



UNAIDS PROGRAMME COORDINATING BOARD

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Agenda item 3

Report on the consultative process to update and extend the UNAIDS 2011-2015 Strategy through the fast track period 2016-2021

**Discussion paper for global consultation on
UNAIDS 2016-2021 Strategy**

**GETTING TO
ZERO:**

**HOW WILL WE
FAST-TRACK THE
AIDS RESPONSE?**

Discussion paper for global consultation on
UNAIDS 2016-2021 Strategy



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Inspired by unprecedented progress over the last several years, the global AIDS community, including the UNAIDS Programme Coordinating Board (PCB), the Member State-led Open Working Group on the Sustainable Development Goals and the UN Economic and Social Council, has embraced the ambition of ending the AIDS epidemic by 2030. To get there, the PCB has asked for the development of an updated UNAIDS 2016-2021 Strategy to guide progress towards several ambitious “Fast-Track” targets.

Fast-Tracking the response will rely on front-loading investments and accelerating rights-based action in the coming years – while accounting for a rapidly shifting geopolitical context and evolving HIV epidemic. It will also mean fundamentally changing the way the response supports those populations that continue to be left behind – as explored in depth in the UNAIDS Gap Report.

Significant progress has been made in the AIDS response (Fig.1). Quickening the pace however is pivotal to global prospects for bringing the AIDS epidemic to an end. Continuing at the current pace will mean leaving people behind, exacerbating inequalities, expanding costs to unsustainable levels and compromising social justice (Fig.2). An ambitious global strategy is required to take us forward – one that mobilizes political commitment, focuses resources and accelerates progress.

Thus, as the end date of the UNAIDS 2011-2015 Strategy nears, and we endeavour towards a Strategy for 2016-2021, we are presented with a critical opportunity and obligation to chart the way forward. Through global, regional, thematic and virtual consultations we hope to arrive at a shared understanding of where we have succeeded and where challenges remain – and collectively define what we must achieve by 2021 and what must be done differently to get there.

Fig.1 Number of people living with HIV, new HIV infections and AIDS-related deaths, 1990-2013

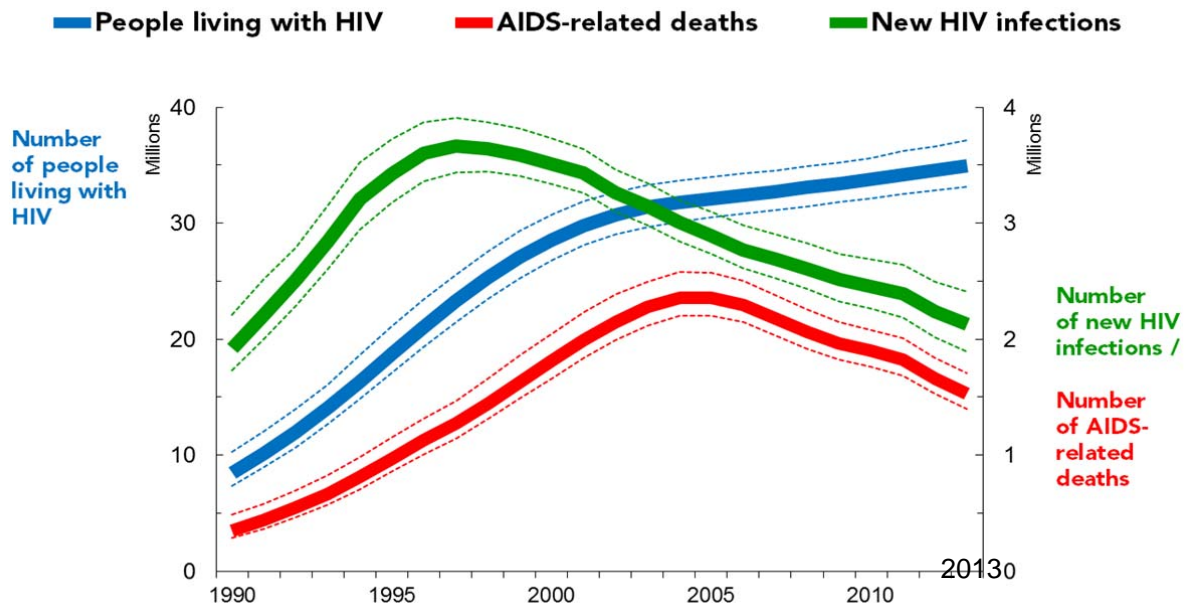
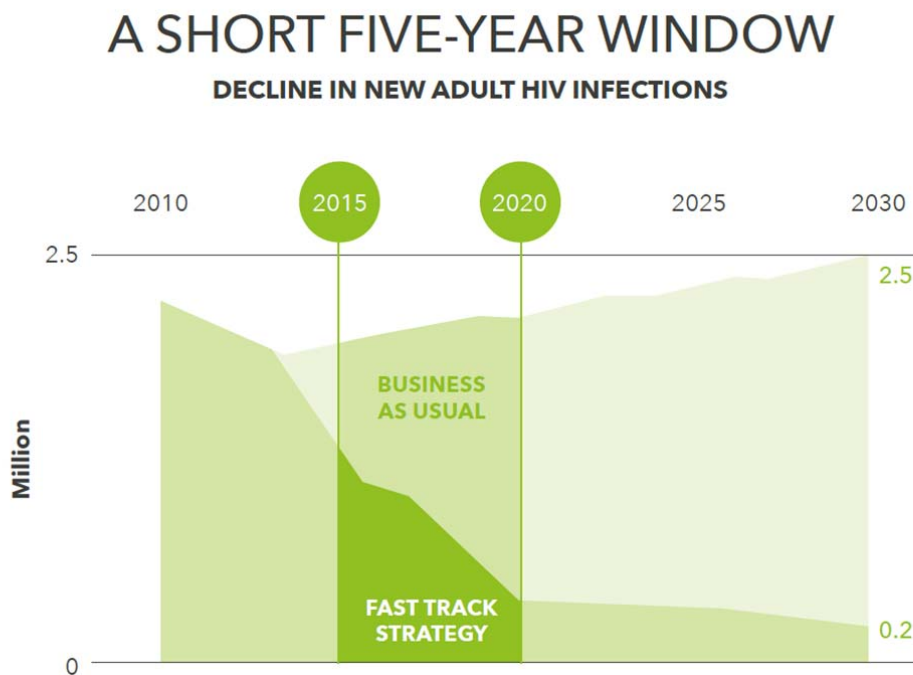


