Agenda item 4.3

UNAIDS/PCB (40)/17.9

UNAIDS 2018-2019 BUDGET

A DYNAMIC, DIFFERENTIATED RESOURCE PLANNING, MOBILIZATION, ALLOCATION AND ACCOUNTABILITY MODEL

27-29 June 2017 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
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Additional document for this item:

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

i. *recall* its decision at the 38th PCB meeting approving the final, prioritized and more detailed 2016–2021 UBRAF based on the recommendations of the PCB working group (7.23);

ii. *approve* UNAIDS 2018–2019 budget and revised resource mobilization and allocation model.

iii. *recognize* that the UNAIDS 2016–2021 Strategy, Unified Budget, Results and Accountability Framework and 2018–2019 budget, as well as the ongoing work to refine the Joint Programme operating model, reflect UNAIDS' engagement in coherent and integrated support as called for in Agenda 2030, and as mandated through the 2016 Quadrennial Comprehensive Policy Review (QCPR).

Cost implications of the decisions:

US$ 484 million (over the period 2018–2019)

CONTENTS

ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral Therapy
ARV	antiretroviral medicines
CEDAW	Committee on the Elimination of Discrimination against Women
ECOSOC	United Nations Economic and Social Council
eMTCT	elimination of mother-to-child transmission
GAM	Global AIDS Monitoring
GBV	gender-based violence
GIPA	Greater Involvement of People Living with HIV
HIV	human immunodeficiency virus
HLCM	High-Level Committee on Management (United Nations)
HPV	human papillomavirus
ICW	International Community of Women Living with HIV/AIDS
JPMS	Joint Programme Monitoring System
LGBTI	lesbian, gay, bisexual, transgender and intersex
PCB	Programme Coordinating Board
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
QCPR	Quadrennial Comprehensive Policy Review
SADC	Southern African Development Community
SDG	Sustainable Development Goal
Sida	Swedish International Development Cooperation Agency
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TB	Tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	United Nations Joint Programme on AIDS
UNDAF	United Nations Development Assistance Frameworks
UNDG	United Nations Development Group
UNDS	UN Development System
UNGASS	UN General Assembly Special Session

Cosponsors

UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
ILO	International Labour Organization
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization
WB	World Bank

PART I – OVERVIEW

I. INTRODUCTION

Overall context

1. The AIDS epidemic remains one of the greatest health and development challenges of our time. The number of adults acquiring HIV each year has remained static over the past seven years. The epidemic continues to claim more than one million lives each year. Nearly 80 million people have been infected with HIV, of whom 35 million people have died of AIDS-related causes since the beginning of the epidemic. AIDS remains a leading cause of death for women of reproductive age. New infections among young women who are 15-24 years disproportionately make up about 20% of new adult HIV infections. Violence against women and girls is widespread and impacts women's ability to protect themselves from HIV infection.

2. At the same time the AIDS response has brought unprecedented gains: 18.2 million people living with HIV were on treatment by the middle of 2016. The number of people dying from AIDS-related illnesses fell by 45%, from a peak of 2 million in 2005 to 1.1 million in 2015. In the world's most affected region, eastern and southern Africa, the number of people on treatment has more than doubled since 2010, reaching nearly 10.3 million people in 2016. Since 2009, 1.2 million HIV infections among children have been averted.

3. Political support for the AIDS response remains strong, but the overall funding environment has become uncertain – not only for the AIDS response or UNAIDS, but the UN Development System (UNDS) as a whole. Accordingly, efforts to reform the UN system are gaining momentum, as called for in the Quadrennial Comprehensive Policy Review (QCPR), which has informed the development of the UNAIDS 2018–2019 budget.

Vision and strategy

4. Since its establishment, the Joint United Nations Programme on AIDS (UNAIDS) has evolved to become a key component of the AIDS ecosystem, providing leadership, vision and strategic direction for the global AIDS response, as well as critical support to countries, civil society, communities of people living with and affected by HIV, working in close collaboration with many partners and funders, such as the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR). It is considered the foremost global authority on the HIV epidemic, and an influential advocate for well-resourced, evidence-informed, gender equality and rights-based responses to HIV.

5. The work of the Joint Programme is guided by a shared vision of Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths—and the 2016–2021 Fast-Track Strategy, approved by the UNAIDS Programme Coordinating Board (PCB) in October 2015. The Strategy was the first to be adopted following the adoption of Agenda 2030 and the Sustainable Development Goals (SDGs). It is aligned with the SDGs, serves to guide the achievement of the SDG target of ending AIDS as a public health threat by 2030, and provided the basis for the targets and milestones in the 2016 Political Declaration on Ending AIDS.

Budget, Results and Accountability Framework

6. The UNAIDS Strategy is operationalized by the 2016–2021 Unified Budget, Results and Accountability Framework (UBRAF), which the PCB approved at its 38th meeting. The UBRAF identifies the expected results, resources and actions of the Joint Programme and provides a planning and monitoring framework that is synchronized with the planning cycles of the Cosponsors and the United Nations system more broadly, as required by the QCPR. See http://www.unaids.org/sites/default/files/media_asset/20160623_UNAIDS_PCB38_16-10_Revised_UBRAF_EN.pdf

7. UNAIDS' budget for 2018–2019 is presented in this document for approval of the PCB. It is the second biennial budget under the 2016–2021 UBRAF. The budget has been developed taking into account decisions of the Board, progress to date against the Fast-Track targets, lessons learned in implementing UBRAF, the current financial resource outlook and the recommendations of the Global Review Panel.

8. Key features of the 2018–2019 budget include:

- A dynamic, differentiated and realistic resource planning, mobilisation and allocation model responding to evolving priorities and an unpredictable funding environment.
- Country and regional priorities at the heart of UNAIDS efforts with a strong focus on Fast-Track countries and a core package of support provided to all countries.
- A minimum allocation of core funding provided to the Cosponsors with additional funding provided through country envelopes to leverage joint action.
- Strengthened accountability and transparency through more comprehensive planning and reporting covering both core and non-core resources.
- Alignment with the requirements of the 2016 QCPR.

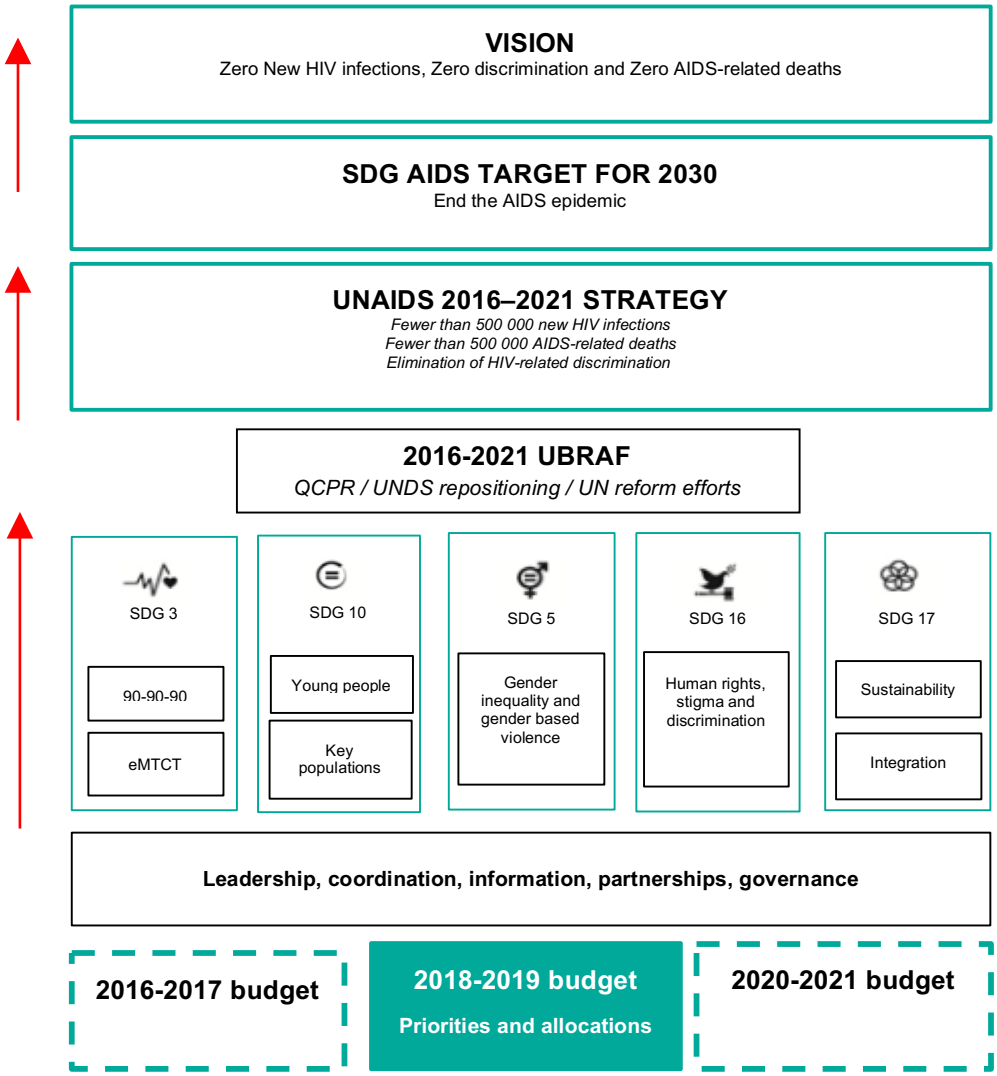
9. The 2018–2019 budget retains the structure of the 2016–2021 Strategy and the UBRAF, as shown in Figure 1 below. This includes 20 joint outputs, five core functions and a theory of change that links the UBRAF outputs to higher-level results in the SDGs and explains how the Joint Programme contributes to outcomes and impact. Success is determined by progress in the AIDS response against the Fast-Track targets in UNAIDS 2016–2021 Strategy.

10. Monitoring and evaluation of the budget will be strengthened, building on the range of tools to measure the performance of the Joint Programme described in the 2016–2021 UBRAF. Existing indicators and the analysis of progress against milestones and targets will be improved. Reporting will be enhanced by distinguishing results by the Secretariat, by individual Cosponsors and collective results, and by including more detailed information on core and non-core expenditures. Furthermore, the quantity and quality of independent evaluations will be increased and sustained with regular reporting back to the PCB. Progress against country level targets and milestones, and expenditures and deliverables against country level allocations, will be monitored and reported annually to the Board.

11. The milestones and targets included in the 2016–2021 UBRAF will be reviewed and revised, as necessary in the second half of 2017, taking into account progress achieved and UNAIDS financial situation. The resource outlook will be monitored closely as part of UNAIDS overall

risk management strategy and scenarios will be prepared and shared with the PCB, as necessary, at future meetings of the Board.

Figure 1. Schematic illustration of UNAIDS 2018–2019 budget



Quadrennial Comprehensive Policy Review

12. The resolution on the QCPR on operational activities for development of the United Nations system adopted by the General Assembly in December 2016 (A/Res/71/243) provides a strategic framework for the implementation of the 2030 Agenda and the SDGs, with mandatory measures to be taken by all UN development organizations, including UNAIDS.

13. Through the new QCPR, Member States call for a UN development system which is more strategic, integrated, coherent, nimble, and results-oriented and which has a central focus on leaving no one behind.

14. UNAIDS contributed to the interagency discussion and provision of information throughout the ECOSOC Dialogues and the QCPR resolution process, including through the Chief Executives Board, HLCM (where UNAIDS Secretariat is Vice Chair) and UNDG ASG Advisory Group (which UNAIDS Secretariat chairs).

15. In the intergovernmental discussions leading up to the adoption of the resolution, recurring themes included integration; multisectorality; linkages between development, humanitarian and human rights activities; multistakeholder and inclusive partnerships (including with the civil society and the private sector); evidence and rights-based approaches; inclusive governance; results-based planning, monitoring and budgeting frameworks; joint programming and collective accountability; and pooled financing. In all respects UNAIDS was able to share examples of lessons learned and good practices from the AIDS response, the Joint Programme and the PCB.

16. UNAIDS is already advancing well on key requirements of the 2016 QCPR, some of which have been achieved already including the mainstreaming of SDGs and Agenda 2030 into strategic and operational planning, into work at all levels and within governance mechanisms. The 2016–2021 UNAIDS Strategy and UBRAF are firmly anchored in and aligned with the SDGs, and are designed to clearly elaborate how UNAIDS—the only cosponsored Joint Programme in the UN system—is engaging in coherent and integrated support, as called for in the 2030 Agenda.

17. The Strategy and UBRAF are organized around five SDGs (3, 5, 10, 16 and 17) that represent the most strategic areas where UNAIDS can have impact across SDG outcomes. Other SDGs are also identified through the Strategy and UBRAF as being highly pertinent to the AIDS response, and representing areas where progress on HIV will also impact: SDG 1, 2, 4, 8 and 11.

18. The Joint Programme's integrated and joined-up approach resonates strongly with Agenda 2030 and the Secretary-General's reform agenda. The fulfilment of Agenda 2030—its 17 goals and commitment to leave no one behind—will rely on enhancing integration and mainstreaming delivered through unprecedented collaboration among partners across sectors. As ECOSOC has emphasized, the Joint Programme model is particularly relevant to Agenda 2030 as an example of "enhanced strategic coherence, coordination, results-based focus, inclusive governance and country-level impact". Box 1 shows how UNAIDS is aligned with the QCPR.

Box 1. Alignment of UNAIDS with the QCPR

QCPR	UNAIDS
Underscores that there is no “one size fits all” approach to development, and calls upon the United Nations development system to enhance its efforts, in a flexible, timely, coherent, coordinated and integrated manner.	UNAIDS is a joint programme of 11 UN agencies and the Secretariat that ECOSOC has repeatedly described as an example “of enhanced strategic coherence, coordination, results-based focus, inclusive governance and country-level impact, based on national contexts and priorities”.
Stresses that the governance architecture of the United Nations development system must be more efficient, transparent, accountable and responsive to Member States and able to enhance coordination, coherence, effectiveness and efficiency of the operational activities for development	UNAIDS has a unique governance model that includes Member States, UN Cosponsoring agencies and civil society. This inclusive governance model has been described by ECOSOC as a lesson learned for the UN system in the post-2015 era.
Further stresses the need to enhance system-wide coherence and efficiency, reduce duplication and build synergy across governing bodies of the entities of United Nations development system	The Committee of Cosponsoring Organizations facilitates the input of Cosponsors into the strategy, policies and operations of the Joint Programme. The ability of the CCO to ensure policy coherence between the UNAIDS Board and the boards of the Cosponsors is expected to be explored by the Global Review Panel.
Calls upon the entities of the UN development system to mainstream the Sustainable Development Goals in their strategic planning documents and their work at all levels.	UNAIDS 2016-2021 Strategy and UBRAF is aligned to the 2030 Agenda and organized in relation to its SDGs, focused on achieving SDG Target 3.3—ending the AIDS epidemic by 2030—as well as contributing to the achievement of broader health, development, human rights and gender outcomes of the SDGs.
Stresses that improvement of coordination and coherence at all levels of the UN development system should be undertaken in a manner that recognizes their respective mandates and roles and enhances the effective utilization of their resources and their unique expertise.	A formal division of labour recognizes Cosponsors’ mandates, roles, comparative advantage and strives to enhance effective utilization of resources.
Underscores the importance of results-based management, within and across entities and at all levels of the United Nations development system, as an essential element of accountability. Requests the United Nations funds, programmes and specialized agencies, as appropriate, that have not already done so to implement integrated results and resource frameworks aligned to their strategic plans in order to strengthen results-based budgeting.	UNAIDS’ UBRAF is a unique unified budget, work plan and results framework that includes the core and non-core resources of all 11 Cosponsors and the Secretariat. UNAIDS developed a more detailed and prioritized results framework for 2016-2021 that provides a complete results chain from inputs through to impact.
Notes the importance of the contribution of the United Nations development system with the aim of supporting government efforts to achieve the Sustainable Development Goals, based on full respect for human rights ... and stresses in this regard that all human rights are universal, indivisible interdependent and inter-related.	UNAIDS consistently amplifies the voice of marginalized communities and works to advance the broader health, development and human rights agendas in order to truly ensure that no one is left behind.
Calls upon all entities of the United Nations development system to continue to promote women’s empowerment and gender equality	UNAIDS Secretariat has a comprehensive Gender Action Plan with clear strategic areas of action and targets, coupled with demonstrable progress towards achieving these targets.
Encourages the United Nations development system to intensify its collaboration with results-oriented innovative national, regional and global partnerships	UNAIDS convenes transformative, inclusive partnerships to unite the UN system, governments, people living with HIV, civil society, the private sector, major financing institutions, academia, science, the media and influential public figures. These partnerships aim to bring about systemic change on critical drivers of the epidemic.
Urges the United Nations development system to mobilize multiple funding sources and deepen partnerships with other relevant stakeholders, with a view to diversifying potential sources of funding. Urges the entities of the United Nations development system to further explore innovative funding approaches to catalyse additional resources.	UNAIDS has been receiving core contributions from a number of non-traditional donors, including seven African member states.

The Global Review Panel

19. At its 39th meeting in December 2016, the PCB approved a review of the operating model of the Joint Programme to ensure it would be fit for purpose in the SDG era. The Board identified three fundamental pillars of interest: joint working, governance, and financing and accountability, and it requested a revised operating model to be presented to the 40th meeting of the PCB (decision 6.4). Details of the process, deliberations and report of the Review Panel are available at: http://www.unaids.org/en/20170127_Global_Review_Panel.

20. The Global Review Panel concluded that the Joint Programme has played and continues to play a critical role within the global AIDS response. The Global Review Panel acknowledged the Joint Programme's commitment to organizational change to strengthen effectiveness, efficiency and accountability within an evolving environment. Issues highlighted to be addressed include uneven commitment, culture and mind set regarding joint working within the Secretariat and across the Cosponsors, and overlapping roles and responsibilities; and the evolving epidemic and shifting landscape of the response, which demand the engagement of new actors, particularly partners critical to taking AIDS further out of isolation.

21. In reviewing the financing and accountability of the Joint Programme, the Global Review Panel also considered ways of enhancing the UBRAF further. Key recommendations included establishing a more differentiated approach to mobilization and allocation of resources; strengthening accountability; and improving reporting on the added value of the Joint Programme collectively, as well as with respect to each Cosponsor and the Secretariat. The development of the UNAIDS 2018–2019 budget took place in parallel with the Global Review Panel process and drew on discussions, findings and recommendations of Panel. The 2018–2019 budget also fulfils a number of core deliverables of the *Action Plan, Innovation for Impact: revising the operating model of the Joint Programme*.

II. CURRENT FUNDING ENVIRONMENT

22. Over the past several years, the UNAIDS Board, ECOSOC and the General Assembly have expressed strong political support for the Joint Programme. Several donors have maintained—or even increased—their contributions to UNAIDS in difficult times, while a few African countries have become contributors to UNAIDS. A number of traditional donors have, however, not been able to maintain past levels of funding to UNAIDS, which is negatively impacting implementation of the ambitious 2016–2021 Strategy and the UBRAF.

23. The UNAIDS Board approved a core budget of US$ 484.8 million for 2016–2017, but 70–75% of the approved budget is projected to be mobilized over the biennium. This reflects a disconnect between the ambitious strategic decisions of the UNAIDS Board and the funding provided by member states to the Joint Programme. For the Joint Programme to be able to continue its unique multisectoral, multi-stakeholder approach to end AIDS, the political support and global commitment to end AIDS need to be matched by commensurate financing of the Joint Programme.

24. To mitigate the funding shortfall, UNAIDS Cosponsors and the Secretariat have reduced and redeployed staff, decreased funding to partners and scaled back programming, while sharpening the focus on Fast-Track countries, specific populations and locations, and promoting a differentiated approach within different epidemic contexts.

25. The UNAIDS Secretariat has repositioned itself for maximum impact, with an organizational design that reflects a coherent structure, more cost-effective and efficient systems and business processes, and strong internal capacity to provide quality support. Notwithstanding the financial constraints and staff reductions, every effort has been made to maintain complementarity with the Cosponsors and core capacities at country level.

26. Cosponsors are working to further integrate and mainstream HIV across their organizations, sectors and mandates, in line with Agenda 2030 objectives, yet the work to leverage existing capacities and systems in support of HIV-specific goals requires resources.

27. Given the financial challenges facing the Joint Programme, Cosponsors have strengthened their resource mobilization efforts, as encouraged by the PCB. Meanwhile, reduced HIV-specific focus and capacity within Cosponsors threatens their ability to continue to mobilize adequate levels of non-core resources, reduces emphasis on HIV within the Cosponsors. To a large extent, resources that Cosponsors are able to raise for HIV can complement the available UBRAF funds, but they cannot replace those funds, which usually are tightly earmarked.

28. Delivering on the UNAIDS 2016–2021 Strategy depends on the mutually reinforcing performance of the Secretariat in its core leadership, advocacy, information, convening, partnerships and accountability functions, and on Cosponsor delivery in the strategic result areas. This requires mobilizing sufficient resources for the Joint Programme, as pointed out in the analysis prepared for the 39th PCB in December 2016 on the impact and implications of the budget shortfall on the implementation of the UNAIDS Strategy—see http://www.unaids.org/sites/default/files/media_asset/20161129_UNAIDS_PCB39_UBRAF_16-21_EN.pdf

29. With the rapidly evolving geopolitical and global economic landscape, and a broad and ambitious sustainable development agenda, the debate on where and how to mobilize development finance has intensified. Shared development ambitions must be accompanied by a shared responsibility to invest in development.

30. The UN system, including the Joint Programme, plays a critical role in supporting countries' efforts to increase domestic funding, access international and private funds and, critically, transition towards sustainable financing arrangements that are country-led and -owned. The evolving epidemic and shifting landscape of the response demand the engagement of new actors, particularly partners that are vital for taking AIDS further out of isolation.

31. Taking forward recommendations set out in the Global Review Panel, the Joint Programme will pursue enhanced joint resource mobilization efforts, leveraging the combined strengths of the Joint Programme to mobilize resources, including non-core contributions, to fund priorities of the Joint Programme as articulated in the UNAIDS Strategy and the UBRAF. At the same time, the 2018–2019 budget is as realistic as possible in order to take into account unpredictability in the current funding environment.

32. Building on recommendations of the recently conducted independent evaluation of the relationship between the UNAIDS Secretariat and the Global Fund, UNAIDS will explore opportunities with the Global Fund for joint advocacy to encourage proportional funding, including through joint communication to key donors. The Joint Programme will work with other partners, as relevant, to encourage understanding and promote good practice among donors on the principle of proportional funding, taking a holistic approach to funding the

global AIDS architecture. UNAIDS is also exploring other funding strategies that complement Member States' financial commitments, such as contributions from the private sector, foundations and others.

III. DEVELOPMENT OF THE BUDGET

33. The 2018–2019 budget is based on the UNAIDS 2016–2021 Fast-Track Strategy and the 2016–2021 UBRAF. It takes into account decisions of the Board, progress, challenges and lessons learned to date in implementing the UBRAF, as well as the financial situation and recommendations of the Global Review Panel.

34. The development of the budget has proceeded in parallel with the work of the Global Review Panel and takes into account the recommendations of the Global Review Panel. The 2018–2019 budget is also built on:

- Global commitments and guidance, following the adoption of the 2016–2021 UNAIDS Fast-Track Strategy:
  - The 2016 Political Declaration on Ending AIDS: on the Fast-Track to accelerate the fight against HIV and to end the AIDS epidemic by 2030.
  - The resolution on the QCPR of operational activities for development of the United Nations System (A/C.2/71/L.63).

- Data on achievements and challenges in 2016 and an inclusive consultative process, including member states and other partners:
  - Data collected through the Joint Programme Monitoring System (JPMS) on indicators, progress, challenges and lessons learned at country, regional and global level (see 2016 performance monitoring reports).
  - A global peer review by the Cosponsors and Secretariat to discuss achievements, challenges, lessons learned and areas where progress is not achieved as expected.
  - Regional consultations including Cosponsors and Secretariat as well as other partners to review of achievements and challenges as well as priorities for 2018–2019.
  - Findings and recommendations of the 2015–2016 Multilateral Organization Performance Assessment Network (MOPAN), which noted considerable progress from its last assessment of UNAIDS Secretariat in 2012, including a shift to a more field-based organization, reductions in overall staffing levels, and systems that ensure greater individual accountability for results.

Lessons learned

35. In its first year, the 2016–2021 UBRAF proved to be an effective framework for guiding the work of the Joint Programme at all levels. This was due particularly to a clearer and simpler structure; fewer outputs (20 compared to 64 previously); improved reflection of regional differences and priorities; and a theory of change linking UBRAF outputs to higher-level results and the SDGs, explaining how the Joint Programme contributes to outcomes and impact.

36. The review of the 2016–2021 UBRAF as a resource planning and accountability framework showed stronger linkages than in the past between the UBRAF framework and operational plans of the Joint Programme at country and regional levels. The simplified framework

facilitated communication, improved coherence and clarified expectations about Joint Programme support. The reduced number of indicators and the shift from process indicators to results indicators (monitoring changes at country level to which the Joint Programme contributes more directly) allowed more joint analyses of country level progress, with important improvements for data use and evidence-based programming.

37. During 2016, the Joint Programme experienced considerable pressure but was able to cope with the impact of significant and unexpected reductions in funding. Coordination at the global, regional and country levels improved as a result of concerted efforts to ensure coherence across all organizations. At the same time, the Joint Programme faced difficulties in maintaining its presence at country level, largely due to the sudden reductions in funding. Partnerships, in particular with civil society, continued to be nurtured to advance national responses.

38. The first year of implementation of the 2016–2021 UBRAF showed the need to strengthen Cosponsors' current approaches for mainstreaming and integrating HIV and AIDS into their country, regional and global programmes in ways that support progress across a range of SDGs. In some countries, HIV and AIDS-related responsibilities were mainstreamed into the existing work of other staff at country level.

39. The strength of the Joint Programme is derived from the expertise and comparative advantages of a diverse range of UN agencies, guided and coordinated by the UNAIDS Secretariat. Joint work has become the rule rather than the exception. Examples of the Joint Programme working effectively include the *Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive* (Global Plan), the Global Commission on HIV and the Law and its follow-up, and the ALL IN initiative.

40. The significant reduction in HIV infections among children shows the success of the Global Plan: coming together on a common goal where there is need for a collective response with clear milestones and guided by strong leadership. This achievement occurred in part because partners had clear tasks and worked together to rapidly assist countries to transition to the "test and start" approach using the simplified "one pill once a day" fixed dose combination treatment delivered for life. Similarly, the ALL IN Initiative has showcased the significant contributions of many partners to undertake collective actions aimed at ending the AIDS epidemic in adolescents in 24 Fast-Track countries. This collaborative effort has now matured into the *Start Free Stay Free AIDS Free* framework, embracing clear goals for elimination of mother to child transmission, paediatric and adolescent treatment, and primary prevention among adolescents and young women.

41. The 2011 and 2016 Political Declarations and the Report of the Global Commission on HIV and the Law have proved to be important frameworks for ongoing efforts by civil society, government and UN actors to promote a rights-based response to the HIV epidemic with implementation of the recommendations known to have taken place in at least 88 countries. The 2030 Agenda provides an unprecedented opportunity to expand rights-based HIV responses and strengthen links with human rights, gender equality, social justice and rule-of-law movements to promote inclusive and equitable societies for sustainable development.

