

UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK (UBRAF) PERFORMANCE REPORTING

Additional document for this item:

- i. UNAIDS Performance Monitoring Report 2016–2017: Organizational Reports
(UNAIDS/PCB (42)/18.9)

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

1. *Take note* of the performance monitoring report and continued efforts to rationalize and strengthen reporting, in line with decisions of the Programme Coordinating Board, and based on experience and feedback on reporting;
2. *Urge* all constituencies to contribute to efforts to strengthen performance reporting and use UNAIDS annual performance monitoring reports to meet their reporting needs;
3. *Request* UNAIDS to continue to strengthen joint and collaborative action at country level as part of UN reform efforts and the implementation of the revised operating model of the Joint Programme.

Cost implications of decisions: none

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
eMTCT	elimination of mother-to-child transmission of HIV
FAO	Food and Agriculture Organization
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRP	Global Review Panel
HIV	human immunodeficiency virus
HLM	High-Level Meeting
IATI	International Aid Transparency Initiative
IATT	Interagency Task Teams
ICW	International Community of Women
INPUD	International Network of People who Use Drugs
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
LGBTI	lesbian, gay, bisexual, transgender and intersex
MNCH	maternal, newborn and child health
NASA	National AIDS Spending Assessments
NGO	nongovernmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office Of The United Nations High Commissioner For Human Rights
PADO	Paediatric ARV Drug Optimization
PAHO	Pan-American Health Organization
PCB	Programme Coordinating Board
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMR	Programme Monitoring Report
PrEP	pre-exposure prophylaxis
QCPR	Quadrennial Comprehensive Policy Review
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SOGIE	sexual orientations, gender identity and gender expressions
SRA	strategic results area
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	United Nations Joint Programme on AIDS
UNASUR	Union of South American Nations
UNGASS	UN General Assembly Special Session
UNITAID	UN International Drug Purchasing Facility
USAID	United States Agency for International Development

Cosponsors

ILO	International Labour Organization
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WFP	World Food Programme
WHO	World Health Organization
WB	World Bank

HIGHLIGHTS

Leadership and political commitment

1. In 2016–2017, the Joint United Nations Programme on HIV/AIDS (UNAIDS) sustained its leadership of the global HIV response. It maintained a focus on HIV in the 2030 Sustainable Development Agenda and continued to promote shared responsibility and global solidarity, ensuring no one is left behind.
2. The impact of this work was evident in the 2016 Political Declaration on Ending AIDS, adopted during the UN General Assembly High-Level Meeting on AIDS in June 2016. Recognizing that ending AIDS requires global commitment to reach bold targets, the Secretariat facilitated a process in which Member States agreed on a set of time-bound targets to mobilize political commitment to implement the ambitious UNAIDS 2016-2021 Strategy.
3. In July 2016, the 21st International AIDS Conference in Durban, South Africa, provided a platform for highlighting key issues such as the slow progress on HIV prevention, the need to empower community health-care workers and further strengthen community engagement, and ensure that HIV remains high on national, regional and global agendas. The need for sustainable and predictable funding, including increased domestic investments, was also emphasized.
4. During the 2016–2017 biennium, the UNAIDS Secretariat worked to support the Joint Programme in ensuring a results-based focus and strengthening the alignment of human and financial resources with corporate priorities, as determined by the UNAIDS 2016–2021 Strategy and the 2016 Political Declaration.
5. Recognizing that the new resource environment, the adoption of the SDGs and the context of UN reform, the Programme Coordinating Board (PCB) welcomed the recommendations of the Global Review Panel (GRP). That review was conducted in early 2017 to advise on refining and reinforcing the UNAIDS Joint Programme operating model. The UNAIDS Joint Programme Action Plan, which had been developed to implement the recommendations, informed that effort. The PCB endorsed the Action Plan in June 2017. Following the PCB's approval of the Plan, the Secretariat has been facilitating a transparent and inclusive transition to the new operating model, providing progress updates on implementation at PCB meetings.
6. The GRP validated the fundamental elements and added value of the Joint Programme. It reiterated the importance of UNAIDS' multisectoral approach and central role in the global health architecture, including as a vital partner to the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR). It highlighted the fact that the Joint Programme embodies key approaches required by Agenda 2030 and the 2016 Quadrennial Comprehensive Policy Review (QCPR), noting that UNAIDS represents a model 20 years ahead of its time.
7. The Action Plan prioritized strategic, coherent approaches that are tailored to country context and led by Joint UN Teams on AIDS. These approaches bring the added value, capacity and skill sets that are required to address specific country needs. They enable and encourage the Joint Programme to make integrated and effective contributions that are informed by country priorities, targets, capacity and resources.

8. In addition, ECOSOC recognized the Joint Programme as a model for UN reform in Resolution E/2017/L.27, where it stressed “the need for the Joint Programme to continue to set the path for reform by revising and updating its operating model, in particular in the areas of joint work, financing and accountability, and governance, as considered by the PCB [...] at its 40th meeting [...]”. This testifies to the efforts of the Secretariat to ensure that a resolution tabled and negotiated in Geneva is then successfully brought to and adopted in New York.

90–90–90

9. A major milestone in the HIV response was met in 2016: for the first time, more than half of all people living with HIV (53%) had access to HIV treatment and AIDS-related deaths had been reduced by almost half since 2005. Fully 19.5 million of the estimated 36.7 million people living with HIV had access to treatment, and AIDS-related deaths had been reduced from 1.9 million in 2005 to 1 million in 2016.
10. The massive expansion of antiretroviral therapy in the past 10–12 years, supported by coordinated activities across the Joint Programme, has been central to this success. Accelerated treatment access continues to underpin the 90–90–90 targets for HIV diagnosis, treatment and viral suppression, a vital pathway to reducing the number of new HIV infections to below 500 000 by 2020.
11. Part of this success can be attributed to the push by UNAIDS to transform the 90–90–90 vision into a reality in countries. The 90–90–90 targets represented a shift in the approach to HIV treatment. The new approach emphasizes the importance of achieving viral load suppression in people living with HIV, as opposed to focussing on the number of people accessing antiretroviral therapy. There has been strong support for 90–90–90, with a remarkable number of countries adopting the targets. Many countries have explicitly included the targets in their National Strategic Plans and other policy documents that guide their HIV responses, and are monitoring and reporting on progress. At the moment, 109 countries measure the first and second “90s”, and 96 countries do so for the third “90”. Up to 168 countries measure the number of people receiving HIV treatment and they are included in the UNAIDS special analysis of progress towards the 90–90–90 treatment targets

HIV prevention

12. The Joint Programme launched major initiatives in 2016–2017 to reinvigorate the HIV prevention agenda and make it more responsive to the needs of adolescents, young people and key populations. It supported countries in identifying the optimal combinations of targeted behavioural, biomedical and structural programmes to reach people who are at increased risk of HIV infection. It also continued to promote access to HIV prevention as a right for every person, supporting efforts to ensure all young people have access to accurate, comprehensive HIV and sexuality education and youth-friendly services.
13. Political leadership and partnerships have been at the heart of the Start Free Stay Free AIDS Free initiative, a collaborative framework to accelerate the end of the AIDS epidemic among children, adolescents and young women by 2020. Consultations with a wide range of national partners and stakeholders (including community members, young people, women living with HIV, religious leaders, philanthropists, donors and private sector representatives) contributed to a new global consensus and fresh momentum.
14. Globally, there was an 8% reduction in new HIV infections among children aged 0–14 years between 2015 and 2016. However, there remains an urgent need to accelerate

treatment for children living with HIV. Progress in preventing new HIV infections among adolescents, as well as improving uptake of HIV testing and treatment, has been slow. Among the 23 priority countries, new infections among adolescents aged 15–19 years declined by only 5% between 2015 and 2016. Almost three quarters (72%) of new infections were in adolescent girls aged 15–19 years. This underscores the disparate burden of HIV among adolescent girls and young women.

15. Ending the AIDS epidemic among children, adolescents and young women requires ambitious targets and a Super-Fast-Track approach. Start Free Stay Free AIDS Free calls for the immediate and accelerated scale-up of access to treatment, prevention, care and support services in order to achieve ambitious targets for 2018 and 2020 that will produce the maximum impact.¹
16. The launch of the Global HIV Prevention Coalition and the HIV Prevention 2020 Road Map in 2017 were defining moments. These initiatives reinvigorated momentum for HIV primary prevention and renewed enthusiasm and political commitment for scaling up prevention at country level.
17. The Global HIV Prevention Coalition unites Member States, civil society, international organizations and other partners in efforts to reduce new HIV infections by 75% by 2020. The current 25 low- and middle-income country members of the Global HIV Prevention Coalition received support to develop 100-day action plans, guided by a Prevention Road Map. The Secretariat assisted them with preliminary action to accelerate HIV prevention, including strategic need assessments, addressing policy and programme barriers, developing or revising national targets, and strengthening national prevention leadership. UNAIDS mobilized the East African Community to join in these efforts and invited the African Union to participate in the coalition.
18. The Road Map lists four main factors that are holding back progress: gaps in political leadership, legal and policy barriers, gaps in prevention financing, and a lack of systematic implementation of combination prevention programmes at scale. The Road Map features a 10-point plan for addressing those factors. Participating countries, including development partners and civil society organizations, have committed to implement the plan, which has clear targets and milestones.
19. All participating countries committed to develop 100-day action plans that will jump-start implementation of the Road Map. Those plans will include initial actions to set or update prevention targets, strengthen prevention programme oversight and management, and address legal and policy barriers. A Global HIV Prevention Coalition Secretariat was established within UNAIDS in Geneva to monitor progress and to activate a mechanism for rapid technical assistance.²

Elimination of mother-to-child-transmission

20. Scale-up of prevention of mother-to-child services is one of the greatest public health achievements. In 2016, 76% of pregnant women living with HIV received effective antiretroviral medicines. In the eastern and southern Africa region, home to 50% of new HIV infections in children aged 0–14 years, 88% of pregnant women were receiving antiretroviral medicines in 2016. Elimination of mother-to-child transmission (eMTCT) remained a priority for the Joint Programme in 2016–2017.
21. Transition to the Start Free Stay Free AIDS Free framework created pathways to ensure that all pregnant women can access antiretroviral medicines and that they are retained in treatment and care; all HIV-exposed infants have access to antiretroviral prophylaxis to prevent infection; human rights and gender equality are upheld in eMTCT efforts; and

community engagement is ensured. In November 2017, the Joint Programme and Start Free Stay Free AIDS Free partners launched a global action plan to accelerate development of paediatric formulations.

22. To build on the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* (Global Plan), and ensure the sustainability of gains made, an eMTCT last mile agenda was adopted by the Joint Programme. It includes the integration of services using different service delivery platforms to close gaps in coverage.
23. In 2017, UN joint work on validating the eMTCT of HIV and syphilis as a public health problem continued to gain momentum. By the end of the year, 11 countries had been validated for eMTCT of HIV and/or syphilis, and all regions had established validation structures. Two WHO regions (Western Pacific and the Americas) have committed to the eMTCT of HIV, syphilis and hepatitis B infection.

Key populations

24. During the 2016–2017 biennium, the Joint Programme supported countries, including civil society members, to implement the recommendations of the Global Commission on HIV and the Law. This is helping empower key populations to realize their right to health and it is support their access to HIV prevention, treatment care and support services. Cosponsors invested in targeted interventions to strengthen the evidence base on key populations. The Fast-Track approach to end the AIDS epidemic has continued to enhance access to prevention and treatment for key populations, including in cities. By the end of 2017, more than 200 cities and municipalities had signed the Paris Declaration pledging their commitment to reach the 90–90–90 Fast-Track targets.
25. UNAIDS' 2016 *Prevention gap report* refocused attention on HIV prevention, including for key populations, and enabled the Joint Programme to make an evidence-based case to countries for achieving 90% coverage of prevention services for key populations.
26. The Joint Programme led landmark initiatives in 2016–2017 to revitalize the prevention agenda and make it more responsive to the needs of adolescents and young people, with a focus on adolescent girls and young women. The HIV Prevention 2020 Road Map outlined five pillars for strengthening national HIV primary prevention responses. The first pillar focuses on combination prevention for adolescent girls and young women and their male partners in locations with a high prevalence of HIV infection.
27. Another significant initiative was to the revision of the international technical guidance on sexuality education, which integrates results of an evidence review, online survey and global technical consultation. It reflects good practices and new evidence and reinforces focus on early pregnancy, puberty and gender equality. The revised guidance was presented at several international events, including the 2017 International Conference on AIDS and STIs in Africa.

Gender equality

28. The Joint Programme addressed the gender dimensions of the HIV epidemic in 2016–2017 through a range of activities. UNAIDS supported countries in integrating gender equality into national HIV strategies, monitoring and evaluating frameworks and budgets, and enhancing leadership and participation of women living with HIV in decision-making.
29. The Joint Programme generated evidence of the impact of harmful gender norms on women's ability to prevent HIV and mitigate its impact. The UN Women global review,

Key barriers to women's access to HIV treatment, led by women living with HIV and governed by a global reference group, highlighted the experiences of women living with HIV in accessing quality care. Its findings were published in the *Health and Human Rights Journal* in December 2017.

30. Promoting leadership of women living with HIV was a major advocacy focus for the Joint Programme. This resulted in young women and networks of women living with HIV taking on greater roles in defining a common agenda and participating meaningfully in HIV policy and programming at national, regional and global levels. This included their active engagement in the 60th and 61st sessions of the Commission on the Status of Women, the High-Level Meeting on Ending AIDS, the 2016 International AIDS Conference and the Women Deliver event.

Human rights, stigma and discrimination

31. Human rights and the quest for zero discrimination are at the core of the 2016 Political Declaration on Ending AIDS. The Joint Programme worked to address human rights and confront stigma and discrimination in legislative and policy frameworks through technical support, advocacy, collection of evidence, and conduct of reviews and assessments. It also targeted discrimination in health-care settings. For example, the Agenda for Zero Discrimination in Health-Care Settings was launched in 2016, guiding collective advocacy, leadership, accountability and implementation of evidence-informed interventions.
32. Building on the Agenda, the Joint Programme developed a statement on ending such discrimination, which was issued by 12 agencies committed to working together to support Member States take coordinated multisectoral action. New discrimination targets were integrated into the Global AIDS Monitoring (GAM) online tool to improve understanding of health outcomes, and interventions to reduce and mitigate HIV-related stigma and discrimination along the treatment cascade.
33. The Key Populations Atlas was established in early 2017 and was made accessible to the public via the AIDSinfo platform. The atlas includes size estimates, prevalence, programmatic indicators and stigma and discrimination-related indicators about key populations.

Strategic information

34. Monitoring the global HIV epidemic and the response is a core function of UNAIDS. The Secretariat supports countries in their annual reporting of programme, behavioural, financial and epidemiological data through the GAM system. The response rate has remained roughly stable since 2012, with 174 Member States (90%) reporting in 2017. Experts from Cosponsors and global partners are consulted to maintain high-quality and up-to-date reporting and analysis methodologies. The Monitoring Technical Advisory Group develops the GAM indicator set and guidelines which countries use to report on progress in their HIV responses.
35. The Secretariat regularly presented and analyzed country data, along with policy recommendations, notably in flagship publications such as the *Do no harm* report, the *Prevention gap report* and the *Life cycle report* in 2016, and the *Ending AIDS: progress towards the 90–90–90 targets* report, the *Blind spot: reaching out to men and boys* report and the *Confronting discrimination* report in 2017.
36. These flagship publications form part of UNAIDS' global advocacy and communications work, and help ensure that policy advice is evidence-informed and analyses are

strategically focused. Analyses of country epidemic and response data are provided to the UN Secretary-General for his annual reporting to the General Assembly. Country data are also made available through the AIDSinfo online resource.³ In early 2017, the Key Populations Atlas was established and made accessible to the public via AIDSinfo. The atlas includes size estimates, prevalence, programmatic indicators and stigma and discrimination-related indicators about key populations.

37. The Secretariat supported Kenya to launch the “situation room” platform in 2016, enabling the tracking of HIV and wider programme coverage and gaps at subnational and district levels. In 2017, Côte d’Ivoire, Lesotho, Mozambique, Namibia, Uganda, Zambia and Zimbabwe joined this initiative, with further launches scheduled for 2018. The initiative is an example of the Secretariat’s role in promoting and supporting shifts in strategic information systems towards collecting and making greater use up-to-date, sustainable and routine data. This includes greater use of routinely collected programme data for surveillance, resource tracking and the establishment of situation rooms that frequently collect real-time data from subnational levels. These data are then used to guide HIV responses, using a location-population approach that focuses on human and financial resources where they are needed the most.

HIV integration

38. The Joint Programme worked to ensure universal access to integrated services, including for HIV, tuberculosis (TB), SRH, cervical cancer, harm reduction, and food and nutrition support. Working with partners, UNAIDS integrated HIV in the programmes of other sectors, including humanitarian responses, education and human rights initiatives. The Joint Programme developed and piloted tools and guidance notes to support country efforts to integrate gender equality in national HIV strategies and in Global Fund funding applications.
39. To advance HIV-sensitive social protection, the Joint Programme worked collaboratively to include such a target in the 2016 Political Declaration on Ending AIDS. The target aims to “strengthen child and national social protection systems to ensure 75% of people living with, at risk of and affected by HIV, who are in need, have access to HIV-sensitive social protection activities”. Social protection packages and various incentives have become prominent in the services packages which the Joint Programme promotes for HIV prevention, treatment, care and support. As a result, people living with, at risk of and affected by HIV are being empowered through national social protection programmes, including cash-based transfers. This was achieved at country level through advocacy, technical support and social protection activities.
40. In 2016–2017, UNAIDS and the Kaiser Family Foundation continued to partner in an ongoing collaborative project to produce more real-time, updated commitments and disbursements from top donor governments for HIV and AIDS, a collaboration that was originally started to inform the annual G7 meetings. The partnership broadened and now provides annual updates of HIV resource availability for low- and middle-income countries.
41. The Kaiser Family Foundation collects data directly, on behalf of UNAIDS, from senior levels in the 13 largest donor governments and the European Commission, which provide validated commitments and disbursements. These data inform the UNAIDS estimates of HIV resource availability, directly from these top government donors (including the European Commission). Commitments, disbursements and in-country expenditures from multilateral entities are obtained directly from the Global Fund and UNITAID. Supporting the project is a process of direct data gathering by UNAIDS, the Government of Japan and the Creditor Reporting System from the

Development Assistance Committee of the Organization for Economic Cooperation and Development, which is used to estimate global funding flows for HIV development assistance.

Sustainable financing

42. Sustainable financing and investment continues to be a major challenge for Fast-Tracking the HIV response. The Secretariat estimates that by 2020 the global cost of implementing this approach will be at least US\$ 26.2 billion per year in low- and middle-income countries (as per 2015 classification). In 2016–2017, as more countries transitioned towards increased domestic financing for their HIV response, the Joint Programme provided technical assistance to support them in defining a sustainable path, maximizing sustainable funding opportunities and minimizing service disruptions of potentially complex transitions.
43. In 2016, UNAIDS estimated the financing gaps in 116 low- and middle-income countries. This involved updating international and domestic resource availability from 2000–2015, estimating resource needs to identify options for sustainable financing schemes, delineating policy options for countries moving to higher income levels, including HIV services within universal health coverage goals, and/or delineating options within national health insurance. The resource needs update helped the Global Fund define resource mobilization targets for its replenishment exercise.
44. The Global AIDS update and the projected impact and resource needs in the Fast-Track update on investments needed in the AIDS response served as the basis for setting time-bound targets in the 2016 Political Declaration on Ending AIDS, which outlined a global framework for the AIDS response for 2016–2020. The World Bank Optima model, an allocative efficiency analysis tool to inform public health (including HIV) investment choices, was rolled out in 2016, and enabled the development of more than 10 allocative efficiency studies across six regions, and the reallocation of HIV resources to avert new infections.

Implementing the recommendations of the Global Review Panel and Action Plan

45. Responding to the Action Plan, the Secretariat and Cosponsors at global, regional and country levels rolled out an integrated approach that was designed to build on and further advance the existing Joint Programme mechanisms and practices. This brought together on a single (online) platform the Joint UN Plan, the country capacity assessment, and the country envelope.
46. The country capacity assessment was designed to inform the priorities and optimized use of human and financial resources under the Joint UN Plan. The Joint UN Plan template was updated, to support Joint UN Teams on AIDS in directing consolidated efforts and resources towards the achievement of prioritized country targets. The country envelope (the allocation of core Unified Budget, Results and Accountability Framework, or UBRAF, resources to Cosponsors at country level) was integrated in the joint UN planning process to close UN capacity gaps and boost impact of Joint UN Teams on AIDS at country level. The Joint UN Plan was positioned as the platform for access to country envelope funding. The integrated processes were planned to enhance collaboration and capitalize on existing country-level partnerships, thereby strengthening transparency and enhancing accountability.
47. The Action Plan has a strong focus on country-level work, integrated and impactful efforts, results for people and accountability. Its implementation positions the Joint Programme as pathfinder in the broader reform of the UN development system. The steps taken thus far are reinvigorating and consolidating the Joint Programme effort at

country, regional and global levels around 2016 Political Declaration commitments and prioritized country targets. These actions support strategic and transparent planning of joint UN action to clear obstacles, bring about major change and capitalize on the UN's comparative advantages. The Action Plan is contributing to enhancing cohesion in the support that UN country-level, regional and headquarter teams provide for effective actions and sustainable results for people.

48. UNAIDS is implementing the new resource mobilization strategy, including diversifying the funding base. It is expected that the core budget of US\$ 184 million will be raised in 2018, and that part of the supplemental US\$ 58 million budget can be mobilized. While this represents a stable financial picture, there is a need to intensify efforts to raise US\$ 242 million in 2018, which would represent a fully-funded UBRAF. At the same time, UNAIDS will maintain strict expenditure controls and ensure the cost-effectiveness and value of its activities.

INTRODUCTION

49. The Performance Monitoring Report presents the performance and achievements of the Joint Programme during 2016–2017 at country, regional and global levels towards the UNAIDS 2016–2021 Strategy and the global targets agreed to in the 2016 Political Declaration on Ending AIDS. The report also outlines key challenges and future actions.
50. As per the recommendations of the PCB made at its 38th meeting, the Performance Monitoring Report 2016–2017 is structured to highlight contributions and results of Cosponsors and the Secretariat, using core and non-core UBRAF funding. Reporting is based on a review of achievements against 2016–2021 UBRAF outputs and indicators.
51. Part I of the report presents a synthesis of key achievements, challenges and future actions. It reviews progress against the eight Strategy Results Areas of the 2016–2021 UBRAF (further, detailed information, structured around the 20 UBRAF outputs, is presented in Part II). Achievements against the Secretariat Functions are detailed in the next section. The third section captures progress in the HIV response in the regions. Part I concludes with a presentation of financial implementation.
52. Part II of the report provides detailed information on the key achievements and progress of Cosponsors against the 20 Strategy Results Areas outputs of the 2016–2021 UBRAF and against core and non-core resources.

STRATEGY RESULT AREAS

Strategy Result Area 1: HIV testing and treatment

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Achievements

53. The Joint Programme continues to play a pivotal role in global efforts to rapidly accelerate testing and treatment access. The 2017 UNAIDS report *Ending AIDS: progress towards the 90–90–90 targets* shows that in 2017, for the first time, more than half of all people living with HIV (53%) were accessing HIV treatment.
54. While antiretroviral therapy coverage exceeds 50%, intensified efforts are needed to scale up treatment further. This is particularly the case for children and adolescents, in certain regions (such as western and central Africa and eastern Europe and central Asia) and for certain populations (including gay and other men who have sex with men, sex workers, transgender persons, people who inject drugs, prisoners and other incarcerated people). Efforts to expand HIV treatment should also take account of the social and structural barriers that women and girls face in accessing treatment and care.

Innovative HIV testing and counselling programmes

55. In 2017, WHO launched the *Guidelines on HIV self-testing and partner notification*. HIV self-testing and partner notification are key strategies to increase access to testing for populations at increased risk of HIV and who are not currently accessing testing. A range of tools and standard operating procedures were collected, reviewed and collated to support countries in implementing these approaches, which have the potential to increase the rate of new HIV diagnoses. A major achievement in 2017 was to prequalify the first rapid diagnostic test for self-testing which uses oral fluid. Several blood-based HIV self-testing kits are being assessed through the WHO prequalification process. WHO support enabled the rapid adoption of HIV self-testing, with countries in all regions developing policies to start implementation.

Percentage of countries with selected HIV testing services in place.	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 90% 2019: 80% 2017: 70%	All:47% [45/96] Fast-Track: 58% [19/33]	All: 59% [57/96] Fast-Track: 76% [25/33]
<p>This indicator shows improvements in HIV testing services as a result of advocacy and technical support provided by the Joint Programme.</p> <p>In 2017, 59% of the 96 countries with Joint Programme presence (including 25 fast track countries) reported that the following services are in place:</p> <ul style="list-style-type: none"> ▪targeted HIV testing services; ▪lay providers HIV testing; ▪quality assurance (laboratory) of testing and re-testing before antiretroviral therapy initiation; ▪HIV partner notification services. 			

56. WHO's HIV self-testing website, www.hivst.org provides a frequently updated repository of all HIV self-testing programmes, national policies and research. WHO is a key partner in the UNITAID-funded STAR consortium in Malawi, Zambia and Zimbabwe, which has distributed more than one million HIV self-testing kits. High acceptability and rates of

first-time testing have been found among populations who tend not to access testing through existing services. This project will expand to Lesotho, South Africa and Swaziland. WHO held a major HIV testing services meeting for 18 countries in Kenya, which focused on equitable and acceptable testing for key populations. WHO also organized a series of community consultations on HIV self-testing to explore community concerns and address these so that communities understand and support self-testing as it is introduced in their countries.

57. WHO provided technical support to more than 45 countries to help them increase the effectiveness of their mix of HIV testing services for improving access, diagnosing greater numbers of people living with HIV and linking them to care. WHO supported countries in improving the quality of testing through a number of tools, including WHO-recommended testing strategies and nationally validated testing algorithms, quality assessment/quality improvement systems and re-testing prior to initiating ART.
58. WHO also hosted webinars on a range of HIV testing issues, including HIV self-testing, partner notification, testing quality and misdiagnosis. WHO co-convened, with the UNAIDS Secretariat and the Global Fund, a major meeting in Senegal on HIV testing services in western and central Africa where testing coverage and quality, particularly for key populations, lags.
59. UNHCR worked to ensure that refugees and other populations affected by humanitarian emergencies have improved access to HIV testing and counselling services. During 2017 in South Sudan, UNHCR provided support for the scale-up of HIV testing services in six camps and two referral hospitals where more than 15 600 people were tested throughout the year. In Rwanda, 13 388 Burundian refugees aged 15 years and older were tested for HIV with support from the Global Fund, with 100% receiving their results.
60. UNFPA supported testing and counselling in Benin and Togo for adolescents and young people. The initiative resulted in more than 75 000 HIV tests. In Indonesia, under the female sex worker strategy, technical assistance in seven districts increased testing coverage from 62% to 90%, and helped surpass testing targets (61 910 tested with a target of 58 779).
61. ILO continued to intensify action on HIV testing in the workplace, focusing on workers more vulnerable to HIV. In partnership with national AIDS authorities, labour ministries, employer, worker and civil society organizations, the UNAIDS Secretariat, WHO, UNICEF, UNDP and UNESCO, the ILO mobilized 1.3 million workers (30% women, 69% men) to test for HIV; 19 439 people tested HIV-positive and were referred to treatment and care services for follow-up. Since the launch of the VCT@WORK Initiative by ILO, UNAIDS Secretariat, the International Organisation of Employers and the International Trade Union Confederation, 4.3 million workers have tested for HIV, 106 592 have tested HIV-positive and 104 887 were referred to treatment and care.
62. Workers vulnerable to HIV from sectors such as transport, mining, construction, entertainment, hospitality, health and the informal economy were targeted. To increase the likelihood of identifying workers living with HIV, the focus was also on communities with a relatively higher burden of HIV in the following countries: Botswana, Cambodia, Cameroon, China, the Democratic Republic of the Congo, Egypt, Guatemala, Haiti, Honduras, India, Indonesia, Kenya, Mozambique, Nigeria, Russian Federation, South Africa, Ukraine, United Republic of Tanzania, Zambia and Zimbabwe.
63. In Mozambique, HIV testing was undertaken for young workers, particularly in the informal economy, sex workers, clients of sex workers, cross-border traders and

migrant workers; 25 415 workers took HIV tests, 1,784 people tested positive and 1,781 people were referred to treatment and care services.

64. In Cambodia, HIV testing focused on key populations in the entertainment and garment industry in partnership with the National Centre for HIV/AIDS, Cambodia Business Coalition on AIDS and Khmer HIV/AIDS NGOs Allianc. A total of 40 577 workers (63% of them women) tested for HIV.
65. In the Russian Federation, the ILO forged partnerships to promote the VCT@WORK Initiative with the Russian Railway, the Irkutsk Oil Company, the Tuapse Oil Refinery Factory and five mines of the Siberian Coal Energy Company. The ILO, UNAIDS Secretariat, national AIDS control programmes and civil society partners made efforts to institutionalize HIV testing in India, Nigeria, South Africa, Ukraine and Zambia.
66. In eastern Europe UNESCO continued to support the UNAIDS-led testing campaign, which provides young people with information and counselling on HIV prevention, testing and treatment and SRH issues from reliable sources, such as the UNESCO-supported social media platform TEENSLIVE.INFO and OK.RU\TEST, developed in cooperation with the UNAIDS Regional Support Team.
67. In Botswana, Kenya, Lesotho, Namibia, Swaziland and Uganda, UNESCO worked with SAfAIDS to develop and roll out the Adolescent Treatment Literacy Toolkit to support young people, teachers and the community share information and strategies on HIV prevention, care and treatment in a simple, entertaining way, and promote awareness of the rights and dignity of young people living with HIV. UNESCO developed a monitoring and evaluation tool to accompany the toolkit and support countries in generating information and evidence on adolescent HIV prevention and treatment literacy.
68. In Uganda, UNESCO supported the Protect the Goal campaign to mobilize young people in the Karamoja region through sports and games. Adolescent SRH service providers were mobilized to provide HIV counselling and testing.

Access to the treatment cascade

69. WHO agreed on 10 key cascade indicators with partners to assess gaps towards 90-90-90. It convened 25 high-burden countries covering 85% of the epidemic to establish testing and treatment gaps, analyse cascades and prioritize actions to fill these.
70. Building on a voluntary licence negotiated by UNITAID-Medicines Patent Pool, a breakthrough pricing agreement was announced in September 2017. This will accelerate the availability of the first affordable, generic, single-pill HIV treatment regimen containing dolutegravir to public sector purchasers in low- and middle-income countries for about US\$ 75 per person, per year. The agreement is expected to accelerate treatment rollout as part of global efforts to reach all 36.7 million people living with HIV with high-quality ART. The agreement was announced by the Governments of Kenya and South Africa, together with UNAIDS, the Clinton Health Access Initiative, the Bill & Melinda Gates Foundation, UNITAID, the United Kingdom's Department for International Development, PEPFAR, USAID, and the Global Fund, with Mylan Laboratories Limited and Aurobindo Pharma. It marks an important step towards ensuring the worldwide availability of high-quality HIV treatment.
71. UNDP supported the development of the African Union Model Law on Medical Product Regulation adopted in January 2016. The model law aims to harmonize medicines regulations and share work among countries in sub-Saharan Africa to ensure quicker,

more predictable and transparent approval of medical products. To date, at least five countries have adapted the model law into national legislation.

72. UNDP co-organized a three-day, high-level meeting with the Government of Malawi that aimed to strengthen policy coherence to promote innovation in health technologies and access to them within the African Regional Intellectual Property Organization (ARIPO) region. The meeting was opened by the President of Malawi and attended by senior representatives of 18 Member States and other authorities and stakeholders. It resulted in an outcome document that proposed reforms of the national and ARIPO legal instruments and policies to align Member States' public health and industrial policy objectives. As a result, in November 2017 the ARIPO Council of Ministers created a new mandate for its Secretariat to address policy and legal incoherencies that hinder access to health technologies.
73. In December 2017, UNDP co-organized with Fiocruz, the Union of South American Nations (UNASUR) and the South American Institute of Government in Health a regional meeting for the 12 UNASUR member countries on the use of competition law to promote affordable access to health technologies. Key outcomes included enhanced national capacity to use competition law and policy to promote access to medicines and other health technologies.
74. UN Women invested in researching women's experiences of treatment availability and their decision-making around uptake. *Key barriers to women's access to HIV treatment: a global review*, commissioned by UN Women and undertaken by the AIDS Vaccine Advocacy Coalition, the ATHENA Network and Salamander Trust, highlighted gender-related barriers and facilitators for women's access to treatment and adherence. This community-based, participatory review was designed, led, governed and validated by and for women living with HIV.
75. A global reference group of 14 women living with HIV from 17 countries guided the review through all its phases: a literature review, data collection and analysis via community dialogues; and case studies from Kenya, Uganda and Zimbabwe, with 200-plus women living with HIV from 17 countries participating. The findings of this global review were published in *Health and Human Rights Journal*.
76. WFP's work on addressing HIV is gender-responsive and focuses on linking food and health systems through the provision of food assistance for better health outcomes, such as nutritional recovery for people living with HIV and/or TB, retention in care programmes, and successful completion of treatment.
77. WFP supports HIV responses in a number of ways, including through advocacy and communications; partnerships; the inclusion of food security and nutrition in comprehensive national plans for addressing HIV in order to meet the needs of vulnerable people living with HIV; and technical support, capacity building and assistance for implementation. WFP also provides direct support, including food and cash-based transfers, to individuals and households to help improve access and adherence to treatment.
78. In 2017, WFP provided technical assistance to governments to integrate food and nutrition services into HIV responses through the development of national guidelines on nutrition assessment, counselling and support for adolescents and adults living with HIV. The support was provided in Kenya, Lesotho, Rwanda, Somalia and Swaziland.
79. In the past two fiscal years, 310.8 million people received essential health, nutrition and population services supported by World Bank operations. The institution manages a

health, nutrition and population portfolio of US\$ 11.5 billion. Through this lending portfolio, the World Bank funds major health system strengthening operations that aim to improve the access and quality of services, including HIV testing and treatment. For example, the East Africa Public Health Laboratory Networking project served four million beneficiaries through a network of 32 upgraded laboratories in Burundi, Kenya, Rwanda, Tanzania, and Uganda.

HIV testing for children and adolescents

- 80. UNESCO’s work contributes to the 90–90–90 targets by supporting health literacy and health-promoting schools. The aim is to encourage positive health-seeking behaviour, including HIV/STI testing and treatment adherence, and to support actions that can help young people living with HIV stay in school, such as the provision of safe spaces and referrals to youth-friendly health services.
- 81. Data from provider-initiated testing in paediatric wards, malnutrition units and TB clinics supported by UNICEF indicate a high yield from routine HIV testing, identifying children living with HIV whose mothers were never tested or did not receive prevention of mother-to-child interventions, and children who acquired HIV during breastfeeding. Increasing the number of HIV-exposed children who are tested requires expanding postnatal testing in maternal, newborn and child health services, adding routine testing to various health services, such as nutrition clinics and in-patient settings, expanding the use of community testing, and piloting family-centred approaches so children are followed up from an adult index case.

Indicator: Percentage of countries adopting quality healthcare services for children and adolescents	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 90% 2019: 80% 2017: 60%	All: 51% [49/96] Fast-Track: 58% [19/33]	All: 51% [49/96] Fast-Track: 64% [21/33]
<p>Addressing the gap in ART and care coverage for children and adolescents is a priority for the Joint Programme to Fast-Track the AIDS response with leaving no one behind.</p> <p>In more than half of 96 countries with Joint Programme presence (including 21 Fast-track countries) a strategy to address loss to follow-up/adherence/retention issues for children and adolescents is in place. In addition, 68% of countries (44 out of 65) with concentrated epidemic reported that provider-initiated testing and counselling for children under five is available, and 9 countries have strategies for identifying older children living with HIV (e.g. via linkages with social protection programmes).</p>			

- 82. WFP has carried out several formative studies in Latin America and the Caribbean on the food and nutrition security of people living with HIV. In 2017, Guatemala implemented this study in seven comprehensive care units, which included 120 children and 272 adults living with HIV, who are assisted by the Ministry of Public Health. WFP provided the technical expertise as well as the financial commitments in collaboration with several partners like the Association for the Prevention and Study of HIV/AIDS, a local NGO, the National Program for the Prevention and Control of STIs, HIV and AIDS, the UNAIDS Secretariat, UNICEF and HIVOS. The findings of these studies have provided a framework for advocacy actions for the food security and nutrition of people living with HIV.
- 83. Despite expanding access to lifelong ART for pregnant women living with HIV in 2016, fewer than half the 1.4 million infants born to mothers living with HIV were tested within two months of birth. Among the 2.1 million children (aged 0–14 years) living with HIV, fewer than half were on treatment. Given the high mortality rates during infancy

and early childhood among children with HIV, UNICEF and WHO continued to find ways to decentralize and improve access to HIV testing to link more children to ART early.

84. WHO established a Paediatric Technical Working Group, which met to discuss HIV treatment optimization for children, including data and research plans on new antiretroviral drugs and formulations and the potential role of emerging options in the HIV drug pipeline (e.g. tenofovir alafenamide, long-acting formulations) from a public health perspective.
85. Declining new HIV infections among children presents a disincentive for pharmaceutical companies to invest resources in developing suitable ARVs for children. In this context, several consultations, led by WHO, have advanced the discussion on drug and formulation development for children, resulting in a more collaborative and coordinated response among stakeholders. WHO convened a third meeting on Paediatric ARV Drug Optimization (PADO 3) in December 2016 to take stock of progress and to advance the paediatric treatment optimization agenda. As with previous PADO meetings, PADO 3 brought together regulators, researchers, clinicians, programme managers and other stakeholders. It provided a forum to foster coordination across the continuum of drug development—from discovery to uptake—that is required to scale up ART for children.
86. WHO is supporting the introduction of the AA-HA! Framework to promote a stronger focus on improving service delivery for adolescents, and ensure their specific needs are addressed through differentiated care models.
87. UNICEF provided technical assistance to countries to scale up targeted HIV testing for children and adolescents, and made quality testing and treatment data available at national and subnational levels. UNICEF expanded support for the introduction of point-of-care diagnostic technologies from seven countries in eastern and southern Africa to three in western and central Africa to improve the access of infants to HIV testing. The point-of-care systems efficiently and rapidly deliver tests results and improve timely linkage to ART.
88. UNICEF supported integrated HIV and TB care in children through the development of improved guidance and tools for community management of childhood illnesses. UNICEF's support ranged from developing innovative models to promote HIV self-testing for adolescents, to community outreach through UNICEF's U-report platform. UNICEF revised national testing and treatment guidelines in eastern and southern Africa.

Fast-Track HIV services in high-burden cities

89. The rapidly expanding global commitment to Fast-Track targets in key cities and major urban areas was reiterated and endorsed through the 2016 Political Declaration adopted by the UN General Assembly at the conclusion of the high-level meeting. The *Cities ending the AIDS epidemic* report, with evidence from more than 30 cities on their progress towards the 2020 targets, highlighted the commitment and leadership role of cities and the strategies, actions and achievements in implementing the Paris Declaration.
90. Continued advocacy and mobilization of political commitment in 2017 resulted in more than 250 cities and municipalities signing the Paris Declaration since its launch in 2014. Fast-Track Cities sessions were organized at various conferences, including International AIDS Society Conferences in Durban (2016) and Paris (July 2017).

Percentage of countries with a plan and allocated resources to achieve Fast-Track targets in high-burden countries.	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 90% 2019: 80% 2017: 60%	All:28% [21/75] Fast-Track: 26% [8/31]	All:34% [27/79] Fast-Track:35% [11/31]
<p>This indicator measures progress in the number of cities, setting Fast-Track targets and relevant plans / resource allocation as a result of the Joint Programme’s advocacy efforts and technical support.</p> <p>In 2017, 34% of 79 countries with identified high-burden cities (including 31 Fast-Track countries) have developed a plan and allocated resources to achieve Fast-Track targets in their high-burden cities.</p>			

91. As part of the joint Secretariat, USAID and World Bank programme in western Africa, the World Bank conducted several size estimation and programmatic mapping studies. The studies, such as the one conducted in Côte d’Ivoire for the cities of Abidjan, Bouake and San Pedro, provided programme managers, planners and implementers with the granular level of information needed to Fast-Track services at city level.
92. In partnership with the Secretariat and other Cosponsors, the World Bank’s allocative efficiency study in Johannesburg provided epidemic and programmatic projections to 2020 and 2030. The analysis responded to the city Fast-Track initiative by assessing past HIV care cascade achievements and future needs to reach 2020 and 2030 targets.
93. UNDP, together with the Joint Team on HIV, supported 19 municipalities in South Africa to identify gaps in local HIV responses and revise plans to include strategies to accelerate reaching the 90–90–90 targets for HIV and TB. In Zambia, the Joint Team supported five municipalities to develop HIV investment cases; In the Democratic Republic of Congo, following UNDP-supported advocacy for the creation of key population-friendly centres to increase their access to health services, five centres were brought on-stream in Matadi, Bukavu, Goma, Kisangani and Bunia, and two more in Kinshasa, staffed by 45 trained nurses and doctors. UNDP support to municipalities in Afghanistan and Pakistan under the Multi-Country South Asia Global Fund HIV Programme resulted in more than 35 000 people being tested for HIV and 23 000 cases of STIs being treated since the programme started in 2014.

HIV services in humanitarian emergencies

94. UNHCR and WFP lead the way in addressing HIV in humanitarian contexts, including through the Inter-Agency Task Team on HIV in Emergencies, with participation from partners including UNFPA, UNODC, the AIDS Alliance, the UNAIDS Secretariat, World Vision, the International Federation of Red Cross and Red Crescent Societies, the Global Fund and the International Rescue Committee. In 2016 and 2017, this platform provided leadership and technical guidance, advocated for funding and policy outcomes, helped coordinate actions and facilitated country-level partnerships. Joint initiatives included:
 - updating the *Inter-agency field manual on reproductive health in humanitarian settings* as well as the SPHERE guidance on universal minimum standards for the humanitarian response;
 - creating advocacy briefs on the HIV response in South Sudan;
 - working with the Global Fund and UNDP to improve supply chains to prevent stock-outs in emergencies; and
 - engaging with the cluster system to integrate HIV into emergency responses.
95. During the 2016–2017 drought in southern Africa, WFP secured a US\$ 25 million grant from PEPFAR/USAID to mitigate the effects of the drought on people living with and

affected by HIV in Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe, where severe food insecurity was occurring. The grant enabled WFP to reach 349 099 beneficiaries in those countries:

- supporting them with treatment of malnutrition (in Lesotho, Malawi, Swaziland and Zimbabwe);
- providing household food support to food-insecure families with people living with HIV and orphans and vulnerable children (in Lesotho and Swaziland);
- preventing acute malnutrition among children (in Swaziland); and
- strengthening supply chains of specialized nutritious foods for people living with HIV/TB & and for eMTCT clients (in Mozambique).

Percentage of countries offering HIV-related services for populations affected by humanitarian emergencies	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 90% 2019: 85% 2017: 80%	All: 77% 74/96] Fast-Track: 67% [22/33]	All:82% [79/96] Fast-Track:79% [26/33]
<p>The Joint Programme advocates for the integration of populations affected by humanitarian emergencies within national health systems where possible. Where national governments are unable to do so, the Joint Programme provides HIV-related services directly through partnerships on the ground including logistical support. HIV services specified are based on the “IASC Guidance for Addressing HIV in Humanitarian Settings.”</p> <p>In 2017, 82% of 96 countries with Joint Programme presence (including 26 Fast-Track countries) offered HIV-related services for populations affected by humanitarian services (refugees/asylum seekers, internally displaced persons, and people affected by emergencies (including non-displaced people), including:</p> <ul style="list-style-type: none"> ▪ HIV testing, eMTCT services, HIV treatment, TB screening and treatment, and screening treatment for sexually transmitted infections; ▪ HIV services for key populations; ▪ services for sexual and gender-based violence survivors, including post-exposure prophylaxis; and ▪ food and nutrition support (sometimes including cash transfers) for people affected by emergencies. 			

96. In 2016–2017, WFP’s worked with the All Ukrainian Network of People Living with HIV to provide food assistance, using e-vouchers and targeting 17.6 household members affected by HIV. This resulted in improved food security for two thirds of beneficiaries while 34% adhered to treatment for longer periods. This intervention also increased viral suppression and achieved the third 90 in the target group.
97. WFP provided food and/or cash-based transfers to vulnerable people, including people living with HIV and/or TB in emergency and refugee settings in Central African Republic, Haiti, Myanmar, South Sudan, Uganda, the Horn of Africa, the Lake Chad basin and countries affected by drought. It supported the Global Fund, UNFPA and UNDP with supply chain and last-mile delivery services in challenging environments and emergencies to prevent stock-outs of critical health commodities.
98. During the biennium, UNHCR support ensured continued HIV services for refugees and other displaced populations affected by humanitarian emergencies in more than 50 UNHCR operations. The number of persons UNHCR supported to access ART following implementation of the test and treat guidelines tripled.
99. In the second half of 2016, UNHCR worked with the national HIV programme and field partners to restart ART for nearly 2000 South Sudanese refugees in an area of north-eastern Democratic Republic of the Congo that was difficult to access and where no HIV services existed. After the influx of refugees from South Sudan to Uganda, the Ministry of Health, UNHCR and other partners provided treatment through UNHCR-

supported clinics to 12 019 people (3,967 refugees, 8,052 people from the host population) in 2017. Of these, 2,616 newly arrived South Sudan refugees were linked to treatment in refugee settlement facilities in the West Nile area.

100. In 2017, UNHCR was sub-grantee of a US\$ 2.8 million grant with the Intergovernmental Authority for Development on HIV and TB in Djibouti, Sudan, South Sudan and Uganda. This grant is focused on scaling up HIV and TB services in 13 refugee camps and improving availability and utilization of HIV and TB services by complementing existing UNHCR-funded programmes. In Rwanda, UNHCR mobilized a US\$ 2.09 million grant from the Global Fund that enabled continued access to HIV/TB screening, care and treatment, and malaria prevention for Burundian refugees in Mahama camp, reception centres and urban settings; 953 people living with HIV were identified, with 924 (97%) on treatment at the end of 2017.
101. UNHCR strengthened programmes to improve adherence to ART in populations affected by humanitarian emergencies. It supports peer-led community interventions to improve adherence in several countries, including Egypt, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Uganda and Zambia. Through these interventions, facility-based ART registers or drug supply management systems are confidentially handled and work in collaboration with adherence supporters, who look for lost patients in the community to ensure continuity of therapy and reduce follow-up losses.
102. In the eastern and central Europe region, UNFPA provided humanitarian support for affected populations, including life-skills education, voluntary counselling and testing, prevention and treatment of STIs through the provision of condoms, drugs and other supplies, and creating safe spaces where adolescents can freely access information, services and peer support networks.
103. UNICEF's HIV programming during emergencies in eastern and southern Africa led to cross-sectoral programming in other areas, resulting in increased access to HIV testing through malnutrition treatment services, better tracing of lost-to-follow-up cases in ART clinics, HIV education in communities and institutionalization of HIV testing and linkage to treatment in community nutrition rehabilitation centres. In Ukraine, UNICEF's efforts averted treatment disruption for people living with HIV in non-government controlled areas, and optimized treatment approaches to align them with WHO standards. This was done by introducing fixed-dose combination as the main treatment regimen, a change that also supports treatment adherence. In Nigeria, UNICEF helped procure HIV test kits for pregnant women and returnees in camps and linked them to care and treatment.
104. The World Bank has a US\$ 2 billion portfolio of active lending operations in fragile, conflict and violent contexts in all regions of the world. These projects apply innovative health service delivery and financing tools, such as performance-based contracting and results-based financing to fragile, conflict and violent contexts. They respond to the unique health needs in fragile, conflict and violent contexts, including for HIV services, maternal and child health, gender-based violence and mental health.
105. With UNAIDS cosponsors collaboration, support was provided by the Secretariat to a strategic response in the crisis in Indonesia, Nigeria, South Sudan and Tanzania. Technical assistance was provided for preparedness and response to humanitarian crises in several countries, including China, Côte d'Ivoire, Czech Republic, Democratic Republic of Congo, South Sudan, Sierra Leone, Togo, Zambia, Lesotho, Indonesia, Palau, Papua New Guinea, Philippines, Malawi, Myanmar, Republic of Korea, Russian Federation and United Republic of Tanzania.

