

## **UNAIDS PROGRAMME COORDINATING BOARD**

UNAIDS/PCB (34)/14.6  
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### **THIRTY-FOURTH MEETING**

**Date:** 1–3 July 2014

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

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#### **Agenda item 5.1**

**2012–2015 Unified Budget, Results and Accountability Framework**

**Mid-term review**

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**Additional documents for this item:**

- i. External Reviews and Assessments of UNAIDS UNAIDS/PCB (34)/14.7
- ii. Country Case Studies UNAIDS/PCB (34)/14.8

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

1. Take note of the report; express appreciation for the role that the Joint Programme has played in the response to AIDS; and urge acceleration of UNAIDS efforts to support countries achieve the global AIDS targets adopted by the UN General Assembly in 2011;
2. Request UNAIDS to develop a post-2015 Strategy, results framework and budget for consideration of the Programme Coordinating Board at its 36th meeting, taking into account lessons learned from the Mid-term review of the UBRAF and the resolution on the Quadrennial Comprehensive Policy Review (QCPR) of Operational activities for development (67/226).

**Cost implications of decisions:** None

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



**MID-TERM REVIEW**



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# Mid-term review of the 2012–2015 UBRAF: overview and key findings

At its 32<sup>nd</sup> meeting in June 2013, the UNAIDS Programme Coordinating Board requested a mid-term review of UNAIDS 2012–2015 Unified Budget, Results and Accountability Framework (UBRAF). The review considers the work of UNAIDS towards achieving the vision of the three zeros – zero new HIV infections, zero discrimination and zero AIDS-related deaths – as well as key principles and recommendations of the Quadrennial Comprehensive Policy Review (QCPR) and other intergovernmental mandates. The review draws on many sources of information, including external assessments of UNAIDS over the past two years, and presents progress and challenges in the AIDS response and key contributions of the Joint Programme. It highlights lessons learned from the UBRAF and the Joint Programme for the post-2015 development agenda.

## **Significant contributions by UNAIDS to progress in the global AIDS response**

Over the past two years historic advances in the AIDS response have been documented. New infections and AIDS-related deaths continue to decline. More babies are born free of HIV. Science has found new ways to prevent and control HIV infections; through early treatment or through male circumcision, for example. Social protection schemes are helping HIV-affected communities. Restrictions by countries on the entry, stay and residence of HIV-positive persons are being eliminated.

While much of this can be attributed to governments, national and international nongovernmental actors and communities, the Joint Programme has contributed to these advances in no small way by promoting and implementing the UNAIDS vision of the three zeros. High-level and strategic policy advocacy by UNAIDS' Executive Director and the Committee of Cosponsoring Organizations, strategic information to underpin the allocation of resources, targeted country-level technical support, strengthened accountability at all levels and a focus on High Impact Countries and key populations have all contributed to the success of the Joint Programme.

Nevertheless, challenges remain. These include: the continued vulnerability of women, often linked to gender-based violence (GBV) and exacerbated in emergency settings; failing young girls and boys despite expanded efforts in school settings; heightened stigma and discrimination against men who have sex with men (MSM), sex workers, injecting drug users, prisoners and migrants; and insufficient attention to links to other health and development issues e.g. between HIV and tuberculosis (TB).

Going forward, UNAIDS commits to: accelerate the pace of combination prevention efforts, including treatment as prevention; engage partners in scaling up treatment, in particular for HIV and TB coinfection; intensify programmes to protect women and girls; intensify programmes to ensure access to HIV services for groups who experience discrimination; and consistently involve young people and affected communities in the response. Increased domestic investments are critical; UNAIDS advocacy and efforts around shared responsibility and global solidarity must evolve to ensure low- and middle-income countries sustain and increase resources for the AIDS response and that these continue to be complemented by international financing.

“We have made remarkable progress in the fight against AIDS but the fight is not over and complacency is our worst enemy. Ending AIDS and extreme poverty is a shared responsibility that must be a priority for Africa and the world.”

— **H.E Yayi Boni**, The President of Benin

## B

### Improved coherence and effectiveness of the Joint Programme

During the past biennium, the Joint Programme has matured by developing and implementing the UBRAF. Coordination at the global, regional and country levels has become more systematic and programmatically focused to ensure coherence across the mandates of the respective organizations in support of national responses. Duplication has been significantly reduced. Collaboration has been good, as evidenced, for example, by work on eliminating mother-to-child transmission of HIV, access to treatment, engaging young people, workplace and social protection and increased joint efforts on addressing gender, stigma and discrimination.

Partnerships, in particular with civil society, continue to be nurtured to advance national responses. Strategic collaboration with major funders of the AIDS response continues to be supported by the Joint Programme through programmatic inputs, including data, design, technical content, country-level back-up and implementation support and mobilization of resources for national responses.

Going forward, the focus will be to strengthen joint work to help achieve the Millennium Development Goals and end AIDS in the post-2015 period. Resource allocation and strategic programming will be based on analyses, evidence and targeted approaches, tailored to country situations and local epidemics and to context-specific challenges.



## Predictability and continuity in efforts to support the global AIDS response

Achievements in the AIDS response have been the result of sustained efforts in which UNAIDS has established itself as a trusted partner supporting nationally-owned responses. Notwithstanding the need to strengthen the accountability of Cosponsors and the Secretariat, developing and implementing the UBRAF has enhanced the effectiveness, efficiency and accountability of the Joint Programme.

While international and domestic funding on HIV has shown an upward trend, UNAIDS has maintained a zero-growth budget with a strong focus on cost-consciousness and value for money. External assessments of UNAIDS and near-full funding of the UBRAF indicate continued confidence in the Joint Programme.

As major shifts occur in the global environment for development cooperation, the UN system needs to continue to provide countries with the support they need to respond to AIDS. As indicated by the UNAIDS Programme Coordinating Board (PCB) and the UN Economic and Social Council (ECOSOC), the model of a joint and cosponsored programme and the multisectoral approach remain relevant for the AIDS response and beyond. Efforts to reduce new HIV infections, support timely and long-term treatment and promote the rights of the vulnerable, should be intensified while foundations are laid to end AIDS as part of the post-2015 agenda.

Going forward, UNAIDS priorities will be to:

- a) support the establishment of global and country-specific targets that are ambitious yet practical to achieve the ultimate goal of ending AIDS by 2030;
- b) improve the quality and utilization of data, evidence and analyses to deliver more effectively in different contexts, at subnational levels and in cities;
- c) direct resources to interventions for most-at-risk groups and key populations to ensure that no one is left behind;
- d) invest in adolescents, particularly young girls, and other vulnerable groups to enhance effectiveness and engagement in the response;
- e) promote a shift from shared responsibility and global solidarity to sustainable financing of the AIDS response in all middle- and low-income countries;
- f) develop a new strategy and UBRAF for the period 2016–2021 to lay the foundation for ending AIDS by 2030, aligning UNAIDS planning cycles with the UN Funds and Programmes.



# 1 Introduction

“The more we lack the courage and the will to act, the more we condemn to death our brothers and sisters, our children and our grandchildren. When the history of our times is written, will we be remembered as the generation that turned our backs in a moment of a global crisis or will it be recorded that we did the right thing?”