42. In an era of sustainable development that demands more coherent and transparent joint UN action, the Joint Programme should more consistently capitalize on its joined-up nature and the comparative advantage of its various Cosponsors, to reinstate its value as more than the sum of its parts. Deliberate steps must be taken to give far greater prominence and attention

to the drivers and incentives of joint work, as opposed to agency-specific initiatives and branding, building on the lessons learned from the Global Plan and other collaborative efforts and applying these to other areas, with clear milestones, tasks and accountability.

43. To remain effective and relevant, the response to end AIDS must align with efforts to achieve the health-related SDG of ensuring healthy lives and promoting well-being for all at all ages, as well as other SDGs that are critical to progress on health, gender equality and women's empowerment and development. Effective integration of HIV services with health and other services is still lacking in many countries. The Joint Programme can and does play a critical role and sets the example for more integrated ways of working, to pursue effective and mutually beneficial integration with wider health, development and humanitarian efforts including social protection, youth employment, comprehensive sexuality education, and more. The role of Cosponsors has been critical to this reality and will continue to be so as the UN supports the implementation of Agenda 2030.

44. However, in many cases, the reduced HIV-specific focus and capacity of Cosponsors threatens their ability to continue to mobilize adequate levels of non-core resources, and weakens the ability to mainstream HIV within their strategic plans and the broader 2030 Agenda. At the same time, it is important for mainstreaming processes to be adequately planned and implemented so that staff are prepared to take up additional HIV-specific responsibilities that concentrate the quality of support being provided to countries. It will also be important to maintain basic functions of country-level support with flexibility and complementarity within Joint UN Teams on AIDS and similar structures. In countries with UNAIDS Secretariat presence, close collaboration will continue with Cosponsors to tap into broader UN capacities and take AIDS out of isolation.

Challenges

45. Reviews across the Joint Programme indicated that HIV prevention remains the most challenging area, with much less progress than expected, particularly among key populations and adolescent girls and young women. Improved understanding and presentation of the long-term value of investing in combination prevention approaches is needed, along with clear national targets. Key populations remain disproportionately affected by HIV in every region, constituting 45% of all new HIV infections globally, while young women aged 15–24 years account for 20% of new HIV infections among adults, even though they represent only 11% of the global adult population.

46. Joint Programme reviews also show that gender inequality, violence against women and girls, and stigma and discrimination remain key challenges. Programmes fail to adequately address the gender-related barriers that women face and policy and guidance does not necessarily equate to practice.

47. Closing gaps in service coverage will also require intensified efforts to address the gender dimensions of health-seeking behaviours, and barriers posed by discriminatory laws, policies and practices. For example, treatment coverage is lower for men living with HIV than for women living with HIV in every region. Globally 52% of women and 40% of men living with HIV are receiving HIV treatment, with men less likely than women to take an HIV test or start treatment. An increased focus on promoting positive health-seeking behaviours and addressing service access inequities is important not just to that ensure that men access the services they need, but to improve the health outcomes of their partners.

48. An enhanced focus on the revision or repeal of discriminatory laws and policies is also a critical and cost-effective way to break down barriers in access to services. This is especially the case for key populations, as well as for young people subject to age of consent laws. Stigma and discrimination in health care settings must also be addressed to ensure that those who need services the most feel safe accessing them, as well as ensuring that people living with, at risk of and affected by HIV, including key populations, know their rights and have access to justice to prevent and challenge violations of human rights.

49. Lack of access to HIV services and commodities in humanitarian contexts also remains a challenge. Structural drivers, such as food insecurity, forced displacement and sexual and gender-based violence often render people affected by emergencies more vulnerable to HIV. There is a need for the Joint Programme to raise the profile of actions in the areas of key and vulnerable populations as well as co-convene and coordinate across initiatives. Moreover, closing gaps in service delivery and reaching the most vulnerable populations will also require integrating community-led services in national AIDS plans.

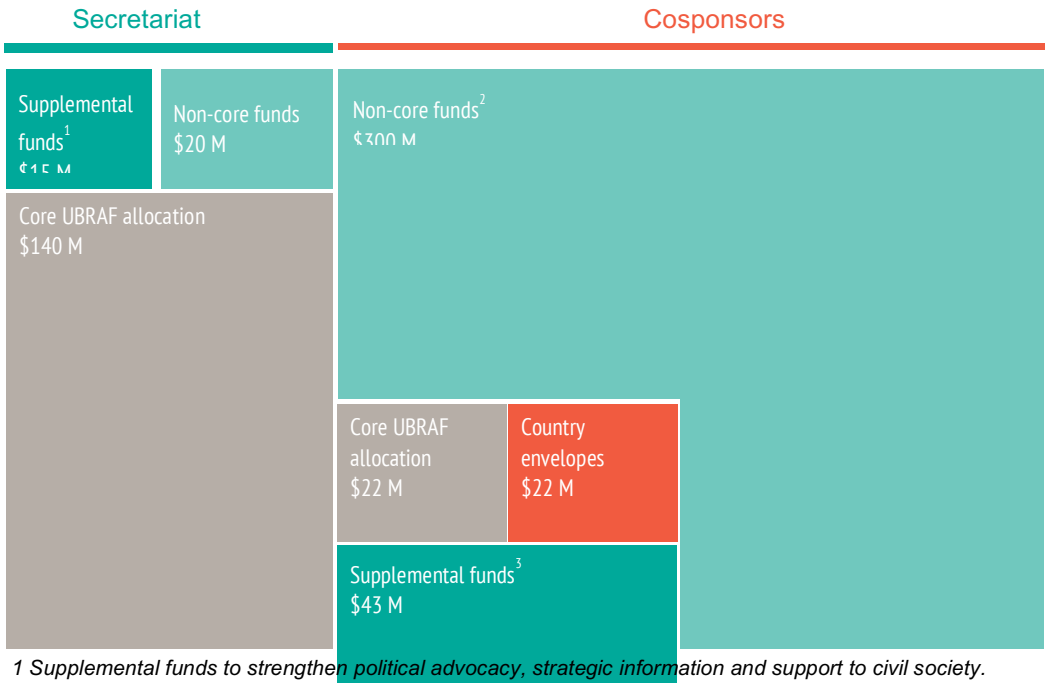
IV. RESOURCE PLANNING AND MANAGEMENT

50. The 2016–2021 UBRAF encompasses the work of the UNAIDS Secretariat and 11 Cosponsors in more than 100 countries. The UBRAF includes 20 joint outputs and the five core functions of the Secretariat. It reflects regional differences and priorities, builds on UNAIDS' division of labour between and among the Cosponsors and the Secretariat, and has a strong link between resources and results. A theory of change links UBRAF outputs to higher-level results and the SDGs, and explains how the Joint Programme contributes to outcomes and impact. Ultimately, success of the Joint Programme is linked to measurable progress in the AIDS response against the Fast-Track targets for 2020 in UNAIDS 2016–2021 Strategy. See http://www.unaids.org/sites/default/files/media_asset/20160623_UNAIDS_PCB38_16-10_Revised_UBRAF_EN.pdf

New elements

51. The 2018–2019 budget captures the core funds estimated to be raised by the Secretariat, supplemental funds to be mobilized through joint resource mobilization, as well as non-core funds estimated to be raised, taking into account the unpredictable funding environment. A schematic illustration of the budget is presented in Figure 2, while key elements related to the mobilization and allocation of resources are presented in Box 2.

Figure 2. Funds to be mobilized for a well-resourced Joint Programme (per year)



1 Supplemental funds to strengthen political advocacy, strategic information and support to civil society.

2 Non-core funds are for the most part earmarked for very specific purposes and cannot easily replace more flexible core funds.

3 Supplemental funds raised through joint resource mobilization efforts.

Box 2. Revised resource mobilization and allocation model

- Allocation of US$ 140 million to adequately resource the UNAIDS Secretariat and enable continued support in more than 100 countries following the repositioning and staff and expenditure reductions in 2016.
- Allocation of US$ 2 million to each Cosponsor to offer a degree of predictability in fulfilling respective roles in their engagement with the Joint Programme.
- A further allocation of US$ 22 million to Cosponsors at country level in the form of country envelopes to leverage joint action in 33 Fast-Track countries and in support of populations in greatest need in other countries.
- Additional resources in the form of supplemental funds to address particular epidemic and country contexts (up to US$ 58 million that would bring total core resources to the level of a fully-funded UBRAF).
- Continued support to more than 100 countries where the Joint Programme currently works.

The allocation of country envelopes will follow some basic steps:

- Use of a formula to establish the country envelopes for based on epidemic, economic, social, structural and other parameters.
- Establish a process in each country with the Cosponsors, coordinated by UNAIDS Country Offices, to fund joint action within the envelopes.
- Ensure that allocations are based on clear deliverables, milestones and regular monitoring and reporting.

52. The UNAIDS Strategy identifies 35 Fast-Track countries that need particular focus to end AIDS by 2030, while also recognizing the need for near-universal action on prevention, treatment, care and support in all countries. Fast-Track countries include countries with the largest number of new HIV infections and people dying of AIDS-related causes; countries that have high levels of infections among key populations; and countries of key political and geopolitical relevance, such as those affected by humanitarian emergencies.

53. In a resource-constrained environment, focusing on Fast-Track countries is a strategic decision to achieve maximum impact. At the same time, the Joint Programme needs to provide tailored support to all countries and populations in greatest need to ensure there is no emergence or resurgence of HIV epidemics in any region. The Joint Programme will continue to provide specific support in areas where it has a strong comparative advantage, for example areas related to key populations, community engagement, human rights, gender equality and women's empowerment.

54. The mid-term review of the UNAIDS 2016–2021 Strategy will be an opportunity to review progress and ensure adequate attention is given to all countries, including emerging or resurgent epidemics and significant concentrated epidemics. It is also an opportunity to adjust focus, where necessary, in countries that are making good progress. Approaches for working with upper-middle and high-income countries also need to be considered to tackle inequalities and ensure that marginalized groups affected by HIV, such as people who inject drugs, are taken into account in policies and programmes.

V. JOINT PROGRAMME PRIORITIES

Strategy Result Area 1: HIV testing and treatment, and HIV/TB integration issues

Challenges (2017)	Joint Programme priorities for 2018–2019
1.1 million people are still dying every year due to AIDS-related causes, and AIDS remains a leading cause of death for women of reproductive age. Although around 1.8 million children (<15 years) are living with HIV globally, only 51% are receiving ART. UBRAF indicator data show that more focus on care linkages and provider initiated testing for children under five is needed. Adolescents living with HIV (15–19 years) continue to have poor adherence to ART. TB remains the leading cause of death among people living with HIV: 390 000 deaths in 2015. HIV drug resistance is a growing threat to sustainable ART scale-up. Countries are making progress in adopting the new WHO treatment recommendations, but implementation is slow with variations across regions. There is very limited access to viral load testing and early infant diagnosis and West and Central Africa in particular shows worrisome gaps in coverage of the treatment cascade. A strategic mix of community- and facility-based testing services is needed. Only about 20% of countries have included self-testing in their national policies or plans. UBRAF indicator data also show slow progress on partner notification strategies. Further focus is needed on supply chain management. Globally only 40% of men living with HIV and 52% of women living with HIV access treatment. Further work is needed to ensure treatment expansion efforts address specific barriers that men and women face in accessing and adhering to HIV treatment. Cities face several challenges in responding to HIV and other health and social issues. The challenges include large numbers of people migrating in and out of cities, difficulties in reaching growing numbers of people living in informal settlements and slums, and stigmatization and discrimination of people living with HIV or at high risk of HIV, which can create barriers to accessing services.	**Output 1.1: HIV Testing and counselling** **UBRAF Target: By 2019, 80% of countries with selected HIV testing services in place** The Joint Programme will continue to support country implementation of WHO's latest testing and treatment guidance. Prioritized focus will be for key populations and areas that are lagging behind, such as self-testing and partner notification, which are expected to result in improved access to services for men. The ILO-led VCT@WORK Initiative will be continued. Focus will be on quality of testing to prevent misdiagnosis and expansion of workplace and community-led approaches. **Primary contributing organizations: WHO, UNICEF, WFP, ILO, World Bank** **Output 1.2: HIV Treatment cascade** **UBRAF Target: By 2019, 60% of countries adopting WHO HIV treatment guidelines** The Joint Programme will advocate for interventions to address gender-related barriers in treatment access for women and men. WHO will support the transition to new ARVs and scale up of viral load testing. A priority for 2018–2019 is the implementation of the HIV Drug Resistance Global Action Plan and scale up and implementation of differentiated service delivery models for all people living with HIV, including for families and key populations. UNODC with agency partners will support countries to enhance HIV testing services, increase access to ARVs and scale up collaborative HIV/TB activities for people in prisons, and improve linkages with health facilities in the community. Focus will increase on eliminating excess TB deaths among people living with HIV, by strengthening integrated delivery of TB and HIV care, and by catalyzing political momentum at the UN General Assembly High-Level Meeting on TB in 2018. UN Women will continue advocacy to ensure the treatment access efforts factor in gender dynamics. **Primary contributing organizations: WHO, UNICEF, WFP, UNODC, UN Women** **Output 1.3: 90–90–90 children and adolescents** **UBRAF Target: By 2019, 80% of countries adopting quality health care services for children and adolescents** The Joint Programme will support the introduction of improved diagnostic tools and improved drugs for infants, children and adolescents in the context of *Start Free Stay Free AIDS Free*. The Joint Programme will support the design and implementation of strategies that promote HIV integration in routine maternal, neonatal and child health services. The Joint Programme will also support countries to devise HIV testing strategies outside health facilities to identify older children and adolescents, as well as promote strengthened uptake and adherence through formal and non-formal school programmes that reduce stigma and promote treatment literacy and health-seeking behaviours.

	Primary contributing organizations: UNICEF, WHO, WFP, UNESCO, World Bank
	Output 1.4: High HIV burden cities **UBRAF Target: By 2019, 80% of countries with a plan and allocated resources to achieve Fast-Track targets in high burden cities** The Joint Programme will capitalise on the Fast-Track Cities initiative to promote and deliver rights-based municipal HIV programmes, with particular emphasis on key populations and young people. City administrations will be encouraged to partner with local nongovernmental organizations and communities to put in place community-led programmes; and with private sector to support innovation in service delivery. Services for refugees, migrants, internally displaced persons and other displaced or marginalized groups residing in cities will also be supported and strengthened. UNODC will advocate for and technically support HIV harm reduction for people who inject drugs in cities and promote linkages with community level HIV services for prisoners on admission and upon release from prison. **Primary contributing agencies: UNICEF, UNODC, WHO**
	Output 1.6: Access to medicines and commodities **UBRAF Target: By 2019, 90% of countries using a functional logistics management information system for forecasting and monitoring reproductive health and HIV related commodities** Efforts will be aimed at strengthening and harmonizing supply chain management, including logistics management information systems for prevention and treatment commodities. With other agencies, the Secretariat will support countries to maximize utilization of TRIPS flexibilities and the recommendations of the High Level Panel on Access to Medicines. **Primary contributing agencies: WHO, WFP, World Bank**
The latest figures show that more than 125 million people were affected by humanitarian emergencies by the end of 2015, while 65.3 million were displaced. The role of humanitarian actors in the HIV response is becoming more important in a world where war, displacement, food insecurity and climate-related disasters are becoming the “new normal”. Tremendous progress has been made to accelerate access to ART and this has led to an increasing need for the continuation of ART at the onset of an emergency. Yet, for people affected by humanitarian emergencies, access to HIV prevention and/or life-saving treatment is often limited, not prioritized or absent. For example, less than 30% of South Sudanese refugees in Northern Uganda are able to access HIV treatment. For people who may have access to such services, the onset of conflict or disaster, which may result in their forced displacement, food insecurity and the collapse of health systems, threatens to increase their vulnerability to HIV infection or to interrupt treatment. UBRAF indicator data show gaps in access to services including ART and identification and follow-up of pregnant women with HIV and their infants. In refugee situations only 52% of countries achieved more than 90% coverage of HIV testing in pregnancy and only 21% of countries achieved 100% coverage. Women and girls are disproportionately affected by the humanitarian emergencies and they often are subject to sexual and gender-based violence. Ensuring access to and quality of services for key populations in the midst of emergencies is challenging, given high levels of stigma and discrimination, overcrowded facilities,	**Output 1.5: Humanitarian contexts and fragile states** **UBRAF Targets: By 2019, in 85% of countries HIV is integrated in national emergency preparedness and response plans and by 2019, 85% of countries offer HIV-related services for populations affected by humanitarian emergencies** The Joint Programme will continue to prioritize the integration of HIV into multiple streams of humanitarian action, while at the same time improving evidence and advocating for resources to meet the HIV prevention and treatment needs of people impacted by emergencies. Moving forward, the Joint Programme will prioritize: protection and reproductive health programming for key populations in humanitarian contexts; the provision of food and nutrition support and cash/vouchers to people living with HIV affected by emergencies; the development of operational guidance and tools for humanitarian actors; scaling up services to address sexual and gender-based violence in humanitarian contexts; improving coverage of programmes for preventing mother-to-child transmission of HIV in humanitarian emergencies; scaling up early infant diagnosis and provision of ART to infected children; operationalizing “heath travel cards” in certain contexts; scaling up the test and treat approach in major operations; increasing support for adolescents and young people; and leveraging supply chain partnerships to reach the most vulnerable people with HIV and health commodities. The Joint Programme will continue to promote the inclusion of refugees and other crisis-affected populations in national strategic

and services that are not specifically designed to meet the needs of vulnerable sub-populations. Adolescents, particularly adolescent girls, are among the people most vulnerable to HIV in many contexts and are still not adequately reached with appropriate services. Many of the biggest barriers to ending the AIDS epidemic are structural. Geopolitical conflicts, food insecurity, gender inequality, sexual and gender-based violence, lack of access to services and commodities due to emergency-related shocks and sexual violence in conflict all represent serious obstacles to achieving the targets set out in the SDGs and the UNAIDS 2016–2021 Strategy.	plans and Global Fund grants, and work with governments to improve health systems to make them more resilient to emergency related shocks. **Primary contributing agencies: UNHCR, WFP, UNICEF, UNFPA, WHO, World Bank**

Strategy Result Area 2: eMTCT

Challenges (2017)	Joint Programme priorities for 2018–2019
There has been important progress in the number of countries implementing the latest eMTCT (Option B+) guidance: 70% in Fast-Track countries and 60% overall by the end of 2016. However, there are regional and country variations regarding provision of the full continuum of PMTCT services required to reach eMTCT. Significant challenges remain. They include late presentation at antenatal services, and poor retention and adherence and incident infections (with accompanying high risk of HIV transmission in areas with high HIV prevalence) during late pregnancy, delivery and/or the during the breastfeeding period, all of which is resulting in ongoing mother-to-child transmission in many countries. Women and girls' access to condoms for triple protection remains poor, as does access to family planning for women living with HIV. Only about 50% of HIV-exposed infants have access to early infant diagnosis, with approximately 50% of those tested receiving their results, and even fewer receiving a final diagnosis at 18 months. This leads to loss of life as the peak for paediatric mortality due to perinatal transmission occurs within the first 4 months of life.	**Output 2.1: eMTCT** **UBRAF Target: By 2019, 95% of countries implementing latest eMTCT guidance** The Joint Programme will address remaining challenges including: innovative methods to strengthen integrated service delivery across maternal, newborn, child and adolescent health to focus on primary prevention in women and girls, modern methods of contraception for women living with HIV including access to male and female condoms, early antenatal care engagement, improved efforts on retention throughout the pregnancy and post-natal period through end of breastfeeding, inclusion of retention and adherence counselling and support in care, use of viral load to gauge response and use of infant prophylaxis (including enhanced prophylaxis, where needed) to mitigate mother-to-child transmission risk. Activities focused on strengthening laboratory systems, and wider use of point-of-care early infant testing and viral load monitoring will be a priority for the Joint Programme. Condom programming will include tailored behaviour change and distribution campaigns for young women. Family planning choices for all women will be promoted in the integrated maternal, newborn, child and adolescent health platforms and initiatives such as FP2020. The Joint Programme will support countries to identify specific gaps in the PMTCT continuum and to support the roll-out of targeted activities at national, district and sub-district levels, as well as at facility and community levels including, where relevant, in prisons and other closed settings. Countries representing the greatest burden of HIV will be prioritized, with Nigeria requiring an even more targeted approach, given its lagging progress and significant contribution to the global burden of new paediatric HIV infections. The UNAIDS Secretariat will continue to support the application of the innovative human rights and community engagement tool in eMTCT validation processes. **Primary contributing agencies: UNICEF, WHO, WFP, UNFPA, UNODC, World Bank**

Strategy Result Area 3: Combination prevention and young people, especially young women and adolescent girls

Challenges (2017)	Joint Programme priorities for 2018–2019
The evidence confirms the need for focusing attention on adolescents (15-19 years). There are growing numbers of new infections in this age group globally, young people's levels of HIV knowledge show declining trends, and major demographic changes are underway in the most-affected regions. Between 2010 and 2015, young women (aged 15–24 years) accounted for 25% of new HIV infections among adults despite representing only 11% of the global adult population. While some countries have national policies that are supportive of youth-friendly health services, there is poor access to large-scale adolescent-friendly services that are integrated with the national health care system and quality sexuality education. Systemic factors such as limited offer of services, under-skilled health workers, poor continuum of care, and legal and social barriers continue to prevail. In particular, age of consent laws relating to sexual activity, access to health services and treatment, and other related areas continue to pose a barrier to young people's health. Addressing the barriers faced by young women and strengthening engagement of young women and adolescent girls in the HIV response remains a priority. Addressing the particular needs of young key populations is similarly vital given the multiple risks and vulnerabilities they face, including criminalization. Despite efforts to set prevention targets and galvanize political commitment for increased investment in prevention, greater efforts are needed to support countries to enact commitments made in the 2016 Political Declaration on Ending AIDS and to adopt a meaningful set of targets that capture their prevention priorities. Several countries are grappling with how to conceptualize and advocate for primary prevention within a context where treatment advocacy has been dominant. Another challenge relates to the availability of the highly granulated sex- and age-disaggregated data that are needed for a targeted combination prevention approach.	**Output 3.1: Targeted combination prevention** **UBRAF Target: By 2019, 60% of countries with targeted combination prevention programme in place** A Joint Programme priority is to reinvigorate the combination prevention agenda, including behavioural, structural and biomedical interventions, as well as to enhance the availability of granular data for tailored and focused approaches. The Joint Programme will promote stronger integration of sexual and reproductive health and rights with HIV, as well as promote greater access to education, information and services for adolescents and keep supporting comprehensive condom programming. Demand creation and behavioural change components are also priorities. The Joint Programme will expand partnerships and advocacy platforms to meet the needs of adolescents and youth including those from key and vulnerable populations; improve monitoring of combination prevention and support national target setting for prevention. The Joint Programme will continue to support the VMMC 2021 agenda in the 14 countries where it is applicable. In line with the SDGs approach, the focus will be on cross-sectoral programmes to address structural barriers such as youth employment, education, initiatives and programmes to address economic and gender inequalities, and to leverage the World Bank lending portfolio. Continued partnerships with initiatives on adolescents and youth will also be key including DREAMS, *Start Free Stay Free AIDS Free*, All IN and others. **Primary contributing agencies: UNFPA, World Bank, UNICEF, ILO, UNESCO, WHO** **Output 3.2: HIV-related health and education needs of young people and adolescents** **UBRAF Target: By 2019, 60% of Fast-Track countries are monitoring the education sector response to HIV and AIDS** There is a need to strengthen sex- and age-disaggregated data collection mechanisms and fill the gaps in knowledge and evidence around young people's health, education and rights. This means ensuring that systems are in place to collect disaggregated data, in addition to improving the utilization of existing data collection mechanisms in other sectors by integrating HIV. For example, a key priority of the Joint Programme will be to provide training and capacity building for national education sector staff to integrate HIV-sensitive indicators with national education monitoring and information systems, and to support enhanced analysis of data. Access to services and commodities must go hand-in-hand with access to comprehensive sexuality education. A priority will be to support countries to provide quality comprehensive sexuality education, and address in an integrated manner HIV and other health problems, such as early pregnancy. The Joint Programme will promote the UN International Technical Guidelines on Sexuality Education, with a specific focus on areas such as early pregnancy, puberty, and gender equality. UN Women will focus on enhancing and expanding meaningful participation and engagement of adolescent girls and young women in general, and those living with HIV, in the HIV responses. **Primary contributing agencies: UNESCO, UNICEF, UNFPA, WFP, UN Women, WHO, World Bank**

Strategy Result Area 4: Combination prevention for key populations

Challenges (2017)	Joint Programme priorities for 2018–2019
UNAIDS estimates that 45% of all new HIV infections occur among key populations and their partners. Increasingly conservative policies in many countries are negative affecting multiple aspects of the HIV response. This is especially evident through increased violence, stigma, discrimination and other human rights abuses against key populations, and a lack of focused HIV programmes for these populations. There is urgent need to raise the profile of preventive actions and address any mismatches between policy/ guidance and practice. Only a limited number of countries have meaningful sets of prevention targets and even fewer have robust granular data, especially for key populations and regarding innovative new approaches (for example, pre-exposure prophylaxis). A strained financial climate accentuates the focus on biomedical interventions at the expense of SBCC and structural interventions that are key to sustainability but that require longer term, well-resourced and consultative approaches. Communities are central to successful preventive interventions and must be empowered to lead the response. Community partnerships and local (e.g. municipal) programmes can sometimes counter political roadblocks. Opportunities for integration and linkages across the prevention treatment continuum should be optimized. As well as focusing of Fast-Track countries, there is a need to also respond to the special needs of key populations and emerging concentrated epidemics in non-Fast-Track countries.	**Output 4.1: HIV services for key populations** **UBRAF Target: By 2019, 80% of countries have defined comprehensive packages of services for men who have sex with men and for sex workers, and included them in national strategies (35% of countries for prisons and other closed settings)** In partnership with civil society, the Joint Programme will promote the use of key population HIV implementation tools (SWIT, MSMIT, TRANSIT and IDUIT) to improve comprehensive and integrated HIV services for key populations. The Joint Programme will advocate for and expand partnerships, including for municipal approaches, to meet the needs of key populations. The Joint Programme will continue to support legal and policy reform. It will also provide the strategic information and analytical support necessary to improve the efficiency of key populations programmes and ensure appropriate allocation of resources to key populations. The Joint Programme will promote occupational safety and health in entertainment establishments in the Asia and Pacific region to increase access to HIV services for key populations. It will introduce comprehensive HIV and sexual and reproductive health and rights packages for young key populations in Eastern Europe and central Asia. The Sex Worker Academy Africa will continue to be supported in order to build capacity of sex worker organizations to deliver community-led responses to HIV and human rights challenges. Opportunities will be examined to replicate this community empowerment model in other regions and for other key populations. UNODC and the World Bank will continue to support the generation of strategic information on the HIV epidemiological situations and service coverage in prisons, and the adoption of HIV services for people in prisons, which are evidence- and human rights-based and gender-sensitive. **Primary contributing agencies: UNFPA, UNDP, UNODC, UNICEF, ILO, UNESCO, WHO, World Bank**
Challenges remain for effective implementation of HIV prevention, treatment and care services for people who inject drugs. Services for this key population are undermined by social marginalization, violations of human rights, violence (including gender-based violence), stigma and discrimination. Harmful laws, policies and law enforcement practices remain barriers for the provision and access to HIV services, both in communities and in prisons. Harm reduction services require gender-sensitive approach to address specific needs of women injecting drug users. In many countries civil society organizations and community-based organizations are not sufficiently supported and engaged in HIV responses for people who inject drugs. International funding has declined and domestic funding for harm reduction remains low. Allocative and implementation efficiency studies show there is a need to improve efficiency of the use of available country resources. HIV responses for people who use drugs should focus also on countries other than Fast-Track countries.	**Output 4.2: Harm reduction** **UBRAF Target: By 2019, 50% of countries are implementing in combination the most essential interventions to reduce new HIV infections among people who inject drugs** UNODC will continue to advocate and provide technical support for policy and legal reforms in high-priority countries and at global level for human rights, and for evidence-based gender-responsive drug policy. Focus will also be on the following: - *Advocacy, technical assistance and capacity building:* The Joint Programme will continue to support the adoption of evidence-, human rights-based and gender-sensitive HIV services for people who use drugs, in line with internationally adopted recommendations. - *Support to community-based organizations* for their meaningful engagement in the development and implementation of HIV programmes for people who inject drugs. - *Guidance Roll Out*: UNODC will promote and support the implementation of the tool for HIV programming with people who inject drugs (IDUIT) and other guidance. - *Strategic information:* The Joint Programme will continue to provide support for the generation of strategic information on HIV epidemiological situations and service coverage on harm

	reduction, as well as improve the joint estimates on people who inject drugs and HIV. The World Bank will provide analytical support to improve the efficiency of resource allocation to people who inject drugs. **Primary contributions: UNODC, UNICEF, UNDP, WHO, World Bank**

