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Country case studies: Cameroon, Guatemala, Indonesia, Islamic Republic of Iran, Jamaica and Ukraine

Additional documents for this item:

- **Mid-term review** : UNAIDS/PCB(34)/14.6
- **External reviews and assessments of UNAIDS**: UNAIDS/PCB(34)/14.7

Action required at this meeting: None

Cost implications of decisions: None

These case studies have been prepared to provide examples of the support of the Joint Programme to the national response in different countries. They are intended to illustrate UNAIDS work at country level to inform discussions of the Programme Coordinating Board.

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CAMEROON

INTRODUCTION

1. This case study provides an overview of the role of UNAIDS in Cameroon's AIDS response, describing how the contributions of the Cosponsors are coordinated, funded and managed through the Joint UN Programme and Team on AIDS. The study highlights successes in the national response and how UNAIDS can further contribute directly to the establishment of national priorities and achievement of concrete progress, as well as identifies the persistent gaps and challenges that need to be addressed. The report concludes that:
 - Cameroon is making valuable strides in the response against AIDS by scaling up prevention and treatment services for the general population including women and children, while also addressing the specific needs of young people and vulnerable populations through empowerment.
 - With UNAIDS support, Cameroon has introduced a tailored programme for the supply chain of HIV/AIDS commodities, while at the same time struggling to improve the human rights situation.

BACKGROUND

2. Cameroon is facing a generalized HIV epidemic with adult prevalence estimated at 4.3 % in 2013 (2.9% for men and 5.6% for women), and varying across the different regions. Some regions have rates of 8% or higher and others have prevalence below 2% mostly in the northern regions. An estimated 51.6% of people living with HIV are women, 17% are young adults aged 15-24 and 9.8% are children under 14. The groups most affected by the epidemic are sex workers and their clients, MSM and people in uniformed services. The main mode of HIV transmission is sexual intercourse, accounting for 90% of new infections; 6% are due to mother-to-child transmission and 4% due to blood supply and other accidental exposures.
3. The Cameroon's AIDS response is anchored on the 2035 Vision, the Strategy Paper for Growth and Employment, 2014-2017, the National Strategic Plan to fight HIV/AIDS & STI, and the UNDAF, 2013-2017.
4. The National AIDS Strategic Plan 2014-2017 prioritizes four key components: a) prevention, b) global treatment of people living with HIV (for both adults and children), c) cross cuttings issues (gender equality and human rights), and d) funding of the revised national strategic framework. The focus of the framework is to consolidate efforts in decentralization and scaling up of HIV prevention, treatment and care, as well as reducing stigma and discrimination.

KEY HIV AND AIDS INFORMATION FOR CAMEROON

Population:	22,100,000
Number of people living with HIV:	600,000 [550,000 - 660,000]]
Adults aged 15–49 prevalence rate:	4.3%
Adults aged 15+ living with HIV:	540,000 [500,000 – 590,000]
Women aged 15+ living with HIV:	310,000 [290,000 – 340,000]
Children aged 0–14 living with HIV:	59,000 [51,000 – 67,000]
Annual deaths due to AIDS:	45,000 [38,000 – 53,000]
Annual new infections:	45,000 [38,000 – 53,000]
Antiretroviral therapy coverage:	45%
Prevention of mother-to-child transmission coverage:	64%[56-73]

Source: UNAIDS Report on the global AIDS epidemic 2013

JOINT UN PROGRAMME AND TEAM ON AIDS

5. The UN presence in Cameroon is relatively large with 18 resident agencies. The Joint UN Team, made up of 19 officers from 13 different UN agencies, is chaired by the UNAIDS Country Director and over sighted by the UN Resident Coordinator, through the UN Country Team.
6. HIV is mainstreamed under the five-year UN Development Assistance Framework (2013-2017) with one outcome and five products. The priorities of the Joint UN Programme of Support on AIDS are aligned with the National AIDS Strategic Plan 2014-2017.
7. The UN expenditures for the Joint Programme of Support 2012/2013 were US\$15,744,476. Activities supported during the biennium address the UN General Assembly High Level Meeting targets 2011 as shown below:

Joint UN Programme of Support on AIDS for 2012-2013	% of overall budget
Reduce sexual transmission of HIV by 2015	25%
Eliminate new HIV infections among children by 2015	34%
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	5%
Eliminate Gender inequalities	6%
Eliminate stigma and discrimination against people living with and affected by HIV	12%
Strengthen HIV integration (Social protection goal)	2%
Governance and accountability	16%

KEY ACHIEVEMENTS

Substantial reduction in Mother-To-Child Transmission

8. The country has made significant efforts towards the elimination of new HIV infections among children born to HIV positive mothers over the past two years. The coverage of women receiving ART for preventing MTCT increased from 30.3% in 2009 to 64% in 2012. The number of new HIV infection among children has dropped from 8,200 [7,000 – 9,500] in 2009 to 5,800 [4,600 – 7,100] by 2012.
9. The government and stakeholders, with support of UNAIDS, succeeded in the development and effective implementation of the comprehensive Global Plan. Under the leadership of UNICEF, UNAIDS Secretariat joined WHO and ICAP to support Cameroon in developing new guidelines and practical tools for integrated supervision of maternal and child health services, including paediatric and PMTCT. PMTCT service strengthening was focussed on 15 priority districts where 679 service providers were trained to integrate HIV testing and care into maternal and child health services, with 15 CD4 machines provided to improve laboratories capacity for testing. With training support from WFP, 80% of government nutrition centres in the targeted zones benefitted from increased capacity on HIV and malnutrition.
10. Through WHO, UNAIDS provided support in training 274 hospital staff members and supervisors in 27 districts in the northern part of the country with a focus on how to diagnose HIV early among children. Additionally, WHO and UNICEF provided HIV test and other related commodities to the nutrition centres to assist them in carrying out HIV screening among malnourished children. Care givers and relatives of the children were also counselled and tested when children were found HIV positive. Also, through UNAIDS' joint advocacy and facilitation efforts, Cameroon recently adopted the Option B+ policy for PMTCT according to the 2013 WHO recommendations¹. The Option B+ is already offered in 210 health facilities with the support of PEPFAR and other partners.

Significant increase in ART coverage

11. The ART coverage based on WHO guidelines has increased from 31% [29 – 34] % in 2009 to 45% [41 – 48] in 2012, with the number of deaths averted annually estimated to have increased from 14,000 to 15,000 over the same period. The number of children receiving treatment has also increased from 2,400 in 2008 to 4,992 in 2012, and the coverage of HIV-positive pregnant women under treatment increased from 46.6 % in 2008 to 56.7% in 2010. This progress is further estimated to have resulted in 30% fewer new HIV infections among children.
12. The Government of Cameroon has developed a decentralization plan that aims at improving access and quality of care at the district level and has allocated additional resources to disadvantaged areas. That contributed to improving the capacity of health system to deliver HIV and other health services at the national, regional and district

¹ Option B+ comprises one pill a day starting in the 14th week of pregnancy (or as soon as the woman is diagnosed HIV+, if she comes after the 14th week), with the woman remaining on ART for life once initiated. The single pill comprises three potent antiretroviral drugs already recommended for first-line therapy, and the non-interruption of treatment enhances the public health approach to ART in Cameroon due to extremely high fertility levels in the country. This simpler regimen and approach greatly eased supply chain, laboratory testing, and general service delivery in Cameroon. The only prerequisite was that the pregnant woman test positive and she was offered the once-a-day antiretroviral pill. Because pregnancy is a finite period, it is essential to minimize disruptions and simplify the woman's access to services both during and after her pregnancy. Option B+ was offered in regular antenatal clinics, transforming these clinics into HIV treatment sites in a matter of months.

levels. UNAIDS' support was through: a) setting up the institutional framework and systems and building capacity to prepare, negotiate, and manage contracts; and b) putting in place a unified information system to generate up-to-date, financial and programmatic reliable data.

13. In 2012 and 2013, Cameroon faced severe stock-outs for HIV drugs and commodities such as test kits and ARVs. This impacted on the treatment compliance and limited performance in monitoring patients on treatment. Therefore, the country needed to expand the decentralization of the healthcare system and improve supply chain management. In that regard, UNAIDS provided commodities, including 181,400 HIV tests (first test) and 18,600 confirmatory tests (second test), in the East and North parts of the country. UNAIDS also provided supplies for care and treatment including ARV, which contributed to stopping recurrent stock-outs that have been happening since late 2012. Through the support of WHO and UNAIDS, new national guidelines and training modules were developed, integrated training on task shifting to nurses conducted and two national trainings were facilitated in the central region of Cameroon. Previously, only doctors could provide HIV testing.
14. UNAIDS intensified its technical and financial support for adequate supply chain management through the development of a tailored programme to improve the procurement and supply management system in Cameroon, in partnership with the Global Fund, UNICEF, MSH, CDC and PEPFAR. With the support from the UNAIDS Secretariat, WHO and UN Women, the new CCM presented a proposal integrating gender issues and more adequately handling the requirements of the New Funding Model. Cameroon should benefit from an amount of US\$ 155,188,052 for its next grants where most of the funds will further support the scale up of ART coverage and the acceleration of efforts to eliminate mother-to-child transmission nationwide to ensure increased uptake of treatment in general and avert deaths.
15. An estimated 63% of the TB treatment centres in Cameroon offer the integrated service package of care including ART for HIV. The number of TB patients living with HIV receiving ART has increased from 2,571 in 2008 to 4,261 people in 2012. Consequently, TB-related deaths among people living with HIV has decreased from 13,000 in 2003 to 7,700 people in 2012. UNAIDS, through WHO, provided technical and facilitation support for the integration of TB and HIV services whereby the joint planning and monitoring between these two programmes was re-evaluated and strengthened. Management tools and training modules were developed for HIV-positive patients. This improvement has resulted in the availability of more accurate data for HIV/TB co-infection and more TB/HIV positive patients being enrolled on antiretroviral treatment.

Greater focus to reduce new HIV infections among young people

16. Government integration of HIV components within the education training curricula has led to a substantial increase in HIV prevention content and services coverage for young people in school and in extra-curricular classes. Through capacity building and self-empowerment workshops supported by UNAIDS Secretariat, UNICEF, UNFPA, UNESCO and other partners in Cameroon, young people are equipped to increasingly assert their leadership in HIV prevention among their peers. They are becoming better educated on HIV issues via various channels and programme interventions. With the support of UNAIDS, the government has also provided training for police officers, judges and lawyers with regard to better understanding national and international legal instruments to enhance their services in supporting the needs of young people, including young most-at-risk populations.

17. UNAIDS, through UNFPA and UNHCR, contributed to address the stock-outs of modern contraceptives by procuring and distributing some 2,18 million male condoms and 810,000 female condoms. With UNDP's support, a community program was initiated in 2012 to educate, sensitize and train local leaders and women`s groups in poorer provinces on gender-based violence in the context of HIV. Youth leaders and social workers from across the provinces in Cameroon were trained on the use of new technology for HIV prevention and in developing HIV prevention activities in youth centres. UNESCO supported the incorporation of HIV/AIDS integration into compulsory national elementary school curriculum for children aged 6 to 12. The extension of the training on HIV/SSR and STIs further reinforced the capacities of 7,300 teachers in 560 primary and elementary schools.

Improved knowledge for prevention among key populations and the general public

18. The findings from the stigma index supported by UNAIDS Secretariat informed the development of an action plan for the reduction of stigma and discrimination. The training of magistrates, lawyers and LGBT associations that followed helped to enhance these key groups' knowledge on HIV and human rights. Similar training was conducted, with UNAIDS support, for sex workers and the LGBT community.
19. Cameroon is also supportive of prioritising HIV prevention among key populations at higher risk, particularly for female sex workers and their partners and men who have sex with men (MSM). Around 36,000 people are being reached daily through an HIV prevention campaign that has been on-going since 2011 involving the Cameroon postal service offices (among 23,000 post offices participating worldwide), using postcards, posters, a website and public events to inform the general public about HIV. Since 2011, UNAIDS Secretariat, ILO and UNDP supported interventions to create an enabling environment for PLHIV. Interventions carried out were on capacity building of judiciary actors for utilization of international and national legal instruments in the context of HIV, development of training modules, communication supports, training of members of PLHIV associations and focal points in the world of work for promotion of human rights in the context of HIV and roll out of the "Know your Rights" campaign.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UN ACTION

Basic programme activities

20. **Behaviour change:** The Government of Cameroon and its partners need to work harder to increase general HIV knowledge, more specifically knowledge of HIV status and opportunities for treatment. Due to legal barriers, key populations such as sex workers and men who have sex with men do not have easy access to prevention services. The situation requires the full engagement and participation of religious community leaders, local communities and non-governmental organizations. The UN needs to advocate for the expansion and strengthening of prevention programmes and in particular the scale up of prevention activities for key populations at higher risk.
21. **Treatment and care for women and children:** ART coverage for children aged 0–14 is only 15%. There is therefore an urgent need to revive coverage and access to treatment for children born to HIV positive mothers. Only 28% of women in rural areas are reached with treatment compared to 80% of women in urban areas.
22. UNAIDS needs to increase its advocacy with the Government of Cameroon and mobilize partners in order to help address these disparities. UNAIDS also needs to advocate for

the establishment of a sustainable funding mechanism to increase local funding (government and private) for treatment with a special focus on rural areas and women and children.

23. **Condoms:** In spite of encouraging coverage of condom use (72.7% among sex workers, 57.3% for MSM and 41.11% for adults aged 15-49 years in 2012), more needs to be done to increase general availability and accessibility and use of condoms. UNAIDS will support a national comprehensive condom programming for both males and females.

Critical enablers

24. **Stigma and discrimination:** To complement the findings of the Stigma Index study, and with the support of UNAIDS, the country is currently conducting a legal audit whose findings will serve for the law reform regarding the criminalization of men who have sex with men. UNAIDS and the government will continue investing in strategies that decrease stigma and discrimination.
25. **Policies and communication:** The political support for strengthening human rights in the context of HIV needs to be enhanced. Currently in Cameroon, there are still no specific laws, policies or regulations on HIV and AIDS in place to protect the rights of people living with HIV. A UN-based guideline on promoting human rights for people living with HIV, through a collaborative partnership between the UN family and the government, might offer a way forward in this regard.
26. **Commodities:** The UN is working together with the government to identify adequate strategies to prevent future stock-outs and to provide an efficient supply chain while trying to fill the immediate and urgent needs in order to ensure people most in need have access and benefit from services and treatment as appropriate.
27. **Gender inequality:** Gender inequality continues to fuel the HIV epidemic in Cameroon — HIV prevalence among women is at 5.6% compared to 2.9% for males. UNAIDS, in close collaboration with UN Women, is currently promoting gender programming to more effectively address these challenges. However much more needs to be done and urgently in order to address the impact of HIV on women.

Synergies

28. The H4+² project led by UNFPA, UNICEF, UN Women, WB and UNAIDS Secretariat is a great opportunity to help address maternal mortality and prevention of mother-to-child transmission in the far north region mainly where disparities and needs are the highest. Through this partnership, the national AIDS programme increases its sustainability, scale up and integration of services at all levels. Further interventions with communities will enhance access to HIV services.
29. UNAIDS, through ILO, is currently working on developing several frameworks in partnership with the government and 52 companies to integrate and improve the response to HIV in the workplace.