— **Nelson Mandela**

1. The 2012–2015 UBRAF is a UNAIDS operational instrument to help achieve the goals in UNAIDS strategy and the targets of the 2011 UN General Assembly Political Declaration on HIV and AIDS. At its meeting in June 2013, the PCB called for a mid-term review of the 2012–2015 UBRAF at its 34th meeting in July 2014.
2. The UBRAF, developed via consultations with Member States, civil society and members of the Joint Programme, brings together 12 UN system organizations to deal with HIV. It ensures coherence and coordination in planning and implementation, and accountability for results. It includes a four-year planning framework, two-year budget cycles and rolling annual work plans.
3. UBRAF incorporates three components: a business plan to capture Joint Programme contributions to achieve the goals of the UNAIDS strategy and the global AIDS targets; a results and accountability framework to measure Joint Programme achievements and provide a link between investments and results; and a budget to fund the core contributions of the Cosponsors and Secretariat.
4. Developing the UBRAF was guided by key requirements and principles of resolution (67/226) on the QCPR of operational activities for development, including a focus on specific goals, results-based planning and budgeting, strengthened joint work and improved effectiveness and transparency to achieve results and ‘deliver as one’.
5. UNAIDS planning and resource management has fundamentally changed since the Unified Budget and Workplan (UBW), the predecessor of the UBRAF. It is now:
  - guided by a vision, mission and strategy, with strategic goals aligned with the targets of the 2011 UN Political Declaration on HIV and AIDS;

- designed to include global, regional and country-level results and resources to enable UNAIDS to play its role as a catalytic force for the AIDS response;
  - focused on results at the country level and leveraging UN system and other capacities in countries where the greatest impact can be made.
6. The core budget of the UBRAF (US\$ 485 million per biennium) remains the same as the UBW in nominal terms and represents about 1% of total funding for HIV. Like the UBW, in 2012–2013 almost 95% was raised through voluntary contributions, but the UBRAF improves on the UBW in other respects, including that it:
- is a results and budget framework, rather than a workplan, which captures the expected results and contributions of the Cosponsors and the Secretariat;
  - allocates resources based on epidemic priorities, performance and funds that Cosponsors themselves raise.
7. The purpose of the mid-term review of the UBRAF is to:
- i. document UNAIDS' contribution to achieving the goals and targets of the UNAIDS 2011–2015 Strategy and the 2011 UN Political Declaration on HIV and AIDS;
  - ii. assess the effectiveness of UNAIDS and the UBRAF in achieving results;
  - iii. analyse how the UBRAF has worked as an instrument to improve coordination, coherence, performance measurement, monitoring and reporting;
  - iv. identify ways to further improve the UBRAF as an instrument for enhanced effectiveness, efficiency and accountability;
  - v. capture lessons from the UBRAF to inform the post-2015 development agenda.
8. The mid-term review analyses UNAIDS' pursuit of the three zeros (zero new HIV infections, zero discrimination and zero AIDS-related deaths) and links efforts to the broader UN system. It presents achievements and challenges in the AIDS response, including: the effectiveness of the Joint Programme in influencing the global agenda; mobilizing political leadership; and promoting multisectorality and synergies between rights, social inclusion and development more broadly.
9. The review outlines recommendations to intensify efforts in the global response and position AIDS in the post-2015 period, including the development of a post-2015 strategy and results framework for UNAIDS. Recognizing the response has been a catalyst for social transformation, the review highlights opportunities to ensure an all-inclusive, comprehensive response to end AIDS in the post-2015 period.

## 2 The AIDS epidemic: a changing landscape with historic gains

### SIGNIFICANT PROGRESS IN THE RESPONSE TO AIDS

New HIV infections and AIDS-related deaths continue to decline; new HIV infections among children can be eliminated and their mothers kept alive; and despite continuing economic challenges and competing priorities, total resources for HIV programmes in low- and middle-income countries continue to grow.

10. With an estimated 35 million people living with HIV (PLHIV), it remains one of the most serious health challenges of our time, yet the world is witnessing historic gains. Sub-Saharan Africa, the region most affected by the AIDS epidemic, has had a 34% decrease in new infections since 2001 and in 16 sub-Saharan countries adult HIV incidence declined by more than 50% from 2001–2012.<sup>ii</sup>
11. Prevention and treatment programmes are working. The number of new HIV infections, 2.3 million globally in 2012, was 33% lower than in 2001, while the annual number of AIDS-related deaths, 1.6 million in 2012, has fallen by 30% since 2005.<sup>iii</sup>
12. **Reductions in new infections** flow in large measure from changes in sexual risk behaviour, including increased condom use, delayed sexual debut and a decrease in sexual partners. Progress continues in efforts to prevent children acquiring HIV. Since 2005, services to prevent **mother-to-child transmission** have averted 850 000 new infections among children. In 2012, 260 000 children were newly infected with HIV, a 35% decline over three years reflecting more progress in the past three years than in the decade before.<sup>i</sup>
13. Scientific advances and increased **access to treatment** have reduced AIDS-related deaths. A 27-fold increase since 2003 in access to antiretroviral therapy (ART) has transformed AIDS responses: there has been a 29% decrease in deaths since 2005 and ART is estimated to have averted 6.6 million AIDS-related deaths, including 5.5 million in low- and middle-income countries from 1995–2012.
14. Considerable gains have been made in scaling up **voluntary medical male circumcision** (VMMC), which has the potential to avert more than 20% of all new infections up to 2030. Since December 2012, 3.2 million African men had been circumcised in the 14 sub-Saharan Africa countries where scale-up has been recommended. Although this represents only 15% of the target of 20 million circumcisions by 2015, the pace is quickening, with double the number of circumcisions performed in 2012 than 2011.
15. There is movement away from **discriminatory restrictions on the entry, stay and residence** of PLHIV. Since 2010, 12 countries, territories or areas have eliminated such restrictions with technical support from UNAIDS. In 2013, Mongolia and Uzbekistan removed their restrictions, and Andorra and the Slovak Republic reported that restrictions were no longer in force.

16. More than 50% of countries are **integrating HIV** and tuberculosis (TB) services or strengthening joint service provision, while 70% of countries have integrated HIV testing, counselling and services with antenatal care and maternal and child health services. Two-thirds of countries have integrated HIV with sexual and reproductive health services, a quarter report linking HIV services with those for chronic noncommunicable diseases, and more than half have integrated HIV testing and counselling in general outpatient care.
17. Evidence indicates **social protection, care and support**, including livelihood protection, financial incentives and economic empowerment, reduce the risk of acquiring HIV. Studies show cash transfer schemes inspire safer sexual behaviours and reduce new HIV and sexually transmitted infections in young women. Linkages are seen between social protection, safety nets and improved adherence and resilience. Economic and psychosocial support is crucial for an estimated 17.8 million children who have lost a parent to AIDS. The measures alleviate hardship, reduce the risk of infection and increase treatment uptake and adherence.
18. In 2012, for the second year in a row, **domestic sources** accounted for a majority of HIV funding, contributing more than 50% of expenditure. Among 43 low- and middle-income countries that reported spending data in 2012, more than two thirds increased domestic resources, with Chad, Guinea, Kyrgyzstan and Sierra Leone more than doubling domestic spending. The African Union Roadmap on Shared Responsibility and Global Solidarity and the development of country-specific investment cases have been important elements to support these decisions.
19. Lessons from the AIDS response can strengthen **broader development efforts**. The emphasis on accountability has influenced the broader development field in target-setting, measurement, transparency and inclusion. The reliance on evidence and data, including that supplied by communities, has enhanced the strategic focus of the AIDS response, contributed to problem-solving and advanced advocacy for political and financial investments, resulting in increased domestic investments.

## HOWEVER, NOT ALL COUNTRIES, COMMUNITIES AND POPULATIONS SHARE IN THESE GAINS

20. The AIDS epidemic continues to disproportionately affect sub-Saharan Africa, which accounts for an estimated 71% of all PLHIV, 70% of new HIV infections and 75% of AIDS-related deaths. In some countries HIV risk behaviours are rising; in South Africa, this is believed to contribute to incidence rates unchanged since 2008 despite scaled-up HIV treatment. Outside sub-Saharan Africa, the largest number of PLHIV is in the Asia-Pacific (4.8 million in 2012). New HIV infections continue to increase in Eastern Europe, the Middle East, North Africa, Central Asia and other parts of Asia.
21. Mid-term reviews reflected declining support in several countries for social and behavioural HIV prevention programmes. Failure to reach key populations of MSM, sex workers, transgender people and people who inject drugs (PWID) with evidence-informed and human rights-based prevention services is hampering efforts to reduce sexual transmission, resulting in HIV prevalence among female sex workers 13.5 times higher than other women, 18 times higher among MSM than other men, and 22 times higher among PWID. A review of 15 countries showed the chance of being infected with HIV is 49 times higher in transgender people than adults in general.