Fig.2 Impact of reaching the Fast-Track targets by 2020: Decline in new adult HIV infections



The aim of this consultation is to explore the following questions:

- ① How will developments – global and regional – impact the epidemic and response in countries and at the sub-national level over the coming years?
- ② Who is being left behind and why? Where are the main challenges and gaps? What achievements in addressing challenges to date should be expanded and built upon?
- ③ In order to reach the Fast-Track targets, what should be the strategic priorities in the response?
- ④ What will need to change in support of those priorities? What are the “game-changers” – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?
- ⑤ How can the opportunity of the new Sustainable Development Goals be optimized in the Strategy – what linkages, policy coherence and collaborative action must be pursued?
- ⑥ What are the most critical ways in which the UNAIDS Joint Programme can support efforts to end AIDS as a public health threat by 2030?

Introduction

This paper seeks to inform and provoke discussion at a series of consultations convened to consider the future of the global AIDS response and to guide the development of UNAIDS Strategy for the period 2016-2021. Consultations will engage all stakeholders including women and men living with HIV, governments, NGOs and networks of key populations and young people, academia, the private sector and international and regional organizations.

The paper explores a number of the leading global trends and geopolitical shifts that characterize the world today, and which carry potentially far-reaching implications for the AIDS epidemic and response. It presents the rationale and imperative for “Fast-Tracking” the response in the coming years, while exploring and inviting discussion on the remaining gaps – at global and regional levels. Finally the paper presents the latest thinking, drawn from several months of consultation, on updating the strategic framework for the next period.

Ultimately, through a series of questions, the paper – and the consultations – aims to foster a discussion on priorities in the response and determining what needs to be done differently to achieve our ambitious aims for 2021.

Several annexes provide an overview of the UNAIDS 2011-2015 Goals (Annex 1) and Strategic Framework (Annex 2), a snap shot of progress in the global epidemic and response (Annex 3), and a selection of the contributions of the Joint Programme to progress (Annex 4). A fifth Annex reviews the progress to date of the multistakeholder consultation on UNAIDS 2016-2021 Strategy and presents next steps.