² H4+ is a joint effort by United Nations and related agencies and programmes, UNAIDS Secretariat, UNFPA, UNICEF, UN Women, WHO, and the World Bank. Harnessing the collective power of each partner's strengths and capacities, the H4+ works to improve the health of women and children and accelerate progress towards achieving MDGs 4 and 5. More at: <http://www.everywomaneverychild.org/resources/h4#sthash.VU3rzRs7.dpuf>

GUATEMALA

INTRODUCTION

30. This case study presents an overview of the role of UNAIDS in Guatemala's response to AIDS and describes how the contributions of UNAIDS – the Cosponsors and Secretariat – are coordinated, funded and managed through the Joint UN Programme and Team on AIDS. The study highlights both achievements and gaps in the overall national AIDS response and with respect to UNAIDS' efforts to strengthen the response and achieve results. The report concludes that:

- Guatemala has begun to reverse the spread of HIV, improving the enabling environment for most at risk populations and people living with HIV. It has also made concrete improvements in prevention, treatment and care.
- The on-going shift in the focus of interventions to key and marginalized populations must be sustained, and persistent stigma and discrimination addressed through strengthened efforts.
- Total spending on HIV increased by 15% in 2010-2012 and the Ministry of Health has committed to assuming progressive ownership of the national response and implementing a sustainability plan in 2016. With the assistance of UN partners, Guatemala has most of the elements in place to develop an investment approach which achieves considerable resource efficiencies.

BACKGROUND

31. Guatemala, a Central American country, has a population of 15.6 million people. Among people aged 15-49, 0.7% (2012) or an estimated 58,000 people of all ages, are living with HIV³. A total of 16,385 people living with HIV are on ART.
32. The HIV epidemic in Guatemala is concentrated. The most affected populations include men who have sex with men (MSM), female transgender people, and female sex workers. In the capital city, HIV prevalence in these populations is 8.9 %, 23.8%, and 1.0%, respectively. Within key populations, some groups are more affected than others. For example, in the city of Escuintla, HIV prevalence among sex workers is 2.6% generally but is 13.3% for street-based sex workers.
33. People who identify themselves as Mayan account for 46% of the national population and 21% of reported cases of HIV. Low education and literacy rates, poverty, high levels of migrant labor as well as low rates of HIV testing and limited knowledge on HIV prevention among this group are causes of great concern.
34. Guatemala's national response is built on four strategic axes, namely – institutional strengthening, prevention, integrated care, and monitoring and evaluation. Within these, particular emphasis has been placed on three strategies: (i) HIV testing and universal access to care and treatment, (ii) condom programming, and (iii) the National Plan for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis 2013-2016.

³ AIDS Info, www.unaids.org (2012 estimations exercise)

35. Civil society has played a pivotal role in the national response, traditionally conducting most of the prevention activities among key populations. The government and Ministry of Health have funded over 80% of ARV treatment costs and nearly 85% of costs related to elimination of mother-to-child transmission (eMTCT) activities, and are beginning to assume greater ownership of prevention activities with key populations. The Global Fund provided 39% (US \$ 5,661,421) of total resources for 2012. Guatemala's Phase II proposal was approved for US\$ 42 million over the next three years.

KEY HIV AND AIDS INFORMATION FOR GUATEMALA

Population: 15,600,000	Women aged 15+ living with HIV: 20,000 [12,000–44,000]
Epidemic type: Concentrated	Children aged 0–14 living with HIV: N/A
Main modes of transmission: Men who have sex with men	Annual deaths due to AIDS: 3,400 [1,800–7,100]
Number of people living with HIV: 58,000 [36,000–130,000]	Annual new infections: 3,000 [1,000–15,000]
Adults aged 15–49 prevalence: 0.7% [0.4–1.5]	Antiretroviral therapy coverage: 51% [37%–87%]
Adults aged 15+ living with HIV: 53,000 [33,000–120,000]	Prevention of mother-to-child transmission coverage: N/A

Source: UNAIDS reports 2012 - 2013

JOINT UN PROGRAMME AND TEAM ON AIDS

36. The Joint Programme of Support on AIDS is aligned with the United Nations Development Assistance Framework (UNDAF, 2010-2014), the National Strategic Plan and the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF). In 2012-2013, the Joint Programme prioritized work towards four outcomes:

- Eliminate stigma and discrimination, focusing on strengthening civil society's human rights work;
- Supporting rapid scale-up of antiretroviral treatment;
- Comprehensive prevention;
- The elimination of mother-to-child transmission of HIV and congenital syphilis; and
- Working towards sustainable financing.

37. The Joint Team on AIDS in Guatemala includes 11 UN organizations: UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, PAHO/WHO, the World Bank and UNAIDS Secretariat. The UNAIDS Country Director leads the Joint Team on AIDS and oversees planning, implementation, monitoring and reporting of outcomes of the Joint UN Programme of Support to the UNCT. The Joint Team meets at least once every two months to review progress towards the results established in the joint biennial work plan.

38. Total UN expenditure on HIV-related activities in 2012 was US\$ 1,159,823. The UN Joint Team on AIDS budget for 2014-2015 is presented in the table below (total US\$ 1,261,519).

Joint UN Programme of Support on AIDS for 2012-2013	% of overall budget
Reduce sexual transmission of HIV	36%
Eliminate new HIV infections among children	6%
Prevent HIV among drug users	0%
Reach 15 million people living with HIV with lifesaving antiretroviral treatment	34%
Strengthen HIV integration (social protection)	0%
Eliminate stigma and discrimination against people living with and affected by HIV	7%
Eliminate gender inequalities	0%
Leadership, coordination and accountability	17%

KEY ACHIEVEMENTS

39. HIV prevalence has declined, from a peak of 0.9% [0.6% – 1.4%] in 2002 to 0.7% [0.4% – 1.5%] in 2012. The country has made commendable progress towards Universal Access to HIV prevention, treatment, care and support.
40. In support of national efforts, the UN Joint Team has contributed to concrete improvements in treatment and care, including the implementation of the WHO's Treatment 2.0 strategy, the development of new guidelines for ART which include pediatric care, a national plan for the elimination of mother-to-child transmission, and expanded testing and referral. UNAIDS has facilitated uptake of HIV testing and enhanced access to integrated HIV care and support for the most vulnerable, including the indigenous Mayan population in the Department of Petén. The UN Joint Team continues to advocate and provide technical support in aspects of the response that require continued efforts, including increased ART coverage, combination prevention among key populations, human rights and reduction of stigma and discrimination. Since 2011, the UNAIDS Secretariat has assisted national partners in working towards the implementation of an investment approach to HIV which will provide the necessary framework for focused and effective programmes.

Improving the enabling environment: Responding to the needs and protecting the rights of key populations

41. In the last years, some progress has been observed in regard to respect of human rights of people living with HIV. From 2005 to 2011, the percentage of people living with HIV who reported having experienced human rights violations fell from 64% to approximately 13%.
42. The Government of Guatemala has also demonstrated commitment to a human rights-based response, creating the new position of Commissioner for Sexual Diversity in the Human Rights Ombudsman's office. The Commissioner will promote equality of

opportunity, inclusion, participation, non-discrimination and respect for sexual diversity. Furthermore, the same office has collaborated with UN agencies (UNDP, UNFPA, PAHO/WHO) to advocate for the reclassification of HIV as a chronic disease.

43. The Government of Guatemala, together with the UN and civil society developed The National Action Framework for Adolescents, Women, Girls, Gender-Based Violence and HIV, which was incorporated into the operational plan of the National Strategic HIV Plan. Several steps have been undertaken to address the persistent challenge of gender based violence, including the inauguration of the first Justice Centre for Women, by the Supreme Court, to follow up on court rulings on cases of violence against women and femicide. Stakeholders have also taken action to raise public awareness on HIV and gender-based violence, through video-clips and support for the national chapter of the UNITE campaign. Guatemala has also developed a streamlined process for attending to victims of sexual violence, based on a critical paths analysis for care and referral of women victims of sexual violence, including sex workers and transgender women.
44. With UN support, civil society has taken the lead in legal and policy reform, human rights and the development of the National Action Plan for the Reduction of Stigma and Discrimination. Since 2010, the Human Rights Ombudsperson, the Legal Network/Human Rights Observatory, the Alliance of People Living with HIV, PAHO/WHO and UNAIDS have collaborated to develop three national reports on the human rights of PLHIV and key populations. Civil society has evaluated the National HIV Law and drafted proposed reforms, and a coalition for the elaboration of a Gender Identity law (comprised of organizations representing the female transgender population, the Office of the Ombudsman and UN agencies) has been formed. Both government agencies and civil society organizations use guidelines for the management of reported human rights violations which were developed with significant support from UN agencies, namely UNFPA and UNAIDS. Additionally, UN support has led to the development and implementation of an advocacy strategy for the Legal Network and an information system for monitoring cases of human rights abuse and key indicators identified in international commitments made by the State related to human rights of PLHIVs and key populations.
45. In December 2013, UNAIDS and the organization Professional Leaders/Action Foundation launched "Equal Access to Justice", an initiative which provides free legal services to people with HIV and key populations. The project joins the efforts of the National Legal Network and the Observatory for the human rights of people living with HIV and key populations, the National Network of Sexual Diversity, the School of Law of the University of San Carlos, and the Office of the Ombudsman . The project has taken advantage of social network sites (such as Facebook, YouTube and a project website) to create demand for legal services.
46. At the request of national organizations of transgender women (OTRANS and REDMUTRANS), UNFPA, the Office of the UN High Commissioner on Human Rights (OHCHR), UNDP, PAHO/WHO, UNAIDS Secretariat and government agencies helped develop a strategy for integrated and differentiated health services for transgender women which addresses multiple levels of service delivery with a human rights approach.
47. UN organizations joined with other stakeholders to develop and implement the *Campaign against Stigma and Discrimination directed to MSM, Transgender Populations, Sex Workers and People living with HIV*. An evaluation study determined that almost 70% of the target population were conscious of the campaign and 87% had positive responses to the campaign messages.

Supporting rapid scale-up of antiretroviral treatment

48. The number of people living with HIV receiving antiretroviral treatment increased by 36% from 12,053 in 2010 to 16,385 in 2013. 30,000 [21,000 – 50,000] were eligible for treatment according in 2012 according to WHO 2010 guidelines and ART coverage went from 38%[27% - 56%] in 2009 to 51%[37% – 87%] in 2012.
49. Over the last 18 months, the National AIDS Programme of Guatemala has reduced the number of recommended treatment regimens from 17 to 6, largely due to successful negotiations related to the purchase of optimal treatment schemes. Currently, 70% of patients on first line treatment are under two schemes (TDF+FTC+EFV and AZT+3TC+EFV). The average annual cost per patient of first-line treatment has fallen from US\$ 926.19 in 2011 to US\$ 400 in 2013, in part due to strategic assistance provided by PAHO. With the aim of further enhancing the affordability of HIV medicines, the Government of Guatemala has pledged to participate in the pooling purchasing mechanism established by the Central America Council of Ministers of Health (COMISCA).
50. With support from the UN Joint Team agencies, the National AIDS Programme has elaborated, and is currently implementing, 27 protocols and guidelines for integrated care, including revised treatment guidelines for antiretroviral therapy and opportunistic infections, clinical guidelines for the management of HIV/TB co-infection, sexual and reproductive health for women living with HIV, and guidelines for nutrition and food security for people living with HIV. These treatment guidelines align with WHO and Treatment 2.0 recommendations, including use of a CD4 threshold of 500 for the initiation of treatment and initiation of lifelong therapy for pregnant women living with HIV, regardless of CD4 count.
51. In 2013, UNAIDS launched a testing and referral pilot project in the Department of Petén, where 70% of the population live in often difficult to reach rural areas and 20% are of Mayan descent. With low levels of education and income strongly correlated with HIV risk, the project focuses particular attention on the Mayan population, 75% of whom live in poverty. The project provides access to HIV rapid tests and integrated care for people living with HIV, with particular attention to the needs of the most vulnerable.

Building comprehensive prevention

52. Young people are a key focus of prevention efforts in Guatemala. The first National Youth Consultation on HIV, guided by the UNAIDS global initiative *CrowdOutAIDS*, was conducted, convening over 300 youths and adolescents from different ethnic backgrounds and geographical areas as well as representatives of the government's National Council for Youth. The consultation generated recommendations and specific actions to improve HIV programming for young people. Additionally, under a separate project, 150 young people on five university campuses were trained as peer educators for combination prevention. The UN Joint Team (UNESCO, UNFPA, PAHO/WHO, UNAIDS) collaborated with the Ministry of Education-Quality Education Department to obtain a ministerial agreement on "Preventing with Education" which led to the development and implementation of the *Strategy for Comprehensive Sexuality Education and Prevention of Violence -EIS/PV*. The strategy is the first to include a gender focus and address sexual violence as it relates to HIV in the national curriculum. Finally, a combination prevention strategy for youth focused on MSM and transgender people was also developed in collaboration with youth organizations and a model for the empowerment of MSM (*Mpowerment*) was piloted in Guatemala City with impressive results.

53. With UN Joint Team support (UNFPA, UNAIDS), in July 2013, the country launched a national condom strategy and Ministry of Health staff working in 17 departments were trained in its implementation. As a result of the strategy, condom procurement and distribution has been included in the annual operational plans of health services as well as condom distribution in the national health information system.
54. The UN Joint Team (UNICEF and PAHO/WHO) provided guidance and technical support for the development and approval of the National Plan for the Elimination of Vertical Transmission of HIV and Congenital Syphilis. During the development of the plan, a total of 158 health centres were evaluated for capacity to implement quality eMTCT care, with results used by the National AIDS Programme and Ministry of Health to improve eMTCT care nationwide.
55. Under the national plan, the country has purchased rapid tests for its eMTCT programme, and 769 health care staff were trained in counselling related to eMTCT, syphilis, Hepatitis B and breastfeeding. The greatest challenge to testing coverage is the low level of ANC attendance; only 40% of pregnant women receive at least 1 ANC visit and only 50% deliver in health care facilities. Of the 182,550 pregnant women who received the test in 2012, 362 were positive and all received treatment. The Integrated Care Unit with the highest case load in the country conducted a study in which MTCT was 5%.

Working towards sustainable financing

56. In 2012, a total of US\$ 53.2 million was spent on HIV-related activities, a 15% increase over 2010. The increase reported in 2012 primarily stems from enhanced support from international sources. From 2010 to 2012, public sector spending declined by US\$ 1.5 million, private sector investments rose by US\$ 4.1 million, and international HIV assistance increased by US\$ 7.7 million. There is substantial scope for Guatemala to better implement 'Know Your Epidemic, Know Your Response' approach, and to ensure that expenditures better reflect the dynamics of the epidemic. (See section on prevention challenges).
57. UNAIDS Secretariat and the World Bank have worked closely with Guatemala since 2010 to analyse and project the country's HIV investment needs, and to inform key partners (e.g. at the Central America PEPFAR Mid-Term Review held in Guatemala in September 2012) regarding the approach. Guatemala has undertaken all four elements of the first 'understand' phase of improving investment approaches (e.g. a NASA, epidemiology review, Stigma Index and gender review) as well as a sustainable financing analysis.
58. The UN Joint Team has provided technical and financial support to leverage resources from the Global Fund to strengthen the national AIDS response. The latest Global Fund grant will improve condom distribution, testing services and prevention activities for the five priority populations identified in the National Strategic Plan (MSM, sex workers, transgender women, incarcerated persons and people living with HIV). The grant will also support capacity building in advocacy and programme administration for these key populations.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UN ACTION

59. Although forward progress in the national response is apparent, important challenges and gaps in the response persist, highlighting areas for future action.