22. The AIDS epidemic continues to exact an enormous toll on **young people** (ages 15–24), who account for 39% of new HIV infections among adults. Risks for young women are especially pronounced; in sub-Saharan Africa, those aged 15–24 are twice as likely to be living with HIV as young men their age. Amid broad declines in deaths, adolescents (ages 10–19) dying of AIDS-related causes increased by 50% from 2005 to 2012. Many adolescents and young people lack access to comprehensive sexuality education and quality sexual and reproductive health and HIV services.
23. Little progress has been made towards the global goal of reducing new HIV infections among **people who inject drugs**, who account for more than 40% of new infections in some countries. Although a comprehensive package of harm reduction services has been demonstrated to substantially lower the risk of acquiring HIV among PWID, service coverage remains low, hampered by punitive laws, including an overuse of incarceration and an acute lack of HIV services in prison settings.
24. Prevention coverage for **pregnant women** remains under 50% in 13 countries with generalized epidemics, below 30% in the Asia-Pacific and under 20% in the Middle East and North Africa. Treatment-eligible children are about half as likely to obtain ART as treatment-eligible adults. Continuing challenges for the elimination of mother-to-child transmission of HIV (**eMTCT**) include the lack of HIV prevention among women and girls of child-bearing age, insufficient access to antiretroviral drugs (ARV) and poor retention in care among pregnant women and mothers.
25. Access to **HIV treatment** is extremely low in Eastern Europe, Central Asia, the Middle East and North Africa. Coverage is notably lower in West and Central Africa than Eastern and Southern Africa, and among individuals coinfecting with HIV and TB, than among other people living with HIV. Among 41 priority countries for HIV treatment, only Brazil, Kenya, Malawi and Ukraine provide HIV treatment to at least 50% of HIV and TB cases. Diagnosing coinfection remains an impediment to progress, with only 46% of notified TB cases tested for HIV in 2012.
26. As scaled-up ART extends lives, **older adults** are accounting for an increased share of people living with HIV. Globally, 3.6 million people living with HIV were aged over 50 in 2012, the first time that older adults comprised more than 10% of the total.
27. **Food and nutrition** support is not prioritized as it is not always understood as a key element of care and as an enabling factor for accessing and adhering to treatment.<sup>ii</sup>
28. **Stigma and discrimination** deter key populations from seeking HIV testing and treatment. Action to address their HIV-related needs is undermined by punitive legal frameworks; 60% of national governments, and nongovernmental informants in 70% of countries, report laws, regulations or policies that hinder HIV prevention, treatment, care and support for female and male sex workers, PWID and MSM.
29. Vulnerability of **women and young girls** remains high, yet programmes are underfunded and the issue not adequately addressed. HIV is not consistently prioritized, nor is gender equality highlighted in AIDS responses. Gender-based violence (GBV) is on the rise, especially in conflict situations, with progress on coordinating interventions limited.
30. By mid-2013, **populations affected by humanitarian emergencies** and assisted or protected by UN agencies stood at 44 million (including 16.1 million refugees and 20.8 million internally displaced persons), the highest on record. HIV remains invisible and is not prioritized by humanitarian actors. Despite agreed interagency guidelines, HIV is not always considered, nor integrated into contingency planning.

## 3 Key achievements of UNAIDS in the 2012–2013 biennium

“Pills on a shelf do not save lives. To end the AIDS epidemic for everyone will require a people-centered approach driven by the community and based on social justice. ”

— **Sveta Moroz** of the Union of Women of Ukraine Affected by HIV

### UNAIDS' VISION OF THREE ZEROS IS SHAPING THE AIDS RESPONSE ACROSS THE WORLD

31. The global community has embraced the UNAIDS vision of getting to zero. It provided the foundation for the targets in the 2011 UN Political Declaration on HIV and AIDS which guides the global response, and also the foundation for Security Council Resolution 1983 of June 2011 which links HIV to international peace and security, peacekeeping and efforts to end sexual and GBV in conflict and post-conflict settings.
32. The three zeros have inspired political commitment and shaped the operations of governments and regional bodies. More than 20 countries implemented new or revised national strategic plans in 2012–2013.
33. The UNAIDS vision and strategy have shifted the discourse on AIDS from managing a disease to ending an epidemic, as reflected in the titles of sessions, conference hubs, abstracts and keynote addresses at AIDS conferences and articles in scientific journals. Toward zero infections was the UK Department for the International Development's (DFID) May 2011 position paper on HIV in the developing world. Getting to zero and the global AIDS 2015 targets have been embedded in the strategies of UNAIDS' 11 Cosponsors and reflected in an updated division of labour.

### ZERO NEW INFECTIONS

34. Scientific innovations in programming have raised hopes of reducing sexual transmission of HIV by 50% by 2015. In the past biennium, UNAIDS helped develop guidelines on HIV programming, including for sex workers and adolescents and young people. UNAIDS led analyses and reviews of national responses to integrate new technologies and advocated for evidence-informed combination prevention.

35. As a result of focused interventions with UNAIDS support, HIV infections among female sex workers declined in the early epidemics of Cambodia, India and Myanmar. Thanks to UNAIDS, considerable gains were made in scaling up VMMC. In 2013, WHO prequalified the first nonsurgical circumcision device for adults.
36. Considerable progress was made in eliminating mother-to-child transmission (eMTCT) of HIV through the Global Plan on the Elimination of New Infections in Children by 2015 and Keeping their Mothers Alive. Co-led by UNAIDS and the United States President's Emergency Plan for AIDS Relief (PEPFAR), it resulted in new paediatric infections in low- and middle-income countries decreasing from 550 000 in 2001 to 260 000 in 2012, with more progress in the past three years than in the previous 10.
37. Contributions by the Joint Programme to the Global Plan included leadership and guiding countries to implement integrated and decentralized approaches. This resulted in 62% of prevention of mother-to-child transmission (PMTCT) coverage among 21 priority countries, with 19 adopting policies to initiate ART for all pregnant and breastfeeding women. In Botswana, Ghana, Namibia and Zambia, antiretroviral drugs (ARVs) were provided to at least 90% of pregnant women living with HIV.
38. The Joint Programme has supported better treatment options. UNICEF and WHO pioneered Option B+, offering HIV-positive pregnant women the triple-combination first-line antiretroviral regimen. This has the potential to enhance adherence and simplify procurement and distribution. With UNAIDS support, Option B+ has been implemented in Namibia, Rwanda, Uganda and the United Republic of Tanzania.
39. UNODC has placed HIV and drug use at the heart of its global agenda and led Joint Programme efforts to increase access to harm reduction services for people who inject drugs (PWID). Over the past biennium, UNAIDS has provided guidance on preventing HIV infection among injecting drug users, including those aged under 18 or in prison settings, to help meet the goal of halving transmission of HIV among PWID by 2015. Legislative guidance and policy analyses contributed to legal reforms for drug-related services in Azerbaijan, Cambodia, Uzbekistan and Viet Nam. Following a joint UN call to close compulsory drug detention and rehabilitation centres and implement social services, Malaysia converted its 10 detention centres into Cure and Care centres.
40. Harm reduction relies largely on external funds but some countries prioritize funding their own services; in former Yugoslav Republic of Macedonia, PWID services account for 31% of HIV spending.
41. Efforts to advance education for HIV prevention and address broader sexual and reproductive health (SRH) have yielded promising results. The Inter-Agency Task Team on education indicated a 30% increase in the number of countries with a specific education-sector HIV policy. UNESCO, UNFPA and UNICEF reviewed curricula and undertook teacher training and peer education for regional and country capacity-building, and UNFPA is leading initiatives to educate young people outside of school on HIV, using street theatre in the Middle East and North Africa and social media in China. In December 2013 UNESCO and UNAIDS convinced health and education ministers in 20 Eastern and Southern African Member States to commit to comprehensive sexuality education and SRH services for young people.



42. UNFPA led efforts to reduce unsafe sex by re-energizing condom programming. Innovative design and marketing of female and male condoms, and improved national supply chain management, are addressing gaps in condom availability.
43. In 2013 UNAIDS co-created with 25 youth-led organizations the PACT for social transformation to create solidarity and collaborate strategically in the AIDS response. Other initiatives during the biennium included consultations with young people from key populations, developing guidelines for adolescents and research on investment in young people and HIV. Innovative social media initiatives, such as crowd-sourcing, to develop UNAIDS' strategy on HIV and young people, helped raise HIV awareness.

“Youth leadership and empowerment can make miracles. If you unite your forces and raise your voices, you will be heard by decision makers. And one day you will be the decision makers.”