Request of the UNAIDS Board

The UNAIDS Board has requested its Executive Director to undertake a multi-stakeholder consultative process to update and extend the existing Strategy through the Fast-Track period, in the context of reaffirming and building upon:

- the UNAIDS Vision of *zero new HIV infections, zero discrimination and zero AIDS-related deaths*, and
- the three strategic directions of the UNAIDS 2011-2015 Strategy: 1) Revolutionize HIV prevention; 2) Catalyze the next phase of treatment, care and support; and 3) Advance human rights and gender equality for the HIV response (*See Annex 2 for further detail*).
- the 2011 UN General Assembly Political Declaration on HIV and AIDS and ongoing discussions on the post-2015 Sustainable Development Goals, including the target of ending the AIDS epidemic by 2030.

We sincerely appreciate your ongoing support and commitment to the Strategy development process.

Negotiating a post-2015 world: What does the shifting global context mean for AIDS?

The dynamics of the AIDS epidemic and response interact in a profound and complex way with the rapidly changing context.

An unequal world

Economic and social inequality is on the rise. If current trends continue, the wealthiest 1% of the global population will have more wealth than the remaining 99% of people in just two years.¹ Today, 75% of the population in developing countries live in more unequal societies than in 1990.² Financial inequalities are compounded by unequal access to power, education, food and healthcare: children born in the poorest households are the least like to finish primary school; and women in rural areas are three times more likely to die in childbirth than their urban counterparts. Socio-economic inequality is closely linked to HIV prevalence – across regions.³

Gender inequalities continue to further drive HIV epidemics. Harmful gender norms and entrenched attitudes and behaviours contribute to women's vulnerability to HIV infection in certain settings, including through unequal access to education, including HIV education, lack of economic security, controlling or violent behaviour towards women, and thus the inability of women to take control of their own sexual health and access HIV services.

The rise of the MICs: A new dynamic in the geography of poverty and global health

Growing income inequality is a global phenomenon, and greatest among middle-income countries (MICs). Today, three out of four poor people live in middle-income countries (MICs)⁴. Even with predicted economic progress in MICs, in 2020, these countries are still likely to be home to half of all people living on less than \$2/day and will continue to carry the bulk of the global burden of disease – including 70% of people living with HIV.⁵ yet several traditional development partners are reducing and/or discontinuing support to countries as they move from low- to middle-income status. The recent increase in domestic resources available for the AIDS response will need to be accelerated and sustained.

¹ Oxfam. Wealth: Having it all and wanting more. January 2015.

² UNDP.(2014) Humanity Divided: Confronting Inequality in Developing Countries. Available at: <http://www.undp.org/content/undp/en/home/librarypage/poverty-reduction/humanity-divided--confronting-inequality-in-developing-countries.html> (Accessed 23 January 2015)

³ Holmquist G. HIV and income inequality: If there is a link, what does it tell us? International Policy Centre for Inclusive Growth United Nations Development Programme. Working paper, April 2009.

⁴ Chandy L, Gertz G. Two trends in global poverty. Brookings, 2011. Available from: <http://www.brookings.edu/research/opinions/2011/05/17-global-poverty-trends-chandy>

⁵ Global Network of People Living with HIV (GNP+). Access challenges for HIV treatment among people living with HIV and key populations in middle-income countries. October, 2013.

The economies and influence of many MICs are growing as they become increasingly integrated into both global and regional markets – stimulating the proliferation of regional and sub-regional mechanisms of cooperation. Such regional blocs between countries offer an opportunity to mobilize political commitment, strengthen knowledge sharing among networks and key stakeholders, and foster a platform to address cross-border, collective challenges that intersect with the HIV epidemic, such as migration and forced displacement.

A more nuanced role for development cooperation

The shift in both the geography of poverty and our understanding of it has major implications for financing, delivering and governing the AIDS response, and broader global health. The notion of aid, where poor countries have development challenges and wealthy countries have solutions and resources, is out-dated. Emerging economies are demanding and instilling a new approach to cooperation. The BRICS countries, for instance, are bringing a new value system that emphasizes “south-south” cooperation, sovereignty and economic development as well as new institutions.

In general however development cooperation has not kept pace with the changing world. By 2030, only 14⁶ of the current 82 countries currently eligible for concessional programmes of multilateral banks are projected to still be eligible, if current rules continue to apply. Meanwhile, many lower MICs have much more in common with low-income countries (LICs) than with upper MICs in their development realities, while there some countries may fall back to LIC status. In this context, challenges arise regarding how to ensure sustainability of AIDS gains, how to ensure that AIDS remains a domestic political priority, and how to accelerate scale-up to end the epidemic. Many argue that traditional aid must transition from playing a supplementary role to a catalytic role—including catalyzing more private investments and innovation for faster and more efficient responses.

