prevention and treatment for sex workers along with an accompanying implementation tool, complementing guidelines previously developed for men who have sex with men and transgender people. A UNAIDS guidance note on HIV and sex work provided recommendations with respect to enabling legal environments, reducing the demand for unprotected paid sex, differentiating consensual adult sex work from human trafficking, and economic empowerment of sex workers. UNAIDS produced operational guidelines for monitoring and evaluation of HIV programmes (for service delivery providers) for men who have sex with men, sex workers and transgender people, and work began on a tool to establish and monitor HIV targets for these populations. WHO developed a target setting guide for sex workers, men who have sex with men and transgender populations.

> The ILO collaborated with the Southern African Development Community and the UNAIDS Secretariat to implement an Economic Empowerment and vulnerability Programme along transport corridors in Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe, focusing on young women from key populations. Preliminary findings closely link economic empowerment and risk reduction, with the proportion of women selling sex falling by 14% and the share of women reporting concurrent partnerships declining from 15% to 7%.

22. The Joint Programme produced new strategic information on HIV prevention for key populations and promoted innovative programming to reduce sexual transmission among these groups. The World Bank, with UNFPA and UNDP, published landmark overview findings on the global epidemics among sex workers and men who have sex with men. To help strengthen HIV prevention programming for sex workers, the World Bank aided the Nigerian government in undertaking a mapping exercise involving more than 160,000 sex workers. UNDP and UNFPA strengthened the capacity of international organizations and networks of key populations, and also provided technical support to enable 26 cities (including 12 capitals) to develop and implement HIV action plans that specifically address the needs of key populations.

Global statistics suggest that prevalence among sex workers has fallen from a median of 3% in 2010 to 1.65% in 2013. The reported median use of condoms by sex workers with their last client increased from 81% to 85% in the same period.

Source: UBRAF indicators A1b, A1.2a

23. *Combination prevention*. UNAIDS continued its longstanding leadership in promoting strategic use of a combination of behavioural, biomedical and structural prevention approaches. In 2012-2013, these efforts continued to emphasize male and female condoms as the most effective tool to prevent transmission. During the biennium, UNFPA was the largest supplier of female condoms (41 million pieces) and the third largest provider of male condoms (1.75 billion pieces), and led the CONDOMIZE! Initiative which emphasizes increased condom access and enhanced community development. The UN Commission on Life Saving Commodities outlined key actions to scale up male and female condoms. WHO pre-approved the Cupid female condom, enabling it to be incorporated in UNFPA procurement, and undertook technical consideration of two additional female condom products.

24. In 2012-2013 UNDP served as interim Principal Recipient for 32 Global Fund HIV grants in 25 countries. Since the start of the partnership in 2003, UNDP-supported programmes also helped nearly 16 million people access voluntary counselling and testing (VCT) services, reached 53 million people with prevention communication to promote positive behaviours, distributed 600 million condoms, provided treatment for 1.8 million cases of sexually transmitted infections (STIs), and provided ARV prophylaxis to over 300,000 HIV positive pregnant women. As WHO reported in two annual progress reports, scale-up of voluntary medical male circumcision (VMMC) quickened in 2012-2013, with especially robust results in several countries where VMMC roll-out had previously lagged. WHO prequalified the PrePex non-surgical device for adult VMMC and issued generic guidance on the use of non-surgical devices. World Bank conducted studies in several countries to estimate the potential cost and impact of VMMC scale-up and directly funded VMMC services in Malawi, which has leveraged the funding to reach the one-quarter mark towards its goal of performing 2.1 million adult VMMCs over five years.

25. WHO issued guidance on pre-exposure prophylaxis for serodiscordant couples, men and transgender women who have sex with men. The joint WHO/UNAIDS HIV Vaccine Advisory Committee advised vaccine development activities in an increasingly complex landscape.

ii. Prevent mothers from dying and babies from becoming infected with HIV

26. The feasibility of eliminating HIV infections among children became increasingly clear in 2012-2013, with the number of children newly infected with HIV falling by an estimated 35% from 2009 to 2011. Among 22 countries prioritized by the Global Plan, coverage for services to prevent mother-to-child transmission averaged 65%, with four countries (Botswana, Ghana, Namibia and Zambia) providing antiretrovirals to at least 90% of pregnant women living with HIV.

UNICEF is assisting efforts to scale up HIV treatment in BRICS and other countries, including Ukraine and Uzbekistan. Through the MAC/UNICEF initiative, these countries are benefiting from technical support on monitoring and evaluation, innovative programming and capacity-building assistance.

27. UNAIDS continued its global leadership and coordinating role towards the global goal of eliminating new HIV infections among children (eMTCT). UNAIDS co-chairs the Global Steering Committee of the Global Plan, which includes all key partners. The Interagency Task Team (IATT) for eMTCT, co-convened by WHO and UNICEF, includes 33 partner

organisations and seven technical working groups. The IATT provided technical support to 11 countries (Botswana, Cameroon, Chad, Côte d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Nigeria, Tanzania and Zambia), for example in terms of data driven planning, proposal development, programme review, revision/adaptation of national policies, and planning and strategy development.

28. In its consolidated antiretroviral guidelines, released in 2013, WHO recommended initiation of triple-combination antiretroviral therapy for all HIV-positive pregnant and breastfeeding women. Through the Optimization of HIV Treatment Acceleration (OHTA) initiative, UNICEF provided technical and financial support to scale up lifelong antiretroviral therapy for all HIV-positive pregnant and breastfeeding women in four Global Plan countries (Côte d'Ivoire, Democratic Republic of Congo, Malawi and Uganda). To support efforts to scale up lifelong HIV treatment for pregnant women, UNICEF has prioritised strategic partnerships with such groups as ICAP, EGPAF and M2M to capitalize on in-country efforts led by key implementing partners. The IATT developed a toolkit on Option B/B+, which includes an easy-to-use checklist and assessment tools to support countries in transitioning from short-course regimens for pregnant women to lifelong antiretroviral treatment. UNICEF collaborated with the Clinton Foundation and the Business Leadership Council for a Generation Born Free of HIV to develop a business case for Options B and B+.

> There has been a significant reduction of maternal deaths associated with HIV, from 12,000 in 2005, to 8,600 in 2010, to 7,500 in 2013. The median percentage of women accessing PMTCT increased from 48% in 2010 to 65% in 2013. Between 2012 and 2013, the number of countries considered to have effective monitoring and evaluation systems for EMTCT[3] almost doubled, from 28 to 52.
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> Source: UBRAF indicators A2b, A2.1, A2.1.4

29. Technical support aided countries in strengthening their eMTCT programmes. The IATT assisted 19 countries in costing their eMTCT plans and organized two regional stocktaking meetings for focus countries. UNAIDS continues to work to ensure that Global Fund grants include funding for eMTCT and paediatric scale-up. Leveraging its critical role in providing food and nutrition support to accelerate and strengthen efforts to prevent mother-to-child transmission, WFP provided technical support to 13 countries, including to ensure integration of food and nutrition support for malnourished pregnant women accessing maternal and child health services.

30. WFP also provided support to malnourished PMTCT clients in the form of an individual ration to improve nutritional status and PMTCT adherence. In 2012 and 2013, nutritional support reached 18,937 malnourished PMTCT clients. A total of 29,952 household members, including clients, were reached through family rations to reduce the sharing factor of the individual ration amongst other household members.

31. Extensive efforts focused on improving the diagnosis and treatment of children living with HIV. WHO convened a technical meeting in September 2013 to discuss early infant diagnosis and scale-up, held the first Paediatric ARV Drug Optimization (PADO) meeting and supported the IATT's Paediatric Working Group to revise and publish recommendations for the paediatric antiretroviral formulary. This guidance was subsequently released as part of the March 2014 Supplement to the 2013 WHO Consolidated ARV Guidelines. UNICEF completed rapid assessments of the current

[3] Countries ascertained to have all four criteria in their M&E system for MTCT: (a) Indicators, baselines and targets set in line with the Global plan; (b) A mechanism for reporting, analyzing, reviewing routine M&E systems, validating and improving data quality in place; (c) A timeline and process for measuring PMTCT programme impact in place; and (d) Annual programme reviews being conducted.

status of early infant male circumcision in 14 priority countries. The WHO Paediatric Conference on ARV Drug Optimisation established medium- and long-term priorities for antiretroviral therapy for children and identified research priorities, taking into account market dynamics and forecasts of future paediatric antiretroviral needs.

32. Service integration to facilitate accelerated scale-up remained an important priority for the Joint Programme in 2012-2013. Through technical support, UNFPA and UNAIDS Secretariat worked to strengthen linkages between HIV and sexual and reproductive health and rights at the policy, system and services levels, including through advocacy and promotion of guidance tools for use at country level. For seven countries, UNFPA and UNAIDS Secretariat developed and pilot-tested indicators to measure progress in integration services for HIV and sexual and reproductive health. UNFPA developed a brief on linking these two service systems, documented experiences with service linkage in Rwanda, supported research on the experiences of women living with HIV in accessing services for sexual and reproductive health, and undertook rapid assessments of linkage efforts. The IATT convened an integrated service delivery meeting (ISDM) in Tanzania in October 2013 which brought together 14 countries and stakeholders from HIV, PMTCT, RMNCH and family planning.

iii. Protect people who use drugs from becoming infected with HIV

33. There has been little change in the HIV burden among people who inject drugs, who are estimated to account for 5-10% of people living with HIV worldwide, due in large measure to the resistance of many countries to implement evidence-based prevention methods. Progress towards the global goal of reducing new infections among people who inject drugs by 50% is further undermined by punitive legal frameworks and practices that impede meaningful access to needed services. In 2012-2013, the Joint Programme undertook extensive efforts to unblock responses for people inject drugs through advocacy, normative guidance, technical support, generation of strategic information, and partnership cultivation and support.

34. The Joint Programme produced a revised version of the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for people who inject drugs. Pilot studies in five countries, a global review of available data and expert consultations informed development of the revised guidelines, which were endorsed by the Programme Coordinating Board and effectively adopted by the Global Fund, PEPFAR and other donor agencies. The revised guidelines emphasized the distinction between drug-user-specific and general interventions, provided guidance on priority indicators, expanded the framework for quality assessment of interventions, and improved guidance for setting targets, measuring implementation of interventions and reporting and analyzing findings.

> UNAIDS-brokered technical support strengthened national responses for people who inject drugs. The capacity of hundreds of service providers to deliver gender-specific services for women who inject drugs was significantly enhanced with support of UNODC and other partners, for example in Afghanistan, Nepal, Pakistan and Ukraine. UNICEF, in concert with other UN and civil society partners, supported national governments in Ukraine and Kyrgyzstan to introduce selected pilot projects for comprehensive, gender-responsive services to address the specific needs of pregnant women using drugs and their children. Through these efforts, comprehensive services addressing the needs of women who inject drugs became available in these countries. The initiative trained service providers from governmental and civil society organisations at national and provincial level, with experiences and lessons learnt distilled, documented and disseminated through publications, websites and global expert networking.

35. The Inter-Agency Working Group on Key Populations, led by WHO, initiated the development of an issue paper and four technical briefs on adolescent key populations, informed by a literature review and focus group discussions among young people, including young people who inject drugs. UNESCO has developed a capacity development and training course on programming for young people in key populations including people who inject drugs, and regional trainings on these guidelines have been conducted for staff among various UNAIDS Cosponsors and the Secretariat, government and civil society partners in the Asia-Pacific, Eastern Europe and Central Asia, East and Southern Africa, Latin America and the Caribbean regions.

36. Use of contaminated injecting equipment during drug use accounts for more than 80% of all infections in Eastern Europe and Central Asia, and is a major entry point for HIV epidemics in countries in the Middle East and North Africa, and South and South-East Asia. New epidemics are also being witnessed in countries of sub-Saharan Africa. UNODC initiated a process involving ILO, UNDP, WHO and the UNAIDS Secretariat to develop a policy brief on HIV prevention, treatment and care in prisons and other closed settings. The policy brief outlined a comprehensive package of 15 essential interventions in such settings, with translations available in Chinese, Russian and French. The brief emphasizes the importance of aligning national programmes with principles of international law, including international rules, guidance, declarations and covenants governing prison health, international standards of medical ethics and international labour standards.

37. Advocacy and normative guidance to facilitate and accelerate enabling environments for effective responses for people who inject drugs were important focus areas for the Joint Programme's work in 2012-2013. In 2012, United Nations entities issued a joint statement calling on countries to close compulsory drug detention and rehabilitation centres and implement evidence-informed and rights-based health and social services in the community. UNODC and the UNAIDS Secretariat have worked to engage civil society organisations and networks, donor partners, other UNAIDS Cosponsors and technical experts in in-depth dialogue and debate to inform policy-makers of the HIV and human rights issues raised by compulsory detention and rehabilitation centres. In Eastern Europe, Central Asia, Asia and the Pacific, UNDP and partners supported legal and policy reviews regarding HIV and drug use.

> Early results from an independent evaluation of UNODC (covering the period 2008-2012) conducted at the end of 2013 found that overall its work was relevant and increasingly integrated in the Joint Programme, and its advocacy work had included some of its greatest successes. Conversely, it was found that its programme work in general should better incorporate human rights, and that country-level project sustainability could improve.

38. The Joint Programme expanded the base of strategic information on HIV responses for people who inject drugs. The World Bank initiated a global economic and modelling analysis on HIV epidemics among people who inject drugs, highlighting the critical role of rights-affirming engagement, evidence-based programming and enabling policy and legal environments in increasing the return on HIV investments for people who inject drugs. In 2013, UNODC, the World Bank and the UNAIDS Secretariat organized an international meeting on the economics and financing of effective harm reduction strategies, during which substantial evidence was presented on the health gains, economic savings and security benefits of enhanced access to such HIV services as opioid substitution therapy and antiretroviral therapy. A UNODC-organised "Global Technical Meeting on Stimulant Drug Use and HIV" in 2012 generated recommendations for a targeted approach to address the unique needs of stimulant users as they intersect with HIV prevention, treatment and care.

B. Catalyse the next phase of treatment, care and support

39. Expanding access to HIV treatment, care and support represents one of the signal achievements in the history of global health, averting millions of deaths in low- and middle-income countries and reviving communities and entire societies. Early efforts to introduce HIV chronic care in resource-limited settings have given way to initiatives to build on lessons learnt, further improve the quality and efficiency of services, and lay the groundwork for long-term sustainability. In 2012-2013, UNAIDS continued to make unique and pivotal contributions to these gains, including providing normative, intellectual and technical support towards the next phase of treatment, care and support.

UNAIDS achievements and contributions

i. *Ensure that people living with HIV receive treatment*

40. Nearly 10 million people were receiving antiretroviral therapy in 2013. Estimated AIDS-related deaths fell by 30% from 2005 to 2012, with scaled-up HIV treatment estimated to have averted 4.2 million deaths in 2002-2012. Global treatment coverage reached 65% of the 2015 global target, although new treatment guidelines substantially increased the number of people eligible for treatment, effectively reducing treatment coverage. At the end of 2012, roughly one-third (34%) of people eligible for treatment under the new guidelines were receiving HIV treatment.

41. Access to antiretroviral therapy has increased in all regions, although with considerable regional and population variation. The greatest scale-up has occurred in Africa, home to 80% of people who initiated antiretroviral therapy in 2012. Coverage among children in 22 priority countries rose only modestly in 2012, and treatment-eligible children remain about half as likely as treatment-eligible adults to obtain HIV treatment. Detailed data on treatment access among key populations is lacking.

42. In 2012-2013, the Joint Programme continued to provide leadership on treatment scale-up, including through normative guidance. WHO outlined a comprehensive framework to guide the national health sector response and strategies for HIV diagnosis, treatment, care and prevention. WHO outlined priorities on implementation science research agendas (which considers strategies to adopt and integrate evidence-based health interventions and change practice patterns in different settings), including specific work related to the strategic use of antiretrovirals. WHO continued to prioritize efforts to optimize treatment scale-up through the Treatment 2.0 innovations.

