



UNAIDS PROGRAMME COORDINATING BOARD

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Agenda item 4.1

2012–2015 Unified Budget, Results and Accountability Framework

UNAIDS 2014 Performance Monitoring Report Highlights

Additional documents for this item:

- i. UNAIDS 2014 Performance Monitoring Report (*UNAIDS/PCB(36)/15.6*)

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

Cost implications of decisions: None

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INTRODUCTION

1. This report highlights achievements, at country, regional and global level, of the Joint United Nations Programme on HIV/AIDS (UNAIDS) towards its strategic vision of the “Three Zeros” - zero new HIV infections, zero AIDS-related deaths and zero discrimination. The report also outlines key challenges, constraints and lessons learned.
2. The report consists of six sections. Following the introduction, the report presents progress against the three pillars of the UNAIDS 2012-2015 Strategy – revolutionizing HIV prevention, catalyzing the next phase of treatment, care and support, and advancing human rights and gender equality for the AIDS response. Then UNAIDS strategic functions of leadership and advocacy, coordination, coherence and partnerships, and mutual accountability are discussed, followed by the cross-cutting themes. Financial implementation is presented in the final section of the report.

PROGRESS TOWARDS THE UBRAF GOALS AND POLITICAL DECLARATION TARGETS

A. Revolutionize HIV prevention

i. Reducing sexual transmission

3. Despite advances made in expanding treatment, overall progress in reducing new infections has been incremental. In 2013, 2.1 million people acquired HIV, the majority through sexual transmission. Young people, particularly young women and girls, bear an enormous burden of the HIV epidemic. Almost one fifth of new infections are among females aged 15 to 24, with most new infections being acquired through sexual transmission. WHO estimates that between 40% and 50% of all new HIV infections among adults worldwide may occur among people from key populations and their immediate partners. Achieving the end of AIDS as a public health threat by 2030 will require concerted efforts to prevent new HIV infections, with a focus on sexual transmission.
4. In 2014, the UNAIDS *Gap report* demonstrated the need to focus the AIDS response on high-burden populations and locations. The UNAIDS report *Fast-Track - Ending the AIDS epidemic by 2030* subsequently called for a strategic equity-based focus on key populations and cities, highlighting the fact that key populations in cities account for a disproportionate burden of the HIV epidemic. The Fast-Track approach also aims to address growing demands that the HIV response should achieve more results with fewer resources.
5. Given the centrality of preventing sexual transmission of HIV to effectively achieving the end of AIDS as a public health threat by 2030, the Joint Programme had undertaken numerous strategic initiatives which seek to significantly curb sexual transmission. These efforts have centered on: scaling up the availability of prevention commodities and interventions; supporting services for key populations in key locations; mobilizing young people; and innovative prevention technologies.

6. In regards to scaling up the availability of prevention commodities and interventions, the simplicity and affordability of male and female condoms means that they continue to remain one of the most effective tools to prevent transmission of HIV, Sexually Transmitted Infections (STIs) and unintended pregnancy. UNAIDS Secretariat, UNFPA, USAID/PEPFAR and the Bill and Melinda Gates Foundation co-convened a global consultation to review and reaffirm the role of condoms in HIV prevention and agree upon key elements of a global acceleration agenda to strengthen condom programming as a core area for preventing sexual transmission of HIV, STIs and unwanted pregnancy. Partners agreed, among other recommendations, to fill the supply gap especially in Africa; provide better guidance on condom programming to countries; and strengthen coordination with private sector manufacturers.

UNAIDS convened a global consultation of key stakeholders including national AIDS Programme Managers from 14 key countries, UN prevention focal points, civil society, technical experts, key partners and priority donors, to renew commitment HIV prevention and examine the state of affairs in preventing sexual transmission of HIV in priority countries. The meeting build consensus on the way forward in HIV prevention, with emphasis on focus, innovation and sustainability, and identifying elements of action to sustainably reduce new HIV infections in high impact countries by 2030.
7. Voluntary medical male circumcision (VMMC) continued to be an important method of prevention in many countries in 2014. WHO played a leading role, particularly in the development of guidance focused on male circumcision devices, in convening meetings of the Technical Advisory Group on Innovations in VMMC, and assessing new data from pilot studies and surveillance. UNICEF supported assessments to improve the quality of counselling provided to adolescent boys for HIV testing and counselling during VMMC.
8. In terms of supporting services for key populations and key locations, the UNDP/UNFPA-led Urban Health & Justice Initiative has supported over 42 cities to implement HIV prevention services. In Mozambique, services for key populations in cities were integrated in the new National Plan on AIDS.
9. Regarding mobilizing youth for the prevention of sexual transmission, and recognizing the important need to address the role of young people, UNICEF, with the UNAIDS Secretariat, UNFPA, WHO and partners, led the mobilization of partners around the All In! global agenda for adolescents. In collaboration with the UN family, civil society, bilateral partners and young people, a global strategic framework was developed to guide action to end the AIDS epidemic in adolescents.
10. Innovative prevention technologies formed another focus of the Joint Programme's efforts around the prevention of sexual transmission of HIV. In the long term, new technologies and vaccines offer one of the best hopes to end AIDS. The joint WHO/UNAIDS HIV Vaccine Initiative (HVI) constitutes the key mechanism to guide and facilitate HIV vaccine research and development. Under this mechanism and with the help of the HIV Vaccine Advisory Committee (VAC), which involves stakeholder representation from across the vaccine research and development "community", in 2014 the Initiative continued to build scientific and ethical consensus, develop guidance on vaccine evaluation, and assist countries in national HIV vaccine development.

11. Looking ahead, some future actions include the roll-out of the *All In Initiative* in 25 countries which will help refocus UNAIDS work on young people and adolescents and prevention, as well as continued efforts to provide prevention services for key populations in key locations. The Joint Programme will support countries develop and use innovative approaches such as pre-exposure prophylaxis (PrEP). UNAIDS, particularly the World Bank, will advocate for optimal allocation of resources to finance HIV prevention programmes, education, social protection and transport sectors. Addressing the social and structural drivers of HIV will help to provide HIV prevention benefits to all populations.

In Eastern Europe and Central Asia, UNESCO and other Cosponsors put HIV prevention education and youth participation on the agenda of the regional AIDS conference. Thematic seminars and activities organized at the youth space facilitated dissemination of evidence-informed approaches to formal and non-formal HIV and sexual reproductive health and rights education using the Internet, social media and the occasion of large sporting events, as well as mechanisms for involving parents.

Building on the ILO Global youth consultation in 2013 and recognizing that young people have unemployment rates three times above those of adults, the ILO published a guide on "Mainstreaming HIV and AIDS in youth employment" which is facilitating the programmes supported by ILO.

In four countries, World Bank-supported studies have shown how conditional cash transfers can reduce sexually transmitted infections for young people, and in particular young women. In Zimbabwe, the World Bank is modelling the impact of combination HIV prevention, including for young people. This evidence is helping policy makers improve their decision process and strategy to target young people.

ii. Eliminating vertical transmission

12. Transmission of HIV from mother-to-child (MTCT) is highly preventable and has been virtually eliminated in the developed world, with many countries reporting rates of less than 1%. Elsewhere, limited access to treatment for pregnant or breastfeeding women, and to family planning services, is resulting in thousands of new HIV infections in babies each year.
13. In the Caribbean region, Cuba is poised to become the first country to be certified by WHO as having eliminated vertical HIV transmission and syphilis, with a validation exercise to be undertaken in March 2015.
14. The Global Plan for the Elimination of New Infections in Children and Keeping their Mothers Alive was launched in 2011 and has helped to galvanize action for achieving an AIDS-free generation and preventing HIV-associated maternal mortality. Over the past year the global community has made remarkable progress towards these goals. According to the latest data, the

UNAIDS has catalyzed roll-out of Option B+ in the Democratic Republic of Congo, Côte d'Ivoire, Malawi and Uganda, through a service delivery model that integrates HIV prevention into the MNCH programme. During the process, the Joint Programme emphasized that the decision to initiate treatment should always be an informed and voluntary one.

Through joint UNFPA and UNAIDS Secretariat support, seven countries (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe) have positioned sexual and reproductive health and rights (SRHR)-HIV linkages/integration into national strategic frameworks as well as SRH/RH policies and strategies contributing to strengthen integration of the AIDS response in national health and development efforts.

estimated number of new HIV infections fell to 240,000 among infants and almost 70% of pregnant women living with HIV now receive highly effective antiretroviral regimens to prevent vertical transmission and safeguard their own health.

15. All of the 22 Global Plan target countries now report adoption of “Option B+”- the WHO recommendation to maintain women living with HIV on ART for life.
16. Although access to paediatric antiretroviral therapy (ART) continues to lag behind, almost 1 in 3 children in need worldwide are now receiving lifesaving treatment. UNAIDS played a critical role in this progress by advocating for rights-based policies to prevent HIV in women and their children; mobilizing resources from the Global Fund, PEPFAR and other bilateral donors; providing in-country technical support; fostering research into novel approaches to optimize drugs, diagnostics and integrated service delivery; and by working within a broader community of stakeholders and civil society to coordinate and support field implementation. As well as promotion of the best formulations for paediatric ART, through support of the Global Fund paediatric ARV procurement working group, UNAIDS has also worked to improve access to paediatric HIV diagnosis with new technologies and service delivery approaches such as birth testing to improve rates of loss-to-follow-up.

With the support of UNITAID, UNICEF undertook market-shaping activities to accelerate the development, uptake and in-country adoption of novel point-of-care technologies for infant diagnosis.

17. In 2015 and beyond, Joint Programme plans include supporting countries close to elimination in the Americas and Eastern Europe to develop requisite monitoring and evaluation systems; linking EMTCT with strategies to eliminate violence, stigma and discrimination; and strengthening linkages between food and nutrition, social protection and economic strengthening to assure the sustainability of MNCH/EMTCT programmes.

iii. Preventing HIV among people who inject drugs

18. There are an estimated 12.7 million people who inject drugs globally, 13% of whom are living with HIV. People who inject drugs account for an estimated 30% of new HIV infections outside of sub-Saharan Africa. Scientific evidence is clear on the impact of harm-reduction programmes in preventing HIV infections. Nevertheless, only 90 needles are available per year per person, while the need is about 200 per year.

The UNAIDS PCB held a thematic segment in December 2014 on the issue of people who inject drugs, with participation from representatives from the injecting drug use community of, to highlight the challenges and successes of working in partnership.

19. During 2014, the Joint Programme strengthened its joint advocacy and technical support to countries in order to increase access to the comprehensive package of evidence-informed interventions for the prevention and treatment of HIV for people who inject drugs.

As follow-up to the Global Commission on HIV and the Law, UNDP supported legal and policy reviews related to HIV and drugs in Eastern Europe and Central Asia and Asia-Pacific regions. UNDP also supported countries in Africa to organize National Dialogues on HIV, human rights and the law as well as conducting Legal Environment Assessment of policies, laws and practices including in relation to people who use drugs and prisoners.

20. UNODC led joint efforts with UNAIDS Secretariat, WHO, World Bank and civil society organizations to improve global

data on HIV and injecting drug use, and data on HIV and harm reduction services for people who inject drugs. The first-ever joint UN global estimates on HIV among people who inject drugs were published in the 2014 World Drug Report and a report on the Global State of Harm Reduction (Harm Reduction International).