106. Through the organization of a joint DPKO and UNAIDS side event “HIV and security: past, present and future” at the 2016 High-Level Meeting, the Secretariat advocated strongly for strengthening the inclusion of HIV into the humanitarian response architecture and the Political Declaration. In that same year, a joint report noting progress on the implementation of the UN Security Council Resolution 1983 from the Secretary General was presented to the UN Security Council.

107. The Secretariat also assisted people living with HIV and their families following the disaster in Sierra Leone in August 2017. It provided technical assistance and strengthened collaboration with local networks of people living with HIV, the UN Interagency Task Team, the National AIDS Secretariat and the wider national disaster response coordination unit. This led to the scale-up of antiretroviral therapy services, livelihood restoration, shelter and psychosocial services, as well as mobilization of resources to support people living with HIV through capacity resilience programmes.

Access to medicines and commodities

108. In 2016, WHO launched the *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV*. In these guidelines, WHO recommends to treat all persons with HIV at any CD4 cell count and rapidly move new science to policy and practice. The guidelines included 52 new treatment and care recommendations covering adults, paediatrics, adolescents and pregnant women, as well as 10 new service delivery recommendations in support of differentiated models of care. These recommendations promote rapid initiation of antiretroviral medicines and the use of innovative testing and diagnostic platforms via a public health approach.

Percentage of countries adopting WHO HIV treatment guidelines.	Targets and Milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 80% 2019: 60% 2017: 50%	All:39% [37/96] Fast-Track: 64% [21/33]	All:51% [49/96] Fast-Track:73% [24/33]
<p>A central element of 2016 WHO Treatment guidance is “treat-all”. With its “treat-all” recommendation, WHO removes all limitations on eligibility for ART among people living with HIV; all populations and age groups are now eligible for treatment and anyone infected with HIV should begin antiretroviral treatment as soon after diagnosis as possible. Joint Programme support to countries includes promotion of task-shifting, adherence support and, where relevant, programmes to address nutritional needs of vulnerable groups</p> <p>In 2017, 51% of 96 countries with Joint Programme presence reported that:</p> <ul style="list-style-type: none"> ▪ the “treat-all” policy had been adopted; ▪ task shifting or task sharing in the provision of ART had been adopted; ▪ policies/strategies for ART retention and adherence were in place; and ▪ a programme for nutritional support to people on ART was in place. <p>Notably, 73% of the Fast-track countries have adopted the WHO HIV treatment guidelines.</p>			

109. Data from November 2017 demonstrated that the proportion of low- and middle-income countries adopting treat all policies increased from 33% in 2016 to 70% during 2017. Data from the WHO HIV Country Intelligence Tool are based on reports from 139 low- and middle-income countries, including 35 Fast-Track countries. Countries are now

putting the newly adopted policies into practice, with 69 countries (50% of all low- and middle-income countries) having already started implementation.

110. A key challenge to reducing HIV-related mortality is the burden of HIV disease, with more than one third of people starting ART having advanced immunosuppression (defined as CD4 cell count <200 cells/mm³). In response, in July 2017 WHO released guidelines for responding to advanced HIV disease within a public health approach.
111. Most countries are following WHO advice to shift to newer, better treatment regimens: 72% of low- and middle-income countries, adopted TDF + 3TC (or FTC) + EFV as preferred first-line therapy and another 40% are making shifts to dolutegravir regimens. In 2017, generic versions of dolutegravir were put on the market and will soon be available at a lower price point, also combined in fixed-dose combination with TDF and 3TC. Many countries are adopting dolutegravir as part of their first-line treatment. WHO recommended adopting drug regimens with high potency, lower toxicity, high genetic barriers to resistance, usefulness across different populations and lower cost.
112. In July 2017 WHO launched a technical update, *Transition to new ARVs in HIV programmes: clinical and programmatic considerations*, and an access policy brief, *Transition to new antiretrovirals in HIV programmes*. WHO co-convened a third Conference on ARV Drug Optimization (CADO 3) in November 2017 to define the critical research necessary to optimize second- and third-line ART regimens for adults in the next five years.

Challenges

113. Progress in testing and treatment and towards the 90–90–90 targets has been impressive but challenges remain. Viral-load testing is WHO's preferred monitoring approach to diagnose and confirm treatment is working, yet it is not routinely available; only 38% of people living with HIV who receive ART have access to tests. Routine viral-load monitoring has been progressively implemented in low- and middle-income countries, though this does not always translate to effective access, particularly for lower-level health facilities. Turnaround times for results, loss of samples and quality management also remain challenges.
114. WHO's *HIV drug resistance report 2017* shows that in 6 of the 11 countries surveyed in Africa, Asia and Latin America, more than 10% of people starting ART had a strain of HIV resistant to certain widely used HIV medicines. Once the 10% threshold is reached, WHO recommends countries urgently review HIV treatment programmes. Increasing HIV drug resistance could lead to more infections and deaths. Modelling shows an additional 135 000 deaths and 105 000 infections could follow in the next five years if no action is taken, and HIV treatment costs could increase by an additional US\$ 650 million.
115. There is continued slow adoption and implementation of critical policies and poor systems capacity in critical regions, such as western and central Africa and eastern and central Europe. "Step Up the Pace: Towards an AIDS-Free Generation in West and Central Africa", a UNICEF/UNAIDS report describes how 25 countries that make up the western and central Africa region are home to 26% of children aged 0–14 years living with HIV worldwide. The region lags on nearly every measure of HIV treatment and care programmes for children and adolescents. To further reduce AIDS-related mortality, countries must improve earlier HIV testing and linkage to care and ensure essential interventions to reduce leading causes of morbidity and mortality.

116. Addressing HIV infections among key populations at higher risk remains a major challenge in all contexts. Similarly, progress towards achieving the 90–90–90 targets for children and adolescents is lagging. Inadequate access to and uptake of timely early infant diagnosis results in half of HIV-infected children dying by age 2 years. Age of consent laws also hinder adolescents' access to HIV testing and SRH services, and stigma and discrimination experienced in the health sector presents a barrier to key populations and youth.
117. Efforts to enhance treatment access and demand for women living with HIV need to factor in the social and structural barriers that exist. Women and girls face multiple forms of exclusion and discrimination, which block access to HIV services and hinder treatment retention. Targeted research is needed on women's experiences of treatment availability and how treatment programmes impact on women and girls living with HIV.
118. Stock-outs of HIV medicines and commodities remain a challenge in some areas, including in humanitarian contexts and hard-to-reach rural settings. UNHCR and WFP work with partners, including the Global Fund and UNDP, to ensure that treatment remains available in challenging operating environments.
119. As more low- and middle-income countries transition from eligibility for donor support, political and other barriers may prevent them from taking full advantage of the policy space available under trade and intellectual property legislation to promote greater access to health technologies.
120. UNAIDS' *Blind spot* report in 2017 showed that men are less likely to take an HIV test and access ART and are more likely to die of AIDS-related illnesses than women. Globally, less than half of men living with HIV are on HIV treatment, compared with 60% of women. Studies show men are more likely to start treatment late, interrupt treatment and be lost to follow-up.
121. Lack of adequate, predictable funding remains the highest risk to Joint Programme work. All Cosponsors have been affected, in all regions. WHO lost 50% of flexible UBRAF funding, more than US\$ 10 million per year. This required shifting the focus to mobilizing resources from within and across the organization and from donors and funding partners. In 2016–2017, WFP was forced to reduce or discontinue food and nutrition assistance programmes for people living with HIV (including refugees) in several non-Fast-Track countries. UNDP has reorganized its global and regional structures to deal with the reduced UBRAF allocations and clustered its regional HIV and health teams for Africa, the Arab States and eastern Europe and central Asia in the UNDP Regional Hub in Istanbul.

Future actions

122. WHO plans to focus afresh on country support, improved programme efficiencies and quality, and on consolidated, streamlined normative products for HIV prevention, testing and treatment. WHO's future work on HIV will be delivered in the context of implementation of the 13th General Programme of Work 2019–2023 (GPW 13), which is structured around three interconnected strategic priorities: advancing Universal Health Coverage, addressing health emergencies, and promoting healthier populations.
123. UNICEF will continue to sharpen its programming approaches in countries to support differentiated service delivery models and strengthen continuum of care (locate-test-link-treat-retain) for all children and adolescents living with HIV. It will focus on programme innovations, health system improvements and working with communities, with an emphasis on settings with low HIV burdens and pockets of underserved

populations. In countries that have made substantial progress in adolescent access to HIV testing, the focus will be on HIV self-testing. UNICEF will leverage its work across multiple sectors to develop approaches that note the multiple needs of HIV-affected children and adolescents for healthy development, including social protection and nutrition.

124. The World Bank HIV team will continue to build evidence and provide technical assistance in support of its lending operations that provide funding for HIV testing and treatment. However, resource constraints will mean more limited capacities for broader health system strengthening operations that include an HIV-specific component.
125. UNDP will continue to provide low- and middle-income countries with technical skills and expertise to develop the systems required to deliver new health technologies for HIV and coinfections.
126. UNHCR will work to strengthen ART treatment adherence for displaced populations by scaling up monitoring and community-based programming in and out of settlement camps. It will scale up HIV work with the health and protection cluster to ensure HIV is effectively integrated into the emergency response, including policies, guidance and training programmes.
127. WFP will maintain efforts to integrate food, nutrition and social protection into the HIV response. It will link food and health systems through the provision of food and nutrition assistance for improved testing and treatment outcomes, such as nutritional recovery for malnourished people living with HIV and TB, retention in care programmes and treatment success, including during emergencies. In 2018, WFP will continue to support partners deliver HIV and TB commodities to the last mile in challenging and humanitarian contexts, including in Central African Republic.
128. UNFPA is to coordinate a US\$ 45 million Joint UN Programme on SRHR/HIV Integration 2018–2021, with funding from the Swedish International Development Agency. The programme will combine the efforts of UNAIDS, UNFPA, UNICEF and WHO to ensure all people can exercise their SRH rights and access quality integrated SRHR /HIV and sexual and gender-based violence services. The project will directly support five countries. Integrated SRHR is central to UNFPA's Strategic Plan 2018–2021.
129. UN Women will disseminate the findings of its *Key barriers to women's access to HIV treatment: a global review* for further policy and programmatic actions and interventions to address gender-specific and other social determinants of health.
130. The VCT@WORK Initiative will remain one of the ILO's prioritized interventions. Despite limited resources, this is one area where the ILO can demonstrate concrete and tangible contributions to the 90–90–90 targets.
131. UNESCO will continue to collaborate with the UNAIDS RST in eastern and central Europe for the next phase of the regional cooperation programme, including through further promotion of the regional HIV testing campaign, and development and promotion of educational videos from young people on HIV prevention, testing and treatment.
132. UNESCO and WHO's Health Promotion Team will collaborate on school health services guidelines, standards for health-promoting schools and an e-platform for their monitoring.

SRA 2: Elimination of mother-to-child transmission (eMTCT)

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Achievements

Comprehensive eMTCT services

133. The scale-up of eMTCT services is one of the greatest global public health achievements of the last decade. In 2016, 76% of pregnant women living with HIV received effective antiretroviral medicines, up from 74% in 2015 and from a baseline of 36% in 2009.⁴ The eastern and southern Africa region, home to 50% of new HIV infections in children aged 0–14 years, had 88% of pregnant women receiving effective antiretroviral drugs, the highest proportion in the world (compared with 75% in Latin America and the Caribbean, and 54% in east Asia and the Pacific). Of concern is the low coverage in western and central Africa (49%), the region with the second highest burden of new HIV infections in children.
134. To build on the achievements of the Global Plan and sustain the progress made, UNAIDS adopted an eMTCT “last-mile” agenda. It includes integrating services using different service delivery platforms to close gaps in coverage. Building on the relatively high utilization of antenatal care in many regions and countries, UNICEF supported maternal, newborn and child health programmes to integrate eMTCT in national policies, guidelines and standard packages of services at all levels. Effective integration often entailed routine HIV testing of pregnant and breastfeeding women, offering male partner testing as part of the package of care, providing effective antiretroviral medicines and monitoring retention in care. It also entailed providing adherence support for pregnant and breastfeeding women living with HIV, infant HIV diagnosis, antiretroviral prophylaxis for HIV-exposed children and infant feeding support.
135. In 2017, UNICEF and WHO supported the eMTCT “last-mile” agenda by promoting the use of data at decentralized levels to further reduce infections by implementing differentiated eMTCT responses. Examples included:
 - introducing subnational data dashboards and performance reviews to address remaining programme bottlenecks in poor performing areas;
 - improving retention of pregnant and breastfeeding women initiated on ART through reminders for clinic appointments (the “remind me” SMS platform);
 - and community-based support strategies.
136. WHO and UNICEF hosted a community consultation to strengthen dialogues between governments and civil society and to propose concrete actions that can improve service utilization, retention, adherence and quality of care for women, adolescents and children with HIV. WHO finalized implementation of science projects under the INSPIRE project and gathered lessons learnt in a journal supplement that was published in July 2017. In addition, UNFPA worked to strengthen the delivery of family planning services to the “last mile” by strengthening the reproductive health commodity supply chain, including in humanitarian settings, and by ensuring a choice of contraceptive options is available, including ones that can be used safely by women living with HIV.

137. WFP worked with partners to integrate food and nutrition support in eMTCT programmes and maternal, neonatal and child health services provided to pregnant malnourished women. This was done mainly through technical assistance to governments, including by supporting the development of guidelines and educational materials. In many contexts, WFP targets pregnant and lactating women, eMTCT clients and children in its food and nutrition support. This can have an impact on adherence to eMTCT, as well as improve health outcomes for newborns.
138. For example, WFP supported Liberia's Government to develop an Essential Package of Health Services, which emphasized maternal and child health services. In 2017, through this intervention, WFP reached 822 eMTCT clients and supported 1,610 eMTCT household members by providing food assistance to support treatment adherence. In Ethiopia, 99.8% of eMTCT clients receiving WFP food assistance attended all their clinical appointments and 99.6% of newborn babies tested were HIV-negative.
139. In the biennium 2016–2017, the World Bank placed strong emphasis on the integration of HIV maternal and child health programmes, using two innovative financing initiatives. The Global Financing Facility and the results-based financing programme supported more than 35 maternal and child health projects around the world to improve the health of women, children and adolescents. It does so by financing high-impact, evidence- and rights-based interventions, and by building resilient systems to increase the use of primary maternal and child health services at facility and community levels and integrating of SRH and HIV services.
140. The implementation process was country-led and the interventions context specific to address barriers, thereby resulting in increased provision of reproductive, maternal, newborn, child and adolescent health information and greater coverage of equitable, high-quality services. For example, in Zimbabwe, the World Bank results-based financing grant is increasing coverage of key maternal and child health interventions, including for HIV positive mothers and children, and covering a population of approximately 4.1 million people.
141. Through its allocative efficiency studies, the World Bank helped governments target countries to identify priority funding needs. This included:
 - analysis of eMTCT programmes;
 - evaluation of costs, quality and impact of expanding coverage of integrated HIV, eMTCT and SRH services to rural and semi-rural locations for improving HIV testing and counselling among pregnant women; and
 - improving access to family planning and antenatal care for women living with HIV.
142. UNHCR played a pivotal role in ensuring equity in programming, advocating for refugees, asylum seekers and other populations affected by humanitarian emergencies to have the same access to eMTCT services as host communities. In 2017, UNHCR conducted a review of HIV prevention policies and practices in 10 operations in different regions, with a focus on eMTCT in humanitarian settings.
143. UNHCR achieved global eMTCT coverage (proportion of first-time antenatal clinic attendees who were pre-test counselled) of 86% in humanitarian settings, both in and out of camp operations. Recognizing that elimination goals are hampered by low rates of retention in care, UNHCR established mother support groups to improve retention rates, mobilized community support in camp settings, and supported implementing partners to provide eMTCT services.

144. The Inter-Agency Task Team on HIV in Emergencies, convened by WFP and UNHCR, completed an online Distance Learning Module on eMTCT in emergency contexts in 2017. This module will be rolled out to UNHCR staff and other humanitarian partners in 2018. In Somalia, WFP and UNICEF held a sensitization workshop on eMTCT, training HIV peer educators on nutritional assessments and provided education and counselling to clients in the Puntland area where they are currently serving as community nutrition workers. In collaboration with UNHCR, UNICEF and WHO, and NGO partners, the World Bank facilitated access to eMTCT services in humanitarian emergencies. In the biennium, through the International Development Association, the Bank doubled its overall resources for fragility conflict and violence-affected countries to some US\$ 14 billion.
145. In 2017, UN joint work on eMTCT as a public health problem continued to gain momentum. Since 2015, WHO headquarters and regional offices, with support from UNAIDS and UNICEF, has led a global eMTCT validation process. WHO serves as the secretariat for the Global Validation Advisory Committee, a group of international experts in eMTCT, including community representatives and human rights experts, and convenes regular meetings to determine whether countries have met the criteria for elimination.
146. By the end 2017, 11 countries had been validated for eMTCT of HIV and/or syphilis and all regions had established validation structures. The WHO regions of Western Pacific and the Americas have committed to the triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B.
147. In addition, the UNAIDS Secretariat supported the International Community of Women living with HIV and Global Network of People Living with HIV/AIDS to develop a framework and criteria, under the guidance of the GVAC, to evaluate whether national efforts to end vertical transmission were upholding human rights, gender equality and community engagement standards.
148. An assessment tool has been included in the second edition of the [eMTCT global validation guidance](#). It measures readiness for the validation and progress towards a human rights-based approach to eMTCT. It also assesses implementation of good practices regarding gender equality and community engagement. The tool is based on human rights issues which women living with HIV have identified as the main barriers to achieving eMTCT of HIV and syphilis. Non-negotiable issues include grave or systematic human rights abuses, including forced sterilizations, contraception or abortion and mandatory testing, and lack of government due diligence in redressing abuses. No country can be validated if there are grave or systematic human rights violations in the context of eMTCT. This is the first time a WHO disease elimination validation process has considered measures for human rights, gender equality and community engagement as a key factor in evaluating whether a country should receive validation.
149. The UNAIDS Secretariat continued to play a pivotal advocacy role to maintain momentum towards achieving eMTCT goals by 2020, raising the visibility of the eMTCT agenda through high-profile initiatives such as engaging the First Ladies of Côte d'Ivoire, Kenya, Namibia and Panama; strategic and catalytic investments made with Luxembourg and Gala funds to all 21 Global Plan focus countries in sub-Saharan Africa including Fast-Track cities; and mobilization and engagement of communities to improve uptake and retention of pregnant and breastfeeding women in antenatal and postnatal care.

150. The Secretariat also led the analysis and publication of a supplement in the Journal of Acquired Immune Deficiency Syndromes in May 2017, on the legacy of the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*. The Secretariat and PEPFAR launched Start Free Stay Free AIDS Free to further galvanize global momentum around a shared and ambitious agenda.
151. Start Free Stay Free AIDS Free seeks to reach a set of super-Fast-Track targets and end AIDS in children and adolescents. WHO and UNICEF are leading two of the work streams: AIDS Free and Stay Free. WHO worked with the Elisabeth Glaser Pediatric AIDS Foundation and provided enhanced technical assistance on treatment and care of children and adolescents living with HIV in 21 priority countries. WHO and its AIDS Free partners launched a global action plan in December 2017 to accelerate development and introduction of new paediatric formulations.
152. UNICEF and PEPFAR lead the Stay Free work stream, which focuses on preventing HIV infection in adolescent girls in 23 countries. WHO and UNICEF are active members of the Stay Free working group to sustain and further expand global and country efforts in preventing mother-to-child transmission. The Secretariat leads the Start Free Work Group, together with ICAP, and broadly supports coordination across all three work streams. Global and country acceleration is being promoted in a more holistic way, with coordinated action across the different work streams in the context of a strong life-cycle approach.

Challenges

153. In some of the highest burden countries in sub Saharan Africa, the high HIV prevalence in women of reproductive age makes it difficult to achieve the elimination goal despite high ART coverage. In western and central Africa, particularly outside cities, fragile health systems with limited human resources, weak procurement and supply management systems, and barriers to service utilization have hindered progress.
154. Several countries face challenges in their operating environments, such as weak governance, poor access to health services and human-made or natural crises that impinge on effective delivery of eMTCT services. In some regions, improved and decentralized data are needed to reach women who are being left behind. Improved knowledge is needed about these women and their circumstances so they can be served and linked successfully to antenatal care and eMTCT services.
155. In 2017, an estimated 214 million women and adolescent girls (aged 15–49 years) in low- and middle-income countries were unable to exercise their right to freely decide whether or when to start a family because they were not using or lacked access to modern contraception. Unmet demand for family planning leads to more than 65 million unintended pregnancies annually in low- and middle-income countries. There is also a large resource gap for family planning in those countries. By 2020, an additional US\$ 173.2 million will be needed annually for procuring contraceptives alone, with costs of quality services pushing funding needs even higher.
156. With the rollout of test and treat for eMTCT, there are concerns about suboptimal adherence to antiretroviral therapy. Supporting lifelong treatment requires addressing issues such as stockouts of antiretrovirals and other commodities, poor adherence and retention in care in the peri- and post-partum periods, stigma, fear of disclosure, user fees and other costs, and socioeconomic barriers. The lack of decentralized capacity for viral load monitoring, limited task-shifting and poor scale-up of early infant

diagnosis also hampers service delivery to children even when they are receiving the most effective antiretrovirals in age-appropriate formulations.

Percentage of countries implementing latest eMTCT guidance	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 100% 2019: 95% 2017: 90%	All: 60% [58/96] Fast-Track: 70% [23/33]	All: 67% [64/96] Fast-Track: 82% [27/33]
<p>Since most countries have already adopted WHO eMTCT guidance, Joint Programme efforts focus on supporting eMTCT implementation, with engagement of networks of women and women living with HIV.</p> <p>In 2017, 67% of 96 countries with Joint Programme presence (27 of which are Fast-Track countries) offered the following services:</p> <ul style="list-style-type: none"> ▪ Lifelong treatment for all HIV positive pregnant women; ▪ Repeat testing of HIV negative pregnant and breastfeeding women; ▪ Partner testing of HIV positive pregnant women in antenatal care settings; and ▪ Networks of women, including women living with HIV, are engaged in eMTCT strategy development and service implementation in these countries. 			

157. Demand-side barriers to access and adherence to eMTCT services include food insecurity. Comprehensive services that integrate food assistance enable more women to start and adhere to eMTCT programmes. Due to funding reductions at global level, some UN agencies such as WFP have limited capacity to address the specific needs of people living with HIV. This undermines the integration of food and nutrition into eMTCT programmes and maternal, neonatal and child health services, which in turn can be harm the nutrition and HIV outcomes of women living with HIV.
158. Data on access to eMTCT services in humanitarian emergencies, such as on the number of patients who require ART in the immediate aftermath of an emergency, is often limited or not available. Inclusion of HIV-related data in rapid assessments is not always possible. Insecurity and conflict frequently prevents services from being established or continued.

Future actions

159. The Joint Programme will continue prioritizing eMTCT based on the mandate and comparative advantage of Cosponsors.
160. UNHCR is working to strengthen data management systems through the revision of health information systems, including updating eMTCT indicators in line with the Global AIDS Monitoring report. Monitoring systems are being strengthened at all levels (facility, camp, country and headquarters) by scaling up the use of electronic accessories to enable real-time and accurate data collection and analysis of eMTCT indicator data. The quality of eMTCT services in humanitarian settings will be enhanced by scaling up mother-to-mother support groups, and access to PCR testing for HIV-exposed infants will be improved.
161. WFP in collaboration with UNICEF will continue to support people living with HIV, eMTCT clients and children through its food and nutrition support activities, specifically targeting these groups where possible and relevant.
162. UNICEF’s critical role in leading the global eMTCT agenda, and in scaling up national programmes in resource-limited settings is ongoing. In eastern and southern Africa, UNICEF will focus on retaining mother-infant pairs after childbirth, increasing

coverage of early infant diagnosis, keeping women who test negative HIV-free, and enhancing services for adolescent eMTCT clients. It will also leverage partnerships, programmes and greater domestic investment to support capacity development, health system strengthening, and policy and tool development. It will also use those channels to promote approaches that can expand access to HIV testing and counselling through improved integration in broader maternal and child health services, and efficient procurement of antiretrovirals. In western and central Africa, emphasis will be placed on high-impact changes in service delivery, including innovations to improve eMTCT coverage and retention in care.

163. WHO will continue to take the lead in developing the normative elements required by the eMTCT agenda. In doing so, it will support countries to adapt and adopt national guidelines and ensure access to the best treatment and diagnostics for pregnant and breastfeeding women, infants, children and adolescents. It will continue contributing to UN joint work on validating eMTCT and it will facilitate those processes by serving on the Global Validation Advisory Committee.
164. With UNAIDS, WHO will continue to support country, regional and global validation of eMTCT and the path to elimination by:
 - providing updated HIV strategic information for policy development and implementation of evidence-based programmes;
 - empowering communities and women living with HIV to participate in validation exercises by identifying rights violations, gaps in implementation and realization of rights protections, gender equality and community engagement; and
 - coordinating with partners to support national strategies achieve Fast-Track targets by 2020.
165. As key contributor of the Start Free Stay Free AIDS Free framework, WHO will foster collaboration with partners to increase access to critical commodities for age-appropriate testing and treatment of children and adolescents living with HIV.
166. UNFPA's work with programme countries, particularly those with the highest unmet need for family planning, is ongoing to develop sustainable human rights-based family planning programmes, including through integrated SRHR delivery platforms that meet the needs of all populations. UNFPA will monitor key sexual, reproductive, maternal and newborn health indicators to better implement responses that address gaps in availability and quality of care. It will also sharpen the focus on increasing domestic financing so countries can transition successfully from donor support.
167. UNFPA will work with governments to develop family planning business cases that set out what works, how much funding is needed and where greater efficiencies can be achieved, and identifying potential sources of funds (e.g. from International Development Association loans or taxation schemes). It will explore ways to expand the financing base to ensure predictable and sustainable resources at global, regional and national levels. UNFPA has begun scoping innovative and blended financing mechanisms that can attract new investors to family planning.
168. The World Bank will continue to support countries in the elimination of mother-to-child transmission of HIV. The Global Financing Facility is in the process of a major replenishment and will keep providing catalytic funding for the expansion of access to essential HIV services. The projects will continue to focus on the integration of SRH and HIV services, the scale-up of existing results-based financing programmes to cover larger geographical areas for greater reach and impact, and enhanced collaboration with partners such as the Global Fund to ensure a more effective supply chain for essential health commodities that reach populations most in need.

SRA 3: HIV prevention among young people

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Achievements

Combination prevention

169. Research shows most young people have inadequate knowledge of their SRH and lack access to youth-friendly services. This increases vulnerability to HIV and is one of the reasons behind their disproportionately high HIV rate. Of the 1.7 million new HIV infections reported in people 15 years and older, 36% occurred in the 15–24 year age group.
170. Adolescent girls and young women are especially vulnerable. In the eastern and southern Africa region, young women (15–24 years) accounted for 26% of new HIV infections in 2016 despite making up just 10% of the population. To address this, the Joint Programme sought to reinvigorate combination prevention and scale up access to youth-friendly SRH services and comprehensive sexuality education, along with measures promoting retention in school and a healthy transition to the world of work.
171. The Joint Programme led several landmark initiatives in 2016–2017 to revitalize the prevention agenda and make it more responsive to the needs of adolescents and young people, with a focus on adolescent girls and young women.
172. Led by UNFPA and the UNAIDS Secretariat, the Global HIV Prevention Coalition and the HIV Prevention 2020 Road Map outlined five pillars for strengthening national HIV primary prevention responses. The first pillar focuses on combination prevention for adolescent girls and young women and their male partners in high prevalence locations.
173. Twenty-five countries adopted the Road Map and developed 100-day action plans. The prevention targets build on the outcomes of the 2016 High-Level Meeting on Ending AIDS, and the resulting Political Declaration, which included a commitment “to reducing the number of adolescent girls and young women aged 15–24 years newly infected with HIV globally each year to below 100 000 by 2020”.
174. To ensure that young people participated in the High-Level Meeting, UNFPA and the Secretariat supported a youth pre-meeting, and UN Women facilitated a space for young women advocates to engage on the Declaration. During the 60th and 61st Commission on the Status of Women, UN Women convened youth forums to provide young people, including those living with HIV, with safe spaces to discuss challenges and opportunities in achieving the SDGs in their local contexts. Thematic discussions on SRH and HIV resulted in priorities being included in the Commission on the Status of Women’s youth declaration outcome documents ([CSW60, 2016](#) and [CSW61, 2017](#)).
175. Another key Joint Programme initiative was to revise the International technical guidance on sexuality education. Led by UNESCO in partnership with UNFPA, UNAIDS Secretariat, WHO, UN Women and UNICEF, the guidance was prepared with input from a global comprehensive sexuality education advisory group with the participation of UNDP and other stakeholders, including civil service organizations and young

people, and integrates results of an evidence review, online survey and global technical consultation. It reflects good practice and new evidence, and reinforces focus on early pregnancy, puberty and gender equality. The revised guidance was introduced at several events, including the 2017 International Conference on AIDS and STIs in Africa (ICASA), the UNAIDS PCB, the 2017 High-Level Technical Meeting in Oslo on advancing comprehensive sexuality education, and the 62nd Commission on the Status of Women. UNFPA is leading a process with UNESCO, WHO and other partners to prepare a version focused on comprehensive sexuality education in out-of-school settings.

Percentage of Fast-Track countries that are monitoring the education sector response to HIV	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 70% 2019: 60% 2017: 50%	Fast-Track: 58% [19/33]	Fast-Track: 67% [22/33]
<p>This indicator measures the commitment of countries to monitor the education sector response to HIV. At the same time, support to the implementation of monitoring systems is a priority for the Joint Programme.</p> <p>In 2017, 67% of Fast-Track countries have integrated the core indicator indicators for measuring the education sector response to HIV in national education monitoring systems, in line with the recommendations of the Inter-Agency Task Team on Education.</p>			

176. In 2017, WHO produced the guidance Global accelerated action for the health of adolescents (AA-HA!) in partnership with UNAIDS, UNESCO, UNFPA, UNICEF, UN Women and the World Bank. A reference document for national policy-makers, AA-HA! includes recommendations on HIV prevention and related SRH issues.
177. The UNICEF/Secretariat-led platform, All In to end adolescent AIDS, supported 25 countries in conducting data reviews to better understand the impact of HIV on adolescents and national response efforts. Targeted support was provided through the All In assessment tool to guide systematic data collection and analyses. Through the Engagement + Empowerment = Equality initiative, for example, UN Women built the leadership capacity of more than 1000 young women, including 250 living with HIV, in Kenya, Malawi and Uganda to take part in the design and validation of All In assessments. UNDP reviewed age-of-consent laws in the 25 priority countries to inform strategies for reform.

Percentage of Fast-Track countries with supportive adolescent and youth sexual and reproductive health policies in place	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 90% 2019: 90% 2017: 85%	Fast-Track: 88% (29/33)	Fast-Track: 91% [30/33]
<p>This indicator measures the commitment of countries to monitor the education sector response to HIV. At the same time, support to the implementation of monitoring systems is a priority for the Joint Programme.</p> <p>In 2017, 91% of Fast-Track countries have supportive adolescent and youth SRH policies in place.</p>			

178. The Joint Programme partnered with the PEPFAR on the Start Free Stay Free AIDS Free initiative, which includes a target on combination prevention, including comprehensive sexuality education, economic empowerment and access to SRH services. UNICEF leads All In, and the Stay Free component of the collaboration, which builds on PEPFAR's DREAMS partnership to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries.

Youth health and education needs

179. The Joint Programme is committed to helping countries ensure adolescents and young people can access the education and services they need to prevent HIV. Condom programming continues to be a cornerstone of these efforts. The Africa Beyond Condom Donation coalition, led by UNFPA in collaboration with USAID, ILO and the NGO Reproductive Health Supplies Coalition, brought together a multisectoral coalition of more than 70 private and public sector groups in order to explore the expansion of the commercial condom market in Africa to increase male and female condoms in low- and middle-income countries to the 20 billion target by 2020.
180. Through the UNFPA-supported programme Safeguard Young People, more than 36 million condoms were distributed to young people in eight countries in the eastern and southern Africa region, along with comprehensive sexuality education. In Kenya, to promote condom use through companies, the Secretariat and ILO, in partnership with the Federation of Kenya Employers, LVCT Health, National AIDS and STI Control Programme and the Swedish Workplace HIV and AIDS Programme SWHAP, conducted a condom audit in 16 companies. A total of 265 600 male condoms and 3,000 female condoms were distributed to mainly young workers in 16 leading companies.
181. Progress is underway to scale up access to voluntary medical male circumcision PrEP for specific locations and populations. WHO has supported the 14 voluntary medical male circumcision priority countries in eastern and southern Africa to implement safe programmes for adolescent boys and young men and continues to review safety and efficacy data for all new devices. The World Bank undertook analytical studies on male circumcision demand creation, cost-effectiveness and return on investment.
182. In South Africa, an impact modelling analysis focusing on age targeting of voluntary medical male circumcision programmes confirmed it as a key intervention to be taken to scale for a more sustainable HIV response. A new global voluntary medical male circumcision framework for 2016–2021 was developed and launched at the 2016 International AIDS Conference. WHO is also working to advance knowledge and evidence on oral PrEP through including adolescents and young people in its PrEP implementation tool. WHO provides support to ministries and partners considering implementing PrEP and HIV testing services for adolescent girls and young women, and developed an information note for the Global Fund to guide programming for this group.
183. Efforts to scale up provision of prevention commodities and services will only have an impact if young people feel safe and empowered to access them and are not impeded by legal barriers. The Joint Programme works closely with civil society and young people to strengthen access to youth-friendly SRH services, including those provided by community health workers, mentors and peers, and those targeted to the specific needs of adolescent and young key populations.
184. Through the Safeguard Young People programme, UNFPA reached 586 513 young people in eight eastern and southern Africa countries with Social and Behaviour

Change Communication and comprehensive sexuality education programmes and 349 125 with SRH services, and seven countries now have maps to identify hot spots, clinics, geographical concentration of young populations and schools. In collaboration with the University of Pretoria, UNFPA analysed laws and policies affecting adolescent SRHR to harmonize legislation in 23 countries.

185. UN Women, UNFPA, UNICEF and UNESCO implemented the 2016–2020 joint UN programme Rapariga Biz5 which is supporting girls and young women in two provinces of Mozambique. Mentors are trained to enhance SRH/HIV knowledge and strengthen access to HIV and other health services. In 2017, 23 518 young women and girls were reached through the programme and an additional 68 967 young people aged 10–24 years were reached via health fairs that offered information on family planning methods, HIV testing and counselling.
186. In Angola, UNDP and UNFPA supported 182 “bancadas feminine”, spaces where young women and girls can discuss their concerns about SRH and learn their rights. More than 22 000 young women and girls were reached with comprehensive HIV and AIDS prevention information. In 2016–2017, joint efforts by UNHCR and UNFPA resulted in more than 19 million condoms being distributed to refugees, internally displaced persons and other populations affected by humanitarian emergencies, in both refugee camps and out of camp settings.
187. UNFPA launched a programming tool on HIV and SRHR among young key populations for nine countries in the eastern Europe and central Asia region, with Georgia, Kyrgyzstan and Ukraine starting the roll out of the new tool. UNDP, African Men for Sexual Health and Rights and the Health Economics and HIV/AIDS Research Division at the University of KwaZulu-Natal in South Africa are implementing a regional project to strengthen legal and policy environments to reduce HIV risk and improve SRH outcomes for young key populations in Angola, Madagascar, Mozambique, Zambia and Zimbabwe. In 2016, WHO drafted a framework on differentiated service delivery for young and adolescent people, as well as for young key populations.
188. The Joint Programme is supporting countries to strengthen delivery of quality comprehensive sexuality education. A key focus has been on efforts to improve monitoring and data collection. Through support from UNESCO, the Technical Cooperation Group for SDG 4 adopted indicator 4.7.2 (percentage of schools that provided life skills-based HIV and sexuality education within the previous academic year) to monitor progress against the education thematic target 4.7. Data on this indicator will be included for reporting in 2018 and are already being collected in many eastern and southern Africa countries through Education Monitoring Information Systems.
189. In 2016–2017, more than 30 African countries received UNESCO training to integrate core HIV and comprehensive sexuality education indicators in EMIS, and 14 countries participated in an online course run by UNESCO’s International Institute for Educational Planning virtual campus.
190. Advances continue to be made through the UNESCO-led eastern and southern Africa ministerial commitment to scale up comprehensive sexuality education and access to SRH services for young people. At the 2016 International AIDS Conference, countries reaffirmed their commitment through the call to action, Let’s Step up and Deliver, and to implementing country road maps to guide progress towards 2020 targets.
191. UNESCO supported a civil society platform to develop a regional report assessing progress in achieving the targets of the commitment, and civil society engagement in

implementing it. In Asia-Pacific, UNESCO, UNFPA and UNICEF completed comprehensive sexuality education implementation reviews in China, India and Thailand, collecting data from more than 500 students. In Latin America and the Caribbean, UNESCO reviewed comprehensive sexuality education curricular content in 19 countries, with results incorporated in an online platform designed by the International Planned Parenthood Federation that will shape future technical support for comprehensive sexuality education. UNFPA developed an eastern and southern Africa regional resource package on comprehensive sexuality education, which has been adopted by six countries.

192. The iCAN package is a facilitator's manual and participant's workbook for young people living with HIV and out-of-school youth. UNFPA also developed content for an online comprehensive sexuality education course for tertiary institutions in eastern and southern Africa. With the lessons learned from the eastern and southern Africa region ministerial commitment, UNESCO is looking to expand it to west and central Africa. In 2016, a regional conference for representatives from 17 western and central Africa countries resulted in a call for action to strengthen comprehensive sexuality education and access to SRH services.
193. Innovative approaches using Information and communication technology and social media are being explored, to engage young people and improve their knowledge. In eastern and central Europe, UNESCO produced a series of 11 edutainment videos for adolescents and their parents on HIV prevention, SRH and relationships, which had 8.5 million views on YouTube. Each day, more than 300 young people in the region accessed information on health and relationships through the teenslive.info web portals. The UNFPA-led comprehensive sexuality education global advocacy hub has 194 active members and 800 followers on the official Facebook page. Support from UNFPA also provided three million young people with SRHR information via the Tuneme.org app and related social media in eastern and southern Africa. In Kenya, the ILO, UNAIDS and partners' #CondomChallengeKe on Twitter got 50 million followers.
194. The Joint Programme supports approaches that retain young people in schools, thereby reducing their risk of HIV infection, through programmes for empowering girls, health promotion, cash transfers and school feeding. An evidence review by UNESCO, UNFPA and WHO led to a set of recommendations on scaling up the education sector response to early and unintended pregnancy, focusing on school re-entry policies to ensure pregnant and parenting girls can fulfil their right to education. As a result, in South Africa, UNESCO is supporting the Department of Basic Education to develop its first Learner Pregnancy Policy. In Latin America, UNESCO organized a subregional consultation on comprehensive sexuality education, early and unintended pregnancy, and menstrual hygiene management with eight countries from Central America, Cuba and Dominican Republic.
195. The World Bank Group's lending for education in 2017 ran to more than US\$ 2.85 billion. Through this portfolio, the World Bank addresses the HIV-related education needs of young people via improved SRH curricula and better-trained teachers and access to primary and secondary education for girls. The Bank supported studies showing how conditional cash transfers can reduce STIs for young people, thereby potentially reducing HIV risk.
196. UNDP's work on cross-sectoral co-financing resulted in a co-financing component being included in South Africa's 2017–2022 national strategic plan for HIV, TB and STIs, with a cash transfer scheme targeting young women and adolescent girls (aged 15–24 years) to address HIV. In Zimbabwe, UNDP supported the Global Fund Concept

Note writing process, resulting in US\$ 426 million for the HIV grant, including US\$ 8 million for interventions focused on adolescent girls and young women.

197. WFP's school meals helped some 17 million children and young people in 60 countries in 2017. In Malawi, more than 990 000 children were reached through its school meals programme, helping them stay in school longer. In 2016, WFP and the Scaling Up Nutrition Civil Society Network also investigated the barriers hindering adolescent girls in Zambia from accessing HIV and nutrition services. They identified low utilization of HIV testing and counselling services, low condom use, limited youth-friendly services and inadequate behaviour change programmes addressing both HIV and nutrition as significant barriers.
198. The Joint Programme seeks to ensure young people have access to safe and health-promoting school environments free from all forms of gender-based violence, including violence on the basis of sexual orientation and gender identity (SOGIE), which is often a cause of missed classes or school dropout. In December 2016, UNESCO and UN Women launched global guidance on school-related gender-based violence, developed under the auspices of a global partners working group co-chaired by UNESCO and United Nations Girls' Education Initiative. As a result, Zambia trained government personnel on school-related gender-based violence, India carried out an assessment, and in the Russian Federation, curricula and a teacher toolkit was introduced in one of the most HIV-affected regions.
199. With UN Women support, the global guidance was also used to guide the draft comprehensive sexuality education and gender-based violence strategy developed in South Africa, and the 2016–2020 Action Plan on Gender Equality for the Education Sector in Viet Nam. UNESCO convened an International Ministerial Meeting on education sector responses to SOGIE-based violence in May 2016, which launched the *Out in the Open* report and resulted in a call for action endorsed by 56 countries.
200. Exploring ways to extend the protective factor of education beyond secondary school to young people entering tertiary education and the world of work is crucial. The ILO, the Secretariat and partners supported scaling up combination prevention programmes in 24 countries. Multiple approaches were used to increase access to HIV services, programmes and policies for young workers, based on evidence from countries. These included:
 - the ILO, Government of Flanders, UNFPA, the Secretariat and UN Women scaled up interventions on HIV;
 - gender equality and SRH in Mozambique that reached thousands of young girls with HIV services;
 - the ILO and Youth Council partnership increased access to HIV testing services for young workers in Ukraine's railway sector;
 - the ILO, Secretariat and the UN Joint Team's Kick Out HIV Stigma campaign in Kenya mobilized young people to play football in the Maisha County League; and
 - ILO's work with the Federation of Uganda Employers, which built the capacity of 30 media professionals to integrate youth-friendly HIV programmes into political talk shows, and entertainment, sports and health programmes.

Challenges

201. Indicator data shows modest gains in implementing combination prevention programmes over the past year. With milestones for the HIV Prevention 2020 Road Map just two years away, targets will not be reached without significantly accelerated actions to scale up combination prevention for adolescents and young people, with a focus on the most at risk and vulnerable groups. The road map identifies significant

gaps in funding and budget allocation, with many countries spending less than 10% of their HIV budgets on prevention, many international donors less than 25%. Countries must be supported to allocate a meaningful proportion of domestic resources to combination prevention programmes that include biomedical, behavioural and structural interventions.

202. Given limited resources, it is even more crucial such programmes are specifically targeted at key and vulnerable populations, in which a disproportionate number of new infections are occurring. The paucity of sex- and age-disaggregated data to inform size estimation and help locate adolescents who are at risk of HIV infection detracts from programme planning efforts. Data collection mechanisms must be strengthened to collect data disaggregated by sex, age, economic status and geographical location. Supporting the shift to a granular approach is a costly, lengthy process requiring significant technical support at country level.

Percentage of countries with targeted combination prevention programmes in place	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 70% 2019: 60% 2017: 50%	All: 32% [31/96] Fast-Track: 45% [15/33]	All: 40% [38/96] Fast-Track: 55% [18/33]
<p>Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Measurements under this indicator cover priority areas of Joint Programme support as part of national combination prevention packages, namely access to male and female condoms and inclusion of life skills-based HIV and comprehensive sexuality education in school curricula.</p> <p>In 2017, 38 out of 96 countries with Joint Programme presence (18 of which are Fast-Track countries) with the all targeted combination prevention programmes in place, namely:</p> <ul style="list-style-type: none"> ▪ quality-assured male and female condoms are readily available universally, either free or at low cost; ▪ gender responsive life skills-based HIV and sexuality education is part of the curriculum in primary schools; ▪ gender responsive life skills-based HIV and sexuality education is part of the curriculum in secondary schools; and ▪ young women are engaged in HIV prevention strategy development and service implementation. 			

203. Gender inequality and harmful gender norms continue to fuel HIV among adolescent girls and young women, particularly in sub-Saharan Africa. For example, almost 30% of adolescent girls in low- and middle-income countries report having their first sexual intercourse before the age of 15, and more than 51% of adolescent girls believe that a husband can be justified in hitting or beating his wife.⁶ More must be done to ensure the participation and engagement of adolescent girls and young women, particularly those living with HIV, and to work with them to understand and address challenges such as low retention in PrEP. Leadership and engagement opportunities should be identified for young women and girls to ensure they can take part.
204. Legal, religious and societal barriers are an issue in many countries, including age-of-consent limitations for access to testing and SRH services, a strong disincentive for adolescents at risk. Yet even without such barriers, the attitudes of service providers can make it difficult for young people to attend health facilities. Training health workers to provide youth-friendly, non-judgmental services is key. Economic barriers also prevent many young people from buying condoms or visiting to health-care services. Food, nutrition and economic insecurity can compel young people to adopt coping strategies that can increased their risk of HIV infection.

205. Finally, a key challenge is the reluctance to address sensitive issues related to young people's SRHR, in particular their right to acquire the knowledge and life skills they need to prevent HIV infection and achieve better health outcomes for themselves, their partners and their families. Persistent misperceptions about comprehensive sexuality education require strengthened advocacy efforts using data and evidence, as well as engagement with parents, communities and traditional/religious leaders.