By contrast, low-income countries will remain highly dependent on international financing for their AIDS responses – particularly for long-term and quickly expanding treatment programmes.

Fragile states and humanitarian emergencies: Challenging operational contexts on the rise

Since 2006, the number of displaced persons has increased by more than 24%. In countries affected by fragility, conflict, post-conflict or humanitarian emergencies, people face increased food insecurity, the destruction of livelihoods and higher levels of extreme poverty. Access to HIV prevention and life-saving treatment, care and support is often limited, deprioritized or non-existent. For those who may have access to such services, the onset of conflict or disaster may lead to increased vulnerability to HIV or interruption of treatment.

In these settings, major challenges include building more resilient communities while delivering or ensuring the continuity of timely, quality services and social protection for people who face multiple vulnerabilities, including displacement, sexual violence, food insecurity, malnutrition, environmental degradation, corrupt/weak institutions and poor infrastructure.

Urbanization compounds inequality at the sub-national level

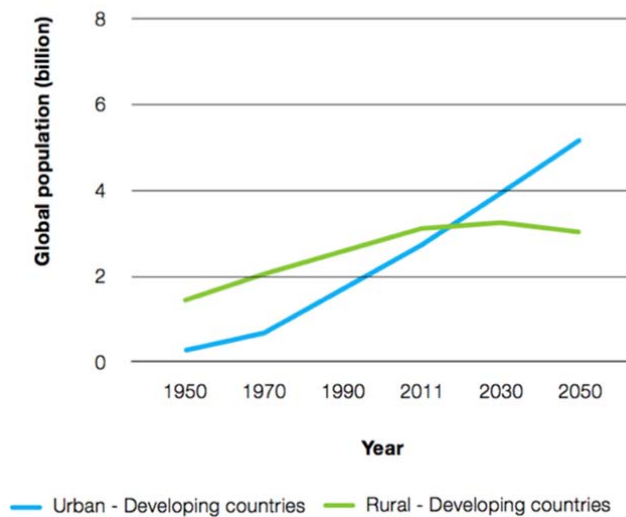
By 2020, 56% of the world population will live in urban settings, where HIV prevalence is higher and poverty is growing faster than in rural areas. Nearly all (about 90%) of the world’s urban population growth between now and 2030 is expected to be in developing countries, mostly in Africa and Asia

⁶ Afghanistan, Nepal, Burundi, Central African Republic, D.R. Congo, Ethiopia, Gambia, Guinea Bissau, Madagascar, Malawi, Niger, Somalia, Tanzania, Uganda. OECD. An outlook on ODA graduation in the post-2015 era. January 2014.

(Fig. 3). Furthermore, one billion people are living in urban slums, which are typically overcrowded, polluted and dangerous, and lack basic services such as clean water, durable housing and sanitation. In Nairobi, for example, the prevalence of HIV in the slum population was reported as 12% compared to 5% in the non-slum population.⁷

While cities have more “resources” that can be leveraged to reach a majority of city residents with services, urban responses to the epidemic have been sparse, poorly coordinated and insufficiently evidence-based. National planning often does not take into account the complexities of urban settings in terms of service delivery and geographical hotspots of HIV vulnerability.

Fig 3. Urban and rural population trends in ‘developing’ countries, 1950–2050



The rise of technology and social media as a tool for sharing information, organizing and accountability

Social media and mobile technologies are increasingly providing a revolutionary array of tools to address limitations in current service delivery systems, ensure financial transparency and reform advocacy, outreach, and mobilization. They offer the ability to connect people from remote geographies of the world to share experiences and access information. Social media provides a potentially cheap and efficient way to monitor real-time programmatic gaps and progress, to equip citizens with data, enhance their participation in the public sphere and extend their agency over development-related decision-making. In the AIDS response, new information and communication technologies can support prevention strategies, improve treatment adherence, engage communities and strengthen local response monitoring systems, including on human rights violations.