43. In June 2013, WHO launched the above-noted consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. The guidelines include 50 new clinical, operational and programmatic recommendations for adults, adolescents, children and pregnant and breastfeeding women across the continuum of HIV care. WHO worked with Ministries of health and in-country stakeholders to facilitate national adaptation through a series of seven regional dissemination workshops from July to November 2013, covering 90 countries from all the six WHO regions; nearly 90% of countries reported intention to adopt new ARV eligibility recommendations. In 2013, UNHCR collaborated with the South African HIV Clinicians Society, the Africa Centre for Migration and other agencies to update the 2007 Clinical Guidelines for ARV management for displaced populations in Southern Africa to be in line with the 2013 Consolidated WHO guidelines on the use of ARVs. This resulted in the development of

> UNICEF worked with WHO to revise community health worker tools for integrated community case management (a strategy to extend case management of childhood illness beyond health facilities so that more children have access to child care) to improve identification of HIV-exposed or -infected children for linkage to care.

Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crises Affected Persons in Sub-Saharan Africa, which will be launched in mid-2014.

Between 2012 and 2013 the number of eligible people receiving antiretroviral therapy increased by 1.7 million; the biggest improvement was reported among women, with access to treatment 10% higher in 2013. In low and middle income countries, the average first line ART cost per patient decreased from USD 155 to 130 between 2009 and 2013, and more significantly for second line treatment from USD 1,678 USD to 330. Between 2012 and 2013, the number of High Impact Countries reporting that their national health system and plan contained key components to address the HIV epidemic[4]: increased from 9 to 16.

Source: UBRAF indicators B1, B1.2, B1.2.1

44. The Joint Programme continued to prioritise advocacy for treatment scale-up. In 2013, the UNAIDS Secretariat joined with WHO, the Global Fund, the U.S. PEPFAR programme and African countries to launch Treatment 2015, which outlines a framework for strategic action to achieve the 2015 global target of 15 million on HIV treatment and to accelerate progress towards the goal of universal treatment access. UNAIDS established a real-time intelligence system to monitor progress and a repository of national treatment policies, as well as created an international reference group to advise UNAIDS on the treatment agenda. UNAIDS is also working with research partners to collect and synthesize all available scientific information on HIV treatment as prevention. Treatment 2015 was informed by a global civil society consultation co-convened by UNAIDS and Caritas International.

45. The Joint Programme is catalyzing the action and commitment needed to address the paediatric treatment gap. UNICEF, and WHO joined with the Elizabeth Glaser Paediatric AIDS Foundation to host a ministerial meeting that endorsed a new action framework for improving the survival of HIV-exposed, -infected and –uninfected infants. This 'Double Dividend' initiative was informed by extensive evidence review, including documentation of outcomes of integrating HIV infant testing into immunization programmes in three countries in 2013, as well as multi-country paediatric assessments in four countries in 2012, the findings from which were published in a supplement of AIDS.

46. A collaborative review conducted by ILO, the Human Science Research Council of South Africa (HSRC) and WHO found that employment significantly contributes on HIV treatment adherence, with employed individuals 39% more likely to adhere to prescribe regimens compared to the unemployed.

47. UNHCR completed a systematic review of HIV treatment adherence and outcomes among conflict-affected and displaced populations. The study confirmed that effective treatment strategies are feasible, with the rate of optimal adherence found to be 87-99%. UNHCR provided antiretroviral treatment to refugees, while also advocating for their inclusion in national programmes. By the end of 2012, 93% of treatment-eligible refugees were receiving HIV treatment.

UNESCO and SAfAIDS developed the Adolescent HIV Prevention & Treatment Literacy Toolkit (ATLT), an edutainment tool kit that aims to help reduce stigma and discrimination, strengthen referral systems for YPLHIV at school level and build a supportive & conducive environment for adolescent uptake and adherence to ART. UNFPA supported development of a similar toolkit for out-of-school YPLHIV.

[4] HIV medicines;, HIV diagnostics; provision of condoms and other essential HIV commodities; and use of intellectual property policy and law, including TRIPS flexibilities.

48. Other members of the Joint Programme provided direct support for HIV treatment programmes. Currently UNDP-supported Global Fund programmes are helping 1.4 million people access life-saving antiretroviral (ARV) treatment; approximately 1 in 7 of those on treatment worldwide. In 2012 and 2013, WFP provided food and nutrition assistance to 481,828 malnourished people living with HIV receiving treatment. In addition to this direct support to individual beneficiaries, in WFP supported national capacity development in the area of HIV among governments and national stakeholders in 44 countries.

49. With the aim of sustaining national treatment programmes, the Joint Programme assisted countries in using public health-related flexibilities from the Treatment-Related Aspects of Intellectual Property (TRIPS) agreement. UNDP provided capacity development support to government officials from nine countries in Latin America and the Caribbean in 2012 on using TRIPS flexibilities to increase treatment access. In addition, UNDP organized training for government officials from five countries on the examination of pharmaceutical patents from a public health perspective and co-sponsored a Regional Consultation and Planning Workshop on 'Use of TRIPS Flexibilities and Access to Affordable Antiretrovirals in Asia' in May 2013, which brought together over 90 participants from nine countries in Asia.

> In 2013, with financial and technical support from UNAIDS, Nigeria developed the President's Comprehensive Response Plan for HIV/AIDS (PCRP) to help accelerate the implementation of key interventions, and to bridge existing service access gaps. The PCRP will form the basis for developing investment cases and operational plans at the state level, and by 2015 aims to: provide testing for 80 million people aged 15 and older; enroll an additional 600,000 eligible adults and children on ART; provide ART for 244,000 HIV pregnant women for PMTCT; and provide access to combination prevention services for 500,000 most-at-risk populations and four million young people. Domestic spending is foreseen to increase from 25% in 2010 to 60% in 2015.

50. In December 2013, UNAIDS Programme Coordinating Board (PCB) discussed the strategic use of antiretroviral medicines for treatment and prevention of HIV. The Programme Coordinating Board called for the acceleration of access to HIV treatment, particularly for key populations as well as women, children and adolescents living with HIV, to be factored into all stages of HIV and health planning, implementation, monitoring and evaluation and resource mobilization. UNAIDS was requested to undertake a gap analysis on paediatric treatment, care and support with specific, time-bound targets for getting all children living with HIV on treatment.

51. WHO developed a policy brief outlining the opportunities and constraints of self-testing, which is an increasingly available form of testing. This built on the first global consultation on self-testing which was convened by WHO.

ii. *Prevent people living with HIV from dying of tuberculosis*

52. The estimated number of TB-related deaths among people living with HIV continues to decline, and the world is now within reach of achieving the global target of reducing the number of TB/HIV deaths by 50% by 2015. From 2004 to 2012, the number of TB-related deaths among people living with HIV declined from 500,000 to 320,000, with 17 of 41 countries reporting having experienced declines of at least 50% in the annual estimated number of annual TB/HIV deaths.

> The percentage of HIV positive TB patients who died by the end of TB treatment fell from 13% to 11% between 2012 and 2013. The proportion of TB patients who had an HIV test result recorded in the TB register increased from 26% in 2009 to 45%; in line with this, the proportion of TB patients known to be HIV positive declined from 34% to 10% in the same period.
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> Source: UBRAF indicators B2, B2.3, B2.3.1b

53. The Joint Programme continued its role as the recognized provider of critical normative guidance on management of TB in the context of HIV. In 2012, WHO released its policy on collaborative TB/HIV activities, recommending early antiretroviral therapy and implementation of the three I's of HIV/TB infection control, intensified case-finding and isoniazid preventive therapy. The 2013 WHO consolidated antiretroviral guidelines incorporated these TB-related recommendations. UNODC led the development, translation and dissemination of a comprehensive package of interventions for HIV prevention, treatment and care in prisons and other closed settings, which also addressed HIV-associated TB.

54. The Joint Programme has worked to assist countries in implementing normative guidance. In Eastern Europe and Central Asia, UNICEF aided the adaptation of TB/HIV guidelines to address the needs of children. To disseminate normative guidance on HIV/TB, WHO has collaborated with key stakeholders to conduct meetings in more than 26 African, 13 Western Pacific and 10 South East Asian countries to identify and address bottlenecks, identify and share best practices, and bolster monitoring and evaluation. After pilot testing in South Africa, Tanzania and Thailand in conjunction with ministries of health of the respective countries, the ILO and WHO finalized the HEALTHWISE Action Manual and Trainers Guide. HEALTHWISE is a practical, participatory quality improvement tool for health facilities addressing a range of issues including HIV and AIDS. It is currently being implemented in China, Sri Lanka, India and Thailand to enhance occupational safety and health for health workers.

55. Evidence indicates efforts to ensure the translation of normative guidance into national policy are succeeding. Among 38 high-impact countries reporting data in 2013, 32 reported having a policy on screening for TB, with 27 having a policy in place on isoniazid preventive therapy. In 2013, 61 countries reported screening 4.1 million PLHIV for TB, almost double the number tested in 2010. Similarly, there was a two-and-a-half times increase for the number of PLHIV reported to have received isoniazid preventive therapy over the same time period. It is anticipated that adoption of WHO's 2013 consolidated antiretroviral guidelines will further strengthen TB-related outcomes among people living with HIV by expanding eligibility for antiretroviral therapy.

56. UNAIDS partners provided direct assistance to strengthen HIV/TB programming. WHO provided technical assistance for the roll out of Xpert MTB/RIF, resulting in the procurement of 1,843 GeneXpert instruments and more than 4.2 million Xpert MTB/RIF cartridges to assist 95 high-burden and low- and middle-income countries to align practices with WHO's recommendation to use Xpert MTB/RIF as the primary diagnostic test for HIV-associated TB. As part of its efforts to enhance collaborative HIV/TB activities, WFP reached 151,982 malnourished TB patients with specialized nutritious food in 2012-2013. In addition, WFP provided food assistance to 310,983 household members, including TB clients, in the form of a family ration.

> To increase access to Food-by-Prescription for co-infected clients in Swaziland, WFP helped strengthen referral and follow-up across HIV and TB programmes and integrate HIV/TB indicators in data systems. WFP promoted improved treatment outcomes in Swaziland through the provision of nutritional supplements and household food assistance to malnourished TB patients living with HIV. WFP also supported the Ministry of Health to improve data reporting and purchased information technology for HIV and TB treatment units to enhance the collection, analysis and reporting of data at the level of service delivery.

57. Through technical assistance and capacity-building support, the Joint Programme has enhanced service uptake and strengthened HIV/TB coordination. ILO trained participants in 22 high-impact countries regarding implementation of joint HIV/TB workplace policies and programmes. UNICEF contributed to the global childhood TB roadmap, adapted

materials on early identification of HIV/TB co-infections, and supported development of decentralized HIV/TB plans in selected countries, including South Africa. UNICEF also generated evidence on the burden of HIV/TB co-infection on maternal and child health and undertook a paediatric assessment in four countries, with results soon to be published in a peer-reviewed journal. UNODC continued to support the scale-up of HIV/TB collaborative programming for people who inject drugs and those in closed settings.

58. The Joint Programme also continued its advocacy to increase HIV/TB collaboration. In particular, UNAIDS highlighted HIV/TB at the AIDS2012-affiliaited high-level consultation Transforming the HIV/AIDS response: defining the next 10 years, the annual CROI (Conference on Retroviruses and Opportunistic Infections)-affiliated HIV/TB Research Frontiers meetings, and sessions at the 2013 Women Deliver and the 2013 Harm Reduction International Conference.

iii. *Social protection and access to care and support*

59. The Joint Programme made major strides in expanding the evidence base on social protection strategies to strengthen the HIV response. The World Bank conducted three randomized control trials in Lesotho, Malawi and Tanzania demonstrating the effectiveness of cash transfers in reducing STI and HIV prevention, which resulted in numerous articles. UNICEF collaborated with EPRI to conduct research on the role of social protection in the HIV response in five countries (Ghana, Kenya, Lesotho, Malawi and South Africa). UNDP developed a position paper on cash transfers for HIV prevention, and ILO led a collaboration with UNICEF, UNDP, UNAIDS Secretariat and GNP+ to undertake research on social protection of people living with HIV and key populations in the informal economy in Guatemala, Indonesia, Rwanda and Ukraine.

60. UNAIDS also prioritized enhancing the profile and role of social protection within the HIV response. The UNAIDS Secretariat, UNDP, World Bank, UNICEF, WFP and ILO organized a satellite session on HIV and social protection at the 2012 International AIDS Conference and at the 2013 ICASA and ICAAP. ILO adopted Recommendation No. 202, which provides strong policy and programme guidance to countries on maintaining social protection floors. The World Bank and UNAIDS Secretariat are undertaking a joint initiative to accelerate efforts to address the interrelated challenges of AIDS, inequality and extreme poverty post-2015, with a particular effort to leverage social protection to address the social and structural drivers of the HIV epidemic. UNDP contributed a social protection lens in the development of the UNAIDS paper "Understanding and acting on critical enablers and development synergies for strategic investments".

> With assistance from the World Bank and UNICEF, Kenya has implemented a social safety net project involving cash transfers to orphans and other vulnerable children. Early evidence suggests that the programme is having a significant impact on poverty reduction, school enrolment and birth registration. As of November 2013, 152,323 households were enrolled, with 99% of children enrolled in basic education. Significantly, the programme is also associated with a 31% reduction in odds of sexual debut among young people aged 15-25.

61. Steps were taken to strengthen national systems for social protection, care and support. UNDP supported the creation and reform of numerous HIV-sensitive social protection programmes, reaching more than 400,000 in India alone by the end of 2012.

> WFP is assisting the Mozambique Ministry of Health with its nutritional rehabilitation programme, which provides nutritious food at health facilities. The project specifically aims to treat acute malnutrition among people living with HIV and to support pregnant and breastfeeding women and children under five. With technical support and market analyses provided by WFP, the programme provides food vouchers valued at US$33/month for six months to purchase a good basket containing rice, maize meal, sugar, salt, oil, beans, peanuts and eggs.

The World Bank is playing a vital role in strengthening national systems and integrating HIV across social protection schemes, with total funding for social protection programmes reaching nearly US$15 billion. WFP aided governments in Congo, Ethiopia, Mozambique and Swaziland to ensure integration of nutritional support into social protection programmes. The Inter-Agency Task Team on social protection, care and support developed a technical guidance note on HIV-sensitive social protection, gearing the note specifically for countries considering applications to the Global Fund.

62. WFP provided food assistance, including cash or vouchers, to food-insecure households of PLHIV and TB-DOTS clients, as well as households hosting OVC, which often constitutes a critical safety net as they experience the double burden of increased health care costs associated with HIV or TB and the temporary loss of income from working age members who become infected. In 2012 and 2013, WFP supported 1,067,788 vulnerable beneficiaries through mitigation and safety nets. WFP provided food and nutrition support to 466,436 OVCs, 439,518 TB-DOTS clients and household members, and 161,834 food insecure ART clients and households.

63. ILO and UNESCO HIV/AIDS workplace policies contributed to a more inclusive and supportive environment for employees. In 2012-2013, ILO collaborated with the UNAIDS Secretariat, UNICEF, WFP, WHO, Global Fund, GBC Health and GNP+ to build the capacity of national social protection and HIV specialists in 22 countries.

64. UNICEF collaborated with World Vision to develop a guidance paper and strategies to enhance protection systems for children affected by HIV. In 2013, UNICEF and IATT members finalized a paper estimating resource needs for children affected by HIV, demonstrating that a modest increase in resources would significantly improve service coverage. UNICEF and the international children's palliative care network undertook research that found a substantial need for children's palliative care in Kenya, South Africa and Zimbabwe.

C. Advance human rights and gender equality for the AIDS response

65. Stigma, discrimination and social marginalization – often codified and reflected in punitive laws and policies – continue to undermine sound AIDS responses. Surveys through the People Living with HIV Stigma Index continue to document high levels of HIV-related stigma and discrimination in some contexts, affecting all people living with HIV and many at high risk of infection but having especially pronounced impact for women, girls, young people and key populations.