Prevention

60. Over recent years, resources have been shifting slowly to programming for MARPs but have not expanded proportional to the needs. Only 5.5% of national expenditures on HIV prevention are spent on the populations at greatest risk (MSM, transgender women and sex workers). In an evaluation of the effectiveness of prevention programmes with MSM, less than half of those surveyed had correct knowledge regarding HIV transmission and prevention, and less than one-third had participated in HIV prevention activities. Based on the evaluation results, improved prevention interventions were proposed for the country's 2nd phase of the Global Fund HIV grant. The public sector is in the process of assuming responsibility for the HIV prevention needs of key populations but has requested support from the UN system.
61. Receptive anal intercourse with commercial partners and low condom use increase the risk for female transgender people and violence is a constant threat. Prevention, testing and care programmes need to be strengthened to include services developed and implemented with the needs of the female transgender population in mind. As many transgender women are sex workers, prevention programmes for sex workers should address the needs of the transgender population. The UN Joint team's expertise in this area will be vital to successful prevention in this group.

62. The rate of mother-to-child transmission (15%) remains high in Guatemala. Consistent application of the National Plan for Elimination of Mother-to-Child Transmission is imperative. The UN system worked closely with the NAP to develop the plan and will continue to provide support to the MoH for implementation. Further and high-level UN commitment will be essential for the rapid scale-up of the strategy.

Treatment

63. According to 2012 estimates, half of the people who are eligible for antiretroviral therapy are not receiving it. This and other gaps pose significant barriers to an effective HIV response. Reduction of antiretroviral drug prices is still an important challenge to maintaining the increasing trend in ARV treatment coverage. The UN Joint Team will provide continued technical and financial support to the implementation of Treatment 2.0 guidelines. Additionally, UNAIDS will continue to support civil society organizations as they intensify their advocacy and expand participation in the national response by acting as a resource for testing and referral to treatment.
64. While nutritional guidelines for PLHIV have been developed with UN leadership, widespread implementation of the guidelines will require continued support. Food insecurity and inadequate nutrition increases risk of HIV infection and reduces efficacy of treatment, through a vicious cycle of immune dysfunction, infectious disease and malnutrition. As a consequence, it accelerates HIV disease progression and can lead to treatment abandonment.

Human Rights

65. Human rights violations against people living with HIV and key populations continue to undermine an effective response. According to the 3rd report on human rights of people living with HIV and key populations, 584 cases of human rights violations were reported

in 2012 and only 70% of cases were resolved. The vast majority (91%) of cases of human rights violations were related to health and security, primarily stemming from medication stock-outs, stigmatizing and discriminatory behaviours of health staff and violations of confidentiality by the same. Among MSM and sex workers, 31% of human rights cases were related to physical and verbal aggression and illegal detention by the police. Transgender women reported 19 cases of human rights violations, with 84% involving death threats or homicide, some with indications of torture. The UN Joint Team will play a significant role in getting to zero stigma and discrimination bringing a wealth of experience and expertise to the response. UNAIDS, in particular, will provide support to the networks and organizations of people living with HIV and key populations by providing free legal services for individuals who file cases.

Monitoring and evaluation

66. Although strategic information is often available, it is not always used for strategic decision-making. UNAIDS has supported a number of processes relating to strategic information, including Modes of Transmission analyses, GARPR reporting, work towards an investment case, as well as the elaboration of a National Evaluation Agenda. However, data generated has yet to be formally triangulated. UNAIDS will continue to support the National Monitoring and Evaluation Committee and the National AIDS Programme in the collection of strategic information, including the GARPR, Estimations and Projections, NASA, a case study for the Investment Framework and a study on the socioeconomic situation of HIV positive households, especially women. The support will be particularly important as the country prepares to develop a new National Strategic Plan.

Critical enablers and synergies

67. The health sector and civil society must continue to collaborate to develop strategies for expanding testing and treatment and reaching marginalized most at risk populations with combination prevention programmes, as well as with free legal services as necessary. Innovation and evidence based focus will be imperative to an effective national response. The UN Joint Team and other international partners will use their comparative advantages to build the capacity of civil society to optimize their role in the response. Additionally, the Joint Team will provide capacity-building support to civil society groups in advocacy, management and monitoring and evaluation. Importantly, UNAIDS will encourage public sector and civil society to collaborate on joint prevention and treatment services and will continue to support the review process of the HIV law and the elaboration of the gender identity law.

68. The national HIV response in Guatemala will benefit from evidence-based strategic planning in the form of the development of a new National Strategic Plan based on in-depth analysis of available data and a comprehensive investment framework. The development of the National Strategic Plan will be a collaborative effort involving governmental, civil society and international partners.

69. While the Government of Guatemala has progressed in assuming leadership of the national response, they have also requested for continued UN support. The Ministry of Health recognizes the challenges they will face in the coming biennium and beyond, particularly in the areas of combination prevention for key populations, the elimination of mother-to-child transmission, human rights and the reduction of stigma and discrimination, and rapid scale up of ART. Each agency comprising the joint team brings expertise and a unique value added to the national response.

INDONESIA

INTRODUCTION

70. This case study provides an overview of the role UNAIDS plays in supporting Indonesia's response to HIV and AIDS. It describes how the contributions of the Cosponsors and Secretariat are coordinated, funded and managed through the Joint UN Programme and Team on AIDS. The study highlights both successes and challenges in the national AIDS response as well as the role UNAIDS played in the establishment of priorities and the achievement of results. Moreover, the case study responds to the request by the Programme Coordinating Board (PCB) that UNAIDS not only report achievements but highlight gaps in progress. It also responds to the need to report on how the Joint Programme is supporting an acceleration of efforts towards the achievement of results. The report concludes that:

- Whilst Indonesia currently enjoys favorable economic circumstances and middle income status, it will struggle to meet a number of the UN General Assembly 2011 Political Declaration targets by 2015.
- Against a rising epidemic, Indonesia is making modest but steady progress towards achieving its commitments to scale up access to treatment, intensify prevention and promote an enabling environment for key populations, and accelerate prevention of mother-to-child transmission services.

BACKGROUND

71. Indonesia is the world's fourth most populous country with a HIV prevalence rate of 0.43% among the 15-49 years age group and an estimated 610,000 people living with HIV. Indonesia is one of four countries in the Asia and Pacific region in which new infections have risen by more than 25% over the last ten years. Between 2002 and 2012, the number of new infections almost doubled, from 39,000 to 76,000.⁴
72. Nationally (excluding the provinces Papua and West Papua) Indonesia is experiencing a concentrated HIV epidemic among people who inject drugs (prevalence of 36%), people with a transgender identity (22%), female sex workers (9%) and their clients, and men who have sex with men (8%).⁵ Papua and West Papua provinces are experiencing low level generalized epidemics with prevalence of 2.3%, which is about 6 times higher than the national average.⁶
73. There have been unprecedented levels of political commitment in Indonesia since 2006 to respond to HIV in Indonesia, and significant domestic and international funding have been secured to support a greatly expanded national response. Until recently, the available data and program review results suggest that while progress was being made, efforts are also needed to strengthen the coverage and intervention effectiveness of the national HIV programmes if they were to have an impact on the course of HIV in the country. However, Integrated Biological-Behavioural Surveillance (IBBS) data collected from key affected populations (KAPs) in 2013 in nine provinces and among the general population in Tanah Papua suggest that program efforts have slowed the growth of the

⁴ Global Report: UNAIDS report on the global AIDS epidemic 2013

⁵ NAC, Indonesia Country Report on Declaration on Commitment 2011-2012

⁶ IBBS Tanah Papua, MoH, 2013

epidemic, and perhaps stabilized epidemic progression among some groups. Further efforts are, however, needed in order to consolidate the gains made and expand program coverage and intervention effectiveness for KAPs among whom HIV transmission continues to expand (primarily men who have sex with men).

74. Since 2010, the national response in Indonesia has been driven by Presidential Instruction 3/2010 on Just Development, which raised national attention on acceleration of efforts to achieve the Millennium Development Goals (MDG), including Goal 6 (MDG 6), which specifically refers to halting and reversing the spread of HIV. As a prerequisite to the implementation of the Presidential Instruction, an MDG acceleration Action Plan 2011-2015 has been developed, helping to keep AIDS high on the national agenda, while calling for a stronger response from the sub-national level.
75. The latest National AIDS Spending Assessment (NASA) shows that Indonesia committed and expended more funds in 2011-2012 on HIV compared to the previous biennium. Although the central government contribution increased from US\$ 21,318,844 in 2009 to US\$ 36,581,918 in 2012, a significant proportion of the total government budget is made up of provincial, district and city funds. These funds are, however, under-reported. More efforts are needed to strengthen local government capacity and commitment to plan for health and HIV and to secure more domestic resources.

On the road towards 2015

76. As one of three countries with a rising HIV epidemic in Asia, Indonesia has put in place the key elements for a coordinated strategy for the large scale expansion of quality prevention and treatment services in high-burden districts. It has mobilized greater political support and resources from provincial and district governments and is addressing the factors related to the enabling environment that are hampering implementation. The UN has provided support in mobilizing Global Fund resources for this effort and is contributing to developing the country's next national HIV and AIDS strategic plan, and thus contributes towards laying a more robust foundation for the post 2015 era.

KEY HIV AND AIDS INFORMATION FOR INDONESIA

Population: 237,500,000	Estimated Women aged 15+ living with HIV in 2013: 252,857*
Epidemic type: Concentrated	Estimated Children aged 0–14 living with HIV in 2013: 19,332*
Modes of transmission: Sex workers and their clients, men who have sex with men, people who use drugs, multiple heterosexual partners	Annual deaths due to AIDS: 29,144*
Number of people living with HIV: 638,643*	Annual new infections: 76,000 (Source: AEM 2012-2016)
Adults aged 15–49 prevalence rate: 0.43%*	Antiretroviral therapy coverage: Numerator: 39,418 (Program monitoring, MoH, 2013) Denominator 201,184* (PLHIV eligible to receive ART in 2013, treatment criteria is CD4 level <350)
Adults aged 15+ living with HIV: 638,643*	Prevention of mother-to-child transmission coverage: 26.1% ⁷

Source: AEM 2012-2016

JOINT UN PROGRAMME AND TEAM ON AIDS

77. The Government of Indonesia has identified the national AIDS response as a priority area for the UN system since 2004, and HIV has remained one of four priority themes under the five-year UN Partnership for Development Framework (UNPDF) 2012-2015 for Indonesia. The key HIV goal of the UNPDF for Indonesia is to provide coherent and unified support, and to leverage UNAIDS funding to scale up the national response, to achieve universal access to prevention, treatment, care and support, in line with the government's commitments to the global AIDS targets set at the UN General Assembly High Level Meeting on AIDS in 2011.
78. The Joint UN Team in Indonesia brings together all key UNAIDS partners. Under the overall guidance of the UN Country Team and Resident Coordinator, the UNAIDS Country Director leads the Joint UN Team on AIDS to ensure planning, implementation, monitoring and reporting of the Joint UN Programme of Support on AIDS. Currently, 13 organizations (UNICEF, ILO, UNESCO, UNODC, UNDP, UNFPA, WHO, WFP, UNHCR, UN-Women, World Bank, FAO and IOM), UNAIDS Secretariat and the Resident Coordinator's Office are members of the Joint Team. The team comprises all UN staff working full or part-time on HIV and AIDS, joining together and "working as one".

⁷ Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission

KEY ACHIEVEMENTS

79. The UN Joint Team on HIV has delivered focused and harmonized support to Indonesia's efforts in getting to zero new HIV infections, zero AIDS-related deaths and zero discrimination, and hence contributed to critical programmatic improvements and policy changes on the national response in the following areas:

Strategic use of antiretroviral treatment

80. Following the visit of the UNAIDS Executive Director in October 2012, the Government of Indonesia took a bold step to embark upon a major national programme to expand testing and early access to antiretroviral treatment, entitled "Strategic Use of ARVs". The UNAIDS Secretariat, WHO and UNICEF supported the Ministry of Health and the National AIDS Commission (MOH/NAC) to undertake a joint assessment in January 2013, followed by a national consultation in March. The joint assessment led to the development of a roadmap to expand HIV testing and the provision of anti-retroviral treatment. It will commence at the district level, in 13 initial demonstration districts, and then expand to 75 districts by the end of 2014 covering approximately 45% of estimated key affected populations and people living with HIV in Indonesia.
81. Noting that a major challenge will be implementation at the district level, where capacity is often uneven, the Ministry of Health and the National AIDS Commission, with support from WHO, UNICEF and UNAIDS Secretariat, developed an implementation strategy for the first 13 districts participating in the 'Strategic Use of ARV' initiative. The strategy called for a district-led implementation process, which includes the establishment of district core teams involving key affected population groups to prepare work plans, targets, budget for outreach, early testing, treatment initiation and treatment retention, based on an analysis of the key barriers to treatment uptake. The second prong of the strategy is the use of facilitators, funded by the National AIDS Commission (NAC), the UN and other development partners, to assist and mentor the district-level teams to train and mentor implementing partners as well as help forge service alliances with networks of key affected populations. Throughout the district roll-out process, UNAIDS and WHO worked with the national project team to support training on implementing the strategic use of ARV, as well as work with community groups to create demand for testing and early treatment.
82. The rapid expansion of treatment to key affected populations who test positive for HIV, individuals with TB or Hepatitis co-infection, sero-discordant couples (without reference to CD4) will allow the government to exploit the prevention impact of treatment. With access to treatment becoming widely available, there is also an opportunity to strengthen the national prevention of sexual transmission programme by including early treatment as an additional component to the four-prong strategy (stakeholder coordination; condom promotion; STI treatment; and prevention education) and support linkage between the sexual transmission and treatment programmes.
83. In recognizing that treatment as prevention can only be successful if the number of persons tested for HIV is dramatically increased, the Government of Indonesia has adopted the WHO guidance on Provider Initiated Testing and Counselling.
84. In 2012, with support from the WHO, the Indonesian government issued compulsory licenses allowing local drug companies to legally make their own drugs for the treatment of HIV and hepatitis. The Presidential Decree authorized the government's use of patents for five HIV and two hepatitis medicines. This has increased the treatment options available. Yet, more work is still required to ensure local generic production meets minimum standards and are priced more competitively.

Reducing sexual transmission

85. Concerned with the rise in HIV infections and the need to step up the prevention effort, the UN Joint Team on AIDS in Indonesia worked with the NAC to undertake a series of national reviews, whose results were fed into the mid-term review of the national response. Those reviews included:
86. A review of the national 'HIV Prevention through Sexual Transmission' programme (or 'PMTS') by the NAC was supported by UNFPA towards the end of 2014. The review included a situation analysis of comprehensive condom programming and an assessment of sexual and reproductive health and HIV linkages in 2 districts, supplemented by a WHO review of STI and HIV prevention programmes amongst sex workers in five brothel complexes. The reviews highlight that there are examples of high programme performance, where better access to local HIV and STI services are occurring, driven by a number of factors: committed individuals, creating client friendly services and linkages; supportive stakeholders such as local government and the brothel managers themselves; and health department staff, engaged in working with the police and community.
87. The national review of the prevention programme for men who have sex with men and transgender community was led by the, with support from UNAIDS, WHO and UNICEF. The assessment identified a number of different factors that have created a 'perfect storm' for HIV transmission among MSM and transgender. These include:
 - limited reach and funding for civil society entities that support prevention activities such as condom and lubricant distribution;
 - limited 'friendly' HIV testing and counselling services resulting in low testing and treatment uptake;
 - concurrent syphilis epidemic;
 - increasing use of amphetamine-like substances;
 - a shift from geographic to online meeting places for making sexual contacts; and,
 - High levels of stigma and discrimination related to sexuality and HIV status, posing further barriers to testing and accessing health services.
88. These findings have provided a pathway for the updating of the MSM and transgender prevention strategy currently being developed in-country.
89. In conjunction with World AIDS Day 2013, the VCT@Work programme was launched in Indonesia by the Indonesian Business Coalition on AIDS, the ILO and UNAIDS, with the goal of expanding testing in the work place to 350,000 workers by the end of 2015. The launching of this initiative was given an initial push by a consortium of a dozen major industrial companies in Indonesia who signed a pledge to promote work place programmes on HIV. Along with this major initiative, an assessment was carried out by ILO and UNAIDS in early 2014 to look at the potential impact of the development of 'Economic Corridors' and mobility on HIV transmission, especially in transport corridors and seaports, plantations, mines, and tourist centres, with view to developing targeted work-place based HIV programmes in localities where high-risk behaviour take place.
90. In November 2013, the UN Joint Team on AIDS organised a South-to-South Learning Exchange Study Tour of Indonesia Officials to India. The objective of the visit was to provide an opportunity for inter-country learning on strategies for HIV prevention scale up in India, and was attended by participants from the Ministry of Health, the National AIDS Commission, and community-based organisations who were taken to different

interventions led by non-governmental organizations (NGO), community-based organizations (CBOs) and government. The visit was hosted by the Technical Support Facility for Asia and the Pacific with logistical support of the Karnataka Health Promotion Trust. A comprehensive set of learning objectives were defined and the experience of the learning exchange has influenced thinking around the need for more systematic approaches to scaling interventions in Indonesia⁸.