— **Mette-Marit**, UNAIDS Goodwill Ambassador  
HRH Crown Princess of Norway

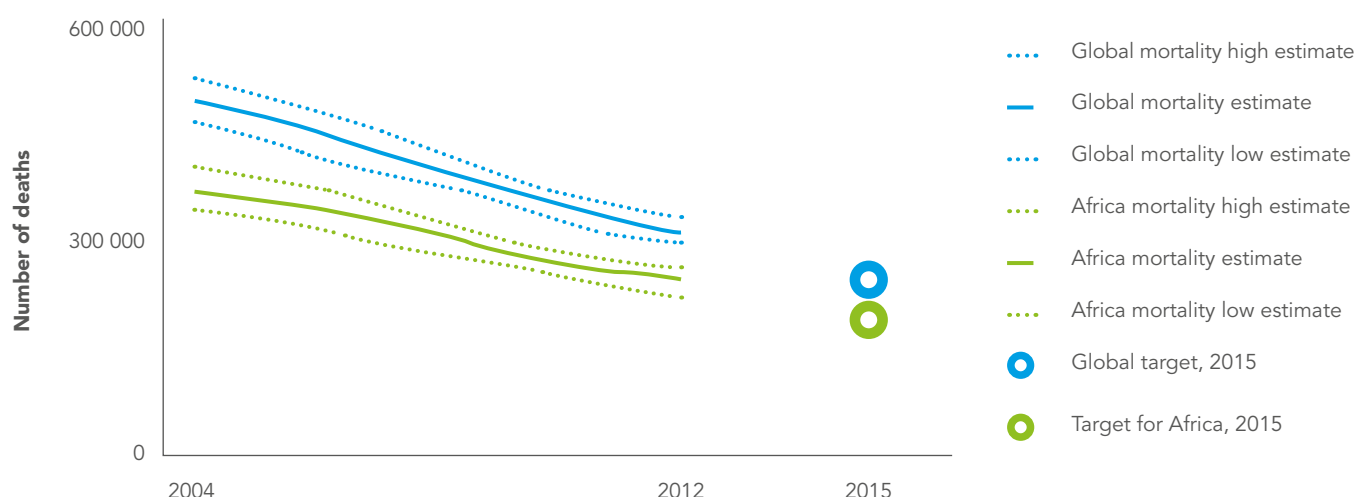
## ZERO AIDS-RELATED DEATHS

44. To reach 15 million PLHIV with lifesaving ART by 2015, UNAIDS has provided global leadership and guidance. Access to treatment has been scaled up, with nearly 10 million people on ART at the end of 2012, the African region showing the greatest increase. Consolidated guidelines on ARVs were issued by WHO, and Treatment 2015 was launched in 2013 by the UNAIDS Secretariat, WHO, the Global Fund and PEPFAR to accelerate treatment scale-up and intensify financial and technical support to 30 priority countries that account for 90% of the unmet need for treatment.
45. UNAIDS guided key populations, including PWID, MSM, transgender people, sex workers, prison populations and adolescents, in accessing treatment. Guidelines were adapted and disseminated in 90 countries. UNAIDS helped countries apply to the Global Fund in pursuit of treatment services for key populations.
46. To maintain ARV supplies and affordable prices, global demand forecasts were assessed and UNDP trained officials from Latin America, the Caribbean and Asia to use TRIPS flexibilities for affordable ARVs. As documented by the ILO, expanding employment opportunities for PLHIV can help sustain treatment gains, as PLHIV who are employed are 39% more likely to adhere to regimens than the unemployed.



47. In line with the target to reduce TB deaths in people living with HIV by 50% by 2015, TB deaths associated with HIV have continued to decline since 2004. However, in 2012, 20% of TB deaths were still related to HIV. Norms, standards and tools continued to be developed over the biennium by WHO, UNDP, UNICEF, ILO and UNODC. The TB/HIV policy was disseminated to 49 countries via workshops and joint TB and HIV programming was undertaken through Global Fund processes.
48. Collaborations with governments and stakeholders brought progress in having food and nutrition included in HIV and TB strategies. The World Food Programme's HIV and TB-specific operations in 2012 and 2013 reached an estimated 2.9 million beneficiaries, with WFP supporting programmes in 44 countries. Research to better understand the food preferences of malnourished adult PLHIV, inform product development and identify barriers to treatment adherence was undertaken, with guidelines to integrate food and nutrition into the response.

## REDUCING TB DEATHS

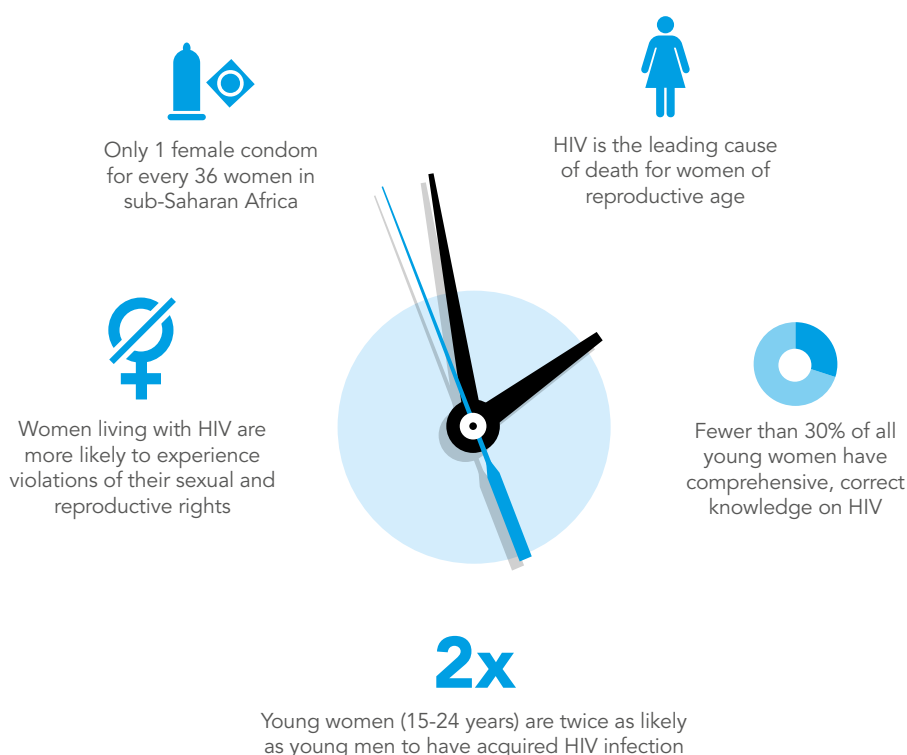


## ZERO DISCRIMINATION

49. High-level policy statements, including by the UN Secretary-General and executive heads of the Cosponsors and UNAIDS, were made at global, regional and country levels, calling for stigma and discrimination against people living with and affected by HIV to be eliminated and for laws and policies that ensure human rights and fundamental freedoms. Joint action has been undertaken in 84 countries to advance the recommendations of the Global Commission on HIV and the Law.

50. At the country level, UNAIDS worked with health and justice ministries, members of parliaments, PLHIV and national AIDS bodies to develop laws and policies that support effective AIDS responses and protect human rights. Dialogues on HIV and the law were held in 49 countries, with UNDP helping 65 countries undertake legal environment assessments and reviews. UNAIDS has helped countries draft legislation, based on public health evidence and human rights principles, and convened consultations on laws. In Congo, El Salvador, Guatemala, Mongolia, Nicaragua, Senegal and Togo, UNAIDS inputs have informed HIV-related laws.
51. UNAIDS and partners developed advocacy and guidance materials to reduce HIV stigma and discrimination and increase access to justice. Fifty countries completed the People Living with HIV Stigma Index, which has informed talks on improving legal and social environments for effective AIDS responses. At the end of 2012, 55% of countries reported HIV-related legal services, up from 45% in 2009; 57% reported training judges and magistrates on HIV and discrimination, up from 46% in 2008. UNAIDS advocated strongly to remove restrictions on entry, stay and residence.

## EVERY MINUTE A YOUNG WOMAN ACQUIRES HIV



Sources: UNAIDS; 2013, UN inter-agency Task Force on Rural Women, 2012; Singh S et al. Guttmacher Institute, 2009; UNICEF, 2011; UNFPA, 2010; WHO, 2009.