66. UNAIDS leadership in positioning issues of human rights and equality at the centre of the response has been widely acknowledged, including in recent reviews by the UK Department for International Development and other independent analysts. In 2012-2013, the Joint Programme continued to provide leadership on human rights and gender issues at country, regional and global levels. While challenges remain considerable – as reflected, for example, in the recent increase in anti-gay legislation in some sub-Saharan African countries – the previous biennium also witnesses important advances, many of them facilitated and supported by UNAIDS.

UNAIDS achievements and contributions

i. Ending punitive laws

67. The report of the Global Commission on HIV and the Law provided the evidence base and outlined key actions to ground the AIDS response in principles of human rights and equity. Led by UNDP, the Global Commission built on the work of the entire Joint Programme, which supported the development of 18 working papers that informed the Commission's final conclusions and recommendations. As further support for the Commission's work, UNDP conducted research on HIV human rights violations in the Asia-Pacific region, and UNESCO, UNFPA, the UNAIDS Secretariat and UNDP collaborated with youth leaders to review laws and policies affecting young people's access to sexual and reproductive health and HIV services.

> National dialogues on HIV and the law in 49 countries afforded opportunities for frank, constructive multi-stakeholder exchanges involving governments, civil society and other stakeholders. In El Salvador, the national dialogue was followed up by steps to review or reform laws, leading to the draft of a gender identity law. In Ghana, the national dialogue prompted the government to review the draft HIV bill, which contained an HIV criminalization provision.

68. UNDP has led joint efforts to implement the findings of the Global Commission on HIV and the Law. In 84 countries, including 31 high-impact countries, the Joint Programme worked with governments, civil society and donors to advance the Commission's recommendations on such key issues as HIV criminalization, criminalization of behaviours of key populations, gender inequality and violence, the rights of young people and key populations to access essential health services, LGBT rights and treatment access. National dialogues on HIV and the Law were held in 49 countries and UNDP supported 65 countries in undertaking Legal Environment Assessments and legal reviews.

> The Joint Programme actively supported litigation cases relating to sex work in Canada and the U.S. The Canadian decision struck down the country's remaining prostitution laws, while the U.S. Supreme Court invalidated a U.S. law that had forced private health organizations to denounce sex work as a condition for receiving U.S. HIV assistance.

69. These efforts have generated results. A guidance note on the public health evidence against HIV criminalization persuaded Gabon and Nigeria to reject overly broad criminalization of HIV transmission. UNDP and other partners supported the development and endorsement in the Middle East and North Africa of the Arab Convention on HIV to protect the rights of PLHIV and the enactment of the East African Community HIV & AIDS Prevention and Management Bill, with the latter having been already formally adopted by Kenya and Uganda. UNICEF assisted Zambia in harmonizing its national legal framework with the Committee on the Rights of the Child and in passing legislation prohibiting gender-based violence and protecting the rights of people with disabilities. In Argentina, the Joint Team supported national passage of a new gender identity law.

70. UNAIDS generated strategic evidence on stigma, discrimination and human rights. Supported by IPPF, UNAIDS, GNP+ and ICW, the People Living with HIV Stigma Index has been completed in 50 countries. More than 1,300 people living with HIV have been trained as interviewers, and 45,000 have been surveyed. Findings from these surveys provided vital evidence with which to argue against discriminatory or stigmatizing HIV laws, regulations and policies. ILO published a handbook titled *'HIV and AIDS and Labour Rights: A handbook for judges and legal professionals'* which supported capacity building programmes for 106 judges, 52 magistrates, 365 lawyers and 225 parliamentarians from 50 countries across all regions.

71. The Global Fund's new funding model provides an important opportunity to strengthen funding for human rights and gender equality programming. UNDP, the UNAIDS Secretariat and WHO worked with the Global Fund Secretariat to develop an implementation plan for the human rights strategic objective in the Global Fund's Strategic Plan. UNDP launched a module on enabling legal environments in its online capacity development toolkit for Global Fund principal recipients, providing a range of resources and tools regarding enabling legal and policy environments for AIDS, TB and malaria.

UNAIDS measures the extent to which it provides technical support (whether normative guidance, technical assistance, resource mobilization, training or advocacy) in a number of indicators. One of these measures the extent to which national capacity is strengthened for reforms in country laws and practices, an area where the Joint Programme contributed in 59 countries. Between different stakeholders, the focus was on policy makers (43%), key populations (30%), law makers (19%) and communities (9%).

Source: UBRAF indicator C1.1.1

ii. <u>Ending travel restrictions</u>

72. Substantial gains have been made towards the global goal of ending restrictions on entry, stay and residence based on HIV status. Since 2011, 12 countries, territories or areas have removed these restrictions, leaving 41 States still having discriminatory and counterproductive restrictions in place.

In Uzbekistan, the national dialogue during the UNAIDS- facilitated review of High Level Declaration targets served as an entry point for advocating the removal of such restrictions, ultimately leading to the adoption of new legislation in September 2013 that lifted restrictions on entry, stay and residence of people living with HIV.

73. Advocacy by UNAIDS contributed to the removal of discriminatory restrictions on entry, stay and residence. In 2012-2013, the UNAIDS Secretariat and UNDP supported the Republic of Moldova in reforming its law to remove HIV-related travel restrictions. The UNAIDS Secretariat also provided technical support for the successful removal of restrictions in the Republic of Korea, Mongolia and Uzbekistan. Andorra and the Slovak Republic clarified their laws to confirm that they no longer enforced any HIV-based restriction on entry, stay and residence.

74. The Joint Programme actively worked to encourage other countries to revise laws that restrict entry, stay and residence. The UNAIDS Secretariat and UNDP worked closely with key national stakeholders to support development of enabling legislation that would end all HIV-related travel restrictions. Work by the UNAIDS Secretariat, complemented by the visit of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, achieved similar results, with the Tajik Parliament expected to pass the new law in 2014. The Secretariat also facilitated the development of a formal request for the removal of HIV-related restrictions in Papua New Guinea. Towards the 2014 International AIDS Conference, the Secretariat has worked with Australian authorities to clarify their national regulations, with the aim of ensuring the easy and non-discriminatory access of people living with HIV to the upcoming conference.

75. In the Middle East and North Africa – which remains the region with the highest proportion of HIV-related restrictions on entry, stay and residence – UNDP supported the League of Arab States to develop the Arab Convention on HIV Prevention and Protection of Human Rights for People Living with HIV, which expressly endorses a rights-based approach to HIV. Recognizing important new opportunities for dialogue afforded by this

breakthrough, UNDP, ILO and the UNAIDS Secretariat in 2013 began exploring opportunities for dialogue with key Arab States.

76. UNAIDS continued to support global advocacy for the removal of HIV-related travel restrictions. In 2013, UNAIDS launched its global campaign against discrimination with Nobel Prize laureate Aung San Suu Kyi, focusing worldwide attention on outdated, discriminatory and ineffective travel restrictions. The Joint Programme organized a satellite event at the 2012 International AIDS Conference to highlight progress and challenges in removing HIV-related travel restrictions and to promote further action. In 2013, the United Nations Secretary-General reiterated to members of UN Plus, the UN system's group of HIV-positive staff, his commitment to strengthen advocacy for the lifting of HIV-related restrictions on entry, stay and residence.

77. UNAIDS enlisted the support of global business leaders against HIV-related travel restrictions. As a result of joint action by UNAIDS, GBCHealth and Levi Strauss & Co., over 40 CEOs signed a global pledge opposing HIV-based restrictions on entry, stay and residence. The mainstream press and social media widely publicized the initiative, emphasizing that restrictions are not only discriminatory and contravene public health principles, but that they are also bad for business.

78. UNAIDS prioritized the generation of strategic information needed to support advocacy to remove HIV-related travel restrictions. UNAIDS maintains an ongoing monitoring system of the countries, areas and territories where HIV-related travel restrictions are in force, including the type of such restrictions. UNAIDS collected data on mandatory health screening practices of migrants from Cambodia, Indonesia and Philippines, and presented the results at the International Congress on AIDS and STI in Asia and the Pacific in 2013. ILO Beirut and the Joint Programme collaborated in the development of a roadmap for research and advocacy on HIV-related travel restrictions in the Middle East and North Africa.

iii. Address the HIV-related needs of women and girls and gender-based violence

79. There are significant and complex differences in vulnerability to HIV and AIDS due to gender. Of the 32.1 million adults living with HIV in 2012, 17.7 million were women, which represent an increase of 1 million since 2011. In comparison to men, women are more likely to acquire HIV at an early age, resulting in a global HIV prevalence among girls and young women that is double or greater than among males of the same age. Conversely, men receiving antiretroviral therapy have higher AIDS-related mortality than women. While legal and policy frameworks to include gender equality have strengthened, discriminatory laws persist and there are differences at the normative level on key issues such as sexual and reproductive health and rights, comprehensive sexuality education, and groups facing multiple and intersecting forms of discrimination.

80. UNAIDS undertook extensive country-level activities to address issues pertaining to women and girls. WHO supported increased antiretroviral coverage among breastfeeding women; UNDP, ILO, WFP, UN Women, WHO and UNFP aided policy and legislative reviews and assessments with regards to the specific needs of women and girls; UNDP, the World Bank and ILO worked with partners to link economic empowerment and HIV prevention programming for women and girls; and all members of the Joint Programme prioritized working with countries to address the gender dimensions of the epidemic.

> The Joint Programme strengthened policy engagement with the Global Fund to promote integration of gender into its policies, strategies, governance mechanisms and programmes. Following advocacy by UN Women, the Global Fund Country Coordinating Mechanism in China was reformed, with a stipulation that one in three civil society organisations on the CCM board must represent women living with and affected by HIV.

Joint UN teams on AIDS provided technical support to integrate gender equality into national strategic plans in Lesotho, Rwanda, Swaziland and Tanzania and in eight countries in West and Central Africa. The UNAIDS family engaged in several broader gender and health initiatives, including Together for Girls, Every Woman Every Child, and Adolescents Girls Initiative.

81. UNAIDS prioritized evidence and tools for supporting increased and targeted action to address the epidemic's gender dimensions, particularly in terms of women and girls. UNAIDS supported 84 countries to include strategic action on HIV in women's rights frameworks. A mid-term review of the UNAIDS Agenda for Accelerating Country Action for Women and Girls increased knowledge regarding country accomplishments, gaps, implementation challenges and priorities for moving forward, providing an important basis for technical and financial support. According to the review, 90% of the 80 countries that launched the Agenda initiated action to better understand their epidemic and context. Nearly two-thirds of countries have strengthened gender equality within their HIV responses, and more than 700 civil society organizations are now engaged in implementing the Agenda. Tools developed to assist countries in integrating gender into national responses included a gender and HIV assessment tool developed by UNAIDS; a checklist generated by UNDP for integrating gender into Global Fund processes; a WHO-developed programming tool for addressing violence against women in the context of HIV; a UNODC guide on gender-responsive HIV services for people who inject drugs; and a compendium of gender equality and HIV indicators produced by UN Women, in collaboration with MEASURE Evaluation, OGAC, USAID, UNAIDS Secretariat, UNDP, UNFPA, WHO, and key civil society and national partners.

> UN Women supported community groups in Cameroon, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda and Zimbabwe to address such issues as housing, land, and property rights in the context of HIV. This support built the capacity of 250 new and existing community justice and legal service providers and increased awareness of more than 20,000 community members on the need to protect women's property

> Between 2010 and 2012, the percentage of countries reporting that an IEC strategy containing messaging to fight violence against women increased from 74% to 86%. Furthermore, the collection and availability of country-specific data on the links between GBV and HIV increased from 16% to 42% between 2010 and 2013.
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> Source: UBRAF indicators C4, C4.1b, C4.1.1

82. Work by the UNAIDS family promoted more robust integration of HIV and sexual and reproductive health and rights in policies, health care, education and service delivery. Piloted indicators measure which services are being combined or integrated, and how, and also capture information on intimate-partner violence and other structural determinants of vulnerability and risk. Twenty-one countries reviewed and mapped national policies on linkages between HIV and sexual and reproductive health and rights, with 79% of the 80 countries having used various models to improve linkages and integration.

83. Building on support provided in 2010-2011 in 60 countries, UNDP, UN Women and the UNAIDS Secretariat strengthened the leadership capacity of women and girls living with HIV and key populations in an additional eight countries: Belize, Bolivia, Grenada, Guyana, Honduras, Nicaragua, Panama and Peru. UNAIDS helped establish the Eurasian Women's Network on AIDS, while UNHCR supported seven regional dialogues that resulted in the development of guidance on enabling women, including women living with HIV, to participate in community decision-making. Support was also provided to the collaborative civil society platform 'UNZIP the lips' which brings together partners with many different perspectives. It provided political space for women living with HIV who

participated in the Women Deliver conference and successfully influences the outcomes at the Asia-Pacific Intergovernmental Declaration assessing progress against High Level Declaration targets.

84. Work towards the elimination of gender-based violence represented a priority focus for UNAIDS in 2012-2013. The mid-term review of UNAIDS agenda for women and girls found that 82% of countries have taken steps to address gender-based violence in the context of HIV, with 61 countries having moved to include gender-based violence in their health policies. Consistent with the action steps outlined in the Agenda, Sri Lanka has integrated HIV into its campaigns to end violence. However, just under 50 countries reported data on the prevalence of intimate partner violence as part of the last Global Report.

85. UNAIDS activities on gender-based violence were wide-ranging, including support by UNDP, UNFPA, UN Women and the UNAIDS Secretariat for digital story-telling to document the linkages between HIV and gender-based violence; evidence and technical support by WFP on the linkages between gender-based violence, food security and HIV; advocacy and other efforts by UNDP, UNFPA, WHO and civil society partners to address gender-based violence in the context of sex work; efforts by UNESCO to address gender-based violence in school settings; activities by ILO to integrate HIV into gender and social protection frameworks; coordinated delivery by UNHCR, UNFPA and UNICEF of sexual and reproductive health and rights and gender-based violence responses in the context of emergencies; and the World Bank's investment in mainstreaming gender and HIV in its operations, which enables the Bank to address gender-based violence also through non-social sectors, such as transport, infrastructure, and urban development.

> UNHCR provided technical support to Tanzania to integrate HIV into clinical management, psychosocial support and legal assistance to rape providers in humanitarian contexts.

86. The Joint Programme worked to strengthen legal and policy frameworks towards the elimination of gender-based violence. Building on the recommendations of the Global Commission on HIV and the Law, reviews were conducted in legal gaps regarding the violation of women's rights in health care settings in South Asia (addressing such issues as forced abortions, sterilizations and discrimination). Findings generated momentum for passage of the Sindh HIV and AIDS Control and Protection Act, which when implemented will help protect women and girls living with and affected by HIV from violence in health care settings. In Malawi, UNAIDS supported passage of the Gender Equality Act in 2013.

> With the support of UN Women, UNFPA, UNODC and the UNAIDS Secretariat, Cambodia included actions to address the needs of women and girls affected by HIV in its second national action plan for violence against women. Related activities include a review of the national HIV policy to provide access to post-exposure prophylaxis for rape survivors.

87. In an effort to reduce gender-based violence and advance progress towards gender equality, UNAIDS prioritized work with men and boys, including through a major four-year collaboration convened by UNDP, UNFPA, UN Women, WHO, UNICEF and NGOs. Following up on global consultations in 2010 and 2011, regional consultations were held in East and Southern Africa and in West and Central Africa, generating action plans to engage men and boys for gender equality. Using findings from the regional consultations, country teams in Belize, Ecuador, Malawi, Nigeria, PNG and Serbia used their country action plans to successfully integrate gender-based violence in national HIV plans.

D. Strategic functions

UNAIDS achievements and contributions

i. Leadership and advocacy

88. UNAIDS produced positive and measurable improvement on key issues and drivers of the epidemic, for example by playing an important leadership role in accelerating progress towards the elimination of mother-to-child transmission, co-chairing the Global Steering Committee for the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, issuing a second progress report (on 11 indicators), aiding Malawi in rolling out Option B+ and encouraging other countries to implement this approach.