Closing the resource gap

91. Despite experiencing a high level of economic growth, Indonesia continues to rely on international sources for HIV financing. Additional funding from the national and district governments is needed to reduce the significant resource gap. The UN Joint Team has supported the development of an 'Investment Case' in 2013, which is being updated to enable its use to: i) inform the deliberations undertaken by the National AIDS Commission and other stakeholders in developing the new National Strategy and Action Plan for the years 2015-2019; ii) inform the government and stakeholders in their preparations for a Global Fund New Funding Model (NFM) concept note later in 2014; iii) leveraging on the roll-out of the universal health/ social protection scheme in 2014 to expand access to HIV treatment, and iv) make the case for increased funding for HIV either as part of or separately from the national health insurance scheme.
92. The development of a joint technical support plan for Global Fund implementation (completed in November 2013) with the country's four Principal Recipients for the HIV grant was also supported by the Joint UN Team.

Ending vertical transmission

93. Although still low, Indonesia has recorded an increase in the percentage of HIV-positive pregnant women who receive ARV to reduce the risk of mother-to-child transmission of HIV, rising from 4.6% in 2009 to 15.7% in 2011. Recent coverage estimates from modelling show a further increase to 26% (UNAIDS 2012).
94. Indonesia's efforts to scale-up PMTCT services coverage have been supported by the UN Joint Team. In particular, UNICEF supported the development of the PMTCT strategic action plan, together with the accompanying operational guidelines, which has incorporated the WHO-recommended approach of Provider Initiated Testing and Counselling, especially for those high priority districts. UNICEF has worked in partnership with the WHO and UNAIDS Secretariat to align support and focus at district level of this initiative to demonstrate the feasibility of providing antiretroviral treatment.

Preventing HIV among people who use drugs

95. A review of the Needle and Syringe Program, led by UNODC, was completed in November 2013⁹. Critical follow-up is required on implementing the recommendations on regulatory issues; service delivery; logistics and capacity building are actioned into 2014. UNODC has also successfully advocated for a new narcotics regulation focusing more on rehabilitating drug users instead of punishing them. Seven government bodies signed a Memorandum of Understanding underlining the preference for rehabilitation rather than prison for habitual drug users. The MoU was signed by officials from the National Narcotics Agency (BNN), the Health Ministry, the Supreme Court, the Attorney General's Office (AGO), the National Police and the Social Affairs Ministry.

⁸ S2S Learning Exchange Study Tour: Indonesia to India Report, NAC 2013

⁹ A Review of the Needle Syringe Program in Indonesia, UNODC 2013

96. The agreement will see the country form joint assessment teams of medical and legal personnel at national, provincial, municipal and regency levels to determine whether a suspect is a drug dealer or a user and therefore determine if they will be sent for rehabilitation or to prison. According to data from 2013, of the total 162,000 inmates and detainees nationwide, more than 54,000 had been convicted for drug offenses.
97. UNESCO was also successful in piloting a Comprehensive Reproductive Health module for young people held in detention centres, which was adopted by the National Family Planning Bureau and will be distributed to all juvenile detention centres.

Protecting the vulnerable

98. ILO and UNDP in coordination with the National AIDS Commission, provided support and advocacy to the National Social Security Scheme on Health (BPJS) Preparation Task Force in the integration of HIV into the BPJS, through regular meetings involving a number of other government institutions, and community networks representing key affected populations including people living with HIV. Results from the consultations will be used by the National AIDS Commission in formulating their HIV response in terms of social protection for people living with HIV and key affected populations. In addition, ILO and UNAIDS also held a CSO policy dialogue to disseminate information on BPJS, in order to increase community's advocacy capacity. Research by the Joint UN Team on HIV on 'Access and Effect of Social Protection Programs on Workers in the Informal and Formal Economies Living with HIV and Their Households' was conducted in 2014 in Malang, Surabaya, and Denpasar in collaboration with PLHIV, to identify key obstacles experienced by community groups in accessing social insurance programmes.

Engaging community and key affected populations

99. The Community Policy Dialogue Forum was established with support from the UNAIDS Secretariat to provide a platform for CSO and community groups to dialogue and address strategic policy issues. The forum is hosted by Atmajaya University and the Indonesian AIDS Coalition. Four Community Policy dialogue forums were conducted throughout 2013, covering issues which included: funding for the AIDS response after 2015; district and provincial funding for CSO work on AIDS; the National Social Protection Scheme and its coverage on HIV; and the rollout of the Strategic Use of ARV. The series will continue into 2014 with a steering committee established to better enable greater representation on the topics and to guide the development of advocacy papers and action plans.

Inclusion of young key affected populations

100. UNICEF supported the National AIDS Commission to undertake a secondary data analysis of the 2011 Integrated Biological and Behavioural Survey on HIV (IBBS) as the data was not disaggregated by age.¹⁰ The analysis showed that young key affected populations in Indonesia have a high prevalence of HIV infection (4–19 per cent) mirrored by a high prevalence of other Sexually Transmitted Infections, which are a risk factor for HIV transmission.

¹⁰ Issue Briefs: Access to HIV Services for Young Key Affected Populations in Indonesia, UNICEF Indonesia, 2014

101. Findings also highlighted that young key affected populations have the least access to information and services, with comprehensive knowledge below 50 per cent.
102. On efforts with broader youth both UNESCO and UNFPA worked with the Ministry of Education and civil society groups to adapt and implement the International Guidelines on Sexuality Education (ITGSE) in Indonesia.

Innovation through technology and social media

Social media uptake in Indonesia is growing rapidly. While only 29 per cent of Indonesians have access to the internet, mobile phone subscription penetration has already reached 100%. In addition, the prevalence of low-cost web-enabled phone plan options is conducive to relatively easy access to the internet through mobile phones, providing Indonesians with enormous social media opportunity. Last year Jakarta was named the number one Twitter city in the world, and for Facebook, Indonesia was the fourth most active country globally.

To leverage this opportunity, UNAIDS supported the Indonesian AIDS Coalition (IAC), a community organization of people living with HIV, to develop a mobile application known as AIDS Digital. The application enables online access to basic HIV information and to a directory of AIDS-related services through a smart phone. Basic features include HIV 101, Directory of Services with Address, Pictures, Call Service and GPS Location Map, with additional features to be added later to provide Drug Stock-out Alerts, Service Reviews and Ratings. The Ministry of Health, Health Promotion Directorate has officially adopted AIDS Digital as a tool for its communication campaign on HIV. MOH has provided direct access to download the AIDS Digital mobile application in its official website. Over 2000 downloads have been recorded in the application during the first few months.

Ending punitive laws

103. Stigma and discrimination, especially in healthcare settings, continues to discourage testing and treatment uptake, especially for key affected populations at higher risk to HIV (MSM, sex workers and their clients, and people who inject drugs). UNDP and UNAIDS Secretariat jointly supported the NAC's conduct of a national review (August - September 2013) and audit of legal barriers to HIV prevention, treatment and care. The report's findings were used as a basis for a national consultation, involving key stakeholders from across the country. The consultation led to consensus on the need to adopt, for instance, a more systematic approach that seeks to empower sex workers, involve local stakeholders and promote partnerships for delivering health services across Indonesia. UNAIDS advocacy has further helped to generate better coordination and education among government and law enforcements bodies. With UN support, the documentation of discrimination is also improving, which will help the National AIDS Commission monitor complaints and ensure laws are more effectively applied. "The UN provides us with 'a safe space' where we feel welcome and supported to carry out difficult and sensitive advocacy work," said one representative of the key affected populations.

Ensuring equal freedom of movement for people living with HIV

104. In February 2014, the Ministry of Education committed to review a 2009 Ministerial decree requiring foreign applicants for teacher visas to have an HIV test and ensure that the decree is not discriminatory or run counter to Indonesia's obligations under the

International Covenant on Civil and Political Rights. The commitment was formally made following active advocacy by the Ministry of Health, supported by the UN Country Team.

Supporting women and girls

105. In the area of gender equality, Indonesia has made considerable progress on a number of indicators that measure gender equality in the HIV response (UNAIDS 2012). The Scorecard on Gender Equality in the National Response documents the country's achievement and engagement of partners under the UNAIDS Agenda for Women, Girls, Gender Equality and HIV. It includes strategic markers, such as a gender sensitive audit of the current National AIDS Strategic Plan; the inclusion of a qualitative study on violence experienced by women living with HIV in 8 provinces; and current ongoing research into improving the existing gender-based violence referral system for women living with HIV and research on violence against sex workers in Indonesia, which serve as proxies for the strategic areas included in the Agenda for Women and Girls.

Integration of food and nutrition

106. With support of WFP, a thorough situational analysis on nutrition for HIV treatment and care in Indonesia revealed that nutrition was not widely recognized by healthcare workers or policy makers. A needs assessment in 2013 among Peer Educators revealed that nutrition related myths and misconceptions are common among people living with HIV. This resulted in the Ministry of Health convening a national multi-stakeholder workshop in 2013, to discuss the gaps identified and to develop action plans to integrate food and nutrition within the HIV response. Plans are underway to demonstrate the feasibility of integrating nutrition into an antiretroviral treatment programme.

Coordination and partnerships

107. The UN Joint Team on AIDS in Indonesia supported the National AIDS Commission in undertaking a Mid-Term-Review of the National Response to HIV and AIDS. The support enabled a comprehensive desk review of all key evidence based evaluations and reviews undertaken in the past 2 years. The findings are being used as the foundation for the development of the new National AIDS Strategic Action Plan 2015 – 2019 and will form the basis of the Global Fund New Funding Model submission in late 2014.

108. All of the work outlined was planned by the UN Joint Team in late 2012 and implemented through the Joint UN HIV and AIDS Support Programme in 2013, with key elements of the programme supported through the Unified Budget Results Accountability Framework (UBRAF).

Shaping post-2015 agenda and Indonesia's regional leadership role

109. At regional level, and as chair of the 2011 Summit of the Association of South East Asian Nations (ASEAN), Indonesia pushed for the regional bloc to commit to the vision of 'zero new HIV infections, zero discrimination and zero AIDS-related deaths', prompting all 10 ASEAN members to emphasize financial sustainability, national ownership and leadership. Indonesia has also taken an active part in supporting the post-2015 development agenda. The President of Indonesia was appointed by UN Secretary-General Ban Ki-moon to co-chair a high-level panel to help Member States and the UN system articulate sustainable development priorities beyond 2015. In March 2013, Indonesia collaborated with UNAIDS and other UN agencies to host a forum that focused on accelerating action on the Millennium Development Goals, through the theme of inequalities. The consultation resulted in a call from civil society to government to protect

the rights of people living with HIV from trade related decisions that reduce their access to affordable treatment, especially through counterproductive free trade agreements. The meeting also recommended greater community consultation in the HIV policy development process.

110. UNAIDS also supported Indonesia in its leading role in coordinating the implementation of the ASEAN cities project by supporting project monitoring and staffing to coordinate inter-country/city implementation.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UN ACTION

Challenges

111. An important element of the case study is to also highlight gaps or areas where the Joint Team on AIDS and UNAIDS Secretariat could further support Indonesia working towards stopping the HIV epidemic.

Programme management and implementation

- Increasing demand for services especially for testing and treatment. There is a need to enhancing the role of community health workers and CBOs to mobilise communities, increase demand for services, and facilitate adherence and compliance.
- Slow decentralization of HIV treatment services from large hospitals to the primary health care clinics at district level.
- Despite reasonably high levels of reported condom use at last sex, reporting of consistent condom use remain slow for both sex workers and men who have sex with men.
- Limited use of information technology (e.g. internet, SMS and social media) to reach “hard to reach” population sub-groups.
- Limited use of “task shifting” to extend the public health workforce, and limited health facility and community support mechanisms for patients on ART.

Stigma and discrimination

- Stigma and discrimination, especially in healthcare settings is a barrier to testing and treatment uptake, especially for key populations at higher risk to HIV (MSM, sex workers and their clients, people who inject drugs).
- Sensitivities (political, social, cultural, and religious) around condom use and frequent attempts by provincial and district governments to close sex work premises.

Decentralization

- Coordination and joint planning between government agencies and CSOs at district level to support the delivery of treatment, and prevention services needs further strengthening.
- Local level leadership and commitment to mounting effective and sustainable responses to HIV.
- The capacity of stakeholders to use data at sub-national level for planning and programme improvement is uneven and limiting the response.

Domestic resources

112. There has been a progressive increase of domestic funding which currently stands at 43%. However there is no guarantee that domestic funding will continue to increase until several structural barriers are addressed:

- District and provincial level budgeting for HIV depends on local level decision making. Greater efforts in mobilizing political support at local government level to invest in HIV will be required if these funds are to be realized and invested in HIV planning, budgeting and service delivery.
- District level funding is often not accessible to local level CSO groups supporting programming for key populations due to the restrictions presently in place which limit the use of local government funds by NGOs. These restrictions must also be addressed.

113. Despite increasing government allocations for HIV, the funding gap (net of government and external contributions) is expected to rise from US\$ 55 million in 2015 to US\$ 80 million in 2016 and US\$ 151 million in 2019. Additional funding from the national and district governments for prevention of HIV infection at 70% coverage is needed to reduce new infections by 2019.

Future actions

114. In order to contain HIV in Indonesia, the reach, integration and quality of HIV-related interventions must be increased further. The following are the priorities for action:

Decentralized and improved integration of services within health facilities, between health facilities, and with the community

115. Getting key interventions implemented in an integrated, efficient manner on a wider geographic scale, including at primary health care clinics and in community settings, is central to increasing service access and use.

Rapid expansion of treatment as prevention

116. In view of the limited success to date in increasing consistent condom use among key affected populations and the Government of Indonesia's unease in openly endorsing condoms as a key to HIV prevention, taking greater advantage of the preventive benefits of HIV treatment is required. However, in order for this approach to be effective, significant improvements will be required in (1) the coverage of HIV testing among key affected populations and other priority population sub-groups, (2) strengthened linkages between testing and CST services and (3) retention of patients on ART.

Increase HIV testing

117. Treatment as Prevention cannot be successful unless the number of persons tested for HIV in Indonesia is dramatically increased. This effort can be jump-started by focusing initially on increasing the rate of HIV testing among key groups of individuals that already have contact with the health system – recipients of STI services, TB patients, women receiving ANC services, and injection drug users receiving MMT and clean needles. Efforts could then be expanded to increase coverage of other important population sub-groups in community settings (e.g. partners of HIV-positive persons, clients of female sex workers). The ILO is planning to continue VCT@Work initiative at most affected workplaces, within the high prevalence areas of Indonesia, targeting areas

of high economic activity such as transport corridors, harbours, mines or plantations, where sex work hotspots exist.