Strategy Result Area 5: Gender equality and Gender Based Violence

Challenges (2017)	Joint Programme priorities for 2018–2019
While new HIV infections have declined among women over the past 15 years, women and girls remain vulnerable to HIV. Globally, women account for 51% of all adults living with HIV and they represent 59% of all people living with HIV in sub-Saharan Africa. In that region, women acquire HIV five to seven years earlier than men, underscoring the disproportionate HIV risks faced by adolescent girls and young women who reside there. Persistent gender inequalities and gender-based violence contribute to women's HIV risk and vulnerability, with 45% of adolescent girls in some settings reporting that their first sexual experience was forced. The availability, gendered analysis and use of sex- and age-disaggregated data in HIV response planning and budgeting remains a challenge. Financing and adequate budget allocations that are geared towards transforming unequal gender norms and preventing violence against women within the HIV response are either absent or inadequate and are not available consistently. Networks of women living with HIV do not have access to sustainable financing to support advocacy and institutional strengthening. UBRAF Indicator data show that in 2016, only 43 (15 of which are Fast-Track countries) out of 96 countries with Joint Programme presence had national HIV policies and strategies that promote gender equality and seek to transform unequal gender norms. Furthermore, only 43% of those countries (including 12 Fast-Track countries) had laws and/or policies and services to prevent and address gender-based violence. Promoting gender equality and women's empowerment requires strategic interventions at all levels of programming, budgeting and policy-making. That, in turn, demands adequate budgets for such activities, as well as the prioritization of empowerment of women and girls in developing, planning, implementing and evaluating national HIV strategic plans and policy frameworks. Women and girls, particularly those living with HIV, must be empowered to engage meaningfully, and spaces must be secured for them to participate in the HIV response at all levels.	**Output 5.1: Integration of gender issues in the HIV response** **UBRAF Target: By 2019, 60% of countries have national HIV policies and strategies that promote gender equality and transform unequal gender norms** The Joint Programme will continue to prioritize integration of gender equality and women's empowerment commitments in national HIV strategies and financing for gender equality within the HIV response, including HIV strategies and the Global Fund funding applications. The Joint Programme will disseminate evidence on the impact of harmful norms on women and girls' ability to prevent HIV and mitigate its impact. It will engage women, girls, men and boys to implement interventions to prevent and address gender-based violence and HIV and promote healthy gender norms and behaviours. It will also renew the engagement with a wide range of partners, with a focus on young women and girl's participation, to strengthen collaboration across movements and initiatives to hold stakeholders accountable for the implementation of their commitments to advance gender equality within the AIDS response. UN Women will continue to invest on meaningful participation of women living with HIV in the HIV response. UN Women, including through its Fund for Gender Equality, will also promote legal and economic empowerment of women and girls, living with and affected by HIV, to reduce burden of unpaid care work and economic vulnerability and enhance their sustainable livelihoods. **Primary contributions: UN Women, UNDP, UNFPA, ILO, UNESCO, WHO, World Bank**
	Output 5.2: Actions to address and prevent gender based violence **UBRAF Target: By 2019, 60% of countries have laws and/or policies and services to prevent and address gender-based violence** The Joint Programme will support countries to repeal discriminatory laws and practices that contribute to gender inequality, and to address and prevent all forms of gender-based violence, with specific attention to violence against women living with or affected by HIV. UN Women, UNFPA, UNICEF, UNDP, UNESCO and other partners will continue to advocate for legal reform to end child marriage. UN Women will work with the countries to integrate HIV issues into the national action plans on violence against women, and national strategies on gender equality. Including through the UN Trust Fund to End Violence Against Women, UN Women will invest in implementing evidence-based interventions to prevent violence and HIV. UNDP will

	support integrated solutions to eliminate sexual and gender-based violence, including in humanitarian settings, through supporting the development of policy and legal frameworks that are inclusive and protective of women and women's rights and improving access to justice and security service delivery. UNFPA will continue to support provision of post-gender-based violence clinical services. UNESCO will continue to lead efforts to address school-related gender-based violence, including violence on the basis of sexual orientation and gender identity/expression. **Primary contributing agencies: UN Women, UNDP, UNFPA, ILO UNESCO, WHO, World Bank**

Strategy Result Area 6: Rights, stigma and discrimination

Challenges (2017)	Joint Programme priorities for 2018–2019
Stigma and discrimination against people living with HIV, women and girls and key populations remain serious barriers hindering access to services and effective HIV responses worldwide. There has also been a shrinking of civil society space and encroachment on rights and freedoms under the pretext of public health or security rationales. Preliminary UBRAF indicator data for 2016 show that 41 out of 96 countries still criminalize HIV non-disclosure, exposure or transmission; 43 criminalize same-sex behaviours, sexual orientation and gender identity; 116 countries criminalize or otherwise punish through a variety of laws sex work, 48 have bans or limits on needle and syringe programmes and/or opioid substitution therapy for people who inject drugs, including in prisons settings. Some 56 countries also restrict adolescents' access to HIV testing or treatment without parental consent (data under validation). Some countries still have no mechanisms in place to record and address cases of discrimination in relation to HIV, no mechanisms to provide access to legal support, and no HIV-sensitive training programmes on human rights or discrimination. There is also a disconnect between protective legislation and its enforcement, especially for key populations. The 2030 Agenda provides an unprecedented opportunity to expand rights-based and gender-responsive HIV responses, and to strengthen links with human rights, gender equality, social justice and rule-of-law movements to promote inclusive societies for sustainable development.	**Output 6.1: HIV-related legal and policy reforms** **UBRAF Target: In 2019, 20% of additional countries (compared to 2017) are positively addressing laws and/or policies presenting barriers to HIV prevention, treatment and care services** The Joint Programme will support countries, including civil society, to follow up on the commitments of the Political Declaration and the recommendations of the Global Commission on HIV and the Law through providing policy advice and support to reforming punitive laws and adopting enabling laws and policies through legal environment assessments, national dialogues, trainings/sensitization of various government branches, and knowledge products. UNDP will undertake a formal evaluation that will assess the impact of the Global Commission on HIV and the Law and its follow-up to identify strengths, weaknesses and opportunities for future work. UNODC and ILO will support legal and policy reforms for effective implementation of HIV prevention, treatment and care for people who use drugs, for people in prisons and for mobile and migrant workers in sectors where workers are at an elevated risk to HIV. **Primary contributing agencies: UNDP, UNHCR, UNODC, ILO, WHO** **Output 6.2: Legal literacy, access to justice and enforcement of rights** **UBRAF Target: By 2019, 65% of countries have mechanisms in place providing access to legal support for people living with HIV** UNDP, UNFPA and UNODC will scale up access to justice programmes for key populations including a focus on inclusive civic engagement and sensitization of the judiciary, parliamentarians and law enforcement. UNODC will advocate and implement capacity building activities for law enforcement and community-based organizations to address violations of human rights, stigma and discrimination, which are hindering implementation of HIV services for people who use drugs and for people in prisons. UN Women, UNDP, UNFPA and partners will support meaningful engagement and participation of women living with HIV in the Committee on the Elimination of Discrimination against Women (CEDAW) reporting and implementation, as well as the monitoring of

	its Concluding Comments. They will also continue advocacy for legal reforms to end child marriage and other forms of gender-based violence, and promote increased access to legal aid services for women and girls. **Primary contributing agencies: UNDP, UNODC, UN Women, UNESCO, WHO**
	Output 6.3: HIV-related stigma and discrimination in health care **UBRAF Target: By 2019, 50% of countries have measures in place to reduce stigma and discrimination in health settings** The Joint Programme will build the capacities of labour inspectors and the labour administration of Ministries of Labour to strengthen monitoring of the application of non-discrimination HIV workplace legislation, employment legislation, policies and programmes, and to advance partnerships and work towards addressing stigma and discrimination in health care settings. The Joint Programme will finalize and disseminate a joint gender-sensitive UN Statement on ending stigma and discrimination in health care settings. Recommendations in the Statement will be implemented through an integrated process of advocacy, policy dialogue, sensitization and capacity building of health care personnel, mainstreaming anti-stigma and discrimination practices within health training institutions and monitoring occurrence of stigmatizing and discriminatory practices displayed by health providers. **Primary contributing agencies: UNDP, WHO, UNFPA, World Bank**

Strategy Result Area 7: Investment and efficiency

Challenges (2017)	Joint Programme priorities for 2018–2019
UBRAF implementation and work in support of country responses revealed several opportunities for increased efficiency that would result in additional funds being available for the HIV response. There is a need to focus on what can be done differently and on implementation efficiency, along with enhancing the Joint Programme response, particularly when resource mobilization is challenging. There is scope for greater efficiency in programmes and in the support being provided to countries, with overall increased efficiency in the implementation of HIV responses. HIV strategies need to be guided by investment cases that prioritize high-impact locations, populations and programmes. Innovative measures, such as e-health and m-health, should be effectively leveraged to improve the reach and impact of HIV efforts.	**Output 7.1: AIDS response sustainability, efficiency, effectiveness and transitions** **UBRAF Target: By 2019, 60% of countries have a HIV sustainability plan developed and 70% have an up-to-date HIV Investment cases (or similar assessing allocative efficiency) that is being used** A partnership including the Secretariat, World Bank, UNDP, WHO and other Cosponsors will place a strong emphasis on sustainability, efficiency and effectiveness of the HIV response in recognition of the dramatic shifts in the funding landscape in recent years. In order to help governments finance programme scale-up with limited resources and support countries as they transition from international financing to increased domestic financing, the Secretariat and the World Bank will provide analytical support to improve the allocative efficiency of resources. They will also continue to provide strategic evidence for improved implementation through technical efficiency studies, and impact evaluations for the use of innovative tools and approach. However, mobilizing and front-loading more resources to avert new HIV infections and reduce the long-term resource needs is also a priority. It is vital that countries monitor their HIV epidemics with real-time and geographically granular information. Developing sustainable, routine monitoring systems, including the ability to measure the SDG target on HIV incidence, is critical for an effective and efficient response. UNAIDS Secretariat and partners are supporting countries to develop these systems and to strengthen the routine data systems to compile the information necessary to identify programmatic gaps. **Primary contributing agencies: World Bank, UNDP, UNESCO, WHO**
	Output 7.2: Technological, service delivery and e-health innovations **UBRAF Target: By 2019, 50% of countries with scale-up of new and emerging technologies or service delivery models** The Joint Programme will promote innovation in HIV service delivery, including e-health, mobile health and telehealth. By fostering partnerships among communities, government agencies, health providers and the private sector, the Joint Programme will encourage countries to develop and use innovative prevention technologies (including new PrEP, voluntary medical male circumcision practices), promote community awareness of and support for innovations, support research to optimize antiretroviral regimens (including for children) and examine broader HIV testing methods. The Joint Programme will expand its work and advocacy for the continued innovation and refinement of HIV-related medicines and technologies, aiming to ensure their availability, quality and affordability. **Primary contributing agencies: WHO, World Bank, WFP, UNESCO**

Strategy Result Area 8: HIV integration

Challenges (2017)	Joint Programme priorities for 2018–2019
Efforts to close access gaps among populations currently being left behind should prioritize integration of HIV care with related services. Such an approach would enhance the impact of the HIV response by eliminating inefficient parallel structures, improving client satisfaction with services, reducing commodity costs and capitalizing on alternative service delivery models. To reach all people living with HIV, health protection must be universal and based on legislation ("national social protection floors"). However, in more than 70 countries, less than half of the population is covered by such protection. The lack of financial resources and capacity gaps remain a challenge for integration of HIV and social protection, as well as reduced overall support for civil society organizations. Integration of programmes, such as cash transfer schemes for young women and girls in school, must be combined with gender initiatives that address unequal power relations. Key populations, adolescents, people living with HIV and TB patients remain underrepresented in social protection programmes. There is lack of adequate advocacy, generation of strategic information on the barriers faced by people living with HIV and capacity building support to mobilize social protection strategies to reduce HIV vulnerability.	**Output 8.1: HIV services decentralization and integration** **UBRAF Target: By 2019, 70% of countries are delivering HIV services in an integrated manner** The Joint Programme will promote collaboration across national health programmes for delivery of integrated services, promote enabling environments and systems strengthening and champion policies that support such linkages. This will include strengthening comprehensive systems for health through the integration of community service delivery with formal health systems, including in the context of universal health coverage. The World Bank will provide financing for the integration and decentralization of services through its health system strengthening lending portfolio. UNFPA will continue to promote the integration of sexual and reproductive health and rights services and HIV services by strengthening policy, systems and service delivery linkages. Work will include building on the sexual and reproductive health/HIV multi-country Linkages Project in eastern and southern Africa to strengthen access to integrated sexual and reproductive health/HIV care, especially for young people, women and key populations, including for people living with HIV. **Primary contributing agencies: UNFPA, WHO, WFP, World Bank** **Output 8.2: HIV-sensitive social protection** **UBRAF Target: By 2019, 60% of countries have social protection strategies and systems in place that address HIV/AIDS** More work will need to be done on understanding and monitoring of HIV sensitivity of social protection programmes. The Joint Programme will continue to build evidence on HIV-sensitive social protection through social protection assessments. Specific attention will be paid to ensuring "national social protection floors" are HIV-sensitive, as well as support governments' HIV sensitive social protection programmes. Programmatic actions will include initiatives to economically empower women and girls, particularly those living with HIV; link social protection to universal health coverage scale-up and support and ensure HIV sensitive social protection programmes at the national level; and the scale up of HIV-sensitive "social protection floors". **Primary contributing agencies: UNICEF, World Bank, WFP, ILO, UNESCO, WHO**

UNAIDS Secretariat focus and priorities

55. The Secretariat works across all result areas in collaboration with Cosponsors, according to UNAIDS' Division of Labour. The Secretariat's functions at global, regional and country levels extend across the 20 UBRAF outputs and support overall Joint Programme achievements, as described in the section above.

56. In 2016–2017, the UNAIDS Secretariat performed a repositioning exercise to deliver on Fast-Track and align itself with the 2030 Agenda within a changing political and financial environment. In 2018–2019, the Secretariat will continue to leverage the strengths of the Joint Programme and deploy a differentiated footprint to accelerate the implementation of the 2016 Political Declaration on Ending AIDS, achieve the Fast-Track targets, and contribute to broader health, human rights and development goals.

S.1 Leadership, advocacy and communication

57. **Drive the global AIDS agenda**. The Secretariat will sustain political leadership and space for the HIV response by engaging existing and new Heads of State, parliamentarians, and religious, civil society and community leaders. It will identify gaps and lead the way forward in the HIV response, promoting equitable access to services and evidence based interventions. The 2018–2019 period will be crucial for building a new prevention coalition with a focus on equity, adolescent girls and young women and key populations. The Secretariat will catalyze support for the Agenda for zero discrimination in health care; support leadership capacity within communities for effective advocacy, demand creation and service delivery; and mobilize like-minded movements working for social justice and inclusion, and scientific innovation.

58. **Advance inclusion, human rights and social justice**. The Secretariat will promote rights of people living with HIV and the Greater Involvement of People Living with HIV (GIPA) principles. In coordination with UNDP, the Secretariat will provide technical support on law reform and the impact of laws, including on HIV-related travel restrictions. The Secretariat will leverage global and regional accountability mechanisms for rights of people, for example, the Human Rights Council, African Commission on Human and People's Rights. It will also mobilize youth, women and key population groups for accountability on the targets in the 2016 Political Declaration on Ending AIDS. It will track and address HIV-related human rights crises and respond to *amicus curiae* requests to leverage public health evidence and human rights standards in courts and human rights bodies. The Secretariat will continue to develop innovations for a sustainable human rights response, for example by strengthening partnerships to expand *pro bono* legal support, encouraging law schools to provide legal services for marginalized populations, and engaging stakeholders to address the shrinking civil space and its impact on the HIV response.

59. **Advocate for AIDS out of isolation.** The Secretariat will continue to lead on the sustainability and transition agenda; it will support WHO in promoting differentiated models of care and service delivery and linkages with community services, and support integration of HIV into broader national health plans. Advancing the policy framework for social contracting will afford civil society and community organizations access to essential funds. In 2018–2019, the Secretariat will lead analyses and discussions on the economics of integration and discrimination; promote integrated and interlinked data systems for multiple conditions including facility and community-level data, surveys; and build synergies with human papillomavirus programmes among others. The Secretariat will, in coordination with

Cosponsors, leverage global fora and platforms to advance commitment and coherence in HIV-related global health fora, such as the 2018 AIDS conference, the 2018 TB High-Level Meeting and the Every Woman Every Child global movement.

2019 UBRAF targets	• 90% of countries have HIV strategies that reflect Fast-Track
	• 80% of Fast-Track countries are on a trajectory to meet the commitments and targets of the 2016 Political Declaration
	• Commitment to end AIDS reflected in the outcome documents of high level political meetings

S.2 Partnerships, mobilization and innovation

60. **Financing the AIDS response and sustainability.** The Secretariat will track needs and resource gaps and advocate for sustained financing of the global AIDS response, including increased funds for civil society. It will promote innovative AIDS financing and work with financing institutions for new instruments, such as an African Bond. It will promote allocative efficiency and strategic investments at national and sub-national levels, and build political commitment and sustainability frameworks to unlock domestic resources for HIV-financing.

61. **Core programmatic partnerships**. Building new partnerships, such as with the private sector around pharmaceutical and technology issues, is a priority for 2018–2019. The Secretariat reconfirms its commitment to the Global Health Partnership H6. It will foster the China-Africa and similar partnerships, and will continue to engage cities and municipalities. It will remain a platform for funders, such as the Global Fund and PEPFAR, for harmonized approaches and implementation efficiency. To this end, specific staff positions to support the effective utilization of Global Fund and PEPFAR grants have been established in some UNAIDS country offices.

62. Galvanize momentum around shared and ambitious **AIDS Global Initiatives** and ensure coherence in their implementation, mutual reinforcement and seamless integration in regional and country programmes and processes. Examples include the *Start Free Stay Free AIDS Free* initiative; building on the progress achieved under the Global Plan towards the elimination of new HIV infections among children by 2015, and keeping their mothers alive; the Plan to Increase Community Health Workers; and the ALL IN initiative.

2019 UBRAF targets	• 80% of stakeholders rate the role of the UNAIDS Secretariat in promoting, facilitating and consolidating partnerships as relevant and effective (in the mid-term review of the 2016–2021 UBRAF)
	• Amounts mobilized by the UNAIDS Secretariat to support civil society action maintained and increased (compared to 2014–2015 levels)
	• 50% of Fast-Track countries have developed a sustainability and transition framework which includes mechanisms for financing civil society action

S.3 Strategic Information

63. **Monitor the implementation of the 2016 Political Declaration on Ending AIDS and target-setting.** Working with the Cosponsors and other partners, the Secretariat will provide guidance for the standardized Global AIDS Monitoring (GAM) and ensure that data are available from all countries and are gathered through scientifically rigorous and inclusive processes. It will support countries with stock-taking exercises, national strategic planning processes and target-setting, and it will lead the reporting to the UN General Assembly.

64. The Secretariat will lead processes for **generation of AIDS-related data** and strengthen the capacities of countries to monitor and evaluate the AIDS epidemic, in collaboration with Cosponsors. In 2018–2019, the Secretariat will:
    - Promote finer resolution (and mathematical modelling) of epidemiological and programme data (at the sub-national, facility and community levels) for identification of people left behind;
    - Partner with GNP+, ICW and other stakeholders on *Stigma Index* implementation;
    - Support the application of social protection assessments tools in 10 countries;
    - Generate information and target setting in new areas such as in PrEP and injectable antiretrovirals, in collaboration with WHO;
    - Forecast needs and demands for commodities (e.g. ART, diagnostics, condoms); and
    - Promote global impact assessments and provide guidance and support for tracking available resources and cost of services.

65. Promote **integration of AIDS information** into wider disease monitoring and surveillance systems in collaboration with WHO, and new **visualization and dissemination tools** for strategic AIDS information via regional data hubs, key population atlas and in-country situation rooms.

2019 UBRAF targets	• 95% of countries report a complete set of Global AIDS Monitoring (GAM) data
	• 50% of Fast-Track countries have established data systems which allow granular programme monitoring and analysis (data disaggregation by sex, age, population groups and geographical location)
	• Over 160 countries are able to report on HIV incidence as required for SDG indicator 3.3 by age and sex

S.4 Coordination, convening and country implementation support

66. **Implementation support.** The Secretariat will promote strategic investments and mobilize expertise and resources to remove bottlenecks at country level. It will promote innovation in service delivery, including community-based delivery. Depending on country contexts, in 2018–2019, the Secretariat will optimize the AIDS coordination function by building existing country structures. It will promote platforms on AIDS prioritization and sustainability, and promote application of implementation science.

67. For effective **Joint Programme support**, the Secretariat will routinely assess and recommend changes necessary to ensure the optimal configuration of UN capacity to respond to specific epidemics at country level. It will ensure adequate joint work plans and accountability mechanisms. The Secretariat will ensure full integration into the United Nations Development Assistance Frameworks (UNDAF) / United Nations Partnership Frameworks (UNPAF) and other sustainable development priorities.

2019 UBRAF targets	• Capacity assessments of the Joint Programme carried out in all Fast-Track countries and areas of accountability defined
	• 80% of Fast-Track countries that have implemented an assessment of the Joint Programme achieve a high success score

S.5 Governance and mutual accountability

68. Together with Cosponsors, the Secretariat will prioritize resource mobilization to fully fund the UBRAF, develop funding scenarios and implement risk mitigation measures. It will support the Joint Programme's inclusive governance model, act as a strong voice for civil society and lead efforts to effectively align the Joint Programme with the **2017–2020 QCPR**. The Secretariat will continue to spearhead efforts to demonstrate the contribution of the Joint Programme to system-wide UN reform efforts, as well as lead Joint Programme reviews and strengthen independent evaluations. The Secretariat will promote new business processes to drive change, maximize cost effectiveness and reinforce accountability. It will enhance efficiency measures, promote development of staff, fully implement the gender action plan and remain environmentally friendly.

2019 UBRAF targets	• Evaluation plan and risk management strategy fully implemented and effectiveness and efficiency targets achieved
	• Gender balance at P5 and above levels and among UNAIDS Country Directors achieved and maintained at 50%

VI. 2018–2019 BUDGET AND RESOURCE ALLOCATION

69. In 2015, the UNAIDS Board adopted the most ambitious strategy for the AIDS response and the Joint Programme to date. Its successful implementation relies on adequate financing of the Secretariat as well as the Cosponsors. The 2018–2019 budget provides an estimate of the resources the Joint Programme will need in 2018–2019 to achieve the milestones and targets identified in the 2016–2021 UBRAF. The budget has been prepared taking into account the unpredictable funding environment and includes two main categories of funding:

    - **Core funds** to fund the Secretariat and implementation of its functions, and to provide catalytic funding for the HIV-related work of 11 Cosponsors with a particular focus on Fast-Track countries; and

    - **Non-core funds** which represent the HIV-related budgets of the Cosponsors that are mobilized internally as well as additional funds that Cosponsors and the Secretariat raise at country, regional and global levels. The non-core funds in the UBRAF reflect regular and extra-budgetary resources of the Cosponsors that contribute to the achievement of UBRAF outputs and are or can be measured through UBRAF indicators. The amounts provided in the 2018–2019 budget represent best estimates and are subject to change as funding is mobilized throughout the biennium.

70. The Global Review Panel on the future of the Joint Programme developed specific recommendations on financing and accountability with the aim to allocate funds where they are needed the most, through dynamic resource mobilization and allocation *to ensure the*

Joint Programme is sufficiently and efficiently financed to set the global vision for the AIDS response, deliver against its Strategy and play its critical role in the HIV ecosystem. Key recommendations for the 2018–2019 budget and resource allocation are:

- Establish a dynamic and differentiated approach to allocation of core funding to the Cosponsors that resources Joint Programme functions, including incentivizing joint work, delivering results at the country level, and facilitating mobilization of complementary non-core resources; and
- Protect the resources and core leadership, advocacy and accountability functions of the Secretariat.

Principles for resource allocation

71. Building on the recommendations of the Global Review Panel, a new approach for the allocation of core resources is introduced in 2018–2019, which takes into account the principles of cosponsorship and the fundamental premise that core UBRAF resources must leverage and catalyze the mobilization of complementary non-core resources while mainstreaming and integrating HIV and AIDS within the broader SDG agenda.

72. Funding from core UBRAF resources is provided based on the following principles, in line with the recommendations of the Global Review Panel:
    - Adequately resourcing the Secretariat functions and protecting the Secretariat's core funding for its leadership, advocacy, strategic information and accountability functions;
    - Providing a minimum core allocation to each Cosponsor to further mainstream HIV and sustain leadership on AIDS among the Cosponsors;
    - Driving the work of the Joint Programme based on country-level priorities with resources for Cosponsors above the minimum allocation for joint action at country-level;
    - Focusing country-level core allocations on Fast-Track countries and populations with greatest need, based on contextual priorities and bottom-up approaches; and
    - Basing country-level core allocations on (a) capacities and expertise to address priority gaps, and (b) performance against clearly defined deliverables and annual milestones.

73. The table below presents the proposed annual allocation of resources in 2018–2019:
    - Allocation of US$ 140 million to adequately resource UNAIDS Secretariat and enable the current level of operations following the repositioning as well as staff and expenditure reductions in 2016;
    - Allocation of US$ 2 million per year to each Cosponsor to offer a degree of predictability in fulfilling respective roles in their engagement with the Joint Programme;
    - A further allocation of US$ 22 million per year to the Cosponsors in the form of country envelopes to leverage joint action in Fast-Track countries and in support of populations in greatest need in other countries;
    - Potential additional resources in the form of supplemental funds mobilized (up to US$ 43 million for the Cosponsors and US$ 15 million for the Secretariat, which would bring total core UBRAF resources to the level of a fully-funded core UBRAF).