UNODC, WHO and UNAIDS Secretariat organised a regional consultation on increasing access to NSP and OST in the Middle East and North Africa Region.

21. The HIV burden among prisoners and in some prison settings may be up to 50 times higher than in the general population. It has been estimated that between 56% and 90% of people who inject drugs will be incarcerated at some stage. Guidance documents and technical briefs on the provision of HIV-related services in both the community and prisons, developed by the Inter Agency Working Group on Key Populations, were disseminated through regional and international meetings. Technical support has also been provided to adapt the international guidance at the country level. The documents and briefs have a specific focus on women who inject drugs, young people who inject drugs, and needle and syringe programmes in prisons.

22. Additionally UNODC plays a lead role providing support to implement strategic interventions addressing the main bottlenecks to ensure HIV services for people who

An assessment of school-based interventions on substance use prevention in 10 countries in Eastern Europe and Central Asia countries was undertaken by UNESCO in 2014. The findings will inform a regional technical consultation on healthy lifestyle education which UNESCO, UNFPA and WHO plan to organise in 2015 with IPPF and BZgA.

inject drugs. Among the UNODC 24 high priority countries for HIV and injecting drug use, these included increasing: the quality and availability of strategic information; the capacity of NGOs and governments on harm reduction with a specific focus on opioid

substitution therapy (OST), needle and syringe programmes (NSP), HIV testing and counselling (HTC) and antiretroviral treatment (ART); the capacity of NGOs and community-based organizations to advocate for harm reduction; and the capacity of law enforcement agencies to support access for people who inject drugs to HIV services both within the community and in prisons.

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

i. Accessing treatment

23. By June 2014, nearly 13.6 million people living with HIV were on antiretroviral treatment (ART), with the global ART coverage rate being 38% in 2013 of all people living with HIV. This was twice that of 2009, although masks considerable differences between men and women aged over 15 years (33% and 40% respectively). In 2014, access to ART continued to increase in all regions, though with considerable regional and population variation.

Notable progress has been made in improving access to ART for people living with HIV in Asia and the Pacific region. By the end of 2013, approximately 1.6 million people were receiving treatment, accounting for 33% of all people living with HIV in the region.

24. However, global treatment coverage among children lags behind - at the end of 2013, less than 25% of children living with HIV globally were receiving ART, compared with

37% of adults. HIV prevalence among key populations remains high in all regions but treatment coverage remains disproportionately low for these populations.

25. UNAIDS 90-90-90 initiative was launched at the International AIDS Conference in 2014, setting ambitious treatment targets to help end the AIDS epidemic. To support the targets, WHO has provided a comprehensive normative framework to guide the health sector response and strategies for HIV diagnosis, treatment, care and prevention and outlined priorities on implementation science and clinical research agenda for optimizing HIV treatment across the cascade.
26. WHO also produced two guideline supplements, updating selected chapters of the 2013 consolidated ART guidelines and producing new recommendations on post-exposure prophylaxis (PEP) and the use of cotrimoxazole. The current normative package includes 72 recommendations for management of HIV in adults, adolescents, children, and pregnant and breastfeeding women across the continuum of care.

WHO worked with Ministries of Health to facilitate implementation of these guidelines via regional workshops reaching more than 100 countries; since the launch of the 2013 ART guidelines, nearly 80% of 58 focus countries adopted at least one major recommendation and another 25 countries planned to adopt.

27. Nevertheless, there are also significant gaps in treatment in some countries and regions as well as amongst some key populations. Although key populations are at higher risk for HIV acquisition, they are often least likely to access HIV services. For example, a global survey found that only 14% of men who have sex with men living in low-income countries reported having meaningful access to HIV treatment services.

28. The multi-sectoral nature of the Joint Programme means it is uniquely placed to address

a wide variety of gaps in treatment in a responsive way. For example, an advocacy and guidance brief on maintaining a minimum HIV programme in the context of the Ebola emergency, including a package of interventions with delivery through community platforms, was developed by UNHCR, WHO, WFP, UNICEF and the UNAIDS Secretariat. UNHCR also published *Guidelines for the*

In Uganda, UNESCO worked with young people living with HIV to provide capacity-development and promote access to and demand for treatment. At least 150 schools received HIV workplace policy to protect the rights and needs of learners and educators LHIV.

The UNAIDS Regional Support Team for West and Central Africa championed the Economic Community of West African States (ECOWAS) Regional Pharmaceutical Plan to ensure access to quality and affordable ARVs for all the populations in West Africa. Treatment rights, strict compliance on quality, good health governance and sustainable development are the mainstays of this plan and have been promoted during high-level discussions between an ECOWAS delegation and the Heads of UNAIDS, WHO, UNIDO and Global Fund in March 2015. The regional ECOWAS ARV security stock, a by-product of the plan has addressed stock-outs in two countries, and four Nigerian companies have acceded to the WHO Good Manufacturing Practices standards.

Delivery of Antiretroviral Therapy (ART) to Migrants and Crisis affected Persons in Sub-Saharan Africa in 2014, for all types of migrants and crisis-affected populations. UN Women commissioned a review of barriers to women's access to HIV treatment and care to complement existing evidence. WFP provided food and nutrition support to malnourished people living with HIV on ART in 22 countries.

29. Treatment remains a central priority of the Joint Programme. UNAIDS will continue to promote the 90-90-90 targets, document country experiences, and explore multi-sectoral solutions to ensure that no one is left behind.

ii. Avoiding TB deaths among people living with HIV

30. Following joint efforts to scale-up collaborative TB/HIV activities, 4.8 million lives were saved between 2005 and 2013. According to the WHO Global Tuberculosis Report 2014, TB/HIV mortality reduced globally by about a third to 360,000 in 2013, short of the 50% target set for 2015. However, in 15 of the high burden TB/HIV countries, the 50% target was surpassed.

31. Increased UNAIDS advocacy at key events in 2014, such as CROI 2014, EECAA, AIDS 2014, TAsP and the Union, helped raise the TB/HIV profile, shape scale-up strategies, share successful examples of scale-up, define the basic and implementation research agendas and mobilize resources. Of particular note was the meeting at AIDS 2014 in Melbourne on *Eliminating TB Deaths: Time to step up the HIV response*, where high level political commitment was affirmed to address the ART treatment gap of TB patients living with HIV.

32. Strategic Information is vital to address TB/HIV issues. WHO and the UNAIDS Secretariat have continued to ensure the reporting of reconciled, consolidated data on TB/HIV for the WHO Global TB, HIV and UNAIDS reports. Improved recording and reporting has resulted in 132 countries reporting outcomes disaggregated by HIV status in 2013, up from 96 who reported in 2012.

A total of 21 countries, with ILO support to Ministries of Labour, workers' trade unions and the Business Coalition on AIDS, developed action plans and scaled up dual TB/HIV workplace programmes into health and wellness programmes, integrated HIV responses into workplace TB programme, or integrated TB responses to existing workplace HIV programmes for employees. For example in Kenya, using the joint ILO and WHO HealthWISE guidelines, capacity was built in the Kenya National Union of Nurses to become master trainers to enhance female and male health workers' occupational safety and health related to TB and HIV.

UNICEF continued to focus on the childhood TB/HIV response through targeted integrated service delivery and community response within platforms for maternal, neonatal and child health, and generation of evidence on the burden of co-infections to inform policy and programmatic shifts. This was achieved through pilot implementation of HIV/TB adapted community case management in Zambia and completion of paediatric HIV and TB assessment in Ghana and Nigeria.

WFP provided food and nutrition assistance to TB patients, including HIV/TB co-infected patients, in 18 countries; in nine of these countries, supplementary household rations were granted to minimize sharing. In Madagascar, the WFP food-by-prescription programme for TB clients, including HIV/TB co-infected individuals, led to a 94% TB treatment success rate. Subsequent advocacy led to the elaboration of a national protocol and national nutrition strategy for malnourished TB/HIV clients; and the elaboration of the Madagascar Global Fund Concept Note for TB.

33. Work on refining and updating guidelines also is important. To increase access to key populations and the more vulnerable, with UNAIDS Secretariat and UNODC inputs, TB/HIV recommendations were mainstreamed into WHO guidelines on prevention, diagnosis and care for key populations; and on the management of tuberculosis in children. WHO and the UNAIDS Secretariat also worked with the Global Fund and PEPFAR to revised the *Guide to monitoring and evaluation for collaborative TB/HIV activities*.

34. Support for countries provided by WHO, the UNAIDS Secretariat and other key partners in 2014 focused on continuing strengthening joint TB and HIV programming. This was achieved through strategic direction provided to the Global Fund TB/HIV Technical Working Group, the development of an Information Note on joint TB and HIV programming, and WHO technical assistance provided to more than 20 TB/HIV high burden countries in the development of national strategic plans, joint programme reviews, and the development of 25 single TB and HIV concept notes for submission to the Global Fund.
35. More than 75% of all estimated HIV incident TB cases are among people living in just 10 countries, nine of them in sub-Saharan Africa. Joint Programme interventions therefore tend to be focused in a small range of countries, addressing different but vital elements of a multi-sectoral response.
36. In the future, the Joint Programme will continue to ensure a high global profile of TB/HIV research and implementation through important international fora such as the International AIDS Society, Conference on Retroviruses and Opportunistic Infections (CROI), Harm Reduction International, International Conference on AIDS and STIs in Africa (ICASA) and the Union Conferences as well as fostering strategic partnerships through key stakeholder networks.

iii. Protecting the vulnerable

37. The Joint Programme has put social protection firmly on the global AIDS agenda in 2014, ensuring that social protection, care and support is understood globally as critical to the AIDS response, building the evidence base for social protection interventions and strengthening national systems for social protection, care and support.
38. The World Bank and UNICEF's co-convening of the Social Protection, Care and Support (SPCS) working group led to a remarkable year in terms of positioning SPCS in the HIV response. A series of Joint Programme events helped convene around SPCS and raised the profile of this thematic area in the HIV response. This led to the first social and structural drivers meeting in Washington (co-hosted by the World Bank President and UNAIDS Executive Director) and the SPCS annual meeting, which brought together the first gathering of researchers and policymakers to showcase the initial findings around SP and HIV prevention.

The UNAIDS 34th PCB thematic session on addressing the social and economic drivers of HIV through social protection, resulted in decision points pertaining to social protection, care and support, including: connecting HIV with eradication of extreme poverty and inequality, promotion of human rights; facilitating country-level dialogues and conducting HIV and social protection assessments; scale-up of social protection programmes that enhance HIV prevention, treatment, care and support; advancing research in social protection; and building social protection literacy among those in need of it.

39. ILO initiated a global awareness raising campaign on national social protection floors (NSPF). This included advocating for the removal of HIV exclusion in insurance policies in Sri Lanka; including coverage for people living with HIV in the national Social Protection Policy and Strategy in Ethiopia; and sensitizing over 2,600 workers on HIV and social protection in Kenya.
40. UNICEF supported national governments to progressively expand social protection coverage and develop comprehensive social protection systems in 97 countries. In

Africa, UNICEF is supporting the design and implementation of cash transfers in 10 countries and is supporting 22 countries in the formulation of multi-sectoral social protection strategies, policies, and systems. UNICEF also led the documentation of lessons learned and models of how synergies between child protection systems and HIV have benefited HIV and child protection outcomes for children in Nigeria, Zambia and Zimbabwe.