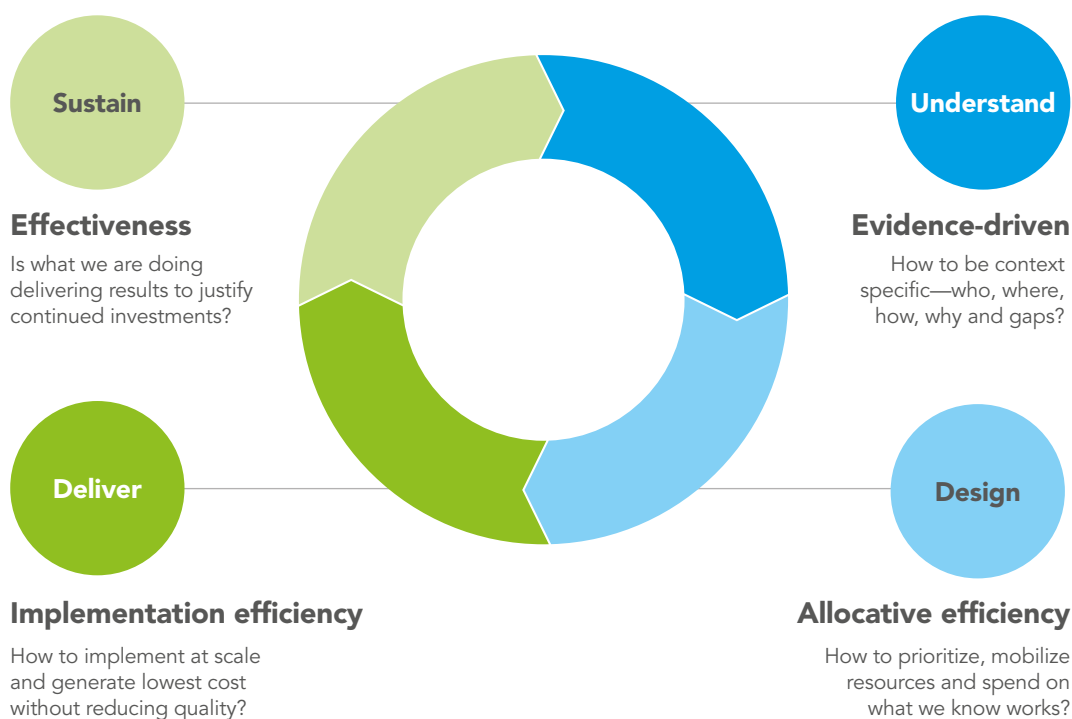
52. UNAIDS invested in strengthening the capacity of organizations of key populations to take their place at the centre of policy-making and service provision. The Network of Sex Work Projects and the Men who have Sex with Men Global Forum are examples of community partners strengthened by sustained UNAIDS assistance.
53. Efforts were intensified to eliminate gender inequalities and GBV and increase the capacity of women and girls to protect themselves from HIV. Through the Global Power network of African women leaders, which seeks to advance gender equality and women's empowerment, the presidents of Liberia, Malawi and Nigeria and the chair of the African Union led calls for an end to GBV and gender inequality.
54. In 2012–2013, UNAIDS implemented the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in more than 90 countries. The Agenda is referenced as a key document by leading intellectual and community organizations, while UNAIDS' strategic guidance on gender and HIV has influenced the work of key partners, such as PEPFAR. A 2012 review of the Agenda found "nearly two thirds of countries strengthened gender equality within their AIDS responses, and gains were made in fostering political commitment and developing an evidence base for policies and programmes". More than 700 civil society organizations are implementing the Agenda, and involving men, boys, religious leaders and human rights advocates.
55. UNAIDS has helped women living with HIV influence HIV planning and implementation by supporting regional networks, such as UNZIP the lips in Asia-Pacific, the Eurasian Women's Network on AIDS and MENA-Rosa in the Middle-East and North Africa region. UN Women and UNDP have helped women living with HIV increase their access to justice, while UNODC and partners have implemented gender-responsive services for women who use drugs.
56. To address HIV in humanitarian settings, interagency country needs assessments and consolidated response plans have been developed; in the Central African Republic, for example, technical advice and resources for additional support have been provided. Much of the funding comes from the Global Fund and additional resources are needed for key interventions, such as HIV prevention and nutrition.

## LEADERSHIP, ADVOCACY AND EVIDENCE FOR DECISION-MAKING

57. UNAIDS remains the source for authoritative information on HIV and AIDS used by national authorities, civil society and international partners such as the Global Fund and PEPFAR. Developing evidence-informed policies and programmes for key populations has been a UNAIDS priority and contributed to declining epidemics.
58. Stocktaking exercises supported by UNAIDS as part of the 2013 mid-term review of the 2015 targets have helped more than 100 countries diagnose gaps and revise strategies to respond to AIDS. With assistance from UNAIDS, at least 30 countries have developed or made plans for HIV investment cases.

59. UNAIDS helps countries and the Global Fund direct investments where they can have the biggest impact. UNAIDS' partnership with the Global Fund has been strengthened through the latter's new funding model. The investment approach promoted by UNAIDS has been endorsed by the Global Fund in this new funding model, and it informs Global Fund guidance to applicant countries.
60. Focusing on investment approaches, underpinned by robust national strategies as the centrepiece of funding requests, UNAIDS has coordinated technical support from donors for early and interim new applicants to the Global Fund. Under the new funding model, UNAIDS helped Zimbabwe develop a concept note in support of its request for US\$ 311 million. In 2012, UNAIDS made contributions to more than 19 grants under review, yielding decisions worth almost US\$ 2 billion.

## JOINT PROGRAMME COMPETENCIES TO SUPPORT NATIONAL AIDS STRATEGIES



## PARTNERSHIPS, COORDINATION AND COHERENCE

61. UNAIDS' partnership with the Global Fund goes beyond strategic analysis, policy advice and technical expertise. A member in nearly 90% of Country Coordinating Mechanisms, UNAIDS helps countries build governance structures and other Global Fund requirements. UNAIDS technical support and capacity building help countries manage all stages of the Global Fund grant cycle, including developing HIV funding requests and building capacity to implement programmes. Technical support facilities established by UNAIDS in Africa and Asia play a key role in scaling up regionally based technical support to countries, with a priority on Global Fund grants.
62. UNAIDS' engagement with civil society remains critical to expand interventions for key populations, reduce stigma and discrimination, and tackle violence against women and girls. UNAIDS is the only UN entity with civil society represented on its governing board. Nongovernmental organizations have been instrumental in promoting rights-based approaches to policy-making and interventions, performing a vital watchdog role to ensure universal access to HIV care and support.
63. UNAIDS was central in establishing the Robert Carr Civil Society Network Fund, which provides core funding to HIV civil society networks, particularly those of PLHIV and key populations. With financial support from the United Kingdom, the United States and Norway governments and the Gates Foundation, 24 civil society networks supporting universal access have been accepted for funding.
64. Innovative partnerships continue to be developed, including those with the private sector, creating synergies across human rights, sexual and reproductive health and in the global health architecture. Partnerships have been created with youth and other organizations towards an accelerated AIDS response, social transformation and solidarity with young people, including through crowdsourcing. Strategic partnerships with regional bodies, such as the African Union, have contributed to significant progress in the region, including through joint efforts such as the publication, *Delivering results toward ending AIDS, TB and malaria in Africa*.
65. Celebrity campaigns have accelerated the response. *Protect the Goal*, launched at the 2010 FIFA World Cup in South Africa and continued throughout 2012–2013, aims to use sport's popularity to unite the world towards an AIDS-free generation. The 2014 *Protect the Goal* world tour will conclude in Brazil for the campaign's official launch. It has enjoyed success thanks to partnerships with regional and national organizations, national authorities and the private sector.
66. Partnerships with the private sector resulted in increased workplace and employment policies; 70% of countries reported including the private sector in their national HIV coordinating authority (102 out of 146 countries) and more than 50% reported a policy or law prohibiting screening for general employment purposes (85 out of 164 countries). The ILO's *Getting to Zero@Work* advocacy campaign was supported by more than 150 heads of state, private sector leaders, human rights advocates and ministers.
67. UNAIDS is working with the UN Department of Peacekeeping Operations and other stakeholders to support the UN Security Council Resolution 1983, adopted in June 2011, to increase efforts by Member States to address HIV in UN Peacekeeping missions. Resolution 1983 calls for HIV prevention efforts among uniformed services to be aligned with efforts to end sexual violence in conflict and post-conflict settings.