Table 1. Expected distribution of core and non-core resources (per year US$ millions)

	Estimated funds (per year)
SECRETARIAT - Core funds	
Global	$66 M
Fast-Track Countries	$42 M
Other Countries	$32 M
Supplemental funds*	$15 M
SUB TOTAL	$155 M
COSPONSORS - Core funds	
Global	$5 M
Fast-Track Countries	$12 M
Other Countries	$5 M
Country envelopes	$22 M
Supplemental funds *	$43 M
SUB TOTAL	$87 M
TOTAL - Core funds	$242 M
TOTAL - Non-core funds	$320 M
GRAND TOTAL - All funds	**$562 M**

** Raised through joint fund raising*

74. **Core allocation to Cosponsors**. The funds that Cosponsors receive from the core UBRAF resources play an important role in leveraging additional, though considerably less flexible, funding. To date Cosponsors have had limited capacity to reallocate any non-core HIV funding, since the vast majority of non-core funding is earmarked. Earmarked non-core funds cannot readily replace core UBRAF resources. A minimum allocation of flexible core UBRAF funding for Cosponsors would continue to enable innovative work to be carried out, and offer some predictability.

75. **Additional core allocation to Cosponsors based on country needs**. An additional allocation of core UBRAF resources responds to the need for a dynamic and differentiated resource allocation to Cosponsors. Additional funding for the Cosponsors will be based on specific proposals, focusing on gaps and priorities in Fast-Track countries and on populations in greatest need in other countries. The amount of core UBRAF funding allocated to each Cosponsor will depend on the outcomes of the allocation of country envelopes among Cosponsors.

Box 3. Country envelopes and additional Cosponsors core allocations

Variables used to determine the size of each country envelope (location/population approach):

- Epidemiological data, for example on disease burden and HIV incidence;
- Particular epidemic contexts, for example HIV concentration among key populations;
- Particular country contexts, for example human rights barriers, HIV-related stigma, gender inequalities and/or violence against women;
- The size of gaps in the HIV response, for example in ART, combination HIV prevention, community engagement;
- Country income levels and the size of resource gaps; and
- The in-country capacity of the Joint Programme to manage the country envelopes.

Process for allocation of country envelopes to Cosponsors:

- Identification of priorities and gaps based on epidemiological and programmatic data, investment cases, HIV response plans, health and development plans;
- Development of proposals by Joint UN Teams on AIDS or similar structures, depending on country context, with clear deliverables that address specific priorities and/or gaps at country level;
- Joint assessment of Cosponsors' capacity and expertise to provide required support at country level;
- Continued funding tied to quality and timely reporting against clearly defined deliverables and annual milestones.

76. **Supplemental funds raised through joint resource mobilization for strategic country, regional and global needs.** These supplemental funds will be mobilized through a Joint Programme investment book to be developed jointly by Cosponsors and the Secretariat in line with the UNAIDS Strategy and UBRAF. Such an arrangement aims to further incentivize joint mobilization of resources by Cosponsors and the Secretariat, and improve transparency and oversight of the work of the Joint Programme by the UNAIDS Board.

Allocation of resources to countries

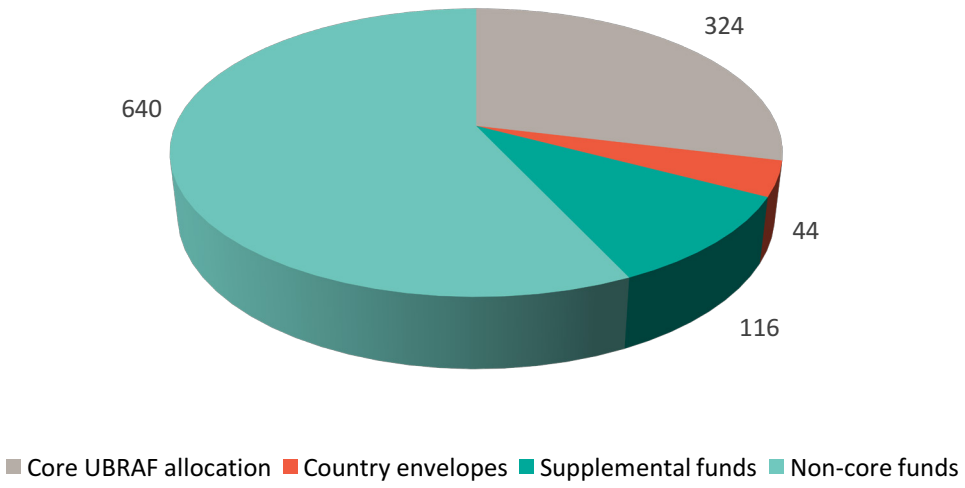
77. UNAIDS Secretariat resources are allocated to countries based on principles and criteria described in the 2016–2021 UBRAF. These take into account the epidemic profile, development context, country capacity, other strategic elements and Cosponsors' actions at country level. The type of country presence and mix of competencies are defined and applied according to country profiles.

78. Cosponsors use comparable approaches that include objective, data-driven methods to allocate core UBRAF resources, adapted to the specificities of each Cosponsor's mandate and structure. Joint assessments and discussions between the Cosponsors and the Secretariat on collective deployment of human resources, country by country are planned to ensure complementarity of skills/expertise and best fit to country needs.

Presentation of the budget

79. The budget represents the best estimate of the resources needed and expected to be mobilized to Fast-Track the response to AIDS during the 2018-2019 biennium. An overview is provided in table 1 (above) of the core and non-core funds, including supplemental funds, that the Joint Programme needs each year to be adequately resourced. The figures and tables below provide a more comprehensive presentation of the allocation of core and non-core resources over the full biennium.

Figure 3. Estimates of total core and non-core funds 2018–2019 (US$ millions)



80. In the tables below, the 2018–2019 budget is presented along the following lines:
    - core and non-core funds;
    - result areas, functions and outputs;
    - global, regional, country and Fast-Track focus.

    The figures in the tables below do not include supplemental funds to be raised through joint fund raising as part of a dynamic and differentiated resource mobilization and allocation model, nor do they include country envelopes as there is no breakdown of these two types of funding as yet. Therefore, the figures showing Cosponsor resources by output, region and Fast-Track countries should be considered indicative as changes in availability of funding, e.g., though country envelopes and other changes may require reallocation of resources and present opportunities for strategic re-programming of funds.

Table 2. Estimates of core and non-core funds by organization 2018–2019 (US$)*

Organization	Core funds	Non-core funds	Total
UNHCR	4,000,000	51,741,300	55,741,300
UNICEF	4,000,000	191,400,000	195,400,000
WFP	4,000,000	55,514,800	59,514,800
UNDP	4,000,000	15,500,000	19,500,000
UNFPA	4,000,000	100,972,800	104,972,800
UNODC	4,000,000	7,651,800	11,651,800
UN Women	4,000,000	5,400,000	9,400,000
ILO	4,000,000	8,700,000	12,700,000
UNESCO	4,000,000	11,232,400	15,232,400
WHO	4,000,000	140,700,000	144,700,000
World Bank	4,000,000	8,500,000	12,500,000
Secretariat	280,000,000	40,000,000	320,000,000
Total	**324,000,000**	**637,313,100**	**961,313,100**

** Supplemental funds, which will be mobilized through joint fund raising as part of a dynamic and differentiated resource mobilization and allocation model, and country envelopes are not reflected in the numbers, as the breakdown of these is not yet known.*

Table 3. Estimates of core and non-core funds by area and by Cosponsor 2018–2019 (US$)*

Strategy Result Areas	Core funds	Non-core funds	Total
Strategy Result Area 1: HIV testing and treatment			
UNHCR	2,923,500	30,853,200	33,776,700
UNICEF	908,600	57,420,000	58,328,600
WFP	1,688,600	21,376,800	23,065,400
UNFPA	155,200	4,099,700	4,254,900
UNODC	375,100	451,100	826,200
UN Women	50,000	150,000	200,000
ILO	823,700	1,524,200	2,347,900
UNESCO	198,000	684,500	882,500
WHO	1,410,000	51,020,000	52,430,000
World Bank	320,000	2,070,000	2,390,000
Subtotal SR Area 1	**8,852,700**	**169,649,500**	**178,502,200**
Strategy Result Area 2: Elimination of mother-to-child transmission of HIV			
UNICEF	784,000	38,280,000	39,064,000
WFP	65,800	159,200	225,000
UNFPA	489,500	14,889,000	15,378,500
UNODC	99,700	135,400	235,100
WHO	410,000	14,100,000	14,510,000
World Bank		1,250,000	1,250,000
Subtotal SR Area 2	**1,849,000**	**68,813,600**	**70,662,600**
Strategy Result Area 3: HIV prevention among young people			
UNICEF	947,400	76,560,000	77,507,400
WFP	92,200	222,800	315,000
UNFPA	1,098,100	27,523,500	28,621,600
UN Women	225,000	337,500	562,500
ILO	908,100	1,216,600	2,124,700
UNESCO	1,884,000	5,190,500	7,074,500
WHO	580,000	13,950,000	14,530,000
World Bank	365,000	630,000	995,000
Subtotal SR Area 3	**6,099,800**	**125,630,900**	**131,730,700**
Strategy Result Area 4: HIV prevention among key populations			
UNICEF	1,360,000	4,740,000	6,100,000
UNDP	1,200,000	4,650,000	5,850,000
UNFPA	790,700	15,672,900	16,463,600
UNODC	2,624,300	5,847,100	8,471,400
ILO	552,500	1,206,500	1,759,000
UNESCO	274,000	714,100	988,100
WHO	780,000	18,230,000	19,010,000
World Bank	400,000	600,000	1,000,000
Subtotal SR Area 4	**7,981,500**	**51,660,600**	**59,642,100**
Strategy Result Area 5: Gender inequality and gender-based violence			
UNHCR	616,400	12,735,100	13,351,500
UNDP	1,200,000	4,300,000	5,500,000
UNFPA	555,900	13,854,300	14,410,200
UNODC	334,800	451,200	786,000
UN Women	3,550,000	4,575,000	8,125,000
ILO	817,400	1,514,000	2,331,400
UNESCO	1,164,000	3,245,800	4,409,800
WHO		6,270,000	6,270,000
World Bank		220,000	220,000
Subtotal SR Area 5	**8,238,500**	**47,165,400**	**55,403,900**

Strategy Result Area 6: Human rights, stigma and discrimination			
UNHCR	460,100	8,153,000	8,613,100
UNDP	1,600,000	6,550,000	8,150,000
UNFPA	187,000	4,118,400	4,305,400
UNODC	566,100	767,000	1,333,100
UN Women	175,000	337,500	512,500
ILO	430,000	1,601,300	2,031,300
UNESCO	140,000	511,800	651,800
WHO	310,000	9,690,000	10,000,000
World Bank		100,000	100,000
Subtotal SR Area 6	**3,868,200**	**31,829,000**	**35,697,200**
Strategy Result Area 7: Investment and efficiency			
WFP		1,438,100	1,438,100
UNESCO	188,000	363,400	551,400
WHO	280,000	17,310,000	17,590,000
World Bank	2,065,000	1,255,000	3,320,000
Subtotal SR Area 7	**2,533,000**	**20,366,500**	**22,899,500**
Strategy Result Area 8: HIV and health services integration			
UNICEF		14,400,000	14,400,000
WFP	2,153,400	32,317,900	34,471,300
UNFPA	723,600	20,815,000	21,538,600
ILO	468,300	1,637,400	2,105,700
UNESCO	152,000	522,300	674,300
WHO	230,000	10,130,000	10,360,000
World Bank	850,000	2,375,000	3,225,000
Subtotal SR Area 8	**4,577,300**	**82,197,600**	**86,774,900**
Total	**44,000,000**	**597,313,100**	**641,313,100**

** Supplemental funds, which will be mobilized through joint fund raising as part of a dynamic and differentiated resource mobilization and allocation model, and country envelopes are not reflected in the numbers, as the breakdown of these is not yet known.*

Table 4. Estimates of core and non-core funds by Secretariat functions 2018-2019 (US$)*

Secretariat Functions	Core funds	Non-core funds	Total
S1 Leadership, advocacy and communications	67,661,000	14,030,000	81,691,000
S2 Partnerships, mobilization and innovation	60,158,000	6,675,000	66,833,000
S3 Strategic information	31,775,000	6,885,000	38,660,000
S4 Coordination, convening and country implementation support	64,844,000	11,110,000	75,954,000
S5 Governance and mutual accountability	55,562,000	1,300,000	56,862,000
Total	**280,000,000**	**40,000,000**	**320,000,000**

** Supplemental funds are not reflected in the numbers as the breakdown of these is not yet known.*

Table 5. Estimates of core and non-core funds by level and focus 2018-2019 (US$)*

Level	Core funds	Non-core funds	Total
Global level	143,114,000	82,976,400	226,090,400
Fast-track countries	107,919,400	354,912,800	462,832,200
Other countries (and regional level)	72,966,600	199,423,900	272,390,500
Total	**324,000,000**	**637,313,100**	**961,313,100**

Table 6. Estimates of core and non-core funds by region 2018-2019 (in US$)*

Region	Core funds	Non-core funds	Grand Total
Global	143,114,000	82,976,400	226,090,400
Asia and Pacific	29,483,700	72,038,800	101,522,500
Eastern Europe and Central Asia	13,037,600	27,036,200	40,073,800
East and Southern Africa	60,988,700	241,430,400	302,419,100
Latin America and the Caribbean	21,858,500	24,733,200	46,591,700
Middle East and North Africa	9,702,600	36,269,400	45,972,000
West and Central Africa	45,814,900	152,828,700	198,643,600
Grand Total	**324,000,000**	**637,313,100**	**961,313,100**

** Supplemental funds are not reflected in the numbers as the breakdown of these is not yet known.*

Role and indicative use of core UBRAF resources by Cosponsors

81. Core UBRAF funds are expected to fund the equivalent of 92 full-time staff of Cosponsors. The number of staff vary by agency: 4 staff in UNDP and UNICEF; 5 in UNHCR; 6 in UN Women; 7 in WHO and the World Bank; 8 in UNODC; 10 in ILO; 12 in UNFPA; 14 in WFP and 15 in UNESCO.

82. During 2018–2019 **UNHCR** will allocate core UBRAF funding directly to countries based on key priorities and gaps identified in the response to leverage further support and integration of HIV at country level. For instance, countries will be supported to improve programming for key populations. An example is Pakistan where UBRAF funding supports a programme that provides harm reduction and detoxification services to people who inject drugs. Scaling up services for adolescents will also be prioritised, as in Malawi where core UBRAF funds support the scale up of youth-friendly HIV prevention services in two refugee camps. Other priorities at country level include improving coverage of eMTCT, improving services to support adherence to ART and scaling up services to address sexual and gender-based violence in vulnerable populations such as adolescent girls. Finally, UBRAF funding will support global and regional level guidance and technical support, providing for two staff at global level, cost-sharing for key regional positions and support for the activities of the Inter-Agency Task Team on Addressing HIV in Humanitarian Emergencies.

83. With the core UBRAF allocation, **UNICEF** will maintain its critical core functions in PMTCT, paediatric and adolescent HIV treatment and adolescent prevention aligned to the Super Fast-Track Framework, *Start Free Stay Free AIDS Free*, and the Global Prevention Framework. In sub-Saharan Africa and Asia and the Pacific, UNICEF will continue to lead the accelerated implementation of quality and comprehensive services for pregnant women, children and adolescents and young women. For PMTCT, the focus will be to support countries to concentrate on those people and areas that are not yet reached with services, and on strengthening retention in care. For paediatric and adolescent treatment, UNICEF will support work to close the diagnostic gap to locate and link people in need of HIV treatment by integrating HIV services in maternal child health platforms. As a co-convener for *Start Free Stay Free AIDS Free*, and building on the ALL IN platform, UNICEF will lead efforts to coordinate, implement and monitor combination prevention efforts in *Stay Free* priority countries, targeting adolescent and young women. Outside sub-Saharan Africa and Asia and the Pacific, UNICEF will lead work on key populations, targeting adolescent and pregnant key populations, as well as children of key populations.

84. The UBRAF core allocation will allow **WFP** to maintain a small capacity to best leverage WFP's existing programmes in Fast-Track countries and in humanitarian contexts. While WFP increasingly mainstreams HIV across its programmes, the UBRAF core allocation ensures that the technical capacity of HIV dedicated staff at global and regional levels provides the right support and continues to generate catalytic funding. WFP is prioritizing the use of UBRAF core funds for outputs related to the treatment cascade (adherence to treatment), humanitarian contexts and social protection. This will ensure the continuation of addressing the needs of vulnerable people living with HIV in WFP's core activities (social protection, school feeding, nutrition and supply chain). Non-core resources will be used to make linkages and contribute to SRAs 2 and 3. The UBRAF core allocation is also crucial to ensure that WFP can provide timely assistance to meet the needs of people living with or at risk of HIV during select humanitarian emergencies.

85. **UNDP**'s allocation of core UBRAF funds reflects UNDP's strategy and mandate on addressing the social, economic and environmental determinants of HIV. Funding will be utilized to strengthen capacity at the global and regional level to support Fast-Track countries and a selection of key non-Fast-Track countries with evidence based programme and policy support on enabling legal and policy environments, key populations, gender-based violence and human rights programmes for effective HIV responses, including in humanitarian contexts. UNDP will strengthen integration of HIV in regional and country processes to support the achievement of the Sustainable Development Goals and leaving no one behind. This includes advocating for HIV as a strategic entry point or pathfinder in the country roadmaps developed as part of the UNDP-led MAPS (Mainstreaming, Acceleration and Policy Support) missions undertaken by the UN Development Group.

86. For **UNFPA**, the allocation of core UBRAF funds reflects UNFPA's strategic focus on strengthening combination prevention programmes, linking and integrating HIV and sexual and reproductive health, promotion of gender equality and tailored programming to meet the needs of women, young people and key populations to reduce sexual transmission of HIV and other STIs, including these programmatic elements within humanitarian contexts.

87. With its core allocation **UNODC** maintains its key functions and contributes to eight UBRAF outputs, highly prioritizing the outputs on HIV services for key populations (prisons) and harm reduction for people who inject drugs (PWID). UNODC delivers specialized support to

at least one third of the 33 Fast-Track countries as well as to additional high-priority non-Fast-Track countries, particularly for people who use drugs (PWUD). In countries, UNODC core UBRAF funds are used to foster strong collaboration between drug control agencies, prison administration, public health, criminal justice and civil society including organizations of PWUD; advocate for and support of legal, policy and practices reforms for people who inject drugs and people in prisons; build capacity for implementing HIV services, including for women who use drugs and for people using stimulants; strengthen partnerships between law enforcement and civil society and build sustainable capacity of law enforcement agencies in HIV harm reduction for people who inject drugs; and deliver training to improve data quality and HIV service monitoring and evaluation. At global level, UNODC core UBRAF funds support advocacy among drug control agencies, ministries of justice, and prison authorities for human rights- and evidence-based, gender- and age-responsive policies and for increasing investments in HIV responses for people who use drugs and in prisons; development of implementation guidance (such as I-DUIT); implementation of a joint work plan with civil society; and generation of strategic information on HIV and people who inject drugs, and HIV in prisons.

88. With the UBRAF core allocation, **UN Women** will prioritize work on five UBRAF outputs. It will maintain technical support to countries through two Gender Equality and HIV Regional Specialists (one in sub-Saharan Africa, one in Asia and the Pacific) and two global Policy Specialists to ensure engagement in the Joint Programme; provision of normative, policy support, knowledge management, learning and advocacy on gender equality and HIV. Other areas of support funded through UBRAF core resources include: technical advice and tools for integrating gender equality into the governance of the HIV responses; evidence-based interventions in the context of HIV in at least 10 countries; policy support to countries to integrate HIV into the national action plans on ending violence against women and implement interventions aimed at preventing violence and HIV; supporting the leadership and engagement of networks of women living with HIV and organizations of young women and adolescent girls in the HIV response, including the development of the Global Fund concept notes; and developing strategies, tools and intervention to ensure that treatment expansion efforts address the specific barriers women face in accessing and adhering to treatment.

89. In 2018–2019, the **ILO** is prioritizing programmatically, geographically and in terms of staffing. Programmatic prioritization will include prioritizing three out of the six UBRAF outputs it contributes to, including scaling up HIV testing, targeted combination prevention and transforming unequal gender norms. More core resources have thus been allocated to these outputs. In terms of geographical prioritization, the limited core UBRAF resources will be used almost exclusively in Fast-Track countries. Staffing prioritisation will see the ILO reducing its Headquarters presence to free up resources for programming in Fast-Track countries. Core resources are also being used to cost-share staff in Fast-Track countries. The prioritization of core UBRAF resources was also informed by non-core resources available. For example, the ILO did not prioritize the UBRAF output on social protection among its three top priorities even though this area of work is core to the ILO's mandate, since non-core resources are available to complement the limited UBRAF resources.

90. Core UBRAF funding in 2018–2019 to **UNESCO** will be prioritized towards continued technical and programming capacity and coverage of priority countries to reach children and young people with good quality comprehensive sexuality education as part of combination

HIV prevention efforts and to address related social determinants of HIV particularly gender inequality, gender-based violence (including homophobic violence) and stigma, through education. The core allocation will be directed towards policy engagement and technical capacity building for: improved delivery and monitoring of good quality comprehensive sexuality education (through roll-out of international technical guidance); strengthened capacities of African countries to provide quality comprehensive sexuality education; and policy and programmatic support to reduce gender-based violence, including homophobic and transphobic violence, and to promote gender equality in and through education. The core UBRAF allocation will contribute to sustaining existing human resource capacity and create synergies with UNESCO's non-UBRAF funds for HIV and health.

91. With its core UBRAF allocation, **WHO** is preserving regional office capacity to actively support Fast-Track countries in Asia and the Pacific, West and Central Africa, Eastern and southern Africa, and Eastern Europe central Asia regions of the Joint Programme. WHO is seeking to ensure effective implementation of WHO normative guidance and optimal HIV integration and linkages across the health systems of Fast Track countries—for example with stronger linkages for HIV and the programmes and services for TB, sexually transmitted infections, viral hepatitis and noncommunicable diseases. Through coordinated support from Headquarters and WHO regional offices, UBRAF core funds will be prioritized to ensure that Fast-Track countries are: implementing updated WHO HIV testing and treatment guidelines, including technical assistance in relation to "Treat All" guidance, HIV self-testing and assisted partner notification; strengthening the systems that support the 90–90–90 HIV treatment cascade, including treatment scale-up, monitoring HIV drug resistance, and improving strategic information systems; progressing towards the elimination of mother-to-child transmission; implementing comprehensive harm reduction programmes; including innovative approaches in combination HIV prevention programmes, notably PrEP and VMMC; addressing the prevention needs of key populations and adolescents; and integrating HIV and other health services.

92. With its core UBRAF allocation, the **World Bank** seeks to preserve capacity to support the mainstreaming of HIV into its multi-sectoral development financing and provide strategic information, economic analysis, technical support and policy guidance for governments and implementers. World Bank core UBRAF funds will prioritize the efficiency, effectiveness, impact, integration and sustainability of national HIV strategic and operational plans, including HIV prevention plans and implementation of national responses.

Table 7. Estimates of core funds by Output and by Cosponsor 2018–2019 (US$ thousands)

Output	UNHCR	UNICEF	WFP	UNDP	UNFPA	UNODC	UN Women	ILO	UNESCO	WHO	World Bank	Total
Strategy Result Area 1: HIV testing and treatment												
Output 1			66					824		460		1,350
Output 2			1,064			144	50			580		1,838
Output 3		412	235						198	370	320	1,535
Output 4		412				231						643
Output 5	2,924	85	284		155							3,448
Output 6			40									40
Subtotal SR Area 1	**2,924**	**909**	**1,689**		**155**	**375**	**50**	**824**	**198**	**1,410**	**320**	**8,853**
Strategy Result Area 2: Elimination of mother-to-child transmission												
Output 1		784	66		490	100				410		1,849
Subtotal SR Area 2		**784**	**66**		**490**	**100**				**410**		**1,849**
Strategy Result Area 3: HIV prevention among young people												
Output 1		474			685			908	952	420	320	3,759
Output 2		474	92		413		225		932	160	45	2,341
Subtotal SR Area 3		**947**	**92**		**1,098**		**225**	**908**	**1,884**	**580**	**365**	**6,100**
Strategy Result Area 4: HIV prevention among key populations												
Output 1		680		1,200	791	1,203		553	274	410	330	5,441
Output 2		680				1,421				370	70	2,541
Subtotal SR Area4		**1,360**		**1,200**	**791**	**2,624**		**553**	**274**	**780**	**400**	**7,982**
Strategy Result Area 5: Gender inequality and gender-based violence												
Output 1					259		1,830	817	304			3,210
Output 2	616			1,200	297	335	1,720		860			5,029
Subtotal SR Area 5	**616**			**1,200**	**556**	**335**	**3,550**	**817**	**1,164**			**8,239**
Strategy Result Area 6: Human rights, stigma and discrimination												
Output 1	460			800		231		430				1,921
Output 2				400		335	175		140			1,050
Output 3				400	187					310		897
Subtotal SR Area 6	**460**			**1,600**	**187**	**566**	**175**	**430**	**140**	**310**		**3,868**
Strategy Result Area 7: Investment and efficiency												
Output 1											1,810	1,810
Output 2									188	280	255	723
Subtotal SR Area 7									**188**	**280**	**2,065**	**2,533**
Strategy Result Area 8: HIV and health services integration												
Output 1			1,266		724					230	595	2,815
Output 2			887					468	152		255	1,762
Subtotal SR Area 8			**2,153**		**724**			**468**	**152**	**230**	**850**	**4,577**
Total	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**4,000**	**44,000**

Table 8. Estimates of non-core funds by Output and by Cosponsor 2018–2019 (US$ thousands)

Output	UNHCR	UNICEF	WFP	UNDP	UNFPA	UNODC	UN Women	ILO	UNESCO	WHO	World Bank	Total
Strategy Result Area 1: HIV testing and treatment												
Output 1		8,019	159					1,524		13,090	200	22,992
Output 2		8,538	15,993			135	150			16,150		40,966
Output 3		18,349	2,605						685	8,030	1,210	30,879
Output 4		18,349				316				1,450		20,115
Output 5	30,853	4,165	2,388		4,100					3,420	250	45,176
Output 6			231							8,880	410	9,521
Subtotal SRA 1	**30,853**	**57,420**	**21,377**		**4,100**	**451**	**150**	**1,524**	**685**	**51,020**	**2,070**	**169,650**
Strategy Result Area 2: Elimination of mother-to-child transmission												
Output 1		38,280	159		14,889	135				14,100	1,250	68,814
Subtotal SRA 2		**38,280**	**159**		**14,889**	**135**				**14,100**	**1,250**	**68,814**
Strategy Result Area 3: HIV prevention among young people												
Output 1		38,280			18,412			1,217	2,565	8,150	630	69,254
Output 2		38,280	223		9,112		338		2,626	5,800		56,377
Subtotal SRA 3		**76,560**	**223**		**27,524**		**338**	**1,217**	**5,191**	**13,950**	**630**	**125,631**
Strategy Result Area 4: HIV prevention among key populations												
Output 1		2,370		4,450	15,673	3,866		1,207	714	9,780	420	38,480
Output 2		2,370		200		1,981				8,450	180	13,181
Subtotal SRA 4		**4,740**		**4,650**	**15,673**	**5,847**		**1,207**	**714**	**18,230**	**600**	**51,661**
Strategy Result Area 5: Gender inequality and gender-based violence												
Output 1				2,500	6,850		2,363	1,514	787	2,590	145	16,748
Output 2	12,735			1,800	7,005	451	2,213		2,459	3,680	75	30,418
Subtotal SRA 5	**12,735**			**4,300**	**13,854**	**451**	**4,575**	**1,514**	**3,246**	**6,270**	**220**	**47,165**
Strategy Result Area 6: Human rights, stigma and discrimination												
Output 1	8,153			3,350		316		1,601		1,410		14,830
Output 2				1,950		451	338		512	500		3,751
Output 3				1,250	4,118					7,780	100	13,248
Subtotal SRA 6	**8,153**			**6,550**	**4,118**	**767**	**338**	**1,601**	**512**	**9,690**	**100**	**31,829**
Strategy Result Area 7: Investment and efficiency												
Output 1										8,330	855	9,185
Output 2			1,438						363	8,980	400	11,182
Subtotal SRA 7			**1,438**						**363**	**17,310**	**1,255**	**20,367**
Strategy Result Area 8: HIV and health services integration												
Output 1			25,353		20,815					8,760	1,100	56,028
Output 2		14,400	6,965					1,637	522	1,370	1,275	26,169
Subtotal SRA 8		**14,400**	**32,318**		**20,815**			**1,637**	**522**	**10,130**	**2,375**	**82,198**
Total	**51,741**	**191,400**	**55,515**	**15,500**	**100,973**	**7,652**	**5,400**	**8,700**	**11,232**	**140,700**	**8,500**	**597,313**