Future actions

206. The Joint Programme will support implementation of the HIV Prevention 2020 Road Map and accelerated action in the 25 Prevention Coalition countries. Led by UNFPA and Secretariat, the coalition will continue to benefit from specific policy advice and programmatic support from all Cosponsors in line with their mandates.
207. The international technical guidance on sexuality education is being translated into French, Spanish, Russian and Chinese. UNESCO, UNFPA, WHO, UNAIDS Secretariat, UN Women and UNICEF will support country implementation throughout 2018 and beyond. UNESCO will launch a global comprehensive sexuality education advocacy campaign, while UNFPA will finalize international guidance for out-of-school comprehensive sexuality education.
208. UNICEF and UNAIDS Secretariat will continue leadership of All In!, which is aligned to the coalition. UNICEF will continue its focus on the Stay Free initiative, including how to best use eMTCT services as an entry point to addressing HIV prevention needs of pregnant adolescents. It will work with community networks to address the needs of out-of-school adolescent girls and young women and develop an evidence-based set of guidance instruments and practical tools to support programming for adolescent HIV prevention.
209. UNESCO and partners will continue follow up to the eastern and southern Africa ministerial commitment, including through the Let's Step up and Deliver call to action and country road maps. The recent Our Rights, Our Lives, Our Future (O3) Programme will advance progress towards the 2020 targets and expand efforts to the western and central Africa region. UNESCO is also planning regional e-training courses in English and French on monitoring and evaluating the delivery of comprehensive sexuality education through the IIEP virtual campus and will use data from Education Management Information Systems in 17 eastern and southern Africa countries to produce a regional report on the status of comprehensive sexuality education implementation in 2018.
210. UNFPA will focus on strengthening capacities to provide high-quality, integrated information and SRH services, including in humanitarian and fragile settings, along with improving access to SRH commodities. A new 2018 condom programming strategy will be launched with USAID and partners, along with continuing the public-private partnership Africa Beyond Condom Donation. UNFPA will intensify advocacy for adolescent and youth empowerment, particularly adolescent girls, and for the rights of young people to participate in civil and political life.
211. UN Women will continue to identify strategic opportunities for young women and adolescent girls, including those living with HIV, to participate in agenda-setting forums at national, regional and global levels, including advocating for membership in Country Coordinating Mechanisms or other coordinating working groups focusing on the implementation of the HIV response, international and regional AIDS Conferences and the Commission on the Status of Women.

212. UNHCR has developed guidelines on adolescent sexual reproductive health in humanitarian settings, which will guide partners on how to launch and sustain programming. A research and mapping exercise of existing services in UNHCR operations will be undertaken to ascertain gaps and opportunities for scale-up. Youth-friendly service centres will be expanded and technical support for scaling up adolescent sexual reproductive health services provided to all UNHCR operations.
213. WHO will release guidance on monitoring and evaluation of PrEP services, with special consideration for adolescents and young people, as part of its PrEP implementation tool. Among other considerations, it suggests disaggregating core and additional PrEP indicators into smaller age bands (five years) to separate younger adolescents from young people.
214. WFP will continue its HIV-sensitive school meals programming in high-prevalence contexts. WFP sees schools as a platform to reach pre-school aged children, school age children, and adolescents with spillover effects into the community. These platforms are powerful channels for nutrition education, BCC, take home rations, linking to complementary health services (supplements, or reproductive health services for example), and social protection programs. WFP supports home-grown school meals programmes in 46 countries, usually with a combination of direct implementation and technical assistance.
215. The World Bank will focus on evidence building and to providing support to implement combination prevention programmes through its multisectoral Health, Education, Social Protection and Transport lending portfolio. HIV specific support to the Education lending portfolio will be reduced due to resource constraints.
216. UNDP will finalize a regional baseline study on HIV and SRH issues facing young key populations in Angola, Madagascar, Mozambique, Zambia and Zimbabwe. It will continue to support applying cross-sectoral cofinancing for the SDGs, to scale up action on the social and structural drivers of HIV.
217. Mainstreaming HIV prevention issues into ILO programmes in social protection, employment, economic empowerment and labour legislation will be intensified. ILO will continue the VCT@WORK initiative, which raises awareness and puts workers on treatment, and, as a result, reduces HIV transmission. It will be boosted among young key affected populations.

SRA 4: HIV prevention with and for key populations

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

Achievements

218. UNAIDS estimates that during 2015, key populations and their sexual partners accounted for approximately 80% of new HIV infections outside sub-Saharan Africa. Within sub-Saharan Africa, key populations and sexual partners accounted for 25% of new HIV infections. During the 2016–2017 biennium, coordinated efforts of Cosponsors focused on HIV prevention, care and treatment for key populations by guiding development and implementation, protecting and enabling legal environments, strengthening the evidence base, scaling up services for key populations and community empowerment.

Percentage of countries with comprehensive packages of services for key populations defined and included in national strategies	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	MSM, sex workers 2021: 90% 2019: 80% 2017: 70%	MSM, sex workers All: 61% [59/96] Fast-Track: 55% [18/33]	MSM, sex workers All: 71% [68/96] Fast-Track: 67% [22/33]
<p>The Joint Programme plays a key role in supporting countries to develop comprehensive packages of services for key populations so that services are adequate and targeted. Elements of empowerment of key populations both as clients and providers of HIV services are also captured.</p> <p>In 2017, 71% of 96 countries with Joint Programme presence, of which 22 are Fast-Track countries have comprehensive packages of services men who have sex with men and sex workers defined and included in national strategies. Furthermore, these countries have size and prevalence estimates for these key populations. The key populations are also engaged in HIV strategy/programming and service delivery.</p>			

219. Implementation of rights-based HIV programming is critical for scaling up responses to reach the 90–90–90 targets by 2020 and to ensure no one is left behind. Guidance development and roll out are instrumental for supporting this and facilitating coordinated and coherent responses.
220. During the biennium, UNODC and INPUD led efforts to finalize the HIV tool for people who inject drugs, the IDUIT, with inputs from UNDP, UNFPA, WHO, the UNAIDS Secretariat and USAID. The tool for working with transgender people (TRANSIT) was published by UNDP, in association with the University of California, San Francisco Centre of Excellence for Transgender Health, UNFPA, WHO and partners. UNFPA supported translating TRANSIT into Spanish and distributed it across 13 Latin American countries.
221. Regional training sessions for transgender-led civil society organizations and allied service providers were held in eight Latin American countries, six southern African countries and in India. The Joint Programme increased programming with sex workers and men who have sex with men, based on the sex worker implementation tool and the men who have sex with men implementation tool in eastern and southern Africa, western and central Africa, eastern Europe and central Asia and Latin America .

Following trainings in eastern and southern Africa in 2016, UNFPA developed regional guides for utilizing MSMIT and SWIT.

HIV services for key populations

222. In the Asia-Pacific region, UNFPA supported integrated SRH-HIV services for key populations, including web resources. Fifteen eastern and southern African countries subsequently included sex worker and other key population programmes within their Global Fund proposals. In eastern Europe and central Asia, UNFPA trained community members and allied providers on using MSMIT. The Southern Africa Development Community (SADC) was supported by UNFPA Regional Office to draft a key population strategy.
223. UNDP is supporting the Global Network of Sex Work Projects to develop a community-led evaluation framework of SWIT. In partnership with Parliamentarians for Global Action, UNDP developed and launched the *Handbook for parliamentarians on advancing the rights and inclusion of LGBTI people* (translated into Chinese, Dutch, French, Nepalese, Spanish, Thai, Turkish and Vietnamese), with sections on key populations, HIV and rights, and guidance on law reform opportunities and monitoring legislative initiatives. UNDP published an issue brief entitled *Advancing human rights, equality and Inclusive governance to end AIDS*, with examples on equipping civil society and key populations to advocate for rights, access legal services and tackle stigma and discrimination.
224. UNDP and UNODC supported the UN Secretary-General's initiatives to strengthen system-wide actions to implement the 2016 United Nations General Assembly Special Session on Drugs recommendations on health, human rights and sustainable development. As part of these efforts, UNDP, in consultation with OHCHR, UNODC and other UN entities, is partnering with the International Centre for Human Rights and Drug Policy at the University of Essex in the United Kingdom to develop international guidelines on human rights and drug control.
225. In 2016, UNDP developed and released a discussion paper entitled *Reflections on drug policy and its impact on human development: innovative approaches*, documenting innovative approaches that UN Member States have implemented on drug control, and acknowledging the nexus between drugs and sustainable development.
226. ILO, with inputs from the International Organization for Migration and the UNAIDS Secretariat, published *Promoting a rights-based approach to migration, health and HIV and AIDS: a framework for action*, which analyses the underlying issues around health and HIV in the context of labour migration.
227. During a 2016 international ministerial meeting, UNESCO launched *Out in the open: education sector responses to violence based on sexual orientation and gender identity/expression*. This report on violence related to sexual orientation, gender identity and expression in school settings, triggered a call for action, affirmed by 56 countries to date.
228. Over the course of the biennium, UNESCO produced four regional publications and two national reports on violence related to sexual orientation, gender identity and expression in schools, as well as regional guidelines for the inclusion of LGBTI people in the educational system. In India, UNESCO supported a study on bullying experienced by young transgender women and same-sex attracted males in Tamil Nadu. Following a joint publication and expert-group meeting with UNODC and WHO

in Istanbul in 2015, UNESCO published a good practice and policy booklet on education-sector responses to substance use in 2017.

229. WHO ensures that key populations are addressed in all WHO guidance, including HIV testing, prevention, treatment, service delivery, strategic information and monitoring and evaluation. In addition to its global efforts on HIV and coinfections, WHO has collected, reviewed and collated good practice examples from national key population-led HIV programmes. As innovations such as PrEP and HIV self-testing have advanced, WHO has partnered with key population community groups and networks within guideline groups, as research collaborators, reviewers and writers. Guidance has been developed to prioritize new interventions in a way that has maximum acceptability and reach. WHO has been working on differentiated service-delivery models for key populations to support countries provide a range of comprehensive community and facility-based services.
230. Some 72 countries and territories criminalize consensual same-sex activities between adults. More than 101 jurisdictions criminalize HIV transmission and 116 countries criminalize some aspects of sex work. Globally, drug use continues to be criminalized and punished despite little evidence to suggest these policies yield positive results. People who inject drugs, sex workers, men who have sex with men, transgender people and prisoners are respectively 24, 10, 24, 49, and 5 times more likely to acquire HIV than adults in the general population. Promoting protective and enabling legal and policy environments is essential for scaling up HIV responses, particularly among key populations.
231. In the biennium, UNDP, with UNFPA, UNODC and the Secretariat, supported countries, including civil society members, pursue recommendations of the Global Commission on HIV and the Law, which helped empower key populations to fulfil their right to health and assisted them access HIV prevention, treatment care and support services. UNDP supported 22 countries to assess legal and policy environments for key populations, resulting in rights-based and key population-oriented action plans in eight countries.
232. UNDP is working with leading African civil society organizations, such as AIDS Rights Alliance for Southern Africa, the Kenya Legal and Ethical Issues Network on HIV and AIDS, ENDA Santé and Southern African Litigation Centre and African Men's Sexual Health and Rights, on the other hand, and with regional economic entities such as the Eastern African Community, the Southern African Development Community (SADC) and its Parliamentary Forum as well as the African Union Commission and the African Commission of Human and People's Rights, to remove legal and human rights barriers and create enabling environments that increase access to HIV and TB services in 10 African countries.
233. In 2017, 34 of 96 countries (35%) indicated they had a significant HIV epidemic among people who inject drugs. Of these 34 countries, 26 (76%) provided needle and syringe programmes, 22 (65%) provided opioid-substitution therapy, and all 34 provided HIV-testing services and antiretroviral therapy for this group. UNODC and partners engaged policy-makers, drug control agencies, the justice sector and civil society, including the scientific community and organizations of people who use drugs, in an evidence-informed dialogue on HIV, drug policies and human rights for the 59th and 60th sessions of the Commission on Narcotic Drugs, the 2016 United Nations General Assembly Special Session (UNGASS) on the world drug problem, the 25th and 26th sessions of the Commission on Crime Prevention and Criminal Justice, and the 2016 UN General Assembly High-level Meeting on Ending AIDS.

Percentage of countries implementing in combination the most essential interventions to reduce new HIV infections among people who inject drugs	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 60% 2019: 50% 2017: 30%	All: 74% [21/31] Fast-Track: 75% [9/12]	All: 62% [21/34] Fast-Track: 69% [9/13]
<p>While the Joint Programme promotes the full set of interventions for people who inject drugs (nine components), the four most essential to reduce new HIV infections are needle and syringe programmes, opioid substitution therapy, HIV testing services and ART, and the expected impact is greatest when these are implemented in combination with sufficient coverage (and quality). Therefore, the UBRAF monitoring captures the implementation of these four elements in combination.</p> <p>In 2017, 34 out of 96 countries with UNAIDS presence (13 of which are Fast-track countries) reported that the full package of interventions for people who inject drugs is applicable in their epidemic situation. Of these 34 countries, 62% implement the four central components of the package in combination. Furthermore, 27% of 96 countries have gender-sensitive HIV needs assessment for people who inject drugs.</p>			

234. UNODC trained law enforcement agencies, strengthened their partnerships with civil society to support harm-reduction programmes for HIV prevention, treatment and care for people who inject drugs, and helped institutionalize HIV training, including by mainstreaming gender, at national police academies. ILO and partners supported evidence-informed actions that increased access to HIV services for key populations in 20 countries, including in labour law and policy reviews, national HIV plans and programmes, occupational health and safety guidelines, capacity development, information hotlines and business skills development. Through its Being LGBTI regional initiatives, UNDP and partners supported 53 countries promote and protect the rights of men who have sex with men and transgender people by ensuring policies and programmes are inclusive and address their needs.
235. At the RTI global conference on ending gender inequalities and addressing the nexus of HIV, drug use and violence with evidence-based action, UN Women supported the engagement of women who use drugs from four countries. These advocates amplified global calls to scale up responses to HIV, drug use and violence against women. UNICEF engaged with vulnerable adolescent and young populations, civil society and other key actors to advocate for legal and social change, and to remove age-related and other structural barriers to services.
236. A strong evidence base on key populations is crucial for delivering effective rights-based responses to HIV and coinfections. During the biennium, Cosponsors invested in targeted interventions to strengthen evidence on key populations.
237. The 2016 UNAIDS' *Prevention gap report* refocused attention on HIV prevention, including for key populations. UNAIDS urged countries to achieve 90% coverage of prevention services for key populations. New global estimates, compiled by UNAIDS, the Global Fund, WHO and the Centers for Disease Control and Prevention, were reported within the *Key populations atlas*, and new estimates on injecting drug use were provided in the *World drug report* (UNODC, WHO, World Bank, UNAIDS).
238. A 2017 UNHCR country review in Malawi and Mozambique found sex work is often widespread in refugee camps and there is a lack of comprehensive knowledge about HIV and SRH, low levels of condom use and a lack of alternative livelihood options. UNHCR conducted focus group discussions with children and adolescents who had dropped out of school to capture their overall concerns at being exposed to sex work

and sexual behaviours in camp settings. UNHCR has also been working with vulnerable and high-risk communities such as, sex workers, people who inject drugs, adolescents and young people, and transgender populations in several countries, including Iran, Kenya, Malawi, Mozambique and Pakistan, to provide outreach to improve access to HIV services and reduce stigma and discrimination.

239. UNDP, in partnership with the World Bank, UNFPA and the NGOs OutRight, the International Lesbian, Gay, Bisexual, Trans and Intersex Association and Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights RSFL⁷, developed an LGBTI Inclusion Index to assist governments, civil society and other development partners measure LGBTI inclusion, identify data trends and gaps, and provide evidence to help advance good policy.
240. In 2017, partners finalized 51 indicators of the LGBTI Inclusion Index – among them 13 indicators for disaggregated data collection related to health, including HIV and discrimination in health-care settings – to be used globally. The indicators will be critical for collecting country-level data on the exclusion of LGBTI people and provide an empirical basis for laws, policies and measures to foster LGBTI inclusion. UNODC, in collaboration with WHO, UN entities, civil society organizations and expert networks, published strategic information on people who inject drugs and HIV among this group, helping to identify country-specific needs in improving data for this key population.
241. The Strategic Advisory Group to the United Nations on Injecting Drug Use and HIV, involving UNODC, WHO, the World Bank, and the UNAIDS Secretariat, contributed to a review of strategic information on injecting drug use, HIV, and of HIV policies, programmes and services for people who inject drugs. It identified gaps in strategic information and agreed on how to fill those gaps.
242. Through its analytical work, the World Bank supported countries to improve HIV resource allocations for key populations. It conducted more than 15 allocative efficiency studies in 2016–2017, in partnership with the Global Fund, the Secretariat and other Cosponsors. Such studies provide governments with the evidence needed to appropriately reallocate budget to key populations. World Bank technical assistance helped scale up HIV services for female sex workers, supporting countries in size estimations and programmatic mapping for this group. UNODC led efforts to explore the nexus between HIV and stimulant use, and presented a scientific statement on this topic as part of its input on science and drug use during the United Nations General Assembly Special Session and the High-level Meeting on Ending AIDS.
243. To achieve the 90–90–90 target by 2020 and to meet the SDG target to eliminate AIDS as a public health threat by 2030, a significant scale-up in comprehensive services for key populations is needed. UBRAF indicators for key populations illustrated that of the 96 countries providing data, 78 (81%) reported having a comprehensive package of HIV services for men who have sex with men, 86 (90%) reported having a comprehensive package for sex workers, and 59 (61%) for prisoners and others in closed settings.
244. During the biennium, Cosponsors focused on supporting the scale-up of interventions and programmes. As a Global Fund principal recipient, UNDP has supported the integration of services targeting key populations in 17 countries, and in four regional grants covering another 34 countries. UNDP and partners also contributed to the Global Fund's initiative on scaling up human rights programmes in 20 focus countries, which received catalytic Global Fund funding for human rights interventions. In its efforts to promote sustainable financing for national HIV responses with specific focus on access of key populations to services, UNDP partnered with Open Society

Foundations and the Global Fund to provide technical support for adapting rights-based responses to specific contexts through global consultations on social contracting. Nine models were explored and recommendations developed on using social contracting to improve government responses to HIV and service provision to key populations, to be implemented by civil society with government funding. This modality is increasingly important in middle-income countries where multilateral health funding is declining.

245. In its work with populations affected by emergencies, the Joint Programme continued to partner with civil society to implement a range of interventions with key populations, including: outreach HIV testing services in Pakistan; partnering with NGOs in Nepal to provide HIV testing in refugee camps and key populations; and sensitization trainings within refugee camps (Kenya) to increase knowledge of HIV prevention and reduce discrimination against sex workers and clients and increase prevention with positives programmes.
246. In Pakistan, UNHCR and NGO Legend Society supported a harm-reduction programme for local population and refugees. In 2016, 9,354 people who inject drugs were reached with HIV testing services, and 71 840 syringes and 79 818 condoms distributed. The programme continued in 2017, distributing 133 569 syringes, 53 989 condoms and 31 879 information, education and communication materials. UNHCR also worked with LGBTI populations in camp and urban settings, with a particular focus on improving the protection of internally displaced LGBTI persons and promoting HIV prevention (for example, in Argentina and Ukraine), establishing referral pathways and providing information on HIV services.
247. UNICEF's support to Côte d'Ivoire, Namibia, Lesotho and Swaziland contributed to a comprehensive behaviour change communication strategy for adolescents and youth, including those from key populations. These programmes have improved the quality of services, making them more responsive to the needs of adolescent key populations, increasing their access to high-impact interventions especially to HIV testing and increased HIV/STI awareness.
248. In 2017, UNICEF worked with UNFPA to support initiatives to increase access of vulnerable adolescents to high-impact, evidence-based biomedical, behavioural and structural interventions, including: peer-support groups and other community programmes in Ethiopia and Lesotho; crowdsourcing demand for services through information and communications technology and innovation in Mozambique; safe spaces for vulnerable adolescents and key population youths to voice concerns and engage in programming in Kenya; and facilitating increased access to SRH services and making referrals for HIV testing and counselling in Malawi. UNICEF also supported countries in the development of the Cash Plus programme, layering social cash transfers with skills-building on SRH, HIV and livelihoods for vulnerable adolescents.
249. WHO supported partners to implement, scale up and improve sustained, comprehensive and effective HIV prevention, testing and treatment efforts targeting key populations. WHO worked closely with UNDP, the Secretariat, civil society and stakeholders to advocate for an evidence- and human rights-based approach for preventing and treating HIV and other sexually transmitted infections and to monitor the performance and impact of its implementation.
250. As part of its financing of comprehensive HIV prevention programmes for key populations in multiple regions, the World Bank supported a project in India, Niger and Nigeria to scale up prevention interventions for sex workers and increase access to and the use of HIV counselling, testing, care and support services. Key populations

programmes have been integrated within the bank's SRH lending operations, as are programmes for reinforcing reproductive health and HIV services. Community-based interventions and health insurance schemes were developed for key populations and financing provided to evaluate health and HIV interventions for the poor and key populations. UNFPA supported the provision of rights-based SRH/HIV services with and for sex workers and men who have sex with men within 10 eastern and southern Africa countries, plus for transgender people and people who inject drugs in several of these countries. In Asia, UNFPA supported programming with and for sex workers and men who have sex with men in six countries, strengthening the provision of integrated SRH/HIV services. Within the Arab states, Egypt, Morocco and Sudan were supported to reduce discrimination and increase access to health care for key populations. UNFPA's small island state programmes in the Pacific and the Caribbean supported sex worker, men who have sex with men and transgender networks with community-led HIV programming.

Harm reduction packages for people who inject drugs

251. UNODC workshops and policy dialogues engaged people who inject drugs in the response to HIV and trained more than 120 representatives of Governments, civil society and community-based organizations in Egypt, South Africa, Tanzania and Vietnam. The efforts of "UNODC-CSO Group on Drug Use and HIV" were focused on implementation and scaling up of evidence-based HIV prevention, treatment and care for people who inject drugs. UNODC supported over 80 civil society organizations worldwide in improving access to HIV harm reduction services.
252. UNODC produced a guidance document *Addressing the specific needs of women who inject drugs— Practical guide for service providers on gender-responsive HIV services* in partnership with the International Network of Women Who Use Drugs (INWUD), Women Harm Reduction International Network (WHRIN) and the Eurasian Harm Reduction Network.
253. UNODC, in partnership with the International Network of Women Who Use Drugs, developed a training programme on addressing the specific needs of women who inject drugs and trained over 70 service providers, managers, and outreach workers in Egypt, Indonesia and Vietnam. The training events were followed by policy-level dialogues with national stakeholders. UNODC also initiated and developed a training module on Gender Mainstreaming Monitoring and Evaluation of HIV Services for Women Who Use Drugs and piloted it at a workshop in Nepal (October 2017).
254. UN Women enhanced the leadership capacity of women who use drugs, including those living with HIV. The Asian Network of People who Use Drugs received capacity development trainings from UN Women to implement gender equality programming in the context of HIV and drug use. In the United Republic of Tanzania, more than 1500 women who use drugs and/or are living with HIV were supported to improve their access to harm reduction and HIV services.
255. UN Women also facilitated the appointment of a woman to the Harm Reduction Committee in Temeke District Council to ensure the specific needs of women who use drugs and are living with HIV are considered in local planning and programming. In Tunisia, UN Women reached 200 women living with HIV who use drugs, linking them to HIV services and supporting them to increase their self-esteem. UN Women worked with service providers to sensitize them to the stigma and discrimination women face due to their HIV status and drug-use.

256. Cosponsors have followed the “nothing about us without us” principle in their engagements with people living with HIV and key populations, including community-led organizations, to ensure HIV-related action is participatory, inclusive and evidence-informed. Eighty-two countries (85%) reported that gay and other men who have sex with men were involved in their HIV strategies, programming and service delivery, and 81 countries (84%) actively engaged sex workers.
257. The Joint Programme invested in global coordination of key population programming by supporting community-led initiatives, including:
- UNFPA, UNDP, UNODC and UNAIDS Secretariat support for the Global Network of Sex Work Projects (NSWP), the MSM Global Forum and their Global Advocacy Platform;
 - the Steering Committee on HIV and Sex Work;
 - the Strategic Advisory Group on HIV and people who inject drugs;
 - the Eurasian Coalition on Male Health; the Asia-Pacific Coalition on Male Health;
 - African Men for Sexual Health and Rights;
 - the African Sex Worker Alliance;
 - the eastern and central Europe Sex Workers Rights Advocacy Network;
 - REDLACTRANS;
 - YouthLEAD;
 - Youth Voices Count;
 - the eastern and central Europe Regional HIV/AIDS Legal Network;
 - the Middle East Network for Legal Aid;
 - and the Equal Rights Association for Eastern Europe.
258. A strong focus of the work with community-led organizations was the rollout of implementation tools for HIV programming with key populations, and on capacity building, competence development and advocacy support, including at national and international forum. Through the Global Platform to Fast-Track HIV Responses among Gay Men, Bisexual Men and Other Men Who Have Sex with Men (Global Platform, Bangkok, March 2017), the UNAIDS Secretariat, UNDP, UNFPA and partners supported advocacy plans to address criminalization, discrimination and the need for disaggregated data.
259. The *Reconsidering primary prevention on HIV: new steps forward in the global response* report was published, focusing on prevention for key populations. A new National Platform for Key Communities was also supported in Ukraine, to advocate and mobilize key population responses. The UNAIDS Secretariat worked with the Global Fund on US\$ 50 million in catalytic grants for key populations.

Challenges

260. An estimated 44% of all new HIV infections globally occur among key populations and their sexual partners. Current epidemiological and modelling data reveal epidemics focused around key populations in all regions. However, there remain barriers to mounting effective responses to HIV, both with and for key populations. Marginalization, stigma, discrimination and violence against key populations continue and are sustained by deeply-rooted social, religious and cultural beliefs, norms and practices. This is evident also in the persistence of punitive laws, the shrinking space for civil society organizations that work with key populations, and increasing populist calls for tougher penalties and further exclusion of key populations from mainstream society.
261. There is a need to contextualize HIV responses for different key populations and settings, such as within conflicts, displacement and migration, and different

sociopolitical environments. Further meaningful participation of key populations is needed, together with increased investment in community-led, rights-based HIV responses. Key populations have intersecting health needs regarding HIV coinfections such as TB, viral hepatitis and other sexually transmitted infections, along with broader SRH needs, and other health concerns such as noncommunicable diseases and mental health issues.

262. Delivering on the pledge to leave no one behind requires a holistic understanding of the intersecting identities and behaviours that lead to increased vulnerability. While we know what interventions work, these are often not available. PrEP, for example is still not available for key populations in many countries. There is limited reach or tailoring of programmes for key populations, and a lack of standard packages, operational procedures and minimum standards.
263. Operational restrictions are a significant challenge for young key populations, with many providers prevented from working with adolescents and young people who have not reached the legal age of majority. Even when services and programmes do reach these adolescents, they are often not tailored for them, and providers often lack skills or are unwilling to work with adolescents at higher risk. Services are quite weak for adolescent boys who are coming to terms with their sexual orientation and gender identity, particularly for those who are gender nonconforming. Little is known regarding their psychosocial and SRH needs.
264. People who inject drugs and incarcerated people are likely to experience specific social marginalization and violations of their human rights. Current legal, policy and law enforcement practices often create significant barriers to evidence-informed HIV interventions for this group, in particular, preventing needle and syringe programmes and opioid substitution therapy. In many countries, HIV and other relevant health services in prisons are severely limited or entirely absent, putting people at increased risk of HIV, and putting people living with HIV at increased risk of declining health, coinfection with TB and viral hepatitis, and possible death.
265. Stimulant drug use (cocaine, amphetamines and new psychoactive substances) is increasing worldwide and is correlated with a high risk of HIV infection, particularly through unsafe sexual practices or sharing drug-injection equipment. Violence against women who use drugs also remains widespread and HIV prevalence is higher among women who inject drugs. Yet national-harm reduction efforts do not respond to specific needs of women who use drugs. Gender-based violence affects women's abilities to negotiate safer sex and injection practices and to seek and use harm-reduction services, HIV prevention and treatment or other services.
266. Lack of data, especially sex- and age-disaggregated data for specific key populations and locations, hampers advocacy and development of evidence-informed HIV responses with and for key populations. Many countries have not yet estimated the sizes of their key populations and therefore are unable to set meaningful targets for the number of persons that should be reached with combination prevention.
267. While the new health architecture (SDGs, Universal Health Coverage) provides an opportunity to leave no one behind, there is a risk that actions regarding key populations may amount to little more than lip service. Parallel community-based HIV programmes may also lose out as the focus changes to a more uniform approach to achieve Universal Health Coverage. All UN agencies are experiencing reduced financial resources for HIV programming that act to reduce or even halt progress in the coverage and impact of HIV programmes, including for key populations. Key population programmes and services still largely depend on donor funding in many

countries, and negative impacts can also be seen, for example, where there are no longer Global Fund investments. While efforts have been made to ensure sustained donor funding for key population-focused HIV responses (for example, by the Global Fund) there is a lack of focused resources, especially within nationally funded HIV programmes.

Future actions

268. Guided by the UNAIDS Division of Labour and the 2016–2021 UBRAF, the UNAIDS Cosponsors will continue to partner on focused, global, regional and country interventions to making tailored prevention services accessible to key populations by engaging communities of key populations, governments, civil society, as well as other relevant stakeholders.
269. The Joint Programme will support the development of the Prevention 2020 Roadmap, with accelerated action in 25 Prevention Coalition and other countries. This will include supporting key population communities to engage in the delivery of HIV services through the roll-out of key population HIV implementation tools. The focus will be to accelerate national HIV prevention programmes with key populations, including community-led responses that include community empowerment and capacity building. Complementing this, UNFPA, WHO and partners will progress strategies to strengthen integrated SRH/HIV service delivery, including for key populations, with a focus on reducing discrimination within health-care settings.
270. UNDP will continue to support key populations by: updating the report of the Global Commission on HIV and the Law, ensuring rights-based responses for key populations are included; engage with partners to develop guidance on social contracting of key population services; finalize international guidelines on human rights and drug policies to reconcile human rights and enforcement frameworks; and strengthen evidence for LGBTI-inclusive developments by collecting disaggregated data. UNFPA, UNDP and OHCHR will further support intergovernmental bodies to increase equality, such as the Equal Rights Coalition and LGBTI Core Group of UN Member States. Support for key populations in humanitarian and fragile contexts will be maintained.
271. UNODC will support roll-out of tools including IDUIT, Addressing the specific needs of women who inject drugs: Practical guide for service providers; and Practical Guide for Civil Society HIV Service Providers among People who Use Drugs: Improving Cooperation and Interaction with Law Enforcement. Training on mainstreaming gender within services for people who inject drugs, including monitoring and evaluation, will continue in high-priority countries. UN Women will promote the participation and leadership of women who use drugs and are living with HIV in decision-making at global and country levels and will support the priorities of women who use drugs to be included in national HIV responses.
272. UNODC, UN Women, WHO, World Bank and the UNAIDS Secretariat will contribute to the work of the Strategic Advisory Group to the UN on HIV and Drug Use. UNODC will also develop normative guidance on HIV services in prisons, support development of monitoring and evaluation tools, update strategic information and continue supporting coordination between health services and the criminal justice system. The UNODC/WHO/UNAIDS toolkit on health in detention will be updated with a specific focus on gender responsiveness. Strategic information on HIV and injecting drug use will be further strengthened with input from WHO, UNAIDS and the World Bank.

273. UNHCR will scale up HIV prevention through community-based programming with key populations, particularly sex workers, working with UNFPA on guidance on HIV and sex work within humanitarian settings.
274. Within the framework of the Global Prevention Coalition, and as the co-lead of Stay Free, UNICEF will support enhanced roll-out of PrEP and self-testing in young key populations. UNICEF will also partner with the information and communication technology business sector to define high-tech solutions for increased access to quality and comprehensive integrated HIV and SRH services. UNICEF and partners will gather comprehensive and multisectoral evidence on the full range of vulnerabilities faced by young key populations to inform integrated HIV/gender-based violence/SRH programming. UNICEF will collaborate with UNDP, UNFPA, UN Women and UNAIDS to advance work to revise legal age of consent and sociocultural barriers to services for adolescents and take this learning to the field.
275. Using the guiding framework of Recommendation 200 concerning HIV and AIDS and the world of work, ILO will continue to support Member States to draft policies and codes, and enact legislation on equality and non-discrimination to ensure the rights of people vulnerable to HIV are protected. ILO plans to roll out Cambodia's occupational health and safety regulations for entertainment/sex workers to protect the rights of sex workers.
276. WHO will continue to prioritize the inclusion of key populations in all its work, including support for community networks. To support young key populations, WHO will develop a technical brief on PrEP for young people and how to provide services that reach young key populations and meet a range of health and other needs. UN Women will promote participation and leadership of women who use drugs and living with HIV in decision-making forums at global and country level and will support priorities of women who use drugs to be included into the national HIV responses.
277. UNESCO and the International Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Youth and Student Organisation are collaborating on a European regional follow-up meeting to the ministerial meeting on SOGIE-related violence in schools. UNESCO is developing a technical brief to improve routine monitoring of violence based on SOGIE in educational institutions and evaluation of education-sector responses. UNESCO and WHO will collaborate on a secondary analysis of Global school-based student health survey data from more than 100 countries to enhance the evidence base on school violence and bullying.

SRA 5: Gender inequality and gender-based violence

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Achievements

Gender equality

278. While new HIV infections have declined among women over the last 15 years, women and girls remain highly vulnerable to HIV. 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.
279. The Joint Programme generated evidence of the impact of harmful gender norms on women's ability to prevent HIV and mitigate its impact. The UN Women global review, [Key barriers to women's access to HIV treatment](#), which was led by women living with HIV and governed by a global reference group, highlighted the experiences of women living with HIV in accessing quality care. Barriers to treatment and adherence include violence and/or fear of violence, stigma and discrimination, low treatment literacy, care responsibilities, and lack of access to and control over resources. Findings were published in the [Health and Human Rights Journal](#) in December 2017.
280. In Zambia, the WFP, in partnership with the Scaling Up Nutrition Civil Society Network, studied the barriers that hinder adolescent girls' access to HIV and nutrition services. The gaps identified included low utilization of HIV testing and counselling services and inadequate behaviour change programmes addressing HIV and nutrition. The World Bank has conducted studies in several African countries to examine social drivers of transmission in young women, including a trial of different incentives (conditional and unconditional cash transfers) to determine their impact on retention in school and risk of HIV infection.
281. In partnership with UNFPA, the UNAIDS Secretariat, WHO, UN Women and UNICEF, UNESCO led publication of the revised *International technical guidance on sexuality education (ITGSE)*. This reflects new evidence and good practices, bringing together education, health and gender equality. Sexuality and HIV education programmes that include gender and power dynamics are five times more effective in preventing sexually transmitted infections.⁸ The revised guidance was presented at the 19th International Conference on AIDS and STIs in Africa (ICASA) in December 2017, the PCB, a high-level technical meeting on comprehensive sexuality education (comprehensive sexuality education) in Oslo, and the 62nd Commission on the Status of Women (CSW).
282. UNDP supported 82 countries to progressively deliver universal access to basic services, which included institutional strengthening focusing on transforming gender and power relations through new policies and laws, developing national action plans on ending violence against women, access to justice for women living with HIV, integrated services for violence survivors, and advocacy and research on legal and policy environments that protect women's human rights, including those living with HIV.
283. Results from the ILO and the Secretariat's economic empowerment programme in Malawi, Mozambique, South Africa, United Republic of Tanzania, Zambia and Zimbabwe found the proportion of women who reduced sex partners rose from 56% in

2011 to 74% in 2015, those who adopted HIV risk reduction strategies from 31% to 81% over the same period. In Uganda, a series of entrepreneurship trainings delivered by UN Women equipped young women, including those living with HIV, with social and economic skills and improved their self-esteem and confidence. Early results demonstrate improvements in attitudes among young women towards uptake and adherence to HIV treatment, an increased demand for HIV prevention commodities, and an increased search for family planning information and services, and reporting of violence cases.

284. The UN Women-administered UN Trust Fund to End Violence against Women awarded more than US\$ 2 million in grants to civil society groups in Cameroon, China, Cote D'Ivoire, Egypt, Haiti, Jamaica, Kenya, Myanmar, South Africa, Tanzania and Thailand for programming to challenge harmful norms and prevent violence and HIV. Grassroot Soccer, a Trust Fund grantee in South Africa, used football to educate and empower more than 8000 girls aged 13-16 years, including those living with HIV. The final evaluation revealed increased HIV knowledge and access to integrated services for violence and HIV.
285. Technical assistance from UN Women, UNDP, UNESCO, WHO, UNFPA and the Secretariat (as part of the Inter-Agency Working Group on Gender Equality and HIV), was key to SADC adopting the 2016 Commission the Status of Women Resolution 60/2 on women, the girl child and HIV and AIDS. This acknowledged women and girls' vulnerabilities in the context of HIV and the importance of securing their SRHR, ending all forms of violence and reducing the burden of care work. In 2017, UN Women, the Secretariat and UNFPA assisted SADC on an action programme to accelerate implementing the commitments of the Resolution.
286. The Secretariat, UN Women, WHO, UNFPA, UNESCO and UNDP's policy support to Member States contributed to strong gender equality commitments in the 2016 Political Declaration on HIV and AIDS, which included a target to reduce the number of adolescent girls and young women newly infected with HIV globally each year to below 100 000 by 2020.
287. The report of the Secretary-General on the Commission the Status of Women resolution in 2017 provided reflection on recent evidence, and contributions from 30 Member States and eight UN entities. The analysis indicated that while there had been progress in the availability of ART and its use by women, challenges in treatment adherence and retention remain. The report also noted a surge of new HIV infections among adolescent girls and young women in high-prevalence settings. It concluded that ending the AIDS epidemic requires an increased commitment to HIV responses rooted in gender equality and the empowerment of women and girls. Efforts should go beyond preventing gender-based violence and eliminating mother-to-child transmission to include support to women beyond their roles as mothers or expectant mothers, including realization of their SRHR and addressing harmful gender norms.
288. To support country efforts to integrate gender equality priorities in national HIV strategies and Global Fund Concept Notes, the Joint Programme developed and piloted tools and guidance notes. These included:
 - the Secretariat, UNICEF, UNFPA and WHO's guidance note on Fast-Tracking HIV prevention among adolescent girls and young women;
 - the Secretariat and the Stop TB Partnership's gender assessment tool for national HIV and TB responses, piloted by UN Women and the Secretariat in Pakistan;
 - WHO and the Secretariat's tool for strengthening gender-sensitive national HIV and SRH monitoring and evaluation systems, piloted for monitoring and evaluation

- staff and civil society partners from 15 countries with UN Women’s support, and replicated by the Secretariat in 12 countries in eastern and southern Africa;
- UN Women’s regional case study and guidance note on applying gender-responsive budgeting to HIV policies and programmes in Asia and Pacific;
 - UNDP’s toolkit for Country Coordinating Mechanism gender and human rights training that was piloted in Namibia, and a discussion paper on gender and TB;
 - UNDP-Global Fund’s capacity development toolkit, with a critical enablers section on gender equality and human rights;
 - WHO’s consolidated guideline on SHRH of women living with HIV, developed in consultation with women living with HIV, UNFPA, OHCHR and the Secretariat;
 - UN Women’s framework and programming guidance for promoting gender equality in sexual, reproductive, maternal, newborn, child and adolescent health; and
 - UNFPA’s position paper and online tool on engaging men and boys for gender equality and SRHR .

Percentage of countries with national HIV policies and strategies that promote gender equality and transform unequal gender norms	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 70% 2019: 60% 2017: 50%	All: 45% [43/96] Fast-Track: 45% [15/33]	All: 57% [55/96] Fast-Track: 70% [23/33]
<p>The Joint Programme provides advocacy, technical advice, legal and policy review and reform and capacity development to promote gender equality and the empowerment of women and girls, including the most vulnerable and marginalized.</p> <p>In 2017, 52% of 96 countries with Joint Programme presence (of which 20 are Fast-Track countries) have national HIV policies and strategies that promote gender equality and transform unequal gender norms with the following elements:</p> <ul style="list-style-type: none"> ▪ Assessments of the social, economic and legal factors that put women and girls at risk of HIV are available; ▪ Sex- and age-disaggregated data and gender analysis are used in HIV planning and budgeting; ▪ Structural and social change interventions to transform unequal gender norms and systemic barriers implemented, including gender-sensitive education curricula and initiatives to engage men and boys. 			

289. UNDP, UNFPA, WHO, UNHCR, UN Women, UNICEF, the World Bank and the Secretariat provided technical advice to countries in the design and costing of their Global Fund Concept Notes. UNICEF leveraged over US\$ 6.5 million in funding from the Global Fund Catalytic Initiative to provide technical support on HIV prevention among adolescent girls and young women in seven countries. In eastern and southern Africa, work by UNICEF, the Secretariat, UNFPA and WHO culminated in integrated programming on SRH, HIV and gender-based violence, and mobilization of an additional US\$ 45 million non-core funds for 2018–2021.
290. To ensure adequate focus and increased financing for gender equality and HIV, UN Women helped women living with HIV engage in designing Global Fund Concept Notes in Cameroon, Uganda, Viet Nam and Zimbabwe. In Uganda and Zimbabwe, this support resulted in the approved Concept Notes prioritizing programming on adolescent girls and young women and HIV, with a total US\$ 18 million allocated for three years. UNDP is working with the Global Fund on strengthening Country Coordinating Mechanism capacity on gender issues related to HIV, TB and malaria.
291. UN Women, UNDP, UNFPA and the World Bank helped countries to integrate gender equality into national HIV strategies, operational plans, monitoring and evaluation

frameworks and budgets. As a result of UN Women, UNDP, UNFPA, WHO and the Secretariat's support in 2016–2017, HIV responses in 11 countries (Cameroon, China, Kazakhstan, Morocco, Sierra Leone, South Africa, Tajikistan, Tunisia, Uganda, Ukraine and Zimbabwe) included gender equality and women's human rights issues. For example, UN Women's policy support to the women's sector of the South African National AIDS Council influenced the 2017–2022 National Strategic Plan on HIV, TB and STIs, which calls for accelerated efforts to transform unequal gender norms, eliminate harmful practices and violence against women and reduce new HIV infections among young women.

292. UNFPA provided technical inputs to Member State deliberations on HIV, gender equality, comprehensive sexuality education and gender-based violence prevention. UNDP supported 11 countries to integrate HIV, health and gender into environmental impact assessments. The World Bank, through its Umbrella Facility for Gender Equality, provides funding for investments that increase implementation of the World Bank Group gender strategy and regional gender action plans.
293. To support implementation of the SDGs in local and national planning, the Joint Programme led in engaging women living with HIV. Unzip the Lips, the regional movement working for the rights of key affected women and girls, and the International Community of Women Living with HIV (ICW) in Asia-Pacific, supported by UN Women, UNDP, the Secretariat and other partners, launched and disseminated a video and brief, [Unzipping agenda 2030](#), identifying opportunities for monitoring and tracking of the progress towards the SDGs for women and girls.
294. UN Women partnered with ICW Global to ensure more than 200 women living with HIV in Belarus, Democratic Republic of Congo, Kazakhstan, Kenya, Mozambique, Namibia, Russian Federation, Thailand, Ukraine and Zimbabwe are voicing their priorities and engaging with policy-makers to make the SDGs more local. A guide for networks of women living with HIV was developed and circulated, outlining key strategies to ensure that SDG implementation works for women living with HIV.
295. UN Women, UNFPA, UNDP, WHO, UNHCR, ILO, UNESCO and the Secretariat's advocacy resulted in greater leadership and mobilization of young women advocates and networks of women living with HIV to define a common agenda and participate meaningfully in HIV policy and programming at national, regional and global levels. UN Women supported the Women's Networking Zone at the 2016 International AIDS Conference, increasing the visibility of women's organizations and providing women living with HIV with a valued space for advocating for greater accountability, funding and implementation of actions to advance their priorities.
296. The Secretariat, UN Women UNFPA and UNDP supported a youth engagement strategy for the High-Level Meeting on HIV and AIDS, including the ATHENA Network-led WhatWomenWant campaign, engaging 120 000 people in more than 40 countries, with 13 million followers on Twitter. Following six months of consultation, the report #WhatWomenWant was published, outlining a transformative framework to place gender squarely on the global development agenda, and what women and young women have said they need to make the commitments real in their lives.
297. UN Women's Engagement + Empowerment = Equality project, working with the International Planned Parenthood Federation (IPPF), mobilized more than 1000 young women and adolescent girls, including 250 living with HIV, in Malawi, Kenya and Uganda, who helped design and validate the All In assessments. The Secretariat, with UN Women, UNDP and UNFPA convened a group of civil society partners to develop

#TeamWomen, an initiative to promote civil society-led accountability for commitments made to women and girls in the HIV response.

Gender-based violence

298. To support country efforts to design and implement effective responses to gender-based violence, UN Women, UNFPA, UNDP, ILO, UNESCO, UNODC, the World Bank and the Secretariat developed and disseminated several guidance notes. These included: UN Women, UNFPA, UNDP and the Secretariat’s regional policy and programme guidance, HIV and gender-based violence: preventing and responding to linked epidemics in Asia and the Pacific Region; the Essential services package for women and girls subject to violence, launched by UN Women with UNFPA, WHO and UNODC, and rolled out by UN Women in Asia and Pacific, and UNFPA in the Arab states; WHO’s manual to strengthen health system response to women who are subjected to violence, based on the 2013 WHO guidelines on responding to intimate partner violence and sexual violence; the Secretariat with civil society partners’ ALIV[H]E framework (Action linking initiatives on violence against women and HIV everywhere), which was implemented in India, Kenya, Malawi, South Africa, South Sudan and Zimbabwe; and the World Bank’s Development Marketplace Innovations in addressing gender-based violence. UNESCO and UN Women also produced global guidance on addressing school-related gender-based violence, and UNESCO led capacity-development workshops to support country implementation, benefiting 27 countries in Africa and Latin America and the Caribbean. In Asia and Pacific, UNESCO, UNICEF, UNGEI, UN Women, Plan International and UNiTE’s curriculum tool, connect with respect, helped teachers address school-related gender-based violence.

Percentage of countries with laws and/or policies and services to prevent and address gender-based violence.	Targets and Milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 70% 2019: 60% 2017: 50%	All: 43% [41/96] Fast-Track: 36% [12/33]	All: 47% [45/96] Fast-Track: 52% [17/33]
<p>The Joint Programme supports coordinated, integrated action across sectors to build broader coalitions addressing barriers to preventing and addressing violence in the context of HIV, and developing actionable recommendations on how to achieve progress, with particular attention to justice, law enforcement, health, education, labour and social welfare. Measurement questions for this indicator identify elements that are more directly linked to Joint Programme support such as availability of relevant data for evidence-based services; existence of laws and policies addressing gender-based violence; mechanisms to report and address cases of gender-based violence and stronger integration.</p> <p>In 2017, 47% of 96 countries with Joint Programme presence, of which 18 are Fast-Track countries have laws and/or policies and services to prevent and address gender-based violence with the following components:</p> <ul style="list-style-type: none"> ▪ Disaggregated data on prevalence and nature of gender-based violence are available and used; ▪ Legislation and/or policies addressing gender-based violence exist; ▪ A mechanism to report and address cases of gender-based violence is available, e.g. special counselling centres, ombudsman, special courts and legal support for victims; ▪ HIV, SRH, and gender-based violence services. 			

299. An ILO-convened Member States meeting identified the causes and effects of violence at work, and links between violence and HIV, that shaped preparation of the 2018 Session of the ILO Governing Body. It is intended that this will inform the first global International Labour Standards on violence and harassment against women and men

in the world of work. In collaboration with United Nations Volunteers and the Secretariat, UN Women conducted a study on the impact of violence and HIV on indigenous women in Paraguay and Brazil to inform implementation of their national HIV strategies, and will advocate for their greater participation in national HIV responses. Maintained by UNFPA, UNHCR, UNICEF, WHO and the International Rescue Committee, the Gender-Based Violence Information Management System continues to harmonize data collection on violence in humanitarian contexts, including access to post-exposure prophylaxis, or PEP.