The evolving HIV epidemic: Importance of location and population

The distribution of new infections within populations has also been changing steadily in many countries. While declining among the general population in many parts of the world, HIV epidemics

⁷ Madise NJ et al. Are slum dwellers at heightened risk of HIV infection than other urban residents? Evidence from population-based HIV prevalence surveys in Kenya. *Health & Place*. 2012; 18(5), pp 1144-1152.

among key populations⁸ are on the rise in many places. At the same time, increasingly diverging views on matters of sexuality and sexual and reproductive health and rights (SRHR) are working to further marginalize these already vulnerable populations. The criminalization of sex work, drug use and same-sex relationships among consenting adults in a large number of countries, compounded by harsh prison conditions and lack of effective services, continues to hinder reaching people at higher risk of HIV infection with the services that have been shown to prevent and treat HIV. In many parts of the world, women and girls, particularly young and adolescent women, experience higher rates of HIV prevalence and incidence than their male counterparts, linked to patterns of gender inequality and unequal power relations between men and women.

Across countries, young people remain at the centre of the HIV epidemic. People aged 10-24 account for a quarter of the global population – and 40% of all new HIV infections. Structural, social and behavioural dynamics make young people vulnerable to HIV. Half of all people in Africa today are under 18. In contrast, the median age is 30 in Asia (see Fig.4). A growing population of young people in high HIV burden countries may result in yet further expansion of the epidemic unless we reach this cohort with evidence-informed, rights-based and tailored services.

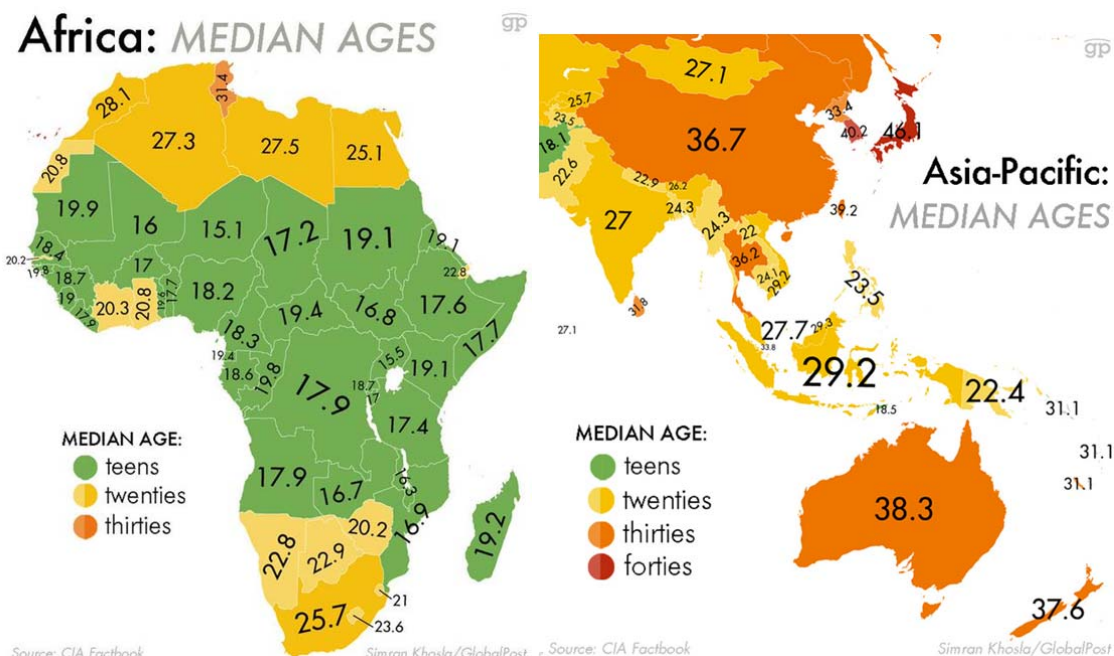


Fig. 4 Median ages in Africa and Asia-Pacific

At the same time, with growing access to treatment, many people living with HIV are ageing. Long-term antiretroviral therapy has been linked to increased risk of non-communicable diseases. In high-income countries, increased mortality among people living with HIV who are 50 years and older is often attributed to an increased risk of a range of non AIDS-defining illnesses such as cardiovascular

⁸ UNAIDS Strategy 2011-2015 defines key populations, or key populations at higher risk, as groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

disease, and kidney and liver failure. An expanded and integrated primary care model that more strongly links HIV and chronic disease prevention, treatment and care is warranted.