89. Through leadership and advocacy, UNAIDS helped strengthen the effectiveness of national responses. More than 30 countries pledged to work with UNAIDS to develop investment approaches over the next two years, with more than a dozen either completing or launching such processes as of December 2013. In 2012-2013, the UNAIDS Secretariat and the Technical Support Facilities assisted more than 20 countries in revising or updating their National Strategic Plans (NSPs) to reflect the three zeros and concerted action to achieve the 10 HLM targets; an additional 36 countries are in the process of developing or revising NSPs. The numerous epidemiological and economic analyses, efficiency and effectiveness studies, as well as allocative efficiency and financial sustainability studies conducted by the World Bank helped inform the development of NSPs with a thorough understanding of national HIV epidemics and responses and of the health and economic effects of different scenarios, and helped improve the effectiveness and sustainability of national responses. WHO published a guide to planning for the health sector response to HIV and contributed to national strategic planning by supporting programme reviews in more than 20 countries.

> In West and Central Africa, high-level advocacy visits by the Executive Director and Regional Director mobilized 20 Heads of State, ministers, first ladies, the Global Women Power Network, and *Francophonie* leaders to increase political engagement, funding and accountability. Domestic funding has increased across the region, and government officials from at least 20 countries and the Economic Community of West African States (ECOWAS) have intensified efforts to accelerate progress towards the 2011 Political Declaration targets.

90. The Secretariat supported more than 100 countries in undertaking mid-term reviews of progress towards the 10 targets in the 2011 Political Declaration. The Secretariat reviewed, validated and analysed data for more than 100 indicators from 172 countries, with results summarized in the 2013 Global report on the AIDS epidemic and the interactive, attractive, user-friendly AIDSInfo system. AIDS by the numbers provided an easily understandable summary of essential strategic information on the response. UNAIDS also assisted the UN Secretary-General in preparing annual reports on HIV progress to the General Assembly in 2012 and 2013.

> The Joint UN Team supported Thailand's efforts to reposition its response to align with available evidence. The country has pledged to significantly increase domestic funding for HIV prevention, with a specific focus on key populations, young people and eMTCT. Innovative strategic information tools have been developed to track the 10 key targets at national and sub-national levels.

91. The Joint Programme worked to keep AIDS high on the global political agenda, with particular focus on the post-2015 development framework. Joining with the Lancet, the Secretariat convened a panel of high-level global experts to analyze the place of the HIV response and global health in the post-2015 agenda. Working papers, commentaries and a range of analytic pieces have been produced through the UNAIDS-Lancet

commission, making the case for continued prioritization of the HIV response beyond 2015.

92. The Programme Coordinating Board discussed the post-2015 agenda on several occasions during 2012-2013, stressing the importance of ensuring that HIV and AIDS are central to the post-2015 UN development agenda and of advocating the inclusion of targets under relevant goals towards achieving the three zeros. The central position of the Joint Programme's multi-sectoral approach was advocated, based on the positive experience of UNAIDS and 'Delivering as One' to unite and strengthen UN, member state and civil society efforts to tackle other complex development challenges in the post-2015 era.

93. UNAIDS communications efforts supported the Joint Programme's advocacy aims. UNAIDS launched its new website, achieved more than 5,000 headlines around the *Results 2012* report launched on 2013 World AIDS Day, and published two editions of its flagship Global Report on the AIDS epidemic. The Secretariat made proactive and innovative use of social media, with more than 96,000 Facebook fans and more than 91,000 Twitter followers as of December 2013.

94. During the biennium, UNAIDS advocacy supported increased investments, including persuading implementing governments and international donors to sustain and strengthen their own contributions. UNAIDS prioritized advocacy to encourage strong pledges at the third replenishment meeting for the Global Fund, which saw a 30% increase in pledges in comparison to the previous three-year period. For more on the specific contributions of the UNAIDS leadership in resource mobilization, please refer to the section on "closing the resource gap".

> Ukraine used the UNAIDS Strategy 2011-2015 as its guide to develop the National AIDS Programme for 2014-2018, which intensifies programmatic focus on key populations and includes a sustainability strategy for HIV treatment scale-up and long-term financing of the response. UNAIDS has undertaken numerous advocacy efforts to support and strengthen the national response, including World AIDS Day activities based on the Three Zeros, national campaigns to increase AIDS awareness, and an information campaign focused on people living with HIV.

95. UNAIDS Executive Director and other senior officials in the Joint Programme had prominent speaking roles at meetings such as the 2012 International AIDS Conference, the 2013 ICASA meeting and the Abuja+12 meeting of the African Union. At the World Economic Forum in Davos in 2013, UNAIDS joined with the UN Secretary-General and other world leaders to emphasize the need for action to improve the health and well-being of women and children affected by HIV.

96. As in previous biennia, UNAIDS played a leading role in efforts to link AIDS with global agendas on health, human rights, gender and development. Building on the work of the UNDP-led Global Commission on HIV and the Law, UNAIDS led global efforts to repeal punitive laws that undermine national responses, including HIV criminalization laws and policies that violate the rights of key populations. UNAIDS joined with other UN partners in a joint statement calling for the elimination of coercive treatment detention centres for people who use drugs. UNDP has led UNAIDS efforts in 84 countries to promote implementation of the recommendations of the Global Commission on HIV and the Law.

97. The Joint Programme has highlighted the need to ensure gender equality and provide women and girls with the means to protect themselves from HIV. UNAIDS published a major report, *Women Out Loud*, that focused on the critical role of women living with HIV in the response and summarized progress towards the ten targets for women and girls. UN Women, UNDP and UNFPA provided leadership training and advocacy – globally,

regionally and in numerous countries – to strengthen the role of women living with HIV in the response.

ii. Coordination, coherence and partnerships

98. Experience in 2012-2013 further demonstrated that technical, political and financial partnerships and programmes accelerate global change. UNAIDS is in the vanguard to change attitudes and practices towards PLHIV, for example through providing technical and financial support for the East African Community's HIV and AIDS Prevention and Management Bill of 2012 to strengthen anti-discrimination protection. With partners, the Stigma Index is being implemented in 50 countries and provides comparable evidence and international benchmarks to national AIDS programme managers in support of the elimination of significant barriers to access HIV prevention, treatment and care services.

> The West and Central Africa Joint UN Regional Team on AIDS met regularly in 2012-2013, and in 2013 admitted civil society participants to its yearly meetings. The Joint Team provides an important platform for building understanding about the UN and providing a forum for constructive engagement with external stakeholders.

99. Partnerships have driven progress towards the aim of eliminating gender inequality and supporting women and girls to protect themselves from HIV. UNAIDS was also involved in extensive efforts to sustain, strengthen and cultivate partnerships with civil society. Some examples included re-launching of the Global Coalition on Women and AIDS (a worldwide alliance of civil society groups, networks of women living with HIV, women's organizations, AIDS service organizations, and the UN system); community consultations on treatment scale-up; and engagement with religious leaders on human rights issues.

> The World Bank and the Secretariat conducted an HIV financial sustainability study in Jamaica. The research project estimated the costs of new infections for the general population, men who have sex with men, and sex workers. The exercise pointed towards the need to ensure the efficiency and effectiveness of prevention programmes, particularly for key populations, as new infections eventually result in additional demand for costly services. The first study has been identified as a best practice and will be replicated in other countries.

100. The last of seven World Bank/USAID debates was held in 2012 at the XIX International AIDS Conference in Washington DC in four languages. The series considered major challenges in designing and implementing evidence-based AIDS programmes. Between 350-860 people participated in each debate, including hundreds of professionals in HIV-endemic countries by videoconference.

101. Partnerships advanced the goal of ensuring AIDS responses that are gender-responsive, country-owned, human rights-based, appropriate, coordinated and sustainable. As a member of the Inter-Organizational Task Team on Community Systems Strengthening, UNAIDS supported development of the Global Fund's Community Systems Strengthening Framework. UNAIDS and the Technical Support Facilities joined with the Global Fund and other partners to organize risk management forums for civil society, attracting 50 Asian civil society participants in Bangkok and 70 from Anglophone Africa in Cape Town. By the end of 2013, 19 countries completed a gender assessment of their national HIV epidemic, context and response using the UNAIDS Gender Assessment Tool, the findings of which informed concept notes.

102. UNAIDS has invested heavily in building country capacity, including with civil society, to generate and make use of the strategic information that is essential to guide national AIDS responses. In the first six months of 2013 alone, UNAIDS held 11 regional workshops with participants from 122 countries to train country partners in the latest modelling and statistical methodologies for producing national HIV estimates and projections.

> The UN Peacekeeping Mission in South Sudan, UNHCR, WFP, the Secretariat, IOM, the National AIDS Programme and the national network of PLHIV collaborated to conduct a rapid assessment of HIV needs, with a contingency plan to ensure continuity of HIV services. Partners developed a comprehensive emergency programme to deliver HIV prevention and treatment services, as well as key commodities, in camps for refugees and internally displaced persons.

103. Towards universal access targets, coordinated UNAIDS efforts supported more robust implementation of evidence-informed, prioritized, costed national strategic and operational plans, aligned with other sectoral processes. UNAIDS agendas on Evaluation, Effectiveness, Efficiency and Sustainability of AIDS responses grew in strength during 2012. There is increasing convergence of approaches both within the Secretariat and between key partners such as the Global Fund, PEPFAR, the Clinton Health Access Initiative and International AIDS Society, centred on recognition that improving allocative and technical efficiency and sustainable financing are increasingly seen as reinforcing each other. UNAIDS data and estimates provided the foundation for the Global Fund's HIV needs and projections, as well as providing a basis for PEPFAR's Blueprint regarding HIV prevalence, incidence and scale-up of HIV prevention, treatment and care. Furthermore, global HIV data is now updated annually, rather than biennially, using GARPR data submitted by countries. Improved strategic information on costs, efficiency and financing of HIV responses was made available in a number of UNAIDS case studies and reports published.

104. The Monitoring and Evaluation Reference Group (MERG) was reconstituted and met three times in the biennium. In close collaboration with PEPFAR and the Global Fund, global monitoring and evaluation (M&E) priorities were set, with specific working groups on indicators and evaluation established. Position papers on aligning surveillance and programme data for key populations were developed.

105. In 2012-2013, the three regional Technical Support Facilities (TSFs) for Eastern and Southern Africa, West and Central Africa and Asia Pacific provided technical support to over 55 countries with about 15,500 consultant days through over 425 assignments. Global Fund processes were supported in 35 countries in 2012 and 28 countries in 2013 through over 135 assignments, including strengthening NSPs and supporting the development of investment cases. In 2013, UNAIDS Secretariat technical contributions to over 50 funding requests (including grant renewals, interim funding requests and early applications) yielded funding decisions work over US$ 2 billion.

106. After an international consultation, UNAIDS developed recommendations to strengthen the coherence, effectiveness and relevance of technical support in a changing environment, and presented these to the Programme Coordinating Board meeting in December 2013.

107. UNAIDS supported mid-term review processes (including stocktaking exercises and national stakeholders' consultations) of the ten targets of the 2011 Political Declaration in 109 countries, using them as an opportunity to renew commitment to HIV prevention, diagnose gaps, foster leadership, coherence and accountability at all levels of the response. These reviews also provided opportunities for UNAIDS to advocate for meaningful and effective implementation of evidence-based combination prevention,

including integration of new prevention technologies in priority populations and geographic areas where new infections are occurring.

iii. Mutual accountability

108. UNAIDS took concerted steps in 2012-2013 to improve efficiency, effectiveness and value for money in its operations. The effects of the collective impact of UNAIDS 2011-2015 Strategy, as carried forward by the comprehensive 2012-2015 UBRAF (supporting the ten High Level Declaration Targets) – underpinned by the UNAIDS Division of Labour – cannot be underestimated. Having a holistic four-year planning framework has allowed all parts of the Joint Programme – at country, regional and global levels – to better understand, embrace and harmonize all aspects of the Programme during the 2012-2013 biennium, providing a solid basis for work in 2014-2015. A central part of UNAIDS approach has involved focused support on the 38 High Impact Countries.

In June 2013, UNAIDS had published a working paper to highlight examples of how the Joint Programme engages with civil society to address the 28th PCB request for "more explicit reporting on resourcing and engagement of civil society". The working paper generated a productive and ongoing dialogue on the issue of civil society engagement, notably the development of a civil society sub-group of the Cosponsor Evaluation Working Group (CEWG) including PCB NGO Delegation representatives. As a consequence, a decision was taken to prepare a similar paper in 2014, guided by the sub-group.

109. UNAIDS has strengthened collaboration with the Global Fund and PEPFAR, which account for two-thirds of international HIV assistance (and more than 90% of donor funding in HIV in the highest-burden and lowest-resourced countries). Globally, close collaboration has supported more effective strategic information and a focus on investments based on epidemic priorities and evidence. At country level, UNAIDS assisted countries in all stages of their work with the two organizations, including (from 2013) ensuring the effective implementation of the Global Fund new funding model.

110. In the 2012-2013 biennium, the UNAIDS Secretariat implemented an organizational realignment with three overarching objectives: to ensure that the internal structure and staffing of the Secretariat is aligned with changing corporate priorities; to continue to strengthen the organization's country focus, particularly in addressing the needs of high impact countries, and; to deliver results with maximum value for money.

111. The realignment of UNAIDS Secretariat resulted in a reduction in staff by 10% and a reduction in operating costs by 8% following the streamlining of headquarters with a refocus of programmatic support around the achievement of the global AIDS 2015 targets; the redeployment of staff to the field, in particular to high-impact countries; the reprofiling of positions (approximately 60 positions were re-profiled to better respond to programmatic priorities); and the development of an IT strategy and governance framework, which included the offshoring of the field and remote IT support to Nairobi, reflecting efforts to improve support to countries, reduce operating costs and foster innovation and technology.

In Iran, the Joint UN Team on AIDS met regularly in 2012-2013, revising the Joint Programme of Support in light with the 2011 Political Declaration targets and the Division of Labour. In December 2013, a gap analysis was conducted during a three-day retreat (building on 2010 methodology), providing a platform for looking forward to the next four years. The UN monitoring and evaluation work group, chaired by UNAIDS Secretariat, played a key role in developing the UNDAF Progress Report.

112. Under the UBRAF, UNAIDS has strengthened its performance reporting and engagement with stakeholders. In 2012, UNAIDS successfully completed the first year of the performance monitoring and reporting cycle of the UBRAF, with the 32nd PCB meeting welcoming the report and especially the case studies that accompanied it. Ahead of the 32nd PCB meeting, in

March 2013 a multi-stakeholder consultation sought inputs into provisional reporting. The same week, an internal global Joint Programme meeting reviewed the 2012 results and 2014-2015 plans for all UNAIDS themes – strategic goals and functions, 2011 Political Declaration targets and Division of Labour areas. The reflections on epidemic priorities, progress and challenges provided an important basis for developing UNAIDS 2014-2015 budget that was approved at the 32nd Programme Coordinating Board meeting in June 2013.

113. UBRAF performance monitoring has improved accountability through a review of programmatic and financial implementation against resource allocations and mobilization. Responding to the 32nd Board request to simplify and refine the indicators of the UBRAF, a multi-stakeholder consultation was held in October 2013 to consider UNAIDS programmatic and financial accountability, which included active civil society inputs.

114. Under the UBRAF, the Joint Programme Monitoring System (JPMS) was developed as the online tool used to measure results and outcomes and global, regional and country levels. During training sessions in 2012 and 2013, over 400 Cosponsor and Secretariat staff participated in webinars in English, French and Spanish. The JPMS enables the Joint Programme to report its progress and actions in a structured and transparent manner (all data is accessible across the Joint Programme). Reporting in the JPMS begins by recording results from Joint Teams at country level, feeding this information upwards through the regional to the global level, where results and outcomes in thematic areas are synthesized and analyzed.

> Independent evaluations of UNAIDS in 2012 and 2013 – by AusAID, Denmark, Norway, the UK, MOPAN – recognized the Joint Programme's strong advocacy and leadership role in the response, its emphasis on partnerships and its leadership on gender, human rights and stigma reductions. According to these assessments, UNAIDS has made important progress in performance management and results reporting, improved efficiency and cost and value consciousness, and in enhancing its strategic focus. Opportunities for further improvement included strengthening the coverage, quality and access to evaluations; and enhancing accountability.