41. A strong focus on HIV-sensitive and HIV-specific research within broader social protection strategies and health sector interventions was a core message during global awareness raising and substantive discussions on HIV and social protection during 2014. In this regard, the UNAIDS Secretariat, with support from Cosponsors and partners, published the HIV and Social Protection Guidance Note.

UNAIDS activities led to Global Fund support in scaling up social protection programmes. Social protection, in particular cash transfers, for HIV prevention were included in country concept notes to the Global Fund for Kenya, Malawi, Tanzania, Uganda and Zambia.

42. In the future, the Joint Programme will continue to support social protection programmes across a range of areas, including further attention to the 34th PCB decision points. Cash transfers remain a focus for a number of Joint Programme members, and work will continue supporting a more refined incorporation of gender awareness into these as well as the development of an indicator for cash transfers and their relation to HIV prevention.

UNDP supports over 53 countries with regard to social protection issues and, in 2014, helped convene a national consultation on HIV-sensitive social protection in Cambodia, leading to the designation of people living with HIV as a “special vulnerable group” within Cambodia’s National Social Protection Strategy.

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

i. Reducing punitive laws

43. To advance the commitments of UN Member States in the 2011 Political Declaration on HIV/AIDS and the recommendations of the Report of the Global Commission on HIV and the Law, the Joint Programme undertook a number of activities in 2014. These include supporting the reform of punitive laws, policies and practices; strengthening the capacity of judiciary, legislature and law enforcement agencies on HIV, human rights and the law; increasing access to justice and legal literacy initiatives; and the production of guidance documents, tools and knowledge products.

44. To advance the findings and recommendations of the Global Commission on HIV and the Law, UNDP developed guidance documents on how to undertake legal environment assessments and national dialogues. This included a guidance document for UN staff entitled ‘Preventing and Responding to HIV related human rights crises’ in partnership with UNFPA, UNODC, ILO, UNHCR, UNICEF, the UNAIDS Secretariat and the Global Fund. In 2014, UNAIDS published the Gap report, focusing on key populations left behind in the HIV response.

In the Philippines, UNICEF, UNFPA, UNAIDS Secretariat and partners organized policy dialogues focused on legal reform for adolescents’ health and rights. UNICEF supported efforts that led to the government of Thailand declaring that children under 18 can have access to HIV testing without parental consent.

45. In the Asia Pacific region, the Regional

Interagency Team on AIDS organized national dialogues in 19 countries to review legal and policy barriers that limit access to services for people living with HIV and key populations. In Pakistan, this led to the passing of the Sindh Provincial AIDS Law, the first AIDS law in South Asia. In Bangladesh, the Government issued a policy recognizing transgender persons. UNESCO, UNFPA, the UNAIDS Secretariat and partners also conducted a review of legal/ policy barriers in Asia Pacific impeding access to HIV/SRH information and services.

46. In Latin America, UNDP supported five countries to revise HIV laws (Costa Rica, Guatemala, El Salvador, Nicaragua and Uruguay) with revised laws in Costa Rica and Uruguay being presented to Parliaments. UNDP also supported the review of Gender identity laws in El Salvador, Guatemala and Nicaragua.

In the Dominican Republic, the UNAIDS Secretariat, in coordination with the United Women's Movement (MODEMU), CONAVIHSIDA, and partners supported the development of a Bill aimed at recognizing sex work as work and providing for comprehensive care for sex workers.

47. In sub-Saharan Africa, the Joint Programme supported authorities in Nigeria to pass an anti-stigma bill. ILO provided technical advisory support for the inclusion of HIV-related protections for workers in Kenya's Health Bill and Occupational Safety and Health Bill. UNDP support resulted in HIV-related law review and reform in Lesotho, Namibia, Swaziland and Tanzania as well as the ECOWAS Secretariat drafting a minimum HIV Law package for adoption by Member States.

UNDP supported successful efforts in DRC to prevent the adoption of new anti-homosexuality legislation, while in Chad, interventions by the UNAIDS Secretariat, resulted in the shelving of a draft penal code provision to criminalize same-sex sexual relations.

48. In the Arab states, advocacy by UNDP led the Government of Djibouti to commit to taking steps to ratify the Arab Convention for HIV Prevention and protection of the rights of people living with HIV. In Somalia, UNDP and the UNAIDS Secretariat provided comments on the draft Sexual Offenses Bill which resulted in improved language being adopted.

49. In Eastern Europe and Central Asia, UNDP and the UNAIDS Secretariat supported the work of the Eurasian

Coalition on Male Health in engaging governments to stop the development and adoption of homophobic laws. A dormant 'gay propaganda' homophobic bill was removed from the Ukrainian parliament due to interventions by the UN

WHO, UNODC, UNDP, UNFPA and the UNAIDS Secretariat co-sponsored a global dialogue on police and HIV convened by LEAHN and IDLO, in Amsterdam.

The UNAIDS Secretariat filed separate amicus curiae briefs in a case before the High Court of Malawi relating to the constitutionality of laws criminalizing homosexuality, and before the European Court of Human Rights challenging the ban on OST in Russia.

Joint team. Abusive police actions targeting sex workers in Kyrgyzstan and Tajikistan have been discontinued due to advocacy of UNDP, UNFPA and the UNAIDS Secretariat.

ii. Eliminating HIV-related travel restrictions

50. Since 2011, 11 countries, territories or areas have removed their restrictions or have officially clarified that they do not apply such HIV-related travel restrictions, leaving 38 countries, territories and areas that still had such restrictions at the end of 2014. In 2013-2014, the Secretariat and UNDP provided technical and advocacy support that was critical to the removal of HIV-related travel restrictions in Australia, Comoros and Tajikistan.

51. In addition to the support that UNAIDS provided for countries to remove restrictions, it has also focused on working with migrant-receiving countries in the Middle East. As a follow up to the joint work started in 2013, UNDP, ILO, the UNAIDS Secretariat and UNHCR are conducting a study for the review of policies, regulatory frameworks and practices in Gulf Cooperation Council (GCC) countries as well as Lebanon and Jordan. The study is planned to be country-led (through the Ministry of Health and the National AIDS programmes). A concept note and national studies methodology have been finalized and sent to respective GCC countries.

In the lead-up to the 2014 International AIDS Conference, the Secretariat worked with Australian authorities to clarify whether the country's HIV-related regulations qualify as "HIV-related travel restrictions" according to the criteria established by the International Task Team on HIV-related Travel Restrictions. In July 2014, UNAIDS welcomed Australia's commitment to ensuring that people living with HIV do not face an automatic exclusion, or unequal treatment when applying for entry, stay or residence visas.

Comoros passed a new law that explicitly protects the free movement of people living with HIV, in response to a validation letter that the Secretariat sent seeking clarification.

In Tajikistan, the Secretariat and UNDP worked closely with national stakeholders to support the development of draft HIV legislation, including provisions that would end all HIV-related travel restrictions. The support of UNAIDS Secretariat in Tajikistan was strengthened by the visit of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The visit provided an opportunity to scale up advocacy on the draft legislation to repeal HIV-related travel restrictions. The Tajik Parliament passed the new law in March 2014.

iii. Addressing HIV needs of women and girls

52. In sub-Saharan Africa, 59% of adults living with HIV are women, and infection rates among young women are twice as high as among young men. Globally, women living with HIV also experience forms of institutional violence, including forced sterilization and forced abortion and the denial of voluntary sterilization or safe abortion services. The AIDS response needs to take account of the full range of women's vulnerabilities, including for young women and female sex workers and for changing harmful gender norms and economic disempowerment.

53. The Joint Programme has made significant contributions to addressing the gender dimensions of HIV epidemics. Integration of gender equality and human rights into HIV National Strategic Plans (NSPs) has improved; human rights and policy frameworks in support of women's rights have been strengthened, especially in relation to women living with HIV and from key populations; while support to women living with HIV, including their participation and leadership in broader health and development initiatives have also enhanced HIV and gender policies.

54. Enhanced technical guidance and tools developed by the Joint Programme and other partners have strengthened national HIV strategies and Global Fund concept notes to increase attention for gender equality, including sexual and reproductive health and rights (SRHR), and key populations. Used by more than 30 countries, the UNAIDS Gender Assessment tool allowed governments and civil society organizations to identify strategic gaps and priorities in national HIV responses.

A Technical Working Group established by UN Women and co-convened with the Global Fund, with participation of UNDP, UNFPA, WHO, UNAIDS Secretariat, donors and CSOs, commissioned and disseminated a menu of key interventions on gender-transformative programming to support and inform concept note development. This also supported networks of women living with HIV to build their capacities to engage in Global Fund processes.

55. Women and girls, especially those living with HIV or from key populations, are important partners in the advocacy, development, implementation, and monitoring and evaluation of gender-responsive HIV programmes. In over 30 countries the efforts of the UNAIDS family focused on capacity development for women living with HIV and their networks to engage in different policy reviews and NSP development, that resulted in recommendations that included women and girls HIV-related needs and priorities.
56. UNAIDS also continued support to the Global Coalition on Women and AIDS (GCWA), which brings together many stakeholders to promote and advance gender equality, women's empowerment, and sexual and health and rights in the context of HIV. During the 58th session of the Commission on the Status of Women (CSW) in March 2014, the GCWA organized a panel on 'Advancing young women's sexual and reproductive health and rights in the Post 2015 development framework'.

UNAIDS supported women living with HIV, including young women, to participate in the 58th CSW including in the negotiations on the HIV Resolution and Agreed Conclusions.

57. UNICEF, UNFPA, UN Women and other Cosponsors supported national partners in producing data examining social vulnerability of adolescents and young women to better address, through youth-friendly, integrated HIV-SRH services, their needs in HIV prevention strategies and new NSPs in Cambodia, Kenya and Mozambique. The also ensured the use of strategic information on young people and key populations in Namibia and supported optimal coverage of SRH/HIV programmes for in- and out- of school adolescents and young people to address high HIV prevalence rates among pregnant girls and young women (aged 14-24) in Uganda.

The adolescent SRH policy in Kenya is being revised to include an education re-entry policy for teenage mothers, following a global consultation organized by UNESCO in Johannesburg in November 2014 on addressing the linkages between HIV, early/unintended pregnancy and the right to education.

58. An initiative by ILO, UNAIDS Secretariat and South African Development Community in East and Southern Africa empowered young women and girls in the informal economy by integrating entrepreneurial skills and economic enhancements, including access to loans, into HIV services. In

UNAIDS Secretariat, UNDP, UNFPA, and UN Women continued to work with traditional leaders and decision makers to safeguard property and inheritance rights of women living with HIV. Following a legal assessment in Malawi, the seven Paramount Chiefs committed to a "Chiefs' Declaration" that included a commitment to raise the age of marriage for girls.