Increasingly, the old concept of concentrated, mixed and generalized epidemics is making way for a new approach of viewing and responding to the epidemic: to pursue a laser-like focus on location and population (See Map, Page 12). African Americans were estimated to make up just 13% of the population of the United States in 2013, yet they accounted for an estimated 46% of all new HIV infections in the country.⁹ While regional and national data help to provide a snapshot of the epidemic, they hide the subnational and local diversities of the AIDS epidemic. In Kenya, HIV prevalence varies significantly between provinces – from 4.9% in Nairobi to 15.1% in Nyanza.¹⁰ Within local epidemics, select populations are disproportionately affected. In the city of Jayawijaya in Indonesia, HIV prevalence among female sex workers is 25% - this compared to a national HIV prevalence among sex workers of 9%, and prevalence among all women below 1%.¹¹ In some countries such as Mozambique and Zambia, HIV prevalence among prison populations is more than double than that among the general adult population. Countries are increasingly focusing on local epidemics for higher-impact and more cost-effective programming.

AIDS in the context of a broad and complex post-2015 global health agenda

While the post-2015 development agenda is not yet adopted, the goal and target framework proposed by the Open Working Group appears to have much consensus from Member States. The agenda as a whole presents opportunities to promote synergies across development goals and sectors, for example on fulfilment of human rights, inclusive social protection, education, food security, inclusive and resilient cities, and decent work for all. For example, the reinvigorated prioritization across the development community to address the specific challenges faced by women and girls provides a particularly critical opportunity for joint working to address gender inequalities within the HIV response while also collectively advancing the physical, economic, and political autonomy of women, adolescents, and girls.

The current 17 goal and 169 target framework includes one goal dedicated to health: 'ensure healthy lives and promote well-being for all at all ages'. The health goal comprises 9 substantive targets (including 'by 2030, end the epidemic of AIDS') that extend beyond the MDG focus to encompass universal health coverage (UHC), NCDs, road traffic accidents and pollution-related ill-health, among others. UHC provides an opportunity to better integrate HIV services in health systems and increase domestic funding for HIV services. It may also present a challenge to the AIDS response, as low-income countries may not generate budgets large enough to cover all UHC services—including HIV treatment. Furthermore, an expanded health agenda offers significant opportunity to pursue multisectoral and joint efforts among different health responses. Weakened visibility of the AIDS response however may lead to losing many of the more unique aspects of the AIDS response – such as the participation and empowerment of affected communities, rights-based multisectoral responses, or a focus on punitive laws, lack of human rights protection and stigma and discrimination.

Thus while international assistance is stagnating (and not available to certain countries), the ambition

⁹ United States Centers for Disease Control and Prevention. HIV among African Americans: Fast Facts. Last updated: April 3, 2015.; United States Centers for Disease Control and Prevention. Black or African American Populations. Last updated: February 12, 2015.

¹⁰ National AIDS and STI Control Programme, Ministry of Health, Kenya. September 2013. Kenya AIDS Indicator Survey 2012: Preliminary Report. Nairobi, Kenya. Available at: <http://nascop.or.ke/library/3d/Preliminary%20Report%20for%20Kenya%20AIDS%20indicator%20survey%202012.pdf> (Accessed 22 January 2015)

¹¹ UNAIDS Gap Report, 2014.

of the global health community to augment the unfinished MDG agenda with new priorities will significantly increase the resource needs envelope and demand optimal allocation and use of resources. At the same time, while innovative and effective in mobilizing resources, the global instruments used to support countries to co-finance their AIDS responses are facing challenges. Under pressure to demonstrate results for public funds, PEPFAR's latest 3.0 Strategy is streamlining the investment portfolio to be more directly in line with the HIV epidemic burden, and high-impact opportunities.

The Global Fund model has been updated to ensure more flexible timing, better alignment to national strategies, greater predictability of funding, and more active engagement of in-country partners. Yet the Global Fund's ability to reach many of those most in need in middle-income countries is hindered by restrictions on country eligibility. Some constituencies have called for the Global Fund to further leverage grants for broader progress on health – recognizing that people affected by HIV, TB and malaria also face a range of other health risks. While grant tracks are available for countries to apply for funding for health system strengthening, the Board has explicitly directed the Global Fund to maintain its focus on AIDS, TB and Malaria as it develops its Strategy for 2017-2021.

Thus the international AIDS architecture continues to struggle with the challenge of being accountable for delivering results in the AIDS response – while increasingly cognizant that progress is contingent on the broader health, education, legal and other systems and addressing the determinants of vulnerability.