## HELPING GLOBAL FUND MONEY WORK IN KENYA

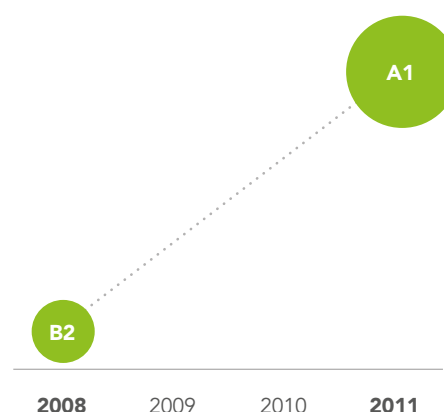
### BREAKDOWN OF US\$ 470,000 SPENT



### CHANGE IN PERFORMANCE

#### Kenya GFATM grant performance

Kenya GFATM grant performance has improved from an average of B2 (inadequate but potential demonstrated) in all grants closed by 2008 to A1 (exceeds expectations) in 2011.

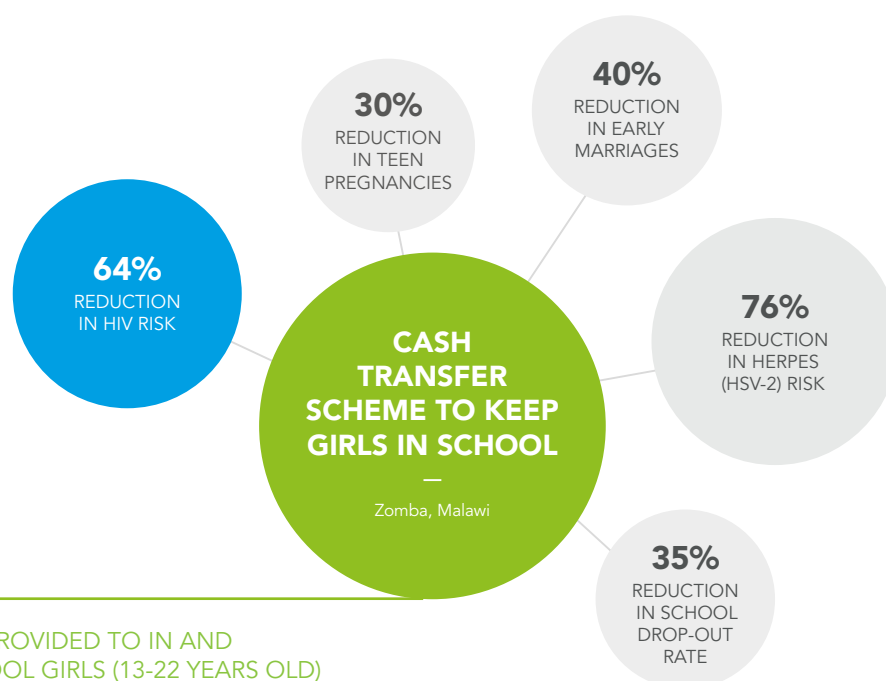


## INVESTING FOR RESULTS, SUSTAINABILITY AND ACCOUNTABILITY

68. The investment approach promoted by UNAIDS has enabled countries to prioritize high-impact interventions, with at least 30 countries making plans for HIV investment cases. This approach should be widely adopted and involve planning and finance ministries to mobilize resources and share responsibility for addressing the AIDS epidemic.
69. UNAIDS brokered with countries and development partners to make the case away from traditional cooperation relationships to more innovative approaches. The African Union's roadmap for a new response to AIDS, TB and malaria exemplifies how African countries and development partners have embraced mutual accountability. Developed with UNAIDS support, the roadmap offers practical, African-owned solutions, structured around health governance, diversified financing and access to medicines. The roadmap also establishes an accountability structure within the New Partnership for Africa's Development (NEPAD) to monitor progress. As a result, UNAIDS developed with NEPAD the first G8 accountability report on AIDS in Africa.

70. Domestic financing of the response has grown significantly, though many countries still rely on external resources, in particular for HIV prevention, especially low-income countries. In 2012, the second year in a row, domestic sources accounted for more than half of HIV funding; among 43 low- and middle-income countries that reported spending data, more than two thirds reported an increase in domestic resources. UNAIDS has engaged with the BRICS countries (Brazil, Russian Federation, India, China and South Africa), which contribute more than half of all domestic spending on the response in low- and middle-income countries, on the agenda for shared responsibility.
71. Social protection schemes, such as cash transfers, pensions and child grants, mitigate the impact of HIV and AIDS on vulnerable communities, contribute to HIV prevention and treatment and address social and economic drivers of the epidemic, as seen in randomized controlled World Bank trials in the past biennium in Lesotho, Malawi and the United Republic of Tanzania. A study in Botswana, Namibia and Swaziland showed safety nets can be expanded in response to additional shocks, such as orphans and vulnerable children programmes. Studies by UNICEF, the ILO and other Cosponsors documented the access to and effect of social protection on PLHIV workers and key populations in the informal economy and their households.

## CASH TRANSFERS DELIVER MULTIPLE BENEFITS



## 4 Organisational effectiveness, efficiency and accountability

72. UNAIDS has led the way on joint and coordinated programming in the UN system, adapting to a changing environment to ensure the best use of resources. The UBRAF has been instrumental in enhancing results-based planning and coordination among Cosponsors and the Secretariat. Having aligned the budget cycles of Cosponsors and the Secretariat, the strategic planning cycles of UN Funds and Programmes, and the recommendations of the QCPR (67/226), must also be aligned.
73. Improved planning and coordination have minimized duplication but synergies between Cosponsor programmes and the Secretariat could still be exploited more effectively in support of national responses. Improving synergies between global, regional and country-level efforts of the Joint Programme is also necessary, while supporting the Global Fund's new funding model offers multiple opportunities for synergies with and between members of the Joint Programme.
74. UNAIDS remains the reference for normative guidance on AIDS. Extensive global guidance has been developed but more needs to be done by the Joint Programme to implement it at country level. Opportunities exist for more holistic approaches across different themes (gender, for example) and government bodies and sectors.
75. The UBRAF has improved performance, monitoring and reporting. Allocations and disbursements are linked to performance, based on financial implementation, leveraging resources, and the quality/timeliness of reporting. Measuring performance has become more systematic, with progress against approved budgets and workplans assessed annually via a peer review involving Cosponsors and the Secretariat.
76. In 2012 UNAIDS introduced a web-based tool to monitor the performance of the Joint Programme and enhance UNAIDS' ability to make adjustments to its work. The Joint Programme Monitoring System (JPMS) captures country, regional and global organizational and thematic levels. The ability to review results for a particular theme across all parts of the Joint Programme is a major step forward. The JPMS has also contributed to better planning and articulation of results at country and regional levels and improved coordination among global interagency mechanisms.
77. The first two years of the UBRAF, in which financial implementation was almost 100%, demonstrate increased accountability of the Cosponsors and the Secretariat and increased attention to risk management. Financial policies, procedures and systems have been strengthened and harmonized. Adopting the International Public Sector Accounting Standards (IPSAS) has improved the quality of UNAIDS' financial reporting, comparability and harmonization with the reporting of other UN agencies, provided more transparency and, ultimately, enhanced governance of the Joint Programme. IPSAS has brought the UNAIDS Secretariat and Cosponsors in line with recognized best practices in public sector financial accounting and reporting, and reinforced results-based management of the Joint Programme.
78. The UBRAF has successfully applied the principles of the QCPR: enhancing the focus on specific goals and joint work; strengthening results-based planning and budgeting; enhancing coherence and coordination; and improving accountability for results and



impact at country level. To strengthen the performance of UN Joint Teams on AIDS and Joint Programmes of Support, collective action and Delivering as One under the Resident Coordinator System (RCS), the UNAIDS Secretariat has doubled its funding to the RCS budget in 2014–2015.