300. During the 72nd session of the General Assembly, the United Nations and European Union launched the Spotlight Initiative to eliminate all forms of violence against women and girls, with an initial contribution of €500 million. UN Women, UNDP and UNFPA are providing technical support to countries to support programming. In Africa, the joint initiative focuses on eliminating sexual and gender-based violence and harmful practices that limit women's ability to prevent HIV, particularly young women.
301. UN Women, UNDP, WHO and UNFPA supported the design and implementation of national action plans on ending violence against women in Argentina, Paraguay, Peru and Viet Nam. UN Women and UNFPA's support in Viet Nam led to a 2016–2020 national thematic project on gender-based violence prevention and response, which includes measures to prevent and address sexual violence and implement integrated gender-based violence/HIV services. UNDP supported Zambia to improve access to justice for violence survivors and perpetrators through the fast track courts in six of 10 provinces. Efforts resulted in a decrease in the period of the review of court cases from two years in 2012 to 30 days in 2017, and an increase in the number of reported cases. In South Sudan, UNDP supported training for 341 police officers, prosecutors, social workers, judges and community leaders on investigating and responses to sexual and gender-based violence. The World Bank approved US\$ 107 million in financial grants to Burundi, Democratic Republic of the Congo and Rwanda to provide integrated health and counselling services, legal aid, and economic opportunities for survivors.
302. UNFPA and UNHCR implemented the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) Minimum Initial Service Package (MISP) in humanitarian emergencies, including provision of PEP, psychosocial support and mental health services for survivors of sexual violence and access to HIV prevention, treatment and care. In Syria, UNHCR supported the setting up of 70 community-based committees serving more than 175 000 beneficiaries, who were able to access information on sexual and gender-based violence, SRH and HIV. In Iran, during 2017, UNHCR helped establish a social centre, with 6532 Afghan refugees benefiting from psychological and legal counselling, life skills training and HIV and domestic violence services.
303. UNFPA, UNDP, UNICEF, UN Women and the UNAIDS Secretariat supported efforts to implement laws to end child marriage in Africa. UNDP assisted the SADC Parliamentary Forum in finalizing the Model Child Marriage Prevention Act. Following adoption of the Marriage, Divorce and Family Relations Bill that raised the marriage age from 15 to 18 years, and with UN Women support, Malawi's Constitution was amended to raise the marriage age to 18 and remove a loophole that allowed children aged between 15 and 18 years to marry parental consent. UNFPA, UNICEF and Girls Not Brides supported Burkina Faso, Mozambique, Uganda and Zambia to develop national action plans to end child marriage. UNFPA empowered more than 65 000 girls and 285 000 community members, increasing their knowledge and access to SRH services to prevent child marriage. In 2017, UNESCO, in consultation with UNFPA and WHO, published recommendations on education sector responses to early and unintended pregnancy, which can lead to stigma, discrimination and school drop-out,

and an increased risk of HIV for adolescent girls and young women as a result. The guidance resulted in school re-entry guidelines being adopted in Kenya, and the development of a Pregnancy Prevention and Management Policy in South African schools.

304. UNDP convened a multi-stakeholder meeting to review implementation of Global Commission on HIV and the Law recommendations. Discussions identified challenges in advancing gender equality and access to services for women and girls in the context of plural legal systems. To help countries implement the commission recommendations and improve the legal environment for young women and adolescent girls, UNDP, with the All In initiative, conducted a systematic review of age-of-consent laws in 25 countries.
305. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is a powerful human rights instrument for articulating, advocating and monitoring women's human rights. With UN Women, UNDP and UNFPA support, women living with HIV contributed to country reporting on CEDAW. For example, a survey by the Ukrainian network of 4000 women living with HIV on how CEDAW implementation addresses their rights resulted in the publication, Human rights of women living with HIV in Ukraine, which informed a shadow report to CEDAW in 2017. This led to CEDAW calling for accelerated HIV prevention among women and girls in Ukraine and improved access to gender-based violence services. The UNAIDS Secretariat, WHO and ICW engaged CEDAW in dialogue on updating its general recommendation 15, on avoidance of discrimination against women in national strategies for the prevention and control of AIDS. In Guatemala and Panama, the UNAIDS Secretariat and UN Women, with ICW and the female sex workers network RedTraSex facilitated the exchange of lessons learned on women living with HIV and sex worker engagement in CEDAW reporting.

Challenges

306. Women and girls experience multiple forms of discrimination because of gender inequality in the context of HIV, and it becomes more pronounced when intersecting with age, socioeconomic status, residence, race, ethnicity, religion, sexuality, HIV status, disability status, and forced displacement and other humanitarian settings. Harmful gender norms affect the ability to negotiate safe sex, build knowledge around HIV prevention and seek health services. These norms also impact on men and boys, who face negative attitudes when seeking health services, leaving them less likely to get tested for HIV and treated.
307. Data disaggregated by sex, age and factors such as gender-based violence is not always readily available, preventing comprehensive gender analysis to fully reveal the inequalities faced by women and girls. This data is critical to implementing the SDGs and ensuring evidence-based and tailored programming to address the needs and priorities of the most marginalized groups of women to prevent and mitigate the impact of HIV.
308. The measurement components of the UBRAF indicators 5.1 and 5.2 require disaggregation and validation to better understand whether they are on track; while they show steady progress, it is not necessarily substantiated by the narrative. Additionally, the measurement components are complex and aggregate several different and important nuances, and do not necessarily constitute achievement of the indicator in its entirety.

309. Reduced resources push prioritization of biomedical interventions in the HIV response, limiting the number of interventions responding to structural and social drivers of the epidemic. Financing to respond to gender inequalities, and to the networks of women living with HIV, remains insufficient in national strategies and international funding mechanisms.
310. Women, particularly adolescent girls and young women, living with or affected by HIV are often excluded from policy-making processes. This reduces their ability to engage and influence agenda-setting, implementation and monitoring of global and national HIV responses.
311. Adolescent girls and young women face gender norms that put them at a disadvantage when negotiating safe sex, increasing their knowledge of HIV, or making informed – and therefore empowered – decisions around HIV prevention. They often must confront barriers to accessing HIV and SRH treatment, such as laws that require parental consent, lack of youth-friendly services or stigma in health-care settings.
312. Discriminatory customary and formal legal systems and frameworks create barriers for women and girls in accessing services, including for HIV, SRH and for addressing sexual and gender-based violence, especially for women and girls in plural legal systems.
313. Women and girls caught up in humanitarian crises are particularly vulnerable to HIV infection, which is exacerbated by the breakdown of health-care systems, gender inequalities, and sexual and gender-based violence.
314. Women, including those living with and affected by HIV, are disproportionately responsible for informal and unpaid care, less likely to have access to and control of land and often face barriers in advancing their economic empowerment. This affects their ability to access and pay for health services and negotiate unequal power dynamics within their households.

Future actions

315. To ensure HIV responses address structural drivers, including gender norms, UN Women will continue to support integrating gender equality commitments in national efforts to implement SDG 3 on health and SDG 5 on gender equality, and in national HIV strategies, budgets and monitoring frameworks, and the scale-up of gender-responsive interventions. UNICEF, UNFPA and UNDP will engage men and boys as agents of change to transform harmful masculinity.
316. UN Women will convene experts on gender-responsive budgeting to assist in developing and disseminating guidance on both financing for gender equality in the HIV response and greater investment in advocacy by networks of women living with HIV.
317. With UNICEF, UN Women will work to promote the leadership and meaningful participation of networks of women living with HIV and adolescent girls and young women in HIV responses. They will also develop policy recommendations and ensure prevention interventions address issues of women left behind in the response, including indigenous women, women who use drugs and adolescent girls and young women. UNICEF will emphasize pre-exposure prophylaxis (or PrEP), cash transfers, keeping girls in school and comprehensive sexuality education.

318. The UNAIDS Secretariat, UN Women, UNDP and UNFPA will engage with the #TeamWomen initiative to promote accountability towards the targets of the 2016 Political Declaration that emphasize gender equality and women's empowerment.
319. UNICEF, UNDP, UNFPA and UN Women will support country efforts to improve legal environments and repeal discriminatory laws and practices, including early marriage, to meet the human rights needs of women and girls, including those living in plural legal systems.
320. UN Women, UNFPA and UNDP will ensure the EU-UN Spotlight Initiative addresses the link between violence against women and HIV risk. UNESCO will further work on preventing school-related gender-based violence by adapting the connect with respect tool for African countries and establishing a platform to monitor school-related violence and bullying for SDG indicator 4.a.1, alongside convening regional consultations.
321. On the final day of the 41st meeting UNAIDS PCB which was dedicated to a thematic session on discrimination in health-care settings, members of the Board gave their commitment to continue working to end stigma and discrimination. The PCB nongovernmental organization delegation called for a global compact to eliminate all forms of stigma and discrimination. UN Women, UNDP and the Secretariat, the PCB NGO delegation and the Global Network of People Living with HIV (GNP+), will co-convene the global compact to eliminate all forms of HIV-related stigma and discrimination.⁹
322. UNFPA and UNHCR will continue to implement the Minimum Initial Service Package in humanitarian emergencies, including preventing and responding to sexual violence, with an emphasis on earlier expansion to comprehensive reproductive and HIV services...
323. The ILO, within its Women at Work Centenary Initiative to 2019, will address the greater burden of unpaid care work that women face in HIV-affected households.
324. Taking an integrated approach to ensure healthy lives, promote well-being and advance universal health care, WHO will heighten focus on gender, equity and human rights through its work. UNFPA's new 2018–2021 strategic plan reiterates its commitment to strengthening capacities to provide high-quality, integrated information and services for family planning, maternal health and STIs and HIV, including in humanitarian and fragile settings. The World Bank will ensure gender and gender-based violence issues are appropriately mainstreamed across all lending projects, including health systems and HIV projects.

SRA 6: Human rights, stigma and discrimination

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Achievements

325. Three decades into the global response to HIV, it has been shown that an evidence-informed, rights-based approach helps ensure services are accessible to those most vulnerable to HIV. It also enables key populations and other affected communities to participate in improving legal and policy environments, which can also have a direct impact on increasing access to HIV and health services, thereby reducing the risk of HIV transmission. By contrast, laws that criminalize HIV transmission, nondisclosure and exposure, consensual same-sex relations between adults, gender expression, sex work and drug use, as well as legal and policy frameworks and practices that fail to protect the rights of people living with HIV, women, girls and key populations, increase risk and act as major barriers to services for the people who need them most. Removing punitive laws, policies and practices is critical to attaining the 2030 Agenda for Sustainable Development, the UNAIDS 2016–2021 Strategy and the 2016 Political Declaration on HIV and AIDS.

Legal and policy reforms

326. The adoption of a new Political Declaration on HIV by UN Member States charts a course to end AIDS as a public health threat by 2030, stating the importance of all human rights as an objective and means to ending AIDS. It contains specific paragraphs devoted to human rights, whereby governments commit to ending violence and discrimination, to reviewing and reforming laws that perpetuate stigma and discrimination, and to scaling up human rights programmes. Some highlights of the work undertaken by the Joint United Nations Programme on HIV/AIDS and partners to remove punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are reflected below.
327. UBRAF indicators show that of the 96 countries providing data, 38 (40%) have shown progress in addressing at least one law or policy that presents a barrier to delivering HIV services. The report of the Global Commission on HIV and the Law continues to provide an important framework for ongoing efforts to promote a rights-based response to the HIV epidemic and to compel countries to reform punitive laws and policies that impede the AIDS response. Since the release of the report, UNDP, in collaboration with UNAIDS Cosponsors, the Secretariat, UN Member States and civil society, has worked in 88 countries to support implementation of the Commission's recommendations to remove human rights and legal barriers to HIV and health services and increase rights-based programming. This work included supporting legal environment assessments (LEAs) and legal reviews in 52 countries. The follow-up to the LEAs has brought many positive results; for example, in the Seychelles, the National Assembly voted to decriminalize male to male sex activity by removing Section 151 from its Penal Code (Amendment) Act in May 2016. UNDP also worked closely with the Stop TB partnership and civil society partners to develop and roll out LEA guidance for TB, which ensures intersectionality and compatibility with the HIV-related LEA operational guidance.
328. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) is a powerful instrument for articulating, advocating and monitoring women's human rights. UN Women facilitated input from networks and organizations of women living with HIV to in-country reporting on CEDAW. For example, in Ukraine, with UN

Women’s support, women living with HIV co-authored a shadow report assessing how CEDAW implementation addresses the rights of women living with HIV.¹⁰ The report’s findings were reflected in CEDAW’s Concluding observations on Ukraine,¹¹ which called for accelerated HIV prevention among women and girls and improved access to gender-based violence services for women to prevent HIV. In Viet Nam, the national network of women living with HIV contributed to the development and review of the monitoring framework of CEDAW’s 2015 Concluding comments.

Indicator 6.1 Percentage of countries positively addressing laws and/or policies presenting barriers to HIV prevention, treatment and care services	Targets and milestones	2016 Progress	2017 Progress
<p>Data source: 2016–2017 JPMS country reports</p>	<p>2021: progress in 20% of countries from 2019</p> <p>2019: progress in 20% of countries from 2017</p> <p>2017: progress in 20% of countries from baseline</p>	<p>With the exception of four countries - South Africa, Brazil, Cuba and Uruguay - (over a sample of 96 countries) all had some law or policy that present barriers to delivery of HIV prevention, testing and treatment services.</p>	<p>All: 40% [38/96] Fast-Track: 45% [15/33]</p>
<p>This indicator measures progress in addressing/repelling laws and/or policies presenting barriers to HIV prevention, treatment and care services, disaggregated by area of discrimination. The Joint Programme is a key/major player (provider of advocacy/technical support, other) in supporting countries to identify and repeal/ reform discriminatory laws and policies. Progress on reforms of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support is enabled in many instances by the support of the Joint Programme.</p> <p>In 2017, 40% of 96 countries with Joint Programme presence (including 15 Fast-Track countries) have shown progress in at least one of the following laws or policies that present barrier to delivery of HIV services.</p> <ul style="list-style-type: none"> ▪ Criminalization of HIV non-disclosure, exposure or transmission; ▪ Criminalization of same-sex behaviours, sexual orientation and gender identity; ▪ Lack of alternatives to imprisonment for nonviolent minor drug related crimes; ▪ Bans or limits on needle and syringe programmes and/or OST for people who inject drugs, including in prisons settings; ▪ Ban or limits on distribution of condoms in prison settings; ▪ Ban or limits on distribution of condoms for young people; ▪ HIV screening for general employment purposes; ▪ HIV-related travel restrictions (HIV-specific regulations on entry, stay and residence); ▪ Restrictions to adolescent access to HIV testing or treatment without parental consent. 			

329. UNODC encouraged UN Member States, UN partners, civil society, communities of people who use drugs and other stakeholders to contribute to the preparatory process for the 2016 UN General Assembly Special Session on drugs (UNGASS 2016). Partners shared their expertise and practical experiences on the ground among people who use drugs. The UNGASS outcome document prioritizes health and addressing human rights and gender in responding to the world drug problem, reflecting UNODC’s joint advocacy with UNDP, UN Women, the UNAIDS Secretariat and WHO, and their technical support, to ensure inclusion of these key issues.
330. As part of efforts to promote a-rights based response to drug policy, UNDP, in partnership with the International Centre for Human Rights and Drug Policy (HRDP) at the University of Essex in the United Kingdom, and in close consultation with OHCHR,

UNODC and other UN entities, is developing International guidelines on human rights and drug control. In 2016 and 2017, UNDP and HRPD convened four consultations with UN Member States and entities, UN and regional human rights mechanisms, civil society and academia to provide feedback on draft guidelines on human rights and drug policy and to share country and regional perspectives on rights violations experienced by communities affected by international drug control efforts.

331. The support of ILO, UNDP, UNAIDS Secretariat and other partners to UN Member States to strengthen legal protections and reduce levels of stigma and discrimination yielded many positive results, including: inclusion of protections against discrimination in the workplace in Ukraine’s AIDS law; regulations on HIV non-discrimination in employment in Uganda; development of the Employment Code of Conduct on HIV and AIDS at the workplace in Zanzibar; development of a draft labour policy in Lesotho; collaboration with the Coalition of Lawyers for Human Rights (a network of pro bono lawyers) to support employees who face HIV-related discrimination; and preparation of the draft workplace policy on HIV in the textile sector in Haiti where more than 10 000 workers from the textile sector are receiving HIV-related information and prevention tools.
332. UNHCR facilitated the inclusion of refugees, internally displaced people and other populations affected by humanitarian emergencies in national reproductive health, TB and HIV programmes, plans and legislation. UNHCR successfully advocated for their inclusion in all relevant government HIV policies, programmes and funding proposals in South Sudan, including funding proposals to the Global Fund and in the UN Interim Cooperative Framework, and for Burundian refugees’ inclusion in Rwanda’s national HIV plan. UNHCR continued to advocate to remove mandatory HIV testing in six countries in the Middle East and North Africa, including unlawful restrictions of freedom of movement for refugees based on HIV status. As a result of this advocacy, no cases of mandatory testing of refugees were reported in South Sudan. In Yemen, mandatory testing for refugees and asylum seekers was halted in one governorate and refugees living with HIV were able to successfully renew their ID cards following advocacy by UNHCR, UNAIDS Secretariat and the National AIDS Programme. UNHCR integrated HIV into its internal training, policies, programmes and needs assessments. This included integrating specific HIV-related information in regional- and country-level training for protection officers, particularly in countries with a high prevalence of HIV.

Access to justice and enforcement of rights

333. UBRAF indicators show that of the 102 countries providing data, 73 (72%) reported having mechanisms to record and address cases of HIV-related discrimination; 76 (75%) reported having mechanisms to promote access to legal support (such as free legal services or legal literacy programmes) for HIV-related issues; 70 (69%) reported having HIV-sensitive training programmes on human rights and non-discrimination laws for law enforcement personnel and members of the judiciary; and 51 countries (53%) reported having all mechanisms in place.

Percentage of countries with mechanisms in place providing access to legal support for people living with HIV	Targets and Milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 70% 2019: 65% 2017: 60%	All: 54% [52/96] Fast-Track: 61% [20/33]	All: 59% [57/96] Fast-Track: 64% [21/33]
Joint Programme efforts to strengthen institutions, systems and legal environments will specifically focus on ensuring protection for people living with HIV, key populations, women, girls and other			

vulnerable groups. In particular, the Joint Programme supports the implementation of mechanisms to record, address and to promote legal access for cases of HIV related discrimination, and it prioritises HIV sensitive training programmes on human rights and non-discrimination laws for law enforcement personnel and members of the judiciary and national human rights institutions.

In 2017, 59% of 96 countries with Joint Programme presence (of which 21 are Fast-Track countries, have mechanisms in place that provide access to legal support for people living with HIV, with the following features:

- Mechanisms to record and address cases of discrimination in relation to HIV;
- Mechanisms to provide promote access to legal support (e.g. free legal services, legal literacy; programmes) for HIV related issues including gender-based related discrimination (for example dispossession due to loss of property and/or inheritance rights in the context of HIV);
- HIV sensitive training programmes on human rights and non-discrimination laws for law enforcement personnel and members of the judiciary and members of national human rights institutions.

334. In 2016–2017, UNDP and the Secretariat contributed to the Global Fund’s initiative on scaling up human rights programmes in 20 countries.¹² The Global Fund has completed baseline assessments in most of them (with several scheduled for 2018) to determine the interventions implemented to address human rights barriers and identify gaps. UNDP has provided policy and programme support to countries, including the Democratic Republic of the Congo, Kenya, Kyrgyzstan, Malawi, Mozambique, Namibia, Senegal and Zimbabwe, to develop funding requests to the Global Fund, with a focus on defining and costing interventions to address human rights and gender-related barriers to secure additional resources.
335. UN Women worked to enhance access to legal aid for women living with HIV to reduce gender-based stigma and discrimination in China, Malawi, Uganda, Viet Nam and Zimbabwe. In Viet Nam, UN Women worked with the national network of women living with HIV to analyse gender-specific discrimination and identify gender-specific bottlenecks in access to legal aid. This analysis was influential in shaping amendments to the legal aid law and included proposals to increase state-funded legal aid to people living with HIV.
336. Through the UN Cares programme, UNFPA coordinated delivery of the UN for All programme to make the UN a more inclusive workplace, including for LGBTI people. To date, nearly 8000 UN employees worldwide have undertaken the UN for All workshop. UNFPA, UNDP and other Cosponsors supported a global interfaith dialogue to encourage acceptance of LGBTI people.
337. In Uganda, UN Women collaborated with judicial officers, lawyers and civil society to develop the *Gender bench book* to help the judiciary better understand the specific needs and priorities of women in the context of HIV. UN Women mobilized, enhanced capacity and mentored cultural and community leaders and elders involved in informal justice and women living with HIV in rural areas to identify women’s rights violations and gender-based discrimination in the context of HIV and respond through informal justice mechanisms. This work has resulted in increased trust in these mechanisms and faster review of complaints for women living with HIV and stronger coordination with the formal justice system.
338. UNODC backed efforts to update national drug policies and supported drug policy consultations among government and civil society counterparts in 16 high-priority countries. The consultations aimed to lay the foundation for drug policies and related legal reforms, and developing human-rights centred and health-focused approaches for people who use drugs and people in prisons.

339. In 2016–2017, UNHCR promoted access to asylum procedures and protection from expulsion, arbitrary detention, unlawful restrictions on freedom of movement, including the right to return (regardless of HIV status) in the context of voluntary repatriation, and an end to mandatory testing for asylum seekers, refugees, IDPs and other marginalized groups.
340. UNFPA made inputs to several UNDG-led “frontier dialogues” on human rights. Within the dialogue on human rights in increasingly urban settings, UNFPA promoted local, city-based programming with key populations, as illustrated in the UNAIDS’ Fast-Track Cities initiative. UNFPA, with technical input from UNESCO, produced a study on harmonizing the legal environment on adolescent SRH in the eastern and southern Africa region. Recommendations include decriminalizing consensual sexual acts among adolescents, introducing legislative reforms to address age of consent to testing and treatment, and providing young people with rights-based, age-appropriate, gender-sensitive comprehensive sexuality education.

Eliminating HIV health-care discrimination

341. UBRAF indicators show that of the 96 countries providing data, 46 (48%) reported having an up-to-date assessment on HIV-related discrimination in the health sector available; 59 (61%) reported health-care workers’ pre- and in-service training includes gender-sensitive stigma and discrimination reduction, including specific attention to the SRHR of women living with HIV; 58 (60%) reported having measures in place for redress in cases of stigma and discrimination in the health sector; and 28 countries (29%) reported having all these mechanisms in place.
342. Discrimination in health-care settings was a key intervention point for the Joint Programme over the biennium. UNAIDS and the WHO Global Health Workforce Network launched the Agenda for Zero Discrimination in Health-Care Settings on Zero Discrimination Day (1 March 2016). The agenda brings together all stakeholders to tackle discrimination in its many forms, including by removing punitive laws, policies and practices that undermine people living with HIV, key populations and other vulnerable groups, or block their access to good quality health-care services, and by empowering them to exercise their rights. In 2017, in support of the implementation of the action plan of the agenda, 12 UN entities issued a Joint UN Statement on Ending Discrimination in Health Care Settings, committing to working together to support Member States in taking coordinated multisectoral action to eliminate discrimination in health-care settings.
343. The Time Has Come training package, developed by UNDP and WHO to reduce stigma and discrimination at health-care settings, was incorporated in national HIV training programmes in Bhutan, India, Indonesia, Nepal, the Philippines and Timor-Leste. More than 1500 health-care providers in 12 countries have been trained since 2014 using the package. The roll-out of the training was supported through the Multi-Country South Asia Global Fund HIV Programme and the ISEAN-Hivos Multi-Country HIV Programme. Together with USAID, UNAIDS and other partners, UNDP convened the Asia Regional Consultation on Addressing HIV-related Stigma and Discrimination in Healthcare Settings in May 2017. As a result, 120 government, civil society and health sector representatives developed 12 country action plans to address stigma and discrimination in health-care settings.
344. In Egypt, WHO supported the Government to develop a national policy to address stigma and discrimination in health-care settings against people living with HIV. The policy identifies the forms of discrimination faced by people in these settings and articulates the right of people living with HIV to health care and the ethical duties of

health-care providers, both within and outside health-care settings, to provide adequate and equal care.

345. In 2017, the ILO Governing Body initiated a process to develop international labour standards on violence against women and men in the world of work. These standards will address physical, psychological and sexual violence, with a focus on gender-based violence in the context of work. HIV concerns have been mainstreamed into the process of developing the standards, which are expected to strengthen the protection of people living with HIV and people of diverse sexual orientations and gender identities from harassment, bullying, mobbing and violence. In South Africa, ILO, in collaboration with Webber-Wentzel, Legal Aid South Africa and SECTION27, supported the South African National AIDS Council (SANAC) to improve the services of the HIV and TB Legal Clinic. This led to the development of the SANAC stigma and discrimination booklet, launched in 2016 and disseminated in 2017. ILO also made significant inputs into the process of drafting a book on HIV and the law in South Africa. Working with the UN joint team on gender, human rights and key affected populations, ILO contributed to the development of Nigeria's draft National HIV Stigma Reduction Strategy.
346. In China, UN Women collaborated with the National Center for AIDS/STD Control and Prevention to design and pilot a training of trainers' manual on gender-sensitive HIV services. Guided by CEDAW, the manual aims to enhance capacity of health-care providers and policy-makers to promote elimination of stigma, discrimination and violence against women living with HIV.
347. UNODC reviewed existing indicators, methods and tools for monitoring and evaluating HIV services in prisons, identified country-specific needs in consultation with national prison and health authorities, and national and international partners, and provided targeted technical assistance for developing and improving harmonized approaches and tools to monitor and evaluate HIV services in prisons. UNODC continued to advocate and strengthen capacity for aligning prison health-sector plans with the recommended comprehensive package of HIV prevention, treatment and care services in prison settings.
348. In 2016–2017, UNHCR collaborated with Yemen's national AIDS programme to campaign against discrimination directed at people living with HIV in public and private health facilities, including denial of treatment, refusal of hospital admission and mandatory HIV testing before surgery and during pregnancy. During this period, UNHCR conducted workshops with 987 health workers and 760 police officers on stigma and discrimination against people living with HIV.
349. WHO and the UNAIDS Secretariat led discussions and efforts on addressing discrimination in health-care settings. Best practice guidelines were developed on discrimination in these settings, urbanization, shrinking space for civil society and prevention of violent extremism.
350. UNFPA supported delivery of rights-based, people-focused SRH services in many countries, including Bangladesh, Egypt, Indonesia, Kenya, Myanmar, Nepal, Pakistan, the Philippines, South Sudan, Zambia and Zimbabwe, ensuring non-discrimination against sex workers and other key populations. WHO, UNFPA, UNAIDS and OHCHR published guidelines for the provision of rights-based SRH services for women living with HIV.

Challenges

351. Stigma and discrimination against key populations remain serious barriers to effective HIV responses worldwide. Despite UN Member States' commitments in the 2016 Political Declaration, an increasing number of countries are debating and introducing punitive laws, policies and practices against sex workers, men who have sex with men, transgender people and people who use drugs, adding to existing punitive laws against these key populations.
352. The work of the Joint Programme, including follow-up to the recommendations of the Global Commission on HIV and the Law and supporting countries to implement the Global Fund's initiative on scaling up human rights, have contributed towards progress in meeting UBRAF goals across all areas in SRA6. Yet progress remains uneven. As UBRAF results show, while at least 50% of countries have made progress towards SRA 6 targets, many have not implemented a comprehensive approach. Initiatives to improve access to justice, including mechanisms to provide access to legal support and to reduce stigma and discrimination in health settings, do not automatically lead to removal of punitive laws, policies and practices. They are part of a process, which takes time, ongoing concerted effort and investment of technical and financial resources.
353. There has also been a shrinking of civil society space and encroachment on rights and freedoms, using public health or security rationales. Discriminatory laws, gender-based discrimination and harmful practices continue to hamper women and girls' abilities to confront HIV and mitigate its impact. Increasing legal literacy of both informal justice community leaders and women, particularly those living with HIV, is critical to advancing women's security and rights. In south-east Asia, the number of people in compulsory detention centres is not decreasing.
354. Lack of domestic resources, limited quantitative data and insufficient focus on key population programming perpetuates this discrimination and limits the effectiveness of responses. Targeted programming informed by sex-disaggregated data and analysis is required to understand the specific needs and priorities of the most disadvantaged groups of women and girls in all their diversity in the context of HIV. These problems are compounded in humanitarian emergencies. Laws and policies must be continuously monitored since positive changes can be reversed when political leadership changes or from societal pressure. Many international standards on HIV, human rights and the law have been developed but translating these into reduced stigma and discrimination, protective laws and law enforcement, and increased access to justice at country levels, remains a challenge.

Indicator 6.3 Percentage of countries with measures in place to reduce stigma and discrimination in health settings	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 60% 2019: 50% 2017: 40%	All: 29% [28/96] Fast-Track: 39% [13/33]	All: 29% [28/96] Fast-Track: 24% [8/33]
Stigma and accompanying discrimination are widely recognized as significant barriers to HIV prevention, treatment and care services reaching those who need them most. The Joint Programme supports the development of improved measurements of scope, nature and impact of stigma and discrimination in the health sector, and efforts to document them. It provides quality support to health-care professionals to reduce and ultimately end HIV-related stigma and discrimination in health care settings, including by adding gender-sensitive stigma and discrimination reduction notions in pre-and in-service training. The Joint Programme promotes legal, policy and programmatic actions and redress mechanisms to eliminate HIV related stigma, discrimination and violence in healthcare settings, including forced sterilization and coerced abortion among women living with HIV.			

In 2017, 29% of 96 countries with Joint Programme presence (of which 8 are Fast-Track countries) have measures in place to reduce stigma and discrimination in health setting with the following elements:

- An up-to-date assessment on HIV related discrimination in the health sector (either through the Stigma Index or another tool);
- Health care workers pre-and in-service training which includes gender-sensitive stigma and discrimination reduction, with specific attention to the SRHR of women living with HIV in all of their diversity and throughout their lives;
- Measures in place for redress in cases of stigma and discrimination in the health sector.

355. Globally, among people who inject drugs, HIV and hepatitis C prevalence is high, and new HIV infections are increasing. Yet, in some countries where unsafe injection drug use is a driving factor of the HIV epidemic, coverage of evidence-based HIV and hepatitis C prevention interventions for people who inject drugs – in particular, needle and syringe programmes and opioid substitution therapy – remains low or non-existent. High prevalence of HIV and hepatitis C among prisoners who inject drugs, low availability and limited access to relevant services, and the lack of continuity of services on admission to and release from prisons and other closed settings, are all major barriers to preventing HIV among inmates.

Future actions

356. Following up on the recommendations of the Global Commission on HIV and the Law in collaboration with governments, UN partners and civil society is critical for a coordinated and effective HIV response that focuses on enabling legal and policy environments. In 2018, UNDP will lead a process to develop a supplementary chapter to the report of the Global Commission and host a global dialogue on successes, persistent challenges and the sustainability of the AIDS response at the pre-conference of the International AIDS conference. UNDP will work with partners to finalize the *International guidelines on human rights and drug control*. UNODC will continue to advocate and provide support for policy and legal reform in high priority countries and at global level for human rights- and evidence-based drug policy.
357. UNHCR will continue to promote the inclusion of refugees and other crisis-affected populations in national strategic plans and Global Fund grants. UN Women will further support the meaningful engagement and participation of women living with HIV in CEDAW reporting and implementation, and monitoring of CEDAW's Concluding comments. UN Women will develop policy recommendations on addressing the needs of women left behind in the HIV response, such as indigenous women, women who use drugs, young women and adolescent girls. ILO will continue to build capacities of labour inspectors and the administration of labour ministries to strengthen monitoring of non-discrimination HIV workplace legislation, policies and programmes.
358. The Global Network of People Living with HIV (GNP+), UNDP, UN Women, the PCB NGO delegation and the UNAIDS Secretariat, will co-convene a global compact to eliminate all forms of HIV-related stigma and discrimination.

SRA7 Investment and efficiency

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Achievements

359. Sustainable financing and investment remains a major challenge. UNAIDS estimates that the Fast-Track AIDS response will cost an estimated US\$ 31.1 billion in 2020 and US\$ 29.3 billion in 2030. Meanwhile, investments needed to implement Agenda 2030 in full are projected to be US\$ 3.5 to US\$ 5 trillion dollars per year. Countries will need to be more strategic and innovative than ever in how they prioritize HIV, health and development, and the UN system will need to provide targeted support accordingly. While more integrated approaches and increased innovative financing are necessary, addressing allocative and technical inefficiencies in existing resources and assets will also enhance the sustainability of the response, especially in a context of reduced international funding.
360. Stable and sustainable financing strategies. It is essential to account for broader trends in development assistance and in the health sector to ensure the long-term sustainability of national HIV responses. As more countries transition towards an increased share of domestic financing for their HIV response, the support of the Joint Programme for cross-sectoral integration helps maximize sustainable funding opportunities and minimize the service disruptions of a complex transition.
361. A key challenge for sustainability is the space HIV prevention and treatment services will find under the Universal Health Care umbrella and multisectoral funding frameworks. The World Bank, WHO and UNDP have been providing global guidance, direct technical assistance and funding to help countries define a sustainable path to Universal Health Coverage. The World Bank and WHO, together with the Government of Japan, the Global Fund and the African Development Bank, launched “Universal Health Coverage in Africa”, which provides a big-picture view of UHC and identifies key areas, including HIV, that are critical to better health outcomes. The World Bank and WHO released *Tracking universal health coverage* to assess countries’ progress. The World Bank also finalized a series of four country studies based on a review entitled *HIV/AIDS and Universal Health Coverage Financing in Africa*, to help the Governments of Côte d’Ivoire, Kenya, Nigeria and the United Republic of Tanzania assess the financial sustainability of HIV interventions within the context of Universal Health Coverage. UNDP supported seven governments in sub-Saharan Africa to finance actions across sectors for HIV, health and Universal Health Coverage. This resulted, for example, in South Africa including a cofinancing component within its National Strategic Plan 2017–2022 on HIV, TB and sexually transmitted infections (STIs).
362. Cosponsors also supported innovative financing approaches to increase domestic resource space. The World Bank, WHO and UNDP have been working with finance and health ministry officials in many low- and middle-income countries to improve the effectiveness and efficiency of their tobacco tax systems and promoting increased tobacco taxes (as well as other health-harming products such as alcohol) to reduce health burdens (including from TB) and raise additional domestic revenues for health and the HIV response. The World Bank provided technical support to several countries to assess the potential of innovative financing; for example, in 2017 it published *Fiscal space for health in Malawi and revenue potential of innovative financing*. UNDP focused on advocacy and multisectoral governance structure support to advance institutional, programmatic, planning and financing synergies between HIV, TB and

noncommunicable disease responses, leveraging its Global Fund partnership. In 2017, UNDP advanced at high-level forums the need for integrated responses to communicable and noncommunicable diseases and published more than a dozen technical and advocacy tools to support integrated responses to interlinked health and development challenges.

363. The Joint Programme leveraged its collective expertise to ensure a more sustainable cross-sectoral approach and benefit from opportunities arising from integration.
364. In 2017, UNICEF, along with UNFPA, UNAIDS and WHO, mobilized funds from Sweden to implement a four-year project (2018–2021) to scale up integrated SRH, HIV and gender-based violence services in eastern and southern Africa. UNICEF's focus in this project will be eMTCT and adolescent HIV. This shared project will have a regional component focused on leveraging the learning and progress to other high-burden countries in this region.
365. UNICEF also collaborated with the Global Fund to leverage US\$ 6.5 million in funding on adolescent girls and young women in seven countries in Africa. Increased advocacy and evidence-driven national plans for eMTCT, paediatric AIDS treatment and adolescent HIV prevention resulted in increased capacity for national programmes to leverage additional partnerships and resources for programme scale-up through domestic resources and through key donors (Global Fund, PEPFAR, and UNITAID) in west and central Africa. In Asia, UNICEF leveraged resources for eMTCT activities from the Global Fund.
366. WFP worked to highlight the importance of addressing emergencies, structural drivers, food and nutrition as a critical part of the HIV response. This global and regional-level advocacy work led to an approximate US\$ 25 million commitment from PEPFAR to support malnourished and food-insecure people living with HIV in Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe. WFP continues to work with partners (including the Bill & Melinda Gates Foundation, UNFPA and the Global Fund) to improve the efficiency of HIV and health supply chains and tackle chronic constraints to commodity availability.
367. UNHCR advocated for the inclusion of refugees and internally displaced persons into HIV programmes and worked with governments to build capacity to address HIV within displaced populations. In 2016, UNHCR ensured all refugee populations living with HIV were fully integrated into the national HIV care and treatment programme in Nepal. In Ghana, UNHCR worked to increase national capacity to deliver integrated SRH services especially for marginalized and vulnerable young people.
368. Through in-country workshops conducted in Belarus, Democratic Republic of Congo, Kazakhstan, Kenya, Mozambique, Namibia, Russia, Thailand, Ukraine and Zimbabwe, UN Women and ICW-Global worked to ensure that women living with HIV networks succeeded in raising gender equality priorities at national SDGs dialogues.

Efficiency and effectiveness of AIDS response

369. The World Bank, UNDP and the UNAIDS Secretariat have kept a strong emphasis on support for investment cases and optimal allocation of resources that prioritize high-impact locations, populations, and programmes. In the biennium 2016–2017, the World Bank was working on more than 15 allocative efficiency studies across the six regions,

in partnership with the Secretariat and in several countries with UNDP. This included, for example, in the eastern Europe and central Asia region an analysis of the effect of the actual reallocation of HIV resources in Belarus after the Optima study. These budget reallocations project to avert an estimated 3200 new infections by 2018 and an estimated 25 000 infections by 2030. In addition, a rapid analysis of antiretroviral medicines (ARVs) prices in Bulgaria, as well as an analysis of implementation and allocative efficiency of programmes for people who inject drugs, were conducted. In the west and central Africa region, the World Bank completed three allocative efficiency studies in Cameroon, Côte d'Ivoire and Togo, underscoring the need for additional efforts to close the significant treatment gap in the region, and stressing the need for continued investment on key population prevention and treatment programmes.

Percentage of countries with up-to-date HIV Investment cases (or similar assessing allocative efficiency) that is being used.	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 80% 2019: 70% 2017: 60%	All: 48% [46/96] Fast-Track: 55% [18/33]	All: 42% [40/96] Fast-Track: 58% [19/33]
<p>The Joint Programme is a major provider of technical assistance to countries to develop quality investment cases or similar exercises to improve allocative efficiency at country level. The Joint Programme is also a main provider of Technical Assistance (TA) for strengthening the monitoring system in countries.</p> <p>As part of national monitoring and evaluation frameworks, the Joint Programme supports countries to track and analyse HIV expenditures per funding source and beneficiary population using the National Aids Spending Assessment (NASA), or other integrated tools. Spending data provide decision makers with strategic information that allow countries to mobilize resources, have a stronger accountability and a more efficient and effective programme implementation. However, there is need to promote the institutionalization of these type of tools for the regular use in the country planning cycles.</p> <p>In 2017, 42% of 96 countries with Joint Programme presence (of which 19 are Fast-Track countries) have up-to-date HIV Investment cases (or similar assessing allocative efficiency with the following components:</p> <ul style="list-style-type: none"> ▪ A computerized monitoring system that provides district level data on a routinely basis including key HIV service delivery variables (ART and eMTCT); ▪ The country tracks and analyses HIV expenditures per funding source and beneficiary population; ▪ Country allocations based on epidemic priorities and efficiency analysis (investment case or similar). 			

370. Joint Programme technical assistance contributed to improving the effectiveness of the response. For example, UNICEF, in partnership with the WHO, led on the adoption of a more efficacious and simple antiretroviral therapy (ART) regime. Thanks to coordinated advocacy and demonstrations of “how to” implement at lower costs, 21 of the elimination of mother-to-child transmission (eMTCT) Global Plan countries adopted the policy. UNICEF also used its community-level work around the world to demonstrate the potential for more efficient use of human resources. In 2013, only 10 of the 21 Global Plan countries applied HIV task-shifting or delegation of HIV-related medical services from doctors to nurses and community health-care workers. Today, through UNICEF’s proof of concept approach, all 21 countries are applying task-shifting to manage HIV among pregnant women, mothers, and their infants.
371. UNFPA supported the implementation of comprehensive male and female condom programming that ensured maximum effectiveness for condom interventions. In 2016, 54 countries implemented all four steps of the development phase as recommended by UNFPA. A UNFPA-funded study found that increasing investments in procuring and distributing male condoms provide significant economic returns for countries with

scarce resources. The study, written by experts from UNFPA and Avenir Health, showed that, in addition to meeting a human right, additional funding for male condoms is a smart investment. An additional investment of US\$ 27.5 billion in male condoms in 81 high-burden countries by 2030 would meet all unmet demands for family planning, as part of a package of contraceptives, and 90% of the condom needs for HIV and STI prevention among high-risk groups. This could prevent 700 million STIs, 17 million HIV infections and 420 million unintended pregnancies.

372. WFP and London School of Hygiene and Tropical Medicine completed a study on the investment returns of food-based interventions for ART patients in eastern and southern Africa. The findings suggest that investment in ending hunger could contribute to improved treatment adherence and retention in care and reduced HIV transmission, and co-investing in HIV and food interventions could enhance the efficiency of HIV treatment and prevention efforts. WFP's vulnerability assessments inform and improve the efficiency of HIV responses in several countries, including in Burundi. WFP is also working with UN partners, such as UNICEF, to standardize monitoring and assessment methodologies to improve the way data are gathered, processed and utilized.
373. In 2017, WHO prequalified the first HIV self-test in a move to increase HIV diagnosis and treatment. The product uses oral fluid as a specimen and provides results as quickly as 20 minutes. The prequalification allows countries to increase access to testing outside clinical and fixed settings. It has huge potential to reach populations who are currently not accessing testing, including men, key populations and adolescents. Ongoing work by WHO is also supporting implementation research on blood-based HIV self-tests and supporting the prequalification of these tests. WHO recommends pre-exposure prophylaxis (PrEP) for anyone at substantial HIV risk. As it is not feasible or cost effective to provide PrEP to all adolescent girls and young women, even in high-incidence countries, WHO has been working with countries in southern Africa to analyse their data on this group to support the focus of PrEP programmes, both geographically and looking at the potential of risk-score.

Technological and service delivery innovations

374. Leveraging mobile health for impact. The Joint Programme pursued innovative mobile, or m-health strategies and developed several new tools to improve the efficiency of the response.
375. In line with its ongoing digital transformation and new nutrition policy, 13 WFP is expanding its digital beneficiary system and developing an application for the electronic registration, tracking and management of beneficiaries of community-based and managed acute malnutrition programmes. The application is known as SCOPE Conditional On-Demand Assistance, (SCOPE CODA). SCOPE CODA merges identity and programme management functions to support improved management for nutrition treatment and health programming for all stakeholders. The application is operating in South Sudan and Uganda. While it has been developed initially for malnutrition treatment, it is presently being expanded to ensure that malnutrition treatment is mainstreamed in essential health services and with other vulnerable populations.
376. UNICEF utilized mobile technologies to create demand and monitor service utilization. For example, U-Report, a social messaging tool that encourages adolescents and young people around the world to speak out on issues that affect them, has more than 2.4 million registered users and is live in more than 25 countries.

Percentage of countries with scale-up of new and emerging technologies or service delivery models.	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 60% 2019: 50% 2017: 40%	All: 35% [34/96] Fast-Track: 48% [16/33]	All: 34% [33/96] Fast-Track: 58% [19/33]
<p>The Joint Programme promotes innovation in HIV service delivery, including e-health and mobile health for comprehensive sexuality education, HTS, ARV case monitoring, and other priority health services. By fostering partnerships among communities, government agencies, health providers and the private sector, the Joint Programme encourages countries to develop and use innovative prevention technologies and examine broader HIV testing methods. The list of new technologies in the indicator measurements are directly linked to Joint Programme support and may vary over the period of the UBRAF based on contextual changes and innovation.</p> <p>In 2017, 34% of 96 countries with Joint Programme presence, of which 19 are Fast-Track countries, have scale-up of new and emerging technologies or service delivery models, such as:</p> <ul style="list-style-type: none"> ▪ Social media/information and communication technologies; ▪ e-health and/or m-health tools for priority HIV services; ▪ Diagnostics for rapid diagnosis, combined HIV/syphilis and for monitoring of viral suppression. 			

377. In Zambia, UNDP is piloting the use of solar panels in 11 primary health-care clinics that provide treatment for people living with HIV as part of Global Fund implementation support. The programme will be scaled up to provide solar power for 1000 health facilities. Drawing on the success of the Zambia pilot, UNDP will install solar panels in 60 health facilities in Sudan and 500 health facilities in Zimbabwe.
378. As part of its work to scale up quality comprehensive sexuality education (comprehensive sexuality education), UNESCO is exploring a variety of innovative media and information and communication technology approaches. In eastern and southern Africa, west and central Africa and Latin American and the Caribbean regions, work has been ongoing to identify pragmatic, cost-effective approaches to information and community technology-based education, including teacher training. In the eastern Europe and central Asia region, UNESCO and UNAIDS have collaborated on several media initiatives, including social media, talk shows and the development of videos. Radio and TV programmes on comprehensive sexuality education, SRH and HIV prevention have been used widely in other regions, including eastern and southern Africa, where more than five million people were reached with comprehensive sexuality education advocacy messages.
379. The World Bank provided financing for multiple projects fostering eHealth innovations; the eGabon project, for example, which aims to improve availability of information to support service delivery. The bank also provided evidence for the use of innovative tools, including an evaluation of a smartphone app in a randomized controlled trial in South Africa.
380. WHO made progress on several work streams on innovation leading to efficiency: treatment optimization, differentiated service delivery models, HIV monitoring and diagnostics, HIV testing, PrEP and innovations for voluntary medical male circumcision. WHO has been engaging with social media groups, particularly those focusing on providing social networking services for men who have sex with men (MSM). Engaging with these groups (for example, via dating apps Blued, hornet, Grindr etc.) is a potentially powerful way of reaching MSM to provide information and HIV messages about where to receive testing, PrEP and other HIV prevention advice.

Challenges

381. Dependency on external funding and the transition to domestic financing mechanisms remain a challenge. While the SDGs provide the overall framework for development, the challenge will be to fund all the priority UNAIDS areas within a broader competitive donor climate. With shrinking HIV resources and even greater competition within HIV programmes, funding priorities will be even more difficult. To maximize funding opportunities, HIV programmes should explore support across several of the SDGs and explore co-funding arrangements with partners from other sectors to identify and pilot innovative financial instruments that can drive investment and support SDG interventions. This process requires HIV expertise that is becoming harder to sustain with the shrinking of flexible funds.

Percentage of countries with an HIV sustainability plan developed	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 60% 2019: 50% 2017: 40%	All: 8% [8/96] Fast-Track: 12% [4/33]	All: 6% [6/96] Fast-Track: 6% [2/33]
<p>Each country should have a sustainability plan, programmatic as well as financial. Financial sustainability is the ability of countries to provide adequate funding for reaching Fast-Track targets primarily by domestic public and private sources (not individual out of pocket) and it is one key area of support by the Joint Programme.</p> <p>A progression in the number of countries having developed a sustainability plan with certain characteristics can be attributed (by proxy) to the efforts of the Joint Programme.</p> <p>In 2017, 8% of 96 countries (including 3 Fast-Track countries] with Joint Programme presence had an HIV sustainability plan developed with the following characteristics:</p> <ul style="list-style-type: none"> ▪ The plan covers financial contributions from the private sector in support of the HIV response; ▪ The plan influenced policy and resource generation and allocation in the country; ▪ The plan indicates substantially increasing domestic public investments for HIV over the years. 			