115. UNAIDS has also worked to coordinate with the broader UN system. To strengthen UN collective action on AIDS at country level, and ensure that UNAIDS is effectively positioning itself in the Resident Coordinator System to fully implement the UNDG Management and Accountability Framework, the posts of UNAIDS Country Coordinators were reclassified as Directors – in order to provide more appropriate and high level policy and strategic guidance and technical support.

116. Four Programme Coordinating Board meetings were held successfully in 2012-2013, with thematic segments on combination prevention, non-discrimination, and adolescents and youth. At the June 2012 PCB meeting, UN Women became UNAIDS 11th Cosponsor. Programme Coordinating Board field visits were conducted in Ukraine and Zambia, enabling members of the Board to see effectively functioning Joint Teams on AIDS supporting the national responses and engage with all stakeholders in the response.

117. The ECOSOC resolution on the Joint Programme, adopted in July 2013 by 33 Cosponsors from all regional groups (representing the broadest co-sponsorship to date for resolutions on the Joint Programme), stressed the importance of AIDS in the post-2015 agenda and the value of lessons learned by the unique approach of the Joint Programme. The Resolution recognizes that the Joint Programme offers a useful example as a way to enhance strategic coherence, coordination, results-based focus and country-level impact, based on national contexts and priorities.

118. UNAIDS participated in numerous inter-agency bodies (such as the UN Development Group (UNDG), the High-Level Committee on Management (HCLM) and the High-Level Committee on Programme (HLCP) to coordinate the HIV response with broader health, development, peace and human rights goals.

iv. Closing the resource gap

119. UNAIDS continued to play a leading role in mobilizing critical resources for the response. During 2012-2013, an estimated US$ 18.7 billion was available globally for HIV activities in low- and middle-income countries in 2012. Notwithstanding persistent challenges associated with the broader economic climate, total HIV resources increased by 10% from 2011, due to a recovery of international assistance and notable increases in domestic financing in many countries.

120. In 2012, more than two-thirds of implementing countries increased domestic spending on HIV, with several (including Chad, Guinea, Kyrgyzstan and Sierra Leone) doubling domestic contributions to the response. Globally, HIV domestic public investments now surpass international HIV funding (52-53% in 2011 and 202, respectively).

121. UNAIDS engaged in extensive advocacy with donor countries in the run-up to the Global Fund replenishment meeting in December 2013, which resulted in US$12 billion in pledges over a three-year period, a 30% increase over amounts pledged during the previous three-year band.

122. In its resource mobilization efforts, UNAIDS emphasized principles of global solidarity and shared responsibility. The fair share and global solidarity agenda headed by UNAIDS Executive Director has been key. UNAIDS organized a series of high-level gatherings to secure the commitment of African leadership to increased and sustainable domestic HIV financing, resulting in the adoption of the Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria response in Africa 2012-2015 by African Heads of State and Government during the 19th African Union Summit.

> To strengthen countries' capacity to optimize the impact of investments by the Global Fund and PEPFAR, UNAIDS assists countries in generating, analyzing and presenting strategic data. For example, to support the Global Fund's approval of US$26.9 million in funding to El Salvador as an applicant under the new funding model, UNAIDS produced strategic information (disaggregated by key populations) as part of the country's situation analysis. As a further example, in countries including Cambodia and Uganda, the National AIDS Spending Assessment (NASA) developed with UNAIDS support served as a basis for the development of the investment case for the country's Global Fund submission. UNAIDS has also assisted countries in developing strategies and systems to monitor the performance of Global Fund grants.

123. In November 2012, UNAIDS and the World Bank co-organized an international gathering of countries, bilateral and multilateral donors, UN agencies and civil society to develop a mutual understanding and definition of the fair share and global solidarity for the response. As a follow up, UNAIDS reviewed donor country HIV financing agreements and identified features (e.g., minimum five years' duration, meaningful involvement of all partners from the outset, ambitious but realistic financing targets, monitoring systems and related incentives/consequences) that should be part of any country /donor compact, with the ultimate goal of ensuring a smooth transition towards domestic financing.

124. As of December 2013, UNAIDS was working with more than 30 countries to develop

> With UNAIDS support, numerous countries (including but not limited to Belarus, Jamaica, Kenya, Nigeria, South Africa, Thailand and Ukraine) have pledged to increase domestic spending on HIV.

national investment cases that identify new sources of domestic revenues, opportunities to increase the efficiency of spending, and strategies (such as hotspot targeting) to enhance the strategic impact of spending. The World Bank supported investment cases through analyses of allocative and programmatic efficiency, effectiveness studies and studies on sustainable financing. The Secretariat joined with the International AIDS Society, World Bank and the Global Fund to organize regional and country forums to build support for making efficiency, effectiveness and sustainability core pillars of the AIDS response.

125. The Joint Programme expanded evidence for action on investment approaches, including strategic information, guidance and tools to inform actions by countries and donors. With financial support from the Bill & Melinda Gates Foundation, the Secretariat and the World Bank co-convene the HIV Economics Reference Group (ERG) that provides countries and international partners with policy and normative guidance for strategic AIDS investments and a research agenda in AIDS economics and harmonization of research methodologies and tools.

126. The Secretariat and WHO organized a series of consultations on the programmatic and cost implications of implementation of WHO's 2013 consolidated antiretroviral guidelines to inform the process of retargeting and new HIV global investment needs through 2030 at both country and global levels. Coordinated by UNDP, the task team to develop guidance on HIV investments for critical enablers and synergies with other sectors produced *Understanding and Acting on Critical Enablers and Development Synergies for Strategic Investment*.

127. The Inter-Agency Working group on costing (WHO, UNICEF, the World Bank, UNAIDS Secretariat, UNFPA, UNDP) developed the OneHealth Tool software that provides a single framework for planning, costing, impact analysis, budgeting and financing strategies for all major diseases and health system components in countries. A Task Force on HIV resource tracking was created, promoting standardization and harmonization of different resource tracking tools, with the aim of alleviating the reporting burden in countries and improve data quality. To support countries accessing support through the Global Fund's new funding model, UNAIDS produced a technical guide for demonstrating value for money of their proposed interventions and joined with partners in organizing capacity building workshops for concept note development. WHO developed technical guidance for the development of concept notes on ARV treatment and care, co-infections, HIV/TB, PMTCT and service delivery among other technical topics.

128. In terms of resource mobilization for the Joint Programme under the UBRAF, income against the core budget amounted to almost 95% of the approved budget (US$ 458 million, but slightly less than US$ 477 million raised in 2010-2011). Several donors (including Finland, Norway, Switzerland and the UK) increased their contributions to UNAIDS. UNAIDS also welcomed contributions to its core budget from Côte d'Ivoire (which committed US$ 1 million, meaning that this was the first time an African country was among UNAIDS top 20 donors), Congo and Senegal.

v. <u>HIV integration and multi-sectoral planning and other strategic functions</u>

129. UNAIDS actively advocated for the integration of HIV with broader health and development efforts and supported integration with extensive normative guidance. The 2013 WHO antiretroviral guidelines recommend

UNAIDS promoted closer links between HIV and the response to non-communicable diseases, as reflected in the UN Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases in 2012.

enhanced integration (e.g., HIV/TB, PMTCT with maternal and child health, and ARVs in OST), and UNAIDS provided global guidance on promising practices regarding human resource for health.

130. UNAIDS facilitated country-level reviews have accelerated commitment towards integration of health governance and service delivery. More than 90% of countries reported in 2013 that integration is a national priority, with 45% reporting that HIV has been aligned with other disease-specific planning. Several countries (including Brazil, Cameroon, Côte d'Ivoire, Fiji, Madagascar, Malawi, Mauritania, Republic of Moldova and Togo) have aligned or fully integrated strategic planning and budget cycles for HIV and health generally, and 20 countries have taken steps to integrate HIV-related M&E with similar systems for other diseases.

> WFP provided critical technical support to countries regarding the inclusion of food and nutrition in multi-sectoral HIV plans. In the DRC, for example, WFP successfully integrated the first-ever nutrition component into the Country Coordinating Committee's concept note to the Global Fund.

131. With strong support from UNAIDS, countries have also taken steps towards integration of service delivery. A majority (53%) of countries have fully integrated HIV/TB services or strengthened joint service delivery; 70% have integrated PMTCT services in antenatal care; two-thirds have integrated HIV and reproductive health services; and 23% have integrated HIV counselling and testing with services for non-communicable diseases.

132. ILO provided technical support for the drafting, review and finalization of workplace components of national AIDS strategies in 43 countries; UNESCO provided technical support in 75 countries to strengthen the education sector response; and UNHCR undertook numerous activities to address HIV in the context of humanitarian responses, including a joint collaboration with the International Organisation for Migration (IOM) and the UNAIDS Secretariat to strengthen national multi-sectoral HIV preparedness in emergency settings.

> Seventy-eight per cent of countries use at least two of the five strategic information tools (Modes of Transmission (MoT), National AIDS Spending Assessment (NASA), AIDSInfo, Gender Audit, Spectrum) supported by UNAIDS. Between 2012-2013 there was a 50% increase in the number of countries undertaking Gender Audits (from 30 to 45). West and Central Africa saw the number of countries using NASAs more than triple from 5 to 19, and using MoTs nearly double from 9 to 17.
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> Source: UBRAF indicator D2.3.2

133. Drawing on investment thinking and the need for key strategic shifts in responding to the new AIDS environment, the World Bank, the UNAIDS Secretariat, UNDP and WHO developed a new draft guidance on National AIDS Strategies and Implementation for Results, which has been utilized in five training workshops for 12 countries in West and Central Africa region. Piloting the draft guidance, Nepal developed its first "Nepal HIV Investment Plan, 2014-2016" that also builds on the three zeroes. To assist countries in making hard choices to maximize the strategic impact of investments, UNAIDS provided technical support in the areas of costing, development of epidemiological databases and references, development of results frameworks, analyses of data quality, implementation efficiency, budgetary allocation efficiency and peer reviews. These efforts were strengthened by UNAIDS-facilitated research, including UNDP research on sustainable financing as well as analytical work by the World Bank's programme offering innovative models (Optimyze and the Fiscal Space Model) on allocative efficiency and financial sustainability.

134. To address the challenge of differential health worker skills and competencies, WHO undertook an evidence review for provision of ART by nurses, midwives and non-physician clinicians as part of the 2013 consolidated ARV guidelines. Related to this, WHO provided technical assistance for policy adoption and implementation of task shifting.

The World Bank completed a 53-country study in the WHO Euro region on allocative efficiency, undertook numerous return-on-investment studies (in Indonesia, Malaysia, Philippines, Swaziland and Viet Nam), and country-specific analyses of fiscal space (in Botswana, Kenya, South Africa, Swaziland and Uganda).

E. Cross-cutting themes

UNAIDS achievements and contributions

i. Address the HIV-related needs of young people

135. Young people aged 15-24 account for 42% of all new HIV infections, with young women being twice as likely to become infected as young men for this age range. Additionally, AIDS-related deaths among adolescents rose by 50% from 2005 to 2012, and these statistics underscore the continuing urgency of addressing the HIV-related needs of young people. To support more effective action for young people, UNAIDS provided normative guidance and leadership in 2012-2013. WHO, assisted by UNESCO, UNFPA, UNICEF and the UNAIDS Secretariat, developed guidance on HIV testing and counselling for adolescents. UNICEF commissioned a global systematic review of the effectiveness of interventions for HIV prevention, treatment and care for adolescents. UNFPA and the UNAIDS Secretariat convened consultations of young people in 11 and 14 countries, respectively, to identify innovative approaches to address the needs of people under age 18. The UNFPA Strategy on Adolescents and Youth, launched in 2013, calls for increased investments in adolescents and youth empowerment initiatives.

At the International Conference on Population and Development's Global Youth Forum in 2012, 2,500 young people gave voice to their issues and priorities for global development. The Forum Declaration included recommendations on young members of key populations, young women and adolescents girls, and young women living with HIV.

136. The Joint Programme undertook concerted efforts to empower adolescents and other young people. The 33rd Programme Coordinating Board meeting focused on adolescents and youth, including those from key populations. Youth delegates and Board members were galvanized into redoubling their efforts to ensure that young people have the tools and space to put themselves front and centre of the AIDS response and play an active role in getting to the end of the AIDS epidemic. The UNAIDS Secretariat supported the PACT for social transformation, a strategic collaboration with 25 youth-led and youth-serving organizations that established ACT 2015, a global social action initiative to support youth advocacy on HIV.

137. The Joint Programme advocated, convened and provided country-level technical assistance to increase young people's access to HIV services, with particular attention to the needs of young people who belong to key populations. UNESCO developed 800 radio programmes in West and Central Africa to train teachers in HIV and sexuality education in primary and secondary

UNFPA-supported radio dialogues reached 7,918 young people in Swaziland. Also in Swaziland, UNESCO developed a handbook for secondary school teachers on comprehensive sexuality education which is being piloted in 25 schools and for which, 26 master trainers 218 secondary school teachers, and 80 principals and guidance counselors received capacity-development training.

schools. UNICEF, working in countries where the epidemic continues to grow (Azerbaijan, Belarus, Georgia, Moldova and Ukraine), trained more than 2,000 care providers to deliver adolescent-friendly HIV testing and counselling services, reaching more than 16,000 vulnerable adolescents. Brazil, Kenya, Malawi, Mozambique, Swaziland, United Republic of Tanzania and Viet Nam implemented comprehensive condom demand generation frameworks that included a specific focus on young people. In Swaziland and Zambia, UNODC supported advocacy on youth in prisons. UNESCO conducted a global review of current issues and approaches in policy, programming and implementation on school-related gender-based violence, contributing to the development of comprehensive guidelines for the prevention and elimination of gender-based violence in and through education.

ii. Ensure high-quality education for a more effective HIV response

138. Nearly three-quarters (74%) of countries have mainstreamed HIV responses in the education sector, and the number of Ministries of Education with HIV workplace policies has more than doubled over the last eight years. The UNESCO-led Interagency Task Team on Education coordinates Joint Programme action on education for an effective global response. The IATT held regular coordinating meetings, developed a series of advocacy communication tools, and published the Global Progress Survey in 2013 to measure trends in national responses.

> Through a UNESCO-led initiative (in partnership with UNAIDS Secretariat, UNFPA, UNICEF, WHO and other partners), education and health leaders from 20 countries in East and Southern Africa pledged increased political commitment to scale up comprehensive sexuality education and increase access to sexual and reproductive health services for adolescents and young people. On 7 December 2013, ministers and representatives affirmed the Commitment, which highlights the urgency of the situation facing young people in the region and puts in a place a platform for increased collaboration between education and health, as well as greater integration of SRH and HIV. A key element of this commitment involves working with and through regional economic communities (SADC and EAC) on time-bound targets including the scale of good quality sexuality education and reducing the unmet need for health services by 2015.

139. UNESCO and UNFPA provided technical support to Ministries of Education for the peer review and revision of curricula in Lesotho, South Sudan, Tanzania, Uganda and Zambia. UNESCO, UNFPA and UNICEF also undertook a scan of HIV prevention curricula in 10 countries. In the Caribbean, UNESCO and UNFPA worked together to engage senior technical education officers on evidence-based approaches to the incorporation of HIV prevention in life skills education, with particular attention to the needs of young members of key populations.

140. UNESCO supported South-South cooperation among 10 countries in Latin America and the Caribbean through the Regional Community of Practice on Sexuality Education. UNESCO, UNFPA and UNICEF are undertaking a joint assessment on implementation of school-based comprehensive sexuality education in several countries in Asia and the Pacific. UNESCO developed the Sexuality Education Review and Assessment Tool (SERAT), which has been used in Cameroon, Cape Verde, Central African Republic, Chad, Congo, Dominican Republic, Equatorial Guinea, Gabon, Ghana, Liberia, Mali and Nigeria. 'Inside and Out' - a version adapted to the needs of civil society partners is also being promoted in a number of countries.