Table 9. Estimates of total funds by Output and by Cosponsor 2018–2019 (US$ thousands)

Output	UNHCR	UNICEF	WFP	UNDP	UNFPA	UNODC	UN Women	ILO	UNESCO	WHO	World Bank	Total
Strategy Result Area 1: HIV testing and treatment												
Output 1		8,019	225					2,348		13,550	200	24,342
Output 2		8,538	17,056			279	200			16,730		42,803
Output 3		18,761	2,841						883	8,400	1,530	32,414
Output 4		18,761				547				1,450		20,758
Output 5	33,777	4,250	2,673		4,255					3,420	250	48,624
Output 6			271							8,880	410	9,561
Subtot. SRA 1	**33,777**	**58,329**	**23,065**		**4,255**	**826**	**200**	**2,348**	**883**	**52,430**	**2,390**	**178,502**
Strategy Result Area 2: Elimination of mother-to-child transmission												
Output 1		39,064	225		15,379	235				14,510	1,250	70,663
Subtot. SRA 2		**39,064**	**225**		**15,379**	**235**				**14,510**	**1,250**	**70,663**
Strategy Result Area 3: HIV prevention among young people												
Output 1		38,754			19,097			2,125	3,517	8,570	950	73,013
Output 2		38,754	315		9,524		563		3,558	5,960	45	58,718
Subtot. SRA 3		**77,507**	**315**		**28,622**		**563**	**2,125**	**7,075**	**14,530**	**995**	**131,731**
Strategy Result Area 4: HIV prevention among key populations												
Output 1		3,050		5,650	16,464	5,070		1,759	988	10,190	750	43,921
Output 2		3,050		200		3,402				8,820	250	15,722
Subtot. SRA 4		**6,100**		**5,850**	**16,464**	**8,471**		**1,759**	**988**	**19,010**	**1,000**	**59,642**
Strategy Result Area 5: Gender inequality and gender-based violence												
Output 1				2,500	7,108		4,193	2,331	1,091	2,590	145	19,958
Output 2	13,352			3,000	7,302	786	3,933		3,319	3,680	75	35,446
Subtot. SRA 5	**13,352**			**5,500**	**14,410**	**786**	**8,125**	**2,331**	**4,410**	**6,270**	**220**	**55,404**
Strategy Result Area 6: Human rights, stigma and discrimination												
Output 1	8,613			4,150		547		2,031		1,410		16,752
Output 2				2,350		786	513		652	500		4,800
Output 3				1,650	4,305					8,090	100	14,145
Subtot. SRA 6	**8,613**			**8,150**	**4,305**	**1,333**	**513**	**2,031**	**652**	**10,000**	**100**	**35,697**
Strategy Result Area 7: Investment and efficiency												
Output 1										8,330	2,665	10,995
Output 2			1,438						551	9,260	655	11,905
Subtot. SRA 7			**1,438**						**551**	**17,590**	**3,320**	**22,900**
Strategy Result Area 8: HIV and health services integration												
Output 1			26,620		21,539					8,990	1,695	58,843
Output 2		14,400	7,852					2,106	674	1,370	1,530	27,932
Subtot. SRA 8		**14,400**	**34,471**		**21,539**			**2,106**	**674**	**10,360**	**3,225**	**86,775**
Total	**55,741**	**195,400**	**59,515**	**19,500**	**104,973**	**11,652**	**9,400**	**12,700**	**15,232**	**144,700**	**12,500**	**641,313**

Human resources

93. The existence of a dedicated Secretariat at global, regional and country levels facilitates coherence, coordination and consistency in the UN system efforts to end AIDS. To ensure optimal delivery of the Fast-Track strategy, the Secretariat undertook a strategic repositioning exercise to continue increasing effectiveness, align its structure, and adapt its ways of working to the ongoing changes in the political and financial environments. Following extensive consultations, a set of reprofiled functions were established within a streamlined organizational structure.

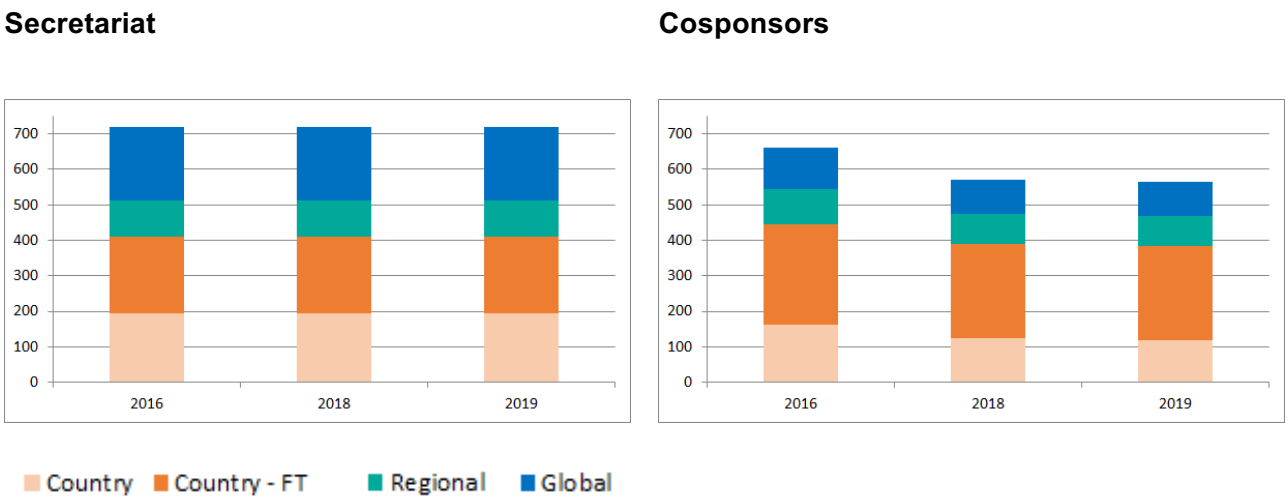
94. A key outcome of the repositioning was a heightened focus on a number of reprofiled functional areas to drive country-level results, including Fast-Track Advisers, PEPFAR/Global Fund Advisers, and Community Support Advisers. Across Headquarters and Regional Support Teams, stronger linkages were created to connect normative and political strategy to country-level action.

95. The current overall target number of Secretariat staff in 2018 and 2019 is 720 (a reduction of some 13%, equivalent to 110 staff, compared with 2015). The aim is to maintain the current 70:30 ratio of field to Headquarters staff. In addition to professional/technical staff in the tables and graphs below, Secretariat staff numbers also include general service staff (including administrative assistants and drivers).

96. The overall number of Cosponsor HIV staff full-time equivalent in 2018 and 2019 is estimated at 571 and 563 (a projected decrease from 662 staff full-time equivalent in 2016 and 862 in 2015 (in the context of a fully-funded UBRAF)). When comparing with Secretariat staff numbers, it is important to note that Cosponsor staff numbers only include professional/technical staff and long-term consultants (with more than six-month contracts), and do not account for general service functions. Eighty-three percent of Cosponsor staff working on HIV are in the field. The presence of Cosponsor staff with dedicated time for HIV issues varies significantly among Cosponsors and across countries, with about half of overall staff time allocated to Fast-Track countries.

97. Cosponsor HIV staff at global and regional levels remain critical for providing countries with normative guidance and technical support in their areas of expertise, keeping AIDS visible and high on the agenda of their organizations, and leveraging additional resources for the response.

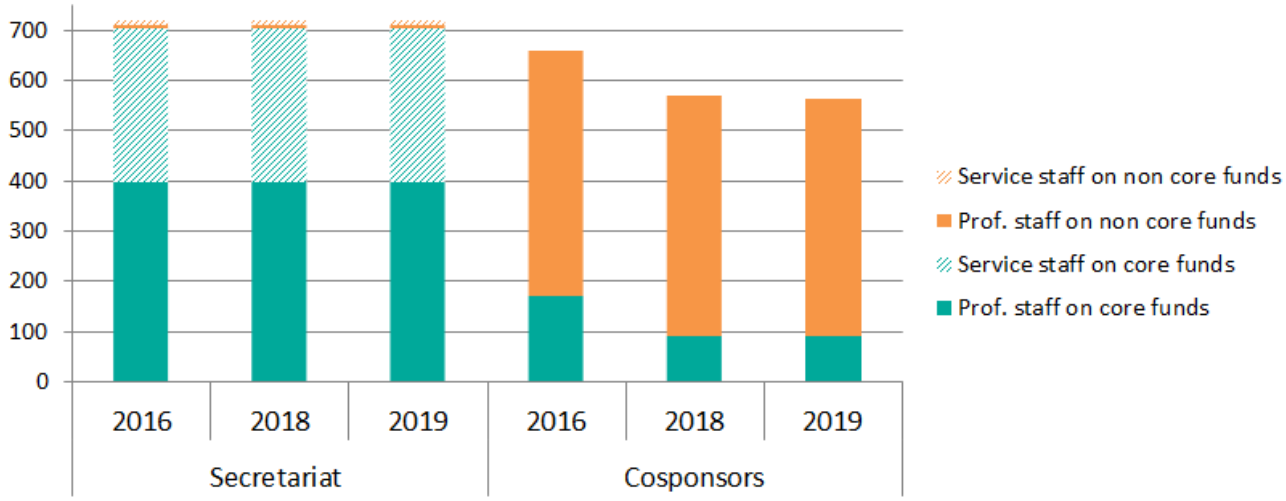
Figure 4. Secretariat and Cosponsors overall full time staff equivalent working on HIV by global level, regional level, Fast-Track countries and other countries



98. Over 95% of Secretariat staff are funded through core UBRAF funds. As the UNAIDS Secretariat is neither a funding nor an implementing organization, the support it offers to countries is largely in the form of staff time and expertise.

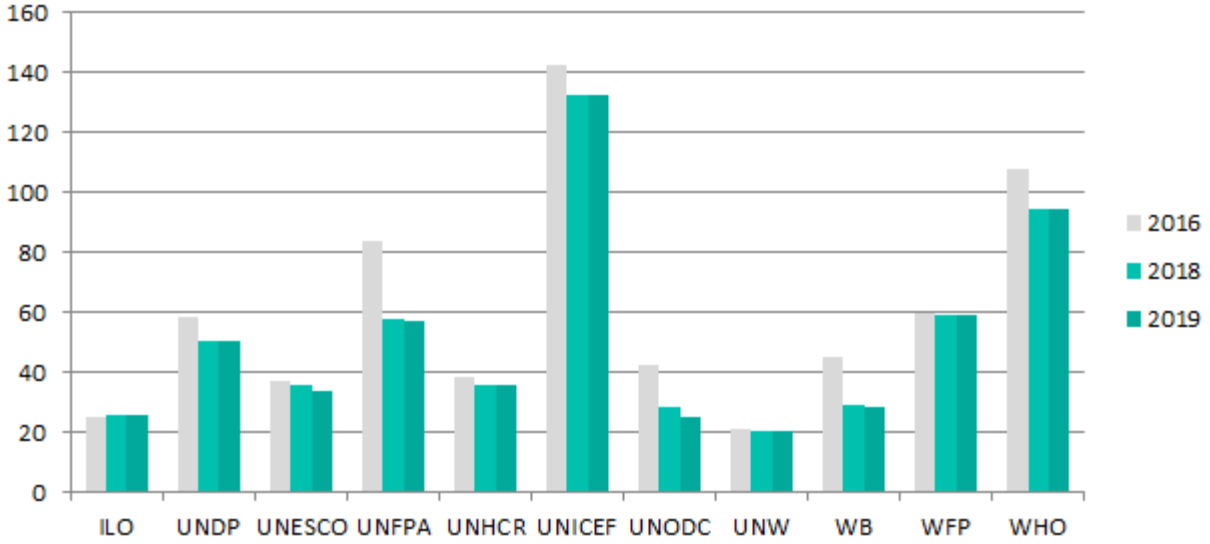
99. UBRAF core funds are critically important for the Cosponsors. The majority of Cosponsors staff (as a whole) is funded from non-core funds—and increasingly so, due to reduced core UBRAF funds.

Figure 5. Secretariat and Cosponsors overall full time staff equivalent working on HIV by source of funds and by year (2016 actuals and 2018 and 2019 projections)



100. Staff numbers and related country presence vary across Cosponsors, with UNICEF and WHO having the largest number of dedicated staff working on HIV.

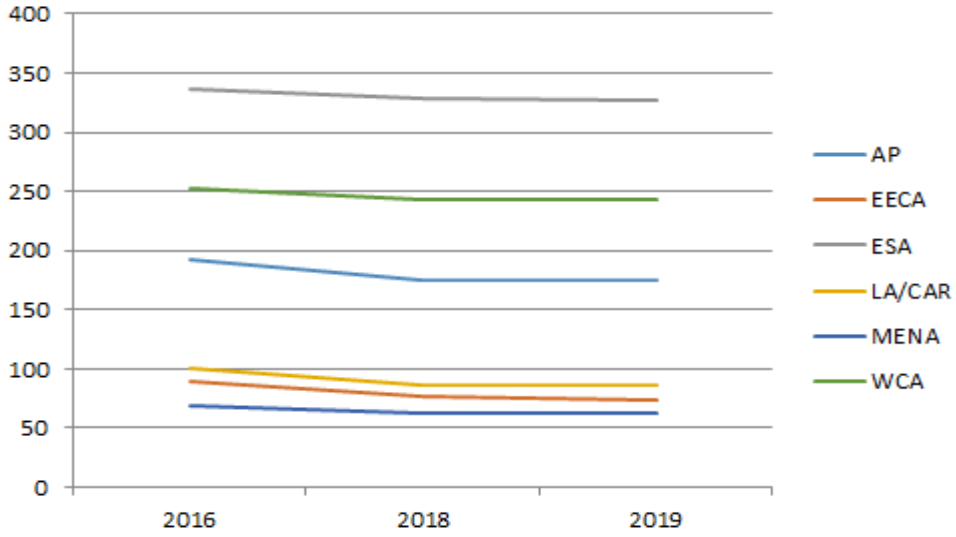
Figure 6. Cosponsors overall full time staff equivalent working on HIV by organisation and by year (2016 actuals and 2018 and 2019 projections)



101. The UNAIDS 2016–2021 Strategy places particular emphasis on strengthening locally-tailored responses by fostering regional leadership and accountability. The UNAIDS Secretariat has six Regional Support Teams, which work closely with the regional Cosponsor AIDS staff to support the UNAIDS Country Directors and UN Country Teams.

102. Figure 6 shows overall Joint Programme staff per region, and reflects staff who are working on AIDS and who are physically based at country or regional levels. Presence is proportionate to epidemic burden and income levels, with larger staff numbers in sub-Saharan Africa. However, the Joint Programme strives to maintain a strategic presence in all regions, acknowledging the need for contextualised responses and for ensuring that no one is left behind. When comparing with 2016 data, the trend is downward across all regions, reflecting expectations of a decline in (non-core) funding.

Figure 7. Secretariat and Cosponsors overall full-time staff equivalent working on HIV by region (regional and country levels)



VII. MONITORING AND EVALUATION

103. The 2016–2021 UBRAF comprises a broad range of monitoring and evaluation tools to measure the performance of the Joint Programme. Quantitative data, using indicators, are combined with narrative descriptions and analyses of progress, external assessments, reviews and independent evaluations to triangulate results and provide a more complete picture of what has been achieved.

104. The indicators in the UBRAF capture progress at country level that represents plausible results of the actions of the Joint Programme. The number of indicators has been reduced as much as possible, with a shift from process indicators to monitoring country-level changes that reflect more direct Joint Programme contributions.

105. A web-based tool, the JPMS facilitates collecting, collating and analysing performance information. Data entry starts at the country level and is performed by Joint United Nations Teams on AIDS or similar structures.

106. The annual performance monitoring report is the primary tool used to report to the PCB on results against the UBRAF. It includes a narrative highlighting the Joint Programme's contributions, progress against indicators, expenditures, case studies and key evaluation findings. The annual performance monitoring report is complemented by annual financial reports prepared for the PCB and the report of the chair of the Committee of Cosponsoring Organisations (CCO).

107. In 2017, an independent evaluation function will be established in UNAIDS Secretariat to strengthen evaluation. The 2016 QCPR and the Secretary-General have placed particular emphasis on increasing the accountability of UN system entities, noting that a strong culture of accountability requires independent capacity of evaluation to measure not only agencies' performance according to their mandates, but how they perform in relation to their contributions to reaching the SDGs.

108. For the 2018–2019 period, the overall monitoring and accountability framework will be strengthened in several ways, in line with the recommendations of the Global Review Panel:

- **Distinguish clearly results by the Secretariat, by individual Cosponsors and collective results.** Drawing on data captured in a disaggregated way in the JPMS, performance reports to the PCB will clearly distinguish between achievements by the Secretariat, achievements by individual Cosponsors, and collective achievements.

- **Strengthen existing indicators to capture results and improve the analysis of progress against annual milestones.** UBRAF indicators will be strengthened further to capture Joint Programme results at country level and improve the analysis of progress against annual milestones, including data triangulation with outcome and impact data, and peer reviews (with participation of external partners) to analyse progress and challenges.

- **Establish robust monitoring and reporting against country level allocations.** Progress against country-level targets and milestones, and expenditures and deliverables against country-level allocations will be monitored and reported annually to the Board.

- **Increase and sustain quantity and quality of independent evaluations.** Quantity and quality of independent evaluations will be increased and sustained, including joint evaluations with Cosponsors, and with regular reporting to the PCB.

- **Improve reporting on core UBRAF funds.** Reporting by the Cosponsors will be enhanced to also include expenditures by standard/commonly used expenditure categories on the core UBRAF allocations. Ways to better utilize existing Cosponsor reporting frameworks and mechanisms will be used to minimize burdensome processes.

- **Reporting to the Board on non-core resources to ensure the full contribution of Cosponsors to the Joint Programme.** Cosponsors will report to the PCB on non-core resources spending. Financial data will be presented with disaggregation for core and non-core resources, and staff numbers funded through core and non-core resources will also be reported separately.

109. In the second half of 2017, the milestones and targets included in the 2016–2021 UBRAF will be reviewed and revised, as necessary, based on validation of indicators, level of progress achieved, and taking into account UNAIDS' financial situation. The resource outlook will be monitored closely as part of UNAIDS overall risk management strategy and scenarios will be prepared and shared with the PCB, as necessary, at future meetings of the Board.

Part II – REGIONAL AND FAST-TRACK COUNTRY PRIORITIES

110. The following section presents the targets and priorities of the Joint Programme for 2018–2019 in each region and the Fast-Track countries. The identification of targets and priorities was initiated by the Secretariat and Cosponsors at country and regional levels as part of UNAIDS' annual reporting through the JPMS, and was subsequently refined by Joint UN Teams on AIDS. Regional consultations were conducted to discuss obstacles, challenges and needs to Fast-Track the response in each region; changes which the Joint Programme, the Secretariat and Cosponsors need to do introduce; and ways for optimizing Joint Programme and other resources. Consultations involved Cosponsors, the Secretariat and partners, such as the Global Fund, PEPFAR and civil society.

111. The targets presented are a selection of agreed national and regional targets to which the Joint Programme contributes significantly, and do not cover the entirety of Joint Programme engagement at regional or country levels. Joint Programme priority actions (organized around Strategic Result Areas) reflect the capacity and the comparative advantages of the Joint Programme on the ground, and will guide development of country proposals for the allocation of the country envelopes to Cosponsors (beyond the core UBRAF allocation of US$ 2 million per Cosponsor).

112. In addressing agreed priorities across activities and interventions, the Joint Programme will follow human rights principles and apply a gender lens to ensure that responses are people-centered; gender sensitive; advance diversity, inclusion and equality; encourage civil society and community participation; and contribute to advancing equitable development for all people, leaving no one behind. The life cycle approach will be used as a lens to better understand the complex dynamics of the HIV epidemic and the response, searching for the best solutions for people throughout their lifetime. Evidence-informed, high-impact approaches will be consistently applied across the life cycle, using a location-population approach that prioritizes the geographical areas and populations in greatest need. Where appropriate, HIV policies, systems and services will be integrated, in line with the interdependent nature of the strategic result areas and the SDGs.

A. ASIA AND THE PACIFIC

2019 targets and priorities for the Joint Programme in Asia and the Pacific

HIV testing and treatment

85% *(or 3.5 million people) of people living with HIV who know their status are on treatment (increase from 64%)*

- Ensuring that all countries in the region adopt and implement "Treat All".

Increased regional median of HIV testing among key populations (people who inject drugs from 30% to 60%, female sex workers from 43% to 70% and men who have sex with men from 43% to 70%)

- Ensuring that at least eight countries have policies that enable community based testing;
- Developing innovative models for reaching key populations, including self-testing and online supported self-testing.

HIV prevention among young people and key populations

Increased access of young key populations to HIV prevention and testing services (testing coverage for young people who inject drugs from 21% to 50%, for young sex workers from 38% to 60%, for young men who have sex with men from 35% to 70%)

- Regional advocacy for lowering the age of legal consent for HIV testing;
- Transforming unequal gender norms, which affect boys and girls differently;
- Development and scale up of innovative approaches, including internet and mobile telephone-based models for outreach.

70% PMTCT coverage in the region (39% in 2015)

- Provision of technical support;
- Strengthened integration with maternal and child health services;
- Addressing gender-related barriers facing women who are living with HIV;
- Technical support for elimination certification in three countries.

At least 15 000 *men who have sex with men on PrEP in eight countries*

- Roll out of PrEP programmes in nine countries;
- Modeling of PrEP cost effectiveness;
- Regional advocacy and technical support to community-based organizations for strengthened capacity of implementation;

Legal environments, stigma and discrimination, gender inequality and gender-based violence

At least six countries have systems in place for monitoring and responding to stigma and discrimination in health care settings

- Regional advocacy, provision of technical assistance and capacity building;
- Development of models for measuring and addressing stigma and discrimination in health care settings.

At least five countries in the region with prevention of and response to gender-based violence against women and girls, and promoting gender equality integrated into HIV national responses

Investment, efficiency and integration

At least 60% of total HIV spending in the region on combination prevention on key populations (increase from 35% in 2015)

- Provision of quality technical support to countries and regional community-based and civil society organizations for Global Fund proposal development;
- Strategic planning, allocative efficiency modeling, optimization analysis and costing of transition plans.

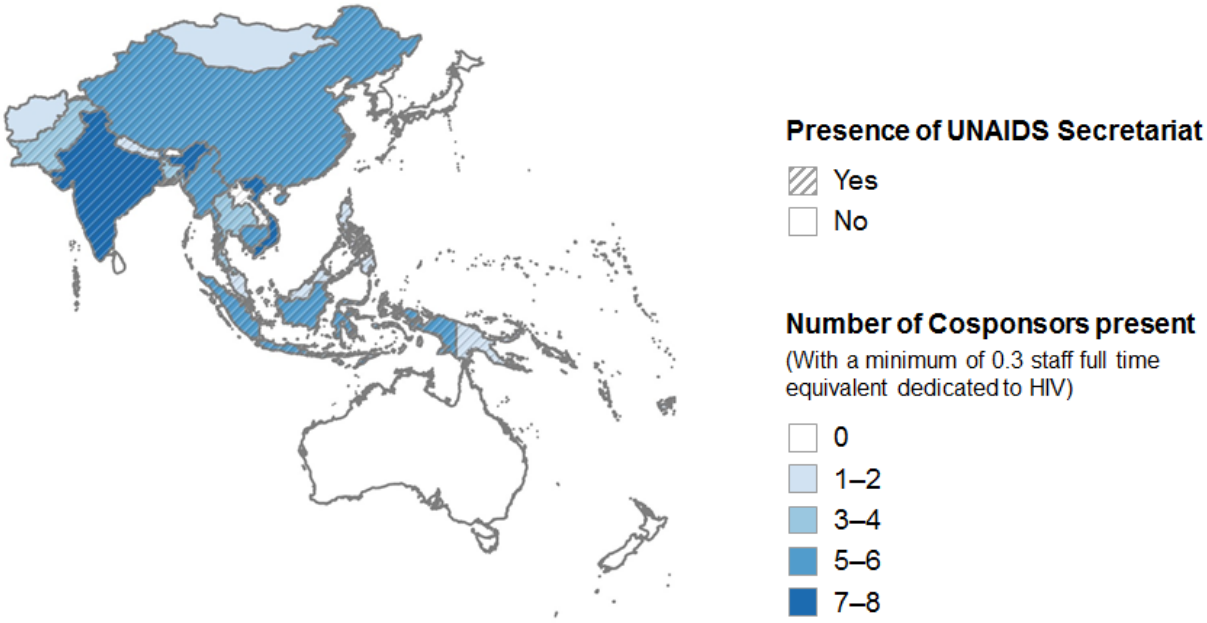
70% HIV testing rate among TB patients (45% in 2015)

- Strengthening integrated approaches in diagnosis, treatment and care of TB-HIV co-infections.