Increase the intensity/quality of implementation

118. Quality and effectiveness of prevention and treatment services need to be improved in order to have impact on the epidemic. There is a need to document good practice and to develop a horizontal learning network of national learning sites (and centres of excellence) to promote inter-district learning on how to design and run effective prevention and treatment programmes. Eliminating stigma and discrimination in healthcare settings is also essential to increasing uptake of services.

Increase programme coverage among men who have sex with men and transgender

119. To date, national programme efforts directed to MSM and transgendered people have been sporadic, and under-funded. Reaching these groups in significant numbers with information and services is essential to national programme success, but will require “out-of-the-box” thinking, a strategy for expanding services at scale, and tapping into more reliable local sources of funding.

ISLAMIC REPUBLIC OF IRAN

INTRODUCTION

120. This case study provides an overview of the role of UNAIDS in Iran's AIDS response, describing how the contributions of the Cosponsors are coordinated, funded and managed through the Joint UN Programme and Team on AIDS. The study highlights successes in the national response, notes persistent gaps and challenges, and describes how UNAIDS can further contribute to reaching national priorities in Iran and achieving concrete results. The report concludes that:

- Iran has primarily focused effective prevention and treatment interventions on people who use drugs and other key populations in specific settings such as prisons and drop-in centres. Such initiatives have recorded important successes, and these service sites have also been used as entry points for scaling up HIV services more generally.
- The epidemic's early concentration among people who use drugs and other key populations has expanded, with the latest data indicating an increase in sexual transmission still mostly among key populations and their immediate contacts or acquaintances. In light of these trends, the response needs to be recalibrated in order to address the needs of the larger population groups. To limit HIV transmission, national authorities are working to scale up HIV services, a strategic move that needs to be accelerated to maximize impact.

BACKGROUND

121. While overall adult HIV prevalence in Iran is low 0.2%(0.1% - 0.2%)¹¹, more than 13 per cent of people who inject drugs are living with HIV. Measures taken over the past 10 years have slowed progression of the epidemic among people who inject drugs, although injecting drug use remains the most important factor fuelling the epidemic.

122. There is also evidence of the growing role of sexual transmission in the spread of HIV in Iran. For example, the proportion of registered cases attributed to sexual transmission steadily increased, with the prevalence of HIV among female sex workers reaching 4.5 per cent. Most female sex workers do not use condoms consistently. Sexual intercourse is not uncommon among people who inject drugs and is frequently unprotected. Evidence of high-risk sexual behaviour has also been observed in connection with the use of amphetamine-type stimulants, which is reportedly increasing.

123. The number of women living with HIV has also increased in recent years. The corresponding increase in the number of pregnant women living with HIV has resulted in an increase in the number of children living with HIV in recent years. Meanwhile, Iran has virtually eliminated HIV transmission through contaminated blood or blood products, with no case of HIV transmission reported in recent years, although existing control measures need to be strengthened and incorporate the latest technology.

124. There is limited information on HIV status of refugee substance users residing in Iran. However, available information indicates that the prevalence is very low and that for longstanding refugees in Iran, the epidemiology is similar to that of the nationals. Although prevention and care services for refugees are included in the national HIV

¹¹ UNAIDS report on the Global AIDS epidemic 2013

programme, there is room for improvement of culturally-relevant and context-appropriate prevention and treatment programmes for refugees.

125. The Government of the Islamic Republic of Iran's commitment to the AIDS response is reflected in its 2010-2014 National HIV/AIDS Strategic Plan, which is based on the "Three Ones" principles: one strategic programme, one coordinating institution, and one monitoring and evaluation framework. The budget for the AIDS response (US\$ 40,761,320¹² in 2010-2011) is largely financed by Iran's national government (88%), with development partners providing 11% of total financing. Iran is conducting a National AIDS Spending Assessment in 2014 to better align programme priorities and investments.

KEY HIV AND AIDS INFORMATION FOR IRAN

Population:	77,195,430
Estimated number of people living with HIV:	71,000
Estimated number of Adult aged 15-49 prevalence rate:	0.2%
Estimated number of Women aged 15 and over living with HIV:	19,000
Estimated number of Children aged 0–14 living with HIV:	N/A
Estimated number of Annual deaths due to AIDS	4,600
Estimated number of Annual new HIV infections	11,000
Orphans due to AIDS	N/A
Antiretroviral therapy coverage:	13%
Prevention of mother-to-child transmission coverage	N/A

UNAIDS Report on the Global AIDS Epidemic 2013

JOINT UN PROGRAMME AND TEAM ON AIDS

126. The United Nations system, under the umbrella of the 2012-2016 United Nations Development Assistance Framework (UNDAF), supports implementation of the 3rd National Strategic Plan (2011-2015). The national government's approach is designed to be multi-sectoral and multi-stakeholder, with the goal of reaching groups most at risk. The Joint UN Programme of Support focuses on five outcomes that are aligned with the UNDAF, the national HIV strategic plan and the UNAIDS Unified Budget Results and Accountability Framework.

127. The Joint UN Team in Iran unites all key UNAIDS partners working under the UNDAF HIV theme in the spirit of Delivering as One. Its membership comprises 17 professional officers from across the UNAIDS partners in Iran (11 agencies). The Joint UN Team is chaired by the UNAIDS Country Director (UCD).

¹² GARPR March 2012

128. The total UNAIDS budget for support through the UNDAF HIV Theme for 2012-2013 work-plan is US\$ 12,778,237 as distributed below between the global AIDS targets endorsed at the 2011 High-Level Meeting on AIDS:

Joint UN Programme of Support on AIDS for 2012-2013	% of overall budget
Reduce sexual transmission of HIV by 2015	39.4%
Eliminate new HIV infections among children by 2015	2.8%
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	2.4%
Eliminate gender inequalities	1.0%
Eliminate stigma and discrimination against people living with and affected by HIV	17.4%
Reduce new infections among people who use drugs	36.5%
Avoid TB deaths	0.5%

KEY ACHIEVEMENTS

129. UNAIDS has worked alongside the Government of Iran, civil society organizations and international stakeholders to strengthen the country's AIDS response.

Reductions in HIV prevalence among prison inmates and people who inject drugs following integration of harm reduction and other prevention strategies

130. Iran's harm reduction programmes, which operates both inside and outside prisons, has contributed to a reduction in HIV prevalence among people who use drugs, from 15.2% in 2005 to 13.63% in 2011. Among prison inmates, HIV prevalence has fallen from 3.2% in 1995 to 1.0% in 2012. More than 90% of people who inject drugs report the use of sterile injecting equipment the last time they injected. Prison-based harm reduction programmes include health and HIV education, HIV testing and counselling, methadone maintenance treatment (MMT), psychosocial support, life skills education and vocational training.

131. There are 580 community-based programmes, including Drop-in Centres which distributed more than 6 million free needles-syringes in the year ending September 2011. MMT coverage has increased steadily since the programme was launched at the beginning of the previous decade. As of September 2012, 4,249 MMT outlets were serving close to half a million people who use drugs.

132. The Joint Programme has worked to assist the government in achieving these major prevention gains. UNAIDS allocated HIC funding to harm reduction and, in collaboration with UNODC, supported conduct of piloting the package for spouses of drug users in five cities, meanwhile UNODC took forward the agenda by developing guidelines for female prisoners to improve harm reduction coverage. UNODC is also supporting four Drop-In Centres to provide harm reduction services to Iranian and Afghan refugees. In addition, UNODC has extensively supported capacity development of Drop-In Centres (development of training packages and organizing workshops) in different areas of harm reduction.

133. UNDP, administering the Global Fund grant, had, as of the end of September 2013, procured 6,384,600 needle-syringes, 6,729,600 alcohol pads, and 5,859,000 condoms.

These items were provided in the form of harm reduction packs to 4,107 people who inject drugs through 55 outreach teams, 22 drop-in and 10 sleep-in centres, which operate under the auspices of the State Welfare Organisation. UNDP is also supporting the delivery of after-release (i.e. after release from prison) MMT in five centres. Peer education programmes in prisons have so far reached 63,174 inmates and 18,984 family members as of September 2013. In addition to the harm reduction package, people who inject drugs who attended UNDP-supported centres are also able to access referral to HIV testing and counselling, First Aid, personal hygiene items, shower facilities, hot meals, and other subsistence needs.

134. UNHCR in collaboration with the government and two NGOs has made services available to refugee substance users, their families and communities. Special harm-reduction measures and strategies are jointly implemented through a variety of activities which include-but not limited to- provision of health services e.g. needle and syringe, condom, basic health/hygiene services; counselling and treatment; trainings on basic hygiene, safe injection, available treatment and care services, training of substance users and their family members about the prevention and treatment of sexually transmitted infections, including HIV, outreach programme including identification of hard-to-reach populations, provision of basic health services and referral to HIV service facilities; Drop-In Centres services e.g. provision of counselling, referral to Voluntary Counselling and Testing (VCT) centers, shelters, substance abuse rehabilitation centres, and provision of MMT.

135. In 2013, community-based harm reduction services were provided to 3,803 Afghan refugee substance users and their families who resided in 10 urban refugee populated locations in nine provinces. These beneficiaries benefitted from a wide range of services of community outreach teams.

Improved access to HIV and other health services for people living with HIV and other key populations

136. Antiretroviral treatment coverage is low, with only 13% of individuals eligible for treatment under the 2010 WHO guidelines receiving therapy in 2012. With the 2013 WHO consolidated antiretroviral guidelines substantially increasing the number of people eligible for HIV treatment, actual coverage is likely to be lower than the 2012 estimate. There are encouraging upward trends, with the number of people receiving antiretroviral therapy increasing from 1,486 in 2009 to 3,558 in 2012. Iran has primarily focused HIV treatment programmes on people who inject drugs and key populations. In this connection, UNODC conducted a needs assessment on access of drug users to HIV prevention and treatment services. The study later resulted in development of booklets for drug users to increase their information on services and facilities available.

137. Iran has expanded service access and contributed to stigma reduction through the creation of centres for voluntary HIV testing and counselling, vulnerable women centres, Drop-In Centres and Positive Clubs. Although primarily focusing on prevention and impact mitigation, these centres also provide care and treatment services and enable people living with HIV and key populations to obtain social services through a peer-to-peer approach. All services provided in these centres are free of charge for people living with HIV (PLHIV) and key populations. The Positive Clubs are also centres where some innovative approaches for patient navigation and retention are implemented, such as hotlines and SMS follow up as well as education through the web.

138. UNAIDS has worked to expand access to services for people living with HIV and key populations. UNDP, through the Global Fund grant, has since 2012 supported the regular provision of a package of sexual and reproductive health as well as harm

reduction services to 1,849 vulnerable women through 27 outlets, in collaboration with the State Welfare Organisation and Universities of Medical Sciences. UNDP procures 100% of second-line ARVs used in Iran, reaching 861 people living with HIV, and also provides for the treatment for 100% of pregnant women diagnosed with HIV.

139. The government, UNDP and UNAIDS collaboratively support 15 Positive Clubs that provide education, orientation and linkage to care, psychosocial support and vocational training for some 4 500 people living with HIV and their families. UNFPA assisted the Centre for Communicable Disease Control in establishing and developing service protocols for 10 women's centres, as well as in the development of educational packages on STI/HIV, training prevention of violence against sex workers, condom social marketing and STI management for staff of the women's centres.
140. UN partners are enhancing national capacity of provincial focal points and providers of services for young people through the development of curricula and training of master trainers. This effort has increased knowledge and skills of 45 master trainers from 20 medical universities, with the aim of expanding capacity-building of counsellors and clinicians in 225 voluntary testing and counselling centres.
141. In 2013, through partnership between UNHCR, government and NGOs, Mobile Centres (MC) provided comprehensive services to a total of 4,237 beneficiaries including MMT to 391 substance users, abstinence-based rehabilitation services to 441 beneficiaries, Needle & Syringe Program (NSP) to 1,685 refugees, Voluntary Counselling and Testing (VCT) referrals to 330 substance-users and distribution of 1,430 hygiene packages. In addition, 30,000 Information, Education, Communication (IEC) materials were distributed amongst refugee substance users and their families and 735 family members received training on HIV and Sexually Transmitted Infections (STI) prevention. The training provided in Mobile Clinic project is expected to lead to sustainable results and reducing HIV/STI transmission. Such collaborative efforts have attained a broader outreach to refugee substance users who are often amongst the hard-to-reach population in local communities.

An evidence-based approach

142. Evidence-based approaches across the various dimensions of the national response have improved the effectiveness of the national AIDS programme. There are signs of renewed commitment from the Government of Iran to improve strategic information and to take into account epidemiological and underlying behavioural factors in the formulation of national priorities. One of the more visible aspects of this work is the country's commitment to report timely and in accurate fashion on the state of its epidemic, within the framework of its international reporting commitments (e.g. Global AIDS Response Progress Reporting, Universal Access reporting, estimations and projections, etc.).
143. UNAIDS has contributed technically and financially to the National AIDS Programme's efforts to generate strategic information, primarily in the form of evaluation studies (e.g. testing and counselling; treatment and care) as well as secondary analyses such as modes of transmission and estimation/projection studies. Iran has used these findings to address epidemic drivers in its National Strategic Plan.
144. The country's evidence-based approach is reflected in the development of a number of guidelines, protocols and policy guidance, including with respect to positive prevention, HIV/TB, harm reduction, HIV care and treatment and prevention of mother-to-child transmission. For the push to eliminate new infections among children, UNICEF, UNFPA, UNDP, and WHO leveraged their resources to assist the national programme in developing normative guidance and in undertaking science-as-advocacy events like the

2012 International eMTCT Conference in Shiraz. Through this type of events, the Joint Team leveraged technical support from the Institute of Global Health at University College London, whilst the first-ever International HIV/AIDS Congress in Tehran was organised in partnership with Harvard Medical School and the International HIV Partnership, with important contributions from the International AIDS Society and the US National Institutes of Health.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UN ACTION

145. With the national response needing to expand beyond key populations to address the growing risks to the general population, it is important to build on the government's visible ownership of the social development agenda. Particular use should be made of the great potential for South-South cooperation in the Middle East and North Africa and beyond, including centres of excellence (e.g. in the areas of harm reduction, epidemiologic surveillance, and clinical sciences) in Iran.
146. Although Iran is classified as an upper-middle-income country, it still needs the UN support in view of the scarcity of bilateral and other multilateral organizations. The UNAIDS family plays an important advocacy and facilitating role for the development and implementation of HIV activities as well as for effective coordination and coherence of programmes.