141. The UNAIDS Secretariat, UNICEF, UNFPA and UNESCO undertook field tests in Jamaica, Namibia, South Africa, Tanzania and Zambia on new and revised indicators to measure HIV responses in the education sectors. ILO and

> In Kenya, ILO, UNAIDS, the Kenya HIV/AIDS Business Coalition, Federation of Kenya Employers, LVCT Treatment and Care, GBCHealth, Aga Khan Foundation Network, Central Organisation of Trade Unions, Swedish Workplace HIV/AIDS Programmes and the National AIDS Control Council launched a knowledge hub and e-support forum on HIV and workplace issues. To date, the site has received 250,849 hits from workplace stakeholders.

UNESCO supported the adoption of policy guidelines on early childhood education that address issues relating to children living with HIV and emphasis principles of non-discrimination. UNHCR developed a global education strategy for 2012-2016 and established a partnership with Harvard University to undertake country-level analyses of implementation of the strategy in more than a dozen priority countries. UNFPA supported training programmes in HIV prevention for nearly 3.3 million young people in East and Southern Africa, and UNESCO trained over 15,000 primary and secondary teachers in West and Central Asia and more than 14,000 students in Central Asia.

iii. Scale up HIV workplace policies and programmes

142. As of 2012, 84% of countries reported having a multi-sectoral HIV strategy that includes the workplace. In 2012-2013, the Joint Programme supported workplace HIV responses through the generation of evidence, legislation and policies, and the VCT@WORK initiative. In 2012, ILO, WHO and UNAIDS Secretariat launched the "Getting to zero at work" campaign, with messages from 150 leaders, including UN agency heads and many heads of state/government.

143. To build the evidence base for action on HIV and the workplace, ILO and the IATT on workplace programmes partnered with the Social Aspects of HIV/AIDS Alliance of HSRC to undertake a 10-country study to highlight what makes HIV workplace programmes effective. ILO, with IATT support, undertook a global literature review to identify best practices on reaching key populations through workplace programmes; publication of the results will occur in 2014.

144. UNESCO and ILO HIV and AIDS Workplace Policies have contributed to creating a more inclusive and supportive environment for employees and learners living with HIV, and UNESCO continues to actively support countries to integrate recommendations in national policies and programmes. In 2012-2013, UNESCO collaborated with UNDP and the ILO to adapt the East and Southern Africa workplace policy to the West and Central Africa region, in consultation with Ministries of Education, teacher unions, and PLHIV networks from 13 countries. UNESCO also provided technical assistance to EECA countries to develop national policies based on the UNESCO-ILO 2011 Regional Recommendations, including the Ministry of Education of Ukraine. In cooperation with EU and GFTAM, a total of 16,000 copies of 'HIV Policy Recommendations for the Education Sector' were produced and disseminated to 8,000 schools in Ukraine, and management and teaching staff were trained to apply these new policies.

145. To support effective policy action on HIV and the workplace, ILO partnered with the IATT to finalize a handbook for judges and legal professionals, which has been used to train 106 judges, 52 magistrates, 365 lawyers and 225 parliamentarians from all regions. ILO supported legislative review in 32 countries, using the principles of the ILO Code of Practice and the ILO Recommendation No. 200 as reference points. ILO provided drafting support for the labour code in Chad, the national HIV law in Ghana, HIV regulations in Guyana, the Shops and Establishments Act in Myanmar, an HIV Anti-Stigma Bill in Nigeria, anti-discrimination legislation in the Philippines, and employment regulations in Uganda. ILO provided strategic guidance to 47 countries to draft, review and/or finalize national or sectoral HIV workplace policies.

146. In June 2013, ILO, the UNAIDS Secretariat, the International Organisation of Employers, the International Trade Union Confederation and GNP+ launched the VCT@WORK initiative, which aims to mobilize 5 million women and men workers to undertake voluntary testing and counselling by 2015 and to link those who test HIV-positive to treatment and care services. Preliminary results from priority countries

indicate that approximately 100,000 people received HIV testing, with people who tested positive referred for care. In 2014, the initiative is being scaled up to additional countries.

iv. Integrate food and nutrition within the HIV response

147. The IATT on Food and Nutrition supported numerous activities in 2012-2013, including a one-day stakeholders meeting prior to AIDS 2012 and publication of three peer-reviewed papers focusing on food security and HIV. The IATT developed a framework to analyze linkages between food security, nutrition, HIV and health systems.

148. WFP participated in joint missions with the UNAIDS Secretariat and the Global Fund to provide technical support on integration of food and nutrition into national responses in Côte d'Ivoire, Djibouti, DRC, Kenya, Lesotho, Swaziland and Zambia. WFP conducted trainings on the New Funding Model of the Global Fund in Dakar, Johannesburg and Rome, and also participated in the Global Fund's High Impact Africa II Regional Meeting in Lusaka, which helped countries jump-start dialogue on a roadmap to develop concept notes.

> A regional food security mapping study in East Africa, Horn of Africa and Great Lakes region found that evidence of strong implementation of supplementary feeding of children under five years and pregnant and lactating women. Supplementary feeding of other HIV and TB patients was less advanced, the mapping exercise found. UNHCR has developed draft guidance specifically highlighting the importance of supplementary feeding for people with HIV/TB.

149. The Joint Programme helped strengthen the evidence base on food and nutrition and HIV. Food and nutrition was incorporated in the 2013 WHO consolidated antiretroviral guidelines. With the support of PEPFAR, WFP and the UNAIDS Secretariat are finalizing a food and nutrition manual for adolescents and adults living with HIV, including those with TB co-infection, with the aim of providing critical guidance to policymakers and programme implementers. WFP and IATT members collaborated on the production of 20 peer-reviewed papers and book chapters on nutrition and HIV in 2012-2013.

> WFP and the Thai Red Cross AIDS Research Centre (TRCARC) are working to continue the Asia Pacific Collaborating Centre on HIV and Nutrition, a tripartite partnership between TRCRARC, Albion Street Centre and WFP. The Centre trains health professionals on HIV and nutrition, conducts research, engages policymakers and supports WFP country offices and governments.

150. The Joint Programme continued to support strategic partnerships for research and technical assistance, including the NorthStar Alliance Partnership. A partnership between WFP, UNICEF and UNESCO for "Nourishing Bodies, Nourishing Minds" has organized the initial stage of programme development, including consultations with governments in the four initial countries. WFP, Wagening University, the Thai Red Cross and Project Peanut Butter in Malawi joined together to conduct qualitative research in Malawi and Thailand. WFP also formed a research partnership with the University of California in San Francisco on HIV, food insecurity and nutrition.

v. Address HIV in humanitarian emergencies

151. Members of the Global Interagency Task Team on Addressing HIV in humanitarian emergencies, which includes members of the UNAIDS family and other partners, worked with key humanitarian cluster leads to integrate key HIV interventions in such sectors as protection, health, nutrition, food security, shelter and education. UNHCR, UNICEF, the UNAIDS Secretariat, WFP, Save the Children UK, and World Vision International updated the Internally Displaced Persons assessment tool, including significant HIV policy changes. UNAIDS Secretariat, UNICEF, UNHCR, UNFPA, IOM and WFP contributed to development of a paper on lessons learnt from Côte d'Ivoire and Haiti on

strengthened national responses to HIV and adolescents in emergency situations. The Global Interagency Task Team collaborated in hosting a workshop on addressing HIV in the context of emergencies in the Horn of Africa, sharing lessons learnt, building capacity and assisting in planning for addressing HIV.

152. UNHCR supported trainings of stakeholders in refugee camps in Ethiopia and along borders in Ecuador and Mexico to support the roll-out of interventions for sex workers. WFP, UNHCR and the Asia-Pacific Network of People Living with HIV/AIDS developed a regional action plan and specific tools for community-based organizations for emergency preparedness and responses to HIV. UNESCO, UNFPA, UNICEF and Save the Children UK conducted a rapid assessment of the situation of young Syrian refugees and hosting communities to design programmes and projects that better respond to the needs of young people.

> In Kenya, national and international partners worked on contingency plans with Kenyan authorities for the March 2013 presidential election. Contingency planning resulted in decentralized antiretroviral distribution hubs in five countries that experienced violence in the 2007 elections. People living with HIV were provided with a three months' supply of HIV medicines. The National AIDS Control Council collaborated with UNHCR, UNAIDS, IOM and other partners to develop the Kenya National Guidelines for HIV Interventions in Emergency Settings.

153. UN partners supported national AIDS programmes in countries affected by crises. UNICEF convened a multi-stakeholders workshop during the mid-term review of the National Strategic HIV/AIDS Plan, and UN agencies supported the inclusion of HIV in strategic plans in DRC, Indonesia and Sudan. UNICEF, the UNAIDS Secretariat and Save the Children UK organized a contingency planning workshop in two provinces in Mozambique to increase knowledge on HIV responses in the context of emergencies and to develop provincial humanitarian response plans for HIV aligned to other planning and strategic tools. UNFPA worked with ministries and with other national and international partners on implementation of a minimum initial service package for reproductive health in crisis situations.

154. One-week trainings to build UN country team capacities were organized, using the IASC guidelines for addressing HIV in humanitarian settings, in several countries. Technical experts were deployed from global and regional level to coordinate and strengthen the HIV response during emergencies in 2012-2013, with missions conducted in Burkina Faso, Central African Republic, Côte d'Ivoire, Jordan, Lebanon, Liberia, Mali, Mauritania, Niger, South Sudan and Syria. The Joint Programme produced advocacy briefs to aid development partners, clusters, humanitarian organizations and donors to prioritize HIV interventions in the Central African Republic and South Sudan.

III. CONSTRAINTS, CHALLENGES AND LESSONS LEARNED

155. A number of constraints and challenges were encountered by the Joint Programme that impeded efforts to strengthen the AIDS response in 2012-2013. These include political, contextual, structural, programmatic as well as institutional and organizational challenges, which will be discussed in this section. At the same time, experience during the biennium has been gained and valuable lessons have been learned which are helping identify actions for the current biennium and beyond to accelerate progress towards the Three Zeros.

- *Stigma, discrimination and social exclusion – as reflected in the persistence of punitive legal frameworks and very low service access for key populations and other vulnerable groups – continue to undermine an effective response.*

156. Punitive legal frameworks continue and reinforce a climate of fear, intolerance and blame that increases the risk of violence against stigmatized groups and deters members of key populations from seeking the prevention and treatment services they need. The failure of national governments to recognize and respond to the HIV-related needs of key populations results in extremely low service coverage for these groups, increases the dependence on international donors and undermines efforts to reduce new HIV infections and AIDS-related deaths. Recent experience – such as the decision by Viet Nam to effectively remove legal restrictions on key populations – demonstrates that progress towards grounding national responses in human rights approaches is achievable, although laying the groundwork for such change often takes time and demands the engagement of diverse constituencies and stakeholders. Even as UNAIDS has prioritized efforts to repeal punitive laws and discriminatory practices, initiatives to impose new or greater legal restrictions on men who have sex with men (in some sub-Saharan African countries) and on sex workers (in Europe) have challenged the Joint Programme's ability to deliver on these aims.

> In Angola, refugees and asylum seekers have not been using the full benefit of health and HIV services as the local population, due to lack of knowledge, fear of stigma and discrimination or simply because of difficulties of access outside of major cities. During the biennium, UNHCR conducted HIV/AIDS awareness sessions for refugees in Luanda and Lunda Norte Provinces.

157. To respond to these persistent challenges, UNAIDS will continue to collaborate with UN partners, civil society and governments to accelerate implementation of the recommendations of the Global Commission on HIV and the Law. The Joint Programme will undertake reviews of laws and policies, sensitize national decision-makers regarding human rights issues, and emphasize access to justice and stigma reduction as overarching priorities. UNAIDS will work with countries to scale up high-impact interventions for key populations and will help ensure that national investment decisions are informed by evidence regarding key populations.

158. The Joint Programme will also continue to develop, document and disseminate evidence and implementation tools regarding effective interventions for key populations (similar to the sex work implementation tool). UNAIDS will provide technical guidance and support to countries and the Global Fund to expand funding for critical enablers that address stigma, discrimination, social exclusion and other social factors that undermine effective responses. UNAIDS will prioritize access to justice, including use of the People Living with HIV Stigma Index to assess stigma in different settings and capacity-building support to enable countries to ensure that legal services are available to those affected by stigma, discrimination and social exclusion.

> In Burundi, key populations face increased stigma and discrimination which is reinforced by legislation against some groups. This makes it increasingly difficult for key populations to receive the appropriate HIV/AIDS treatment, care and support. To build understanding of the impact more broadly, UNAIDS undertook a study on the analysis on the effect of stigma and discrimination on PLHIV, as well as MSM and female sex workers.

- *Although the world is poised to reach the 2015 target for treatment scale-up, most people who are eligible for treatment do not currently receive it. Particular treatment coverage deficits are apparent in Eastern Europe, Central Asia, North Africa and the Middle East, as well as among children and key populations.*

159. Even in sub-Saharan Africa, where progress in scaling up HIV treatment has been most striking, a number of countries lag behind in expanding treatment access, including countries with among the largest populations of people living with HIV. On average, people enter HIV treatment extremely late in the course of HIV infection, underscoring the urgent need to increase knowledge of HIV serostatus. Outcomes across the HIV treatment continuum are also sub-optimal, reducing the proportion of people living with HIV with durable viral suppression and lowering the public health impact of treatment services. Children living with HIV are about half as likely as treatment-eligible adults to receive antiretroviral treatment. Although technological challenges remain in ensuring prompt diagnosis and linkage to age-appropriate care for children living with HIV, current coverage deficits primarily stem from the widespread failure to use tools and strategies that are currently available.

> In Georgia, there are legislative and service barriers for most at risk adolescents (MARA) and other vulnerable young people regarding HIV Testing and Counselling (HTC). UNICEF and partner Bemoni Public Union (BPU) collaborated under Regional funding from EU-UNICEF to build capacity of experts from NGOs and government to provide HTC for MARA and other vulnerable adolescent throughout Georgia. UNICEF promoted HIV prevention services in the Abkhazia region through awareness raising activities among 3,000 young people and women of reproductive age in 42 villages.

160. To help close treatment access gaps and maximize the health impact of treatment scale-up, advocacy efforts under the umbrella of Treatment 2015 will continue. As part of a comprehensive effort to develop new targets for the post-2015 agenda, new treatment targets that take account of important advances in scientific evidence regarding the therapeutic and preventive benefits of early treatment initiation will be developed. UNAIDS will prioritize work with countries that are ready for rapid implementation of the 2013 WHO treatment guidelines, with a roadmap for updating the guidelines over the next five years under development to ensure that recommendations reflect the very latest scientific evidence. To ensure equitable treatment access for children, the Joint Programme is forging new partnerships specifically focused on paediatric HIV treatment, hosting a global experts' consultation to identify strategic actions and prioritizing technical support to countries to implement existing tools. The Joint Programme will also increase its focus on adolescents, including efforts to support adolescents who need care and treatment as they transition to adult services.

- *Progress in reducing the numbers of new infections is sustainable only with continued investment in HIV prevention*

161. Some countries in Sub-Saharan Africa are seeing re-emergence of high risk behaviours, such as low condom use, and diminishing knowledge and awareness of HIV. Uganda, for example, is experiencing increased HIV incidence and South Africa is facing stubbornly high rates of incidence (469,000 infections among persons over two years of age in 2012). In the current biennium UNAIDS has begun working to re-energize evidence-informed HIV prevention efforts with a particular focus on key populations, young women and incidence hot spots.

> The low baseline, and progressive fall, in the percentage of young women and men correctly identifying ways of preventing the sexual transmission (and rejecting major misconceptions about HIV transmission) is of considerable concern. The median values in 2010 were 28% and 34% for women and men, falling to 25% and 28% in 2013.
>
> Source: UBRAF indicator A1.1

- *Structural factors – including income inequality and inadequate access to safe housing and adequate food and nutrition – continue to undermine HIV outcomes and diminish the impact of programmes.*

162. Studies, as well as considerable programmatic experience, have conclusively demonstrated that housing instability, food insecurity, poverty, transportation barriers and other structural factors impede access to life-saving prevention and treatment services, decrease adherence and retention, and increase risk and vulnerability. HIV interventions alone are unable to overcome these challenges, underscoring the importance of complementing HIV programmatic activities with critical enablers and development synergies.