382. Reallocating funding, translating technical efficiency knowledge into actions and reaching full-scale implementation at the desired coverage levels are also major challenges. Additional technical support is needed to help countries implement recommendations and ensure maximum impact.
383. There is a continued challenge in supporting investment analyses due to limitations in data availability and lack of political commitment for prioritization, efficiency and sustainability to ensure modelling results in all countries lead to policy and implementation changes. The capacity of the Joint Programme to conduct vulnerability assessments has also been reduced. For example, in 2016 WFP had to discontinue several vulnerability assessments, meaning reduced capabilities to target interventions for these populations, which has a negative impact on the Joint Programme’s collective understanding of the epidemic and ability to design interventions based on actionable data.
384. For m-health, a key challenge is ensuring continuity of use of internet/cloud/mobile-based platforms, since access to wi-fi is not always easy, and data can be costly. UNESCO, for example, is considering options to offer an offline version of its comprehensive sexuality education courses that can be delivered from a CD-ROM, thereby bypassing the need for internet access.
385. Finally, many influential actors constantly seek newer technologies at the expense of current, proven ones. Condoms are inexpensive, relatively known, and require relatively little educational effort to inform younger, sexually active generations about their use. However, many donors have reduced their support for condom programmes and governments have not allocated their own resources to these.

Future actions

386. To mitigate its budgetary shortfall, UNICEF reallocated some of its core funding to stabilize essential staff posts and redefined its programme of support by applying a more differentiated approach that considers both the HIV epidemic context and the strength of the country response. UNICEF is also working to further integrate and mainstream the HIV response across other sectoral mandates, while ensuring accountability to results.
387. WFP will continue to support partners (including the Bill & Melinda Gates Foundation and the Global Fund) to improve the efficiency of their investments in HIV and health supply chains in an innovative and transformative manner. WFP will support delivery of HIV and health commodities in challenging areas, at the same time mapping supply-chain bottlenecks, developing solutions and building local capacity.
388. UNDP's focus is on supporting the implementation of the following three global programmes for low- and middle-income countries that aim to strengthen intersectoral coordination and include specific approaches to finance HIV and other development priorities: cross-sectoral cofinancing for HIV and Universal Health Coverage; activating national responses to noncommunicable diseases; and strengthening implementation of the WHO Framework Convention on Tobacco Control to achieve the SDGs.
389. UNFPA will provide scientific evidence to governments and provide technical assistance to facilitate the implementation of condoms availability in high schools. Because of the high exposure to sexual activities in universities, UNFPA will support governments and academia to research interventions for/with students to curb the STIs, HIV and unintended pregnancies in these settings. Urgent actions are needed to help young people protect themselves from infections.
390. UN Women will continue to advance meaningful participation of women living with HIV and ensure sustainable spaces are established for this group to voice priorities and advocate for actions, budgets and accountability frameworks.
391. The World Bank will continue to support countries in their efforts to build a sustainable HIV response by providing technical assistance and implementation support. The World Bank is planning 15 additional allocative and implementation studies in the 2019 financial year as well as a series of regional capacity-building workshops across three regions. The workshops will aim to build country capacity to use decision science and optimization tools as well as big data analytics and machine learning.

SRA 8: HIV and health service integration

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

Achievements

392. Through joint and individual activities, the Joint Programme worked to ensure people living with, at risk of and affected by HIV have access to integrated services, including for HIV, TB, SRH, harm reduction, and food and nutrition support. The Joint Programme also works with partners to integrate HIV in other programmes, including humanitarian responses, education, decent work and human rights.
393. The World Bank is a co-convenor with WHO of Universal Health Coverage 2030, the global movement to build stronger health systems towards achieving Universal Health Coverage. Typical projects financed by the World Bank in 2017 included activities that aim to improve the utilization of maternal, child health and nutrition services at the primary level of care in target regions. The immediate beneficiaries are women and children dependent on primary health services, pregnant women and children under five, for whom HIV testing is promoted and available as well as eMTCT. The Global Financing Facility is providing catalytic funding for reproductive, maternal, newborn, child and adolescent health and nutrition, ensuring integration of SRH and HIV services in essential benefits packages and in performance-based financing systems. In Liberia, for example, the country is focusing on counties with the highest reproductive, maternal, newborn, child and adolescent health and nutrition burden, with the goal of delivering quality emergency obstetric and neonatal care and enhancing service delivery at the community level. In 2017, after conducting HIV allocative efficiency studies in Belarus, Peru and South Africa, the World Bank led additional TB allocative efficiency studies in the three countries.
394. In 2017, UNICEF played a leading role in integrating HIV in programmes across both decades of childhood, including: those focusing on eMTCT; nutrition to promote optimal feeding practices, including exclusive breastfeeding and appropriate complementary feeding; enhanced maternal ART adherence counselling during the breastfeeding period; maternal, newborn and child health; early childhood development; vaccinations; and TB management.
395. WFP worked with governments and partners to ensure the needs of vulnerable people living with HIV are addressed in all national and WFP programming and strategies, including in humanitarian responses. WFP's work to address HIV is gender-responsive and focuses on linking food and health systems through the provision of food assistance for better health outcomes, such as nutritional recovery for people living with HIV and TB, retention in care programmes, and treatment success. WFP contributes through advocacy and communication, partnerships, including food security and nutrition in comprehensive national AIDS plans to address the needs of vulnerable people living with HIV, and technical support, capacity-building and implementation support. WFP provides direct support, including food and cash-based transfers, at individual and household levels to facilitate improved access and adherence to treatment.
396. In Lesotho, for example, WFP continued to provide technical assistance and support to the Ministry of Health to enhance nutrition surveillance for people living with HIV. WFP, in partnership with UNICEF and the Elizabeth Glaser Pediatric AIDS Foundation,

provided technical and financial support to integrate acute malnutrition and infant and young children feeding indicators into Ministry of Health information systems.

397. UNDP has established a SDG Technical Support Team to support countries in the rollout of the 2030 Agenda and has prepared a prospectus on SDG3 (ensuring healthy lives for all) that outlines UNDP’s service offerings in this area. UNDP, under the umbrella of the UN Development Group, is supporting countries to implement, monitor and evaluate the SDGs using the MAPS (mainstreaming, acceleration and policy support) approach. In 2016–2017, the HIV team supported 27 country missions by providing an analysis of the HIV and health situation and identifying strategic opportunities to include HIV and health issues in the roadmaps developed to support implementation of the 2030 Agenda. Up to 23 additional missions are planned for 2018.
398. UNDP continued to support multiple aspects of health systems strengthening. These include: building the capacity of health workers; strengthening government capacity to deliver services; removing human rights- and gender-related obstacles to access to HIV services; acting on comorbidities; and strengthening preparedness for health emergencies. For instance, UNDP supported the Zimbabwe Ministry of Health to roll out the Ministry of Finance Public Financial Management System in the health sector, resulting in real-time budgeting, electronic payment in all 59 districts and an accounting system at a central, provincial and district level for Global Fund grants.

Decentralization and integration of HIV-related services

399. UNESCO supported the decentralization and integration agenda through support to develop and refine multisectoral strategies for life skills-based HIV and comprehensive sexuality education, including in 12 countries in the Latin America and the Caribbean region. A recent success has been the adoption, by the SDG 4 Technical Cooperation Group of an indicator on the delivery of comprehensive sexuality education (including HIV prevention education) to monitor progress against SDG 4 Thematic target 4.7. The data collected on this indicator will significantly enhance UN and Joint Programme capacity to monitor progress on the education sector response to HIV by measuring comprehensive sexuality education delivery.

Percentage of countries delivering HIV services in an integrated manner	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 80% 2019: 70% 2017: 65%	All: 65% [62/96] Fast-Track: 64% [21/33]	All: 65% [62/96] Fast-Track: 73% [24/33]
<p>The Joint Programme promotes collaboration across national health programmes for delivery of integrated services, to promote systems strengthening and policies that support linkages. The Joint Programme supports countries to assess and monitor progress on HIV programme decentralization and integration; advocates and provides operational guidance and technical support for integrating services. It supports countries to embed the AIDS response within efforts to achieve universal health coverage.</p> <p>In 2017, 65% of 96 countries with Joint Programme presence (of which 24 are Fast-Track countries) have been delivering services in an integrated manner, i.e., a client can receive services in one facility (in a single visit) for multiple interventions such as:</p> <ul style="list-style-type: none"> ▪ HIV, SRH, and gender-based violence services; ▪ HIV and TB; ▪ HIV and antenatal care. 			

400. The 13th WHO General Programme of Work for 2019–2023 (GPW 13), which sets the strategic framework and vision for the organization, was drafted in 2017 and developed with inputs from the WHO HIV department. It provides an important framework for evolving HIV efforts within and across WHO and the broader health sector in support of Universal Health Coverage. During 2017 WHO ensured that HIV elimination targets were included in the overall GPW 13 mission. The GPW 13 proposes five platforms to help promote integration, supporting the over-arching goal of ensuring healthy lives and promoting well-being and the three strategic priorities of advancing Universal Health Coverage. WHO, together with UNAIDS, UNFPA and OHCHR also published consolidated guideline on SRHR of women living with HIV.
401. UNFPA supported the training of about 1500 health-care workers to strengthen the integration of SRHR /HIV/gender-based violence (gender-based violence) services and expand the number of facilities providing these in Botswana, Lesotho, Malawi, Namibia, Swaziland, South Africa, and Zambia. New and draft national policies, strategies, frameworks, assessments and analyses were included in the integration process in Botswana, China, Colombia, Kenya, Kyrgyzstan (for key populations), Malawi and Zambia. Support to NGOs in Swaziland helped them reach almost 38,000 adolescents and youth with integrated information and services, and in Kenya, peer educators reached 1,086 first-time young mothers aged 10–24 years, 32 of whom were found to be living with HIV and referred to treatment. Varying delivery models in Bangladesh (drop-in centres), Moldova (positive initiative), Tajikistan (trust point), Ukraine (outreach and referral) and Mexico (PrEP) have increased access for key populations. UNFPA and UNAIDS have supported Kenya, South Africa, Swaziland and Uganda to undertake a situational analysis on SRHR /HIV and gender-based violence integration and continue to support Prevention Coalition countries in implementing the Prevention Roadmap 2020, including establishing national prevention targets.
402. Through the LINKAGES Project to strengthen the provision of integrated SRHR /HIV and sexual and gender-based violence (SGBV) services in 10 Eastern and southern Africa countries, UNFPA and UNAIDS have documented and shared information on best practices and realized the several milestones.
403. For example, UNFPA, WHO and the International Planned Parenthood Federation IPPF produced SRHR and HIV Linkages Infographic Country Snapshots for 25 countries, providing an overview of national-level data for more than 150 indicators. The SRHR and HIV Linkages Index, a 30-indicator dashboard for integration to track progress, support advocacy, extend knowledge of the drivers and effects of linkages, and highlight data gaps across 60 countries, continues to be promoted.
404. To take HIV out of isolation and integrate it into broader health and development concerns, the ILO, through strategic partnerships with governments, employer and worker organizations, UN agencies and civil society, supported Member States to implement health and wellness programmes. HIV testing initiatives were situated within multi-disease testing programmes and included screening for cholesterol, blood pressure and blood sugar, an approach that significantly reduced stigma and discrimination, while enhancing interest in and uptake of HIV testing. Integration also ensures the sustainability of HIV workplace programmes targeted at vulnerable workers. During the biennium, more than one million (30% women and 69% men) were mobilized to take an HIV test and 19 000-plus tested positive and were referred to treatment and care services.

HIV-sensitive social protection

405. The Joint Programme worked to ensure that people living with, at risk of and affected by HIV are empowered through HIV-sensitive national social protection programmes, including cash-based transfers. This was done at country level through advocacy, technical support and social protection activities.
406. At the global level, the Inter-Agency Task Team (IATT) on social protection led by the World Bank and UNICEF, with support from the Secretariat, WFP and the ILO, raised the profile of social protection in the HIV response and provided technical support, oversight and advocacy on HIV and social protection. As part of its global work, the Joint Programme worked extensively to include a social protection target in the 2016 Political Declaration. As a result, social protection has become a prominent part of the recommended packages promoted by the Joint Programme on preventing HIV among adolescent girls and young women and treatment care and support.
407. ILO, the Secretariat, UNDP and partners organized a panel discussion at the World Health Assembly on the theme Fast-Tracking social protection to end AIDS. Other joint advocacy efforts included an event at the UN General Assembly, where World Bank and ILO inaugurated the Global Partnership for Universal Social Protection and launched 23 country experiences to show that universal social protection is feasible in developing countries.

Percentage of countries with social protection strategies and systems in place that address HIV	Targets and milestones	2016 Progress	2017 Progress
Data source: 2016–2017 JPMS country reports	2021: 70% 2019: 60% 2017: 50%	All: 63% [60/96] Fast-Track: 67% [22/33]	All: 52% [50/96] Fast-Track: 55% [18/33]
<p>The Joint Programme supports scale-up of sustainable, HIV sensitive and evidence-informed social protection programmes and strengthens national social protection floors. It works to ensure that social protection programmes reach those living with and affected by HIV, and advocates for increased investment and provides guidance and support for implementation of HIV sensitive measures to address the needs of orphans and vulnerable children.</p> <p>In 2017, 52% of 96 countries with UNAIDS presence (of which 18 are Fast-Track countries) have social protection strategies and systems in place that address HIV which cover the following:</p> <ul style="list-style-type: none"> ▪ People living with HIV and affected by HIV; ▪ Orphans and vulnerable children. <p>Furthermore, 52% of these countries (including 18 Fast-Track countries) have national health insurance (and social health insurance where distinct), life or critical illness insurance that cover people living with HIV. Social protection programmes, such as safety nets and livelihood interventions, are provided to men and women living with HIV and affected by HIV in 52 countries (of which 23 are Fast-Track countries)</p>			

408. By September 2017, the World Bank’s annual lending on social protection programmes reached US\$ 13.5 billion with US\$ 8.4 billion lending in Industrial Development Authority countries targeting the world’s poorest. These resources support safety-net programmes, including cash transfers, public works and school feeding in more than 70 countries. Examples of World Bank projects include the Swaziland Health, HIV/AIDS and TB Project, which aims to increase social safety-net access for orphans and other vulnerable children. In addition to providing financing for HIV-sensitive social protection programmes, the World Bank continued to increase the evidence base for use of HIV-sensitive social transfers, building on its studies investigating how conditional cash transfers can reduce STIs, which has been shown to be effective Lesotho, Malawi and the United Republic of Tanzania.

409. In 2017, WFP collaborated with All-Ukrainian Network of People Living with HIV to expand a food assistance, social protection intervention via conditional e-vouchers (cash-based transfers), targeting 17 600 HIV-affected household members (6,826 people living with HIV) who lost all other means for survival because of the conflict. This intervention focused on assistance to internally displaced people living with HIV, especially women with young children. People living with HIV on ART, or who planned to start ART, received eight monthly rounds of assistance, contingent on regular attendance at clinics. This resulted in improved food security status in two thirds of beneficiaries, and 34% of beneficiaries improved their adherence to treatment. This intervention also led to reductions in viral load in most of those receiving assistance. In nongovernment-controlled areas, people living with HIV were assisted with two monthly rounds of in-kind food parcels.
410. UNICEF's community system strengthening aimed to institutionalize community health as an integral part of the health system and a vehicle to reach Universal Health Coverage. In eastern and southern Africa, cash transfer and social protection initiatives helped children and adolescents living with HIV gain better access to HIV/SRH, treatment and care services.
411. UN Women has helped improve sustainable livelihoods for women living with HIV by facilitating their access to and control over economic resources. UN Women's Fund for Gender Equality provided small grants to civil society organizations to economically empower women's groups in marginalized and impoverished communities, particularly women living with and affected by HIV. Since its inception in 2009, of the 121 projects supported by the fund, 7% of projects globally, 17% in Europe and central Asia and 16% in Africa involved women living with HIV.
412. In Kyrgyzstan, the fund grantee strengthened the business skills of 73 marginalized women, including those who were living with HIV, used drugs, or were partners of drug users, or were former prisoners, and awarded five micro-grants to women's groups to develop livelihood business plans.
413. In Uganda, UN Women launched an empowerment programme for adolescent girls and young women aged 15–24 years, including those living with HIV. The programme provided young women and girls in Karamoja region with life-skills training to improve self-esteem, decision-making and knowledge in entrepreneurship, small/medium business management and financial literacy. All participants are linked to HIV services. The intervention also educated the larger community to the norms/practices that predispose young women and girls to HIV and violence. In 2017, the programme benefitted 265 girls. Early results demonstrated improvements in attitudes towards uptake and adherence to HIV treatment, increased demand for prevention commodities, increased appetite for family planning information and services, and reporting of violence.
414. In 2017, UNDP supported more than 80 countries in social protection, up from 62 countries in 2016. UNDP's HIV and Health Team ensured HIV-sensitive social protection and cross-sectoral co-financing were included within its broader organizational offer on cash-based programming. This work sets the stage for increased attention to HIV-sensitive social protection in UNDP's in-country programming.
415. For example, through UNDP assistance, more than 100 Indian state and central social assistance schemes extended benefits related to pensions, scholarships, travel allowances, subsidies for food and shelter, among others, to address the needs of HIV-affected people. Lowering the pension age for spouses, for instance, recognizes they

may lose their partners at an earlier stage of life. So far, the schemes have responded to more than a million requests for benefits, including multiple types of assistance for individuals with diverse requirements. The experience has informed efforts to expand social protection to HIV-affected people in Cambodia. HIV-sensitive measures in survey instruments now allow a more precise identification of all poor urban households eligible for social protection schemes.

416. With data from 204 countries and territories, the ILO published the *World social protection report (2017–2019)*, which indicated that only 45% of the global population are covered by at least one social protection benefit, leaving 55% with no coverage. The report reinforces the need to ensure social protection schemes are consistently HIV-sensitive in order to leave no one behind. As part of global advocacy efforts, the ILO, UNAIDS and UNRISD as well as, UNDP, Helpage, STOP AIDS NOW and Housing Works, organized two panel discussions in 2016 and 2017 on the theme of HIV-sensitive social protection to realize the right to health and social security and Fast-Tracking social protection to end AIDS. Twelve countries were supported to implement HIV-sensitive social protection programmes that focus on development of national plans and strategies (Kenya, for example) and strengthening the legal policy framework (Nigeria).

Challenges

417. For progress to be sustained, the scope of integration work across other sectors and systems must be accelerated in line with Agenda 2030. The logic of integration is unassailable, but the experience of HIV programmes with integration or mainstreaming has often been disastrous; when earmarked HIV money and personnel are exhausted, the HIV services too often fade away. The integration of HIV into other sector programmes and services requires funding to ensure sufficient HIV expertise is embedded in the social, political, structural and biomedical dimensions of the response, and ownership and responsibility for HIV results are promoted and sustained in the recipient sectors.
418. SDG targets on HIV and SRHR will not be achieved without government support for integrated, people-centred approaches that further the inter-related HIV and SRHR agendas. This includes the need for rights-based laws and policies that underpin good HIV and SRHR outcomes, including support for appropriate age-of-consent laws to expand adolescent access to services, ending child marriage and eliminating violence in all its forms. Stigma, discrimination and criminalization of sex work and same-sex relations also hinder access to services. Coordination among data systems is limited, while initiatives to keep girls in schools, or social protection schemes to financially support women and girls, are rarely accompanied by complementary interventions to address power relations, enhance self-confidence and the decision-making power of young women and adolescent girls, expand women's access to and control over economic resources (including livelihood and entrepreneurship opportunities), increase women and girls' knowledge, and skills and ability to negotiate safer sex. Despite some progress, the Joint Programme must intensify its work to mobilize all actors to ensure social protection schemes are HIV-sensitive.

Future actions

419. Strengthening national health systems will be prioritized through integration of community service delivery with formal health systems and supporting countries with differentiated service delivery. The Joint Programme will continue to link social protection to Universal Health Coverage scale-up and support HIV-sensitive social protection programmes at country level. Identifying ways to support the Global Fund

and PEPFAR's new commitment to social protection in the AIDS response will also remain a priority. The Joint Programme will continue to work with political leaders to increase demand for HIV-specific social protection programmes. Agency-specific future actions include the following:

420. UNICEF will provide leadership on results-driven integrated approaches in three major areas: elimination of mother-to child-transmission of HIV, paediatric treatment and retention in care, and prevention of new infections among adolescents. UNICEF will continue its support to cash transfer plus and other social protection initiatives as part of its combination prevention and to programmes targeting adolescents living with HIV.
421. WFP will continue to deliver on its mandate to integrate food and nutrition and humanitarian emergencies into HIV responses, and work to better link food/nutrition and health systems with social protection programmes by advocating at global level and by supporting governments. The new WFP 2017–2022 Strategic Plan and Nutrition Policy reiterates its commitment to strengthen capacities to ensure social protection programmes are HIV and nutrition sensitive, including in humanitarian and fragile settings.
422. ILO will work to link social protection to Universal Health Coverage scale-up and identify ways to better support the Global Fund and PEPFAR's commitment to social protection in the AIDS response.
423. UNDP will support the implementation of the recommendations of the high-level panel on access to medicines, continue its engagement with the Global Fund, multilateral development banks and key donors to broaden their assistance for health, and further sensitize UN regional bureaux and community organizations on their roles in fully responding during health emergencies.
424. UN Women, including through its Gender Equality Fund, will continue supporting grass-roots organizations to economically empower women and girls living with and affected by HIV.
425. UNESCO will collaborate with WHO and partners on the development of a joint UN paper on the links between SRHR and HIV.
426. WHO will address the most critical gaps in normative guidance and place greater emphasis on developing guidance to accelerate country implementation and define packages of essential HIV interventions that should be integrated into national health benefit packages.
427. UNFPA will maintain its leadership on strengthening integration of SRHR /HIV/gender-based violence in all settings, including metrics, as outlined in its new Strategic Plan 2018–2021, including through technical support alongside WHO, UNICEF and UNAIDS to the five-country Joint UN Programme on SRHR /HIV Integration 2018–2021, with funding from the Swedish International Development Cooperation Agency. UNFPA will fully utilize the integrated SRHR /HIV/gender-based violence platform in its leadership role of the Prevention Coalition and country support for implementation of the Prevention 2020 Roadmap.
428. The World Bank will continue to provide funding and technical assistance for HIV integration and mainstreaming into health services integration with TB and SRH services. The World Bank will keep working with partners to accelerate progress towards Universal Health Coverage.

SECRETARIAT CONTRIBUTIONS

429. This section provides an overview of achievements, challenges and future actions by the UNAIDS Secretariat, organized against the five functions outlined in the 2016–2021 UBRAF. More detailed information can be found in Part II of the report.

S1: Leadership, advocacy and communication

Achievements

430. The Secretariat continued to lead the Joint Programme's efforts to raise public awareness, mobilize political leadership and generate broad-based commitment for a global HIV response that can achieve the 2030 Agenda target to end AIDS as a public health threat. The UNAIDS Executive Director continued the focus on repositioning the global HIV response in a challenging international environment, mobilizing support from Member States, donors, civil society and other partners. The success of this high-level work was evident in the adoption by the United Nations General Assembly in 2016 of the progressive Political Declaration on Ending AIDS. This reinforced the UNAIDS 2016–2021 Strategy and provides clear direction to accelerate efforts to reach the 90–90–90 targets.
431. Fast-Track is an agenda for quickening the pace of implementation, focus and change at global, regional, country, province, district and city levels and recognise that more energy needs to be put into HIV prevention—stronger leadership, increased investment and community engagement—to ensure everyone, particularly those at higher risk of HIV, can protect themselves. During the opening session of the UN General Assembly in September 2017, the Secretariat mobilized officials for an event on Fast-Tracking the response. It reinforced the life-saving impact of donor investments, and the commitment of countries, including Heads of State, to ending AIDS and putting in place a sustainable response, as did the high-level Congressional briefing organized by amfAR, Making AIDS history: a roadmap for ending the epidemic.
432. The political mobilization made possible through the Secretariat's unique ways of working, nurturing partnerships and lead role on Fast-Track advocacy, have led to bold decisions, enabling countries to refine their HIV responses to leave no one behind. Its technical and strategic guidance, partnership activities and progress reviews in the UN General Assembly, continue to galvanize progress, call attention to gaps and shortcomings, promote country ownership and enable accountability for results.
433. The political leadership leveraged at the global, regional and country levels ensured that 70% of Fast-Track countries aligned their national strategies with the Fast-Track targets, including prevention programmes and the goals of the 2016 Political Declaration on Ending AIDS. Since their launch in 2014, the 90–90–90 targets have become central to the global quest to end AIDS. During 2016–2017, the Secretariat maintained the momentum of treatment scale-up.
434. The launch of the Global HIV Prevention Coalition in 2017, and the HIV Prevention 2020 Road Map, was another defining moment. Spearheaded by the Secretariat and UNFPA, it reinforced momentum for HIV primary prevention and renewed enthusiasm and political commitment for scaling up prevention at country level. The coalition brings together Member States, civil society, international organizations and other partners in efforts to reduce new HIV infections by 75% by 2020, compared to a 2010 baseline.

435. Building on the successes achieved under the *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*, the Secretariat is a co-convenor of Start Free Stay Free AIDS Free, a collaborative framework to accelerate the end of the AIDS epidemic among children, adolescents and young women by 2020. Political leadership and partnerships have been crucial to driving action. Consultations with national partners and stakeholders, community members, women living with HIV, religious leaders, philanthropists, donors and private sector representatives of leading pharmaceutical and diagnostic companies have all contributed to building global consensus and momentum.
436. Building on the Agenda for Zero Discrimination in Health-Care Settings launched in 2016 with the WHO Global Health Workforce Network, the Secretariat led development of a Joint United Nations statement on ending such discrimination. The statement was issued by 12 agencies committed to working together to support Member States take coordinated multisectoral action. New discrimination targets were integrated into the Global AIDS Monitoring (2018) online tool to improve understanding of health outcomes, and interventions to reduce and mitigate HIV-related stigma and discrimination, along the treatment cascade. A report, *Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond*, presented at the Human Rights Council Social Forum, shows people living with HIV experiencing high levels of HIV-related stigma are more than twice as likely to delay enrolment into care than those who do not.
437. During missions and country visits in 2016–2017, UNAIDS' call for an accelerated response, shared responsibility and solidarity to ensure no one is left behind. The Secretariat developed a media outreach strategy and communication plans to promote HIV in the global health and development landscape at high-profile events and technical conferences; conducted briefings, interviews and monitoring; and developed strategic communication materials. UNAIDS' advocacy role was enhanced through collaboration with partners, including celebrity advocates and Cosponsors at global, regional and national levels. Actions and events included:
- In September 2017, the President of Uganda, Yoweri Museveni, in collaboration with UNAIDS, brought together six heads of state or government to accelerate action and get countries on the Fast-Track to ending AIDS. World leaders also joined around 500 partners from government, the private sector and civil society on the side-lines of the UN General Assembly, to reinvigorate political leadership around HIV;
 - During the opening session of the UN General Assembly in 2016, the Secretariat mobilized the participation of high-level officials for the event on Fast-Tracking the response to the epidemic;
 - The Secretariat additionally engaged new champions for HIV, including Prince Harry of the UK and developed a social media campaign aimed at Ministers of Health in advance of the G20 and H20 meeting, utilizing key data and developing targeted messages for the Ministers of Health. The Secretariat has been refining the use and presentation of data, ensuring that communication around data is accessible and interesting to multiple audiences, targeting particular agenda or events, seeking to be more influential and leveraging opinions at the global political level.
438. Communication with partners alongside various thematic campaigns, brought global awareness to the AIDS response and the technical leadership of UNAIDS. This included briefings, reports, promotional materials, webcasting, information and materials for media, a snapshot messaging series, newsletter, UNAIDS briefing book, social media campaigns and country-based promotion packages. Social media and online platforms have been increasingly integrated into corporate communications

strategies, to achieve campaign objectives, amplify messages and encourage desired action, through analytics, performance monitoring and feedback. Innovative ways of promoting third party content through UNAIDS' storytelling has also helped expand issue-based communication.

Examples include:

- The *Cities Ending the AIDS Epidemic* report was launched on 6 June 2016 in New York, with evidence from more than 30 cities on their progress towards the 2020 targets;
- A series of Executive Director opinion editorials reinforcing core messages have been run in niche publications reaching key audiences and decision makers;¹⁴
- UNAIDS flagship publications and specific materials for U.S. audiences were used to educate and engage Congress and civil society, positioning UNAIDS as the world's expert source for data, to drive decisions and investment to end the epidemic;
- 2017 Flagship Reports included: *Right to Health; Women's Report; Data Book; SDGs and the HIV response; Harm Reduction; Global Report; and Blind Spot*;
- The UNAIDS website was relaunched and reach increased, resulting in 12.3% growth compared to the previous annual period.

Challenges

439. The Secretariat's high-level advocacy, which encourages decision-makers and stakeholders to be bold in their aspirations and actions, is vital in a turbulent global context. Regions are witnessing human rights regressions, shrinking political space for civil society and encroachment on individual rights and freedoms using public health, economic or security rationales. The number of people displaced by conflict has climbed to unprecedented levels. This requires scaled-up HIV action in humanitarian contexts and fragile communities to ensure mobile and other vulnerable populations receive a continuum of prevention, testing, treatment and care services.
440. The 90–90–90 targets have guided a substantial increase in the coverage and quality of HIV testing and treatment services. However, many challenges remain, including insufficient availability of innovative testing methods, such as self-testing and early infant diagnosis; insufficient adoption of treat-all, community-based treatment approaches; and low access to viral-load testing among people receiving treatment.
441. Despite increased political commitment for primary HIV prevention in low- and middle-income Prevention Coalition countries, challenges exist in implementing the 10 action points of its road map, including lack of investment in HIV prevention and in prevention capacity to support carrying out the work at country level. Generally, lack of systematic programme implementation, managerial oversight and accountability are other challenges that have been identified early and require action.
442. The first year of the *Start Free Stay Free AIDS Free* framework was marked by promising developments, but much remains to be done. In particular, prevention of new infections among women needs to improve. Efforts must be stepped up to close the coverage gap in services to prevent mother-to-child HIV transmission and to ensure all children potentially exposed to HIV are tested. In addition, age-appropriate sexuality education, information and services should be available for adolescents and young people. Their right to health also includes protection from sexual violence and abuse and access to health services and social support.

Future actions

443. Working closely with the Cosponsors, the Secretariat will continue to champion United Nations reform and the H6 Partnership, finding opportunities to take AIDS out of isolation and position UNAIDS as a pathfinder for the 2030 Agenda. The Secretariat will continue to mobilize support of Member States, civil society and partners to accelerate efforts towards the 90–90–90 targets. Continued leadership and advocacy will be provided to implement a Fast-Track approach in fragile states and at country and city levels. Focus is needed in 35 high-priority countries where about 90% of new HIV infections occur. Examples of future actions include:
- Continue to provide leadership and advocacy to ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020. Successfully transition at least 25 countries¹⁵ to Dolutegravir based regimens with progress tracked through biannual reporting.
 - Engage and monitor the evolving geopolitical landscape, humanitarian contexts and fragile states.
 - Generate momentum towards zero discrimination in health-care settings through a review to identify evidence-informed interventions and political and technical support to countries.
 - Strengthen human rights at country level through the expanded roll-out of the UNAIDS guidance note, *Fast-track and human rights*.
 - Develop and launch Global compact and roadmap to end discrimination in 10 countries.¹⁶
 - Country-level advocacy to quicken the pace to scale up early infant diagnosis, including uptake of new point of care technologies that allow same-day return of results to providers and parents and rapid initiation of antiretroviral treatment. Parallel efforts to increase awareness of the importance of early infant diagnosis, and encouraging parents living with HIV to have all their children tested, are components of enhanced paediatric case-finding along with increased HIV testing of children hospitalized for illness, those seen in malnutrition centres, TB clinics, and among orphans and vulnerable children of HIV-affected families.

S2: Partnerships, mobilization and innovation

Achievements

444. Through its leadership in convening stakeholders at national, regional and global levels, and its expertise in HIV strategy, policy, prioritization and programming, the Secretariat has established trust with governments, communities and partners. Partnerships strengthen dialogue between governments, affected communities, and other stakeholders for effective global policies and country level implementation.
445. The Secretariat continued to strengthen partnerships with civil society. In 2016–2017, the Secretariat mobilized US\$ 28 million to support several civil society actions such as, the work of the Elton John Foundation, Robert Carr Fund, Global Forum on men who have sex with men and HIV, AIDS Infoshare and faith-based organizations.

Supporting countries accessing the Global Fund grants

446. Together, UNAIDS and the Global Fund have ensured that millions of people living with HIV have access to treatment and that people most affected by the epidemic have the health and support services they need.

447. The 2017 Independent Evaluation of the Global Fund-UNAIDS partnership noted that the “UNAIDS–Global Fund cooperation at all levels of the organization has resulted in a number of achievements that enhanced the effectiveness of Global Fund assisted programmes”. UNAIDS supported more than 50% of 2017-2019 Global Fund country applications and facilitated access to approximately US\$ 2.5 billion of grants to accelerate the HIV and TB response.
448. UNAIDS improves the return on investment of Global Fund grants by strengthening the focus on populations and locations. For example, support to Indonesia and Togo generated valuable information on key populations, including their needs, vulnerabilities and limited service uptake. Data on key populations have enabled the integration of measurable and time-bound targets into Global Fund applications, resulting in increased accountability and the effective mobilization of valuable resources for key population programming. Secretariat support to the Global fund and countries was provided for the \$50 million in catalytic funding for key populations.
449. Enhancing access to financial mechanisms, the Secretariat facilitated Ministries of Gender/Women Affairs and Ministries of Education to reengage with the Global Fund and provided information on catalytic funding for Adolescent Girls and Young Women (AGYW) in 13 countries in the eastern and southern Africa region. The Secretariat also worked with the Global Fund to develop a format for mapping intervention by age and geography in AGYW catalytical grants that will be key for the work on the Prevention Coalition AGYW work stream.
450. It also continues to co-ordinate the work of the IATT on Social Protection and supporting countries to strengthen programming on HIV sensitive social protection. Zambia’s Global Fund Concept Note included the targeting of 3000 adolescent girls and young women with cash transfers to keep them in school and assist in meeting their basic needs in efforts to protect them from getting HIV. Cash transfer programme for Kenya is targeting 20 000 adolescent girls with cash incentives to increase access to HIV prevention, treatment and care services.
451. The Secretariat supports the Global Fund 2016 *Sustainability, Transition and Co-Financing Policy* by helping countries undertake transition readiness assessments. This involves identifying risks and opportunities for programme and financial transition and sustainability. A systems approach is used, whereby the AIDS response is put in the context of wider health and other sector reforms. After being validated by the country and donors, the assessments are used to develop road maps towards sustainability that guide policies and investments for HIV. The aim is to gradually move away from donor financing and towards domestically funded and sustainable health systems.
452. In the new Global Fund cycle, the Secretariat successfully engaged communities that had previously been excluded from decision-making processes, by enabling their participation in country dialogue and assisting them to include priority interventions in Global Fund country applications. In Cameroon, Congo, Cote d’Ivoire, Ethiopia, Indonesia and Kenya, support for country dialogue stimulated essential policy and strategy dialogue on key cross-cutting issues, such as gender, human rights, stigma and discrimination. In Indonesia, Secretariat supported the development of the human rights component to access the Global Fund funds, including the catalytic funds for human rights.

453. Cities are home to more than half of the world's population and a large and growing proportion of people living with HIV, TB and other diseases. Cities also serve as hubs of innovation, community involvement and strong local leadership. In 2014 the Secretariat, the City of Paris, the International Association of Providers of AIDS Care (IAPAC) and UN-Habitat joined 26 key cities from around the world to launch the 2014 Paris Declaration on ending the AIDS epidemic. By the end of 2017 more than 250 cities and municipalities have signed the declaration, pledging their commitment to attaining the 90–90–90 targets by 2020, to addressing disparities in access to basic health and social services, social justice and economic opportunities, and to ending AIDS as a public health threat by 2030.
454. UNAIDS has mobilized resources from USAID and the MAC AIDS Foundation to support 23 high priority cities, together accounting for about four million people living with HIV, to Fast-Track their responses towards achieving the 2016 Political Declaration on Ending AIDS targets and to deliver on the commitments of the Paris Declaration. These resources are aimed at strengthening HIV service delivery in cities by working with key partners and stakeholders and to support the collection and analysis of strategic information on the epidemic and response. Progress in the HIV response in cities has been assessed through several forums including regional meetings and international conferences. The Secretariat organized or supported Fast-Track Cities sessions at various conferences, including International AIDS Society Conferences in Durban (2016) and Paris (July 2017), and the International Conference on AIDS and STIs in Africa (ICASA) in December 2017. In line with the urban agenda, the Quito Declaration on Sustainable Cities and Human Settlements for All was adopted at the United Nations Habitat III conference in October 2016. UNAIDS successfully advocated for the inclusion of the target to end AIDS, TB and malaria as global public health threats by 2030 and of a commitment to address various multiple forms of discrimination, with particular attention to people living with HIV.

Strengthening dialogue with governments, communities and stakeholders

455. In 2016–2017, the Secretariat worked to strengthen dialogue and partnerships with governments, communities and other stakeholders. Through its leadership role in convening stakeholders at the national, regional and global levels, in addition to its expertise in HIV strategy, policy, prioritization and programming, This uniquely positions UNAIDS to deliver focused technical support to achieve impact. For example, a new set of materials for U.S. audiences was developed, highlighting:
- UNAIDS' unique leadership role in accelerating action to end the epidemic;
 - The ways in which the long-standing collaboration between UNAIDS, PEPFAR and the Global Fund helps ensure that the US Government reaches its goals of saving lives, achieving epidemic control, enhancing national/global health security and increasing global burden sharing; and
 - The ways in which UNAIDS can serve as a model for UN reform.
456. These materials have been shared with other partners who continue to call for sustained support for UNAIDS and help articulate UNAIDS' critical role in efforts to end AIDS.
457. The Secretariat has also worked with the private sector on issues related to stigma and discrimination. For example, the UNAIDS Secretariat established a partnership with DLA Piper, a global business law firm that dedicates time to pro bono and community projects tackling stigma and discrimination.

458. The UNAIDS Secretariat is supporting the International Development Law Organization (IDLO) to implement a project on building sustainable approaches to reduce discrimination and advance access to justice for people living with HIV and other key populations. The project is designed to strengthen the capacity of university legal clinics to support human rights-based responses to HIV in Uganda, and the United Republic of Tanzania.

Supporting countries towards a smooth transition of HIV responses from external aid

459. The Secretariat established a partnership with the African Development Bank in the area of transition and system strengthening, whereby countries will be supported to identify innovative financing mechanisms for HIV. The goal is to reduce financial dependency on international aid, as well as establishing ongoing dialogue between the Ministers of Finance and the Ministries of Health/National AIDS Programmes, for adequate and efficient funding for HIV.
460. Consensus has been built with countries and regions on UNAIDS' approach, role and added value in helping countries prepare and plan for smooth transitions from external aid, as well as building systems for increased ownership and sustainability. For example, countries such as Cambodia, Mozambique, Morocco and Senegal have been supported to develop multidimensional roadmaps for transition preparedness and sustainability. Preparatory work has been undertaken to help additional countries, including Cote d'Ivoire, Jamaica, Kenya and the Philippines, to undertake similar steps.
461. The Secretariat has been an active member of the Universal Health Coverage 2030 Group on Transition and Sustainability. Within the group, the Secretariat's experience and concerns regarding the complexity of transitioning HIV responses has been put forward and the Secretariat has been able to advocate for concerted action by all international players to avoid multiple transitions, which might ultimately reverse achievements of countries.

Removing punitive laws and ending human rights violations

462. In close partnership with OHCHR, the Secretariat also initiated and engaged UNDP and WHO to catalyze and support efforts to address stigma and discrimination, especially in healthcare settings, and the misuse of criminal law and other punitive laws that impact HIV-related rights. This involved convening civil society, communities affected by criminalization, lawyers, academics, public health experts and the UN bodies. Through courageous advocacy and strategic information, UNAIDS helped shape public policy on HIV and push boundaries in the face of reluctance to fight stigma and address the needs of key populations.
463. The Secretariat and OHCHR organized an expert meeting in Bellagio, Italy, in February 2017 to link organizations working against the unjust application of criminal laws. Participants came from all regions of the world and included experts from the judiciary, legal field, academia, health practice, international and UN agencies and civil society. They explored ways to remove laws that negatively impact on health and human rights and debated strategies for addressing the impact of such laws and for challenging the misuse of criminal laws. The meeting resulted in innovative new thinking on how to address discriminatory use of criminal law and identified entry points for action. A follow-up meeting will be held in 2018 to develop principles to address the detrimental impact on health, equality and human rights of the misuse of criminal law.
464. The Secretariat also leveraged existing partnerships with regional mechanisms such as the African Commission on Human and Peoples' Rights to advance human rights.

This resulted in the adoption of [Resolution 376 about Human Rights defenders in Africa](#) and the launch of the first ever report of the African Commission on HIV and human rights in Africa, addressing emerging human rights challenges including civil society space (December 2017). This [report](#) was launched during a high level event at the 30th African Union Assembly in January 2018.

465. In 2016, the Secretariat and OHCHR supported the launch of the report of the first joint dialogue on sexual orientation and gender identity between the Inter-American Commission on Human Rights, the African Commission and the UN human rights system. The [joint dialogue](#) discussed best practices for the protection of the human rights of LGBTI persons and their access to health and HIV services. It outlined commitments for further work in this area by the regional mechanisms.
466. The Secretariat has continued its efforts to address punitive laws and to help create enabling responses for the response to the epidemic by working closely with members of parliament, civil society and other partners. In 2016, the Secretariat supported advocacy to address punitive provisions draft legislation in Malawi (overly broad criminalisation of HIV exposure and transmission); Georgia (restrictive drug legislation) and Palau (overly broad criminalisation of HIV exposure and transmission). The Secretariat also intervened in individual cases of arrests of people living with HIV and key populations in the Czech Republic, Indonesia and Tanzania, as well as HIV-related travel restrictions in Canada, China, Northern Cyprus and Serbia.
467. The Secretariat has also acted as “friend of the court”, or amicus curiae, in a number of high profile HIV and human rights cases. In 2016, the UNAIDS Secretariat submitted amicus briefs to the East African Court of Justice on a Ugandan anti-homosexuality law; to the Kenyan High Court on a case of coercive sterilization; and to the UN Human Rights Committee on mandatory HIV testing for foreign language teachers in the Republic of Korea.
468. The Secretariat and the WHO Global Health Workforce Network launched the Agenda for Zero Discrimination in Health-Care Settings in 2016. The Agenda brings together all stakeholders to join efforts towards tackling discrimination in its many forms, including by removing punitive laws, policies and practices that undermine people living with HIV, key populations and other vulnerable groups, or block their access to good quality health-care services, and by empowering them to exercise their rights. Zero discrimination is at the heart of the UNAIDS vision, and one of the targets of a Fast-Track response, which focuses on addressing discrimination in health-care, workplace and education settings. The [41st PCB thematic session](#) was dedicated to Zero Discrimination in Health Care in order to accelerate action to end discrimination in health care settings.
469. In support of the implementation of the action plan of the Agenda, in 2017, twelve UN Agencies issued a [Joint UN Statement on Ending Discrimination in Health Care Settings](#), committing to work together to support Member States in taking coordinated multisectoral action to eliminate discrimination in health care settings. In addition, in 2017, the Secretariat launched the [Fast-Track and human rights — Advancing human rights in efforts to accelerate the response to HIV](#), a guidance that explains why and how efforts to Fast-Track HIV prevention, testing and treatment services can and should be grounded in human rights
470. The Secretariat further launched the report [Confronting Discrimination: overcoming HIV related stigma and discrimination in health care settings and beyond](#) in 2017. This report compiles the latest body of evidence on how stigma and discrimination create barriers across the HIV prevention, testing and treatment cascades and reduce the

impact of the AIDS response. The report also brings together best practices on confronting stigma and discrimination, providing a valuable resource for programme managers, policy-makers, health-care providers and communities.

471. The Global Fund is implementing an intensive support initiative in 20 countries towards comprehensive scale-up of programs to remove human rights-related barriers to services. The Secretariat participated in all stages of the development of the intensive support initiative involving catalytic funding to 20 countries, from developing the criteria for country selection to coordinating with counter partners at country level the roll out of baseline assessments, the development of grants for matching funds (a funding stream of US\$ 45 million), the development of a five-year plan to monitor and evaluate the impact of scale up as well as providing technical assistance for implementation support.

Supporting and convening young people

472. The Secretariat supported The PACT to develop and launch the #uproot youth-led political agenda to end AIDS by 2030. The objective of the PACT is to increase the visibility of the root causes of risk and vulnerability, including inequities, violence, exclusion and stigma and discrimination, which jeopardize young people's health, access to HIV and SRH services and rights, as well as the sustainability of the AIDS response. With technical and financial support from UNAIDS, #uproot managed to undertake several initiatives including:
- Developing policy briefs to challenge harmful policy;
 - Assessing the organizational capacities of young people networks working on HIV;
 - Crowdsourcing young people's recommendations to make services youth friendly;
 - Developing a scorecard to track commitments related to youth on the 2016 Political Declaration on Ending AIDS; and
 - Developing a mentorship module to support emerging youth leadership in the HIV response.
473. The Secretariat also supported medical students to launch a public declaration of commitment for non-discrimination in healthcare settings and produced guidance to inform more inclusive medical curricula at country level. An advocacy brief to mobilize medical associations was also produced, against discrimination in healthcare, alongside a series of webinars to sensitize medical students.
474. Other initiatives include:
- Development, piloting and launch of an age of consent advocacy toolkit;
 - Co-organizing sessions at the 2017 ECOSOC Youth Forum;
 - Strengthening strategic alliances, including between networks of young people living with HIV from different regions and between medical students and young key populations for non-discrimination in healthcare, resulting in a Memorandum of Understanding between the networks and initiated the final evaluation for the ACT!2030 initiative, which ends in June 2018.

Supporting leadership, advocacy and strengthening the capacity of faith-based organizations to deliver on Fast-Track

475. The Secretariat and PEPFAR launched a partnership Initiative with Faith-Based Organisations to strengthen the leadership, advocacy and HIV service delivery

capacity of FBOs in up to six PEPFAR and UNAIDS priority countries. Phase I of the initiative concluded in September 2017 with good results from the partnership.