Basic programme activities

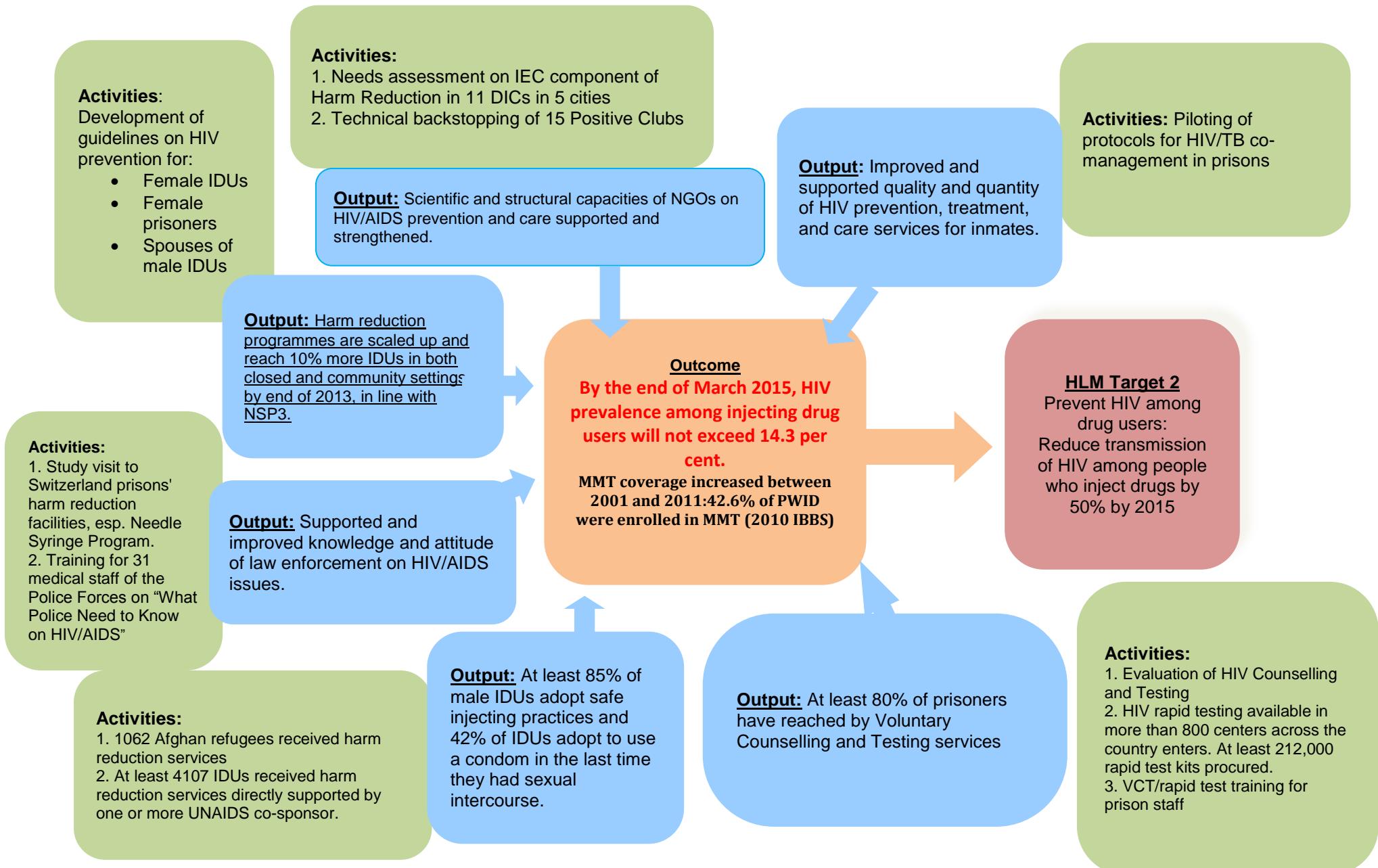
147. The national AIDS programme needs to invest even greater resources in mapping and programming for emerging dimensions of the epidemic, such as sexual transmission (and its possible association with the use of amphetamine-type substances), prevention of mother-to-child transmission and increasing antiretroviral treatment coverage. For example, immediate steps are needed to implement the national plan for the elimination of mother-to-child transmission. In addition, there is need to expand the scope and improve the quality of existing programme components, notably HIV testing and counselling, antiretroviral treatment and HIV/TB management, whilst maintaining the performance and effectiveness of current services, e.g. harm reduction. Particularly, bold steps have to be taken to increase treatment coverage to not only help the country throughout its long way toward its treatment goals, but also to support the national response with its prevention targets through reducing community viral load.

Critical enablers

148. Given the significant and commendable investment that the various partners in Iran make in generating knowledge relevant to the epidemic, the national response would benefit from a more dynamic approach to the monitoring and evaluation of the national programme, including periodic reviews of the National Strategic Plan based on the most up-to-date information. The government could mobilise a wide range of actors (public and private sectors and international organisations) to maximise the impact of an evidence-based national response. Sensitization and awareness raising among decision makers and general population will accelerate progress towards achievement of the Millennium Development Goals.
149. Appreciating the fact that Iran is making every effort to provide a wide range of non-discriminative services to people living with HIV and key populations, however ensuring access to better-quality services, specific interventions are needed to reduce and eliminate discrimination that sometime is experienced by people living with HIV and key populations seeking healthcare.

Results Chain of the Joint UN Programme on AIDS in Iran for the Methadone Maintenance Treatment

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JAMAICA

INTRODUCTION

150. This case study provides an overview of the role of UNAIDS in supporting Jamaica's HIV response, describing how the contributions of its various agencies are coordinated, funded and managed via the Joint UN Team and the Joint UN Programme of Support. The study highlights successes in the national response, in particular how UNAIDS contributes directly to the establishment of national priorities and achievement of concrete progress, as well as identifies the persistent gaps and challenges that need to be addressed. The report concludes that:

- Jamaica is making significant progress against the epidemic through strengthened prevention efforts, scaled-up HIV treatment and legal reviews and other actions to ensure that the national response is evidence-informed, gender-sensitive and human rights-based.
- While Jamaica relies heavily on external funding, national authorities have taken steps to reduce financial dependency and lay the groundwork for a more sustainable response. The country will need to continue working with partners to leverage strategic information and investment principles to implement a plan for long-term sustainability.

BACKGROUND

151. The Government of Jamaica has prioritized the response to HIV. Adult HIV prevalence (ages 15-49 years) is 1.7%, with an estimated 28,000 people living with HIV in 2012. The HIV epidemic in Jamaica is heterogeneous, with concentrated pockets in key and vulnerable groups, such as men who have sex with men, sex workers and prison inmates, as well as considerable transmission in the general population. The National HIV/AIDS Strategic Plan (2012–2017) guides the national response, prioritizing (a) prevention, (b) treatment and care and (c) an enabling environment and human rights. The Jamaican National HIV Programme (NHP) is charged with coordinating the national response, including building strategic partnerships with public, civil society and private sector institutions.

152. Preliminary reports for 2012 and 2013 indicate that total HIV spending in Jamaica amounted to US\$ 24.7 million and US\$ 26.3 million, respectively. The Global Fund is the largest source of HIV funding (US\$ 24.0 million), followed by UNAIDS (US\$17.8m, including World Bank support), and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (US\$5.1m). The Government of Jamaica reported US\$ 2 million for fiscal years 2012 and 2013. The on-going 2014 expenditure exercise will provide more details when finalized. Recent financial implementation data available (from 2010-2011) indicate that prevention represents the largest component of HIV spending (36.2%), with much of the spending geared towards "communication for social and behavioural change" targeting the general or young population, as well as programmes focused on sex workers and their clients, men who have sex with men and drug users. Treatment and care absorbed 27.7% of the spending, the bulk of which is accounted for by the cost of antiretroviral therapy (19%).

KEY HIV AND AIDS INFORMATION FOR JAMAICA

Population	2.8 million
Number of people living with HIV	28,000
Adults aged 15–49 prevalence rate	1.7%
Adults aged 15 and over living with HIV	28,000
Women aged 15 and up living with HIV	9,300
Children aged 0–14 living with HIV	N/A
Annual deaths due to AIDS	1,300
Annual new HIV infections	1,400
Orphans due to AIDS aged–17	N/A
Antiretroviral therapy coverage	69%
Prevention of mother-to-child transmission coverage	N/A

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JOINT UN PROGRAMME AND TEAM ON AIDS

153. In 2012, nine UN organizations¹³ were active members of the Joint Team, drawing on respective agency mandates and the UNAIDS Division of Labour. The Joint Team manages implementation of the Joint UN Programme of Support on AIDS, which is linked to the coordination structure of the United Nations Development Assistance Frameworks 2012-2016.

154. The Joint UN Programme of Support (JPS) has responded to five targets agreed at the 2011 UN High Level Meeting (HLM) on AIDS: a) reduce sexual transmission, b) eliminate new HIV infections among children, c) reach 15 million people with treatment d) eliminate gender inequalities, and e) eliminate stigma and discrimination.

155. Total expenditure in Jamaica by the Joint Programme in 2012-2013 was US\$ 7,692,143 allocated across the UNAIDS family as follows:

¹³ UNESCO, UNICEF, UNFPA, PAHO, IOM, UNDP, FAO, UN Women and the Secretariat.

Total expenditures by UN agencies (2012-2013)	
Agency	Core/Other AIDS funds
ILO	\$ 199,337
Secretariat	\$ 1,502,488
UN Women	\$ 267,611
UNDP	\$ 175,000
UNESCO	\$ 348,429
UNFPA	\$ 149,221
UNICEF	\$ 480,934
WHO	\$ 112,022
World Bank	\$ 4,457,101
Grand Total	\$ 7,692,143

The estimated distribution of these resources by HLM targets is:

Joint UN Programme of Support on AIDS for 2012-2013	% of overall budget
Reduce sexual transmission of HIV by 2015	10%
Eliminate new HIV infections among children by 2015	6%
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	63%
Eliminate Gender inequalities	11%
Eliminate stigma and discrimination against people living with and affected by HIV	10%

KEY ACHIEVEMENTS

156. Working collaboratively with the Government of Jamaica, civil society organizations and international stakeholders, UNAIDS recorded important achievements in the country's response in 2012-2013.

Substantial reductions in new infections among adults and key populations

157. Adult HIV incidence in Jamaica has declined by more than 50% between 2001 and 2012. To achieve this important milestone, Jamaica maintained a rate of mother-to-child transmission below 5%. HIV prevalence declined from 1.3% in 2007 to 0.9% in 2011 among antenatal attendees and from 9% in 2009 to 4.2% in 2011 among sex workers.

158. The UN Joint Team played an important role in Jamaica's progress towards the elimination of mother-to-child transmission, generating a renewed sense of shared responsibility. At the government's request, PAHO, UNICEF and the UNAIDS Secretariat led a multi-sectoral committee of technical partners that helped align national efforts with international standards, identify and help fill strategic information gaps, disseminate guidelines, strengthen national indicators and foster strategic partnerships.

159. The UNAIDS Secretariat, the UN Secretary General's Special Envoy for AIDS in the Caribbean, and the UN Resident Coordinator, among others, actively advocated for evidence-informed and human rights-based HIV prevention approaches. The Secretariat offices served as a safe space for groups of marginalized youth, faith-based leaders, civil society activists, and people living with HIV to openly articulate their needs, an approach that has strengthened cultivation of partnerships between different communities.

160. UNAIDS facilitated an enabling environment through support to the National Family Planning Board to develop guidelines and policies. These include the national action plan on women, girls and gender equality and HIV, national policy and planning frameworks on sexual and reproductive health and HIV linkages, guidance for integrating life skills in schools, and the development of Caribbean-specific guidelines for Family Planning, the first health sector action plan on sexual and reproductive health and HIV in sex work settings, and integration of human rights issues in national development plans and budgets.
161. PAHO, the UNAIDS Secretariat and UNICEF spearheaded the support to the government to assist in coordination of partners. For example, the multi-agency eMTCT task force helped the government plan eMTCT scale-up. Through UNICEF technical and financial support, the Ministry of Health has incorporated the Mentor-Mom programme managed by a civil society organization, Eve for Life, into its programme on prevention of mother-to-child transmission. The Mentor-Mom programme aims to provide peer support and referral services to adolescents and young mothers to facilitate scaling up early infant diagnosis and paediatric treatment, and to disseminate information on breastfeeding options and guidelines for mothers living with HIV.
162. UNESCO, UNICEF, UNFPA and ILO supported the Ministries of Education, Youth and Culture and Health to increase young people's access to comprehensive sexuality education. Guidelines and tools were developed to enable school personnel to assess and refer students in need of sexual and reproductive health (SRH) services and commodities to appropriate client-friendly health and social services. Through enhanced outreach by field officers, approximately 20,000 adolescents have improved access to information on healthy lifestyle choices, including information for the prevention of HIV and STIs. Capacity building efforts enabled an estimated 10,000 providers of services to children and adolescents to provide quality referral services for key affected groups of adolescents and young people. Health care providers were trained in the provision of client-centred, youth-friendly sexual and reproductive health services. UNAIDS supported the Ministry of Education to enhance Health and Family Life Education and to improve prevention commodity access for key populations. The Ministry of Labour and Social Security launched the National HIV Workplace Policy, based on the principles of the ILO Recommendation Number 200 and the ILO Code of Practice, and ILO provided technical support to the ministries to promote implementation of the policy among businesses in the food industry.
163. Drawing on evidence regarding the effectiveness of cash transfers in reducing HIV risks among young people, the World Bank provided financial support for a cash transfer programme for people living with HIV, facilitating their access to treatment, care and support. The World Bank collaborated with the Secretariat to generate an evidence-based analysis regarding the sustainability of the national AIDS response.
164. World Bank assistance also enabled the government to strengthen prevention interventions, especially among key populations. The coverage of sex workers and men who have sex with men reached through prevention activities was at 79.6% (2011) and 86.9% (2011) respectively. A vast majority (88%) of sex workers reported using a condom with their most recent client in 2011.
165. UNAIDS also aided Jamaica in strengthening prevention programming for young people, including a training initiative for 50 youth leaders in the use of social media for advocacy campaigns in their communities. With technical and financial support from the UNAIDS Secretariat, Colour Pink Group developed and implemented a capacity building project to empower young, mostly homeless men who have sex with men and sex workers to protect themselves from HIV infection and to acquire vocational skills.

Increased human rights advocacy and awareness

166. The Joint UN Team advocated for the revision of the legal framework and the national HIV policy to specifically address populations at higher risk of HIV transmission and vulnerable groups such as adolescents. Joint technical and financial support by UN partners resulted in the development and implementation of a new strategy for men who have sex with men, a human rights costing tool, gender assessment tool, a tool to assess the legal framework, and the Stigma Index. Support provided for the development of the National Strategic Plan (2012-2017) generated increased national debate regarding the human rights of men who have sex with men. With UNAIDS support, the government has embraced a human rights approach to the AIDS response.
167. The Jamaica Stigma Index Study (2013), which will be launched in 2014, involved about 500 people from all four health regions. The study found that nearly 40% of participants had experienced some measure of stigma and discrimination, and that people living with HIV are significantly more likely to communicate their HIV status to spouses, health workers, social workers, or adult family members than religious or community leaders, and women are more likely to report experiencing physical harassment or physical violence.
168. The Joint UN Team's engagement and advocacy with governmental and civil society partners resulted in important legislative advances. When an Anti-Homosexuality Law was proposed, UNAIDS helped mobilize civil society and issued statements stressing the importance of upholding and respecting the human rights of all people. UNAIDS worked with civil society to engage parliamentarians and the general public regarding a 'conscience vote' that parliamentarians will take in the near future and also helped persuade the Cabinet to establish an inter-ministerial committee to propose legal and policy changes to enhance young people's access to sexual and reproductive health services. The Secretariat assisted civil society in developing a proposal for the establishment of a human rights observatory, which will assist in documenting human rights violations and advocacy for a human rights-based approach. The Joint UN Team has developed a communications strategy to engage parliamentarians over a four-year period on human rights issues, aligned with the Justice for All programme initiated by the UN Secretary-General's Special Envoy for AIDS in the Caribbean.
169. UN partners supported an assessment of HIV-related laws and policies against international commitments by the government regarding HIV and human rights. The assessment identified gaps in laws, policies, programmes and research and described how these weaknesses affect access to treatment and prevention services for key populations. Drawing on international best practices, the report recommended changes in critical areas. The plan of action on legal reform was completed and disseminated to a range of national partners committed to the elimination of stigma, discrimination and punitive laws.