79. The UBRAF has enabled the AIDS response to focus on countries where the biggest impact on the epidemic can be made. This included an additional US\$ 10 million allocated through the UBRAF for Cosponsors to support efforts in 38 High Impact Countries. The UNAIDS Secretariat reviewed positions and redeployed staff to the field, particularly to High Impact Countries, reducing numbers by almost 10%. Cost efficiencies reduced total expenditure by 8%, yielding net savings of US\$ 48 million compared with the UBW in 2010–2011. Efficiency measures reduced general operating expenses of the Secretariat by 20%, travel by 30% and contractual services and consultant costs by 35% during the biennium.
80. External reviews of UNAIDS identify several areas of strength, including: global advocacy and leadership of the AIDS response; promoting gender, rights and stigma reduction; and partnerships. Organizational progress has been noted in: strategic focus; performance management and results reporting; and efficiency, cost and value consciousness. Opportunities for further improvement include: resource planning and monitoring; demonstrating accountability of the Joint Programme; and strengthening the coverage, quality and access to evaluation.
81. The UBRAF and JPMS are important steps forward, streamlining indicators, strengthening results-based reporting and better linking resources with results. The UBRAF has led to improved reporting by Cosponsors and the Secretariat at country, regional and global levels and increased transparency, accountability and access to information. Indicators in the UBRAF have been refined and reduced, with 31 of the original 42 measured by the JPMS retained to measure the Joint Programme's contribution to the response, with reference indicators retained for overall context.
82. Progress has been made in building data collection but there is still a need for better data in general, smarter systems for collection and analysis and better disaggregation of data to provide the evidence for the right investment decisions.
83. Consultation with stakeholders and partners has been appreciated and the willingness of Cosponsors and the Secretariat to adapt based on lessons learned is a hallmark of the Joint Programme. UNAIDS' governance and coordination structures at global, regional and country levels have played a key role in strengthening the accountability, effectiveness and relevance of the Joint Programme.
84. Engagement by countries is evidenced in the progress reports by 186 Member States in 2013. Also in 2013, 109 countries undertook a mid-term review of progress towards the 10 targets and elimination commitments of the 2011 UN Political Declaration on HIV and AIDS: the most comprehensive overview of the response at the country level, with inputs from national bodies, broader society and other stakeholders, including PLHIV.

## 5 Challenges going forward: ensuring no one is left behind

85. Despite much progress, intensified efforts are needed to achieve the Millennium Development Goal of halting and reversing the spread of HIV and reaching the targets of the 2011 UN Political Declaration on HIV and AIDS. UNAIDS and partners must accelerate the pace and sharpen the focus of the response, targeting High Impact Countries and local epidemics within countries to ensure no one is left behind.

### PROGRESS IN THE AIDS RESPONSE IS CONTINGENT ON CONTINUED, MORE TARGETED AND EFFECTIVE INVESTMENTS IN HIV PREVENTION

86. In several countries, high-risk behaviours are re-emerging, such as low condom use, and diminishing knowledge and awareness of HIV. UNAIDS needs to step up support for evidence-based prevention to lower the unacceptably high rates of new HIV infections and avert increases in risky behaviours. A focus on key populations, young women and areas with high HIV incidence is required.

### STIGMA, DISCRIMINATION AND EXCLUSION, REFLECTED IN PUNITIVE LEGAL FRAMEWORKS AND LOW SERVICE ACCESS FOR KEY POPULATIONS AND OTHER VULNERABLE GROUPS, NEED TO BE ADDRESSED

87. Persistent inequalities, with a concentration of infections among key populations and a growing conservatism, threaten to reverse past gains. The failure of some governments to recognize the HIV-related needs of key populations results in low service coverage for these groups, increases dependence on external donors and undermines efforts to reduce new HIV infections and deaths. Recent experience, such as the decision by Viet Nam to remove legal restrictions on key populations, demonstrates that progress towards grounding national responses in human rights is achievable. The groundwork for such change takes time, however, and demands that diverse constituencies and stakeholders are engaged. Even as UNAIDS has prioritized efforts to repeal punitive laws and practices, an increasing number of developed and developing countries are debating and introducing such laws, policies and practices on MSM (sub-Saharan Africa) and on sex workers (Europe).
88. UNAIDS will continue to collaborate with governments, civil society and other partners to implement recommendations of the Global Commission on HIV and the Law. The Joint Programme will review laws and policies, sensitize decision-makers on human rights and prioritize access to justice and stigma reduction. UNAIDS will work with countries to scale up high-impact interventions and ensure investment decisions are based on evidence. The Joint Programme will document and

disseminate evidence and implementation tools for effective interventions. UNAIDS will provide guidance to countries and the Global Fund to expand funding for critical enablers addressing stigma, discrimination, social exclusion and other social factors undermining AIDS responses. UNAIDS will prioritize access to justice, including the Stigma Index, to assess stigma in different settings, and capacity-building to help countries provide legal services to those affected by stigma and discrimination.

“It is a great honour to be chosen as a champion for people who live on the fringes of society and struggle every day to maintain their dignity and basic human rights. I would like to be the voice of the voiceless.”

— **Daw Aung San Suu Kyi**

## ALTHOUGH THE WORLD IS POISED TO REACH THE 2015 TARGET FOR TREATMENT, MOST PEOPLE ELIGIBLE FOR TREATMENT DO NOT RECEIVE IT

89. Increased efforts are needed particularly in Eastern Europe, Central Asia, North Africa and the Middle East, and among children and key populations. Even in sub-Saharan Africa, where treatment scale-up has been most striking, several countries lag behind in expanding treatment access, including those with the largest populations of PLHIV. On average, people enter HIV treatment late in the course of infection, highlighting the need to increase knowledge of HIV serostatus. Treatment outcomes are suboptimal, reducing the number of PLHIV with durable viral suppression and lowering the public health impact of treatment. Adherence must be given prominence as 25% of people initiating treatment are lost to follow-up after three years. Children living with HIV are about half as likely as adults to receive ART. Although challenges remain in ensuring prompt diagnosis and linkage to age-appropriate care, deficits primarily stem from not using available tools and strategies.
90. To help close gaps in access and maximize the health impact of treatment scale-up, advocacy efforts under the umbrella of *Treatment 2015* will continue. Part of an effort to develop targets for the post-2015 agenda, treatments taking account of scientific advances in the benefits of early treatment will be developed. UNAIDS will prioritize work with countries ready to implement the 2013 WHO treatment guidelines, with a roadmap for updating the guidelines being developed to ensure recommendations reflect the latest evidence. To ensure equitable treatment access for children, UNAIDS is forging partnerships focused on paediatric HIV treatment, hosting a global experts' consultation to identify strategic actions and prioritizing technical support to countries to implement existing tools, including through

the Double Dividend initiative to accelerate paediatric treatment access through alignment with broader child health efforts. The Joint Programme will also increase its focus on adolescents, including those who need care as they transition to adult services.

## STRUCTURAL FACTORS, INCLUDING INCOME INEQUALITY AND INADEQUATE ACCESS TO SAFE HOUSING AND ADEQUATE FOOD AND NUTRITION, CONTINUE TO UNDERMINE HIV OUTCOMES AND NEED TO BE ADDRESSED TO INCREASE THE IMPACT OF PROGRAMMES

91. Studies and experience demonstrate that housing instability, food insecurity, poverty, transport barriers and other structural factors impede access and reduce adherence to prevention and treatment services and increase vulnerability. HIV interventions alone cannot overcome these challenges, emphasizing the need to complement HIV programmatic activities with critical enablers and development synergies.
92. The UNAIDS family will intensify efforts to mobilize social protection strategies to reduce HIV vulnerability and enhance services. The World Bank and UNDP, with UNAIDS Secretariat support, will carry out research to build the evidence base for action on social protection and HIV and to strengthen monitoring and evaluation. WFP will advocate for HIV and TB to be included in broader social protection, with a food and nutrition component, while the ILO will build the capacity of AIDS coordinating bodies, networks of PLHIV and key populations, on social protection literacy, the benefits of PLHIV employment and reaching key populations via workplace programmes.

## WOMEN AND GIRLS REMAIN UNDER-REPRESENTED IN HIV POLICIES, PROGRAMMES AND RESOURCE ALLOCATION

93. HIV is not consistently prioritized in efforts to address gender and women's issues. Noting robust political support in countries implementing the UNAIDS Agenda for Accelerated Country Action for Women, stakeholders cite lack of political commitment as a barrier to achieving Agenda objectives. Few countries conduct gender analyses and there are insufficient efforts to address GBV and other gender inequalities. This lack of women's engagement is a critical gap in the response.
94. UNAIDS will intensify efforts to integrate gender analysis and action into the country roll-out of strategic investment approaches. The Joint Programme will disseminate tools to support gender-transformative planning, implementation, assessment and indicators. UNAIDS will strengthen efforts to mobilize resources for networks of women living with HIV and advocate to remove discriminatory laws. Efforts to engage men and boys as partners for gender equality and to eliminate GBV will be intensified. UNAIDS will support partnerships with women's health and rights organizations and groups of women and girls living with HIV.