Zambia, the percentage of young women who used a condom during their last sexual encounter increased from 37% to 53% and the percentage who accessed HIV services increased from 76% to 89%. Overall, there was a 72% increase in average profits and a 58% increase in expenditure on education by women. Such outcomes provide concrete evidence on how addressing the socio-economic determinants of HIV can reduce the vulnerability of young women.

iv. Stopping gender-based violence

59. Intimate partner violence is an unacceptable violation of basic human rights, and disproportionately affects women and girls - an estimated one in three women is beaten, coerced into sex or otherwise abused by an intimate partner during her lifetime. Such violence has been shown to increase the risk of HIV infection and violence (and the fear of violence) deters people from seeking services for HIV prevention, treatment, care and support.

60. UNAIDS has strengthened the evidence base on the human rights violations faced by women, women and girls living with HIV and key populations (sex workers, women who inject drugs, transgender people). The Joint Programme has additionally addressed the intersections of HIV and different forms of gender-based violence (GBV), limits to accessing justice and what works programmatically in health-care, educational and community settings in order to respond to these issues.

The UN Trust Fund to End violence against women, managed by UN Women, supported women living with HIV organizations to use Stepping Stones methodology in Malawi to prevent violence and reduce women's vulnerability to HIV by engaging men and traditional leaders to challenge unequal gender norms and by mobilizing communities to advocate for more effective laws. This community mobilization and advocacy around violence against HIV-affected women contributed to the adoption of a law criminalizing marital rape.

61. To address stigma and discrimination in health-care settings, the UNAIDS family supported a legal analysis of rights violations of HIV-affected women in healthcare settings in Asia, produced a related toolkit, as well as leading an initiative to respond to this form of discrimination in Latin America and the Caribbean, in partnership with regional and national CSOs. UNESCO expanded its work on school-related gender-based violence (SRGBV) in at least thirteen countries to generate evidence for supporting and developing policies that promote safe schools for young people, including gender non-conforming and LGBTI youth; and to raise awareness of school administrators and teachers about GBV, homophobic and transphobic bullying in educational institutions.

62. Better evidence on violence against women living with HIV and women from key populations has sharpened and ensured evidence-informed national policy and programme responses in different epidemic settings. Technical and capacity support to national AIDS coordinating authorities and ministries of gender in 2014 has resulted in strengthened HIV-GBV linkages in HIV National Strategic Plans (NSPs) and National Action Plans (NAPs) on ending GBV in at least 10 countries.

In Indonesia, an action plan was developed to respond to the evidence on sex workers and advocate for its inclusion in the new HIV National Strategic Plan. In Nigeria, UNAIDS Secretariat, UNDP, UNFPA and UN Women supported the development, implementation and dissemination of the National Plan on 'Addressing GBV and HIV/AIDS Intersections'. It built on the mapping of laws, policies and services on GBV and HIV supported by UNDP. In South Africa UNDP, UNFPA, and UN Women technical support to the National Gender Summit, held by the South African Commission for Gender Equality, led to the adoption of NAP on scaling-up GBV and HIV Prevention.

A regional report produced by UNDP, UNFPA, Asia-Pacific Network of Sex workers and SANGRAM, made recommendations to inform policy and programmes to prevent and respond to violence against female, male and transgender sex workers. Using findings from four countries (Indonesia, Myanmar, Nepal and Sri Lanka), the study received the Robert Carr Research Award, presented at the International AIDS Conference in Melbourne.

WHO, UNFPA and UN Women published a clinical handbook for health-care providers on service and care provision to violence survivors, including the provision of post-exposure prophylaxis (PEP) to prevent HIV transmission.

UNHCR and its partners strengthened the integration of quality HIV-SGBV prevention, treatment, care and support in protection and health coordination mechanisms and in community-based structures through training of social, health and community workers on anti-retroviral (ARV) treatment adherence and counselling.

STRATEGIC FUNCTIONS AND RELATED AREAS

UNAIDS achievements and contributions

i. Leadership and advocacy

63. In 2014, the vision of ending AIDS as a public health threat by 2030 was firmly established. The foundations of political support for this ambitious goal were laid and momentum gained for ensuring that no one is left behind on the road to achieve this ultimate goal.

64. The compelling message of UNAIDS vision of 'Getting to zero' - zero new HIV infections, zero discrimination and zero AIDS-related deaths - has been adopted by political leaders and activists worldwide. Inspired by the progress made in the AIDS response over the past few years, the international community (including the PCB and the Open Working Group on the Sustainable Development Goals) has embraced the ambition of ending the AIDS epidemic as a public health threat by 2030.

In 2013-2014, UNAIDS Executive Director met with Heads of State and Government and Ministers and undertook numerous bilateral country visits (including to, Brazil, Tunisia, Equatorial Guinea, Ghana, India, Indian Ocean Islands, Ivory Coast, Mali, Mauritania, Russia, Rwanda, Senegal, South Africa, Thailand), and carried out three joint country visits with key partners (Central African Republic with UNOCHA, Namibia with the Global Fund, and Mali with the Global Fund and WHO). In addition, senior UNAIDS staff undertook a number of country visits to engage directly with key partners in the AIDS response and reinforce UNAIDS' corporate priorities. This extensive advocacy has generated new, bold commitments to support UNAIDS' call for acceleration of the global AIDS response, shared responsibility and global solidarity.

65. Significant efforts by UNAIDS Secretariat, to increase political momentum and political capital to position AIDS and the Joint Programme within the wider post-2015 development agenda, have continued. The International AIDS Conference in Melbourne

and the UN General Assembly September 2014 session were critical global platforms where UNAIDS mobilized unprecedented support from UN Member States, donors, civil society and other partners to accelerate and scale-up efforts over the next five years. Key multi- and bilateral commitments were secured in the last quarter of 2014, including from BRICS Ministers of Health, US Department of State, the United States President's Emergency Plan For AIDS Relief (PEPFAR), and Luxembourg—which made the first pledge to UNAIDS of direct financial support for implementation of the 90-90-90 targets.

66. The UNAIDS Secretariat continues to fulfil its core function and leadership role to provide strategic information, producing epidemic data and extensive strategic analysis provided in flagship reports, on the AIDSinfo website and in various publications. For example, the 2014 mid-year *Gap report* focused on locations and populations that are currently being left behind in the AIDS response. The *Fast-Track - Ending the AIDS epidemic by 2030* report and targets, launched at the UN General Assembly in September 2014, provided the evidence base for solidified global engagement and commitment to the goal of ending the AIDS epidemic as a public health threat by 2030. Finally, the *Cities Report* provided data, analysis, case studies and inspiring profiles of urban innovators, leading to the Paris Declaration on Ending AIDS in December 2014. Together the reports have provided compelling evidence, highlighting a five-year window of opportunity to accelerate the response in order to end the AIDS epidemic by 2030.

67. UNAIDS has reinforced Africa's leadership and progress in the AIDS response. As a result of the African Union (AU) Meeting of Ministers of Finance in Abuja in March 2014 and the AU annual meeting in Malabo in June 2014, additional political support has been mobilized for countries to develop robust, inclusive and results-focused national strategies and investment cases, providing a solid framework for change.

A new UNAIDS initiative to promote South-South collaboration between the African Union and the Caribbean Community worked to facilitate the Caribbean HIV Roadmap, which will go to Caribbean Heads of Government in 2015.

The League of Arab States endorsed a new, ground-breaking Arab AIDS Strategy (2014-2020) to address the growing HIV epidemic in the region.

68. In 2014, UNAIDS highlighted and shared lessons from the AIDS response for the Ebola response. This includes identifying new and innovative ways of ensuring a people-centred approach to health, which strengthens and reinforces human security and thus national security. A joint mission to Mali in October with the Global Fund, WHO and the Special Representative of France for Ebola was conducted and a [conference room paper](#) sharing lessons from the AIDS response was also prepared for the PCB in December 2014.

ii. Coordination, coherence and partnerships

69. The value of the lessons learned from the unique approach of the Joint Programme has been acknowledged by its governing body, the PCB, and by ECOSOC resolution (E/RES/2013/11). The Resolution cites the Joint Programme as a useful example of good practice for the rest of the UN to enhance strategic coherence, coordination and results-based focus and country-level impact in the post-2015 period.

70. UNAIDS results-oriented approach and principles - including holistic multi-stakeholder engagement, inclusive governance, evidence and data, mutual accountability, equity and human rights - can be considered as a pathfinder for health, human rights and development governance in the post-2015 era.

71. The AIDS response continues to demonstrate the power of public-private partnerships. UNAIDS and UNCTAD co-chaired a panel to improve access to high-quality low-cost medicines and promote domestic production through renewed public-private partnerships. UNAIDS Secretariat, the World Bank, UNDP and the Global Fund are also working together to increase the effectiveness of AIDS investments, with focus on taking AIDS out of isolation in financing and policy. A new UNAIDS–Global Fund Cooperation Agreement was signed in December 2014, outlining strengthened coordination mechanisms, timely information-sharing at all levels and mutual accountability.

In 2014 UNAIDS, the Clinton Health Access Initiative, the Global Fund, the US Government, and Roche negotiated a landmark global agreement to reduce by at least 40% the cost of the leading viral load testing technology. Countries are already expanding access to this essential diagnostic tool and the new price is expected to save at least US\$150 million over the next five years.

72. In 2014, UNAIDS promoted strategic investment approaches for domestic and international spending and financial sustainability transition plans to augment local investment in responses, demonstrating economic returns on investment up to 15 times higher than investments required. UNAIDS Secretariat, the World Bank, UNDP and the Global Fund are working together to increase effectiveness of AIDS investments, with focus on taking AIDS out of isolation in financing and policy.

UNAIDS Secretariat supported 45 country-HIV or HIV/TB concept notes for the new funding model of the Global Fund totaling more than USD 5 billion.

73. Throughout 2014, UNAIDS inclusive governance model has enabled dialogue between affected communities, governments and the UN, ensuring progressive global policy setting and ambitious global targets informed by evidence and country realities. Close collaboration was maintained between UNAIDS Secretariat, the Cosponsors and other partners, such as, the United States President's Emergency Plan For AIDS Relief (PEPFAR) - to help countries implement an investment approach in national planning processes and support the alignment of the new PEPFAR 3.0 strategy with global priorities.
74. At country level, UNAIDS provided extensive technical assistance to ensure that national plans on HIV are in place, resources available, approaches integrated and decentralized and local capacities improved. UNAIDS is actively participating in three technical support coordination groups in order to assure strong collaboration among partners in supporting countries leverage Global Fund resources. In 2014, the Technical Support Facilities and UNAIDS regional support teams assisted over 60 countries through 125 technical support assignments related to the New Funding Model.
75. The Joint Programme continues to refine mechanisms to ensure coordination is as effective as possible in the areas that count. The establishment of a sex work steering group in May 2014, including UNDP and UNFPA, and a new UN strategic advisory group on drug use and HIV, including UNODC, WHO and other partners, have strengthened UNAIDS' coordination and leadership role and increased efficiency of action around these two key populations.
76. Throughout 2014, UNAIDS Secretariat strengthened partnerships with civil society and spearheaded several collaborative initiatives, for example to advance treatment as prevention, non-discrimination and gender equality targets, fast track initiatives, youth

and community participation and service delivery, global retargeting, support from faith leaders on human rights and advocacy for Sustainable Development Goals. UNAIDS Secretariat led UN engagement with the faith-based organization sector to address the Ebola epidemic - providing technical support on the development of a strategy and community engagement guidelines in Ebola vaccine clinical trials and inputs for a safe and dignified burial protocol.