> A public health-centred, human-rights based and evidence-informed approach to drug use and drug dependence has not been sufficiently implemented. One example of UNAIDS attempts to address this is in China, where many people who inject drugs (PID) have difficulty obtaining prevention services. To reach the most disadvantaged population, a cross-border project was conducted by UNAIDS between China and Myanmar to enhance coordination on providing comprehensive prevention services for PIDs in China. Additionally, 204 homeless PIDs along the China/Myanmar border areas were provided with food, shelter and harm reduction services in Ruili, Zhenkang and Longchuan County.

163. Members of the UNAIDS family will intensify advocacy, generation of strategic information and technical and capacity-building support to mobilize social protection strategies to reduce HIV vulnerability, enhance the impact of HIV services, and strengthen the response. The UNAIDS Secretariat, UNDP and the World Bank will undertake a wide range of research efforts to build the evidence base for action on social protection and HIV and to strengthen monitoring and evaluation. The World Bank has launched a major new trial to better understand how social protection systems reduce HIV infection, particularly among young women in the highest burden hyper-endemic countries. WFP will continue to support the mainstreaming of social protection with a food and nutrition component, and ILO will continue to build the capacity of national AIDS coordinating bodies, as well as networks of people living with HIV and key populations, on scaling up HIV services to key populations through workplace structures.

- *Women and girls remain under-represented in HIV policies, programmes and resource allocation.*

164. HIV is not consistently prioritized in efforts to address gender and women's issues. Noting the robust political support exhibited in countries that have actively worked to implement the UNAIDS Agenda for Accelerated Country Action for Women, stakeholders consistently cite lack of political commitment as a barrier to the Agenda's goals and objectives. Few countries systematically conduct gender analyses, and official efforts to address gender-based violence and other gender inequalities remain insufficient. This lack of women's engagement represents a critical gap in the response, as women represent nearly 60% of new HIV infections in sub-Saharan Africa, with young women several times more likely to acquire HIV than men their own age.

> In Tajikistan, women with disabilities and living with HIV face barriers in the labour market. The conference 'Entrepreneurship Development for women with disabilities and living with HIV' was supported by UNAIDS Secretariat, ILO, UN Women and other partners. Recommendations for employment and entrepreneurship development for this group were addressed to the Government, employers, donors and civil sector.

165. UNAIDS will intensify efforts to integrate gender analysis and action into the country roll-out of strategic investment approaches. The Joint Programme will finalize and disseminate tools to support gender-transformative planning, implementation, assessment and indicators. UNAIDS will strengthen efforts to mobilize resources for networks of women living with HIV. The Joint Programme will enhance efforts to ensure the gender-sensitivity of HIV programmes for key populations. UNAIDS will advocate for the removal of discriminatory laws and for other steps to reduce stigma and discrimination against women living with HIV. Intensified efforts will be made to engage men and boys as partners for gender equality and for the elimination of gender-based violence. To support progress towards gender equality, UNAIDS will support partnerships with women's health and rights organizations, HIV service organizations and groups of women and girls living with HIV.

> In Karnataka in India, adolescent girls from vulnerable and marginalized communities face marriage at an early age, premature sexual debut and possible entry into sex work. The UNAIDS family funded the Karnataka Health Promotion Trust to implement the Sabala project in the South Indian state of Karnataka, whose goal is to improve the quality of life of young women in two districts by delaying their marriage, sexual debut, and entry into sex work. Project objectives include increasing the percentage of adolescent girls entering into and continuing in formal secondary education.

166. The Joint Programme will undertake particular activities towards elimination of gender-based violence. Steps will be taken to strengthen the evidence base and normative guidance on gender-based violence and HIV. In collaboration with the UNiTE campaign, the UN family will support the roll-out of national action plans on gender, gender-based violence and HIV, linking these plans with enhanced technical support at country level.

- *Although a substantial AIDS resource gap persists, AIDS is no longer perceived as a burning issue it used to be and now competes with a growing array of other priorities for funding and political attention.*

167. In 2012, an estimated US$18.9 billion were available for HIV activities in low- and middle-income countries – a 10% increase over 2011 but well shy of the goal of mobilizing US$22-24 billion annually for the AIDS response by 2015. It is estimated that implementation of the 2013 WHO consolidated antiretroviral guidelines will require an additional 5-10% increase over earlier estimates of resource needs, further increasing the AIDS resource gap. Low- and middle-income countries have demonstrated important leadership in mobilizing domestic resources for the response; in 2012, domestic spending accounted for a majority of AIDS resources. However, many countries have yet to allocate domestic resources in line with national capacity and HIV burden. Moreover, there appears to be flagging interest in the AIDS response among some traditional international donors, who will remain vital in future years, especially for resource-constrained countries that lack the capacity to fully finance their response.

> Djibouti suffered in the last biennium from the delay of disbursement of funds related to the planned implementation of the 2012-2016 National Strategic Plan due to the suspension of the Global Fund grant. As a consequence of this reduced funding, many staff left which significantly reduced the capacity of the national response. In these difficult circumstances, the Joint Team helped to coordinate a National AIDS Spending Assessment (NASA) which will take on an increased significance in guiding resource decisions.

168. To ensure sustainable financing for the response, UNAIDS will continue to support countries apply investment thinking to nationally led and owned planning process, to better prioritize resources and improve the cost-effectiveness and impact of national responses. UNAIDS will support the development of conceptual frameworks and

definitions for sustainable HIV financing and the transition towards domestic funding, taking into account issues such as the fiscal space in specific countries for health and social sectors. To support investment approaches, the Joint Programme will develop tools to facilitate more reliable and timely expenditure tracking, helping to close a key data gap that has impeded strategic action on investments.

169. Through advocacy and sharing of modeling results and other strategic information, UNAIDS will encourage national governments to increase domestic AIDS spending and work to ensure continued support for the response by international donors. Scenarios for global HIV investments through 2030 will be developed, reflecting the latest normative developments and cost data, to encourage robust, timely and strategic investments.

- *To be effective, technical support needs to be clearly defined, owned and accepted by participants, and well-coordinated, with clear correlation between supply and demand.*

170. To put this lesson learned into practice, UNAIDS will continue to ensure that countries are supported to scale up and implement proven, effective and context-specific interventions and human rights-based approaches. The Joint Programme will work to ensure that all technical and financial support is optimally aligned with key priorities, with the ultimate aim of accelerating progress towards achievement of the MDGs and global AIDS targets. UNAIDS will prioritize efforts to ensure the success of the Global Fund's New Funding Model, including providing technical support to countries in implementing national dialogues, developing concept notes and more detailed proposals, supporting national proposals with strong evidence, and navigating the process required under the New Funding Model. Similar support will be provided to ensure the success of the PEPFAR Blueprint.

171. UNAIDS will continue to work through Joint UN Teams and Joint Programmes of Support as critical mechanisms to increase the coherence, coordination and impact of technical support. UNAIDS will participate actively in interagency mechanisms, such as the Chief Executive Boards, High-Level Committee on Management, High-Level Committee on Programmes and the UN Development Group, in order to ensure that the entire UN delivers as one in the AIDS response. Particular efforts will be made to expand the access of civil society to technical support and as providers of technical support.

- *While important lessons have been learned with respect to integrating HIV into broader health and development efforts, substantial additional work is needed to ensure an integrated, coordinated response.*

172. Integration is highly country- and context-specific, underscoring the fact that no single approach will fit all circumstances. Integrating HIV services must be implemented in a way that ensures that gains are secured and monitored, highlighting the importance of high-quality impact evaluations.

The risk of contracting HIV remains significantly high among key populations, such as sex workers. In national consultations in the Russian Federation, members of sex worker networks, policy makers and government representatives met to identify mechanisms for reducing HIV risk. Using the UNAIDS/ UNFPA/WHO/Global Network of Sex Work Projects (NSWP) guidelines for reducing HIV transmission among sex workers in low and middle income countries, policy guidance for sex workers and other key populations were developed and are planned to be rolled out in 2014. In addition, IEC materials for sex worker peer counsellors were provided.

173. Taking into account the diverse needs of different countries, UNAIDS will support priority countries to accelerate efforts to integrate the AIDS response into health and development sectors. Guidance will be provided on integration, including development of a "how to" manual on leveraging integration to accelerate progress towards AIDS targets. The Joint Programme will provide guidance on health

systems strengthening, including the skills mix and task-shifting options countries might consider in integrating services. To support high-quality impact evaluations, UNAIDS will develop new and review existing integration indicators and work with countries to ensure that integration initiatives are grounded in human rights, client-centred approaches and high-quality service delivery.

- *Important lessons have been learned by the Joint Programme on how to overcome institutional and organizational challenges to become more effective*

174. UNAIDS remains the reference for normative guidance on AIDS and extensive global guidance has been developed, but more needs to be done by the Joint Programme to roll out and implement guidance at country level. While much progress has been made in building and strengthening data collection, there is still a need for better data, smarter systems for data collection, and better disaggregation of data to provide the necessary evidence and persuasive arguments for the right investment decisions.

175. Improved planning and coordination have minimized overlap and duplication, but at country level synergies between the programmes of different Cosponsors and the Secretariat could still be improved, more effectively building up from many – and sometimes fragmented – programmes to support more comprehensive national responses. Improving synergies between global, regional and country level efforts of the Joint Programme is also necessary. Supporting the Global Fund's new funding model offers multiple opportunities for synergies with and between members of the Joint Programme, which will require good coordination.

HIV /TB/ mortality is increasing in a number of countries. More than half of TB patients do not know their status, and routine screening has not been reported among PLHIV in more than 70% of countries. However, under the New Funding Model, the Global Fund is asking for applications to fill out HIV and TB together on the same form. This provides a key opportunity to coordinate and work in a more focused way. The Joint Programme will provide support to these applications as well as look to build a higher global profile of TB/HIV research and implementation through international fora such as IAS, CROI, Harm Reduction International, ICASA and the Union conferences.

176. Opportunities also exist to develop more holistic approaches between different themes (e.g. gender, social protection, education, sexual and reproductive health, etc.) across different government bodies and sectors.

IV. FINANCIAL IMPLEMENTATION

177. The 2012-2013 total expenditure of the Joint Programme is analysed and presented in several viewpoints, namely: by funding sources, by geographical distribution and by Strategic Goals/ Functions. Moreover, the tables and graphs show implementation against projections and assumptions to illustrate clearly how the Cosponsors and Secretariat invested UBRAF resources in the last biennium.

178. The overall core resources implementation rate is 99.5%, with individual organizations spending within the range of 95.6% to 100%. The agencies also succeeded in leveraging more AIDS funding using their core allocations, collectively going beyond their initial forecasts by nearly 20%. The geographical distribution of resources underscored UNAIDS' commitment and focus on the 38 High Impact Countries (HICs). More than half of 2012-2013 spending went to HICs while 38% went to the rest of the countries where UNAIDS is present. Expenditure at global level was kept at 7%. From the programmatic perspective, 44% of total 2012-2013 UBRAF funding was

allotted to the Strategic Direction A (Catalysing Prevention) with Strategic Goal A (Reducing Sexual Transmission) getting the lion's share at 39%.

179. The financial information found in this section is supplemented by the 2012-2013 Expenditure and Indicator matrix accompanying this paper, where breakdown of expenditure: core resources by Key Output and non-core resources by Strategic Goals are made available.

A. Overview of AIDS spending for 2012-2013 (in US$)

By funding source

FUNDING TYPE	PROJECTED TOTAL RESOURCES	%	EXPENDITURE	%
Core funds	484,820,000	13%	482,250,713	11%
Other AIDS funds	3,360,805,000	87%	3,952,758,349	89%
GRAND TOTAL	**3,845,625,000**	100%	**4,435,009,062**	100%

Geographical distribution

FUNDING LEVEL	PROJECTED TOTAL RESOURCES	%	EXPENDITURE	%
Global level	288,492,000	8%	328,395,445	7%
HICs	1,917,109,000	50%	2,437,768,688	55%
All other countries	1,640,024,000	43%	1,668,844,929	38%
Grand Total	**3,845,625,000**	**100%**	**4,435,009,062**	**100%**

Strategic Directions /Functions

STRATEGIC DIRECTION/FUNCTIONS	PROJECTED TOTAL RESOURCES	%	EXPENDITURE	%
Prevention	1,988,779,000	52%	1,935,275,653	44%
Treatment, Care and Support	1,014,607,000	26%	1,213,077,843	27%
Human Rights and Gender	174,626,000	5%	182,151,700	4%
Strategic functions	667,613,000	17%	1,104,503,865	25%
GRAND TOTAL	**3,845,625,000**	**100%**	**4,435,009,062**	**100%**

B. 2012-2013 Expenditure of the Joint Programme (in US$)

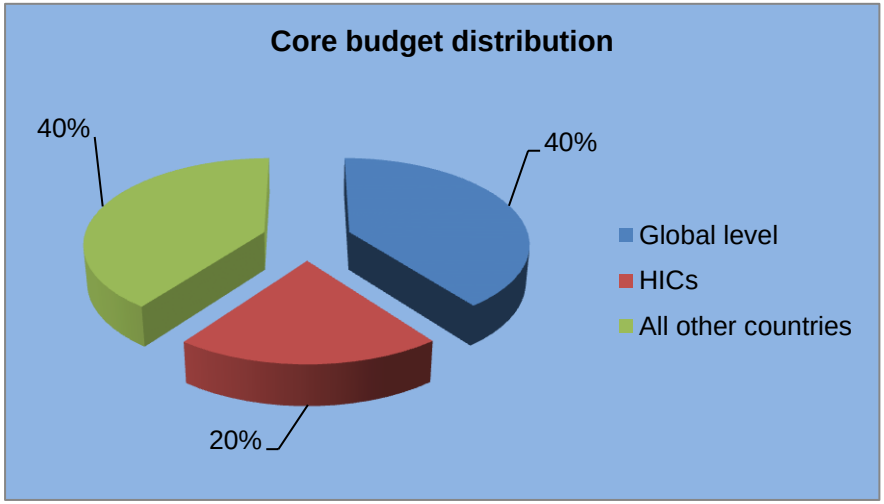
ORGANIZATION	CORE			OTHER AIDS FUNDS			TOTAL		
	BUDGET	EXPENDITURE	% IMPLEMENTATION	PROJECTED RESOURCES	EXPENDITURE	% IMPLEMENTATION AGAINST ORIGINAL ESTIMATE OF OTHER AIDS FUNDS	PROJECTED TOTAL RESOURCES	EXPENDITURE	% IMPLEMENTATION AGAINST ORIGINAL ESTIMATE OF TOTAL RESOURCES
UNHCR	9,800,000	9,365,973	**95.6%**	16,500,000	62,997,262	**381.8%**	26,300,000	72,363,235	**275.1%**
UNICEF	24,000,000	23,412,928	**97.6%**	381,772,000	187,466,935	**49.1%**	405,772,000	210,879,863	**52.0%**
WFP	9,800,000	9,671,719	**98.7%**	185,431,000	198,731,480	**107.2%**	195,231,000	208,403,199	**106.7%**
UNDP	17,200,000	17,200,000	**100.0%**	546,000,000	565,060,108	**103.5%**	563,200,000	582,260,108	**103.4%**
UNFPA	21,000,000	20,604,093	**98.1%**	97,560,000	140,805,136	**144.3%**	118,560,000	161,409,229	**136.1%**
UNODC	11,500,000	11,500,000	**100.0%**	50,297,000	29,534,633	**58.7%**	61,797,000	41,034,633	**66.4%**
UN WOMEN[5]	-	-	**0.0%**	-	19,840,521		-	19,840,521	
ILO	9,800,000	9,713,108	**99.1%**	25,000,000	19,166,211	**76.7%**	34,800,000	28,879,319	**83.0%**
UNESCO	12,400,000	12,220,248	**98.6%**	27,845,000	27,921,903	**100.3%**	40,245,000	40,142,151	**99.7%**
WHO	35,000,000	34,431,271	**98.4%**	186,400,000	139,504,325	**74.8%**	221,400,000	173,935,596	**78.6%**
WORLD BANK	14,000,000	13,995,196	**100.0%**	1,799,000,000	2,503,843,320	**139.2%**	1,813,000,000	2,517,838,516	**138.9%**
SECRETARIAT	320,320,000	320,136,178	**99.9%**	45,000,000	57,886,514	**128.6%**	365,320,000	378,022,692	**103.5%**
TOTAL	**484,820,000**	**482,250,713**	**99.5%**	**3,360,805,000**	**3,952,758,349**	**117.6%**	**3,845,625,000**	**4,435,009,062**	**115.3%**

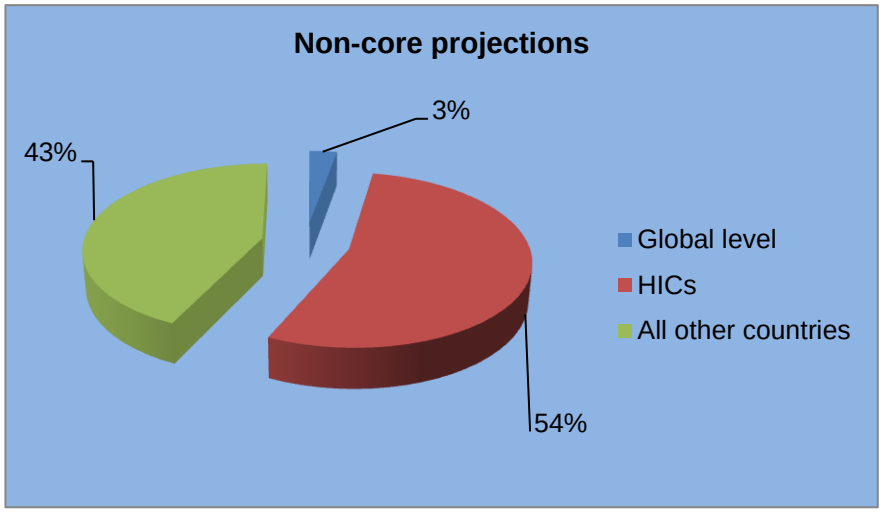
[5] UN Women did not have UBRAF core allocation in 2012-2013 as it only became a UNAIDS Cosponsor in 2012.