- A series of advocacy events convened under the leadership of Caritas Internationalis, hosted by Cardinal Turkson at the Vatican led Pharmaceutical companies, regulators and other partners to commit to scale up access of HIV medication for children.
- The World Council of Churches led an Ecumenical advocacy campaign for “Faith on the Fast-Track”. Religious leaders were encouraged to lead by example, to challenge stigma and promote HIV testing, treatment and referral to care. Over 1,500 religious leaders took the HIV test as a result in 2017 and spoke out to encourage their faithful to follow their example.
- The WCC “framework for dialogue” methodology has proven to be an important tool to generate meaningful dialogue between networks of people living with HIV and faith communities and solid joint action plans to address stigma and discrimination on an ongoing basis. This methodology has been applied in two high-HIV-burden counties in Kenya. In addition, the WCC, in partnership with the International Network of Religious Leaders Living with and personally affected by HIV (INERELA+) applied the SAVE methodology to reduce gender inequities, gender-based violence, stigma in communities, increase uptake of HIV testing and pastoral accompaniment to support retention in care.
- The academic consortium of the initiative documented FBO health service delivery on HIV in Kenya down to facility level and created an interactive data platform to view the results.
- The African Christian Health Associations platform developed a monitoring and evaluation platform and mentoring programme to strengthen reporting from their network members into national data collection mechanisms.
- The Secretariat has renewed a partnership with Islamic Relief which will strengthen their response to HIV in the context of their work on Gender in situations of conflict and crisis in Phase II.
- Five national FBO Action plans in support of Fast-Track were developed during five national consultations hosted as initial Phase II activities in March 2018. These consultations also provided the opportunity to re-establish or strengthen national interfaith collaboration platforms in support of national AIDS responses.

476. The Secretariat provided leadership, coordination and management to the initiative, and supported partners to lead several global advocacy events for FBOs and religious leaders to support and mobilize their communities around Fast-Track.

Challenges

477. The Secretariat’s role, expertise and track record on community engagement make it uniquely placed to advise governments, civil society and international partners on the integration of community responses in national AIDS programmes. However, resources are necessary and limited financial investment in community responses to date does not match the commitments made in the 2016 Political Declaration on Ending AIDS. Lack of funding is impacting on the required push for HIV-sensitive social protection, while limited understanding of HIV and social protection work is affecting uptake of social protection among people living with and affected by HIV.

478. In many countries, countries implementing national plans and strategies rely on resources from the Global Fund. Optimizing Global Fund support involves strategic use

of epidemiologic data, broad engagement of community stakeholders, effective project management and oversight capacities to ensure funds are utilized for greatest impact. UNAIDS is a valued partner providing support to countries and the Global Fund as documented in the independent evaluation, but constrained resources impact the ability to more fully support important elements of this work.

479. Early and ongoing UNAIDS engagement in PEPFAR Country Operational Planning processes is necessary, particularly for aligning data and the role of civil society in national responses. Joint mapping of key policy barriers, normative shortcomings and other obstacles to programme acceleration in PEPFAR-supported countries is required, along with a joint strategy to address them.

Future actions

480. Working closely with the Cosponsors, the Secretariat will continue to develop and strengthen partnerships, mobilize resources and promote innovation. Technical support will be a particular focus to reinforce the use of Global Fund and other resources as effectively as possible. Examples of concrete actions include:
- Map funding for civil society from international and domestic resources and equip country partners with tools to integrate community responses in national plans and resource allocation, plus practical tools on political commitments and accountability frameworks.
 - Implement phase two of PEPFAR-UNAIDS' faith initiative in six countries, in collaboration with five global implementing partners.
 - Provide strategic support to PEPFAR across the Country Operational Planning (COP) cycle in the 23 standard COP countries¹⁷, leveraging U.S. investments to advance UNAIDS/country Fast-Track goals.
 - Continue to work with the International Association of Providers of AIDS Care (IAPAC) to implement the USAID-funded project supporting Fast-Track responses in 20 high-burden cities.
 - Support 16 Fast-Track countries¹⁸ complete HIV-sensitive social protection assessments by Q4 that review existing social protection programmes and their sensitivity (or lack of) to the HIV response, in coordination with ILO and the World Bank.
 - Identify key countries and share mapping document of community health worker programmes at the African Union Summit. Develop protocol tool for counting and linking new community health workers as part of the African Union initiative to add 2 million Community Health Workers in Africa.
 - Develop and implement Humanitarian roadmap in three countries¹⁹ with report launch at the African Union assembly.
 - Support youth to organize to challenge policies, broker partnerships, and engage in decision-making processes from community level to global governance fora and in context of H6.

S3: Strategic information

Achievements

481. Monitoring the global HIV epidemic and the response is a core function of UNAIDS. The Secretariat supports countries in their annual reporting of programme,

behavioural, financial and epidemiological data through the GAM system. The response rate has remained roughly stable since 2012, with 174 Member States (90%) reporting in 2017. Experts among Cosponsors and global partners are consulted to maintain high-quality and up-to-date reporting and analysis methodologies. The Monitoring Technical Advisory Group (MTAG) develops the GAM indicator set and guidelines used by countries to report progress.

482. UNAIDS Secretariat continues to support countries to develop estimates of the impact of HIV on their population. In 2017, estimates were produced for 170 countries representing almost 99% of the global population. The UNAIDS Reference Group on Estimates, Modelling and Projections reviews the HIV estimates model annually to ensure it is based on the latest science and statistical methods, and therefore more accurate estimates of epidemiological indicators, including trends in HIV incidence. In 2017 the Secretariat trained more than 500 country-based individuals on using estimation and projection software to better understand their epidemic. The Secretariat worked with WHO to improve estimates of TB incidence and deaths among people living with HIV and the collection and analysis of country data. Country teams worked with global experts using a model to develop district-level age and sex specific estimates of the HIV burden for 10 high-burden countries.
483. In 2016, the financing gaps in 116 LMICs were measured. This involved updating international and domestic resource availability from 2000–2015, estimating resource needs to identify options for sustainable financing schemes, delineating policy options for countries moving to higher income levels, including HIV services within universal health coverage goals, and/or delineating options within national health insurance. The resource needs update helped the Global Fund define resource mobilization targets for its replenishment exercise. Donor government disbursements for HIV in 2016 and in 2017 were estimated and a joint report launched with the Kaiser Family Foundation under an ongoing collaboration for annual monitoring of the global flows. HIV allocative efficiency studies supported by the World Bank, UNDP and the Secretariat were used to inform Global Fund funding applications in Armenia, Belarus and Georgia, and for transition to domestic funding processes in Bulgaria and the former Yugoslav Republic of Macedonia. Working with the International Federation of the Red Cross, expenditures per unit of community-based service delivery for antiretroviral therapy and testing were collected in Haiti, Lesotho, Malawi and Myanmar. UNAIDS supported the beginning of a process to cost expenditures on services for gay and other men who have sex with men in Argentina, Brazil, Dominican Republic, Ecuador, Guatemala, Paraguay and Peru.
484. WHO reported on the price tag for the health SDGs in 67 countries, according to the typology of their systems, including HIV (consistent with the Fast-Track 2016 updated modelling). The results show a need to significantly increase resources dedicated to health if countries are to reach the SDG goals and end AIDS by 2030.
485. The Secretariat regularly translated country data into policy recommendations, notably through flagship publications such as the *Do no harm* report, the *Prevention gap* report and the *Life cycle* report in 2016, and 2017's *Ending AIDS* report and the *Blind spot* report. These flagship publications are tied to UNAIDS global advocacy and communications, ensuring policy advice is evidence-informed and analyses are strategically focused. Analyses of country epidemic and response data are provided to the UN Secretary-General for his annual reporting to the General Assembly. The Secretariat also prepared economic and epidemiological analyses, including studies on the level and financial cost of homophobia in more than 160 countries, the link between poverty, inequality and HIV, and between human rights violations and vulnerability to HIV infection, and the economic returns of the Fast-Track initiative.

486. *Ending AIDS* shows the resource availability (international and domestic) from 2006 to 2016 by regions and income level groups, as well as comparing against the 2018–2020 resource needs for each region, global level and for low- and middle-income countries, including the total international disbursements from bilaterals, multilaterals and foundations. It demonstrates the impact in the regions where resources are available and highlights regional differences. An analysis on HIV allocations from health and government budgets for the 33 LMIC Fast-Track countries was updated with IMF data. *UNAIDS Data 2017* highlights the latest data on the global HIV response. The Secretariat consolidated part of the huge volume of data it has collected, which has shaped and guided the development of the response to HIV in regions, countries and cities worldwide. Fourteen background publications provided the basis for five policy briefs on shared responsibility for financing the global response, integrating HIV and AIDS funding in universal health care, guiding principles for agreements to smooth the transition to domestic financing, managing the transition, and Kenya’s example of financing AIDS treatment through a health insurance fund.
487. Country data are also made available through the AIDSinfo online resource.²⁰ With some 30 000 users per month in 2017, it was updated during the funding period to include more subnational data and treatment cascades. In early 2017, the Key Populations Atlas was established and made accessible to the public via AIDSinfo. The atlas includes size estimates, prevalence, programmatic indicators and stigma and discrimination-related indicators about key populations.
488. Ad hoc reports and analyses on resource availability, donor dependency and resource needs were undertaken to Fast-Track the response, make policy recommendations for cost-effective strategies and allocation of resources to places and populations where they will make the most impact. Some examples of efforts and products include:
- a Secretariat triangulation exercise to ascertain if procuring generic medicines could support estimates of people on ART concluded that for most countries where generics are accessible (sub-Saharan Africa, for example), the volume of purchased generic ARVs is consistent with the reported number of people on treatment in the same number of countries. UNAIDS/WHO presented triangulation of people on ART and ARV procurements at a meeting with pharmaceutical companies;
 - an analysis of resource availability and future needs for prevention services in sub-Saharan Africa, low- and middle-income and Lusophone countries was produced. An annual report on investments for HIV prevention research and development was published in July 2017;
 - estimates of the global and regional distribution of incidence by mode of transmission were produced, providing important data for advocacy to ensure key populations get the prevention, care and treatment they require;
 - health financing data was produced for various purposes, including the Prime Minister of Denmark’s town hall address on the country’s contributions to the HIV response in low- and middle-income countries;
 - an update on resource flows for HIV were presented at the G20 meeting;
 - a detailed global database of HIV estimates was developed and shared with Cosponsors and UNAIDS regional advisers to ensure consistency and ease of access.
489. During the biennium the Secretariat played a leading role in advocating for a shift in strategic information systems to rely more on sustainable and routine data. This

included greater use of routinely collected programme data for surveillance, resource tracking and the establishment of situation rooms that frequently collect real-time data from subnational level and guide responses using a location-population approach focusing human and financial resources where they are most needed. The Secretariat supported Kenya to launch the situation room platform in 2016, enabling tracking of HIV and broader programme coverage and gaps at subnational and district levels. In 2017, Côte d'Ivoire, Lesotho, Mozambique, Namibia, Uganda, Zambia and Zimbabwe joined the initiative, with launches scheduled for 2018. A mobile application enables users to view and analyse programme and procurement data in real time and communicate quickly on programmatic action. Data can be published on dashboards on websites, increasing public accountability, promoting use and improving personnel analytical skills.

490. The Secretariat continued to participate in the working group on resource tracking for prevention research led by AVAC, and in the Global Health Cost Consortium, on country-focused guidelines and a database that helps countries produce unit costs of the HIV response and future global resource needs estimates. Emphasis was on resource tracking, innovative methods to estimate costs and facility consumption of resources to triangulate existing estimates with non-traditional information sources.
491. An online version of the AIDS spending module was rolled out to facilitate data collection and management of indicator 8.1, which measures progress against the HLM commitment 8 adopted in the 2016 Political Declaration, to “ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers”. Overall, 54 countries reported. A supplement on GAM post-2015 was published in the journal *AIDS and Behavior*. GAM was also used to update the domestic public spending on HIV database to adjust for non-reporting country/years. GAM includes the option to report the expenditure of commodities for each specific service separately from the service delivery and other components.
492. Through an agreement with the Centers for Disease Control and Prevention, UNAIDS country offices in eight countries supported the development of more granular HIV estimates and improvements to their monitoring systems for prevention and treatment targets. The Secretariat raised funds from multiple donors to support this work.

Future actions

493. In the area of strategic information future actions include:
 - Continue supporting Fast-Track countries to strengthen their health information and other systems, and collect the sub-national data needed for a location-population approach.
 - Work with WHO, PEPFAR, the Global Fund and partners to support countries smoothly transition to using routine data for HIV surveillance.
 - Develop summary impact measures that signal whether countries are moving towards ending AIDS as a public health threat by 2030.
 - Update the National AIDS Spending Assessments (NASA) framework, methods and tools to support low- and middle-income countries conduct assessments and use them in other economic analyses.
 - Promote existing information systems to estimate real-time facility-based expenditure tracking.
 - Develop and launch Global Report demonstrating how to invest for greater impact as well as build on data collected from the Gap Report.

- Develop reports on sustainability plans building from the Dependency crisis report.
- Support 10 countries²¹ identify programmatic gaps at district level through improved granularity, accuracy and speed of estimates of HIV epidemiology through geospatial models (reported biannually).
- Provide support to situation rooms running in 7 countries²² through gap analysis and advanced cloud-based tools.
- Develop and implement effective strategies to achieve sustainable AIDS responses in a least 20+ countries.²³

S4: Coordination, convening and country implementation

Achievements

494. Together with Cosponsors and other partners, the Secretariat facilitates and coordinates support to countries, sub-national locations and cities, to ensure progress towards the achievement of Fast-Track targets. The Secretariat brokers, strengthens and leverages synergy and accountability between technical support mechanisms and providers of essential HIV services. Examples of Secretariat support to countries in 2017 included:
- Technical support and guidance to implement Fast-Track in cities, outlining required actions to accelerate the HIV response.
 - Catalytic funding was provided to Botswana, Namibia, Nigeria, Uganda, Zambia and Zimbabwe to strengthen national prevention targets setting.
 - Capacity-building workshops were organized in East and Southern Africa and the Asia-Pacific regions, with joint interagency missions undertaken to gather information on systems and capacities for implementation.
 - Missions in Lesotho, Mozambique, Uganda and Zambia engaged key country stakeholders on national prevention strategy, management architecture, capacity and implementation, identifying key issues/gaps and making recommendations;
 - Guidance and support was provided in a meeting of the Bill & Melinda Gates Foundation and USAID condom landscaping study.
 - Assistance was provided to the condom need and gap analysis in Kenya, which informed the Global Fund concept note and supported training on Fast-Tracking combination prevention in the western and central Africa region.
 - The Secretariat participated in the International Advisory Group for the HPTN 071 PopART study on the impact of community provision of combination HIV prevention intervention in Zambia and South Africa.
 - A mapping of men's and boy's HIV policies and programmes in eastern and southern Africa region was conducted to discuss a way forward for the new voluntary medical male circumcision framework.
 - The Secretariat was selected for the Executive Committee of the Equal Rights Coalition that includes 35 Member States, civil society organizations and multilateral organizations.
 - Worked towards revitalization of the UNAIDS-European Union collaboration and organized a "EU day" in June with civil society organizations, ECDC, Members states on EU priorities on HIV and the expectations towards UNAIDS and the UN support;

- For the country launch of the Global HIV Prevention Coalition and Prevention 2020 Road Map, the Secretariat continued to convene the Focal Points task force. Comprising Cosponsors, civil society organizations, the Global Fund, PEPFAR and the Gates Foundation, it established five multipartner working groups and produced a prevention scorecard – a rapid assessment tool to gather information on systems and capacities – to measure and track progress in priority Fast-Track countries, including on indicators for the five prevention pillars. It will be updated annually.
495. The Secretariat's contribution to the Commission on the Status of Women (CSW) Res 60/2 resulted in 15 Southern Africa Development Community (SADC) countries developing plans of action that were aligned to the 2016 Political Declaration on Ending AIDS targets. These plans included expansion of multi sectoral engagement around HIV and enhancing focus on structural drivers of the HIV epidemic among women and girls, among other issues. Technical and financial support was provided in close collaboration with UNESCO, UN Women, UNICEF and UNFPA. Further enhancing the integration of HIV in the broader SDG agenda, with a focus on gender equality, the Secretariat also contributed to the expert paper on SDG 5 and the recommendations informing the High Level Political Forum (HLPF) 2017.
 496. The Secretariat, with UN Women, UNDP and UNFPA convened a group of civil society partners to develop #TeamWomen, an initiative to promote civil society-led accountability for commitments made to women and girls in the HIV response. The Secretariat, UN Women, UNDP and UNFPA is engaging with the #TeamWomen initiative to promote accountability towards the targets of the 2016 Political Declaration on Ending AIDS that emphasize gender equality and women's empowerment. Finalizing #TeamWomen actions and expanding to include regions and countries.
 497. The Violence Against Women and HIV Everywhere (ALIV[H]E) Framework, was launched in 2017. The Framework was developed with Salamander Trust, HEARD, Athena network, AIDS Legal Network and Project Empower. Six webinars were conducted on violence against women, HIV programming, service integration and the meaningful engagement of women in their diversity - including transgender women, sex workers and women and girls who are disabled.
 498. The ALIV[H]E framework is the result of two years of evidence informed community interventions, with systematic engagement between researchers, NGOs and UNAIDS in six pilot countries. A global reference group of women living with HIV and a technical review group have also been convened. The Framework is now being used in five countries in the Middle East and North Africa, with the AIDS Alliance and MENAROSA and by the Medical Research Council in South Africa and the Organization of Disabled in Botswana. The ALIVHE Framework was also presented as part of a UNAIDS moderated panel, during the a PEPFAR/USAID and SOAR meeting on "Gender-based Violence as a Barrier to Women's Use of HIV Services".
 499. The Secretariat continues to co-ordinate the work of the Inter-Agency Task Team on Social Protection, including identifying countries for common actions and focusing on strengthening programming on HIV sensitive social protection in regions. The Secretariat continues to collaborate with HIV and non-HIV actors. In coordination with cosponsors and other partners, the Secretariat developed and rolled out the HIV and social protection assessment tool to support countries to link HIV with actions for ending poverty and inequality. HIV and social protection assessments were undertaken in Liberia and Sierra Leone.
 500. The Secretariat, in collaboration with PEPFAR as cosponsors of the *Start Free Stay Free AIDS Free* Framework, coordinated global collaboration around the goals of

accelerating prevention of mother-to-child HIV transmission, paediatric and adolescent treatment, and prevention of new infections in adolescents and young women:

- UNAIDS and PEPFAR convened, under the auspices of the Holy See and Vatican and with the support of WHO and Elizabeth Glaser Paediatric AIDS Foundation, a meeting in November 2017 bringing together pharmaceutical companies, global leaders and implementers, the faith community and civil society to develop an Action Plan to improve development of paediatric drug formulations.
- Two Ministerial meetings were convened in December 2016 and May 2017 to secure the commitment and monitor progress of implementation by countries towards the *Start Free Stay Free AIDS Free* targets adopted in the 2016 Political Declaration on Ending AIDS.
- Secretariat worked closely with the Organization of First Ladies of Africa Against AIDS (OAFLA) and the African Union on the launch of the Free to Shine continental campaign to eliminate mother-to-child HIV transmission and ensure access to treatment for children and adolescents.
- The *Start Free Stay Free AIDS Free* 2017 Progress Report was prepared jointly with PEPFAR, noting the progress made in 2016 towards the targets set in the 2016 Political Declaration on Ending AIDS and promising strategies to accelerate progress.
- In collaboration with UNICEF, the Secretariat co-convened a satellite session at the 2017 ICASA conference, The western and central Africa Catch Up Plan: Reaching the Children, bringing together political leadership, partners from government, implementing organizations, communities and civil society to address the slow progress on EMTCT and paediatric treatment in the western and central Africa region.

501. The Secretariat continued to play an active role in the Global Validation Advisory Committee convened by WHO, supporting data analysis and country assessment of community engagement and respect for human rights.
502. The Secretariat, through a USAID grant via the Office of the U.S. Global AIDS Coordinator, supported more than half of the 2017–2019 cycle of the Global Fund country applications, and facilitated access to approximately US\$ 2.5 billion in grants to accelerate the HIV and TB response. The Global Fund's Technical Review Panel noted that UNAIDS-supported funding requests from the Democratic Republic of Congo, Ethiopia, Rwanda, United Republic of Tanzania and Zambia were strategic and focused on the most affected populations and programme gaps due to alignment with their HIV/TB national strategic plans. Secretariat support resulted in:
- 14 new national strategic plans and refined investment cases to reach prevention and treatment targets shaping 2017 country applications;
 - 17 countries developing funding applications, and 27 principal recipients and subrecipients strengthening capacities for operational and financial management of Global Fund grants;
 - 52 countries implementing investment frameworks, many developing stand-alone investment cases or using frameworks to inform their national strategic plans.
503. UNAIDS, in partnership with the World Bank, the United States Government and other key partners, has led this vital country support. The Global Fund and PEPFAR revised their approach to funding programmes by aligning their methodology with investment principles

Future actions

504. Examples of future actions include:

- Develop a virtual-team approach to support countries with Fast-Track, enabling efficient and strategic technical support, maximizing Secretariat resources.
- Work with key partners to support accelerated eMTCT and paediatric treatment programmes, including a focus on programmes in western and central Africa.
- Finalize #TeamWomen actions and expand to regions and countries. Review and refine the role and membership of the Global Coalition on Women and AIDS, and clarify joint actions.
- Continue to work with UN Women to engage with gender ministries, harnessing work on the Commission on the Status of Women Resolution aligned to the 2016 Political Declaration on Ending AIDS. Roll out the implementation framework on addressing violence against women and HIV, ALIV[H]E, linking it to the Secretary-General's Spotlight gender initiative where relevant
- Convene stakeholders to develop a strategic framework for adolescent girls and implement interventions to end gender-based violence & discrimination in support of 10 eastern and southern African countries.²⁴
- Strengthen networks to support HIV/TB integration. Stage a UN General Assembly High-Level Meeting side-event and support the campaign for a strong High-Level Meeting TB Declaration.
- Finalize a revised HIV gender assessment tool and provide technical support for its implementation. Promote the agenda for integrating services for SRHR, gender-based violence, human papillomavirus, cervical cancer and female genital schistosomiasis, particularly by supporting civil society to create demand for integrated services to address the myriad challenges facing women and girls. Leverage UNAIDS' role in the Pink Ribbon-Red Ribbon partnership to combat cervical and breast cancer, an example of the response as a force for women's health.

S5: Governance and mutual accountability

Achievements

505. During the 2016–2017 biennium, the Secretariat worked to support the Joint Programme to ensure a results-based focus and strengthen alignment of human and financial resources with corporate priorities as determined by the UNAIDS 2016–2021 Strategy, the 2016 Political Declaration and UN reform. The recommendations of the Global Review Panel, conducted in early 2017 to advise on refining and reinforcing the UNAIDS Joint Programme operating model, and the Action Plan developed to implement these recommendations informed this effort.
506. Furthermore, ECOSOC recognized the Joint Programme as a model for UN reform in Resolution E/2017/L.27 where it stressed “the need for the Joint Programme to continue to set the path for reform by revising and updating its operating model, in particular in the areas of joint work, financing and accountability, and governance, as considered by the PCB [...] at its 40th meeting [...]”. This is a testament to the efforts led by the Secretariat to ensure that a resolution tabled and negotiated in Geneva is then successful brought to and adopted in New York.

The Global Review Panel and the Action Plan

507. The Global Review Panel validated the added value and fundamental elements of the unique Joint Programme; reinforced its multisectoral approach and central role within the global health architecture, including as a critical partner to the Global Fund and PEPFAR; and further emphasized that the Joint Programme embodies the key approaches required by Agenda 2030 and represents a model 20 years ahead of its time. The Panel identified specific, actionable recommendations on financing and accountability, joint working and governance, that were taken on board in the Action Plan to refine the UNAIDS Joint Programme operating model.
508. The Action Plan translated the key Global Review Panel recommendations into specific results areas towards achieving three overarching objectives: (i) to deploy human and financial resources where they are needed most; (ii) reinvigorate country-level joint work and collaborative action; and (iii) reinforce accountability and results for people.
509. The Action Plan prioritized strategic, coherent approaches, tailored to country context and led by diverse Joint UN Teams on AIDS that bring added value, capacity and skill sets required to address specific country needs, as called for in the 2030 Agenda and the 2016 Quadrennial Comprehensive Policy Review (QCPR), enabling and encouraging the Joint Programme to deliver integrated and impactful contributions informed by country priorities, targets, capacity and resources.
510. The Action Plan on refining the UNAIDS Joint Programme operating model was endorsed by the UNAIDS PCB in June 2017. Following the PCB approval of the Action Plan, the Secretariat has been facilitating a transparent and inclusive transition to the new business model.

Implementing the recommendations of the Global Review Panel and Action Plan

511. Responding to the Action Plan, the Secretariat and Cosponsors at global, regional and country levels rolled out an integrated approach that was designed to build on and further advance the existing Joint Programme mechanisms and practices; it brought together on a single (online) platform the Joint UN Plan, the country capacity assessment, and the country envelope. The country capacity assessment was designed to inform the priorities and the optimized use of human and financial resources under the Joint UN Plan.
512. The Joint UN Plan template was updated, to support Joint UN Teams on AIDS in directing consolidated effort and resources towards achievement of prioritized country targets. The country envelope (allocation of core UBRAF resource to Cosponsors at country level) was integrated in the joint UN planning process as the means to close the UN capacity gaps and enable the Joint UN Team to deliver impactful contribution at country level. The Joint UN Plan was positioned as the platform for access to country envelope funds. The integrated processes were planned so that to enhance collaboration and capitalize on existing country level partnerships, thus strengthening transparency and enhancing accountability.
513. To date, 97 Joint UN Teams on AIDS undertook country capacity assessments and worked on joint plans; in 71 eligible countries, Joint UN Teams on AIDS and partners finalized the allocation of the country envelope portion of the core UBRAF funds. The country-level Cosponsor allocations of US\$ 22 million (country envelope funds) for 2018 were disbursed to Joint Teams and are being utilized as planned.
514. Implementation of the Action Plan, with its strong focus on country-level work, integrated and impactful effort, results for people and accountability, positions the Joint

Programme as pathfinder amid broader reform of the UN development system. Actions put in place to date are reinvigorating and consolidating the Joint Programme effort at country, regional and global level around 2016 Political Declaration commitments and prioritized country targets. It is allowing strategic and transparent planning of joint UN action around bottlenecks, game changers and UN comparative advantage. It is contributing to enhancing cohesion in the UN country-level, regional and headquarter teams' engagement for effective country support and sustainable results for people.

Successful resource mobilisation efforts

515. Extensive efforts were made by UNAIDS to address resource constraints and to secure funds for UBRAF. Through these intensified efforts, UNAIDS leadership successfully sustained core UBRAF funding in an economically and politically challenging environment, engaging with more than 40 donors. US\$ 180 million was raised in 2016 and US\$ 175 million in 2017. In 2017, Germany doubled its annual contribution to € 5 million per year, committing the same for 2018. Ghana also announced it was doubling its contributions to US\$ 200 000. Additional contributions were received from Côte D'Ivoire, the US and Sweden.
516. Joint Programme staff visited Australia, Canada, France, Germany, Ireland, Japan, the Netherlands, Sweden, US and other countries to raise funds. Visits with civil society, parliamentarians, universities and government officials additionally took place in Belgium, Flanders, Luxemburg, UK, and the EU to sustain or increase funding and to identify entry points for new funding. Nordic working group meetings with civil society organizations, governments and other international organizations reinforced focus on HIV policies by governments in Nordic countries. Synergies between Canada and UNAIDS were also outlined for further discussions on partnership.
517. A resource mobilization recovery task force and a working group was also established, with a recovery plan developed to guide strategic work with donors. A reference guide, donor roadmap and targeted brochures around resource mobilization were developed for country staff. To expand funding from foundations and private sector, guidance on setting up new national committees, together with a digital fundraising strategy for online contributions, were established.
518. The PCB further confirmed its confidence in UNAIDS and its leadership by adopting the 2018–2019 UBRAF budget, which provides a stronger strategic focus and new resource mobilization strategy.

Effective coordination of governance processes and platforms

519. Coordination of governance processes and platforms was enforced by the Secretariat in 2016–2017, in order to strengthen political engagement, support implementation of the UNAIDS Strategy, 2016 Political Declaration on Ending AIDS and SDGs and ensure UNAIDS is fit for purpose. This work included:
 - Conducting a thematic segment on HIV prevention in the PCB, paving the way for the launch of the prevention coalition and commitments of the Cosponsor Heads of Agency. Other thematic segments that have been organized on issues of strategic importance for the HIV response included:
 - In close collaboration with Brazil and Belarus, the Secretariat together with OHCHR co-hosted a Social Forum of the Human Rights Council for its segment on HIV. The Social Forum provides a space for open and constructive dialogue between member States, civil society, intergovernmental organizations and other stakeholders on issues linked to promoting a national and international environment for the enjoyment of all human rights by all;

- Steering orientation sessions for new PCB members, PCB briefings for missions and field visits to China (2016) and Swaziland (2017) to familiarize board members with the work of the Joint Team with partners in fast track countries. PCB field visits provide participants an opportunity to engage with all country stakeholders in various epidemiological settings and allows them to witness the work undertaken by the UNAIDS family together with national and international partners in a given country. The delegates subsequently take these experiences into the discussions at Board meetings. The delegation is representative of the Board and includes member states, civil society and Cosponsors;
- Organizing meetings of the Committee of Cosponsor Organizations and Global Coordinators for critical discussions on difficult issues, including financial constraints;
- Ensuring that members of the NGO delegation are always included in UNAIDS processes and events;
- Strengthening the relationships with a broad range of key stakeholders, particularly African Ministers of Health;
- Effective engagement in the HLPF through statements, panel engagement and side-events on UN reform, linkages to global health and H6; and
- The Secretariat was increasingly engaged with UN reform negotiations and positioning and linking to opportunities from H6 chairmanship.

Strengthened accountability

520. An integral component of the accountability mechanism of the 2016–2021 UBRAF—a joint annual review (Peer Review) of the first year of UBRAF implementation by Cosponsors and the Secretariat—took place in April 2017. The review presented a key opportunity to discuss achievements, challenges, lessons learned and areas where progress is not yet achieved as expected. For the first time, external stakeholders participated in this review. The Peer Review also fed into 2018–2019 Budget development discussions with Cosponsors, strengthening accountability and transparency.
521. In 2016, the Secretariat achieved the target of becoming International Aid Transparency Initiative compliant and Secretariat data is published online. All reporting materials were made available on the Investing for Results web portal. A financial overview, funding levels and trends reflecting the expenditure and UBRAF indicators data was also presented
522. Enhancement of the Internal Control Framework is an integral part of efforts initiated to strengthen risk management and accountability at the Secretariat. New features of the JIU web-based tracking system and related online reporting were adopted, a risk guide and related training materials, quality assurance of reporting data, internal control and management accountability frameworks were developed.

Evaluation

523. Based on UNAIDS evaluation policy, annual evaluation plans for 2016 and 2017 were prepared and shared with the PCB. Evaluation guidance to complement the existing evaluation policy for human rights and gender responsive evaluation within UNAIDS has been developed. The following evaluations have been implemented as per the 2016 and 2017 evaluation plans:
- The independent joint evaluation of the UNAIDS-Global Fund partnership was finalized and presented during the 40th PCB (http://www.unaids.org/en/resources/documents/2017/PCB40_CRP3) and

recommendations adopted (please refer to cover letter to the Evaluation as presented to the 40th PCB in June 2017). Findings from the evaluation are informing ongoing discussions on a revised Cooperation Agreement, designed as a vehicle to guide the partnership between the two institutions. The Agreement will help consolidate further the current partnership and build accountability mechanisms.

- The final report for the evaluation of the effectiveness, efficiency, relevance and sustainability of the UNAIDS programme in eastern and southern Africa region (Independent Evaluation of UNAIDS Regional Programme: “Expanded Accelerated AIDS Response towards HLM Targets and Elimination Commitments in Eastern and Southern Africa Region, 2013–2017”), supported by SIDA, was finalized and validated by the multi stakeholder steering committee. The management response by the Regional Support Team is being implemented.
- The PEPFAR/UNAIDS Independent Evaluation, Strengthening Faith Community Partnerships for Fast-Track, has been finalized and validated by the joint Steering Committee. Findings from the evaluation informed the development of the second phase of the project. The management response is under implementation.
- The mid-term 2016 review of the Technical Support Facilities for eastern and southern Africa, western and central Africa, and Asia-Pacific was finalized and the report is available. Distinct management responses were developed by Technical Support Facility in each region as part of the extension of their working agreements with UNAIDS. Evaluation recommendations allowed the revision of working agreements.
- The Evaluation of UNAIDS programme in eastern Europe and central Asia has been finalized and the report is available. The Regional Cooperation Programme involving Armenia, Kyrgyzstan, Tajikistan and Uzbekistan is aimed at strengthening the systems of response to the HIV epidemic in those countries, developing national HIV response programmes, as well as technical assistance in reinforcing the systems of HIV surveillance, prevention and treatment. Recommendations were adopted by UNAIDS and implementing partners in relevant countries.

Challenges

524. In 2016–2017 the UNAIDS Secretariat intensified dialogue with governments and other stakeholders and strengthened its partnership with key donors and partners. The Secretariat made extensive efforts in 2016–2017 to secure the necessary resources to continue delivery of Joint Programme’s shared mission, vision, and strategy at a time of considerable financial constraints and pressures on the budget. UNAIDS has undertaken a series of initiatives to grow and diversify funding from additional sources such as emerging governmental donors, corporate giving, foundations and individuals. Some new relationships were established however a wider development of funding relationships with foundations, corporations and individuals is still at an early stage.
525. There is need for an ongoing realignment exercise to ensure UNAIDS remains fit for purpose, demonstrates effectiveness and efficiency for optimal implementation of UNAIDS strategy, the HLM Declaration, SDGs and Fast-Track targets.
526. Vigilance is needed to sustain an organization-wide culture for cost consciousness, results-based budgeting and risk management, and accountability for results.

Future actions

527. The 2016 Political Declaration, 2016–2021 Strategy, UBRAF and Action Plan will guide efforts to strengthen governance accountability further. The implementation of the

revised business model will continue to require changes and adjustments to the way the Joint Programme works, focusing on a country-focused, bottom-up process. This requires a shift to an approach driven by Fast-Track targets and commitments and will have programmatic and operational implications. The commitments in the Action Plan will continue to be operationalized through an integrated approach which is the vehicle to deliver the new financial allocation model.

528. The Joint Programme Strategic Resource Mobilization Plan 2018–2021, which was endorsed in December 2017 at the 41st PCB, will be a key pillar in implementing the revised operating model, and guide efforts to mobilize US\$ 242 million and fully fund the UBRAF in 2018.
529. The Secretariat embraces the UN reform process by promoting the vision of the Secretary-General in a number of areas. The refined Joint Programme operating model, with more efficient human and financial resources deployment for greater impact under the UNRC leadership is the clearest example of this. The empowerment and deployment multi-skilled staff, who can deliver across the SDGs and champion the UN reform as another example. Yet another example is innovative and inclusive governance, facilitating cross-board coordination, more meaningful engagement of the non-state actors and participation of private sector and foundations. UNAIDS is also working with its H6 partners to show that global health is a driving force for change across the SDGs.

REGIONS

Regional summary report for Asia–Pacific

UNRITA is a mechanism for making decisions and recommendations to ensure harmonized UN support for country level AIDS responses to implement UNAIDS strategy, UBRAF, and Fast-Track targets. The members of United Nations Regional Interagency Team on AIDS (UNRITA) are UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO, The World Bank. The key functions are to:

- Coordinate efforts among the UNAIDS Cosponsors, UN Women, ESCAP, OHCHR and the UNAIDS in support of country responses and in line with the DOL and guided by the UNAIDS strategic directions, the HLM commitments and UBRAF targets.
- Enhance joint efforts and alignment in setting regional priorities and provision of technical support to countries, including sharing of TOR for the joint organization of country missions, and joint country reporting;
- Discuss and propose solutions for programmatic and strategic issues that are common to a number of agencies, have cross-border or inter-country aspects; and/or are sensitive or difficult where regional approaches are more effective to add value to country level efforts.
- Promote human rights-based approaches and gender equality to the HIV response.

The UNRITA meeting take place once a month or some once in every two months. Members participate in a flexible range of ways including teleconference, e mail and skype. The UNAIDS RST serves as the Secretariat for the UNRITA providing support for the preparation, logistics and reporting on the meetings. Priorities and focus areas, along with a join annual work plan is developed guided by the UBRAF, and HLM targets. UNAIDS also established an extended Regional Partnership Forum composed of UNRITA members, representative of donors, civil society organizations, NGOs. The Forum meets twice a year to discuss pros and cons of implementation of agreed regional priorities.

Achievements

Treatment

530. A national HIV, hepatitis and STI programme managers meeting in WHO's Western Pacific region in June 2017 reviewed progress on global goals. Recommendations informed the regional operational plan for 2018–2019. Similarly, a meeting earlier in 2017 led to an action plan to guide provision of WHO and UNAIDS technical support for ending AIDS as a public health threat in south-east Asia. The action plan was launched on World AIDS Day 2017.
531. Technical support to adapt new WHO HIV treatment guidelines to national circumstances was provided in China, Cambodia, Lao People's Democratic Republic, Malaysia, Papua New Guinea and Viet Nam. The Philippines is at the last stage of adapting the guidance. A regional review in response to declining external funding for HIV programmes was carried out, and a country fact sheet on HIV financing status 2009–2015 published.
532. China, Myanmar, Papua New Guinea, the Philippines and Viet Nam received technical and financial support from WHO and the Regional Support Team to assess case-based and patient monitoring systems. Systems improvements have been made to better monitor HIV and sexually transmitted infections responses. Eight countries also received support to validate data and develop the HIV treatment cascade to monitor progress towards the SDGs, which was shared on public websites and in a data visualization programme. Support to develop HIV drug resistance surveillance protocol was provided to China and Papua New Guinea.

Elimination of mother-to-child transmission

533. Joint work with WHO's maternal and child health and immunization units and other partners resulted in the Regional Framework for Triple Elimination of Mother-to-Child Transmission of HIV, Hepatitis B and Syphilis in Asia and the Pacific 2018–2030, which was endorsed by member states in October 2017. The framework sets the norm and momentum for an integrated and coordinated approach to eliminating mother-to-child transmission of the three diseases. Dedicated support to help countries validate eMTCT was provided. Malaysia, in particular, was supported by WHO, UNAIDS and UNICEF in preparing the national elimination report for the elimination of mother-to-child transmission of HIV and syphilis, including a pre-validation review and internal validation of data.
534. Following a national consultation in China in September 2016, UNICEF, WHO and UNAIDS supported the launch in September 2017 of a demonstration programme on validating elimination of HIV, syphilis and hepatitis B. UNICEF, UNAIDS and WHO, in partnership with the International Training Center, Thailand's Ministry of Public Health and the Centers for Disease Control and Prevention, organized a South-South learning and exchange workshop on the country's validation of eMTCT. This helped in building the commitment, and capacity, of the governments of China and Myanmar. A global webinar on the experience and lessons from Thailand was organized in March 2017.

Key populations

535. UNFPA and APMGlobal Health developed a web-based curriculum, The Connect Effect, (connect-effect.com). The site helps national health programmes and communities to better meet the integrated HIV and SRHR needs of key populations, especially their SRH, choice about pregnancy, safety from violence, financial security and overall well-being. The curriculum was rolled out in Bangladesh, China, Mongolia, Myanmar, Papua New Guinea, Philippines and Viet Nam among key populations, policy-makers, health planners and service providers, and community organizations.
536. To address the rising HIV epidemic in the Philippines, a demonstration project for pre-exposure prophylaxis (PrEP) for men who have sex with men and transgender women was initiated by the WHO regional office with support from their country office. By the end of 2017, 250 people had enrolled.

HIV prevention among young people

537. The Inter-Agency Task Team on Young Key Populations, which includes UNFPA, UNICEF, UNESCO and the UNAIDS Secretariat, helped provide leadership and life skills on HIV, SRH, laws and policy to improve young people's access to HIV and other health services. UNFPA, UNICEF and UNAIDS supported the launch of TeenGen, a leadership training workshop for adolescents from key populations. The IATT has also supported Youth Voices Count in a study on PrEP preparedness among adolescent men who have sex with men and transgender people.
538. UNFPA, UNESCO, UNICEF and UN Women held a regional technical consultation to push the agenda on comprehensive sexuality education in the region. UNFPA and UNESCO backed the development of a legal advocacy toolkit to help youth-led organizations understand legal and policy barriers in accessing SRHR services and advocate for their removal. The NGO Youth LEAD held country initiatives on the toolkit in Myanmar and the Philippines with support from UNAIDS, UNICEF and UNFPA.

Human rights, stigma and discrimination

539. Together with USAID, UNAIDS and partners, UNDP convened a regional consultation on HIV-related stigma and discrimination in health-care settings. The consultation, in

May 2017, provided a platform for representatives from 12 countries to achieve tangible objectives, with technical assistance from partners. It led to country action plans for implementation in 2017–2018. UNDP provided support to review and draft transgender inclusion laws in Pakistan, Thailand and Viet Nam, the adoption of the HIV law in India, and to parliamentary review processes in Nepal, Cook Islands and Palau.

540. In partnership with the Asia Pacific Transgender Network, UNDP completed an assessment of laws, regulations and policies on legal gender recognition of transgender people in nine countries in Asia (Bangladesh, China, India, Indonesia, Malaysia, Nepal, Pakistan, Philippines and Thailand). The study informed policy debate in China, Hong Kong Special Administrative Region, India, Nepal, Thailand and Viet Nam. In October 2017, a multicountry round table brought together policy-makers, transgender activists and technical experts to discuss the status, opportunities and obstacles in advancing legal gender recognition. UNDP facilitated South-South learning exchanges between Viet Nam and Thailand to encourage sharing of good practices in legal gender recognition.
541. Over the two years, UNDP and the Asia Pacific Forum of National Human Rights Institutions trained national human rights Institutions, national human rights experts and LGBTI civil society representatives from 16 countries in south Asia, south-east Asia and the Pacific to increase their capacity to promote and protect the rights of key populations. In 2017, UNDP and APF developed a manual and blended learning training (combines online digital media with traditional classroom methods) for national human rights institutions on protecting the rights of sexual and gender minorities. From 2015 to 2016, UNDP, through the Being LGBTI in Asia Programme, engaged in policy dialogue with 130 government departments, 357 civil society groups, 17 national human rights institutions and 88 private sector organizations across 33 countries, contributing to better awareness and knowledge of LGBTI inclusion issues, increased political will and support, and progress towards more protective legal and policy environments for key populations. This was achieved through South-South engagement and providing technical support to regional and national partners.
542. Through UNDP support, The Time Has Come training package, developed with WHO to reduce stigma and discrimination against LGBTI people in health-care settings, was adopted in national HIV training programmes in Bhutan, India, Indonesia, Nepal, Philippines and Timor-Leste. UNDP backed trainings of trainers in 12 countries, reaching 400 health-care providers in 2016, and almost 1500 since 2014. Training roll-out was supported through the Multi-Country South Asia Global Fund HIV Programme and the ISEAN-Hivos Multi-Country HIV Programme. UN Women supported the International Community of Women Living with HIV on strategic plan development during a workshop in Bangkok in November 2017. The workshop focused on strengthening gender advocacy in the HIV response for women living with HIV in the Asia and Pacific region.

Gender inequality and gender-based violence

543. To support national and local planning to implement the SDGs, UN-Women, UNDP, the UNAIDS Secretariat and other partners supported engagement of women living with HIV. Unzip the Lips and the International Community of Women Living with HIV (ICW)-Asia/Pacific, with support from UN-Women, UNDP, the UNAIDS Secretariat and other partners, launched and disseminated the video and [Unzipping Agenda 2030 for Key Affected Women and Girls in the HIV Epidemic in Asia and the Pacific](#), identifying the opportunities for monitoring and tracking of the progress towards SDGs for women and girls in the context of HIV.

544. UN Women, UNFPA, UNDP and the UNAIDS Secretariat launched a regional [*Policy and Programme Guidance: HIV and gender-based violence Preventing and responding to linked epidemics in Asia and the Pacific*](#). UN Women developed a regional Guidance on Gender Responsive Budgeting for the HIV response in Asia and the Pacific to offer top management, national planners, and civil society organizations a resource on how to integrate gender equality into HIV policy and planning.
545. Building on UNDP research, and collaborating with networks of women and people living with HIV, UNDP and UNAIDS supported civil society initiatives in Cambodia and Nepal to protect the rights of women and people affected by HIV in health-care settings.
546. The UN Refugee Agency UNHCR worked with UNFPA and the Women's Refugee Commission and NGO partners to address sexual and gender-based violence, including child marriage and spousal rape, faced by Rohingya-speaking female refugees in Malaysia, India and Indonesia. Throughout the region, activities have been conducted to prevent sexual and gender-based violence, notably by engaging all actors to end violence against women and strengthening community-based protection.

Investment and efficiency

547. UNDP supported countries to build capacity, strengthen legal and policy environments and undertake assessments to improve access to affordable medicines, as well as helping with regional collaboration and experience sharing. In Thailand, for example, this was achieved through a South-South collaboration report on the lessons drawn from achieving universal ART access under the Universal Health Coverage system; in Indonesia, via capacity building of government officials to address access to affordable medicines in the context of Universal Health Coverage and financial sustainability, and the use of medicine price comparison methodology as a tool for decision-making; in Bhutan, through support for a review of intellectual property law and international negotiations; and in Cambodia, with a study to assess the gaps, threats and opportunities related to intellectual property rights, trade and access to medicines.
548. An ASEAN-wide regional consultation, organized by UNDP with the Malaysia Competition Commission, helped build the capacity of government officials, including competition authorities and ministries of health, on using competition law to promote access to health technologies. An issue brief was also developed.

Health-system strengthening and service integration

549. Through the Global Fund-supported Multi-Country Western Pacific Programme, UNDP helped to strengthen national HIV and TB programmes in 11 Pacific countries. It provides technical assistance, lab support, and medicines and diagnostic procurement and supply management. It also builds capacity of civil society and strengthens community engagement in health programmes. As a result, 63% of TB patients have been tested for HIV, 83% of pregnant women know their HIV status, 87% of pregnant women have been tested for syphilis, and 100% bed-net coverage has been reached in Vanuatu contributing to malaria elimination, with one province declared malaria free in 2017.
550. To improve access to social protection for people living with and affected by HIV, UNDP and the Government of Myanmar conducted a nationwide study on the socioeconomic impact of HIV at household level. In Cambodia, UNDP provided support to develop survey instruments for identifying HIV-affected poor households in urban areas to increase access to social protection. UNDP also supported the

Philippines and Viet Nam to review aspects of their health procurement and supply management systems, providing training for the Philippines Department of Health.

551. In 2017, the World Bank continued to finance major health-system strengthening projects with HIV components, particularly in India, where the Bank provides funding for prevention. Support for programmes on multisectoral determinants of health in education, transport, gender and HIV-sensitive social protection in the region led to institutional development and capacity building for the response and increased access to health and social protection services for people living with HIV and those most at risk.

Humanitarian emergencies

552. UN Women, together with APCOM, an advocacy coalition for men who have sex with men and transgender people, the International Planned Parenthood Federation and Edge Effect, which encourages organizations to work with sexual and gender minorities, organized a session on ending violence and discrimination LGBTI people in humanitarian settings at ILGA Asia 2017. The session looked at barriers to accessing services, including SRH/HIV, and ending stigma and discrimination, which makes people more vulnerable in disaster and crisis contexts.
553. UNHCR ensures refugees and persons of concern can access HIV and reproductive health services, mainly through referrals to national services, including those delivered by community-based organizations run by key affected populations. Many countries in the region are not party to the 1951 UN Refugee Convention and therefore do not extend their national HIV policies to refugees. To achieve sustainable financing for services for these populations, local arrangements for HIV testing, procurement and provision of ART and viral load testing have to be negotiated on a yearly basis. The biennium report for Malaysia illustrates areas of ongoing advocacy and success, and the lifesaving assistance still required to maintain an equitable balance between refugee and national HIV rights.