Table 10. Estimates of core and non-core funds in Asia and Pacific 2018–2019

Organization	Core funds US$	% Fast-Track countries	Non-core funds US$	% Fast-Track countries
UNHCR	346,700	38%	3,138,400	30%
UNICEF	632,000	70%	18,400,000	69%
WFP	86,800	100%	2,286,200	100%
UNDP	560,000	80%	1,400,000	65%
UNFPA	563,400	18%	11,086,700	41%
UNODC	1,040,000	88%	200,000	47%
UN Women	840,000	62%	600,000	75%
ILO	479,800	87%	1,504,300	91%
UNESCO	480,000	64%	643,200	26%
WHO	850,000	100%	22,750,000	30%
World Bank	910,000	100%	2,030,000	70%
Secretariat	22,695,000	46%	8,000,000	60%
Grand total	**29,483,700**	**53%**	**72,038,800**	**51%**

Joint Programme country presence in Asia and the Pacific



Source: 2018 staff data projections

2019 targets in Fast-Track countries in Asia and the Pacific

India	2019 targets
HIV prevention among key populations (SRA 4)	*89% [770 000] prevention coverage among female sex workers (74% in 2016)* ▪ Resource mobilization, new size estimation and adapted service delivery models for unreached and diverse sex work networks. *80% [141 000] prevention coverage among people who inject drugs (68% in 2016)* ▪ Advocacy for policy/legislative changes, increased investment in and design of enhanced gender-sensitive harm reduction packages, including opioid substitution therapy, Hepatitis C and prison setting interventions. *74% [260 000] prevention coverage among men who have sex with men (63% in 2016)* ▪ Facilitating legislative changes and development of new outreach methods (social media and networking).
HIV testing and treatment (SRA 1 and 2)	*90% of people living with HIV know their status (83% in 2016)* ▪ Strengthening capacity and guidance on innovative outreach approaches, community-based testing, adoption of self-testing policies and effective use of strategic information. *At least 81% of people living with HIV [1.6 million] receive ART (50% in 2016)* ▪ Implementation of "Treat All" policy; guidelines revision, capacity-building, cascade monitoring, ensuring commodity security, and development of community monitoring system. *90% of HIV positive pregnant women receive ART (49% in 2016)* ▪ Implementing a plan of action to Fast-Track e-MTCT based on integration of universal HIV testing among pregnant women in public and private sector; addressing gender-related barriers women face in accessing services; and technical support to sub-national certification of eMTCT in five states.
Increasing domestic AIDS funding (SRA 7)	*75% of the annual national budget for HIV is funded from domestic sources (63% in 2016)* ▪ Advocate for and organize an AIDS financing summit, and develop a strategy for increased domestic and more diversified investment.
Indonesia	**2019 targets**
HIV prevention among key populations (SRA 4)	*75% of key populations, in particular sex workers and men who have sex with men have access to combination prevention* ▪ Roll out of PrEP in Jakarta and Bali; saturation with condoms and lubricants in 23 high-prevalence districts and innovative service delivery models.
HIV testing and treatment (SRA 1 and 2)	*75% of people living with HIV in the 96 high-prevalence districts (80% in Jakarta) receive ART* ▪ Implementation of test and "Treat All"; reconfiguration of service delivery, including task-shifting and community service delivery. *75% of key populations (sex workers, men who have sex with men and people who inject drugs) in the 96 high-prevalence districts know their HIV status and are linked to prevention and care services* ▪ Strengthening capacity and guidance on innovative outreach approaches, community-based services, including HIV testing, and effective use of strategic information. *90% of all pregnant women in the 96 high-prevalence districts receive HIV testing and PMTCT services* ▪ Development and implementation of national policies and guidelines for the elimination of MTCT, and of social media campaigns and communication strategies.
Human rights, stigma and discrimination and gender	*90% of key affected populations in 23 priority districts have access to legal aid* ▪ Recruitment, training and placement of paralegal capacity; linkages to local legal aid networks, and implementation of community-based monitoring systems; capacity building and addressing stigma and discrimination in health care settings.

equality and gender-based violence (SRA 6 and 5)	▪ Policies and guidelines implemented to end gender inequalities, gender-based violence and health are stigma and discrimination facing women living with HIV.
Myanmar	**2019 targets**
HIV prevention among key populations (SRA 4)	*79% of men who have sex with men in the 46 highest burden townships are reached with effective prevention packages (behavioural change communication, condoms, testing, STI treatment) and PrEP piloted in one city* ▪ Enhanced outreach models; technical support to PrEP; partner referral; and registration of a transgender group as a nongovernmental legal entity with appropriate governance tools. *70% of people who inject drugs in the five highest burden regions/states are reached with effective prevention packages, including gender-sensitive harm reduction and opioid substitution therapy* ▪ Enhanced outreach models, improved case management, support to local enabling environment and decentralized service delivery.
HIV testing and treatment (SRA 1)	*83% of people living with HIV in the 46 highest burden townships know their HIV status* ▪ Innovative testing services, including community testing and task shifting. *74% of people living with HIV in the 46 highest burden townships receive ART* ▪ Innovative service delivery including task shifting, establishment of differentiated models of care, electronic reporting and monitoring, and integration of HIV-TB-STI-RH/FP, Hepatitis and ANC services.
Human rights, stigma and discrimination (SRA 6)	*A new HIV law; national drug law and a new harm reduction policy are approved and implemented in the five highest burden region/states* ▪ Technical support to Parliament, MOHA and Attorney-General Office; political advocacy at all levels; resource mobilization and training of community representatives, media and political leaders.
Pakistan	**2019 targets**
HIV prevention among key populations and sustainability (SRA 4 and SRA 7)	*Domestic allocation represents at least 30% of the national prevention budget (0% in 2015)* ▪ Continued advocacy with central and state level governments, the use of an investment analysis, and engagement of legislators and decision makers for a sustainable and effective HIV response. *45% of people who inject drugs (28 priority cities, 18% in 2015) and men who have sex with men (21 priority cities, 15% in 2015)* ▪ Access to combination prevention, including harm reduction and opioid substitution therapy, through technical support to innovative outreach models and implementation support to national and community-based programmes.
Human rights, stigma and discrimination (SRA 6)	*50% of provinces have tabled HIV legislation to remove HIV related stigma and discrimination barriers* ▪ Training and advocacy with leaders' group and decision makers (including religious leaders, parliamentarians, judicial officers and media). *100% of health facilities in Lahore and Karachi have systems established to monitor and respond to stigma and discrimination* ▪ Advocacy with health authorities; technical support and capacity strengthening of health professionals; advocacy and leadership of women living with and affected by HIV.
HIV testing and treatment (SRA 1 and 2)	*45% of key populations know their HIV status* ▪ Strengthening capacity and guidance on innovative outreach approaches, community-based testing, and effective use of strategic information.

	80% of key populations who know their HIV status receive ARV treatment (from 25% in 2016) ▪ Implementing test and "Treat All", supporting expansion of ART treatment centres from 26 to 44 and supporting scale-up of viral load testing.
Viet Nam	**2019 targets**
HIV testing and treatment (SRA 1, SRA 4)	*170 000 people living with HIV who know their HIV status receive ART (106 000 in 2015)* ▪ Implementation of the "Treat All" policy, eMonitoring, and innovations to remove access-to-treatment barriers among men who have sex with men in urban settings. *85% of people living with HIV know their HIV status (from 72% 2016)* ▪ Development and implementation of national guidelines on community-based testing and self-testing, and standardized training programme for lay testers. *65% of men who have sex with men know their HIV status (41% in 2016) and 90% of them receive treatment in provinces implementing community-based testing* ▪ Increased community-based testing, case finding and improved linkage to care and treatment is implemented.
HIV prevention among key populations (SRA 4)	*Scale-up of PrEP for men who have sex with men initiated* ▪ Development of national guidelines and policies, technical support; and assessment of feasibility and acceptability with pilot in Ho Chi Minh City as a Fast-Track City. *70 000 people who inject drugs will receive methadone maintenance therapy (50 000 in 2016)* ▪ Sustained advocacy and technical support.
Human rights, stigma and discrimination and gender equality and gender-based violence (SRA 6 and 5)	*Laws on HIV prevention and control and law on sex work amended to incorporate the protection of human rights of people living with HIV and key populations* ▪ Technical support and advocacy. *All high-burden provinces effectively address stigma and discrimination in health care settings* ▪ Development of national guidelines including integration into the national M&E system; training; and community-based monitoring of HIV services. *The Legal Aid Law will be amended to enable people living with HIV, including women living with HIV and victims of gender based violence, to access state provided legal aid services and gender based violence prevention and response interventions enhanced* ▪ High-level advocacy and technical support including for the implementation of the National Thematic Project on gender based violence prevention and response 2016-2020.
Transitional financing and social protection (SRA 7 and SRA 8)	*80% people living with HIV on ARV treatment are enrolled in Social Health Insurance (50% in 2016)* ▪ Generation of up-to-date understanding of barriers for people living with HIV to ensure long-term coverage by social health insurance, and related advocacy. *A transition plan towards sustainability without compromising quality and coverage of services, implemented in close coordination with Government, the Global Fund and PEPFAR*
China	**2019 targets**
HIV testing and treatment and eMTCT (SRA 1 and 2)	*90% of people living with HIV know their HIV status (68% in 2015)* ▪ Implementation of optimized and updated HIV testing services guidelines (including HIV self-testing), intensified key populations engagement, and tailored community mobilization and communication strategies. *Certificate of Pharmaceutical Product approved by the CFDA to allow at least 10 patent ARV medicines which are manufactured in China with MPP licensing to be exported to LLDCs*

	Triple elimination of mother-to-child transmission of HIV, Hepatitis B and syphilis certified at subnational level in Yunnan, Guangdong and Zhejiang Provinces, and a national plan developed and implemented for country wide elimination certification ▪ Technical support and sustained advocacy.
HIV prevention among key populations (SRA 4)	*Men who have sex with men in at least 50 China Comprehensive Response (CARES) program cities have access to combination prevention including PrEP* ▪ Updated outreach models (including use of information and communication technology), and capacity building for wider and quality engagement of men who have sex with men.
Human rights, stigma and discrimination and gender (SRA 6 and 5)	*Policies and implementation guidance on the entry, stay and residence of foreigners living with HIV are harmonized and aligned for the full implementation of the 2010 Law* *Policy review and analysis on the regulations concerning the full employment of people living with HIV in public service conducted and used for sustained advocacy* *Policies and guidance implemented to end gender inequalities, gender-based violence and health care stigma and discrimination facing women living with HIV*

B. EASTERN AND SOUTHERN AFRICA

2019 targets and priorities for the Joint Programme in Eastern and southern Africa

HIV testing, treatment and eMTCT

85% of people living with HIV (approximately 3 million), including adolescents and key populations, who know their HIV status receive ARV treatment (54% in 2015), and 70% are virally suppressed (46% in 2015)

- Adoption and implementation of "Treat All" in all countries.
- Promotion and accelerated implementation of innovative service delivery systems including task shifting, community service delivery, self-testing and home-based testing.
- Implementation of differentiated models of care and community adherence support, including quality assurance and control mechanisms.
- Roll out of viral load testing, strengthening of laboratory facilities and systems.
- Establishment of effective monitoring and reporting systems
- Further strengthening of integrated antenatal/maternal and child health/PMTCT services

In Fast-Track countries, 85% of children (0-14 years) living with HIV receive ART (63% in 2016)

- Promoting and replicating best practices in postnatal follow-up and targeted paediatric HIV testing outside the PMTCT platform, with strong linkage to treatment.
- Technical support to strengthen early infant diagnosis.
- Addressing stigma and discrimination in health care settings and in communities.

At least eight Fast-Track countries are reaching and sustaining an ART coverage of 90% of pregnant women living with HIV and have a MTCT rate of lower than 5%

- Expansion of community systems for demand creation, adherence support and stigma and discrimination reduction.

HIV/TB co-infection related mortality reduced to 15% (35% in 2015)

- Ensuring integrated HIV/TB testing.
- Full integration of ART services in TB settings.

HIV Prevention among young people

New HIV infections among young people, adolescent girls and young women reduced to 150 000 (350 000 in 2015)

- Expansion of combination prevention including access to free condoms and VMMC through strengthened community systems.
- Comprehensive sexuality education, economic empowerment and access to youth-friendly sexual and reproductive health services.

HIV Prevention among key populations, human rights, stigma and discrimination

New HIV infections among key populations and their partners reduced to fewer than 50 000 (200 000 in 2015)

- Increased access to evidence-informed and human rights-based combination prevention programmes through expanded community service delivery, including HIV testing and adherence support.
- Accelerated implementation of PrEP.
- Greater engagement of regional and sub-regional bodies, including the African Union, Southern African Development Community and East African Community.

Gender inequality, human rights and community support

All Fast-Track Countries in the region have rolled out the CSW '60 resolution by organizing country dialogues and by implementing high-impact interventions that foster greater male engagement and address structural drivers of risk and vulnerability in girls and young women.

HIV and health services integration, Investment and efficiency

Domestic investment in the AIDS response increased to at least 25% in selected Fast-Track countries

- Advocacy and technical support to sustainability and transition planning.
- Expanded public-private partnerships.

At least 25% primary health care facilities in a minimum of 10 countries provide integrated sexual and reproductive health/HIV/TB/Hepatitis services

- Support to system strengthening for integrated service provision.

Humanitarian and emergency settings

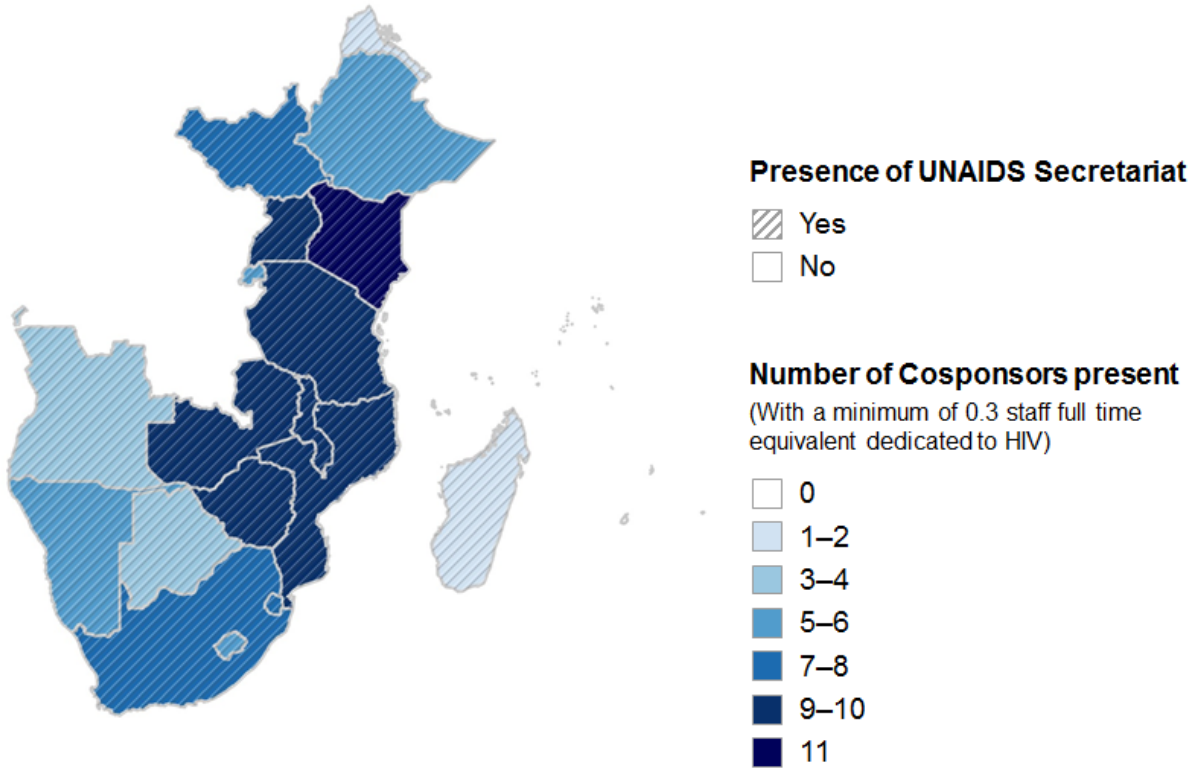
Integrate HIV in emergency preparedness and response plans

- Interagency collaboration, integrated vulnerability assessments, planning and resource mobilization.

Table 11. Estimates of core and non-core funds in Eastern and southern Africa 2018–2019

Organization	Core funds US$	% Fast-Track countries	Non-core funds US$	% Fast-Track countries
UNHCR	1,749,300	100%	21,772,900	98%
UNICEF	840,000	95%	76,000,000	94%
WFP	1,210,800	53%	26,819,100	54%
UNDP	672,000	80%	5,400,000	80%
UNFPA	1,143,000	71%	52,640,000	90%
UNODC	680,000	100%	4,860,500	100%
UN Women	905,000	89%	1,200,000	88%
ILO	947,600	100%	3,299,000	100%
UNESCO	1,200,000	80%	5,073,900	85%
WHO	1,080,000	100%	31,380,000	53%
World Bank	1,845,000	100%	2,485,000	98%
Secretariat	48,716,000	93%	10,500,000	67%
Grand total	**60,988,700**	**92%**	**241,430,400**	**82%**

Joint Programme country presence in Eastern and southern Africa



Source: 2018 staff data projections

2019 targets in Fast-Track countries in Eastern and southern Africa

Angola	2019 targets
HIV prevention among young people and key populations (SRA 3 and 4)	*40% reduction in HIV incidence among sex workers and men who have sex with men* ▪ Gender-sensitive HIV combination prevention with a focus on Luanda and Cunene with coverage rates that are near saturation. ▪ Expansion of community services for sex workers and men who have sex with men. *20% increase in knowledge of HIV prevention among adolescent girls and young women* ▪ Expansion of sexual education ▪ Strengthening HIV/sexual and reproductive health and rights integration. ▪ Scaling up of targeted programmes for vulnerable rural women.
HIV testing and treatment (SRA 1)	*50% increase in adult ART coverage in Luanda and in Cunene* ▪ Implementation of revised ART and HIV testing guidelines (including community-based testing, assisted partner notification and self-testing). ▪ Enhanced civil society organizations engagement and strengthened community-facility linkages. ▪ Implementation of innovative interventions for key populations, men and youth. ▪ Improvement of TB/ HIV integration, and integration of eMTCT into reproductive, maternal, newborn, child and adolescent health.
Investment and efficiency (SRA 7)	*10% increase in domestic investment* ▪ Improvement of public private partnerships, private sector social investment and multisectoral coordination ▪ Development and implementation of the HIV/TB Global Fund funding request.
Botswana	**2019 targets**
HIV prevention among young people and key populations (SRA 3, 4)	*Reduction to under 1,000 of new HIV infections among adolescents (from 2,000 in 2012)* ▪ Accelerated implementation of comprehensive sexuality education in 100 schools. ▪ Implementation of adolescent HIV prevention framework at national and district levels ▪ Strengthened early infant diagnosis. *10% increase in PrEP coverage among female sex workers* ▪ Implementation of a public-private service delivery model. *Development and implementation of the HIV/TB Global Fund funding request*
HIV testing and treatment (SRA 1)	*90–90–90 targets achieved* ▪ Scaling up community-led approaches for “Treat All” Strategy. ▪ Implementation of city planning in five major cities. ▪ Integration of sexual and reproductive health/HIV/TB services; strengthening partner notification and HIV self-testing. ▪ Intensified strategies to reach males with HIV testing and treatment programmes.
Gender equality, gender-based violence and removal of stigma and discrimination (SRA 5 and 6)	*Stigma and discrimination, inequality and violence against women reduced* ▪ Use of age- and gender-disaggregated programme data to improve HIV programming for equitable service access, including targets setting. ▪ Implementation of an integrated HIV and gender-based violence strategy. ▪ Assessment of stigma and discrimination in health care system and system-wide action linking with efforts for universal health access.

Ethiopia	2019 targets
HIV testing and treatment, eMTCT and HIV/TB integration issues (SRA 1 and 2)	*85% ART coverage in adults (from 49.8% in 2016); 70% in children <15 (from 23%); 80% in young people (10–19 years), especially young women and adolescent girls, and key populations; and 90% viral suppression after 12 months of therapy (from 53% in 2015)* ▪ Technical and institutional capacity development for demand creation, access to quality, comprehensive HIV testing and treatment, and retention in services. ▪ Implementation of integrated HIV/ TB services. ▪ Integration of cervical cancer services with HIV programmes. *Virtual elimination of mother-to-child transmission of HIV attained* ▪ Provision of strategic guidance; accelerated service delivery (including point-of-care for early infant diagnosis). ▪ Increased ART adherence and improved follow-up. ▪ Implementing family-centered care and engaging men. ▪ Strengthened analysis, routine monitoring and supervision; and “End Line” evaluation of the eMTCT programme.
Combination HIV prevention (SRA 4)	*46 million people from populations at higher risk of HIV infection reached with high-impact combination prevention interventions* ▪ Institutionalizing nationwide HIV combination prevention programme and implementation in 13 key sectors of minimum prevention/ sexual and reproductive health service packages.
Investment and efficiency (SRA 7, 5)	*High-quality gender disaggregated data and evidence is generated and informs design and implementation of sustainable HIV policy and programmes in all nine Regional States and at federal level.* *Robust in-country accountability mechanisms for Global Fund and PEPFAR resources efficiency and impact fully implemented and analysed* ▪ Programme joint support supervision; field-based oversight monitoring committee assessment and full engagement of civil society and affected communities.
Kenya	**2019 targets**
HIV testing and treatment (SRA 1 and 2)	*90% testing coverage among men (from 43%)* ▪ Workplace interventions in major companies in five priority counties. ▪ Community approaches to reach underserved men. ▪ Targeted testing interventions for men at high risk in five priority counties. *95% adherence among adolescent/young people (12 months) (from 50%)* ▪ Peer support and enabling school and community environment. ▪ County-level monitoring viral load testing. *50% increase in number of eligible women/children living with HIV accessing nutritional support in two ASAL priority counties* ▪ Integrated HIV/nutrition service delivery and capacity building of health workers. *MTCT rate reduced to under 5%* ▪ Generation and use of data. ▪ Targeted interventions for adolescents/young people. ▪ Addressing unmet family planning need, particularly among women living with HIV ▪ Scaling up new technologies.
HIV prevention among young people and key populations (SRA 3 and 4)	*90% of adolescents/young people (10–24) in five priority counties have comprehensive HIV/sexual and reproductive health knowledge and adopt HIV prevention* ▪ Adolescent and youth-led mobilization; youth designed integrated HIV/sexual and reproductive health services. ▪ Real-time disaggregated incidence data. ▪ Targeted prevention interventions in national/county plans.

	90% key populations adopt HIV prevention ▪ Peer-led campaigns for comprehension knowledge and risk perception. ▪ Expanded condom programming for key populations.
Gender equality gender-based violence and removal of stigma and discrimination (SRA 5 and 6)	*90% of people living with HIV and key populations know, claim and enjoy their rights* ▪ Rights-based country programming leveraging "Know Your Rights". ▪ Capacity building and increased public awareness of the HIV and AIDS tribunal. ▪ An enabling environment for access to justice. *Gender equality and women's empowerment advanced, and sexual and gender-based violence reduced in 10 priority counties (by 50% among key populations)* ▪ Comprehensively addressing harmful and negative norms and alcohol abuse, capacity building of health care workers, access to justice for survivors, integration of gender equality in relevant national strategies and frameworks, gender-responsive interventions. ▪ Innovative interventions to enhance empowerment and leadership of women living with HIV and women's economic empowerment in the context of HIV. ▪ Creation of an enabling environment and comprehensive strategies to prevent and address sexual and gender-based violence.
Lesotho	**2019 targets**
HIV testing and treatment (SRA 1 and 2)	*90% adult ART coverage (from 56%) in the five high-burden districts* ▪ Implementation of revised HIV testing services policy and HIV testing services / ART guidelines with a focus on priority populations. ▪ Expanded engagement of civil society organizations. ▪ Scale-up of innovative programmes targeting men and young people.
HIV prevention among young people (SRA3)	*40% reduction in HIV incidence among adolescent girls and young women* ▪ Expanding and strengthening combination prevention targeting adolescent girls and young women, their partners and key populations. ▪ Scale up of condom programmes; and implementation of the "Three FREES" framework.
HIV and health service integration (SRA 8)	*Legal, policy and institutional environment enables effective HIV and health service integration at national and sub-national levels* ▪ Revision and implementation of the national HIV strategic plan and HIV policy. ▪ Enhancing institutional capacities for leadership and governance in integrated decentralized responses. ▪ Strengthening implementation capacity at decentralized levels.
Malawi	**2019 targets**
HIV testing and treatment (SRA 1)	*100% paediatric and 81% adult ART coverage* ▪ Scale-up of early infant diagnosis for HIV-exposed infants and improved linkages to care. ▪ Implementation of differentiated models of care at community level. ▪ Improved access to HIV testing services and good quality ART services.
HIV prevention among key populations (SRA 4)	*60% increase in combination prevention services coverage for key populations (sex workers, men who have sex with men, prisoners)* ▪ Implementation of SOPs for key population-led interventions. ▪ Scale up of focused interventions in Blantyre and Lilongwe. ▪ Transformational dialogues implemented at all levels. ▪ HIV Act enacted and operationalized.
HIV prevention for young people, in particular adolescents girls and young women in high-	*80% of adolescent girls and young women in high-burden districts reached with programming aimed at reducing new HIV infections within the multi-sectoral adolescent girls and young women strategic plan aligned with the "Three FREES" Framework* ▪ Implementation of DREAMS-like interventions in high-burden districts. ▪ Expanding community-based support and two-way community-facility referral. ▪ Enforcing the law and the constitutional amendment on increasing the marriage age and end child

prevalence settings (SRA 3)	marriage. ▪ Promote leadership and participation of young women living with HIV including for cervical cancer screening.
Making the money work, and sustainability (SRA 7)	*Effective, coordinated and optimal utilization of resources* ▪ Efficiency study and expansion of efficiencies modalities in service delivery. ▪ Development and effective implementation of the COP and Global Fund grants.
Mozambique	**2019 targets**
HIV prevention among young people and key populations (SRA 3 and 4)	*Increased coverage of HIV combination prevention programmes in 5 provinces (Nampula, Zambezia, Tete, Gaza and Maputo City) from 14% (2016) to 25% among adolescent girls and young women, from 53% in 2016 to 60% among sex workers; and from 25% in 2016 to 93% among prisoners* ▪ Implement an evidence-based communication strategy to revitalize prevention. ▪ Support demand creation for sexual and reproductive health and HIV services, including comprehensive sexuality education both in- and out-of-school and in the informal sector. ▪ Integrate gender equality and gender-based violence issues into HIV strategies, budgets and M&E frameworks, including empowerment and leadership of women living with HIV. ▪ Elaborate national targets and innovative programmes and services for key populations, including community-based mobile outreach. ▪ Strengthen communication for cash transfer programme and innovative data collection via mHealth platforms.
HIV testing and treatment and eMTCT (SRA 1 and 2)	*Increased testing coverage* ▪ Implementation of country adapted WHO testing guidelines. ▪ Enhanced male engagement in hotspot areas (transport corridors, border posts and informal settings). ▪ Enhanced engagement with health care workers, parliamentarians and law enforcement agents (judges, police, prosecutors and Members of Parliament). *At least 74% ART coverage for adults and children living with HIV (55% in 2016)* ▪ Implementation of an HIV acceleration plan for differentiated care models, including community service delivery. ▪ Strengthened treatment literacy, including paediatric transition to adult treatment. ▪ Establishing a communication strategy for demand creation and retention on treatment. ▪ Improving sub-national 90–90–90 cascades, scale up of electronic patient-tracking and data visualisation. ▪ Developing, implementing and monitoring Fast-Track strategies in Maputo, Matola and Xai-Xai. *Decrease in MTCT rate from 11.1% in 2016 to 6.4% at age of 18 months* ▪ Elaboration of an updated eMTCT plan and point-of-care/early infant diagnosis plan. ▪ Identifying gaps in the PMTCT cascade and implementing appropriate corrective actions. ▪ Engaging political leadership on *Start Free Stay Free AIDS Free.* ▪ Integrating HIV, sexual and reproductive health, and gender into maternal and child health programmes.
Investment and efficiency (SRA 7)	*US$ 35 million increase in domestic public spending for HIV* ▪ Advocacy with policy makers and mobilize resources, including for prevention services. ▪ Development of HIV sustainability plan to increase efficiency in resource allocation and sustain services. ▪ Technical support tor HIV/TB Global Fund grant for 2018/2020.
Namibia	**2019 targets**
Investment and efficiency (SRA 7)	*AIDS response is funded at 90%, with 75% from domestic resources* ▪ Support implementation of the sustainability framework for epidemic control. ▪ 25% of HIV budget is for prevention and domestic resources for civil society increase by 10%. ▪ Support submission and implementation of 2018–2020 Global Fund grant.