ii. Mutual accountability

77. The Joint Programme continues to produce results and demonstrate value for money, while the Unified Budget Results and Accountability Framework (UBRAF) is proving to be an effective accountability tool – linking the achievement of specific goals and the measurement of results and contributions of the UNAIDS family to indicators and other performance metrics.
78. Through the UBRAF mid-term review, which was delivered to the 34th Programme Coordinating Board (PCB) in 2014 and was informed by external reviews, extensive data collection and analysis, the Joint Programme was able to assess its effectiveness and identify ways to improve UBRAF to enhance coordination, performance monitoring and accountability. A separate review of UBRAF indicators, which began in mid-2013, resulted in a revised and simplified indicator framework of 32 core indicators.
79. UNAIDS' first Financing Dialogue was held on 12 November 2014 with some 80 participants representing over 40 Member States in addition to the PCB NGOs and the Cosponsors. A web portal, *Investing for Results* (<https://results.unaids.org/>), was also introduced in November 2014, providing information on country level achievements, results against priorities, funding trends and expenditures. The portal is expected to become an important way of complementing paper-based reporting to the PCB by providing regularly updated programmatic and financial information.
80. An external audit certified UNAIDS 2014 accounts as unqualified (i.e., 'clean') and UNAIDS Secretariat was commended for the implementation of all ten recommendations from the previous external audit. These included the development of an overall procurement plan, strategy and manual. Areas where governance of UNAIDS resources could be further enhanced are included in the external audit report, which forms part of the 2014 financial report presented to the 36th PCB (UNAIDS/PCB (36)/15.8).
81. The adoption of the International Public Sector Accounting Standards (IPSAS) by the Secretariat continues to improve the comprehensiveness, quality and comparability of the Secretariat's financial reporting. Building on a risk management policy and governance model developed for UNAIDS Secretariat, a Risk Management Committee was established in June 2014 to guide and oversee the implementation of enterprise risk management in the Secretariat.
82. In 2014, UNAIDS Secretariat entered the consolidation phase of strategic realignment. Efforts have continued to strengthen management and administrative systems and workforce planning strategies, including staff development and implementation of the Secretariat Gender Action Plan. Several initiatives demonstrating value for money and efficiency were undertaken during the course of 2014, such as the replacement of Blackberries with iPhones, a new flat rate plan for HQ mobile users and the transition to an offshore travel agent that provides expanded coverage and savings, with lower transaction costs as compared to Geneva-based travel services (a saving of approximately CHF 137,000 in the first nine months of operations).

83. UNAIDS has been integrally involved through the UN Development Group (UNDG) and the High Level Committee on Management (HLCM) in the development of Standard Operating Principles (SOPs) for Delivering as One as part of efforts to develop a more coherent and effective UN system. A joint high-level mission to Brazil enabled participants to engage with organizations and government on a new business operations strategy and the establishment of the first joint operating facility for the UN system.

v. **Close the resource gap**

84. The commitment by UNAIDS and the international community to end AIDS as a public health threat by 2030 not only necessitates setting ambitious targets, but must also be matched by considerable upfront investments from both countries and donors, based on principles of fair share and global solidarity. At country level, UNAIDS Secretariat acts as a broker, working with countries and development partners to make the case for moving from traditional cooperation relationships towards shared responsibility and global solidarity.

The African Union's roadmap for the response to AIDS, tuberculosis and malaria exemplifies how African countries and development partners rallied around this mutual accountability agenda for a revitalized response to the three diseases.

85. In 2014, UNAIDS projected new HIV investment needs estimates for ending AIDS by 2030, presenting the likely impacts and funding requirements and the likely economic benefits and returns, as well as options for funding strategies. The process involved consultation with experts, modellers, regional representatives, civil society and other partners on defining global aspirational targets and models. Global inputs by 36 countries that bear 90% of the burden of disease and spending were validated through regional consultations. UNAIDS Secretariat and the World Bank also convened the HIV Economics Reference Group (ERG) and its respective technical working groups to contribute to the global resource needs estimates.

86. UNAIDS has studied the relationship between critical enablers and AIDS mortality in order to determine the impact of critical enablers in the HIV epidemics. A quality assured database of all available HIV expenditure data for the period 2006-2013 for 33 priority countries has been developed and the different consultations of the Task Force on HIV Resource Tracking have laid the foundations for development of the Performance Oriented Resource Tracking and Investment Assessment that will connect resource tracking with performance and outcomes of interventions.

UNAIDS Regional Support Teams in Eastern and Southern Africa and Asia and Pacific have conducted regional studies of the current funding landscape as well as identifying options for sustainable HIV financing through domestic resources.

In East and Southern Africa, evidence generated by investment cases and National HIV Strategic Plans has been central to Global Fund concept note development. Nine concept notes (Zambia, SADC Cross Border Initiative, Uganda, Mozambique, Tanzania, Swaziland, Mauritius, and Zanzibar) were submitted to the Global Fund, eight of which were successful.

The World Bank supported countries in Latin America to conduct HIV Allocation Efficiency Analysis to inform resource allocation and HIV strategic planning.

Based on many years of experience of supporting countries to develop sustainable financing HIV plans, UNAIDS has produced a methodological note addressed to experts in the area, managers and planners in charge of developing these plans. The Secretariat, UNDP, WHO and the Global Fund have collaborated together in developing a guidance note for countries to help them demonstrate value for money of their interventions in the national strategic plans or proposals to donors.

vi. **HIV integration**

87. Integration of HIV with other health and non-health programmes and vice versa will be essential to the achievement of the sustainable development goals, including ending AIDS. In many countries, progress has been achieved in integrating service delivery in the areas of HIV and tuberculosis, elimination of mother to child transmission (EMTCT), maternal and child health (MCH), sexually transmitted infections (STIs), family planning, and non-communicable diseases (NCDs) and in primary health care. However, what works in one country or region may not be effective in another setting, and countries are at different stages with HIV integration.

A guidance tool was drafted by UNAIDS (including input from UNFPA, WHO, UNICEF, IPPF and other partners) on convening and engaging country led processes aimed at impactful accelerated multi-sectoral integration and identifying opportunities to implement HIV integration at service delivery level.

The UN Interagency Task Force on the prevention and control of NCDs promoted better linkages of HIV with NCDs services as reflected in UN Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs.

UNFPA co-led, with IPPF, WHO, UNICEF, UNAIDS Secretariat, and the IATT Integration WG, development of a joint commodities framework linked to the EMTCT Global Plan Job Aid for Healthcare Workers to support programmes to deliver the full range of commodities for effective EMTCT programmes including ARVs, contraceptives, STI and TB drugs, and commodities related to GBV, pregnancy, delivery, infants, and children.

The Interagency Working Group on Sexual and Reproductive Health Rights (SRHR) and HIV Linkages (UNFPA, WHO, UNAIDS Secretariat, IPPF, and other partners) developed the SRHR and HIV Linkages Compendium: Indicators & Related Assessment Tools, and the country level index of indicators for measuring progress in HIV and SRHR, which was applied in 50 countries.

88. The integration of HIV and services for sexual and reproductive health including sexually transmitted infections was reported at the facility level, by 67% of countries. More than 90% of countries indicate that mainstreaming HIV into broader development frameworks and integration of HIV with other systems is a national priority, and 70% report that they are on track to achieve national integration commitments.

89. In regards to primary health care, 71 countries (over half) reported a high number of HIV counselling and testing services integrated with general outpatient care in health facilities, and about one third reported that only few services were providing joint services. Almost one third of the countries had gone further in integrating services and reported a high number of facilities offering integrated HIV counselling and testing, antiretroviral therapy and general outpatient care.

90. Throughout 2014, the Joint Programme has been actively promoting and supporting these efforts in the various areas of the comparative advantage in line with the Division of Labour. At the global level, efforts also focused on advocacy on the benefits of an integrated approach to achieve the Millennium Development Goals (MDGs), on increasing awareness of the breadth and depth of integration, and to support efforts leading to better tracking and monitoring the achievements at country levels.

vii. **Multisectoral planning**

91. High quality, rigorous and robust National AIDS Strategic Plans (NSP) that focus attention on achieving results - including stopping HIV transmission and extending the quality of life of people with HIV - are critical to the success of every national HIV response. The process of developing realistic and adaptable NSPs needs to keep pace with an evolving epidemic and a changing environment.

92. In 2014, the Joint Programme developed and launched the 3rd generation National HIV Strategic Planning guidance. The World Bank worked with partners and used several optimization tools, including the Optima HIV analysis, to support HIV allocative efficiency (AE), epidemic scenario, and financial commitment analyses. Working with UN partners, the Global Fund and US Government, financial sustainability and AE analyses for national HIV responses were implemented in several countries in East Asia, Eastern Europe and Central Asia, and Africa.

The World Bank, working with IMF colleagues, developed an HIV fiscal liability analysis framework and conducted financial sustainability analyses in Swaziland, Zambia, Kenya, Cote d'Ivoire and Indonesia.

93. Together, these activities led to improvements in national strategies focusing on high-impact programmes to minimize new infections and deaths. For example in Sudan, HIV resource allocations were almost doubled, including for treatment, and with a high priority programme and four-fold increase of allocations for key populations.

94. Following a regional consultation in Eastern Europe and Central Asia convened by UNAIDS Secretariat, the World Bank, UNDP and the Global Fund, seven countries in the region began developing HIV investment cases, and a strong partnership was

established to provide financial and technical support. An HIV investment case was developed in Tajikistan, and modelling of epidemiological impact and cost-effectiveness of various investment scenarios is being finalized elsewhere. UNAIDS Secretariat and partners have supported the development of HIV investment cases in 20 other countries globally.

UNESCO, UNFPA, UNICEF, UNDP, UNAIDS Secretariat, Save the Children, GNP+ and WHO supported an analysis of young key populations at higher risk of HIV exposure in national strategic plans on AIDS in the Asia-Pacific region.

The first-ever respondent-driven sampling (RDS) study of young MSM in Myanmar was supported by UNESCO and a national young key population situation analysis was produced with support by UNESCO, UNICEF, UNFPA and UNAIDS Secretariat.

ILO supported 28 countries (including 21 high impact countries) in the development of National Strategic Plans that include scaling up HIV workplace programmes to meet the needs of vulnerable workers.

WFP provided technical assistance to advocate for the inclusion of a food and nutrition component in national strategic plans, national protocols, as well as Global Fund grants for HIV/TB in 17 countries.

95. Looking ahead, the Joint Programme will continue to provide technical assistance to support multisectoral approaches in national AIDS responses, including on allocative efficiency analyses, as part of Global Fund concept notes, and towards Universal Health Coverage and HIV programme financing integration.

CROSS-CUTTING THEMES

UNAIDS achievements and contributions

i. Address the HIV related needs of young people

96. Despite progress made in responding to AIDS, young people remain marginalized, both from life-saving services and participation in decision-making. In 2013 alone, 670,000 young people aged 15 to 24 were newly infected with HIV, with HIV the number two cause of death among adolescents globally. Lack of information remains a significant problem. In Eastern and Southern Africa just 36% and 27% of 15-24 year old men and women are able to correctly identify at least two ways to stop HIV transmission. Figures are even lower in other regions.