Challenges

554. Lack of enabling legal and policy environments for effective HIV responses together with punitive laws, policies, institutional practices and other human rights violations against key populations continue to act as major barriers to prevention and treatment efforts. Stigma and discrimination still hinder access to HIV services, especially for key populations who are disproportionately affected by the epidemic. This is a challenge in the Pacific region, in particular, where the epidemic is relatively small but fear is high.
555. Rising extremism and shrinking civil society space is impacting on the ability to advance the policy/advocacy agenda; for example, police confiscation of condoms in China, and rising anti-LGBTI sentiment and a bill proposing to criminalize extramarital sex.
556. The impact of declining external financing is becoming apparent in several countries, including in the reduced number of national programme staff and community workers, and lack of funds, which may seriously affect programme implementation. Shrinking HIV resources for UN Cosponsors requires innovative approaches to carrying out mandates, and the requisite country support. Several agencies have been required to integrate HIV work within other programmes. UNFPA, for instance, is deepening HIV/SRHR integration work to ensure both outcomes for people living with and at higher risk of HIV.

557. The underinvestment and lack of strategic prioritization to address gendered dimensions of the response, particularly those facing women, is a concern. In many countries, HIV transmission from people from key populations to their female intimate partners is rising. Without proper diagnosis, and a response in place to address the trend, getting to zero will be impossible.

Future actions

558. Countries require continuing support on financial transition to sustain achievements and progress to date. The Regional Framework for Action on transitioning to Integrated Financing of Priority Public Health Services in the Western Pacific Region endorsed in October 2017 may support this process. There is also a need to revisit current service delivery models to consider integration, coordination and normalization within existing health services.

559. The magnitude of the humanitarian situation facing Bangladesh since 2017 with the Rohingya refugee crisis has increased vulnerabilities to HIV and requires an integrated multisectoral response. UNAIDS, UNHCR, UNFPA, WHO, UNICEF and IOM are working together to support the government to use the challenges as an opportunity to develop prevention and integrated HIV care services that will benefit refugees and host populations.

560. Tailored approaches to local contexts are imperative. Working with local municipalities and cities results in faster, more effective programming that provides communities with what they need. To ensure practical solutions, and outcomes, this work needs to be strengthened as an approach for in-country action.

561. For young key populations, several key actions are planned. In 2018, the World Bank will organize a one-week capacity building workshop to improve data use for decision-making. The Big Data and Optimization Analytics training course in Bangkok will include countries from across the region. The Bank also plans new allocative efficiency studies in at least three countries. The Connect with Respect curriculum tool to address gender-based violence in schools will be piloted in the region. A brainstorming session, En Route to Adulthood, with adolescents at risk of HIV from nine Asia-Pacific countries will be convened by the IATT on Young Key Populations. Forming gender identities, socializing and the adolescent HIV vulnerability will be discussed.

562. Countries will be supported to strengthen data and analysis on adolescents and young key populations, and in-country discussions on PrEP will be organized for them. The TeenGen curriculum for adolescents from key populations will also be rolled out in India and the Philippines.

2016–2017 Expenditures and encumbrances in Asia-Pacific (US\$)

Organization	Core Exp & Enc	% Fast-Track countries	Non-core Exp & Enc	% Fast-Track countries
UNHCR	538 114	37%	3 415 135	51%
UNICEF	1 520 092	40%	12 743 840	47%
WFP	175 745	31%	3 441 323	9%
UNDP	1 000 035	30%	7 900 254	61%

UNDP Global Fund Grants			23 661 429	0%
UNFPA	948 145	30%	6 271 785	64%
UNODC	1 357 709	56%	383 063	48%
UN Women	471 611	72%	4 933 107	25%
ILO	508 349	68%	1 680 928	91%
UNESCO	748 642	43%	5 095 599	68%
WHO	2 159 758	39%	18 900 234	31%
World Bank	1 306 336	82%	3 133 224	70%
Secretariat	24 279 412	43%	11 392 300	78%
Grand Total	35 013 948	44%	102 952 221	39%

Regional summary report for eastern and southern Africa

The **Regional UN AIDS Team for eastern and southern Africa** originates from the Regional Directors Team (RDT) and is mandated to deliver on its AIDS-related outputs. It is an integral part of the UN's regional support system and complements five other main inter-agency clusters including, quality support and assurance/peer support group (UNDG), humanitarian action (OCHA), capacity building (UNDP), food security (FAO) and MDG monitoring (UNDP). The regional joint team is led by UNAIDS and is accountable to the RDT. Its vision is that the people of eastern and southern Africa take control of the AIDS epidemic; that young people, women and men have the information, skills, services and support to stop new HIV infections; that all people living with HIV have an environment free from stigma and discrimination and access to life-saving treatment and care; and that children, especially orphans, and families affected by HIV and AIDS receive equitable, compassionate and comprehensive care, protection and support, and are empowered for impact mitigation. The mission is to mobilize partnerships and draw upon the collective strengths of the United Nations system to support country efforts in scaling up national programmes towards achieving universal access to prevention, treatment and care. The UNAIDS Regional Support Team convenes the RATESA management group every quarter, organizing events—retreats, planning/training workshops, skills-building, self-assessment—according to needs.

Achievements

563. The years 2016–2017 have been a vibrant period of transition and progress for the eastern and southern Africa region. Joint work has pushed the 90–90–90 and prevention agenda across all eight strategy result areas (SRAs) and the new business model has been leveraged to strengthen the Regional UN AIDS Team for Eastern and Southern Africa (RATESA) as a results-oriented UN partnership.

HIV testing and treatment

564. The regional joint team promoted roll out and implementation of WHO's 2015 consolidated guidelines on HIV testing services in 14 Fast-Track countries by the end of 2016, and in all 21 eastern and southern Africa countries in 2017. It led the joint HIV/TB/eMTCT/STI and viral hepatitis programme reviews in Botswana, Lesotho, Swaziland and Zimbabwe that informed new national strategic plans, domestic resource mobilization and proposals for the Global Fund and PEPFAR Country Operational Plans. It facilitated the 2017 HIV estimates and use of data at national and subnational levels to inform treatment target setting and dissemination through the HIV and AIDS Data Hub.
565. It advocated for promising practices identified in HIV testing, including interest and acceptability to self-testing and targeted campaigns focusing on high risk groups. It generated evidence on innovative approaches to paediatric testing, which were promoted through family-centred practice, integration in existing maternal, newborn and child health programmes and nutrition platforms, and through point-of-care technologies.
566. The regional joint team completed an analysis based on data from South Africa's National Health Laboratory Service that demonstrated low viral load suppression in children and helped make the case for improved paediatric treatment. A 90–90–90 situational analysis of innovative service delivery approaches in relation to the HIV treatment cascade in the region was also commissioned. It is currently in phase one.

567. In 2017, the Horn of Africa faced a serious drought affecting Ethiopia, Somalia and Kenya with an estimated 15 million people in need of emergency food assistance and at catastrophic levels of food insecurity and malnutrition. It was established that people living with HIV were potentially at risk in these countries. The UN Joint teams in the three countries worked to ensure inclusion of HIV clients into ongoing emergency programme responses including nutrition and food assistance for malnourished people living with HIV. In Kenya, the UN Joint team successfully advocated for inclusion of HIV into the Drought Flash Appeal and helped raise the profile for HIV in the Arid and Semi-Arid Lands (ASAL) with government and humanitarian partners. They further commissioned a rapid assessment on the impact of the drought on HIV and AIDS and the findings of assessment will be utilized (in 2018) to advocate with all relevant partners at national and county levels to strengthen the HIV response in all the ASAL counties.
568. In Uganda, developed by ICW-East Africa and supported by UN Women, *Socio-cultural and Gender-related Barriers that Affect the Enrolment and Retention of Women and Girls Living with HIV in HIV Prevention, Treatment and Care Services* uncovered good practices used by service providers to promote the enrolment and retention of women and girls, including the use of mobile phones, physical visits and follow-up, establishment of youth-friendly services, support groups, counselling, and decentralization of services and group-based care models. There is a need for countries to implement policy and programmatic actions and interventions that address gender-related and other social determinants of access to HIV treatment.

Elimination of mother-to-child transmission

569. Programmes to eliminate mother-to-child transmission (eMTCT) and paediatric HIV were informed by a series of regional workshops. These included Option B+ implementation (all pregnant women living with HIV offered life-long ART, regardless of their CD4 count), in August 2016, the follow up of HIV-exposed infants, in February 2017, and the role of community peer support programmes for eMTCT in November 2017. Country uptake of new guidance, evidence-driven planning and resource mobilization increased following the first two meetings. Guidance on peer support from the third is due for release.
570. Technical assistance was provided to 11 countries developing new eMTCT plans. The Regional Validation Secretariat on eMTCT was established and is providing technical guidance and support to front-runner countries. The Regional Validation Secretariat has contributed to consensus building around criteria for the "path to elimination" for high-burden countries and supported a satellite session at the International Conference on AIDS and STIs in Africa (ICASA).
571. The Joint Programme engaged in the steering committee meeting of African First Ladies at ICASA, which focused on eMTCT and formulated a new continental campaign, Free to Shine, supported by the UN team and other partners. The super-Fast-Track framework for ending AIDS among children, adolescent and young women, Start Free Stay Free AIDS Free, was also promoted at regional and country level.

HIV prevention among young people

572. The Joint Programme promoted revitalizing the prevention agenda. In March 2017, it organized a regional meeting in Zimbabwe for the 15 Fast-Track countries, to plan target-setting for the UN's five pillars for HIV prevention, including comprehensive programmes focused on young women and adolescent girls and their male partners.

573. Joint UN prevention assessment (All In) missions were conducted in Lesotho, Malawi, Mozambique, South Africa, Swaziland, Uganda and Zambia. These identified gaps in adolescent programming and resulted in concrete improvements, such as disaggregating data within health management information system in some countries, including adolescents in district HIV technical working groups, and leveraging Global Fund resources for adolescent girls and young women. The impact of cash transfer for young women in Swaziland was also evaluated, and ways to improve implementing the programme identified.
574. UN Women's Engagement + Empowerment = Equality project, working with the International Planned Parenthood Federation, mobilized more than 1000 young women and adolescent girls, including 250 living with HIV, in Malawi, Kenya and Uganda, who helped design and validate the All In assessments.
575. Voluntary medical male circumcision 2021, a WHO and UNAIDS framework for voluntary medical male circumcision, was disseminated across the region. Priority directions and country-specific actions to scale up voluntary medical male circumcision were developed, focusing on adolescent boys and young men.
576. The regional joint team supported integrated SRHR services, particularly for adolescent girls and young women, through impact evaluations in South Africa on using smart health apps to improve links to care, and in Zimbabwe on efficiency gains with HIV and SRH services.
577. UN Women together with UNFPA, UNICEF and UNESCO implemented the Joint Programme "Rapariga BIZ" 2017–2020 to support girls and young women in realizing their SRHR in 2 provinces of Mozambique. The partners launched a mentorship programme for youth to enhance SRH/HIV knowledge and strengthen access to HIV and other health services. In 2017, more than 23,000 young women and girls were reached through the mentorship programme and almost 69,000 young people (10–24 years) were reached at health fairs that offered information on family planning methods, HIV testing and counselling, vaccination and other maternal and child health services. The Joint Programme also ensured that almost 5,000 adolescent girls and young women enrolled or re-enrolled in school and that some 1,400 adolescent girls (10–19 years) obtained ID cards.

Key populations

578. In partnership with the African Sex Workers Alliance, a South-South knowledge exchange was convened to accelerate implementation and effective national management of sex worker programmes in the region.
579. Financial and technical support was provided for the fourth meeting of the Africa Key Population Experts Group. This resulted in substantive inputs into guidance on using complaints to address health-care violations.
580. The joint team pushed for the Global HIV Prevention Coalition road map and accountability mechanism to be put in place. It supported the Southern African Development Community (SADC) and the East African Community to establish a regional strategy for key populations, build capacity on harmonized target-setting, develop a road map and monitor progress through scorecards via civil society organizations and community networks. It also mobilized 15 countries to undertake national consultations on HIV prevention, attend the launch of the coalition and develop a 100-day post-launch plan seeking urgent action.

581. In 2017, the Joint Programme continued to advocate for proportionate funding for key populations through HIV allocative efficiency work in eastern and southern Africa countries. It strove to meet challenges and promote an enabling environment, including a mission to the United Republic of Tanzania to deal with service continuity after the closure of clinics for key populations.
582. The team led the development of terms of reference for adapting the Connect with Respect curriculum tool to address school-related gender-based violence. In November 2016, MPs from across the region gathered to discuss the landmark eastern and southern Africa Commitment on scaling up comprehensive sexuality education and SRH services for young people. At the meeting, hosted by UNESCO, UNFPA with SADC, Members of Parliament committed to complementing the work of national ministries on prevention.

Gender equality and the empowerment of women and girls

583. UN Women, UNDP, UNESCO, UNFPA and the UNAIDS Secretariat continued to promote the SADC programme of action on Commission on the Status of Women Resolution 60/2, on women, the girl child and HIV and AIDS, and the Mahé Declaration on the role of parliamentarians in reducing HIV among girls and women. As follow up to the Mahé Declaration, the Joint Team collaborated with the SADC Parliamentary Forum and SADC Secretariat on a Gender Responsive Oversight Model, an instrument designed to monitor the implementation of Resolution 60/2. This GROM will be utilised by all SADC national parliaments.
584. UN Women, UNFPA, UNDP and the UNAIDS Secretariat and other members of the Joint Team supported and encouraged women's organizations and women living with HIV in seven countries to engage strategically and advocate, which resulted in government-led measures to fund interventions focusing on young women and girls. The RSTIt led joint efforts to develop a male engagement framework and improve men's involvement in eMTCT, which were circulated at two regional meetings and ICASA.
585. In Uganda and Zimbabwe, UN Women helped to facilitate meaningful engagement of women living with HIV in the design of the Global Fund Concept Notes. This support resulted in the approved Concept Notes prioritizing programming on adolescent girls and young women and HIV, with a total of \$8 million allocation in Zimbabwe and \$10 million in Uganda.

Human rights, stigma and discrimination

586. Work with the African Think Tank on HIV, Health and Social Justice promoted constructive engagement in controversial and sensitive matters; for example, helping revitalize the HIV Bill that was adopted in Malawi.
587. The Joint Programme continued its support of the African Regional Judges' Forum to ensure continuity of rights-based jurisprudence in the context of HIV and AIDS and key and vulnerable populations. This led to a series of evidence-based rights-affirming judgements ruled by members of the forum. It facilitated the development, adoption and launch of the first report on HIV and human rights by the African Commission on Human and Peoples' Rights. The report was disseminated at ICASA and the African Union.
588. Working with the SADC Parliamentary Forum and Girls Not Brides, it developed a tool simplifying the process for adopting at country level the SADC law on eradicating child marriage and protecting children already married.

589. UN Women's work with traditional and community leaders in Malawi resulted in their increased engagement and commitment to preventing HIV among girls and ending child marriage. In 2017, UN Women and other partners have successfully advocated for a ground-breaking amendment of Malawi's Constitution in early 2017 to raise the minimum age of marriage from 15–18 years. With UN Women's support, Paramount Chiefs developed a unified by-laws framework to guide implementation and monitoring of the constitutional amendment and 2015 Marriage, Divorce and Family Relations Bill at the community level to eliminate child marriage and prevent HIV among adolescent girls.
590. A regional analysis of the status of sexual and reproductive rights services for young people living with disabilities was validated by governments and civil society partners from 13 countries and the three regional economic communities, SADC, the East African Community and the Intergovernmental Authority on Development.

Investment and efficiency

591. UNAIDS provided extensive technical guidance to support the development and implementation of Global Fund proposals. It published the eastern and southern Africa Sustainable Finance Analysis, for which groundwork commenced in 2015. Individual countries will use the analysis to develop action frameworks for minimum implementation of better service delivery, ensuring no one is left behind.
592. Country level dialogues on developing HIV investment cases were made possible in four countries. HIV prevention strategies or a review of treatment plans and targets were used as the platform to ensure Fast-Track was integrated in national responses and plans.
593. The regional joint team completed allocative efficiency studies using Optima in Malawi and Zambia, and an allocative efficiency study and analysis of the HIV care cascade for Johannesburg. A TB allocative efficiency study was launched in South Africa.

Health-service integration

594. With technical guidance from UNAIDS, seven countries developed integrated reproductive, maternal, newborn, child, adolescent health strategies, some including nutrition. Work to integrate HIV services, and maintain service continuity, in the El Niño drought response was undertaken. An advocacy paper resulted in PEPFAR resources being generated for this purpose. UNAIDS technical assistance also enabled countries to make 2016 HIV and infant feeding guidance context specific.
595. WFP, with the Food and Agriculture Organization of the United Nations (FAO), organized the SADC consultative meeting in February 2016 on preparedness and response to the impact of El Nino on agriculture, food and nutrition security in southern Africa. SADC member states agreed to short, medium and long-term measures to mitigate future disasters, with a commitment to HIV services.
596. UNAIDS, with UNFPA, advocated and provided technical assistance through the Linkages Project for a comprehensive approach to SRHR /HIV in national health and development strategies, plans and budgets. This ongoing guidance helps institutionalize and scale-up integrated SRH and HIV services, and makes good 'people' sense. It also provided 20 health-system strengthening projects, further facilitating access to services through integrating SRHR and HIV. More than 10 social protection projects were supported in the region.

597. UNAIDS, UNFPA, UNICEF and WHO jointly collaborated on developing a \$45 million regional programme for the period 2018–2021, integrating SRHR and HIV with services for gender-based violence.

Challenges

598. The joint team as a regional mechanism continues to re-orient itself based on the changing dynamics of the epidemic. The diverse locations of members, however, pose a challenge to effective coordination. Further significant funding cuts have limited the flexibility and ability of some Cosponsors to deliver fully on regional efforts. On a positive note, the uncertainty of future funding has inspired team members to conduct business differently, and in a more coordinated, strategic and effective manner that will contribute to ending AIDS in the region.
599. Increasingly insufficient resources, combined with poor strategic information, has led to many high-impact HIV prevention programmes not being implemented at the necessary standard or scale, including interventions addressing the structural drivers of HIV among adolescent girls and young women. Gender inequality and legal barriers are acknowledged as contributing to the high risk of HIV among this group, along with limited youth-friendly health services.
600. Key populations are often marginalized due to punitive legal frameworks and policies that impact on service availability and accessibility. High donor reliance and eliminating mother-to-child transmission in high-burden countries remains unfinished business.
601. Country ownership of their response, and domestication of the eastern and southern African commitment, differs across the region. The quality of comprehensive sexuality education varies, and social attitudes and norms are reflected in implementation levels. There is also a lack of consultation with the regional joint team by global partners, often resulting in unnecessary doubling up and missed opportunities to capitalize on the team's capacity.

Future actions

602. The regional joint team will continue to build its capacity, including aligning workplans around regional priorities and strengthening agency contributions to Joint Programme activities to maximize its comparative advantage. Leveraging resources for priorities and gaps is a key future action.
603. Its 2018 mechanism maintains four thematic working groups: eMTCT and treatment (UNICEF and WHO); prevention among adolescents, young people and key populations (UNFPA and UNICEF); strategic information (UNAIDS); and social justice (ILO). Crosscutting by the strategic information and social justice (gender, human rights, social justice) working groups will support the others.
604. To reach Fast-Track targets, including 90–90–90, the regional joint team will strengthen national capacities through its technical support. By adopting and expanding well-established, innovative and community-based approaches, countries will improve HIV testing and treatment coverage. It will advocate and provide guidance to maintain momentum towards eliminating mother-to-child transmission of HIV, including through tailored support for pregnant adolescents and young women and improved postnatal retention.

605. It will work with Regional Economic Communities and civil society organizations to monitor progress against the Prevention Coalition's road map targets and holding countries accountable, and coordinate programming for key populations at all levels
606. The high numbers of new infections among adolescent girls and young women will be addressed. Working through a range of partners, including regional bodies, countries will be supported to mobilize and leverage resources, improve prevention and treatment service uptake, and expand integrated gender-responsive HIV combination prevention services and sexuality education in and out of schools.
607. The Joint Team will provide technical guidance, financial support and South-South learning to further scale up integrated SRH/HIV/SGBV services. It will share good practices on sexuality education implementation and, through review, will assist countries to align their curricula with revised international technical guidance. On human rights, it will advocate for countries to remove legal and social barriers to services, including stigma and discrimination, through the African Think Tank, Amplifiers and Champions, among others.

2016–2017 Expenditures and encumbrances in eastern and southern Africa (US\$)

Organization	Core Exp & Enc	% Fast-Track countries	Non-core Exp & Enc	% Fast-Track countries
UNHCR	2 140 973	92%	24 585 435	96%
UNICEF	1 912 183	92%	74 542 378	74%
WFP	1 349 334	52%	45 968 851	26%
UNDP	2 057 579	56%	9 485 942	84%
UNDP Global Fund Grants			407 735 367	98%
UNFPA	1 695 612	56%	34 427 851	74%
UNODC	969 263	78%	7 363 254	100%
UN Women	691 119	100%	5 174 111	72%
ILO	1 278 256	100%	3 430 169	99%
UNESCO	1 208 521	41%	8 120 199	78%
WHO	5 059 844	59%	20 980 973	45%
World Bank	2 804 972	100%	3 221 346	92%
Secretariat	39 294 752	77%	15 684 077	32%
Grand Total	60 462 408	76%	660 719 954	85%

Regional summary report for eastern Europe and central Asia

The regional UN joint team on AIDS in eastern Europe and central Asia is composed of the UNAIDS Secretariat, ILO, UNDP, UNESCO, UNFPA, UNODC, UN Women, WHO and the World Bank. UNHCR and WFP are not present but are continuously invited. The team works under the overall coordination of the Director of the Regional Support Team for eastern Europe and central Asia, who is also a member of the Regional UN Development Group for Europe and Central Asia. Members are dispersed across the region (ILO and UNICEF are in Geneva, WHO is in Copenhagen, the Regional Support Team and UNESCO are in Moscow, UNDP, UN Women and UNFPA are in Istanbul, UNODC is in Kiev and Astana, and World Bank is in Washington).

Alignment of activities between the Secretariat and Cosponsors is reached through sharing work plans, ad hoc consultation at events and bilateral and multilateral conference calls. In May and June 2017, the regional joint team agreed the regional priorities of the Joint Programme to be included in the 2018–2019 UBRAF. In November 2017, it reviewed and approved country envelopes. For 2018, total funding of US\$ 1.2 million supports activities of the Joint Programme at country level (in Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Ukraine and Uzbekistan). Of the funding, 32.4% will be spent on technical support for HIV testing and treatment, 28.3% on key populations, 14.7% on human rights, 11.2% on eMTCT, 5.6% on gender and gender-based violence, 4.3% on integration and 3.5% on investment and efficiency.

The greater part of activities falls on countries in eastern Europe and central Asia. The Joint Programme has weaker capacity in the Balkans. In 2017, the human resource capacity of the Joint Programme further contracted, with the UNAIDS Secretariat closing its Uzbekistan office to optimize programme delivery.

Achievements

608. In 2017, the Joint Programme was instrumental in helping national counterparts obtain additional resources, optimize available and ensure uninterrupted provision of HIV commodities and services. resources
609. The UNAIDS Secretariat and Cosponsors provided technical support to Country Coordinating Mechanisms in Kyrgyzstan, Kazakhstan, Ukraine and Tajikistan to help design successful funding requests to the Global. With WHO, UNDP and UNODC, the Secretariat also advised the Global Fund on terms of reference for a call for regional proposals to sustain HIV prevention services for key populations. These focused on using local mechanisms for funding NGOs. The Secretariat, UNDP and UNFPA provided technical support for plans to transition to domestic funding in Armenia, Georgia, Republic of Moldova and Kyrgyzstan.
610. The World Bank, jointly with UNAIDS and UNDP, worked with Armenia, Belarus, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, the former Yugoslav Republic of Macedonia, Republic of Moldova, Tajikistan, Ukraine and Uzbekistan on papers for a regional summary of HIV allocative efficiency studies from 2014–2016 and the follow-up by countries. For example, Armenia, Belarus and Georgia used the analysis to inform their Global Fund concept notes, while Bulgaria and the former Yugoslav Republic of Macedonia prepared processes to transition to domestic funding processes. Lessons were transferred into other areas, with TB allocative efficiency analyses in Belarus and Republic of Moldova identifying major potential for enhancing efficiency.
611. In Ukraine, UNDP support resulted in a cost-sharing agreement with the Ministry of Healthcare to continue emergency procurement of medicines. Savings increased the

number of people accessing treatment. UNDP also supported the development of a concept note for an NGO social contracting mechanism in Montenegro, and by-laws for operating an NGO social contracting law in Kyrgyzstan.

612. UNICEF organized two workshops to increase knowledge and capacity on HIV procurement among government staff and NGOs from nine countries. The workshops were used to introduce international platforms to help with procurement and supply chain management for antiretroviral medicines and diagnostics for children and pregnant women.
613. WHO worked with the Global Fund to ensure antiretrovirals were used according to WHO recommendations under Global Fund grants. It sought agreement from central Asian countries on a basic package of HIV services for migrants at a subregional meeting supported by the Secretariat, UNODC and the International Organization for Migration.

Key populations

614. The Joint Programme remained instrumental in building capacity of civil society groups representing key populations at risk for HIV. With UNDP support, the Regional HIV Legal Network increased its members to 36 in 10 countries, with two additional members from Tajikistan and two from Ukraine. Network members successfully supported 71 strategic litigation cases in 2017. UNDP also conducted a Being LGBTI subregional dialogue, bringing together more than 120 development partners, national human rights institutions, LGBTI people and government and civil society members from 10 countries and territories in eastern Europe and central Asia.
615. In 2017, UNFPA continued to build capacities of regional and local networks of key populations, including the Sex Workers' Rights Advocacy Network, Eurasian Coalition on Male Health and the Eurasian Women's Network on AIDS, through rolling out programming tools for HIV and STI prevention. These included the sex worker implementation tool, an implementation tool for men who have sex with men, the transgender implementation tool TRANSIT, and IDUIT, for people who inject drugs.
616. UNFPA, UNDP, UN Women and the Secretariat built the capacity of the Eurasian Women's Network on AIDS to help achieve the SDGs at local level. Members in Kazakhstan, Ukraine and Tajikistan established working groups that prepared shadow reports on women living with HIV achieving the CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) treaty. A survey of 4,000 women living with HIV was conducted in Ukraine, with UN Women's support, by the national network to assess how CEDAW implementation addresses the rights of women living with HIV.²⁵ This work resulted in the CEDAW Concluding Comments to Ukraine calling for accelerated HIV prevention among women and girls and improved access to gender-based violence services for women to prevent HIV. One network member also joined a national working group to develop SDG indicators in Kazakhstan.
617. In Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan and Ukraine, UNODC strengthened partnerships between law enforcement and community-based organizations (CBOs), and developed police referral pilot schemes to drug-related HIV services as alternatives to punishment for people who use drugs in Belarus and Ukraine, expanding the scheme in Kazakhstan, Tajikistan and the Republic of Moldova.

618. The Secretariat provided technical support to the treatment preparedness coalition ITPC.ru to strengthen patient organizations' capacity to monitor national antiretroviral procurement and distribution processes in Armenia, Belarus, Kazakhstan, Kyrgyzstan and Republic of Moldova.

Young people

619. On top of its work for key populations, the Joint Programme reaches out to young people with a comprehensive prevention message. UNESCO worked to advance formal and non-formal HIV and health sexuality education, specifically in Armenia, Belarus, Kyrgyzstan and Russia. In Kyrgyzstan, teachers were trained in HIV/health education in most schools in six regions and delivered lessons to more than 20 000 students. Eleven edutainment videos on HIV/SRH, recommended by education ministries in Armenia, Belarus and Kyrgyzstan, had 8.5 million YouTube views (<https://www.youtube.com/user/nowchpok>).
620. The regional teenslive.info web portal for adolescents on health and relationships, brought together by UNAIDS and UNESCO and already available in Russian, Ukrainian and Romanian, was made available in Armenia (teenslive.am) and Kyrgyzstan (teens.kg). These were accessed daily by more than 500 young people. Some 1.5 million parents were sensitized on the importance of HIV/sexuality education.
621. With the support of the Secretariat, UNFPA and UNESCO, young people's SRH, and their role in ending AIDS, was placed high on the agenda of the World Festival of Youth and Students 2017 in Sochi, which was attended by 25 000 young people from 188 countries. UNFPA increased the capacity of local Y-Peer networks to address SRHR, HIV prevention, gender equality and the response to gender-based violence in Belarus, Kazakhstan and Republic of Moldova. In Georgia and Ukraine, UNFPA supported promoting y-peer methodology to equip young people with the knowledge and skills to help them to make informed decisions about their reproductive health and relative risks, including information on HIV and STIs.
622. UNHCR provided refugees and other people of concern with counselling and materials (in six languages) on sexual and gender-based violence, domestic violence, trafficking, HIV and existing protection mechanisms and services. In Georgia, it supported a local NGO to provide health counselling through mobile visits in rural areas, including information about contraception, family planning and HIV prevention.

Guiding national partners

623. The Joint Programme remained an essential provider of capacity building and normative guidance for national partners in 2017. The ILO, for example, organized seven training seminars for 238 participants, including ILO tripartite constituents (the ILO is the only UN agency with government, employer and worker representatives), and health experts and representatives from 23 large enterprises in 11 Russia territories. Sessions were co-moderated by professional trainers living with HIV. The ILO also supported VCT@WORK events during Russian health and safety week, to encourage voluntary counselling and testing at work, and continued introducing its VCT@WORK at two branches of Russian Railways, each with 60 000 to 70 000 workers. Nine territorial AIDS Centres reported reaching 185 000 workers with information and 98 000 with counselling and testing, with 292 referred for treatment and care.
624. UNODC provided guidance on developing the protocol for opioid substitution therapy in prisons and assisted in introducing it in one prison in Tajikistan.

625. WHO, UNICEF and the Secretariat supported Belarus and Armenia in validating the status eMTCT in 2017. WHO reviewed HIV treatment and testing policies in Kyrgyzstan, Republic of Moldova, Tajikistan, Ukraine and Uzbekistan, supporting Ukraine to optimize ART and train HIV specialists. Training of trainers was carried out to ensure key clinicians provide expertise at regional and national levels, further optimizing ART for increased coverage across the region.
626. WHO provided early assessment and technical assistance to 15 non-EU/European Economic Area (EEA) countries on implementing the action plan for the health sector response to HIV through national strategies, hosting an HIV programme managers meeting for non-EU/EEA and eastern and central Europe countries in September 2017 supported by the Secretariat, UNODC and UNFPA. In 60% of non-EU/EEA countries, the national HIV strategy defines an essential comprehensive package of HIV services, integrated into the national health benefits package.
627. UNICEF produced an adolescents and HIV manual, available in Russian, Ukrainian and Tajik languages, for care workers providing psychosocial services for adolescents living with HIV. In addition, UNICEF supported several capacity-building activities, including six webinars offered through the regional knowledge hub for HIV, and training courses, in Dushanbe, Tajikistan, for central Asia, and Irkutsk and Saint Petersburg. It also continued to support capacity building of HIV paediatric and adolescent care providers through horizontal cooperation seminars that brought cutting-edge knowledge on HIV care and treatment to the region. Technical seminars were organized in Shymkent and Khabarovsk.
628. With UNESCO support, more than 1,000 educators and psychologists across the region were trained to improve the response to school-related gender-based violence. In Russia, preventing gender-based violence and discrimination against learners and teachers living with HIV was integrated into the teacher in-service training curricula in six regions. In Republic of Moldova, the 1500 country schools were trained and supplied with a guide on addressing gender-based violence and discrimination.
629. UNFPA supported policy advocacy and capacity building efforts to strengthen health-system responses to domestic and gender-based violence and to further integrate mechanisms of multisectoral response and referral at regional and national levels.
630. Regional standard operating procedures on multidisciplinary responses to gender-based violence were adapted to national contexts; in Ukraine, for example, health and psychosocial support services were offered to 20 000 women and girls through a strengthened multisectoral response.

Challenges

631. At both country and regional levels in 2017, the Secretariat and Cosponsors enabled essential HIV services and commodities to be provided to people affected by the continuing armed conflict in eastern Ukraine.
632. UNICEF ensured life-saving HIV treatment and diagnostics were delivered for more than 11 000 people living with HIV in non-government control areas. Since 2015, and despite multiple obstacles, UNICEF has delivered 56 tons of ART and commodities, with a total volume of 230 cubic metres, for a value of more than US\$ 4.7 million.
633. UNFPA strengthened the HIV/STI prevention component of emergency SRH services for the most vulnerable women and adolescent girls. It also provided emergency

reproductive health kits, including for post-rape treatment, and more than 7 million male condoms to prevent STIs and HIV transmission. Approximately 70 000 people benefited from the targeted SRH/HIV/STI services, with some 100 000 receiving condoms.

634. In Ukraine, UNDP support resulted in a crisis response point model. This standardized intervention model involved providing rights-sensitive social support to women and girls living with and/or at risk of HIV as well as those affected by violence. The model was applied in the government-controlled areas of Donetsk and Lugansk oblasts, where 56 women received legal and social assistance over three months. In most cases, the rights violations were related to violence and sexual harassment.
635. During 2016–2017, UNHCR, with its partner, provided humanitarian services in Donetsk to more than 1000 people living with HIV affected by the emergency, including individual in-kind assistance, psychological support, preparations for winter and safe shelter for survivors of sexual and gender-based violence. In 2016, UNHCR helped improve mobile health units to provide TB screening services and primary health examination to emergency-affected and internally displaced people. More than 30 000 people living in the grey zone benefited from the project.

Future actions

636. In 2018, the Joint Programme in eastern and central Europe will mobilize domestic and donor resources to expand comprehensive HIV prevention services for key populations. It will also mobilize local leadership to expand available harm reduction services, particularly to reach women and the younger cohorts of drug-using populations and reinforce evidence-based advocacy for OST and needle and syringe programmes, including in prison settings.
637. PrEP and condom and lubricant programmes for men who have sex with men and sex workers will be promoted. It will advocate for treat all and support the revision of national HIV testing and treatment policies and the scale up of innovative testing and counselling programmes that reach out to key populations, young people and workers, including through youth-led and youth-serving information and community technology solutions.
638. Countries will receive support to optimize ART regimens, and to ensure equitable access to eMTCT by implementing approaches that reach the most marginalized and excluded and integrating eMTCT into maternal and child health services and primary health care
639. The Joint Programme will build the capacity of key populations and people living with HIV networks to advocate for the repeal of restrictive and punitive laws and policies. It will support regulatory frameworks, policies and strategies for monitoring rights violations and ensuring access to justice and redress mechanisms, and the implementation of the CEDAW recommendations on gender equality and HIV.
640. A favourable legal framework for strengthening the role of civil society organizations and enabling governments to finance HIV prevention and care services provided by NGOs will be pursued. As will implementing the transition to domestic funding and sustainability plans in six countries. The Joint Programme will provide guidance on domestic financing options, using TRIPS flexibilities, international procurement and local production of antiretroviral medicines. It will support additional allocative and implementation efficiency studies in six countries and organize a Big Data and Optimization Analytics course for the region.

2016–2017 Expenditures and encumbrances in eastern Europe and central Asia (US\$)

Organization	Core Exp & Enc	% Fast-Track countries	Non-core Exp & Enc	% Fast-Track countries
UNHCR	2 487	100%	1 181 730	15%
UNICEF	1 013 763	30%	6 558 348	46%
WFP	70 161	0%	1 148 500	75%
UNDP	900 466	13%	2 166 857	14%
UNDP Global Fund Grants			42 261 380	0%
UNFPA	1 167 511	9%	3 558 566	5%
UNODC	590 558	25%	1 453 285	44%
UN Women	233 689	26%	1 143 870	24%
ILO	230 686	100%	559 096	98%
UNESCO	573 518	27%	320 378	54%
WHO	1 294 658	21%	3 587 540	39%
World Bank	197 327	62%	727 300	5%
Secretariat	9 178 914	20%	5 437 548	0%
Grand Total	15 453 738	22%	70 104 398	11%

Regional summary report for Latin America and the Caribbean

UNAIDS cosponsoring organizations coordinate and collaborate through an established regional inter-agency working group: the UNAIDS Cosponsor Regional Group (UCRG) that includes the regional offices of the UNAIDS cosponsoring organizations. As of 2017, the UNAIDS Secretariat, UNODC, UNICEF, UNDP, UN Women, UNCHR, World Bank, ILO, UNFPA, WHO, UNESCO and WFP are full members. Each agency appoints a focal point that acts as the agency representative in the UCRG. The group meets twice a year, or more if necessary, with regular communications on regional events and joint activities conducted via email. It is co-chaired by the Director of UNAIDS RST and a Regional Director of a cosponsoring agency on an annual, rotational basis.

The UCRG aims to enhance the synergy of the United Nations response to HIV in Latin America and the Caribbean, harmonize technical and financial assistance to strengthen national and subregional responses to HIV, and support the efforts for greater coherence among UN organizations and coordination with external partners towards the achievement of the SDGs.

Achievements

641. The World Bank produced final reports and dissemination briefs for the epidemic, and allocative efficiency analysis was conducted in Argentina, Colombia, Mexico and Peru based on the Optima model. Lessons from HIV efficiency analysis were transferred into other areas: a TB allocative efficiency analysis conducted in Peru, for example, identified potential to enhance efficiency and strengthen active case-finding modalities. Support for programmes on multisectoral determinants of health in education, transport, gender and HIV-sensitive social protection led to institutional development and capacity building for the HIV response and increased access to health and social protection services of people living with HIV and those most at risk.
642. PAHO/WHO advocated for more focused approaches on key populations, including community-based outreach activities, to increase access to HIV testing in the region. All countries have national plans and strategies aligned to the new PAHO Plan of Action for the prevention and control of HIV and sexually transmitted infections 2016–2021, and regional prevention targets have been incorporated, fully or partially, in those plans in 33 countries. Six Caribbean countries were validated by WHO for eMTCT of HIV and syphilis, and Cuba was revalidated for another two years. There was an estimated 21% reduction in the mother-to-child transmission rate in Latin America in a single year, from 2015 to 2016.
643. Up to 22 countries have updated their national HIV care and treatment guidelines to include the WHO treat all recommendation, and antiretroviral therapy (ART) coverage is increasing in the Latin America and Caribbean region, reaching 56% of all people estimated with HIV in 2016. Decentralization and integration of HIV care and treatment services is progressing, with 14 countries providing ART in health facilities of the first level of care. HIV drug resistance surveillance based on WHO-recommended methodology was implemented in six countries, with an additional 11 ongoing surveys providing information for policy updates and improved rational use of antiretroviral medicines.
644. WFP established joint actions with governments and other key actors to generate crucial information regarding the food and nutrition security status of people with HIV and its relationship with ART adherence. Additionally, field interventions were supported and carried out in collaboration with civil society organizations; urban-

community and family gardens were a case in point. The aim of the intervention was to improve food and nutrition security and the dietary diversity of the population. In 2017, WFP expanded its partnership base to achieve common objectives and reinforce actions to make them sustainable and replicable. Emphasis was placed on improving coordination between sector partners, such as those in health, agriculture and social development, to provide better access to services for people affected by HIV. As part of these efforts, the food and nutrition needs of the population have been incorporated in some countries' social protection programmes. Additionally, a food and nutrition component is reflected in some national HIV guidelines.

645. UNICEF provided technical assistance to country offices to advance the HIV elimination initiative, and to the three Fast-Track countries in the region to prevent new HIV infections among adolescents. Data collected via the All In initiative was used to ensure a greater focus on adolescents in these countries. UNICEF conducted a regional analysis on adolescents and HIV, in collaboration with the National Institute of Public Health in Mexico and the UNAIDS Secretariat. Preliminary results were presented at a round table organized by ICW Latina (International Community of Women living with HIV) and will be disseminated further. UNICEF is also a member of the Regional Task Force on PrEP, convened by WHO/PAHO and which helps shape strategies to better address the prevention needs of adolescents from key populations.
646. UNHCR collaborated with national institutions, civil society and UN agencies to ensure refugees, asylum seekers, returnees and displaced and stateless people had access to HIV prevention and treatment. UNHCR prioritized most at-risk individuals, such as LGBTI people, and individuals involved in survival sex. UNHCR raised awareness on HIV risks, and advocated for the issuance of valid documentation, which is required to access national health and protection services. In Mexico, UNHCR referred refugees and asylum-seekers to HIV/ STI testing and treatment services. This was done in collaboration with reception transit centres and safe shelters, and by providing individual and group counselling.
647. UNFPA provided technical support to governments and civil society organizations in nine Caribbean countries to strengthen national and regional capacity to deliver client-centred, rights-based integrated SRH services to underserved populations at high risk of transmission of HIV and other STIs and to youth in particularly vulnerable circumstances. UNFPA collaborated with the Pan Caribbean Partnership Against HIV/AIDS, PAHO and the UNAIDS Secretariat to facilitate dialogue and capacity development for integrating SRH and HIV programmes and services in these countries.
648. UNESCO reviewed the content of sexuality education official curricula for the 9–12 and 12–14 age groups in 19 countries in the region, revealing important disparities in what is included. UNESCO engaged in joint work with other agencies and partners to provide advocacy and technical support to countries with a challenging context, particularly in six where progress has stalled due to pressure from conservative groups that oppose gender ideology. UBRAF funds were used to build the capacity of teachers and teacher-training institutions in Brazil, Chile, Guatemala and Jamaica. At the same time, UNESCO continued to provide financial support to an online teacher-training course managed by FLACSO Argentina, reaching approximately 240 experienced comprehensive sexuality education teachers in 20 countries. Subregional capacity building related to school-related gender-based violence and puberty education, as well as to school violence related to sexual orientation, gender identity and gender expression (SOGIE), have been well received by member states.

649. UNDP, in partnership with PANCAP, organized a Caribbean regional forum of parliamentarians focusing on key populations and HIV. The forum highlighted the legal and policy barriers that hinder key populations' access to HIV prevention, treatment and care services. Parliamentarians committed to advocate for a broad-based stakeholder engagement to address issues affecting key populations, with an emphasis on human rights. UNDP and the Latin American and Caribbean Network of Transgender People (REDLACTRANS) organized a capacity-building workshop for Caribbean transgender activists. Following the workshop, trans women can record rights violations to the regional observatory hosted by REDLACTRANS. Technical support was provided to ICW Latina for a high-level forum carried out in partnership with the Ministry of Foreign Affairs in Costa Rica. UNDP supported the implementation of Global Fund grants in Belize, Bolivia, Cuba and Panama.
650. The UNAIDS Secretariat, in collaboration with WHO, brought partners together (including national officials, the United States President's Emergency Plan for AIDS Relief, or PEPFAR, and the Global Fund) at the LAC-III Regional Forum to reach consensus on strategies to support sustainable HIV responses. The Secretariat collaborated with WHO also in certifying mother-to-child transmission elimination in six Caribbean countries and territories. It supported prevention activities in the region, resulting in advances towards the Global HIV Prevention Coalition road map targets, and the development of 18 successful Global Fund concept notes focused on prevention in key populations.
651. The Secretariat advocates for SRH health services and reaching zero discrimination targets, and mobilized political commitment to Fast-Track and sustainably end AIDS. The Secretariat continues its efforts to strengthen countries' capacity to generate strategic information, including community-generated data to inform the HIV response. Fast-Track countries completed and implemented country workplans aligned with a location and population approach that includes clear strategic engagement with PEPFAR, the Global Fund and South-South cooperation efforts to achieve 2016 Political Declaration targets.
652. UN Women advocated for a comprehensive approach on HIV in Latin America and the Caribbean following UNAIDS guidelines, best practices and UN Women's strategy on HIV 2016–2017. National women's institutions in six countries in Latin America, local governments, legislations and strategic plans recognized the links between violence against women, gender-based violence and gender inequalities as drivers of the HIV epidemic among women and girls.
653. UN Women supported the design and implementation of the national action plans and policies on violence against women in Argentina, Paraguay and Peru to also address the link between violence and risk of HIV. UN Women provided technical assistance to the proposal to raise the minimum age for marriage and the elimination of exceptions in the Dominican Republic; the positioning of the topic in the media, and a regional meeting, titled Accelerate actions to eradicate child marriage and early unions in LAC, took place in October 2017. In collaboration with UNV and the UNAIDS Secretariat, UN Women conducted a study on the impact of violence and HIV on indigenous women in Paraguay and Brazil that is utilized to inform implementation of the national HIV strategies in the two countries and advocate for greater participation of indigenous women survivors of violence, particularly those living with HIV, in the national HIV responses.
654. ILO promoted the private sector's contribution to the 90–90–90 strategy by enabling access to HIV-related services in the workplace in Central America and the Caribbean. Through technical advice and co-investment with its stakeholders

(government, employers and workers organizations), ILO has promoted public-private partnerships between the private sectors and ministries of health to increase access to HIV-related services among mobile populations and in rural areas. HIV testing, counselling and information, condom access and referral to treatment are among the services that have been integrated in workplace health promotion programmes within enterprises employing more than 15 000 workers, mainly women. A stigma and discrimination free environment is also ensured as an essential condition for service access.

Challenges

655. One of the key challenges moving forward is the impact of the reduction in UBRAF staff activity resources and budgets compared with previous biennia. This applies to all agencies. The development and implementation of programmes reaching the most vulnerable continue to be hampered by laws and policies, and by groups opposing so-called gender ideology, discouraging access to services and fostering an environment of stigma and discrimination. Stigma and discrimination in health settings towards key populations and people living with HIV remains a barrier to access and retention in care.
656. The mother-to-child transmission rate of HIV in the Caribbean is stagnant and greater effort is needed to reach pregnant women, both adolescent and adult, from key populations and under conditions of vulnerability.
657. Countries are not offering the complete set of available HIV prevention options, especially PrEP and non-occupational post-exposure prophylaxis for consented sexual exposure and STIs. Many barriers to HIV testing persist, including written informed consent and lengthy pre-test counselling, while late diagnosis continues to hinder timely access to care and treatment and has an overall negative impact on HIV-associated morbidity and mortality.
658. HIV prevention services focused on key populations, and the offer of peer support to persons with HIV in care and treatment, still depends greatly on external donor funds or volunteer services. Not all countries have yet adopted the treat all policy, and emerging NNRTI (non-nucleoside reverse transcriptase inhibitor) drug resistance threatens the effectiveness and sustainability of treatment programmes.
659. Lack of awareness among refugees, returnees and displaced and stateless people of HIV risks and available services remains another key challenge. People without legal documentation are at heightened risk of survival sex and face challenges accessing public health services.
660. The incorporation of nutrition indicators in the compendium of indicators for HIV care in national guidelines continues to be limited or absent.

Future actions

280. Cosponsor regional offices will monitor the implementation of the 2017–2018 envelopes at country level in 11 countries, accounting for 2.4 million annually.
661. WFP will strengthen partnerships to develop joint fundraising efforts to support evidence generation and continue advocacy efforts to have nutrition and HIV included in all appropriate national guidelines.