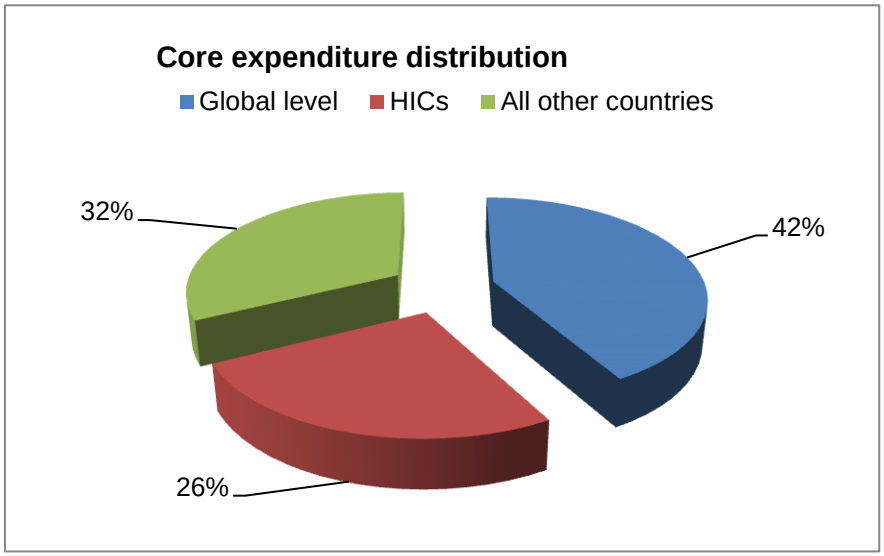
C. Geographical distribution of 2012-2013 UNAIDS Expenditure (in US$)

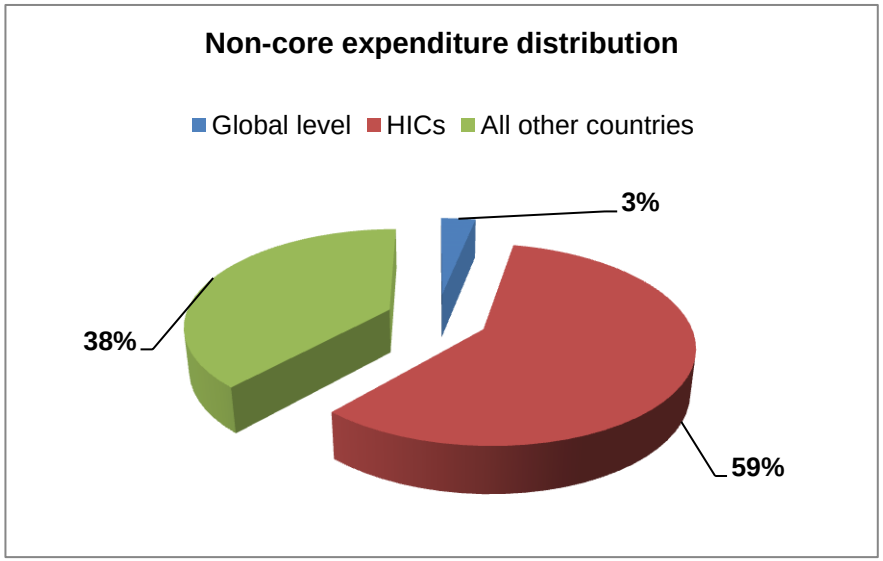
ORGANIZATION	GLOBAL	HICs	AP	CAR	EECA	ESA	LA	MENA	WCA	TOTAL
UNHCR	5,825,882	51,448,852	3,891,328	343,000	430,869	5,134,783	969,992	1,209,978	3,108,551	72,363,235
UNICEF	13,847,771	98,951,688	16,989,388	2,299,073	4,959,760	42,659,900	2,926,088	3,798,687	24,447,508	210,879,863
WFP	3,986,877	163,454,565	193,728	205,105	3,622,901	2,243,018	1,280,222	23,885,754	9,531,029	208,403,199
UNDP	10,337,932	338,665,003	11,931,449	19,625,498	97,943,898	35,438,753	13,400,991	36,613,484	18,303,100	582,260,108
UNFPA	36,622,557	73,160,329	4,418,877	2,041,111	8,654,425	6,998,026	18,187,936	5,869,664	5,456,302	161,409,229
UNODC	2,650,825	24,476,593	4,326,826	111,500	3,513,025	1,389,989	822,551	3,177,300	566,024	41,034,633
UN WOMEN	1,890,616	8,609,795	1,971,511	420,797	603,181	5,228,750	-	-	1,115,870	19,840,521
ILO	8,089,038	15,039,230	1,195,308	856,796	678,902	725,915	729,282	550,543	1,014,305	28,879,319
UNESCO	6,382,307	23,797,038	1,981,451	390,469	1,129,626	2,455,797	1,298,565	732,290	1,974,608	40,142,151
WHO	55,191,286	38,648,664	26,518,933	1,383,430	11,112,994	7,078,007	4,107,379	19,140,523	10,754,380	173,935,596
WORLD BANK	11,220,187	1,508,554,353	253,102,938	25,136,303	20,875,306	391,388,668	35,828,069	2,105,490	269,627,202	2,517,838,516
SECRETARIAT	172,350,168	92,962,577	26,559,943	7,126,638	14,943,917	16,159,869	12,969,992	10,621,796	24,327,792	378,022,692
GRAND TOTAL	**328,395,445**	**2,437,768,688**	**353,081,680**	**59,939,721**	**168,468,805**	**516,901,476**	**92,521,067**	**107,705,509**	**370,226,672**	**4,435,009,062**
% EXPENDITURE	**7%**	**55%**	**8%**	**1%**	**4%**	**12%**	**2%**	**2%**	**8%**	**100%**

D. Geographical Distribution of 2012-2013 UNAIDS Expenditure (by funding source)







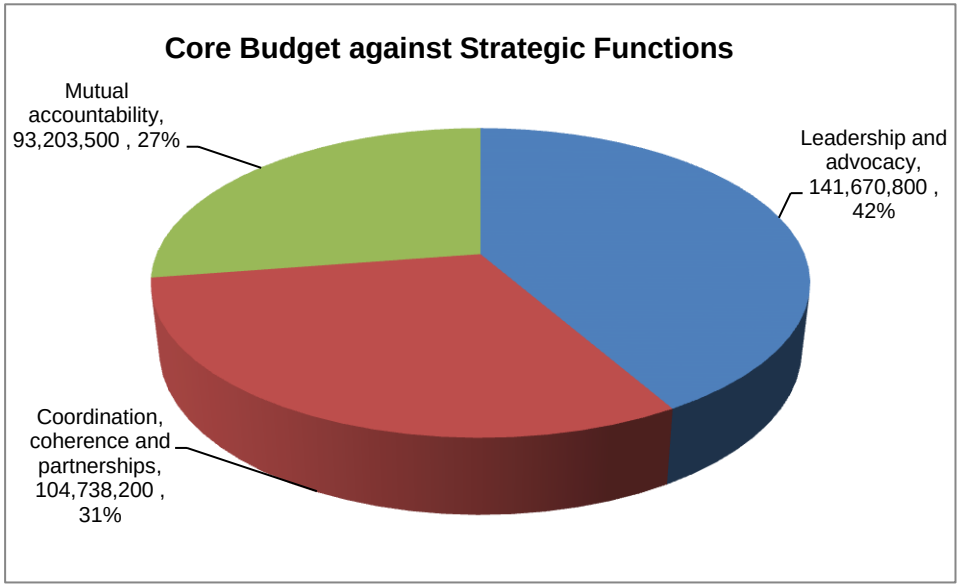


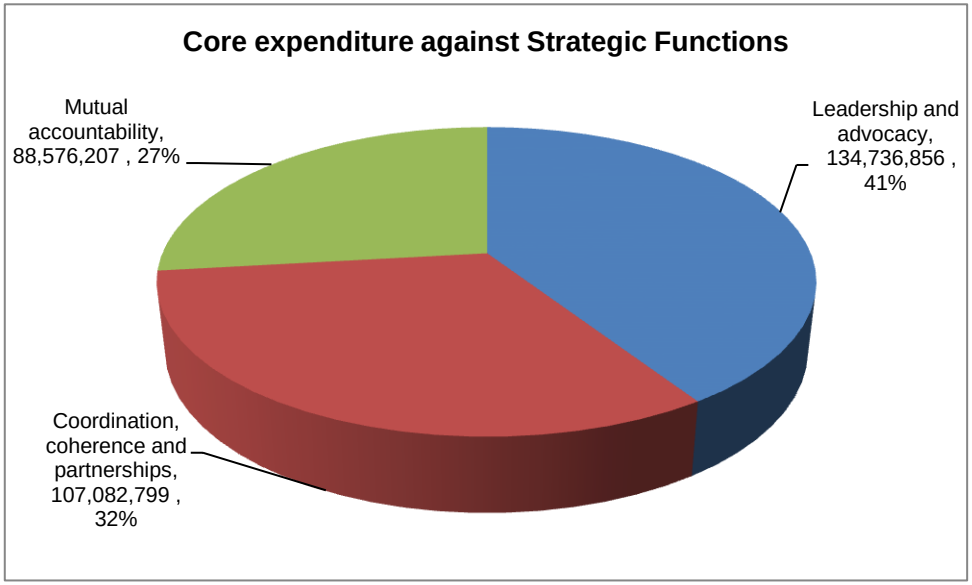
E. 2012-2013 Expenditure of the Joint Programme by Strategic Goals/Functions (in US$)

STRATEGIC GOALS	PROJECTED RESOURCES	%	EXPENDITURE	%
Reducing sexual transmission	1,725,987,800	**44.9%**	1,710,280,710	38.6%
Eliminating vertical transmission	166,976,500	**4.3%**	141,029,679	3.2%
Preventing HIV among PUD	95,814,800	**2.5%**	83,965,264	1.9%
Accessing treatment	686,064,500	**17.8%**	914,553,547	20.6%
Avoiding TB deaths among PLHIV	159,299,500	**4.1%**	147,470,060	3.3%
Protecting the Vulnerable	169,243,700	**4.4%**	151,054,237	3.4%
Reducing punitive laws	48,085,300	**1.3%**	47,449,039	1.1%
Eliminating HIV-related travel restrictions	2,283,100	**0.1%**	2,709,708	0.1%
Addressing HIV-needs of women and Girls	80,427,400	**2.1%**	72,412,129	1.6%
Stopping gender-based violence	43,830,400	**1.1%**	59,580,825	1.3%
Leadership and advocacy	387,030,900	**10.1%**	836,458,796	18.9%
Coordination, coherence and partnerships	167,801,700	**4.4%**	169,922,034	3.8%
Mutual accountability	112,780,000	**2.9%**	98,123,035	2.2%
GRAND TOTAL	**3,845,625,000**	**100%**	**4,435,009,062**	**100%**

F. Core expenditure against strategic goals (in US$)

STRATEGIC GOALS	PROJECTED RESOURCES	%	EXPENDITURE	%
Reducing sexual transmission	51,135,400	35.2%	48,791,388	32.1%
Eliminating vertical transmission	12,900,900	8.9%	15,167,981	10.0%
Preventing HIV among PUD	16,724,400	11.5%	15,988,810	10.5%
Accessing treatment	21,288,500	14.7%	24,618,992	16.2%
Avoiding TB deaths among PLHIV	6,715,800	4.6%	4,988,180	3.3%
Protecting the Vulnerable	13,005,900	9.0%	16,077,739	10.6%
Reducing punitive laws	8,287,100	5.7%	10,977,148	7.2%
Eliminating HIV-related travel restrictions	675,200	0.5%	643,310	0.4%
Addressing HIV-needs of women and Girls	9,610,800	6.6%	7,780,179	5.1%
Stopping gender-based violence	4,863,500	3.4%	6,821,124	4.5%
GRAND TOTAL	145,207,500	100.0%	151,854,851	100%





V. CONCLUSION

180. This report has presented a broad but representative selection of the range of work undertaken by the Joint Programme in 2012-2013 –by individual organizations or jointly, across different regions of the world and different areas of work. It is complemented by other information, including indicator and expenditure data, thematic reports, case studies, and snapshots of UNAIDS work in the high impact countries.

181. From a reporting perspective, one of the significant achievements of the UBRAF has been facilitating increased coherence and transparency in the Joint Programme at all levels. Through the Joint Programme Monitoring System (JPMS), staff at every geographical level have engaged with the UBRAF and this in turn has helped them to better understand their contribution to the High Level Declaration targets. The detailed information in the UBRAF matrix, for example on budgets and deliverables, has generated constructive discussion within the Joint Programme and guided the application of the Division of Labour. Furthermore, the fact that the UBRAF is a four-year framework means that the Joint Programme is more unified in planning and looking ahead within the 2014-2015 biennium.

182. In this spirit, the Performance Monitoring Report has been developed as an important milestone in the performance measurement process. Following reporting through the JPMS at country, regional and global (individual organization) levels, the final stage saw reporting by global 'thematic groups', building on existing platforms such as inter-agency task teams (IATTs). These reports formed the basis of the final Performance Monitoring Report, aiming to more accurately capture the most important achievements and challenges. This increased alignment of UNAIDS global coordinating and technical mechanisms was called for in the Second Independent Evaluation of UNAIDS.

183. Capturing UNAIDS achievements nevertheless remains an ongoing challenge, and there is always space for improvement. The Joint Programme's performance monitoring aims to continue to respond to the observations and suggestions of the Board and other developments to ensure that it remains relevant and useful. The engagement and interaction of Programme Coordinating Board member states, NGO delegates, observers and other stakeholders as part of the refinement and simplification of the UBRAF indicators, undertaken since the 32nd Programme Coordinating Board meeting, provides a solid basis for future efforts in this regard.

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