HIV prevention among young people and key populations (SRA 3 and 4)	*75% reduction in new infections among young people; 50% reduction among key populations* ▪ Advocacy for legal reform based on results of the Legal Environment Assessment report to enhance access to services. ▪ Increased access to HIV combination prevention services for sex workers from 40% to 75% and for men who have sex with men from 30% to 60% by addressing stigma and discrimination, demand creation and community service delivery. ▪ Updating critical strategic studies to inform improved provision, demand and uptake of targeted services for young people, sex workers, prisoners, and men who have sex with men. ▪ Updating and expanding coverage of the combination prevention strategy for youth.
HIV testing and treatment (SRA 1 and 2)	*Increased HIV testing (76% to 85 %) and ART coverage (70% to 85%)* ▪ Scale-up of "test and offer" based on the lessons learned. ▪ Improving targeted responses through development of Fast-Track strategies in 3 cities, addressing male and key populations' testing and the treatment uptake. ▪ Civil society organizations dialogue to adopt and implement the social accreditation process to deliver HIV testing and ART services. *HIV transmission from mother to child reduced to under 2% (4% in 2016)* ▪ Developing the eMTCT road map and enhancing access to services for pregnant women in informal settlement and remote areas.
South Africa	**2019 targets**
eMTCT—Last mile elimination of MTCT in South Africa (SRA 2)	*MTCT rates reduced from 4.3% to 3.2% at 18 months* ▪ Implementing and monitoring district-level micro-plans in 14 high-transmission districts with a focus on building systems for postnatal tracking of mothers and infants in the PMTCT and MNCH cascade, safe infant breastfeeding and viral load monitoring, and strengthened management of high-risk HIV-positive breastfeeding mothers. ▪ Improving participation of community-level young women living with HIV (pregnant and breastfeeding mother groups) through creating stronger peer support networks. ▪ System products will include development of a standard, integrated essential postnatal care package, postnatal cohort tracking tools, and bi-directional facility and community referral and linkage tools, including community peer support structures.
Reducing new HIV infections among adolescents and young women (SRA 3 and, 5)	*Reduction in new infections from 1.2% to 0.7%* ▪ Fast-Track HIV prevention responses in 10 priority districts. ▪ Implementation of the national "She Conquers" campaign targeting adolescents and young women. ▪ Economic empowerment of young women and adolescent girls living with or affected by HIV. ▪ Implementing "HeForShe" campaign. ▪ Supporting improved collection and analysis of sex-disaggregated data for more gender-sensitive HIV responses. ▪ Addressing intersections of violence against women and HIV. ▪ Increased access to combination prevention information and services (including condoms, post-exposure prophylaxis, PrEP, eMTCT, diagnosis and treatment of STIs) for all adolescents and young people, with a special focus on young girls and women. ▪ A costed coordination framework developed and operationalized in the priority districts.
Improved quality of HIV treatment data and monitoring in priority districts (SRA 1 and 7)	*90% ART retention (from 78% in 2016) and 90% viral load suppression (from 85% in 2016)* ▪ Capacity building in 27 priority districts to generate and use quality-assured HIV treatment data and cascades for enhanced ART programme monitoring to improve HIV patient care and retention, using the updated WHO Guidelines on person-centered HIV patient monitoring and case surveillance. *Development and implementation of HIV/TB Global Fund funding request*
South Sudan	**2019 targets**
Gender inequality and gender-based violence (SRA 5)	*Gender-related barriers to services removed* ▪ Support to studies to inform the national programme, such as the gender-based violence KAP survey.

	▪ Partnerships for gender-based violence-HIV integration, especially in humanitarian settings. ▪ Development of enabling policies for the HIV response that address human rights, stigma and discrimination and gender inequality.
HIV testing and treatment (SRA 1)	*40 000 people living with HIV receiving ART* ▪ Implementation of latest ART guidelines and supporting the creation of an enabling environment for provision of services. ▪ Strengthening capacity of civil society for scale-up of testing. ▪ Enhancing role of community groups, including networks of women living with HIV in community support and ARV adherence. ▪ Addressing inequities in service access. ▪ Ensuring that services meet the needs of people living with and affected by HIV in humanitarian emergencies.
HIV prevention among key populations (SRA 4)	*50% coverage of combination prevention services for higher-risk populations in priority locations (Juba, Nimule, Yei, Yambio), including sex workers, people living with HIV, men who have sex with men, young women and girls and in prison settings.* *Increase to 25 million condom distribution and condom promotion, with a focus on higher-risk populations* ▪ Scaling up interventions for sex workers and men who have sex with men. ▪ Building capacity of people living with HIV networks to implement Global Fund grants. ▪ Development and implementation of the Global Fund funding request for 2017–2019.
Swaziland	**2019 targets**
HIV testing and treatment (SRA 1 and 2)	*Paediatric and adult ART coverage increased to 90% (from 69% and 80%, respectively) and PMTCT coverage sustained above 95%* ▪ Roll-out of the "test and treat" approach and HIV testing services to reach children, adolescents and young people, men and key populations. ▪ Enhancing community service delivery for people living with HIV with emphasis on treatment literacy and mobilization for "test and treat". ▪ Advocacy for the enhancement of supply chain management and follow-up systems. ▪ Enhancing the availability of granular and age- and sex-disaggregated data..
HIV prevention among young people and key populations (SRA 3 and 4)	*At least 40% reduction in HIV incidence among adolescent girls and young women* ▪ Implementing innovative approaches in delivering HIV services for young people. ▪ Roll-out of the national life skills education programme for in- and out-of-school youth. ▪ Strengthening national condom programming, forecasting, innovative distribution, marketing and promotion. ▪ Integration of male circumcision services in the national health system. ▪ Scale-up of gender-based violence prevention and response programmes. ▪ Building capacity of civil society organizations to implement evidence-informed HIV prevention programmes for young people, especially girls and young women.
HIV integration (SRA 8)	*Sexual and reproductive health/HIV, TB and social protection issues integrated and mainstreamed in new and existing national programmes and resource mobilization strategies* ▪ Integration and mainstreaming of sexual and reproductive health/HIV/TB and social protection in the national strategic plan, Global Fund and PEPFAR applications. ▪ Development of a national social protection strategy. ▪ Advocacy and support to the establishment of a national coordination mechanism for social protection. ▪ Development and implementation of the HIV/TB Global Fund funding request.
Uganda	**2019 targets**
eMTCT (SRA 2)	*Uganda on-track to achieving eMTCT by 2020* ▪ Establishing a roadmap for complete elimination by 2020. ▪ Attaining eMTCT pre-elimination status in 2018; conducting a mock pre-elimination assessment; addressing the identified gaps and bottlenecks.

	95–95–95 super Fast-Track targets achieved among children (0-14 years) ▪ Intensifying case finding among pregnant and lactating women in 15 high HIV burden districts. ▪ Implementing innovative approaches to increase retention in care for mother-baby pair, viral load testing, exposed infant testing; reduce unmet family planning need; and ensure sustained adoption of safe breastfeeding.
HIV testing and treatment (SRA 1)	*90–90–90 Fast-Track targets for men achieved* ▪ Using cultural platforms to mobilize men to increase access to HIV testing, treatment and viral load monitoring, using those platforms as entry points for engaging men on gender-based violence, multiple partnerships and support to families for HIV testing, treatment and adherence.
HIV prevention among young people and key populations (SRA 3 and, 4)	*Reduction to 40 000 of new infections among young people and key populations (from 83 000 in 2015)* ▪ Scaling up HIV combination prevention services (including integrated safe male circumcision, condom programming, behaviour change communication, comprehensive sexuality education and youth-friendly services) with particular focus on adolescent girls and young women, men and key populations in high-burden districts.
Financing and sustainability (SRA 7)	*Donor dependency reduced to 40% of the total HIV budgets from a mix of domestically generated HIV/health resources* ▪ Advocacy for increased domestic resources, integration in the AIDS Trust Fund of contributions from capital projects and the private sector. ▪ Allocative and technical efficiency analysis and implementation of a customized resource tracking system. ▪ Development and implementation of the HIV/TB Global Fund funding request.
U.R of Tanzania	**2019 targets**
HIV prevention among key populations (SRA 4)	*50% combination prevention services coverage for men who have sex with men to 60%, 80% for sex workers, and 50% for people who inject drugs* ▪ Advocacy with Ministry of Health for increasing service provision in key locations, building capacities of five key populations networks and promoting their participation in policy development and programmes, legal access, peer outreach and advocacy for access to services.
HIV prevention for young people, in particular AGYW in high-prevalence settings (SRA 3 and 5)	*80% HIV prevention coverage of adolescent girls and young women in 19 target districts with high HIV prevalence, high rates of teenage pregnancies and high incidence of intimate partner violence* ▪ Comprehensive prevention services through support to economic empowerment. ▪ Strengthening health adolescent services, establishing safe spaces and support groups for adolescent girls and young women, and addressing negative social norms.
HIV testing and treatment (SRA 1 and 2)	*95% paediatric ART coverage and 94% adult ART coverage in high-priority districts* ▪ Improved HIV testing strategies, including male-targeted services, linkage to care, and treatment literacy. ▪ Implementation of mother-child pairing initiative, improved transitioning of children to adult services. ▪ Harmonisation of monitoring and evaluation systems for improved monitoring of 90–90–90, provision of data, normative guidance, and technical support.
Human rights, stigma and discrimination (SRA 6)	*Stigma and discrimination reduced* ▪ Reforming laws that are blocking an effective HIV response. ▪ Implementation and follow up on recommendations from the people living with HIV Stigma Index to improve access to services and address discrimination in the health sector, at the workplace and in communities.
Making the money work, and sustainability (SRA 7)	*Domestic resource mobilization increased from 3% in 2017 to 9%* ▪ Utilize the recently established AIDS Trust Fund. *Implementation of the HIV/Global Fund funding request*

Zambia	2019 targets
HIV testing and treatment (SRA 1)	*77% of people living with HIV know their HIV status and are receiving treatment (67% in 2016)* ▪ Improving testing-treatment linkage and implementing "test and start". ▪ Strengthening monitoring systems and implementing strategies to maximize treatment adherence and retention in care. ▪ Track linkages particularly in high-burden populations and geographical areas.
HIV prevention among young people and key populations (SRA 2, 3 &4)	*Reduction to 600 of new HIV infections among children aged 0–14 years (10 300 in 2016) and 20 000 in new adult (15–59 years) HIV infections (46 000 in 2016)* ▪ Intensifying community eMTCT initiatives and gender-sensitive combination prevention programming for adolescents, young people, and vulnerable and key populations. ▪ Development and implementation of the HIV/TB Global fund request.
HIV integration (SRA 8)	*High-impact HIV, TB and sexual and reproductive health response strategies mainstreamed in district development plans.* ▪ Development, financing and implementation of integrated gender-sensitive HIV Fast-Track action plans in 14 high-burden districts.
Zimbabwe	**2019 targets**
HIV prevention among key populations and young people (SRA 3 and SRA 4)	*30% reduction in HIV incidence among adolescent girls and young women* ▪ Implementing innovative combination HIV prevention targeting adolescent girls and young women. ▪ Ensuring that multisectoral programmes addressing adolescent girls and young women remain prioritized, scaled-up, resourced and coordinated. ▪ Increased access to sexual and reproductive health information, HIV-related knowledge and integrated/comprehensive services. *Reduction to 5% of HIV incidence among young sex workers (10% in 2016), men who have sex with men and inmates (data for men who have sex with men and inmates not available)* ▪ Innovative approaches, including increased access and utilization of combination prevention by key populations (sex workers, men who have sex with men and inmates). ▪ Strengthening collection and analysis of key strategic information relating to key populations especially sex workers, men who have sex with men and inmates. ▪ Advocacy and technical assistance for the development of a harmonized national strategy on key populations to guide policy and programming.
HIV testing and treatment (SRA 1 and 2)	*90–90–90 targets achieved* ▪ Expanded implementation of early infant diagnosis, integrated service delivery; scale up HIV treatment (including diagnostic) service delivery through community channels. ▪ Facilitating the country validation of eMTCT including creation of a cadre of grassroots champions for PMTCT elimination. ▪ Implementation of assisted partner notification and HIV self-testing and intensified strategies to reach males with HIV testing and treatment programmes.
Human rights and gender equality (SRA 6 and 5)	*Stigma and discrimination, inequality and violence against women, misuse of criminal and punitive laws reduced* ▪ Scale-up of integrated services for addressing sexual and gender-based violence, livelihoods support and mentorship especially for women aged 20–24 years.

C. LATIN AMERICA AND THE CARIBBEAN

2019 targets and priorities for the Joint Programme in Latin America and the Caribbean

HIV testing and treatment

90% of people living with HIV know their status (increase from 75%)

- Fostering policies to address demand and supply for HIV testing.
- Review of protocols.
- Implementation of community-led services and self-testing, especially for key populations and (in the Caribbean) at workplaces.
- Implementation of task shifting and early diagnosis

75% of people living with HIV are on treatment (increase from 55%) and 60% virally suppressed (increase from 41%)

- Scale-up of ART for people with TB-HIV (the Caribbean)
- Improved adherence and strengthened laboratory capacity and health systems.
- Promoting regional initiatives for price reduction, use of pooled procurement (such as the PAHO Strategic Fund), efficient ARV purchasing and supply chain management systems.

Another six countries certified as having attained eMTCT of HIV and congenital syphilis

- Guiding the validation of countries that have reached dual elimination targets.
- Implementation of eMTCT acceleration plans for countries in need (Caribbean).

HIV prevention among young people and key populations

Decline in new infections to 75 000 among adults (from 100 000) and to 25 000 among young people (from 35 000)

- Scaling up combination prevention programmes to reach 90% target of gay men and other men who have sex with men, transgender women and sex workers (increase from 76%, for sex workers, and 57%, for men who have sex with men, respectively).
- Expanding the use of community expertise and strengthening continuum of care.
- Public education, including comprehensive sexuality education.
- Data generation.
- Scaling up PrEP in selected countries.
- Strengthening capacity of youth leaders to advocate for interventions for young people and implementation of ALL IN (Caribbean).
- Fostering social protection programmes for key populations.

Zero HIV-related discrimination, including gender inequalities and gender based violence

In 20 Latin America and Caribbean countries, at least 15% reduction in discrimination and denial of health services experienced by people living with HIV and key populations

- Ensuring that countries establish concrete benchmarks and have a resourced monitoring system.

80% of countries have eliminated legal barriers in access to sexual and reproductive health information and services, including legal reforms to reduce gender-based violence, teenage pregnancies and early marriage

The regional programme Every Woman Every Child has developed policies and programmes to address gender-based violence, teenage pregnancies and elimination of child marriage.

Sustainability and transitions

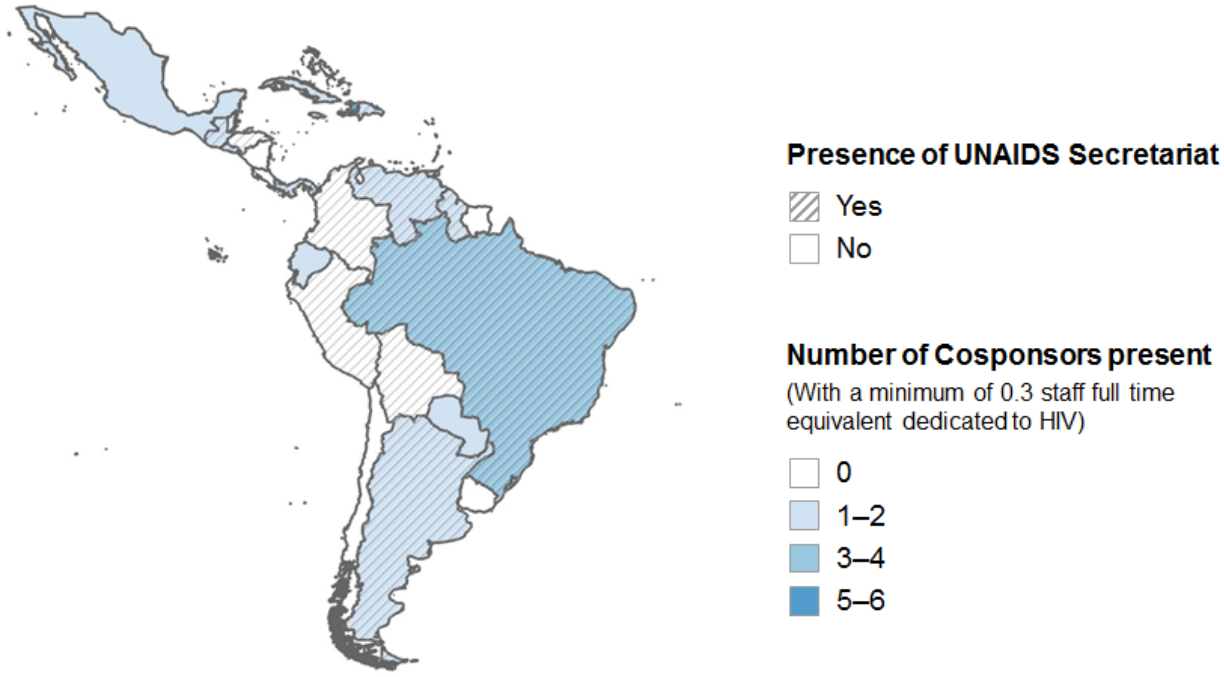
Countries in the region have developed sustainability plans featuring increased and diversified, innovative domestic investments.

- Strengthening regional coordination mechanisms for HIV in the Caribbean.
- Promoting cost-efficient allocations and investments based on populations and location, and strengthening links between HIV and social and economic inclusion (Latin America).

Table 12. Estimates of core and non-core funds in Latin America and the Caribbean 2018–2019

Organization	Core funds US$	% Fast-Track countries	Non-core funds US$	% Fast-Track countries
UNHCR	299,800	0%	742,900	33%
UNICEF	338,000	70%	4,999,000	64%
WFP	593,800	21%	205,100	21%
UNDP	364,000	55%	4,000,000	25%
UNFPA	393,300	24%	4,617,900	12%
UNODC	100,000	100%	120,000	100%
UN Women	200,000	100%	750,000	40%
ILO	184,600	78%	455,200	49%
UNESCO	240,000	32%	143,100	41%
WHO	-	-	7,500,000	8%
World Bank	60,000	100%	700,000	55%
Secretariat	19,085,000	33%	500,000	32%
Grand total	**21,858,500**	**34%**	**24,733,200**	**28%**

Joint Programme country presence in LAC



Source: 2018 staff data projections

2019 targets in Fast-Track countries in Latin America and the Caribbean

Brazil	2019 targets
HIV testing and treatment (SRA 1)	*85% of people diagnosed with HIV are on treatment (64% in 2015)* ▪ Ensuring access to voluntary and confidential testing services, counselling and immediate access to treatment, with an emphasis on key populations, adolescents and young people among them, and a particular focus on 25 cities and states that signed the Paris Declaration. ▪ Working with public health systems to ensure discrimination-free services.
HIV prevention among key populations (SRA 4)	*Increased access to combination prevention services (including condoms, post-exposure prophylaxis, PrEP, PMTCT, diagnosis and treatment of sexually transmitted infections) for key populations, including for adolescents and young key populations, with the focus on the 25 cities and states that signed the Paris Declaration* ▪ Advocacy to address regulatory barriers, protocol development, price negotiations, demand creation and local-level implementation. ▪ Comprehensive HIV response for transgender persons, gay men and other men who have sex with men. ▪ Promotion of human rights, gender and race equality with engagement of civil society and people living with HIV. ▪ Strengthening of civil society capacity and advocacy for combination prevention services and increased uptake.
Human rights, stigma and discrimination and gender equality (SRA 5 and 6)	*The legal framework strengthened to protect the rights for people living with HIV and vulnerable populations and reduce stigma and discrimination in health care facilities, workplaces and communities* ▪ Generating evidence on stigma and discrimination and its negative impact on access to health care settings to inform public policy concerning the rights of lesbian, gay, bisexual, transgender and intersex. ▪ Advocacy for laws and policies that protect the rights of vulnerable populations and reduce discriminatory practices at local level, with special focus on the 25 cities and states that signed the Paris Declaration. ▪ In partnership with all key stakeholders, raising awareness on the rights of vulnerable populations, gender and race equality.
Haiti	**2019 targets**
HIV prevention among young people and key populations (SRA 3 and 4)	*At least 80% of adolescents and youths reached with HIV prevention services (from 50% in 2017)* ▪ Mobilizing the Government, UN, faith-based organizations and civil society to implement the ALL IN initiative, empower young girls and young men to access sexual and reproductive health and HIV services; and address gender-based violence, especially in the six Fast-Track cities. ▪ Supporting targeted cities to develop Fast-Track action plans. *At least 10% of most-at-risk key populations reached with PrEP (from 0% in 2017)* ▪ Providing guidelines for the implementation of PrEP for key populations. ▪ Facilitating an inclusive dialogue among partners working with key populations. *At least 50% of communities living along the Haiti-Dominican Republic border reached with prevention messages, including reduction of sexual and gender-based violence* ▪ Providing technical support for joint assessment along the border and mobilize partners (Governments, civil society organizations, UN). ▪ Promoting an early community warning system and prevention of sexual and gender-based violence. ▪ Ensuring access of survivors of gender-based violence and sexual trafficking, including women and girls living with HIV, to comprehensive quality care and support services.

HIV testing and treatment (SRA 1)	*85% of adults and children have access to quality care and treatment (from 52% in 2015)* ▪ Implementation of same day ART initiation and harmonization of treatment guidelines. ▪ Strengthening capacity of civil society organizations for community engagement to increase ARV patient retention. ▪ Leading an active campaign with community health workers and with people living with HIV to retrieve patients lost to follow-up. ▪ Establishment of situation rooms that provide real-time, visualized epidemiological and programme data for national and district decision-making.
eMTCT (SRA 2)	*PMTCT coverage increased to 100% (from 95% in 2015)* ▪ Bottleneck analysis and removal of identified barriers strengthening national capacity for data analysis and use. ▪ Implementing opt-out/routine HIV testing services for pregnant women in antenatal care and their male partners. ▪ Strengthening capacity and empowering community leaders and civil society organizations to advocate for improved quality and decentralization of PMTCT services. ▪ Implementing integrated programming, linking HIV-positive mothers and infants to other services, including immunizations, family planning, hygiene, food security, nutrition and economic development. ▪ Strengthened community engagement and community outreach to retrieve people lost to follow-up. Mobilize the First Lady as champion for eMTCT.
Human rights, stigma and discrimination and gender equality (SRA 5 and 6)	*80% of health facilities providing HIV care offer user-friendly services to key populations and people living with HIV (from 0% in 2017)* ▪ Development and implementation of a national plan addressing human rights, stigma and discrimination against key populations and people living with HIV. ▪ Finalization, adoption and implementation of the HIV legal and policy framework. ▪ Promoting human rights and gender equality with engagement of civil society, people living with HIV and women living with HIV.
Jamaica	**2019 targets**
HIV prevention among key populations and young people (SRA 3 and 4)	*75% reduction in new infections among key populations and adolescents and 20% decrease in adolescent pregnancy rate* ▪ Technical assistance to sharpen the prevention strategy. ▪ Full-scale implementation of PrEP for most-at-risk key populations and self-testing. ▪ Expanding targeted programming for men who have sex with men, sex workers and transgender persons, and strengthening community-based responses and the accountability of local councils. ▪ Integrated sexual and reproductive health and HIV prevention package for adolescents, strengthened comprehensive sexuality education in schools. ▪ Technical support for gender-based violence reduction strategies in communities.
Increase treatment uptake, retention in care and viral suppression (SRA 1)	*75% of diagnosed people living with HIV receive treatment (37% in 2015) and 80% virally suppressed (20% in 2015)* ▪ Implementation of “Test and Start”, including advocating for differentiated service delivery models, and technical support for expansion of viral load testing capacity. ▪ Retention in care strategies such as adherence clubs, treatment literacy, support groups and local community leadership.
Reduce stigma and discrimination towards key populations and people living with HIV (SRA 6)	*25% reduction in stigma and discrimination in health care facilities, workplaces and communities* ▪ Strengthening partnerships with civil society, faith-based organizations and networks of people living with HIV. ▪ Accelerating implementing of anti-discrimination campaigns. ▪ Generating and use of strategic information to inform health and workplace HIV policies. ▪ Sensitization of health workforce. ▪ Advocacy for legal reviews.
eMTCT (SRA 2)	*Jamaica is certified as having eliminated mother-to-child transmission of HIV and syphilis* ▪ Addressing disparities in data collection and reporting, quality and completeness of data, and the level of adherence by health care staff to existing PMTCT protocols.

D. MIDDLE EAST AND NORTH AFRICA

2019 targets and priorities for the Joint Programme in the Middle East and North Africa

90–90–90 and elimination of mother-to-child transmission of HIV

70% of people living with HIV know their status, >50% are on treatment and >80% are virally suppressed

- Enabling policies and normative guidance.
- Technical support to communities and private health care providers in scaling up testing and linkage to care.
- Facilitating access to reasonably priced, quality ARVs and HIV diagnostics.
- Mobilizing resources for community engagement, treatment literacy and adherence programmes.

eMTCT certified in two countries; 95% testing and 90% treatment coverage among pregnant women in eight countries

- Normative guidance and integration of eMTCT services in maternal and child health programmes and scale-up plans.
- Mobilization of women leaders to champion eMTCT.

HIV combination prevention among key and vulnerable populations

Reduction in new HIV infections to fewer than 12 000

- Setting national targets, increasing investment, engaging national and regional networks, implementing innovative service models and ensuring access to combination prevention for >80% of key populations.
- Enhancing strategic information on key and vulnerable populations at national and subnational levels.
- Mobilizing leadership in metropolitan areas of five large cities (Tehran, Algiers, Casablanca, Alexandria and Djibouti), as well as in economic corridors.
- Expanding partnerships with religious leaders, media, youth, community and grassroots organizations.

Addressing stigma and discrimination and promoting gender equality

At least 70% of people living with, key populations and women and girls enjoy stigma-free access to services

- Enhancing partnerships with parliamentarians, law enforcement agents, health worker unions and syndicates
- Implementation of rights-based national strategic plans.
- Systematically addressing stigma and discrimination in health care settings.

Leadership of women living with HIV enhanced in 12 countries

- Mobilization of resources for women living with HIV groups (MENARosa).
- Ensuring meaningful involvement of women living with HIV in the national AIDS response.
- Integration of gender equality into national HIV planning processes (with linkages to SDG5).

80% of people living with HIV, key populations and other affected populations who report experiencing discrimination have access to justice

- Legal empowerment.
- Generating evidence on gender-based violence and HIV linkages in the region.
- Ratification and implementation of the Arab Convention on HIV Prevention and Protection of the Rights of people living with HIV.

Enhancing resilience and responding to emergency situations in countries

80% of people living in areas affected by humanitarian emergencies have access to essential combination prevention and treatment services

- Integrated provision of humanitarian and HIV services.
- Partnerships and technical support to countries and humanitarian organizations, and effective implementation of the Global Fund Middle East Response Initiative.
- Effective implementation of Security Council Resolution on HIV/AIDS (1983).