662. Countries should focus on strengthening resolution capacity at the first level of care and providing people-centered attention, and on expanding sustainable community-based and peer-led services. The efficiency of HIV testing services must be improved by focusing on people and places where HIV is concentrated and removing programmatic and structural barriers to accessing these services.
663. Continued efforts are needed to engage pregnant women in early antenatal care, with early screening and immediate interventions and follow-up for those diagnosed with HIV. All countries should implement the treat all policy and advance the process of decentralization and integration of HIV care and treatment at all levels of the health system, based on differentiated care and a person- and community-centred approach. HIV drug-resistance is an emerging threat, and the region needs to strengthen and expand its surveillance and to update treatment policies and ARV use accordingly.
664. WHO will address structural barriers that impact on HIV prevention and the continuum of care, particularly stigma and discrimination in health settings towards people living with HIV and key populations. UN Women will continue efforts to strengthen capacities in gender-responsive planning and budgeting for programmes to prevent and respond to violence against women and girls. It will collaborate with partners to build the capacity of regional civil society networks of women living with HIV and sex workers to prepare CEDAW Shadow Reports and other international instruments. UNESCO will roll out its revised International technical guidance on sexuality education.

2016–2017 Expenditures and encumbrances in Latin America and the Caribbean (US\$)

Organization	Core Exp & Enc	% Fast-Track countries	Non-core Exp & Enc	% Fast-Track Expenditure
UNHCR	150 569	10%	632 423	21%
UNICEF	805 537	41%	2 096 507	39%
WFP	475 395	0%	154 000	0%
UNDP	685 859	26%	2 099 047	20%
UNDP Global Fund Grants			24 305 927	27%
UNFPA	701 429	45%	3 473 702	5%
UNODC	298 866	47%	49 772	59%
UN Women	251 484	49%	2 424 539	35%
ILO	346 641	62%	357 739	31%
UNESCO	470 654	34%	1 329 630	70%
WHO	683 923	10%	3 619 542	11%
World Bank	232 291	40%	1 125 081	47%
Secretariat	18 423 719	27%	609 811	50%
Grand Total	23 526 366	28%	42 277 720	27%

Regional summary report for Middle East and North Africa

The regional joint team and its technical working groups are the key coordination mechanisms for the Joint Programme in the Middle East and north Africa. The team has at least one annual meeting in which the Joint Programme reviews its progress and organizations present their workplans to capitalize on combined efforts and eliminate duplication of activities. The working groups provide platforms for better collaboration around specific technical areas, such as strategic information, treatment, prevention among key populations and prevention of mother-to-child transmission.

Achievements

665. Continued advocacy and technical support from UN agencies in the region resulted in a better understanding of the HIV epidemic and response. The improved availability of strategic information at regional and country level influenced the use of evidenced-based national strategic plans and grant applications to the Global Fund. UNAIDS and WHO jointly supported the generation of up-to-date HIV information within countries through HIV estimates, Global AIDS monitoring and regional surveillance data, along with producing regional surveillance reports and country profiles used for advocacy and planning. In Egypt, technical assistance was provided to the Ministry of Health and Population to develop a health information management system and to build staff capacity for better case reporting.
666. As a result of continued scale up of HIV testing and treatment services for children and pregnant women, the number of new HIV infections among children (0–4 years) decreased in 2017 to less than 1500; almost two thirds of children in need of treatment received it in 2017. Advocacy and technical support provided by UNICEF, UNAIDS and WHO resulted in a substantial increase in service uptake and increased support from governments and partners in countries.
667. Partnerships and resources were mobilized jointly by UNICEF and UNAIDS in 2016 to implement the All In initiative in countries to develop national strategic frameworks based on adolescent and HIV situation assessments.
668. During the reporting period, the UNODC Regional HIV/AIDS Prevention, Treatment, Care, and Support in Prison Settings project provided almost 40 000 prisoners and prison staff with HIV services. UNODC ROMENA organized a regional training workshop on providing comprehensive HIV and other services in prison settings that was attended by 23 delegates from Egypt, Morocco and Tunisia.
669. UNFPA supported the Y-PEER Regional Centre for Youth Development, and prioritized its support to comprehensive and integrated SRH strategies and services in eight countries in the region. As part of its support for the implementation of the Regional Arab AIDS Strategy, UNFPA and UNAIDS jointly organized a follow-up meeting to the Algeria Call for Action on advancing gender equality, the HIV response and universal access to treatment and prevention in the region.
670. UN Women Regional Office for the Arab States developed with UNFPA a road map for the roll out of the essential services package for women and girls subject to violence in the region and introduced it to 60 governmental stakeholders from six countries. The package includes guidelines on minimum services to be delivered to survivors of violence, including HIV and sexually transmitted infection (STI) post-exposure prophylaxis in cases of sexual assault. As a result, action plans for the roll out of the

package were developed in alignment with other national policies and priorities, including HIV plans.

671. In the State of Palestine, UN Women supported the production of radio spots that improved the knowledge of women and youth on HIV and AIDS, SRH and gender-based violence.

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

672. Following the Algiers Declaration to Fast-Track HIV testing, technology innovations and community testing, UNAIDS and Cosponsors mobilized political support and provided technical support to countries, resulting in an increase in community testing and the adoption of test and offer policies in countries. WHO conducted a regional review of access to diagnosis, care and treatment services for people who inject drugs, which was shared with nongovernmental and government stakeholders and used for advocacy. WHO also provided technical support to integrate HIV diagnosis and ART for high-risk groups in harm reduction services in Iran. This integration effort will continue in 2018, resulting in better access to services.
673. WHO's promotion of the treat all approach has resulted in all countries of the region, except Egypt, adopting the policy and updating their national treatment guidelines. Support was provided to countries to overcome stock-outs of antiretroviral medicines and to update the national treatment protocol.
674. Implementation of the Global Plan to eliminate new HIV infections in children and keep their mothers alive continues to progress, based on the regional framework developed and supported by UNICEF, UNFPA, WHO and UNAIDS. Most countries in the region (except Iraq and Yemen) have adopted Option B+ (all pregnant women living with HIV offered life-long ART, regardless of their CD4 count).
675. The UN joint team in Somalia worked to ensure HIV clients were included in ongoing emergency programme responses, such as nutrition and food assistance for malnourished people living with HIV and food-insecure households, and registration of HIV clients into the online biometric system to ensure they receive support from WFP.
676. UNHCR supported access to appropriate education and information, and free condoms, as well as the continuation of HIV prevention, care and treatment services for populations affected by humanitarian emergencies in the region. UN agencies supported resource mobilization from the Global Fund Middle East Response to address the needs of Syrian refugees and refocus the response in Yemen based on the existing situation.

Political and financial commitment to ending AIDS

677. The Joint Programme supported the endorsement of a resolution to end AIDS by the Council of Arab Ministers of Health during UNAIDS Executive Director's Michel Sidibé's visit. It coordinated with Arab missions and developed a briefing note for national advocacy and supported civil society organizations to develop a Middle East and North Africa region high-level meeting position paper and ensured key networks participated at the meeting. As a result, for the first time, the League of Arab States addressed the United Nations General Assembly on HIV and expressed a commitment to Fast-Track the response through increased investment and regional solidarity. A UNAIDS, WHO and United Nations Industrial Development Organization joint technical mission supported the establishment of the Regional Centre for Research and Cooperation on HIV in Algeria, which was also endorsed by Arab heads of states.

678. WHO and UNAIDS supported strategic planning and resource mobilization from the Global Fund for Middle East Response grant. WHO also assessed vulnerability among Syrian refugees in Lebanon.
679. UNAIDS and the LAS mobilized regional media leaders to support implementation of the Arab AIDS Strategy and the Political Declaration; religious leaders were also mobilized, and they endorsed calls for action. The regional joint team provided support to the Intergovernmental Authority for Development (the eight-country trade bloc in Africa based in Djibouti City) to develop a subregional grant on HIV and TB focusing on refugee settings in its member states, including Djibouti, Somalia and Sudan. The grant of US\$ 10 million will provide essential support to Fast-Track the HIV response, especially the prevention component, among this vulnerable group.

Gender inequality and the rights of people living with HIV and key populations

680. WHO, with support from UNAIDS, lead a campaign with the slogan Dignity above All that focused on reducing stigma in health-care settings. At least 14 countries developed national committees to adopt and produce their national policies, and some announced their policies on World AIDS Day 2016. WHO supported countries in improving the efficiency of HIV testing.
681. UNAIDS has supported advocacy and awareness on stigma and discrimination, and addressed vulnerability of women by working with regional GWA law enforcement agents and regional gender forums and with a women's leaders conference in the United Arab Emirates.
682. UNDP conducted an in-depth assessment of gender-based violence and violence against women and law in 20 Arab countries. It supported the establishment of the Middle East Network for Legal Aid. With UNDP advocacy, the health and social welfare ministries in Sudan extended social health insurance for all people living with HIV in the country. This will provide support to more than 5000 people living with HIV on treatment and to their families. Together with UNDP and UNFPA, the UN Women Regional Office for Arab States continues to work on the national validation of the Gender Justice Studies, which include a mapping of discriminatory laws, namely those related to gender-based violence and the rights of key populations at higher risk of HIV infection. The final report is expected in 2018.
683. UN Women provided capacity-building trainings that improved knowledge on women's rights and gender-based violence among 2121 Syrian women refugees in camps and host communities. Public awareness campaigns reached 500 000 men and women. The capacity of 85 service providers on gender-based violence prevention and response, including HIV prevention, was enhanced. UNHCR and its partners supported the provision of post-exposure prophylaxis to survivors of sexual assault. In Syria, 90 000 women and girls, boys and men were reached with more than 3000 sexual and gender-based violence awareness prevention events/programmes, while 70 community-based committees were established, serving 175 000 beneficiaries. UNHCR monitors crude mortality rates and ensuring 100% coverage in the contracted health facilities for survivors. Advocacy was undertaken to prevent the deportation of HIV-positive refugees in various countries in the region. Affected refugees were provided with access to treatment and medical and psychosocial social support until a durable solution is found.
684. The World Bank support for programmes on multisectoral determinants of health in education, transport, gender and HIV-sensitive social protection, led to institutional development and capacity building for the HIV response and increased access to

health and social protection services for people living with HIV and those most at risk. UNAIDS has worked with partners to develop and launch the region's men who have sex with men toolkit for enhanced outreach and rights-based programming.

Challenges

685. The concentration of HIV infections among key populations at higher risk remains a major challenge for national programmes in the region. Some countries have gradually expanded the reach to those populations by empowering civil society organizations to deliver services. However, a rapid increase in prevention, testing and treatment coverage is difficult to achieve, since homosexuality, sex work and drug use continue to be stigmatized and criminalized. Complicated social and legal contexts, and a lack of political commitment to provide comprehensive HIV services to key populations, adds to the complexity. Limited access to HIV prevention, testing and treatment services in prison settings poses another key challenge.
686. Access to HIV diagnosis services remains the biggest bottleneck to accessing treatment for people living with HIV. Lack of resources and weak health systems pose further challenges to national HIV programmes seeking to monitor treatment.
687. Political instability, combined with a reduction in the UBRAF and other HIV funding, has severely impacted on regional and country capacities to sustain past efforts and provide services to key populations, such as refugees and internally displaced persons.
688. Addressing sexuality and reproductive health and rights, and the needs and rights of key populations, provide yet further challenges. Prevailing social norms and attitudes perpetuate gender inequalities and continue to put women at higher risk of HIV infection. HIV is seen as less of a priority due to low prevalence and other emerging challenges. There are considerable gaps in the coverage of services to prevent mother-to-child transmission in the region. As a result, nearly one third of women living with HIV pass the virus to their children.
689. There is a critical need for reliable and robust data, disaggregated by age and sex, to strengthen the HIV response in the region.

Future actions

690. Advocacy and technical support to integrate HIV services into broader health, community and humanitarian programmes are key to addressing the challenging environment and shrinking resources in the region. Supporting countries to better understand their epidemics, and reviewing their national strategic plans and Global Fund applications, are priorities.
691. WHO's focus on improving access to the continuum of HIV diagnosis, care and treatment remains crucial. Establishing new integrated service delivery models and prevention, diagnosis and treatment approaches and techniques will be pursued. UN Women will continue to work on the links between HIV and AIDS and violence against women in the Arab states region, work with key partners to support the roll out of the essential services package for women subject to violence and induce policy and legal reforms.
692. UNODC will expand HIV prevention, treatment and care services to those living in closed settings and pursue outreach to introduce those same services to people who

inject drugs. UNICEF in partnership with other agencies will adopt a new, differentiated approach to HIV programming and supporting efforts to prevent HIV in adolescents.

693. UNHCR will seek to strengthen protection efforts for displaced people living with HIV by advocating for an end to mandatory testing for HIV and strengthening services for key populations in humanitarian settings. UNDP will support ratification of the Arab Convention, capacity building of specialized civil society networks and developing legal environment assessments in Somalia and Tunisia.
694. The World Bank will prioritize health systems strengthening, universal health coverage and multisector reach, including in infrastructure, transport, education, social protection and social inclusion sectors. UNFPA will continue to provide support to the Y-PEER Regional Centre, reinforcing the capacity, engagement and contribution of young people to HIV prevention, with a focus on those most at-risk and vulnerable.

2016–2017 Expenditures and encumbrances in Middle East and North Africa (US\$)

Organization	Core Exp & Enc	% Fast-Track countries	Non-core Exp & Enc	% Fast-Track countries
UNHCR	385 812	0%	15 055 772	0%
UNICEF	355 807	34%	3 495 597	34%
WFP	198 694	0%	1 215 801	0%
UNDP	457 241	10%	1 438 686	14%
UNDP Global Fund Grants			31 158 859	18%
UNFPA	364 458	0%	6 811 278	2%
UNODC	600 359	3%	972 859	0%
UN Women	73 328	0%	1 794 859	0%
ILO	19 950	0%	26 627	0%
UNESCO			162 023	0%
WHO	1 156 265	14%	4 911 770	8%
World Bank			155 761	0%
Secretariat	6 620 915	11%	1 343 885	0%
Grand Total	10 232 829	11%	68 543 777	11%

Regional summary report for western and central Africa

Achievements

To increase coordinated and coherent support for HIV responses in west and central Africa, the Joint United Nations Regional Team on HIV/AIDS was expanded to non-UN stakeholders in 2012 and is now composed of some 40 member organizations, from UNAIDS Cosponsors and other UN entities (OHCHR, OCHA, IOM), regional organizations (ECOWAS/WAHO, ECCAS), bilateral organizations (USAID, the French 5% initiative), medical/pharmaceutical networks (Solthis, Esther, ACAME), to civil society organizations specializing in HIV response (such as AfriCASO or Aids Alliance), representing key populations (AMShE, people living with HIV networks) and working on human rights (such as RADDHO or Association des Femmes Juristes).

The Joint United Nations Regional Team on HIV/AIDS (JURTA) operates through thematic working groups to collectively deliver on regional priorities. The working group on eMTCT supports countries in developing and implementing results-based, costed and decentralized plans. The procurement and supply management working group supports countries and REC efforts to address stock-outs and other bottlenecks.

The group on young people and key populations endeavours to address the specific situation and needs of those vulnerable groups through advocacy and capacity building. The group on HIV in emergency situations is pushing for improved prevention and response to HIV and gender-based violence in crisis and post-crisis settings. Human rights, gender and community mobilization are transversal aspects of the regional joint team's work.

Navigating coordination challenges due to different mandates, agendas, geographical coverage and capacities, the expanded team has leveraged the main group, and the thematic subgroups, to move the regional agenda forward. Regional meetings bring partners together to build consensus for action. They are held on a quarterly basis. Annual retreats also enable partners to engage with one another.

HIV testing and treatment

695. In 2016, in the western and central Africa region, less than half of the 6.1 million (42%) people living with HIV knew their status, 35% were on antiretroviral medicines (ARVs) and 25% had a suppressed viral load. The figures, though rising, were too low, and trail those in the eastern and southern Africa region. Of the 540 000 children living with HIV, eight in 10 were not accessing ART. Access to early infant diagnosis was 20%, with 43 000 AIDS-related deaths among children.
696. Médecins Sans Frontières (MSF), a member of the Joint United Nations Regional Team on HIV/AIDS (JURTA), in its 2016 *Out of focus* report advocated for strengthened action. A regional catch-up plan was developed. Initially eight countries (Cameroon, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Nigeria, Sierra Leone and Liberia) developed country specific plans and began implementing them in the first quarter of 2017. By end of the year, 12 countries had plans and nine had started implementation.
697. Specifically, 70 participants were trained to put 2015 WHO guidelines into effect, with 70 more reached via webinar. Nine countries were supported to adopt the policy and update national guidelines. Three countries introduced innovative point-of-care diagnostic machines to monitor viral load and increase access to early infant diagnosis. Twelve countries developed national acceleration plans for paediatric and adolescent HIV treatment, and nine adopted a comprehensive family-centred approach, with paediatric case-finding and links to ART.

698. During ICASA 2017, UNICEF and UNAIDS launched Step Up the Pace, the first regional report on children and AIDS in western and central Africa. They co-chaired a high-level event on catalysing paediatric ART within treatment catch-up plans. This resulted in a road map for accelerating focus on key policy and programmatic bottlenecks.
699. UNICEF facilitated dissemination of lessons learned, and development of programmatic guidance and tools for index case testing, the routine family testing of children and partners of an adult diagnosed with HIV. WFP provided nutritional support to 188 000 malnourished ART/TB clients, orphans and vulnerable children and their households in nine countries.

Elimination of mother-to-child transmission

700. The number of new infections among children fell to 60 000 in 2016, a 46% reduction since 2000. Some 37 000 new paediatric infections were averted and 49% of pregnant women living with HIV received antiretroviral medicines, eight countries with a sustained high coverage of more than 80%. During review of the catch-up plan at an ICASA satellite session, progress on recommendations from the Dakar Call to Action on eliminating HIV among women, children and adolescents was discussed.
701. Burkina Faso was helped to launch an eMTCT operational plan, and six countries were supported to include eMTCT within reproductive, maternal, newborn and child health (RMNCH) services. Cameroon, Democratic Republic of the Congo and Senegal introduced point-of-care platforms to decentralize early infant diagnosis and viral load monitoring for women and children with assistance from UNITAID. Cape Verde was supported to enrol in the WHO eMTCT certification process.
702. Best practices on eMTCT integration and community-facility linkages—an Optimizing HIV Treatment Access initiative—were disseminated to improve retention in HIV care, and a regional road map for accelerating eMTCT and paediatric ART was revised. Technical assistance was provided to five countries for eMTCT plan revision in line with the 2016 Political Declaration.
703. Africa's First Ladies advocated for the super-Fast-Track framework Start Free Stay Free AIDS Free for ending AIDS among children, adolescent and young women. The World Bank supported 15 concessional lending operations in western Africa focusing on RMNCH and eMTCT and using result-based financing to improve use and quality of reproductive health services.

Prevention among young people

704. To enable adolescent girls and young women to protect themselves from HIV, the team initiated several joint actions focusing on access to combination prevention services. With support, 12 countries conducted multisectoral assessments on adolescents and HIV through phases one and two of the All-In Initiative, informing priority interventions for prevention among young people.
705. In Cameroon, Côte d'Ivoire, Democratic Republic of the Congo and Nigeria, All In advocacy resulted in increased resources to high-burden geographic areas. In subnational operational plans, innovative approaches helped identify adolescents and young people at higher HIV risk, and track the use of high-impact services. Mobile health (mHealth) strategies such as U-Report were adapted to bridge knowledge gaps and increase the uptake of HIV services.

706. UNESCO, UNFPA and partners helped translate the Dakar Call to Action on reproductive health education into tangible actions with two policy guidance briefs, and also strengthened comprehensive sexuality education in curricula in Benin, Côte d'Ivoire, Gabon and Senegal, multisector programming in Mali, Côte d'Ivoire and Togo, teacher training in Côte d'Ivoire, learning tools in Ghana, and strategic information in Côte d'Ivoire and Gabon.
707. To achieve the 90–90–90 targets, ProTest HIV, a global initiative that encourages young people to get tested for HIV, was launched in Gabon. Four countries also received support from UNICEF and UNFPA to address the SRHR of teenage girls to accelerate action to end child marriage.
708. WHO, UNAIDS and the Global developed technical assistance modules and approaches to support seven countries in combination prevention programming for adolescent girls and young women.
709. A situation analysis was completed in selected countries on the legal and policy barriers affecting young people's sexual health and reproductive rights; an advocacy tool to be used within the Economic Community of West African States (ECOWAS) region
710. The joint regional team supported the 7th Africa Conference on Sexual Health and Rights in Accra in 2016, mobilizing the Organisation of African First Ladies against HIV/AIDS from western and central Africa. The First Ladies championed the launch of the continental All In campaign to end AIDS among adolescents. The Organisation also launched an initiative to end child marriage by 2020.

Gender inequality and gender-based violence

711. There was advocacy on the issue of child marriage, and its impact on the SRH of girls and migrants, with the regional joint team collaborating with the African Union and its campaign to end child marriage in Africa.
712. With support from UNESCO, UNICEF, Plan International and UN Women, Cameroon, Senegal and Togo addressed school-related gender-based violence, training key education staff and developing and applying a tool to assess the education sector's response to such violence.
713. The regional team, led by UNHCR and WFP, developed a toolkit for mainstreaming and managing HIV-related issues within humanitarian crises, prioritizing access to treatment and services and addressing nutrition-related issues and gender-based violence.

Human rights, stigma and discrimination

714. UNDP and the Office of the United Nations High Commissioner for Human Rights (OHCHR) launched an international initiative to reduce violations of human rights by promoting dialogue between stakeholders from government, UN agencies and civil society organizations in African countries, including Cameroon, Nigeria and Senegal.
715. The joint regional team supported dissemination of a guide on treatment literacy for pregnant women and mothers living with HIV as part of the Positive Health, Dignity and Prevention programme. UNAIDS believes treatment literacy reinforces a person's right to know their HIV status and to decide on ART, providing an entry point for reducing stigma and discrimination.

716. UNAIDS, WFP, UNCHR, UNICEF, the International Organization for Migration and the African Union co-organized a satellite session on migration and HIV during ICASA 2017. This was aimed at sensitizing decision-makers on the need to ensure continuity of care in cross-border contexts, using a human rights-based approach.

Investment and efficiency

717. Technical support was provided through three mock Technical Review Panels (which provide recommendations to the Global Fund Board) and 19 of 23 country funding requests for the Global Fund 2018–2020 period were successful, representing an estimated US\$ 530 million in funding. The World Bank and UNAIDS also provided technical support to the National AIDS Councils of Côte d'Ivoire, Senegal and Togo to conduct AIDS optimization and efficiency studies. These were instrumental in the reprogramming of Global Fund and PEPFAR Country Operational Plan resources and for national strategic planning processes.
718. Working with Avenir Health, UNAIDS assisted in developing investment cases for six of the most affected states in Nigeria. The process involved Cosponsors at country level. These will ensure sustainability, and help stimulate state-level investments in the HIV response.
719. UNAIDS and USAID developed the HIV sustainability index and dashboard tool in six PEPFAR countries and two non-PEPFAR countries. They also supported the transition preparedness assessment and sustainability process in Senegal (in partnership with USAID's health policy project, The Palladium Group and the Global Fund) and Côte d'Ivoire (with GAVI, the Vaccine Alliance, and World Bank). The work, which involved Cosponsors at country level, is linked with health assurance coverage and health system strengthening initiatives.
720. Technical support from UNICEF, the World Bank and WFP ensured the HIV-sensitive social protection agenda was advanced in the region. Equatorial Guinea and Senegal developed HIV-sensitive social protection plans. Through its concessional lending portfolio, World Bank and UNICEF supported more than 13 social protection projects.

HIV and health-service integration

721. Through WFP, contributed to strengthening the capacity of some 700 health workers and community agents to manage nutrition assessment, counselling and support programmes targeting people living with HIV and TB patients in seven countries.
722. The World Bank supported 25 concessional lending operations in western Africa, focusing on health-system strengthening and universal health coverage, and providing both funding and technical assistance to facilitate HIV and health service integration.

Challenges

723. In the region, a 30% decrease in funding from the Global Fund over the next three years presents a serious test, compromising Fast-Track achievements, and eMTCT and paediatric care and treatment. Inadequate funding through the UBRAF and other sources seriously challenged the work of Cosponsors and the regional joint team. Other problems include insufficient political priority setting on testing and treatment of children and adolescents, the chronic weakness of maternal, newborn and child health platforms and community systems, persistent procurement and supply management deficiencies as well as limited resources to provide nutrition support to the many malnourished people living with HIV initiating treatment.

724. There have been missed opportunities due to insufficient provider-initiated HIV testing in routine child care, and poor implementation of the advocated family-centred approach. Countries are also resistant to task-shifting policies in HIV paediatric care. Likewise, the limited capacity of health-care providers and families in managing the disclosure of HIV status in children and the transition during adolescence must be addressed.
725. Limited availability of quality data presents difficulties in measuring progress and in the design of tailored, integrated eMTCT and paediatric ART programmes. Few countries have fully integrated HIV in their humanitarian contingency plans. Comprehensive sexuality education has not yet been institutionalized, although it is improving. Information and communication technology solutions need to be bettered to enable larger-scale training of teachers.
726. Improved governance and funding absorption is necessary to avoid funding cuts. Inadequate access to key interventions and programmes for people living with HIV hampers efforts, as well as slowness in adopting new technology, such as self-testing for HIV and PrEP.
727. Poor decentralization and integration of HIV testing and treatment, and limited investment in differentiated care models for ART and in establishing community-based service delivery models remain problematic. Frequent stock-outs of HIV commodities (such as antiretroviral drugs, condoms, reagents) and fragile health systems, due to limited qualified human resources, and weak procurement and supply management continue to be barriers to service utilization, especially for key populations.
728. Key populations and people living with HIV, meanwhile, still face stigma and discrimination, while gender inequality and gender-based violence continue to make girls and young women vulnerable to HIV.

Future actions

729. The regional joint team will engage strategic global and regional partnerships to influence policies, budgets, planning and programme implementation, and monitor the Dakar Call to Action. A third regional stocktaking meeting on eMTCT and paediatric treatment will be convened. Social protection systems will also be assessed, with a view to strengthening the HIV-sensitivity of existing schemes. Strategies to ensure the continuation of HIV services and care in emergency contexts will be strengthened, with HIV in emergency toolkits disseminated, HIV-sensitive contingency plans developed, and differentiated service delivery models promoted.
730. Certification of elimination of vertical transmission (for HIV, syphilis and viral hepatitis) will be supported, focusing on Cape Verde, which began the process in 2018 and Benin and Burkina Faso, which will be assessed for readiness. The Organisation of African First Ladies Against HIV/AIDS and the African Union's Free to Shine campaign to stop children acquiring HIV, prevent AIDS-related deaths and keep mothers healthy across Africa will be leveraged. Implementation of new delivery models in RMNCH will be fostered, and existing initiatives leveraged, including the Every Newborn Action Plan, the Muskoka initiative for maternal and child health, and the Every Child Alive Campaign.
731. The regional joint team will engage strategic global and regional partnerships to influence policies, budgets, planning and programme implementation, and monitor the Dakar Call to Action. A third regional stocktaking meeting on eMTCT and paediatric treatment will be convened. Social protection systems will also be assessed, with a

view to strengthening the HIV-sensitivity of existing schemes. HIV services in emergency contexts will continue, with HIV-sensitive contingency plans developed and differentiated service delivery introduced.

732. The team will secure political commitment to increase adolescent and young people's access to comprehensive sexuality education and SRH services, and implement innovative approaches. This will include modelling work on targeting for at-risk adolescents, including on testing and self-testing, mobile technology for real-time monitoring and response using U-Report and family-centred approaches. Also, models of adolescent health service delivery for girls combining school, community and health platforms focusing on pregnancy, HIV and nutrition, such as the Muskoka partnership's pilot in Benin with UNICEF and UNFPA. There will be support for self-testing focusing on male partners and high-risk adolescents, and HIV in emergency toolkits will be disseminated.
733. There will be assistance for national procurement and supply management systems to reduce stock-outs. New All In countries will also be supported. The focus on adolescent key population will be reviewed, and investment approaches expanded where expedient. Resources for prevention, especially for adolescent girls and women, will be leveraged, with the Global Fund among others, and new partnerships sought, for example with PEPFAR's DREAMS that aims to reduce HIV infections among adolescent girls and young women, with the World Bank, and with France, UK-AID, and the Nordics. The region will provide targeted technical support, including joint missions, to Global Fund and PEPFAR programmes. With the World Bank, efficiency and sustainability plans in Cameroon will be developed.

2016–2017 Expenditures and encumbrances in western and central Africa

Organization	Core Exp & Enc	% Fast-Track countries	Non-core Exp & Enc	% Fast-Track countries
UNHCR	971 514	74%	16 087 484	63%
UNICEF	1 237 485	62%	61 131 862	61%
WFP	589 774	17%	17 355 773	0%
UNDP	548 688	28%	3 226 281	35%
UNDP Global Fund Grants			32 804 905	83%
UNFPA	1 055 222	62%	5 910 445	74%
UNODC	193 000	51%		
UN Women	517 740	100%	3 590 825	57%
ILO	363 514	61%	1 301 589	96%
UNESCO	679 584	28%	1 368 273	77%
WHO	1 252 783	55%	12 045 533	33%
World Bank	964 126	63%	2 406 545	67%
Secretariat	32 570 748	44%	5 993 329	13%
Grand Total	40 944 179	47%	163 222 845	56%

FINANCIAL INFORMATION

734. The financial information included in this section presents the investments made to achieve the collective results of the Joint Programme as well as the individual achievements of the Cosponsors and the Secretariat. It also presents actual resources mobilized against projected resources for the 2016–2017 biennium. Expenditures and encumbrances are presented in several perspectives, namely: by funding source, by Strategy Result Area, by geographical region and by expenditure category to allow various stakeholders to view the information through their respective lenses.
735. The periodic release of funds during the periods of the challenging financial environment in 2016–2017 led to a degree of uncertainty and more cautious utilization of funds by Cosponsors. 25% of the 2017 Cosponsor allocations was available in the last quarter of 2017, resulting in lower than usual implementation rate as at 31 December 2017 for a number of Cosponsors. Extension until 30 June 2018 was therefore granted to enable sufficient time for implementation of the UBRAF funds where necessary.
736. Biennial spending was in line with programmatic projections. Of the Strategy Result Areas, HIV testing and treatment (SRA 1) received the biggest share of core expenditure at 26%. Of the strategic functions, leadership, advocacy and communication received the biggest share, equivalent to 27%.

Table 1: Overview of 2016–2017 AIDS spending by funding source (US\$)

Funding source	Available funds	Breakdown (%)	Expenditures & Encumbrances	Breakdown (%)
Core	400 830 987	11%	342 237 001	22%
Non-core	3 225 099 000	89%	1 213 272 999	78%
Grand Total	3 625 929 987	100%	1 555 510 001	100%

Table 2: 2016–2017 Core expenditures and encumbrances by Strategy Result Area (US\$)

Strategy Result Area	Core Exp & Enc	Breakdown (%)
SRA 1. HIV testing and treatment	19 153 500	26%
SRA 2. Elimination of mother-to-child transmission	4 423 011	6%
SRA 3. HIV prevention among young people	12 059 511	16%
SRA 4. HIV prevention among key populations	13 495 571	18%
SRA 5. Gender inequality and gender-based violence	6 833 055	9%
SRA 6. Human rights, stigma and discrimination	4 836 085	7%
SRA 7. Investment and efficiency	5 033 818	7%
SRA 8. HIV and health services integration	7 554 515	10%
Grand Total	73 389 066	100%

Table 3: Core expenditures and encumbrances by Secretariat function (US\$)

Secretariat Function	Core Exp & Enc	Breakdown (in %)
S1. Leadership, advocacy and communication	71 684 816	27%
S2. Partnerships, mobilization and innovation	45 724 493	17%
S3. Strategic information	39 564 629	15%
S4. Coordination, convening and country implementation support	48 394 080	18%
S5 Governance and mutual accountability	63 479 917	24%
Grand Total	268 847 935	100%

Table 4: Core and non-core expenditures and encumbrances by organization (US\$)

Organization	Core			Non-core			Total		
	Available funds	Expenditures & encumbrances	%	Projected resources	Expenditures & encumbrances	%	Projected resources	Expenditures & encumbrances	%
UNHCR	4 900 000	4 900 000	100%	60 481 000	63 211 644	105%	65 381 000	68 111 644	104%
UNICEF	12 129 016	10 155 222	84%	200 000 000	169 694 024	85%	212 129 016	179 849 246	85%
WFP	5 563 736	4 321 237	78%	55 514 000	70 166 748	126%	61 077 736	74 487 985	122%
UNDP	9 437 834	7 820 486	83%	23 300 000	29 169 836	125%	32 737 834	36 990 322	113%
UNDP GF Grants				425 500 000	562 948 760	132%	425 500 000	562 948 760	132%
UNFPA	11 514 597	8 471 452	74%	110 707 000	88 496 481	80%	122 221 597	96 967 933	79%
UNODC	5 982 551	5 600 898	94%	11 600 000	10 829 080	93%	17 582 551	16 429 978	93%
UN Women	4 326 041	2 899 848	67%	26 709 000	20 839 207	78%	31 035 041	23 739 055	76%
ILO	5 607 924	4 584 569	82%	15 000 000	9 228 063	62%	20 607 924	13 812 632	67%
UNESCO	6 548 376	4 848 369	74%	26 320 000	21 947 649	83%	32 868 376	26 796 018	82%
WHO	18 153 811	13 457 116	74%	98 468 000	98 241 344	100%	116 621 811	111 698 460	96%
World Bank ²⁶	6 447 101	6 329 869	98%	2 131 500 000	11 219 257	1%	2 137 947 101	17 549 126	1%
Secretariat	310 220 000	268 847 935	87%	40 000 000	57 280 907	143%	350 220 000	326 128 842	93%
Grand Total	400 830 987	342 237 001	85%	3 225 099 000	1 213 272 999	38%	3 625 929 987	1 555 510 001	43%

Table 5: Core and non-core expenditures and encumbrances by region (US\$)

Organization	Global	AP	EECA	ESA	LAC	MENA	WCA	Grand Total
UNHCR	2 964 195	3 953 249	1 184 217	26 726 408	782 992	15 441 584	17 058 998	68 111 644
UNICEF	12 435 847	14 263 932	7 572 111	76 454 561	2 902 044	3 851 404	62 369 347	179 849 246
WFP	2 344 633	3 617 068	1 218 661	47 318 185	629 395	1 414 495	17 945 547	74 487 985
UNDP	5 023 387	8 900 289	3 067 323	11 543 521	2 784 906	1 895 927	3 774 969	36 990 322
UNDP GF Grants	1 020 893	23 661 429	42 261 380	407 735 367	24 305 927	31 158 859	32 804 905	562 948 760

UNFPA	30 581 929	7 219 930	4 726 077	36 123 463	4 175 131	7 175 736	6 965 667	96 967 933
UNODC	2 197 990	1 740 772	2 043 843	8 332 517	348 638	1 573 218	193 000	16 429 978
UN Women	2 438 771	5 404 718	1 377 559	5 865 230	2 676 023	1 868 187	4 108 565	23 739 055
ILO	3 709 088	2 189 277	789 782	4 708 425	704 380	46 577	1 665 103	13 812 632
UNESCO	6 718 997	5 844 241	893 895	9 328 720	1 800 284	162 023	2 047 857	26 796 018
WHO	36 045 637	21 059 992	4 882 198	26 040 817	4 303 465	6 068 035	13 298 316	111 698 460
World Bank	1 274 818	4 439 560	924 627	6 026 317	1 357 372	155 761	3 370 671	17 549 126
Secretariat	155 299 432	35 671 712	14 616 462	54 978 829	19 033 530	7 964 800	38 564 077	326 128 842
Grand Total	262 055 618	137 966 169	85 558 136	721 182 361	65 804 086	78 776 606	204 167 024	1 555 510 001

Table 6: Expenditures and encumbrances by Strategy Result Area (US\$)

Organization	Core	Non-core	Grand Total
Strategy Result Area 1: HIV testing and treatment			
UNHCR	3 691 000	38 973 537	42 664 537
UNICEF	2 494 296	62 490 604	64 984 900
WFP	1 760 757	29 857 730	31 618 487
UNDP	1 012 629	3 500 381	4 513 010
UNDP GF Grants		174 436 104	174 436 104
UNFPA	274 342	2 145 538	2 419 880
UNODC		433 161	433 161
UN Women	63 629	294 047	357 676
ILO	1 139 624	1 594 708	2 734 332
UNESCO	193 935	778 223	972 158
WHO	7 247 723	46 596 396	53 844 119
World Bank	1 275 566	1 932 314	3 207 880
Subtotal SRA 1	19 153 500	363 032 743	382 186 244
Strategy Result Area 2: Elimination of mother-to-child transmission			
UNICEF	2 213 067	29 138 775	31 351 842
WFP	121 451	8 495 813	8 617 264
UNFPA	105 982	8 153 601	8 259 583
WHO	1 718 187	15 069 336	16 787 523
World Bank	264 324	969 009	1 233 333

Organization	Core	Non-core	Grand Total
Subtotal SRA 2	4 423 011	61 826 534	66 249 545
Strategy Result Area 3: HIV Prevention among young people			
UNICEF	1 873 874	22 485 962	24 359 836
WFP	148 584	2 524 743	2 673 327
UNDP	93 863	1 562 941	1 656 804
UNDP GF Grants		99 678 468	99 678 468
UNFPA	4 361 236	41 264 127	45 625 363
UNODC		216 582	216 582
UN Women	180 138	1 917 716	2 097 854
ILO	1 144 088	1 803 801	2 947 889
UNESCO	3 393 858	9 763 392	13 157 250
WHO	472 734	5 036 353	5 509 087
World Bank	391 135	1 172 240	1 563 375
Subtotal SRA 3	12 059 511	187 426 325	199 485 836
Strategy Result Area 4: HIV Prevention among key populations			
UNICEF	1 214 742	9 714 137	10 928 879
UNDP	1 516 459	6 297 627	7 814 086
UNDP GF Grants		50 007 288	50 007 288
UNFPA	2 752 401	11 215 060	13 967 461
UNODC	5 600 898	8 771 555	14 372 453
ILO	424 000	1 081 845	1 505 845
UNESCO	242 418	1 063 613	1 306 032
WHO	1 247 295	10 675 620	11 922 915
World Bank	497 358	1 737 911	2 235 269
Subtotal SRA 4	13 495 571	100 564 656	114 060 228
Strategy Result Area 5: Gender inequality and gender-based violence			
UNHCR	708 113	14 904 178	15 612 291
UNICEF	415 111	1 149 657	1 564 768
WFP		465 000	465 000
UNDP	1 405 459	5 490 044	6 895 503

Organization	Core	Non-core	Grand Total
UNDP GF Grants		62 750 518	62 750 518
UNFPA	61 933	7 987 910	8 049 843
UNODC		324 873	324 873
UN Women	2 497 632	15 004 649	17 502 281
ILO	961 551	1 369 954	2 331 505
UNESCO	727 255	8 811 709	9 538 964
WHO		861 815	861 815
World Bank	56 000	623 356	679 356
Subtotal SRA 5	6 833 055	119 743 663	126 576 718
Strategy Result Area 6: Human rights, stigma and discrimination			
UNHCR	500 887	9 333 929	9 834 816
UNDP	2 866 929	7 292 459	10 159 388
UNDP GF Grants		64 757 637	64 757 637
UNFPA	448 150	1 752 688	2 200 838
UNODC		1 082 909	1 082 909
UN Women	158 449	3 622 795	3 781 244
ILO	512 195	1 654 015	2 166 210
UNESCO	169 693	615 042	784 735
WHO	179 783	3 874 950	4 054 733
Subtotal SRA 6	4 836 085	93 986 423	98 822 508
Strategy Result Area 7: Investment and efficiency			
UNICEF	263 216	4 316 263	4 579 479
WFP	106 868		106 868
UNDP	517 246	3 036 721	3 553 967
UNDP GF Grants		20 738 541	20 738 541
UNFPA	995	748 714	749 709
WHO	1 435 223	9 606 957	11 042 180
World Bank	2 710 270	1 851 843	4 562 113
Subtotal SRA 7	5 033 818	40 299 039	45 332 857
Strategy Result Area 8: HIV integration			

Organization	Core	Non-core	Grand Total
UNICEF	1 680 916	40 398 626	42 079 542
WFP	2 183 577	28 823 462	31 007 039
UNDP	407 901	1 989 663	2 397 564
UNDP GF Grants		90 580 204	90 580 204
UNFPA	466 413	15 228 843	15 695 256
ILO	403 111	1 723 740	2 126 851
UNESCO	121 209	915 669	1 036 879
WHO	1 156 171	6 519 917	7 676 088
World Bank	1 135 216	2 932 584	4 067 800
Subtotal SRA 8	7 554 515	189 112 709	196 667 223
Subtotal SRAs	73 389 066	1 155 992 093	1 229 381 159
Secretariat functions			
S1	71 684 816	17 894 036	89 578 852
S2	45 724 493	10 847 900	56 572 393
S3	39 564 629	6 103 275	45 667 904
S4	48 394 080	17 817 996	66 212 076
S5	63 479 917	4 617 699	68 097 616
Subtotal Secretariat functions	268 847 935	57 280 907	326 128 842
Grand Total	342 237 001	1 213 272 999	1 555 510 001

Table 7: 2016–2017 core expenditures by category (US\$)

Organization	Staff costs	Contractual services, consulting	General operating costs	Direct financial contribution	Equipment and supplies	Travel	Training	Programme support costs	Total expenditures	Encumbrances (commitments)	Total 2016-17 Exp & Enc
UNHCR	568 791	275 644	38 307	3 328 864	212 923	30 323	124 588	320 560	4 900 000		4 900 000
UNICEF	6 814 082	767 016	564 073	539 569	49 011	669 233		752 238	10 155 222		10 155 222
WFP	1 689 140	595 579	718 242	207 555		623 952	174 325	312 444	4 321 237		4 321 237
UNDP	2 942 152	2 106 066	352 457	130 033		817 541	722 474	585 728	7 656 451	164 035	7 820 486
UNFPA	3 472 852	1 344 060	1 855 634	133 474	16 184	1 021 138		628 111	8 471 452		8 471 452
UNODC	4 257 383	98 180	200 788	126 561		352 865		352 267	5 388 045	212 853	5 600 898
UN Women	536 655	977 128	270 436		37 010	319 145		280 694	2 421 069	478 779	2 899 848
ILO	3 500 585	257 714	12 783	14 915	1 625	76 496	193 022	527 429	4 584 569		4 584 569
UNESCO	3 476 265	705 894	16 542	1 065	46 435	210 273	111 172	280 723	4 848 369		4 848 369
WHO	9 741 193	1 933 009	282 262	83 318	97 586	558 025		761 723	13 457 116		13 457 116
World Bank	1 608 664	634 453	156 220	277 000	5 099	791 431	387 260	288 750	4 148 877	2 180 992	6 329 869
Grand Total	38 607 761	9 694 745	4 467 745	4 842 353	465 873	5 470 422	1 712 841	5 090 667	70 352 407	3 036 659	73 389 066

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¹ Start Free Stay Free AIDS Free — 2017 progress report

² Implementation of the HIV Prevention 2020 Road Map - First progress report, March 2018.

³ <http://aidsinfo.unaids.org/>.

⁴ Reference: On the Fast-Track to an AIDS-free generation, pages 4-5

http://www.unaids.org/sites/default/files/media_asset/GlobalPlan2016_en.pdf

⁵ <http://mozambique.unfpa.org/en/news/rapariga-biz-prevents-obstetric-fistula-mozambique>

⁶ The State of the World's Children 2016: a fair chance for every child. New York: UNICEF; 2016 (https://www.unicef.org/publications/files/UNICEF_SOWC_2016.pdf).

⁷ RSFL or "Riksförbundet för homosexuella, bisexuella, transpersoners och queeras rättigheter" is the Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights

⁸ Nicole A. Haberland, "The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies", International Perspectives on Sexual and Reproductive Health, vol. 41, No. 1 (March 2015).

⁹ At the PCB, UNAIDS Executive Director Michel Sidibe committed towards the creation of the Global Compact on Stigma and Discrimination and shared that Executive Director Phumzile Mlambo-Ngcuka of UN Women confirmed to co-chair the convening of a working group that move the Global Compact forward. The NGO Delegation, in partnership with key population networks, will be initiating a series of consultations to ensure that there will be stronger engagement and leadership of key population and people living with HIV communities. <https://www.unaidspcbngo.org/?s=global+compact>.

¹⁰ Human rights of women living with HIV in Ukraine: findings of community-based research through the lens of CEDAW. UN Women, 2017.

¹¹ CEDAW regularly questions states that have ratified the treaty on their progress towards guaranteeing women's human rights and publishes its findings in its Concluding comments series.

¹² Benin, Botswana, Cameroon, Democratic Republic of Congo, Côte d'Ivoire, Ghana, Honduras, Indonesia, Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine

¹³ WFP/EB.1/2017/4-C.

¹⁴ (e.g. <http://thehill.com/opinion/healthcare/362723-world-aids-day-lets-strengt...>).

¹⁵ Argentina, Armenia, Azerbaijan, Bulgaria, Cambodia, Cameroon, Chile, Cuba, Democratic Republic of the Congo, Gambia, Georgia, Guatemala, Haiti, Kazakhstan, Lebanon, Lesotho, Mexico, Mozambique, Namibia, Nicaragua, Peru, Rwanda, South Sudan, Swaziland, Ukraine, United Republic of Tanzania.

¹⁶ Brazil, Côte d'Ivoire, Ghana, Indonesia, Jamaica, Kyrgyzstan, Mozambique, South Africa, Tunisia and Uganda.

¹⁷ Botswana, Burundi, Cameroon, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, South Sudan, Swaziland (eSwatini), Tanzania, Uganda, Ukraine, Viet Nam, Zambia, Zimbabwe.

¹⁸ Brazil, Cameroon, Ghana, Haiti, Indonesia, Jamaica, Lesotho, Malawi, Mali, Mozambique, Myanmar, Namibia, Nigeria, South Sudan, Swaziland, Uganda, United Republic of Tanzania and Vietnam.

¹⁹ Chad, Mali and South Sudan

²⁰ <http://aidsinfo.unaids.org/>.

²¹ Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe

²² Côte d'Ivoire, Lesotho, Kenya, Namibia, Uganda, Zambia, Zimbabwe

²³ Cambodia, Cameroon, Côte d'Ivoire, Ghana, Guyana, India (selected States), Kenya, Kyrgyzstan, Malawi, Morocco, Mozambique, Myanmar, Namibia, Nigeria (selected States) Philippines, Senegal, Sudan, United Republic of Tanzania, Uganda, Ukraine, Vietnam, Zambia and Zimbabwe.

²⁴ Botswana, Kenya, Lesotho, Malawi, Mozambique, South Africa, United Republic of Tanzania, Zambia, Zimbabwe, Uganda

²⁵ Human Rights of Women Living with HIV in Ukraine: Findings of Community-based Research through the Lens of CEDAW. UN Women, 2017

²⁶ The World Bank (WB) mobilizes major grants and concessional AIDS-specific and AIDS-sensitive financing for countries which are then managed by country governments. As per WB's articles of establishment and for fiduciary and transparency reasons, WB staff do not have access to and cannot use any of these grants, credits or concessional loans to pay for WB staff time or technical, analytical or advisory activities. For the 2016–2017 estimates of available non-core funding, such concessional funding were included, as was done in previous years. However, for the 2016–2017 non-core expenditures, only the WB's own financing used for supervision, technical assistance and quality control of its portfolio of concessional financing in support of achieving HIV outcomes, are included and this is how the WB will report in future Performance Monitoring Reports.