97. As the AIDS epidemic and response mature, a new generation of leadership is required to take the world towards the end of AIDS. The Joint Programme has supported powerful engagement of young people at policy setting fora in 2014, with a particular focus on SRHR in the post-2015 agenda. For example, at the International AIDS Conference a Youth pre-conference, Youth pavilion and 5-Day Youth SRHR networking zone were supported.

UNFPA supported creative peer education approaches to sexual reproductive health (SRH) and HIV education. For example, Theatre based peer education reached 31,931 young people in Lebanon, 12,000 in Egypt and 18,000 in the rest of the region. In addition the Y-PEER Let's Talk campaign reached 1,490,000 young people in the Middle East and North Africa region.

UNICEF, with the National Institutes of Health and other partners, published a special supplement in the Journal of AIDS which highlighted the complexity of the adolescent HIV epidemic, illustrating opportunities to scale up interventions.

98. UNAIDS has been supporting the PACT, a collaboration of 25 youth-led and youth-serving organizations. Using the innovative CrowdOutAIDS initiative, young people from around the world used social media tools and crowdsourcing technology to develop strategy recommendations for UNAIDS to work more effectively with young people.

99. Most adolescent AIDS-related deaths are among long-term survivors who were infected through mother-to-child transmission and were either never diagnosed, diagnosed late, failed by or fell out of care, underscoring the inadequacy of HIV and broader health programmes. UNAIDS is leading global efforts to address this through evidence, advocacy and technical guidance.

In 2014, UNAIDS conducted a regional analysis in Latin America regarding legal barriers affecting access of young people to HIV and Sexual Reproductive Health services. Analysis is on-going and will be launched at the end of the first quarter in 2015.

100. Guidance on young key populations was developed by interagency group and youth and community-led organizations, coordinated by WHO. WHO also included special considerations for adolescents in its normative guidance on key populations.

In Kenya, Mozambique, Uganda and Cambodia, UN Women ensured that the young women networks are integral part of the processes around the HIV strategic planning. In Cameroon, UN Women work focused on engagement of men and boys that resulted in formation of a nation-wide network to advocate for girls and young women's rights.

ii. Ensure high-quality education

101. Globally, the education sector is underfunded and increasingly under pressure. Resources are focused on meeting basic knowledge-level targets and there is often little left to build the capacity of educators to foster the skills of learners on the range of issues concerning HIV, such as sexuality education.
102. In 2014, UNESCO and UNFPA strengthened the capacities of over 97 countries to scale-up the education sector's response to HIV and AIDS through evidence-based, age-appropriate comprehensive sexuality education (CSE) and support to address school-related gender-based violence (SRGBV). The Joint Programme advocated for CSE at policy-making fora including the SADC regional gender ministers meeting and the Eastern Europe and Central Asia regional AIDS conference.
103. In Eastern Europe and Central Asia a practical guide for schools was developed on SRGBV, and UNESCO, UNICEF and UN Women advanced action on SRGBV in the Asia and Pacific region through a social media campaign on International Women's Day. Global guidance on SRGBV is being developed by the IATT on Education, UN Women and the UN Girls Education Initiative (UNGEI).

UNESCO and UNFPA developed an accountability framework for implementation of the Eastern and Southern Africa Commitment on CSE and services for young people, with 20 key indicators set for 2015, 2017 and 2020. As a result, in Zambia, a new CSE programme was launched, targeting 1,750,000 young people and over 12,000 teachers benefiting from training.

Through the Shuga partnership, UNICEF, PEPFAR, MTV and UNAIDS Cosponsors supported the provision of CSE information to over 4 million young people through TV and radio programmes targeting young people in Tanzania, Kenya, DRC, Lesotho, South Africa and Cameroon

104. Officials from 27 countries were supported to better monitor and evaluate the education sector response to HIV through trainings by UNESCO, UNICEF and the SADC Secretariat to integrate HIV-related core indicators in education management information systems (EMIS). The Focusing Resources on Effective School Health (FRESH) monitoring and evaluation toolkit was translated into Russian and shared with the ministries of education in 10 Eastern European and Central Asian countries to standardize HIV and health education programmes.

In Eastern Europe and Central Asia, UNESCO, UNICEF, and UNDP supported development of various multi-media tools, including a multi-language website for adolescents on SRH (teenslive.info); an interactive educational video game about the harm caused by drug use (Xroad.tv); and a special resource for sex workers (malina-center.by).

iii. Scale up HIV workplaces policies and programmes

105. In 2013 UNAIDS reported that 19 million of the 35 million people living with HIV globally were unaware of their HIV status. To achieve the fast track 90-90-90 targets and take a major step towards ending AIDS as a public health threat by 2030, HIV testing must be scaled up exponentially, especially among key populations and those currently being left behind. The [VCT@WORK](#) (Voluntary Counselling and Testing at Work) Initiative was developed on this basis and launched in June 2013 by ILO, UNAIDS Secretariat, Governments, Employers Organizations and Workers Organizations, with the aim of mobilizing five million workers to test for HIV by December 2015.
- In Nigeria, the ILO collaborated with UNAIDS Secretariat, UNICEF, the Federal Ministry of Labour, Nigeria Labour Congress, National Employers Consultative Association, Network of people living with HIV, National and State AIDS Control Agencies, to mobilize workers from Delta State, Lagos State and the Federal Capital Territory to test for HIV within the context of a broader health and wellness medical check-up. A total of 36,603 (49% men and 51% women) workers tested in 2014.*
106. In 2014, the Inter-Agency Task Team (IATT) on workplace programmes and private sector mobilization organized its work around the key priority of scaling up the VCT@WORK Initiative in high impact countries. Two additional sub-priorities were also pursued - developing new indicators for measuring employment related discrimination and establishing a global information hub for workplace HIV material.
107. In June 2014, the IATT called for the establishment of an ILO-led working group to develop indicators to measure HIV-related stigma and discrimination in workplaces. The working group agreed that the proposed indicators should measure HIV-related stigma and discrimination in the workplace focusing on employers and managers or supervisors; workers and their representatives; and members of key affected populations, including people living with HIV and affected communities.
- Over the past 18 months, 1,230,306 workers have taken the HIV test (58% men, 40% women and 2% other). 36,376 workers, representing approximately 3.0% tested positive (62% men, 36% women and 2% others) and were referred to treatment and care services for follow up.*
108. ILO with support from WHO, UNESCO, UNDP, the UNAIDS Secretariat, the IATT membership, networks of people living with HIV, CSOs and over 200 country partners mobilized networks and constituencies in 32 countries (including 25 high impact countries) to generate demand for HIV testing.

iv. Integrate food and nutrition within the HIV response

109. One challenge is that insufficient resources are dedicated to providing food and nutrition to ensure that there is continuing adherence to ART treatment and retention in care. The Joint Programme is focusing on practical, implementation-oriented approaches that can be built
- WFP worked closely with the UNAIDS Secretariat, the PCB NGO delegation, France, Switzerland, and other Member States and Cosponsors to ensure the 35th PCB's adoption of a decision point highlighting nutritional support as one of the critical factors contributing to HIV prevention and treatment adherence.*

around integrated programmes which link HIV services with food and nutrition, as well as social protection, livelihood strengthening and education.

110. The Joint Programme worked towards strengthening the evidence base on food and nutrition. For example, WFP coordinated the publication of an *AIDS and Behavior* supplement (October 2014) containing eight peer-reviewed papers on food security and the role of food and nutrition in HIV adherence to care and one book chapter on nutrition and HIV to be published early 2015.
111. WFP, WHO, and the UNAIDS Secretariat, in collaboration with PEPFAR, finalized and published a food and nutrition programming guide on National AIDS Commissions for adolescents and adults living with HIV, which provides guidance to policymakers and programme managers on the role of food and nutrition in comprehensive HIV and TB care, with specific focus on demand creation for services including improving access and adherence to treatment and retention in care. WHO released guidelines for nutritional care and support for patients with TB.
112. The “Nourishing Bodies, Nourishing Minds” partnership between WFP, UNICEF, UNESCO, and partners in the private sector has continued its three-year push for improved, integrated access to health care, nutrition and education for underserved children. The pilot phase has focused on four countries with high levels of malnutrition and low levels of schooling – Haiti, Mozambique, Niger and Pakistan – countries, which also showed a significant HIV burden.
- WFP updated nutrition-related terms in the UNAIDS Terminology guide and worked with WHO and the UNAIDS Secretariat to develop a new UNAIDS Guidance Note on food and nutrition, which provides practical steps for integrating food and nutrition interventions as part of the standard package of HIV care, treatment and support. WFP also updated nutrition-related terms in the UNAIDS Terminology Guide.*
113. Another initiative that demonstrates a joint integrated approach to addressing the interrelated challenges of food insecurity, malnutrition, and HIV is the sustained partnership between UNICEF, UNFPA and WFP. This partnership delivers food and nutrition interventions and SRH education side-by-side to improve nutrition and health outcomes (including HIV) for adolescent girls, which ultimately contributes to the broader goals of maternal, newborn, and child health, prevention of stunting, and ending AIDS.
- WFP school feedings and World Bank programmes increased retention in and quality of primary and secondary education. By keeping vulnerable children and adolescents in school, these programmes provided a platform for the delivery of CSE, SRH and other education to build life skills, support healthy lifestyles (including good nutrition) and delay early marriage and childbearing.*

v. Address HIV in humanitarian emergencies

114. HIV is not a priority in humanitarian contexts, especially in areas where prevalence is low. There is also often weak capacity in countries with fragile health systems to be able to respond to emergencies. This compounds the problem further and makes it even harder to respond to HIV in an emergency.
115. UNHCR and WFP have continued co-convening the Inter Agency Task Team (IATT) on HIV in Emergencies, including other members of the Joint Programme, which aims

to improve HIV preparedness and response during emergencies. In 2014 its activities included support to integrate HIV in humanitarian clusters and capacity building of governments, development agencies, NGOs and other actors, including during the 20th International AIDS Conference.

In 2014, Guidelines for the Delivery of Antiretroviral Therapy (ART) to Migrants and Crisis-affected Persons in sub-Saharan Africa were published. These guidelines were developed by UNHCR in partnership with 14 different agencies. The updated guidelines have been broadened to include all types of migrants and crisis-affected populations, including those forcibly displaced. Clear recommendations are provided for states, clinicians and programme managers, civil society, donors and UN agencies.

116. UNHCR worked with WHO, WFP, UNICEF and UNAIDS Secretariat to develop an advocacy and guidance brief on the need for continuity of a minimum HIV programme in the context of the Ebola emergency, to protect investments made in the region. This brief outlined the recommended minimum HIV package of interventions and actions required to ensure continuity of HIV services, including through community platforms.

UNICEF, working with UNHCR and Save the Children, developed guidance on prevention of mother-to-child HIV transmission (PMTCT) in humanitarian settings. The document includes a review of lessons learned and published literature and a guidance note for key considerations for integrating humanitarian action in PMTCT, and PMTCT into humanitarian action.

117. A joint UNHCR, WHO and UNAIDS policy statement was released on HIV counselling and testing for refugees and other persons of concern to UNHCR, stressing the conditions for providing HIV counselling and test for such populations. It also emphasizes that the Joint Programme does not support compulsory or mandatory HIV testing of individuals on public health grounds or for any other purposes.