Sustainability and investment

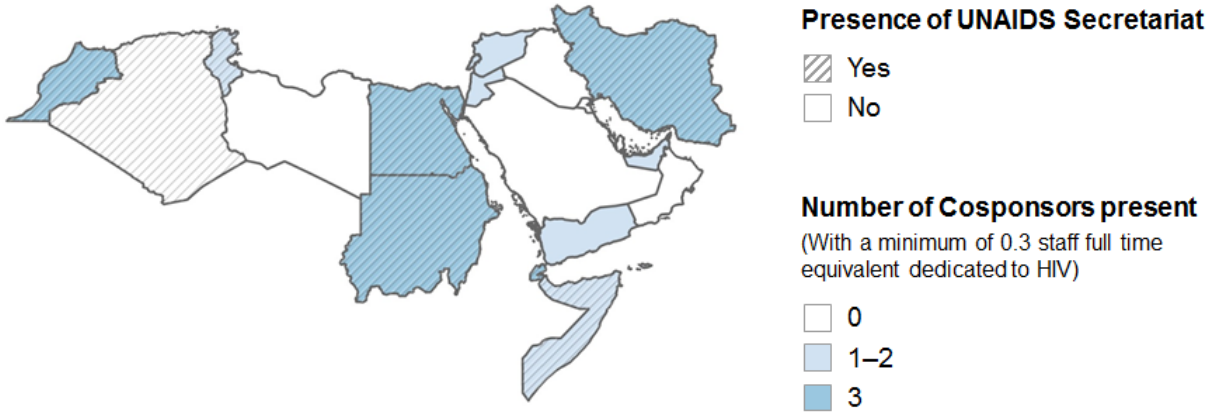
At least 50% of domestic investment in low- and middle-income countries (from 20%)

- Development of national investment cases and transition and sustainability plans, and integration of needs of people living in social protection schemes.
- Reinforcing regional solidarity and accountability mechanisms for the implementation of the 2016 Political Declaration and the Arab AIDS Strategy (2014–2020).

Table 13. Estimates of core and non-core funds in the Middle East and North Africa 2018–2019

Organization	Core funds US$	% Fast-Track countries	Non-core funds US$	% Fast-Track countries
UNHCR	196,200	0%	8,723,600	4%
UNICEF	145,000	37%	5,200,000	37%
WFP	185,400	0%	3,559,800	0%
UNDP	364,000	10%	450,000	10%
UNFPA	212,000	0%	8,883,700	5%
UNODC	200,000	10%	1,800,000	0%
UN Women	200,000	0%	450,000	0%
ILO	-	-	35,600	0%
UNESCO	-	-	66,700	0%
WHO	-	-	6,100,000	5%
World Bank	-	-	-	-
Secretariat	8,200,000	8%	1,000,000	0%
Grand total	**9,702,600**	**8%**	**36,269,400**	**8%**

Joint Programme country presence in the Middle East and North Africa



Source: 2018 staff data projections

2019 targets in Fast-Track countries in the Middle East and North Africa

Iran	2019 targets
HIV testing and treatment (SRA 1 and 2)	*HIV testing gap reduced from 62% in 2016 to less than 25%* ▪ Simplified testing algorithms and HIV testing service provision by lay-providers and outside health services. ▪ Expansion of testing and treatment services outside health facilities. ▪ User-friendly monitoring and reporting systems. *ARV treatment gap (between those knowing their HIV status and those on treatment) reduced from more than 65% in 2016 to less than 30%* ▪ Addressing access barriers for people who use drugs, community (people living with HIV, key populations) empowerment (through "positive clubs"). ▪ Simplified and streamlined national care and treatment guidelines. *Number of new child infections due to mother-to-child transmission reduced from 76 in 2016 to less than 50* ▪ Full integration of eMTCT and other sexual and reproductive health services into primary health care and linkage with private practitioners nationwide.
HIV prevention among young populations (SRA 3 and 4)	*Estimated number of adult new infection reduced from 4 930 in 2016 to less than 2 500* ▪ Technical support and advocacy to youth-oriented programmes, especially the ALL IN initiative. ▪ Scaling up quality services for prevention, treatment and care of STI within a sexual and reproductive health/HIV framework. ▪ Scale-up of combination prevention services for underserved key populations, including HIV prevention services for intimate partners of male key populations.
Investment and efficiency (SRA 7)	*National and sub-national stakeholders have access to quality data for policy setting and programme management* ▪ Data quality of routine monitoring (case/ART, e-registries) at national and subnational levels. ▪ Improving key population routine data and linkage with integrated HIV surveillance, promoting evaluations of key programme components and allocative efficiency studies.

E. WEST AND CENTRAL AFRICA

2019 targets and priorities for the Joint Programme in West and Central Africa

HIV testing, treatment and elimination of mother to child transmission of HIV

At least 75% ART coverage for adults and children living with HIV in all West and Central Africa countries (28% in 2015)

- Implementation of test and "Treat All'' policy, scale-up of differentiated models of care, task-shifting and community-based service delivery.
- Strengthening procurement and supply chain management systems.
- Enhancing regional cooperation in production and procurement of medicines.

70% viral suppression among people on ART (increased from 12%) at least in the seven Fast-Track countries

- Introduction of innovative point-of-care viral load monitoring and resource mobilization for community engagement, treatment literacy and adherence programmes.
- At least 90% PMTCT coverage (48% in 2015) in all West and Central Africa countries through engaging political leadership; strengthening partnerships; enhancing community capacity to deliver services; identifying and removing service access and delivery barriers and bottlenecks; integrated service delivery and community-facility linkages; strengthening national strategic information capacities and systems; and advocacy for reduction of user fees.

HIV prevention among young people and key populations

- At least 70% reduction in new infections among young people and adults in all countries in the region through scale-up of innovative, high-impact programmes and services targeting adolescents and young girls and boys (including comprehensive sexuality education linked to friendly services); strengthening country capacities to design and deliver evidence-based inclusive programmes for key populations; and integration of community-led prevention services in national plans.
- At least 80% of key populations in 15 Fast-Track cities have access to HIV combination prevention services.

Close the condom gap

- Strengthened comprehensive condom programming for key populations and other populations at higher risk through setting national condom targets; reducing the condom and lubricant availability gap from 70% to 35% (increase in annual availability to 1.7 billion condoms per year); saturating high-prevalence and key locations and "hotspots" with free or low-cost condoms via proximity outlets and community-based distribution; and implementing programmes that increase women and girls' safe sex negotiation skills.

Human rights, stigma and discrimination, gender inequality and gender-based violence

- Reduced stigma and discrimination, gender inequality and gender-based violence through building capacity of national institutions and law enforcement agencies; implementing existing anti-discriminatory acts, revising discriminating legal provisions (including those related to women inheritance, right to property and gender-based violence) and introducing new protective laws; implementing the Stigma Index; and scaling up programmes that empower key and vulnerable populations and reinforce positive social norms.

Investment and efficiency

- By 2019, reduce donor dependency to at least 50% of the total HIV budget in West and Central Africa countries through developing transition and sustainability plans; advocacy with leadership for increased domestic resources for HIV; improved public private partnerships; innovative local resource mobilization; increased efficiency in resource allocation and implementation of optimized service delivery models (including use of social media and m-health to improve demand creation, increase retention and treatment adherence).

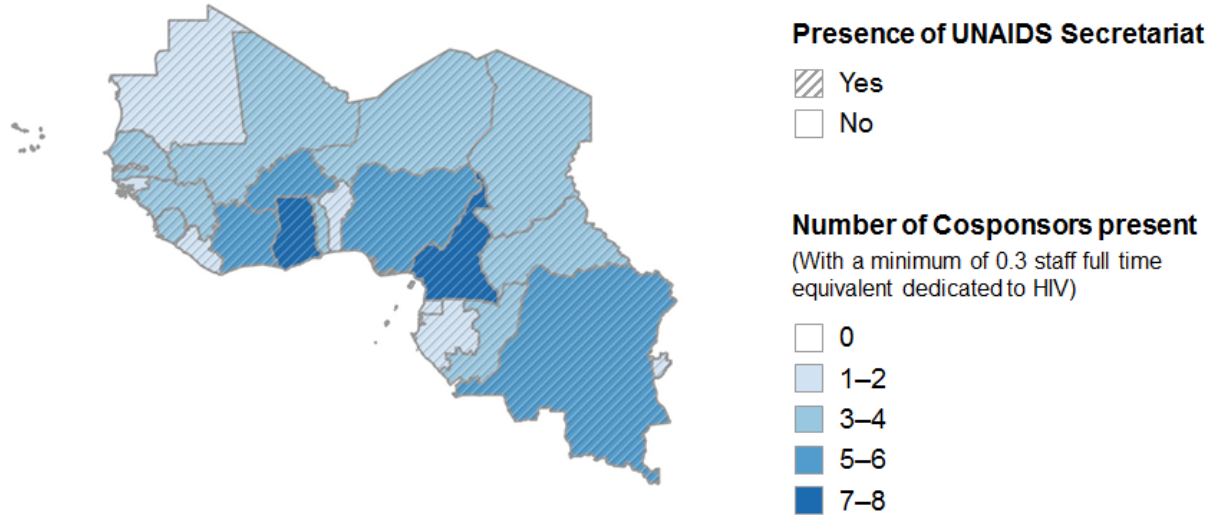
HIV and health services integration

- Expanded and enhanced provision of integrated services through resource mobilization for systems strengthening, decentralization and integration of HIV services across health platforms; scale-up of community-led services; and advocacy for HIV-sensitive social protection programmes.

Table 14. Estimates of core and non-core funds in West and Central Africa 2018–2019

Organization	Core funds US$	% Fast-Track countries	Non-core funds US$	% Fast-Track countries
UNHCR	808,000	70%	13,542,500	52%
UNICEF	518,000	90%	68,000,000	90%
WFP	535,100	17%	17,395,300	17%
UNDP	476,000	75%	2,200,000	80%
UNFPA	634,700	44%	17,343,400	57%
UNODC	50,000	100%	-	-
UN Women	645,000	83%	900,000	50%
ILO	288,100	100%	1,192,600	96%
UNESCO	600,000	60%	3,254,900	71%
WHO	720,000	100%	20,920,000	53%
World Bank	430,000	86%	2,080,000	83%
Secretariat	40,110,000	50%	6,000,000	36%
Grand total	**45,814,900**	**52%**	**152,828,700**	**67%**

Joint Programme country presence in West and Central Africa



Source: 2018 staff data projections

2019 targets in Fast-Track countries in West and Central Africa

Cameroon	2019 targets
HIV testing and treatment (SRA 1 and 2)	*60% ART coverage (from current 32%), 30% viral suppression (from 7%) in selected five cities (Ebolowa, Bamenda, Bertoua, Edea and Limbe)* ▪ Advocacy with municipalities, mobilization of domestic resources, innovative public-private partnerships for the implementation of cities' action plans. ▪ Capacity building of community-based organizations on simplified and differentiated models of care, active search of pre-ART patients and those lost to follow-up, treatment literacy, promotion of infant early diagnosis of children born to HIV-positive mothers, linkage to care and same-day ART initiation; sensitization of all health care providers on routine viral testing for proper monitoring; promotion of index case and family testing and strengthening of national capacity on sub-national data collection and analysis.
HIV prevention among key populations and young people (SRA 3 and 4)	*At least 70% of adolescents and young girls and at least 80% of sex workers and their clients have access to HIV combination prevention services (comprehensive sexuality education, condom promotion, HIV/STI diagnosis and treatment, gender-based violence prevention, post-exposure prophylaxis, PrEP), in five selected cities (Ebolowa, Bamenda, Bertoua, Edea and Limbe)* ▪ High-level advocacy and mobilization of mayors. ▪ Implementation of the ALL IN programme. ▪ Promotion of community policy dialogue. ▪ Support implementation of the "Three FREES" framework.
Elimination of stigma and discrimination and gender inequality (SRA 5 and 6)	*Stigma and discrimination towards people infected and affected by HIV/AIDS, key populations and vulnerable groups, gender inequality and violence against women have been reduced* ▪ Technical support for baseline assessments on human rights and gender barriers and implementation of the recommendations. ▪ High-level advocacy and engagement of key opinion leaders, such as parliamentarians, magistrates, religious leaders, media. ▪ Capacity building of civil society and community-based organizations on "Know your Rights Campaigns".
Chad	**2019 targets**
HIV prevention among key populations (SRA 4)	*New infections reduced by half* ▪ Resource mobilization and capacity development for increased access to prevention services for youth and adolescents, sex workers in the Lake region, the south-eastern region and 10 other regions. ▪ Tailored interventions that provide peer-led education sessions, reproductive health services and testing.
eMTCT (SRA 2)	*75% PMTCT coverage (increase from 46%)* ▪ Mobilizing partners for eMTCT. ▪ Operationalization of task shifting in 13 provinces. ▪ Strengthening capacities of health workers in identified provinces and integration of eMTCT in the minimum package services.
HIV testing and treatment (SRA 1)	*71 600 people living with HIV on ART (44 200 in 2016)* ▪ Ensuring regular ARV stock delivery. ▪ Capacity development, implementation of task shifting and community service delivery in 13 provinces.
Côte d'Ivoire	**2019 targets**
HIV testing and treatment (SRA 1)	*85% treatment coverage (41% in 2016)* ▪ Implementation of task shifting, health/community system strengthening, community service delivery, "test and treat" including differentiated care models, early infant diagnosis and advocacy for local production of ARV, particularly in paediatric form.

	77% of people on ART virally suppressed (increase from 11%) ▪ Roll-out of SMS and other mobile telephone platforms (m-Health, M-TEW Orange platform), reminder alerts and innovative data collection via mobile platforms for treatment adherence and retention in care services. ▪ Increased community capacity, engagement, differentiated care models and advocacy for increased access to viral load services through public-private partnerships.
HIV prevention among young people and key populations (SRA 3 and 4)	*90% testing coverage among sex workers (81% in 2014), 86% among men who have sex with men (59% in 2012), 83% among people who use drugs (47% in 2014) and 50% increase in testing coverage among young people* ▪ Friendly services and increased combination prevention services (including condoms, post-exposure prophylaxis, diagnosis and treatment of STIs, health care and reproductive health services and access to protection from violence and legal services). ▪ Engagement of civil society and people living with HIV, key populations size estimates, implementation of revised community service delivery models. ▪ Advocacy for updated guidelines on testing (i.e. self-testing) with focus on the 13 Communes of Autonomous District of Abidjan.
eMTCT (SRA 2 and 5)	*90% PMTCT coverage (80% in 2015)* ▪ Demand creation of increased access to PMTCT services with strong national leadership and community engagement. ▪ Advocacy (involving UNAIDS Special Ambassador) and partnerships, removing the barriers and bottlenecks identified in the Catch-up Plan and implementing relevant recommendations from gender assessments and Stigma Index studies.
D. R. Congo	**2019 target**
HIV testing and treatment (SRA 1)	*80% HIV treatment coverage (increase from 38%)* ▪ Support community service delivery implementation including “test and treat” campaign, differentiated care models, home visits, early warning system, active search of loss and support for adherence, and support integration of HIV and TB programmes at national and provincial levels. ▪ Combined strategic approach using geographic focused in three high-burden provinces (Kinshasa, Katanga, Kisangani) and targeting key populations will be implemented. ▪ Promote using mobile voluntary counselling and testing involving community and ensure appropriate test and treat linkage system.
HIV prevention among young people and key populations (SRA 3and 4)	*90% HIV testing coverage (increase from 46%)* ▪ Implementation of human rights and combination prevention programmes for key populations, people living with HIV, prisoners, youth and uniform personnel; promote comprehensive sexuality education and youth-friendly services. ▪ Sensitization campaigns on key populations’ rights. ▪ Deploying mobile HIV testing services to reach key populations in partnership with the civil society organizations. ▪ Revision of current law to strengthen the provisions protecting people living with HIV and repealing criminalizing articles.
eMTCT (SRA 2)	*90% eMTCT coverage (increase from 74%)* ▪ Support scaling up of eMTCT coverage by ensuring decentralization and integration into lower-level facilities; mobilizing faith-based leaders, women networks, community and grassroots organizations to promote eMTCT and family testing; mobilizing financial resources. ▪ Awareness campaign targeting pregnant women to attend antenatal consultations. ▪ Revision of PMTCT services at health facilities.
Ghana	**2019 targets**
HIV testing and treatment (SRA 1, 4)	*82% of HIV-positive individuals (HIV-positive pregnant women, sex workers, men who have sex with men and partners of HIV-positive pregnant women) on ART in geographically defined areas* ▪ Scaling up innovative interventions targeting HIV-positive pregnant women nationwide, and

	sex workers and men who have sex with men in eight selected districts. ▪ Implementation of task sharing, integration of PMTCT and early infant diagnosis into maternal and child health and EPI services, and post-training monitoring and supervision in high-burden districts. ▪ Revision of HIV testing algorithm. ▪ Undertaking data driven missions to address bottlenecks affecting achievement of 90–90–90 targets in high-burden districts and facilities. ▪ Developing advocacy and communication materials for local pharmaceutical products and strengthening capacity for coordinating entities. ▪ Developing regional and district sub-national estimates using EPP Spectrum to monitor progress towards 90–90–90.
eMTCT (SRA 2)	*82% PMTCT and ART coverage (33% in 2016)* ▪ Implementation of operations research to increase understanding of testing and treatment for spouses/partners and children of HIV-positive pregnant women (as reflected in the Global Fund 2018–2020 proposal). ▪ Roll out of the paediatric HIV acceleration plan. ▪ Conducting eMTCT validation in high-burden regions, districts and facilities.
HIV prevention among young people and key populations (SRA 3 and 4)	*Increased HIV knowledge of HIV and AIDS* ▪ Innovative use of social media and podcasts to increase knowledge of HIV testing and condom use among young people, especially those in tertiary institutions. ▪ Develop comprehensive sexuality education guidelines for teaching and learning that will be integrated into the public and private school curriculum. ▪ Strengthen the capacity of CHRAJ to report and address human rights abuse in order to eliminate barriers to the uptake of HIV services, especially among key populations. ▪ Conduct advocacy sessions with 2,000 widows and young women through Mama Zimbi Foundation to reduce stigma associated with HIV testing and treatment, including positive messaging around treatment and survival.
Mali	**2019 targets**
HIV prevention among young people and key populations (SRA 3 and 4)	*30% reduction in new HIV infections* ▪ With the commitment of civil society and people living with HIV, increase access to combined prevention services (including condoms, post-exposure prophylaxis, PrEP, PMTCT, diagnosis and treatment Of STIs) among key populations, including adolescents and young people (with a focus on Bamako, which signed the Paris Declaration) based on human rights, gender and racial equality.
HIV integration (SRA 2 and 8)	*85% coverage of PMTCT (46% in 2016)* ▪ Advocacy and mobilization of partners for eMTCT. ▪ Integration of NPC services, sexual and reproductive health. ▪ The country's increased capacity, including political leadership and community capacities to rapidly track MTCT electronically. ▪ Support the analysis of bottlenecks and advocate the elimination of these obstacles through technical assistance. ▪ Strengthened national capacity for data analysis.
HIV testing and treatment (SRA 1)	*70% ARV treatment coverage (increase from 53%) in three major cities where the HIV burden is high (Kayes, Sikasso and Segou and in conflicts Zone)* ▪ Advocacy with the municipality, increased mobilization of local resources for delivery of services, community participation, increased public-private partnerships and the establishment of an effective strategic information system. ▪ Developing, implementing and monitoring action plans to accelerate achievement of the 90–90–90 target for treatment using the HIV and Cities strategy.

Nigeria	2019 targets
HIV testing and treatment (SRA 1 and 2)	*2.4 million people living with HIV receive ARV treatment (980 000 in 2016) and tested for viral load* ▪ Advocacy and technical support to roll out task-shifting and sharing, differentiated models of care and community based ARV service delivery. ▪ Addressing barriers to service uptake such as user-fees, stigma and discrimination. ▪ Removing sample transport barriers. ▪ Strengthening capacity of labs and community adherence programmes. *95% ANC attendance in 4+1 state (82% in 2015)* ▪ Demand creation by civil society organizations, community health care workers through traditional and social media. *95% of pregnant women are tested for HIV in 4+1 states (68% in 2015) and 95% of HIV-positive pregnant women are receiving ART in 4+1 states (62% in 2015)* ▪ Strengthening links between informal ANC providers, traditional birth attendants and health care workers. ▪ Training and deployment of community health care workers for demand creation. ▪ Sustain advocacy at the local level and same-day "test and treat". *50% early infant diagnosis coverage (16% in 2015)* ▪ M2M involvement in demand creation and adherence counselling. ▪ Healthcare workers trained to monitor and interpret viral load testing result.
HIV prevention (SRA 4)	*New baseline of HIV/AIDS epidemic in Nigeria established* ▪ Technical support to develop protocol, training, data analysis and publication, also as a first step to strengthened prevention programming. *90% of key populations, especially sex workers and men who have sex with men, in the three priority states and selected local government administrations access combination prevention* ▪ The national condom strategy is developed and implementation supported. ▪ Mapping of key populations, analysis of programme data and prioritization. ▪ Roll out of PreP for high risk men who have sex with men in selected locations.
Human rights, stigma and discrimination (SRA 6 and 5)	*95% of people living with HIV have access to legal support services (52% in 2015)* ▪ Technical support to implement the national stigma reduction strategy. ▪ Monitor and redress human rights violations with support of the Nigerian Bar Association and the Coalition of Lawyers for Human Rights. *Human rights, gender, gender-based violence and anti-discrimination programmes are mainstreamed in the AIDS response* ▪ Sustain advocacy for rights-sensitive and gender-responsive bills. ▪ Strengthen health services to provide integrated gender-based violence/HIV services.

F. EASTERN EUROPE AND CENTRAL ASIA

2019 targets and priorities for the Joint Programme in Eastern Europe and central Asia

HIV Prevention among key populations

Increased coverage of HIV comprehensive prevention programmes among key populations

- Mobilize domestic and donor resources and expand availability of comprehensive HIV prevention services to key populations, among others through a consistent use of key populations implementation tools designed by the Joint Programme, such as SWIT, MSMIT, TRANSIT and IDUIT. Mobilize local leadership to expand availability of harm reduction services, with particular attention to reaching women and younger cohorts of drug-using populations; reinforce evidence-based advocacy in support of opioid substitution therapy and needle and syringe programmes, including in prison settings. Promote PrEP and expand condom and lubricants programmes for men who have sex with men and sex workers. Promote a stronger focus on integrated provision of HIV and sexual and reproductive health services.

HIV Testing and Treatment

10 countries in the region provide *universal access to early and rapid* diagnosis*, including self-testing. 10 countries in the region adopted WHO-recommended "Treat All" policy*

- Advocate adoption of "Treat All" and support revision of national testing and treatment policies; scale up innovative HIV testing and counselling programmes reaching out to key populations, young people and workers, including through youth-led and youth-serving ICT-solutions. Support implementation of self-testing, using different models to reach and test those most at risk of HIV outside of medical settings, including at workplaces and at community level. Support countries to optimize treatment regimens and simplify laboratory testing and monitoring. Strengthen linkage between HIV testing and treatment and care; support integration of HIV testing and treatment with care for other communicable diseases and co-infections (especially TB and hepatitis), primary health care and other referral services.

Elimination of MTCT

Three more countries in the region achieve validation of elimination of MTCT

- Continue to support countries' efforts to ensure equitable access to PMTCT by implementing innovative approaches to reach most marginalized and excluded women and their children and by integrating PMTCT into maternal and child health services and primary health care. Ensure that PMTCT programmes cover equally all four prongs and ensure women's access to comprehensive sexual and reproductive health / HIV services, including for contraceptive choices and family planning.

Human rights, stigma and discrimination

All forms of HIV-related stigma and discrimination, gender inequalities and gender-based violence reduced in 10 countries in the region. HIV-related travel restrictions lifted in one of the two countries maintaining the restrictions

- Support capacity development of key population and people living with HIV networks, relevant national authorities and human rights bodies to counteract attempts to reintroduce criminalization of drug use and HIV transmission, travel restrictions for people living with HIV, and penalization of same-sex relationships and sex work. Advocate for repeal of restrictive and punitive laws and policies. Support regulatory frameworks, policies and strategies for monitoring rights violations of key populations and people living with HIV and ensuring access to justice and redress mechanisms. Support implementation of the CEDAW recommendations on gender equality and HIV.

Resilient and sustainable systems for health

Transition to domestic funding and sustainability plans implemented in six countries in the region

- Provide tools to key government counterparts to estimate resources needed to Fast-Track national AIDS responses and set up public expenditure tracking systems for health including HIV. Broker expertise to develop and implement national sustainability and transition plans. Provide guidance on innovative domestic financing options, use of TRIPS flexibilities, international procurement and local production of ARV drugs. Pursue a favourable legal framework for strengthening the role of civil society organizations and enabling governments to finance HIV prevention and care services provided by nongovernment organizations.

Table 15. Estimates of core and non-core funds in Eastern Europe and central Asia 2018–2019

Organization	Core funds US$	% Fast-Track countries	Non-core funds US$	% Fast-Track countries
UNHCR	-	-	896,200	31%
UNICEF	327,000	65%	5,600,000	65%
WFP	77,100	100%	2,065,800	100%
UNDP	364,000	47%	1,150,000	20%
UNFPA	553,600	8%	2,217,800	5%
UNODC	730,000	56%	671,300	26%
UN Women	340,000	50%	750,000	20%
ILO	279,900	100%	536,900	100%
UNESCO	480,000	15%	143,200	32%
WHO	650,000	100%	7,150,000	12%
World Bank	410,000	55%	855,000	6%
Secretariat	8,826,000	19%	5,000,000	0%
Grand total	**13,037,600**	**31%**	**27,036,200**	**30%**

Joint Programme country presence

Presence of UNAIDS Secretariat

- Yes
- No

Number of Cosponsors present

(With a minimum of 0.3 staff full time equivalent dedicated to HIV)

- 0
- 1–2
- 3–4
- 5–6
- 7–8
- 9–10

Source: 2018 staff data projections

2019 targets in Fast-Track countries in Eastern Europe and central Asia

Ukraine	2019 targets
Optimized HIV treatment cascade (SRA 1, 2 and 4)	*80% of key populations have access to prevention, treatment and care programmes* ▪ Re-configured service delivery and innovative partnerships on HIV testing. *167 000 people living with HIV receive ART (85 000 in 2016)* ▪ Implementation of "test and start", optimization of treatment protocols, intensified community adherence support and cost reduction of commodities (first-line treatment ARV). *eMTCT certification obtained* ▪ Technical support and sustained advocacy. *16 000 people living with HIV, including key populations, in the non-Government controlled areas have access to HIV treatment* ▪ Resource mobilization and local service delivery.
Sustainable HIV response, particularly among key populations (SRA 7 and 4)	*50% of a basic HIV prevention package, including community service delivery, is funded* ▪ Domestic resources through technical support to transition planning. ▪ Standardize costing and social contracting. *15 000 people who inject drugs receive opioid substitution therapy funded by domestic resources* ▪ Implementation of a transition plan and sustained advocacy.
Human rights, stigma and discrimination, gender equality and gender-based violence (SRA 6 and 5)	*HIV services (including for armed forces), justice and gender-based violence mitigation are integrated in the Humanitarian Response Plan and implemented* ▪ Coordinated donor assistance. ▪ Enhanced participation of networks of women living with HIV in the national response. ▪ Addressing gender equality issues and sexual and gender-based violence in the context of post-conflict situation. *Barriers to HIV services for key populations are removed* ▪ Strengthened capacity of community networks. ▪ Advocacy with national authorities. ▪ Technical assistance to policy revisions.