Greater focus for gender issues on the national political agenda

170. The government released its National Policy for Gender Equality in 2011, reflecting robust government support for gender-based approaches. The same year, thanks to advocacy interventions in the UN programme, a bipartisan political declaration to eliminate stigma, discrimination and gender inequality was signed by the Prime Minister. The government also led a gender assessment of the National HIV Programme and has initiated a process to finalize a GenderBased Violence Strategic Action Plan.

171. UN Women supported leadership and advocacy of women living with HIV through sensitization and training workshops for women living with HIV, business development and education grants, and advocacy development for women living with HIV. High-level dialogues organized by Jamaica AIDS Support for Life (JASL) generated 47 declarations of HIV commitment from key actors (including media, parliament members, faith-based organizations, women's organizations, and cultural leaders) to reaffirm their decision to participate in the response to HIV and AIDS and raise awareness. According to JASL, ten of the 47 commitments have been fulfilled.
172. An evaluation, supported by the UN Women-EC programme, found greater commitment and action on gender equality and HIV at the national level, with informants citing the Prime Minister's support for the 2011 declaration as a key milestone towards a more gender-based response. Women living with HIV participated in consultations for the development of the National HIV/AIDS Strategic Plan, which the UNAIDS Secretariat leveraged to help mainstream gender into the HIV programme. A gender budget analysis of prevention and policy programming has been undertaken, although the National AIDS Programme has yet to follow up on these findings due to commitments associated with the merging of the National AIDS Programme and the Family Planning Board.

A continuing upward trend on treatment access

173. Antiretroviral treatment coverage rose from 53% in 2009 to 69% in 2012 (under the previous 2010 WHO treatment guidelines). Under current treatment guidelines released in 2013, which significantly increased the number of people eligible for antiretroviral therapy, HIV treatment coverage is considerably lower.
174. The World Bank provided loan support to enable the national programme to procure antiretroviral drugs for pregnant women living with HIV and for treatment of people living with HIV. The World Bank supported training of health staff on HIV treatment issues.
175. World Bank support strengthened diagnostic capacity of the health system (laboratory equipment with CD4 viral count capability) and efficient integration of information between laboratories and health facilities. CD4 technologies are being used at major points of care, but additional work is needed to increase capacity for viral load monitoring. The World Bank loan has expanded the availability of CD4 count machines, reducing turnaround time for HIV-related diagnostic tests from an average of 20 days to within 1 day, which has reduced costs and facilitate earlier initiation of HIV treatment.

Championing sustainability of HIV financing and eliminating parallel systems

176. With the strong support of UNAIDS, Jamaica has begun planning for a sustainable response. The Secretariat provided technical and financial support for the completion of a Modes of Transmission Analysis, the National AIDS Spending Assessment and an analysis of financial sustainability. Jamaica has used this strategic information to review its National Strategic Framework and to develop a sustainability framework and an investment case. With its investment case identified as a best practice, Jamaica hosted key meetings that enabled more than 100 stakeholders to discuss issues pertaining to sustainability, including a regional meeting on investment and sustainability as well as the UNAIDS/Lancet Caribbean Dialogue.
177. An important element of sustainability is improving the strategic focus of national programmes to increase value for money. Although transmission among men who have sex with men and sex workers is a significant factor in the country's HIV epidemic, the country allocated only 1.4% of HIV spending in 2010–2011 to programmes focused on these key populations. Using comparative cost-effectiveness data, developed with the

support of UNAIDS, to inform its planning for 2012 to 2016, Jamaica is increasing the proportion of HIV resources allocated to programming for men who have sex with men and sex workers to 6.4%.

178. To advance the HLM commitment to eliminate parallel systems, UNAIDS' advocacy efforts played an important role in the decision to merge the National HIV Programme and the National Family Planning Board. This move will facilitate the integration of HIV and sexual and reproductive health and promote synergies between the AIDS response and other social and development programmes. With UNAIDS' support, HIV has been integrated in the long term National Development Plan as a development issue, which is projected to yield savings of more than US\$ 700,000. The country is also exploring linking HIV to primary health care and non-communicable disease programmes.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UN ACTION

179. To build on its important gains in the response, Jamaica will need to continue its efforts towards achievement of universal access for HIV services. Ensuring an enabling environment that is grounded in human rights will be critical for future success. To reduce dependence on external donors and to sustain gains over the long term, effective mobilization of external resources will be critical.

Basic Programme activities

180. Urgent efforts are needed to increase focused and evidence-based interventions for key populations and adolescents. Jamaica's decision to increase funding for programming for key populations is an important first step towards a robust response for the populations most at risk.

181. Jamaica is on track to eliminate new infections among children. To eliminate mother-to-child transmission, the Joint Programme must continue to support Jamaica to address the identified gaps in system design and service delivery, including diagnosis, procurement of antiretrovirals and reagents for steady and sufficient supply.

182. Jamaica's heavy reliance on external financing remains cause for concern. Although domestic funding for HIV is increasing, the country faces an average annual funding gap estimated at US\$ 9 million. Any further shortfalls, such as an anticipated reduction in external financing over the next two years, could seriously impede efforts to deliver life-saving HIV services. The UN will continue to support the government in gaining efficiencies (e.g. Integration of services) and completing and operationalizing a sustainability plan.

183. The UN will support continued institutional capacity building for prevention and treatment activities of key service providers, including those in the health and education sectors, to increase sexual and reproductive health knowledge and deliver client-friendly sexual and reproductive health services to adolescents and youth.

Critical enablers

184. Criminalization of private, consensual same-sex sexual acts, sex work, and drug use perpetuates stigma and discrimination against the most vulnerable populations and impedes their access to HIV-related and other health information and services. Jamaica will require continuous support to address these legal and policy issues to ensure justice for all especially people living with HIV and other key populations at greater risk of HIV infection. The UN family should intensify its investment in advocacy and technical

assistance for legislative and policy reform to build on the evidence already generated through substantive reviews. Efforts are also needed to increase awareness of key populations and people living with HIV of their legal rights and to invest in strengthening legal services and social protection for people living with HIV and key populations.

185. There is a persistent and widespread belief in Jamaica that HIV is a ‘disease of homosexuality’ and that a human rights approach involves acceptance of homosexual behaviour. These perceptions are often reinforced by religious and cultural activists. Critical investments are needed in public education and an anti-discrimination campaign involving faith-based and cultural leaders, community-based organizations and the judicial system.
186. Confronted with a steadily increasing bill for antiretroviral medicines, Jamaica has committed to reducing costs for first-, second- and third-line antiretroviral medicines. Jamaica determined that improved forecasting would reduce antiretroviral medicines costs by 10%, in part by averting expensive emergency orders and preventing expiry of medicines within inventory stock.
187. The high debt-GDP ratio is crippling government efforts to make advances in the implementation of its development agenda. With a tight fiscal space, there is little room for investment. Furthermore, under conditions imposed by the International Monetary Fund, Jamaica is unable to borrow funds from the international market until the debt-GDP ratio is reduced. These challenges are further compounded by a likely reduction in external support for social programmes, stemming from Jamaica’s classification as a middle-income country. Innovative ways to mobilize new resources and raise domestic funding will be needed.

Synergies

188. While HIV integration and synergy with wider development programmes is advancing well, successful completion of this process will require sustained political commitment and investment. Specific additional advocacy work will be required to ensure that other health and development programmes incorporate HIV-related priorities in their activities.
189. Jamaica will continue to need the assistance of UNAIDS to address the growing challenge posed by gender-based violence. Sexual violence appears to be the most common form of gender-based violence in Jamaica and has been on the increase for over a decade. Available statistics indicate that youth constitute roughly 50 % of the offenders and victims of sexual violence.

UKRAINE

INTRODUCTION

190. This case study provides an overview of the role of UNAIDS in Ukraine's AIDS response, describing how the contributions of the Cosponsors are coordinated, funded and managed through the Joint UN Programme and Team on AIDS. The study highlights the successes in the national response, notes persistent gaps or challenges, and describes how UNAIDS can further contribute to national priorities in Ukraine and achieve concrete results. The report concludes that:

- HIV prevalence among people who inject drugs (PWIDs) has declined, and Ukraine is close to virtually eliminating mother-to-child HIV transmission. Early adoption of internationally agreed standards and an effective integration of HIV/AIDS interventions with other health activities have been critical for these achievements.
- HIV prevalence among PWIDs remains high, especially in cities, with more than 30% of PWIDs living with HIV in some settings. Specific prevention and treatment strategies are needed for hard-to-reach individuals in cities and prisons settings. Other key populations such as sex workers (particularly those who are using injectable drugs) and MSM will be included in these efforts. The UN system has a critical role to play in providing strategic information and best practices.

191. This document was prepared at the beginning of 2014 when the political situation at the country level was quite different: since then, the political turmoil and economic challenges Ukraine is facing raises serious concerns regarding the sustainability of public funding for the HIV response. Unrest in Eastern Ukraine, safety and security concerns, and the wave of internally-displaced persons, including from Crimea region, further threaten gains in controlling the HIV epidemic. Following the approval of the Law on occupied territories that prohibits *inter alia* financial transfers to Crimea from mainland Ukraine, there are major concerns regarding the continuation of HIV prevention, treatment and care services that have been funded from the Global Fund grant in the region, covering 19,667 representatives of the most vulnerable populations in 2013 (including people who inject drugs and people who use non-injecting drugs, sex workers, men having sex with men, and street children). OST services in the Crimea region have reportedly been suspended in line with Russia's stance against methadone and buprenorphine-assisted drug dependency treatment.

BACKGROUND

192. With an estimated 230,000 people living with HIV, Ukraine has one of Eastern Europe's most serious HIV epidemics. While overall adult HIV prevalence is 0.9%, much higher prevalence has been reported among PWIDs (21.5% in 2011), sex workers (9.0% in 2011) and men who have sex with men (4.2% in 2011). These key populations account for the bulk of new HIV infections.

193. Ukraine's epidemic is undergoing a transition, with new infections increasingly resulting from sexual transmission, primarily involving people of working age. However, injecting drug use remains one of the key factors in the epidemic. HIV prevalence among PWIDs declined from 22.9% in 2009 to 21.5% in 2011.

194. Women comprised 45% of all adult people living with HIV in 2012. HIV prevalence among pregnant women fell from slightly over 0.5% in 2009 to just under 0.5% in 2012. Through implementation of its national strategy to reduce new infections among children, Ukraine has achieved high coverage of prevention of mother-to-child transmission and effectively encouraged HIV-positive women to avoid breastfeeding their newborns.¹⁴
195. Antiretroviral treatment coverage remains inadequate, with only 26,720 people living with HIV, including 2,268 children receiving treatment by end 2012. The Ukraine public sector covered costs for the vast majority (22,216) of people requiring or eligible for treatment, with the remainder covered by the Global Fund Round 6 award.¹⁵ The vast majority (22,216) were treated through the state budget and the rest were covered by the Global Fund Round 6 grant.¹⁶

KEY HIV AND AIDS INFORMATION FOR UKRAINE

Population:	45,600,000
Number of people living with HIV:	230,000 [190,000 – 270,000]
Adults aged 15–49 prevalence rate:	0.9% [0.7% - 1.0%]
Adults aged 15+ living with HIV:	230,000 [190,000 – 260,000]
Women aged 15+ living with HIV:	95,000 [80,000 – 110,000]
Children aged 0–14 living with HIV:	N/A
Annual deaths due to AIDS:	18,000 [15,000 – 22,000]
Annual new infections:	11,000 [7,500 – 15,000]
Antiretroviral therapy coverage:	41% [36%-46%]
Prevention of mother-to-child transmission coverage¹⁷:	N/A

UNAIDS Global Report 2013

JOINT UN PROGRAMME AND TEAM ON AIDS

196. HIV is a priority theme in the Government of Ukraine – United Nations Partnership Framework 2012-2016 (UNDAF) for Ukraine. The key HIV goal of the UNDAF for Ukraine is to provide coherent and unified support, and to leverage UNAIDS funding to achieve universal access to prevention, treatment, care and support, in line with the Government's commitments to the targets set forth at the 2011 UN General Assembly High-Level Meeting on AIDS (HLM).
197. The Joint UN Programme coordinates individual and collective work of the resident and non-resident UN organizations. The Joint UN Programme, which articulates the UN system's practical support in implementation of the Three

¹⁴ Ukraine harmonized AIDS and response progress report

¹⁵ National estimates on HIV in Ukraine

¹⁶ www.kff.org

¹⁷ www.unaids.org

One's principles, aligns with Ukraine's Millennium Development Goals for 2015, the National AIDS Programme (NAP) 2014-2018, the Global Fund grant-supported programmes on AIDS and TB, the National Targets for Universal Access. The Joint Programme also aligns with the 2011 Political Declaration on HIV and AIDS, the UNAIDS Strategy for 2011-2015, and the Unified Budget, Results and Accountability Framework (UBRAF) for 2014-2018. The Joint Programme harmonizes its work with other development partners, including the Partnership Framework between the Government of the United States of America and the Cabinet of Ministers of Ukraine on Cooperation in Countering HIV/AIDS 2014-2018.

198. The UN work plan focuses on several priority areas: universal access to harm reduction services for people who use drugs and prisoners; reducing sexual transmission; elimination of mother-to-child transmission of HIV; access to treatment; enabling laws, policies, practices and systems, reduction of stigma and discrimination, gender equality and protection of human rights.
199. In 2012-2013, UNAIDS expenditure in Ukraine amounted to US\$9,728,184. The amount budgeted for the 2012-2013 biennium was distributed according to the HLM targets set for 2015 as shown below:

Joint UN Programme of Support on AIDS for 2012-2013	% of overall budget
Reduce sexual transmission	27%
Reduce transmission among people who use drugs	6%
Eliminate new HIV infections among children	13%
15 million accessing treatment	4%
Eliminate gender inequalities	6%
Eliminate stigma and discrimination	6%
Strengthen HIV integration	36%

KEY ACHIEVEMENTS

200. Working alongside the Government of Ukraine, civil society organizations and international partners, UNAIDS made important contributions to the national AIDS response.

Important prevention gains for PWIDs

201. The number of new HIV cases among PWIDs declined from 7,009 in 2007 to 5,847 in 2013.¹⁸ HIV prevalence among PWIDs has fallen by nearly two-thirds, from 61.2% in 2007 to 21.5% in 2011 and more specifically HIV prevalence among PWID under the age of 25 years has decreased from 25.5% to 9.7% in 2013.^{19,20}

¹⁸ UN country office

¹⁹ www.aidsinfo.org

²⁰ WHO Good Practices in Europe. HIV prevention for People Who Inject Drugs implemented by the International HIV/AIDS Alliance in Ukraine. Updated as of April 2014

202. Although injecting drug use remains a driving factor in the epidemic, gains in reducing the epidemic's burden among PWIDs are considerable.
203. Ukraine has taken active steps to ensure access to evidence-based prevention methods for PWIDs. The proportion of PWIDs who reported receiving HIV testing over the last 12 months rose from 26% in 2009 to 35.7% in 2011. The share of PWIDs who report practicing safe injecting methods rose from 87% in 2009 to 95.5% in 2011.²¹ At the service level, annual coverage of low-threshold services for PWIDs (i.e. harm reduction-based health care centres specifically designed for people who use drugs) increased from 32% in 2009 to 63% in 2013, within range of the UN's recommended coverage of 60% and one of the highest coverage rates in Eastern Europe and Central Asia.²²
204. Ukraine prioritizes opioid substitution therapy (OST) – both to manage opioid dependency among people living with HIV and to prevent new HIV infections. Opioids are the most frequently injected drug in Ukraine, and most PWIDs living with HIV are opioid users. Revised HIV-related regulations specifically recognize PWIDs' right to medical treatment, while the previous NAP identifies a national target of reaching 20,000 opioid-dependent people with OST. In the first year of the previous NAP, OST utilization doubled, with the number of OST patients rising from 160 in 2006 to 8,614 at the end of 2013.²³
205. UNICEF launched an innovative and comprehensive model of HIV prevention, care and support for young female sex workers, people who inject drugs and other vulnerable street-involved youth in Zaporizhzhya, Ukraine. The model strengthens outreach, services, and competencies of NGOs involved in HIV prevention programme implementation. Through a pilot project UNICEF generated evidence and guidelines on prevention of mother-to-child transmission among PWIDs. Due to the joint efforts of UNICEF and UNAIDS, Ukraine has prioritized elimination of new infections in children born to pregnant women who inject drugs.
206. WHO supported trainings to enhance integrated services for PWIDs living with HIV, with the aim of improving communication and presentation skills of specialist instructors in the country's OST programme. Trainings have been systematically conducted across all 27 regions of Ukraine by neurologists, physiologists, social workers, and other specialists in OST treatment, increasing national capacity to provide comprehensive care and treatment for individual's comorbidities.
207. UNODC supported the Government to develop and endorse the National strategy for countering drugs for 2014-2020 that encourages a shift from repressive measures to a more human right-based and evidence-informed health-oriented approaches in drug control policy, promotes comprehensive harm reduction programmes to address HIV challenges related to injecting drug use.