95. The evidence base and normative guidance on GBV and HIV will be strengthened. In collaboration with the UNiTE campaign, the UN family will support the roll-out of national action plans on gender, GBV and HIV.

## ALTHOUGH A SUBSTANTIAL AIDS RESOURCE GAP PERSISTS, AIDS IS NO LONGER PERCEIVED AS A BURNING ISSUE AND COMPETES WITH A GROWING ARRAY OF OTHER PRIORITIES FOR FUNDING AND POLITICAL ATTENTION

96. In 2012, an estimated US\$ 18.9 billion was available for HIV activities in low- and middle-income countries, a 10% increase over 2011 but shy of the goal of mobilizing US\$ 22–24 billion annually for the AIDS response by 2015. It is also estimated that implementing the 2013 WHO consolidated ART guidelines will require an additional 5%–10% increase over earlier estimates of resource needs. Low- and middle-income countries have demonstrated leadership in mobilizing domestic resources but many countries have yet to allocate domestic resources in line with their capacity and HIV burden. The limited HIV prevention efforts for key populations are overwhelmingly financed by international donors, underlining the need for substantially greater national leadership and commitment. Interest in the AIDS response seems to be flagging among some traditional international donors, who will remain vital in future years, especially for countries that lack the capacity to fully finance their response.
97. To ensure sustainable financing, UNAIDS will continue to help countries apply investment thinking to planning processes, to prioritize resources and improve the cost-effectiveness and impact of national responses. UNAIDS will help develop conceptual frameworks and definitions for sustainable financing and the transition towards domestic funding. To support investment approaches, the Joint Programme will develop tools for reliable expenditure tracking, closing a key data gap that has impeded strategic action on investments. Through advocacy and sharing modelling results and other information, UNAIDS will encourage governments to increase domestic AIDS spending and foster continued support from international donors.

## TECHNICAL SUPPORT NEEDS TO BE DEFINED, OWNED AND ACCEPTED BY PARTICIPANTS, COORDINATED AND DEMONSTRATE A CLEAR CORRELATION BETWEEN SUPPLY AND DEMAND

98. UNAIDS will help countries scale up proven and context-specific interventions and human rights-based approaches. The Joint Programme will work to ensure all technical and financial support is optimally aligned with key priorities, with the ultimate aim to accelerate progress towards the MDGs and global AIDS targets. UNAIDS will prioritize efforts to ensure the success of the Global Fund's new funding model, including technical support to countries in implementing national dialogues, developing concept notes, navigating the process and supporting national proposals with strong evidence. Support will be provided to ensure the success of

the PEPFAR Blueprint to Creating an AIDS-free Generation. UNAIDS will continue to work through Joint UN Teams and Joint Programmes of Support to increase the coherence, coordination and impact of technical support and will participate in interagency mechanisms, such as the Chief Executive Boards, to ensure the UN delivers as one.

99. Effective technical support will be essential to ensure investments are directed where the greatest impact can be achieved, with attention and funding from donors and domestic sources for gender, human rights, key populations and civil society.

## IMPORTANT LESSONS HAVE BEEN LEARNED ON INTEGRATING HIV INTO BROADER HEALTH AND DEVELOPMENT EFFORTS BUT ADDITIONAL WORK IS NEEDED TO ENSURE AN INTEGRATED, COORDINATED RESPONSE

100. Integration is country- and context-specific; no single approach will fit all circumstances. HIV services must be integrated in a way that ensures gains are secured and monitored, highlighting the importance of quality impact evaluations.
101. Taking into account the diverse needs of countries, UNAIDS will help priority countries accelerate efforts to integrate the AIDS response into health and development sectors. Guidance will be provided on integration, including a “how to” manual on leveraging integration to accelerate progress towards targets. The Joint Programme will guide health systems strengthening, including the skills mix and task-shifting options for countries in integrating services. To support impact evaluations, UNAIDS will develop integration indicators and work with countries to ensure initiatives are grounded in human rights and client-centred.

## CONTINUED REDUCTIONS IN NEW HIV INFECTIONS AND AIDS-RELATED DEATHS, COMBINED WITH A GROWING RECOGNITION OF THE NEED TO FOCUS ON RIGHTS AND GENDER, MAKE IT POSSIBLE TO START CONCEIVING AN END TO AIDS

102. The foundation for ending AIDS must be laid as part of efforts to achieve the Millennium Development Goals and continue in the post-2015 period. Ending AIDS and leaving no one behind is contingent upon human rights-based, joined-up action across the social, political and economic determinants of HIV, health, poverty and inequality. Ending AIDS can serve as a catalyst in global health and development, promoting synergies between human rights, gender equality and poverty eradication.
103. Ending the AIDS epidemic can make a key contribution to an overarching vision of social, economic and environmental justice post-2015. A commitment to ending AIDS should be based on significantly reduced HIV incidence, universal access to treatment and reduced stigma and discrimination.

104. Achievements in the AIDS response are the result of persistent efforts over a long period during which the Joint Programme has established itself as a trusted partner, guiding and supporting nationally-owned responses. Notwithstanding the need to further strengthen the accountability of the Cosponsors and Secretariat, the development and implementation of the UBRAF has enhanced the effectiveness, efficiency and accountability of the Joint Programme.

105. As major shifts occur in the global environment for development cooperation, the UN system needs to continue to provide countries with the support they need in the AIDS response. Modalities and approaches of the Joint Programme that have worked well should be strengthened and experience of UNAIDS built on. The model of a joint, cosponsored programme remains relevant and ways of enhancing efficiency and effectiveness should be explored. Efforts to reduce new HIV infections, support timely and long-term treatment and promote the rights of the most vulnerable should be intensified while the foundation is laid to ensure the goal of ending AIDS as part of the post-2015 agenda.

106. Ending AIDS by 2030 must be UNAIDS' ultimate goal. Going forward, UNAIDS will:

- (a) support the establishment of global and country-specific targets which are ambitious yet practical to achieve the ultimate goal of ending AIDS by 2030;
- (b) improve the quality and utilization of data, evidence and analyses to deliver more effectively in different contexts, at subnational levels and in cities;
- (c) continue to direct resources to interventions for most-at-risk groups and key populations to ensure that no one is left behind;
- (d) invest in adolescents, particularly young girls, and in other vulnerable groups to enhance effectiveness and engagement in the response, and;
- (e) promote a shift from shared responsibility and global solidarity to sustainable financing of the AIDS response in all middle- and low-income countries.

107. For 2016–2021, a new Strategy and a UBRAF should be developed through a consultative process taking into account the findings of the mid-term review. This would align UNAIDS planning cycles with those of the UN Funds and Programmes, in line with the QCPR recommendations. The strategic approach to ending AIDS may be refined once the targets of the post-2015 development framework have been established and following a UN General Assembly High-Level Meeting on HIV and AIDS, proposed by the Secretary-General for 2016.

## Notes:

<sup>i</sup> Key populations, or key populations at higher risk, are groups more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful AIDS response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations key to their epidemic and response based on the epidemiological and social context.

Source: UNAIDS 2011–2015 strategy, getting to zero (UNAIDS (27)/10.12) adopted by the Programme Coordinating Board in December 2010. See [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034\\_UNAIDS\\_Strategy\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf)

<sup>ii</sup> Unless specifically mentioned, data on the epidemic and response are based on the report of the United Nations Secretary-General to the General Assembly Towards ending the AIDS epidemic: meeting the 2015 targets and planning for the post-2015 era (A/68/825) as well as Global report: UNAIDS report on the global AIDS epidemic 2013 (UNAIDS / JC2502/1/E) and HIV and Aging: A special supplement to the UNAIDS report on the global AIDS epidemic 2013 (UNAIDS / JC2563/1/E).

<sup>iii</sup> In 2012, the number of new HIV infections globally was 2.3 [1.9–2.7] million, 260 000 (130 000–320 000) of which were children newly infected with HIV. The annual number of AIDS-related deaths was 1.6 [1.4–1.9] million. Globally, 3.6 (3.2–3.9) million people living with HIV were over the age of 50 in 2012.