In West and Central Africa, the Joint UN Regional Team on AIDS continue to advocate for the inclusion of HIV activities in the Sahel regional strategy and response plan across interagency working groups, including governance and security.

118. In the Asia-Pacific region, WFP and UNHCR have been supporting the development of people living with HIV networks' capacity to deliver HIV services within the humanitarian response. In addition, HIV-in-emergencies related guidelines have been promoted among both HIV and humanitarian stakeholders operating in the region; key related issues have been addressed and incorporated into new HIV National Strategic Plans.

In 2014 beneficiaries of WFP food assistance included people living with HIV in several countries, including high impact countries affected by conflict (e.g. Central African Republic, Democratic Republic of Congo, and South Sudan), Ebola (e.g. Sierra Leone, Guinea), transition and post-crisis situations (e.g. Cote d'Ivoire, Haiti), as well as refugees and IDPs (e.g. Ethiopia, Cameroon, Central African Republic, Democratic Republic of Congo, Rwanda).

119. In the conflict-affected zones of Ukraine, through its UN Trust Fund grantee, UN Women engaged nearly 300 state and CSO service providers to respond to SGBV cases, focusing on girls and young women, including living with HIV, resulting from

escalating conflict. Based on this work, a protocol on rapid response to SGBV in emergency situations has been approved by the Ministry of Social Policy.

vi. Men who have sex with men, transgender people, and sex workers

120. National responses continue to be inadequate in reducing HIV risk and vulnerability among key populations and international funders are insufficiently matching their investments to the epidemic realities. Currently, programmes to reach key populations account for approximately four percent of HIV expenditure globally, yet UNAIDS recommends that expenditure increase to fourteen percent by 2015.
121. In 2014, the Joint Programme made a concerted push to assist countries in generating better strategic information on key populations. The UNAIDS GAP Report increased the visibility and awareness of populations being left behind in the AIDS response, including key populations of sex workers, men who have sex with men, transgender people, people who inject drugs and people in prisons.
122. The UNAIDS Secretariat, UNDP, UNFPA, World Bank and WHO worked with the Global Fund, MEASURE Evaluation, PEPFAR and other key partners to support 42 countries in preparing for size estimations and programmatic mapping of key populations for better tailored national and city-level responses. Four countries (Dominican Republic, Democratic Republic of Congo, Mauritius, and Madagascar) have completed the research.

The World Bank, together with PEPFAR and the Bill and Melinda Gates Foundation, supported a collection of peer-reviewed manuscripts on "Focus on Delivery and Scale: Achieving HIV Impact with Sex Workers" on epidemiologic trends and programme challenges, successes, cost-effectiveness, and impact among female sex workers.

123. Removing punitive legal frameworks, policies, practices, stigma and discrimination towards key populations, including young key populations, are integrally linked to reducing sexual

UNFPA supported a consultation on SRH/HIV programming (East and Southern Africa), peer education for young key populations (West and Central Africa), rights-based SRH/HIV programming with key populations in 12 countries, developing condom strategies in three countries, and developing strategic plans that include key population responses in four countries.

transmission. UNDP supported successful efforts in DRC to prevent the passing of new anti-homosexuality legislation. The ILO carried out the PRIDE study in Argentina, Hungary, South Africa and Thailand, examining the nature of discrimination that LGBT workers encounter in formal and informal employment as well as good practices in countering these challenges.

The Joint Programme is also leading international efforts to defend the right to education of young people, regardless of sexual orientation or gender identity. UNDP's "Being LGBT in Asia" initiative addresses SRGBV on the basis of perceived sexual orientation/gender identity in Indonesia, the Philippines, Viet Nam, Cambodia, China, Thailand, Mongolia and Nepal.

CONSTRAINTS, CHALLENGES AND LESSONS LEARNED

124. While progress continues to be made in the AIDS response, gains are reversible. The Joint Programme continued to face and address challenges in 2014, to be able to respond more effectively to the epidemic. This section builds on the findings of the

2014 Mid Term Review of the UBRAF, addressing challenges and highlighting lessons learned by the Joint Programme and its partners in 2014.

Stigma and discrimination, punitive laws, HIV-related travel restrictions and growing conservatism are preventing people from seeking and accessing the treatment, information and support they need

125. Safeguarding human rights and enhancing health equity is critical to reaching global and national targets for tackling HIV epidemics. However, discrimination on the basis of HIV status, sexual orientation, gender identity or behaviour persists within civil society, health systems, policy and government in many countries. Stigma and discrimination against key populations remains one of the greatest barriers to effective AIDS responses worldwide. Lack of domestic resources, limited quantitative data and insufficient focus on key population programming perpetuates this discrimination and continues to limit the effectiveness of responses.
126. UNAIDS reports 77 countries criminalize adult consensual same sex conduct. Punitive laws also remain in place against transgender people, sex workers, men who have sex with men and people who inject drugs in many countries. Women and girls face multiple forms of exclusion and discrimination, which pose obstacles to accessing HIV services. Harmful social norms, stigma and gender-based violence additionally constrain people's capacity to access information and services and make healthy choices to avoid HIV transmission.
127. Despite commitments made by UN Member States in the 2011 Political Declaration, an increasing number of developed and developing countries are debating and introducing punitive laws, policies and practices. Punitive laws that criminalize key populations and laws that hinder access to sexual reproductive health and rights services among young people are also increasing vulnerability to HIV infections and threatening gains made in reversing the epidemic.
128. While in 2014 the number of countries, territories and areas imposing some form of restriction on entry, stay and residence based upon HIV status was reduced, there is still a strong need for further action. For example, the lack of political will on the part of host governments in Gulf Cooperation Council (GCC) countries remains a challenge to efforts to remove travel restrictions in many migrant receiving countries. In addition, there are reports indicating that discriminatory practices still persist in countries that have ostensibly removed travel restrictions, for example the Republic of Korea's imposition of HIV testing on foreign English teachers.
129. Growing conservatism, "traditional values" and pressure from certain political and religious groups additionally act as a barrier to open dialogue and services to allow key populations, particularly young people, to protect themselves. Some countries block access by young people to web resources containing preventive educational and informational materials. Restrictive social norms for young women and girls additionally prevent them from accessing related information and services, as well as having ownership over their sexual health. Parental consent requirements remain a big challenge for young people, especially young key populations, to have access to SRH services. Lack of youth-friendly harm reduction services remains a big challenge in many countries.

Laws and policies must be continuously monitored since positive changes can be reversed when new political leadership gains power or from societal pressure.

Inconsistent procurement and supply management have resulted in commodity insecurity, especially in high-burden countries

130. Condom accessibility remains a constant struggle in sub-Saharan Africa. In 2013, donors provided only eight male condoms for every man aged 15-49 and one female condom for every eight women of reproductive age. Many countries with the greatest burden of HIV remain largely dependent on donor support for condom provision, while access to condoms in prisons is particularly problematic.
131. Despite access to the voluntary pool procurement services for all Global Fund grantees, a number of countries in Africa and Eastern Europe pay above the norm prices for antiretroviral drugs and HIV diagnostic tests, due mostly to inappropriate forecasting, inefficient tendering procedures or small regional markets. Stock-outs also remain a challenge, particularly in humanitarian settings.

To address the issue of stock outs, WFP signed a Memorandum of Understanding with the Global Fund for logistics to improve preparedness and immediate response, through its six humanitarian hubs.

Weaknesses in health care systems, infrastructure and service integration are allowing key populations to fall through the gaps in the AIDS response

132. According to reports submitted by countries that conducted mid-term reviews, there is a continued need for upfront investments in health systems strengthening, workforce training and cross-sectoral collaboration beyond the health sector to ensure the needs of key populations are met and the effective integration of services is achieved. This includes the engagement and ownership of key populations over the design, implementation and delivery of services.
133. Insufficient numbers of trained health workers and a lack of task shifting is a significant weakness of many healthcare systems, particularly in low- and middle-income countries. This is further compounded by poor infrastructure, particularly at the primary healthcare level.

Challenges related to integration are being remedied. For example, pregnant women, women living with HIV and their children are increasingly benefiting from maternal and newborn child health programmes that include integrated reproductive health, EMTCT and paediatric HIV services and food and nutrition support.

In a competitive funding environment, AIDS funding is coming under pressure, with some viewing AIDS as a declining threat, leading to reduced funding security as well as negative repercussions for HIV transmission rates

134. Austerity measures in major donor countries have had direct repercussions for HIV, with funding for AIDS becoming more difficult to mobilize than in previous years. Additionally, increasing numbers of governments are demanding an increased focus on, results, impact, accountability and efficiency. Programming must therefore be cost-effective, efficient, targeted and underpinned by a people-centred, human rights based approach.
135. Despite the increase in domestic investments for HIV, a considerable resource gap remains. AIDS funding dependency continues to be high especially in low- and middle-income countries, where approximately 50 out of 133 countries depend on international contributions for more than 75% of their responses. Unpredictability,

coupled with the flattening and potential decline of external HIV funding beyond 2015 is a significant challenge for closing the resource gap, with many countries and regions expressing doubts over being able to meet the demands of increased domestic investment.

136. The current generation of young people is additionally growing up in a context where HIV is seen as a declining threat. As a result, the risk of complacency is increasing, leading to an increase in risky sexual behaviours and decrease in HIV testing in some contexts. Increases in risky sexual behaviours, such as increases in number of sexual partners and declines in condom use, have been documented in several countries, highlighting that advocacy on safe sexual behaviours must be maintained.

This challenge requires sustained focus and demonstrates the importance of a multi-sectoral AIDS response, as embodied through the UNAIDS Joint Programme.

Despite progress in addressing gender equality and empowerment of women within the AIDS response, harmful gender norms, practices and discriminatory laws and policies continue to have a negative impact on women and girls, while policies and plans still fail to fully address the full diversity of women and girls

137. National AIDS responses continue to some extent to reflect gender biases in policies, programmes, institutions and budgets, while underlying power relations are yet to be fully understood and addressed. Gender biases and unequal power relations must be reversed in order to ensure equal access to and benefits from treatment, information and prevention services for women, men, girls, boys, transgender men and transgender women. This will only happen through sustained investment in research and evidence on social and structural drivers, political advocacy and technical knowledge and know-how towards transforming HIV responses.

Long-term investment and support is needed to facilitate the greater engagement of networks of women living with HIV as leaders and key participants in HIV responses. This includes support to their organizational capacities, alliance building and mobilizing of constituencies. The engagement of men in gender equality activities must also be improved.

138. Comprehensive knowledge about HIV remains unacceptably low, especially among adolescent girls. Given the high levels of coerced sexual experienced by young women, better education and programmes for violence prevention, , condom use and negotiation skills are needed to increase adolescent girls' HIV knowledge and skills to prevent HIV.
139. There is an apparent lack of political will, institutional support and capacity to address gender-based violence (GBV), in addition to an insufficient evidence base on what works. Many countries have little or no domestic funding allocated to GBV, with programmes largely dependent on donor funding. Contentious issues, human rights violations and entrenched gender norms also continue to impede progress in addressing GBV.