²¹ www.aidsinfo.org

²² WHO Good Practices in Europe. HIV prevention for People Who Inject Drugs implemented by the International HIV/AIDS Alliance in Ukraine. Updated as of April 2014

²³ UN country office

208. UNODC, in cooperation with the Ukrainian Institute on Public Health Policy and State Penitentiary Service, supported the development and implementation of an OST strategy in prison settings. The authorities of the penitentiary service, especially the medical department, considered the recommendations in their plans for reorganization of the medical sector in prisons. In that line, Ukraine was supported by the same organization to mainstream and integrate HIV related services including OST into the state-run drug dependence treatment services system. Technical support is provided to update post-graduate training curricula for drug dependence treatment physicians in line with the internationally recommended model programme. 30 trainers from the medical schools and post-graduate trainings institutes have been trained on evidence-based contemporary drug dependence treatment including OST.
209. UNODC conducted a series of advocacy and capacity building activities to raise awareness among law enforcement officials and promote comprehensive harm reduction programmes for PWIDs. More than 100 law enforcement officials and officers have been trained on HIV and harm reduction issues.
210. UNODC contributed to the development and endorsement of the revised and updated draft of the Government's Decree #333 on regulations of the use of controlled drugs for medical purposes in health care facilities, approved on 13 May 2013. The decree establishes staff- and patient-friendly rules for the use of narcotic drugs in medical facilities. UNODC also contributed to the development of an official Ministry of Health order that endorses rules and regulations for OST, clearly defining responsibilities of state and local governments regarding the planning, reporting and evaluation of OST.
211. UNODC gender sensitive initiative Women-for-Women exceeded the intended coverage for marginalised women; during the six months, 2,036 women (vs. 1,500 planned) received services through the W4W initiative. The W4W projects resulted in providing comprehensive, quality HIV services closer to women, offering access to a range of resources and care and thus addressing the multiple barriers vulnerable women encounter when seeking help and following thorough treatment. Multi-sectoral partnerships and local government involvement are crucial to scale up and sustain the efforts and to fully mainstream gender-sensitive approach into the local service delivery structures.
212. Capacity of civil society partners was enhanced to provide effective and quality harm reduction services for PWIDs. UNODC facilitated technical inputs to support Network of the Resource and Training Centres on HIV. Assistance provided to develop specific guidelines, training of the trainers and consultants of the Resource and Training Centres.
213. UNFPA provided technical support for effective integration of Reproductive Health, Family Planning and STI services for women who inject drugs and their sexual partners in three regions: Kiev, Nikolayev, and Kirovograd. UNFPA supported an assessment of existing chains of service provision to women who inject drugs and their sexual partners, and developed an algorithm for service delivery chain for the target populations, which increased the capacity of governmental and NGO partners to deliver integrated services.
214. Based on the assessment of the system of management and provision of HIV prevention, treatment, care and support services to key populations in Odessa city UNDP developed and launched the on-line client assessment tool of HIV

related services. It led to efforts in building new partnerships across the private sector, civil society, academia and government institutions to not only increase service delivery but also develop new approaches to improve the quality of HIV services.

215. UNFPA, jointly with WHO, initiated work on introduction of syndromic approach to STI treatment, as an effective way of HIV prevention among most at risk groups (including PWID). For this, a cascade of training workshops was conducted for dermatologists from regional STI and AIDS centers. As a result, medical doctors from all 27 regions of Ukraine were advocated on using a syndromic approach in STI treatment and obtained basic skills on the necessary protocols to be used in the future in their medical practice for STI treatment.

216. ILO provided technical support to the government, employers and trade unions in development and adoption of the National Tripartite Cooperation Strategy on HIV/AIDS in the World of Work for 2012-2017 under the aegis of the National Tripartite Socio-Economic Council. Within a project in Cherkassy and Kyiv regions of Ukraine, ILO supported development and implementation of HIV workplace programmes at 13 enterprises employing about 10 thousand workers. The programmes are based on the provisions of ILO Recommendation concerning HIV and AIDS and the World of Work, №200, 2010 and focused on reducing HIV-related stigma and discrimination at work.

Virtual elimination of mother-to-child transmission

217. HIV prevalence among pregnant women decreased from 1% in 2001 to 0.5% in 2011. As Ukraine has scaled up prevention services for pregnant women, the rate of mother-to-child HIV transmission declined from 27.8% in 2001 to 3.7% in 2011.²⁴ The country has the highest coverage of PMTCT services in the Eastern Europe and Central Asia region, including a very high proportion of HIV-positive pregnant women receiving ARV prophylaxis (96.2 % in 2013). Nearly all (94.1% in 2013) of HIV-exposed children have access to Early Infant Diagnostics of HIV using polymerase chain reaction testing.²⁵

218. Several factors have contributed to the success of the programme to prevent mother-to-child transmission. Prevention programmes were fully integrated into standard maternal and paediatric health amenities. In addition, the NAP extensively promoted capacity-building since the introduction of the national programme to prevent mother-to-child transmission in 2001. Education on prevention of mother-to-child transmission has been integrated into the curriculum of all the medical educational institutes in Ukraine.²⁶

219. Children born to HIV-positive mothers are provided with a free breast milk formula. Counselling of HIV positive mothers on feeding newborns has been integrated into the framework of current normative and legislative documents and practice by medical staff of the AIDS Centres at reproductive health facilities (e.g. maternity hospitals, antenatal clinics, centres for family planning, etc.).²⁷

²⁴ www.aidsinfo.org

²⁵ Ukraine harmonized AIDS and response progress report

²⁶ Ukraine harmonized AIDS and response progress report

²⁷ Ukraine harmonized AIDS and response progress report

220. UNICEF advocacy and technical assistance resulted in the development of a new national clinical guideline/protocol on antiretroviral therapy for children living with HIV, which was distributed among healthcare specialists. An assessment of the situation in Early Infant Diagnosis of HIV (EID), initiated by UNICEF, revealed gaps in coverage and timeliness of identification of HIV-infected children and generated evidence for the introduction of Dry Blood Spot (DBS) technology. UNICEF collaborated with the Ukrainian Ministry of Health on introduction of DBS method for EID into all maternities. With 98% of HIV-positive women delivering at hospitals, this will facilitate universal access to EID for children 48 hours after delivery, leading to timely initiation of treatment and improved survival. The new NAP formally supports DBS EID. It is projected that national scale-up of DBS will benefit more than 4,000 children born to women living with HIV every year. The DBS method has been piloted in six oblasts of Ukraine. The National Academy of Postgraduate Medical Education has approved an education programme and training on DBS, developed with UNICEF Regional Office for CEE/CIS technical assistance, and included it as part of its institutional training curriculum. UNICEF also assisted in strengthening knowledge and building capacity of paediatricians and family physicians at primary level health facilities to ensure that HIV-positive children have access to up-to-date and quality care, treatment and support.
221. WHO assured on-going technical assistance in developing of the new protocol for the prevention of mother-to-child transmission. WHO assistance has strengthened scale-up of antiretroviral therapy for eligible women, including provider-initiated testing and counselling principles as a routine component of the package of care in antenatal, childbirth and postpartum care settings. WHO also assisted in the development of a new national antiretroviral clinical guideline for children living with HIV.
222. The UNAIDS Secretariat brokered funds and provided technical support in the development of the review of the Prevention of Mother-To-Child Transmission programme and for prevention services to pregnant women who inject drugs. The NAP for 2014-2018 integrated recommendations of the review, as well as results from UNICEF's pilot model of prevention services for HIV-positive pregnant women who inject drugs.

A doubling of antiretroviral treatment coverage

223. Antiretroviral treatment coverage in Ukraine increased from 26% in 2011 to 41% in 2012.²⁸ The NAP 2014-2018 establishes the goal of providing treatment services to at least 80% of treatment-eligible individuals by 2018. The country is attempting to achieve this goal through on-going decentralization of HIV treatment services. Altogether, 145 sites offer antiretroviral therapy. Although treatment coverage remains sub-optimal, the sharp increase in coverage in 2012 indicates that Ukraine is moving in the right direction.²⁹
224. WHO provided active technical support in developing the national strategy on antiretroviral treatment scale-up, with a particular focus on treatment optimization and HIV testing and counselling. WHO and UNAIDS worked to align national treatment policy with WHO treatment guidelines, assisting Ukraine in including recommendations for early treatment of people living with HIV using fixed-dose combination regimens. With WHO support, Ukraine has expanded access to

²⁸ www.aidsinfo.org

²⁹ www.euro.who.int

simplified community-centred diagnostics. UNAIDS has specifically raised treatment-as-prevention and rapid testing as key issues for the Working Group on Transition Strategy at the Ministry of Health in Ukraine.

225. In 2012-2013, the World Bank joined with UNAIDS to conduct the HIV Program Efficiency Study, which focused on needle and syringe programming, OST and antiretroviral therapy in three regions of Ukraine. The study documented as many as 29 different first-line regimens at one facility, generating recommendations to decrease the number of regimens and actively consider fixed-dose regimens. The study also increased stakeholders' awareness of joint procurement mechanisms to lower drug costs.
226. Domestic funding for antiretroviral treatment rose from US\$ 12,835,973 in 2009 to US\$ 16,551,099 in 2010. The domestic public sector supplies 87% of funding for antiretroviral treatment.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UN ACTION

227. Ukraine seems well on track to reach most of the HLM targets. Further efforts may be necessary to sustain these gains and increase access to HIV services for key populations, especially prisoners. However, with the epidemic shifting towards increased sexual transmission, interventions for the general populations, such as behaviour change communication and condom use will be critical to averting a further expansion of the epidemic, as well as reducing stigma and discrimination, gender-based violence and inequality.

Basic programme activities

228. **Care & treatment:** Tuberculosis remains the most common HIV-related disease, diagnosed in 5,745 cases (62.5%) out of 9,189 new AIDS cases in 2011.³⁰ The number of TB patients who test positive for HIV increased from 4,157 in 2010 to 4,727 in 2012, while total TB cases rose from 34,237 in 2011 to 40,990 in 2012.³¹ Increased access to antiretroviral therapy has improved TB outcomes for people living with HIV, but more must be done. Only 35.7% of estimated HIV-positive incident TB cases received treatment for both TB and HIV in 2011, in part due to low testing levels among TB patients.³² Ukraine aims to ensure that 100% of people living with both HIV and TB receive treatment for both diseases by 2018.
229. **Prevention among PWIDs and other key populations:** Although HIV prevalence among PWIDs has declined, infection levels remain extremely high. HIV prevalence among PWIDs is estimated to be 43.8% in Mykolayiv at 43.8%, 41.3% in Dnipropetrovsk, 37.5% in Chernigiv, 34.9% in Khmelnitsky, 31.6% in Odessa, and 30.6% in Lviv. UNAIDS will collaborate with the government of Ukraine to address areas where prevalent infections among PWIDs are concentrated. Also, special attention for prevention should be given to sex workers, particularly those with current or previous history of drug use (6% prevalence among those never using drugs and 41% among those injecting in the last year) and MSM (5.9%).

³⁰ National report Ukraine

³¹ www.aidsinfo.org

³² www.euro.who.int

230. **HIV testing and counselling:** Less than 15% of the general population accesses HIV testing and counselling services. Indeed, there is evidence of a decline in HIV testing, with the share of population testing in the previous year falling from 13.1% in 2009 to 12.4% in 2011. UNAIDS will invest in capacity development and quality control for voluntary HIV testing and counselling services, including through workplaces.
231. **Behaviour change:** Sexual transmission is becoming increasingly prominent in Ukraine's epidemic. The percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who reported the use of a condom during their last intercourse increased from 61% in 2009 to 63.9% in 2011. In addition, 40% of young women and men aged 15–24 had comprehensive and accurate knowledge about HIV prevention in 2010. Information and educational campaigns are needed for young people to increase their awareness of HIV prevention. UNAIDS will continue to support comprehensive condom planning and expanding education for young people.

Critical enablers

232. **Stigma and discrimination and enabling legal environment:** Discrimination against PWIDs remains widespread in Ukraine, deterring PWIDs from the prevention and treatment services they need. The Ministry of Health should introduce and sustain courses on drug dependency for graduate and postgraduate specialists in infectious diseases, drug dependency, mental health, surgery, TB and family medicine, as well as nurses, social workers, police and staff of current justice system. The 2011 amendments to the HIV law explicitly guarantee harm reduction services.
233. **OST policy development:** The Government of Ukraine has yet to provide financing for OST. The MoH should establish OST as a backbone of public (free) narcology service and fund its service from the core budgets with initial national funds for medicine. The goal should be to reach at least 40% of estimated opioid injectors with OST in community settings and in detention centres by 2018.
234. **Stronger HIV response in correction facilities:** Ukraine has one of the highest incarceration rates in the world (323 per 100,000 population), with approximately 130,000–140,000 people in prison settings at any time. Yet only little over one third of people living in prisons settings have been tested for HIV. In 2011, studies found that 13.7% of prisoners were living with HIV. The HIV response should improve through implementation of the current sectoral HIV prevention policy and strengthen funding and expand the number of specialists for implementation of its HIV programme for incarcerated individuals³³.
235. **Sharing international experience for HIV prevention in prison settings:** UNAIDS should collaborate with the Government of Ukraine to share and apply international experience in the Ukrainian context. Key issues for consideration include changes to the legal and regulatory environment, optimizing budget allocations to enhance strategic impact, expanding the range and reach of HIV-related services for prisoners (especially in facilities where non-governmental organizations do not yet operate), to reform of the prevention and treatment programmes for PWIDs, strengthening human resources, enhancing cooperation

³³ www.unodc.org

between institutions and organizations of both governmental and non-governmental sectors, and analysis of best practices and international recommendations related to the improvement of health of prisoners.³⁴

Synergies

236. Gender equality is an important area where progress needs to be accelerated. A 2012 World Bank study suggests that gender inequality impede access to services, especially for women who inject drugs. Most existing services primarily target male drug users. The UNAIDS Secretariat, UNDP and other UN agencies need to provide technical support in the drafting of the HIV and gender strategy to be integrated into the 2014–2018 National AIDS Plan. In addition, UNAIDS Secretariat should collaborate with UN Women to provide special integrated HIV and IDU services especially for HIV-positive women who use drugs.

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³⁴ www.unodc.org

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