Substantial efforts are needed to address gender-based violence and strengthen the coordination of a multi sectoral response, including referral capacities of health, social, legal and law enforcement institutions and providers in practice. There is also a need to strengthen capacities for uptake of evidence-based programming and policies on prevention and response to gender-based violence.

ps in access to treatment and retention in treatment, particularly for key populations are causing many to be left behind by the AIDS response

140. Despite the recommendation to initiate ART earlier, many people continue to start treatment late, leading to avoidable mortality and morbidity and additional costs. While access to HIV testing and the numbers of people initiated on ART is increasing, there is substantial patient attrition across the cascade of care, from HIV testing and counselling to long-term adherence and viral suppression. Even in high-income countries, urgent work is required to better support uptake, treatment adherence and retention across the continuum of HIV care.

An estimated 40% to 50% of all new HIV infections among adults worldwide may occur among people from key populations and their immediate partners. However, many members of key populations report having no contact with HIV prevention programmes in the past 12 months, highlighting a major gap in the HIV response.

141. National responses continue to be inadequate in reducing HIV risk and vulnerability among key populations. Retention of women post-partum in B+ and family planning programmes is also poor – in many settings the risk of loss-to-follow-up may be five times more than for other clients on ART.
142. There remains a lack of attention at global, regional and country level regarding the benefits of food and nutrition to sustaining treatment success through improved adherence to ART treatment and retention in care. This has impacted the ability to ensure adequate funds for food and nutrition within HIV and TB-specific funding mechanisms that prioritize provision of treatment. As a result, many countries in 2014 faced resource shortfalls for food and nutrition interventions, forcing temporary discontinuation of this vital adherence support. It is imperative that structural factor, such as adequate food and nutrition, safe housing and social protection and support are addressed to increase the impact of AIDS programming and reduce barriers to adherence to treatment and retention in care.

FINANCIAL IMPLEMENTATION

143. 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 estimated resources for 2014-2015. Expenditures are presented in several ways in order to facilitate comparison between the projected estimated resources and actual expenditures.
144. The overall core resources implementation rate in this first year of the biennium was 49%. Cosponsors successfully leveraged other AIDS funding using their core UBRAF funds, collectively investing US\$ 2.87 million, which represents 75% of the original estimate of other AIDS funds. Two-thirds of the total 2014 spending went to High Impact Countries (HICs), while the rest of the countries with UNAIDS presence received 28%. This demonstrates the Joint Programme's commitment and focus on countries where the biggest impact on the epidemic can be had. Global level expenditure was kept at 5%, slightly lower than the 7% biennial projection.
145. Core expenditure in 2014 is in line with programmatic projections, e.g., Strategic direction A (Catalyzing prevention) received the biggest share at 52% versus 48% projected resources. Leadership and Advocacy has the biggest spending percentage among Strategic Functions.

146. The financial expenditure summary tables and graphs shown in this section are supplemented by the more detailed core expenditure reports by UBRAF output and by organization in the Performance Monitoring Report. This paper also features spending by Strategic goal and function against core resources and other AIDS funds.

Table 1: Overview of UNAIDS Cosponsor and Secretariat 2014 spending (US\$)

Funding Type	Estimated resources 2014-2015	Breakdown (in %)	Expenditure and commitments in 2014	Breakdown (in %)
Core funds	484 820 000	11%	237 232 832	8%
Other AIDS funds	3 832 820 000	89%	2 872 507 516	92%
Grand total	4 317 640 000	100%	3 109 740 348	100%

Table 2: Core expenditure for global level, high impact countries and other countries (US\$)

Funding level	Estimated resources 2014-2015	Breakdown (in %)	Expenditure and commitments in 2014	Breakdown (in %)
Global level	201 410 000	42%	99 229 651	42%
30+ HICs	125 405 000	26%	66 864 634	28%
Other countries	158 005 000	33%	71 138 547	30%
Grand total	484 820 000	100%	237 232 832	100%

Table 3: Core expenditure by strategic direction (US\$)

Strategic Direction	Estimated Resources 2014-2015	Breakdown (in %)	Expenditure and commitments in 2014	Breakdown (in %)
Prevention	79 102 000	48%	38 449 367	52%
Treatment, Care and Support	47 539 000	29%	21 074 061	28%
Human Rights and Gender	37 885 000	23%	14 566 478	20%
Grand Total	164 526 000	100%	74 089 906	100%

Table 4: Core expenditure by strategic function (US\$)

Strategic Function	Estimated resources 2014-2015	Breakdown (in %)	Expenditure and commitments in 2014	Breakdown (in %)
Leadership and Advocacy	131 642 000	41%	67 831 267	42%
Coordination, Coherence and Partnerships	105 118 000	33%	50 730 193	31%
Mutual Accountability	83 534 000	26%	44 581 466	27%
Grand Total	320 294 000	100%	163 142 926	100%

Figure 1: 2014 total expenditure for global level, high impact countries and other countries

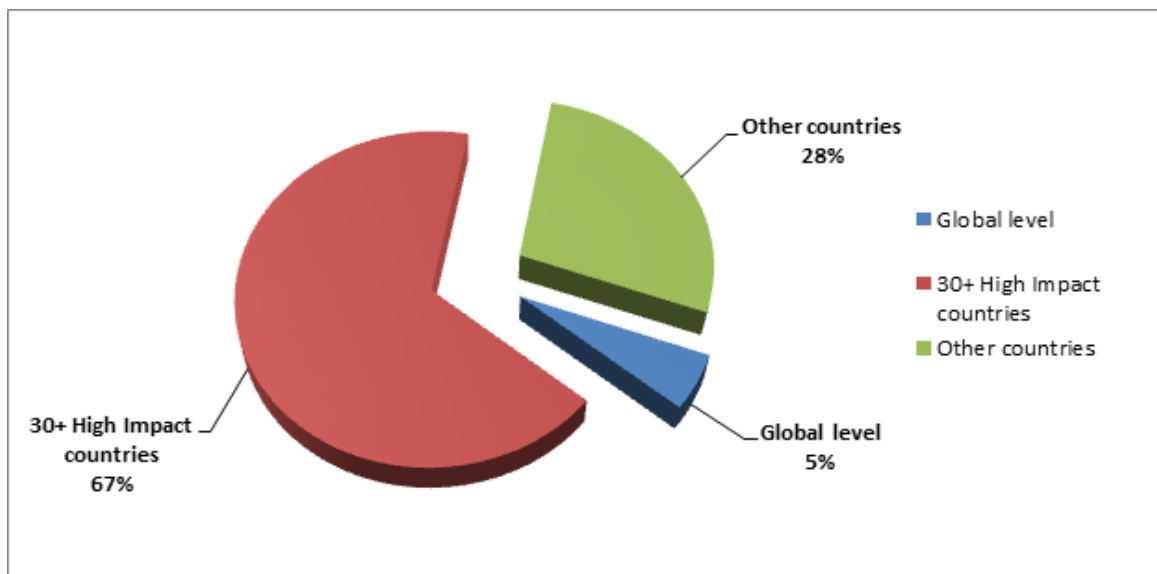


Table 5: Breakdown of core and non-core expenditure* (US\$)

ORGANIZATION	CORE			OTHER AIDS FUNDS			TOTAL		
	Budget (2014-2015)	Expenditure (2014)	%	Projected Resources (2014-2015)	Expenditure (2014)	%	Projected Resources (2014-2015)	Expenditure (2015)	%
UNHCR	9 800 000	4 900 000	50%	16 500 000	24 564 381	149%	26 300 000	29 464 381	112%
UNICEF	24 000 000	8 620 973	36%	198 000 000	98 494 865	50%	222 000 000	107 115 838	48%
WFP	9 800 000	4 396 279	45%	197 153 000	45 264 523	23%	206 953 000	49 660 802	24%
UNDP	17 200 000	7 836 977	46%	520 000 000	326 059 204	63%	537 200 000	333 896 181	62%
UNFPA	21 000 000	8 519 783	41%	106 106 000	64 637 520	61%	127 106 000	73 157 303	58%
UNODC	11 500 000	5 750 000	50%	29 076 000	14 243 900	49%	40 576 000	19 993 900	49%
UN Women	7 600 000	3 775 960	50%	26 704 000	17 351 132	65%	34 304 000	21 127 092	62%
ILO	10 900 000	5 069 264	47%	17 126 000	7 058 861	41%	28 026 000	12 128 125	43%
UNESCO	12 400 000	5 607 387	45%	13 850 000	14 754 440	107%	26 250 000	20 361 827	78%
WHO	35 000 000	16 100 000	46%	169 029 000	60 850 440	36%	204 029 000	76 950 440	38%
World Bank	15 400 000	7 443 079	48%	2 494 276 000	2 068 255 258	83%	2 509 676 000	2 075 698 337	83%
Secretariat	310 220 000	159 213 130	51%	45 000 000	43 869 048	97%	355 220 000	203 082 178	57%
TOTAL	484 820 000	237 232 832	49%	3 832 820 000	2 785 403 572	73%	4 317 640 000	3 022 636 404	70%

* includes actual expenditures and commitments

Table 6: Total expenditure by global level, high impact countries and other countries* (US\$)

Organizations	Global	HICS	AP	CAR	EECA	ESA	LA	MENA	WCA	TOTAL
UNHCR	1 323 121	15 099 576	1 307 602	-	1 153 235	1 644 186	502 595	6 535 194	1 898 872	29 464 381
UNICEF	4 202 831	58 853 589	14 259 546	2 326 177	3 341 373	11 268 690	2 693 030	2 350 280	7 820 323	107 115 838
WFP	1 730 796	39 753 751	81 589	45 143	1 154 539	2 545 386	233 132	546 941	3 569 524	49 660 802
UNDP	11 198 826	248 558 722	1 300 149	6 014 244	31 281 545	1 305 212	2 814 956	14 930 998	16 491 528	333 896 181
UNFPA ¹	15 221 988	36 785 551	1 365 328	893 167	2 340 035	2 295 117	4 694 914	6 372 890	3 188 315	73 157 303
UNODC	1 230 000	14 010 191	1 252 735	46 170	1 445 600	181 109	485 150	1 243 185	99 760	19 993 900
UN Women	2 534 978	11 042 020	1 638 505	489 710	1 011 270	1 005 956	988 662	969 455	1 446 532	21 127 092
ILO	4 216 396	6 650 193	99 693	50 963	2 250	393 753	380 178	35 414	299 285	12 128 125
UNESCO	2 215 337	13 585 114	604 727	146 886	346 583	1 582 765	341 662	374 998	1 163 755	20 361 827
WHO	21 917 540	24 185 000	8 971 260	900 640	5 000 300	3 763 520	1 895 740	4 386 960	5 929 480	76 950 440
World Bank	10 559 944	1 527 692 467	195 858 696	26 534 889	87 274 045	37 550 082	68 784 862	22 755 723	98 687 629	2 075 698 337
Secretariat	90 167 310	43 568 834	14 749 800	3 454 046	14 111 565	12 202 799	5 785 125	5 371 971	13 670 728	203 082 178
Grand Total	166 519 067	2 039 785 008	241 489 630	40 902 035	148 462 340	75 738 575	89 600 006	65 874 009	154 265 731	3 022 636 404

* includes actual expenditures and commitments

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¹ Expenditures include components of sexual and reproductive health (SRH) and gender programmes.