Risks to commodity security

As the global health agenda expands, with the concomitant need to shift from providing affordable diagnostics, prevention commodities and medicines for millions to billions, threats to commodity security multiply. This will be acutely felt in the AIDS response where an estimated 6% of people receiving first-line antiretroviral treatment must shift to second-line regimens each year, and eventually to third-line, which is significantly more expensive. Market-driven research and development (R&D) often fails to develop goods for people without the means to pay, or don't represent a large enough market; TRIPS flexibilities are insufficiently applied while efforts to include TRIPS+ provisions in bilateral and regional trade agreements further circumscribe generic competition and access. Despite such restrictions, Africa has become overly dependent on Indian generics, particularly in relation to HIV treatment. Although political commitments to regulatory harmonization and enhancing local production have been made, progress is slow. In this context, new models to stimulate innovation on research, development, local manufacturing, commercialization and enabling regional markets are needed—for Africa and elsewhere.

UNAIDS 2011-2015 Strategy: Progress and gaps

In 2010, UNAIDS Board endorsed a Vision for the future of the response. The Vision of *zero new HIV infections, zero discrimination, zero AIDS-related deaths*, quickly captured the imagination of global leaders, national AIDS councils, community NGOs and activist networks at all levels. Bold, short and memorable, the “Three Zeros” have been frequently cited in speeches of the UN Secretary-General, Presidents, Prime Ministers, and heads of UNAIDS’ Cosponsoring organizations as well as other partners in the AIDS response. The Vision was adopted as the theme of World AIDS Day for 2011 and 2012 and inspired similar visions to be adopted by the tuberculosis and malaria responses.

While the Vision of the Three Zeros is aspirational, the journey towards its attainment was set out through three Strategic Directions and a series of concrete milestones for 2015 in the UNAIDS 2011-2015 Strategy: ‘Getting to Zero’. The Strategy emerged from several months of intensive multi-stakeholder consultation and negotiation and was endorsed by UNAIDS’ Board in December 2010. It sought to focus the global response on ten ambitious, results-oriented goals—a limited number that represent the areas where progress was most needed. The Strategy elevated the issue of advancing human rights and gender equality as a guiding strategic direction, alongside revolutionizing HIV prevention and catalyzing a new phase of treatment.

UNAIDS’ Vision and 2011-2015 Strategy brought clarity of purpose and a fresh approach to the Joint Programme, set the global agenda, fostered renewed political commitment and provided a framework for national priority-setting. The Strategy was embraced as a key reference document in the development of the 2011 UN General Assembly Political Declaration on HIV and AIDS, the latter adopting much of the strategic focus and ambitious goals for 2015 put forth by the Strategy.

Significant progress has been achieved through the AIDS response. Annex 3 summarizes progress towards the 10 goals of the UNAIDS Strategy. A few highlights are presented here.

Since 2001, new HIV infections have fallen by 38% - to 2.1 million new HIV infections in 2013 (15 countries accounted for 75% of these new infections, Fig. 5). New infections among children have fallen by 58%, dropping below 200 000 in the 21 most affected countries in Africa for the first time. This is a significant milestone on the journey to an AIDS-free generation.

Countries are also starting to discuss self-testing as another tool to prevent HIV transmission. France is “completing its arsenal” of tools to address HIV by allowing pharmacies to sell HIV self-tests. In high-prevalence regions of the world, voluntary medical male circumcision is being rapidly scaled up to reduce the risk of men acquiring HIV through heterosexual sex by up to 60%.

In mid-2014, record numbers of people (13.6 million) were accessing life-saving antiretroviral medicines, setting the world on track to reach its goal of 15 million people living with HIV on treatment by 2015. Treatment access is contributing to steady declines in the number of AIDS-related deaths

and further buttressing efforts to prevent new infections. Thailand recently became the first country in Asia to offer life-saving treatment to everyone, including both document and undocumented migrants.¹² The scale-up of collaborative HIV/TB activities (including HIV testing, ART and recommended preventive measures) prevented 1.3 million people from dying from 2005 to 2012.

While tremendous challenges remain in addressing the high rates of new HIV infections among women and girls, there is progress in the recognition by countries that gender equality and addressing harmful gender norms are critical to success in curbing new HIV infections. In just two years, over 30 countries have used the UNAIDS gender assessment tool in the context of assessing their epidemics and engaging women living with HIV in national strategic planning processes.

The trend towards the removal of HIV-related restrictions on entry, stay and residence demonstrates how progress can be made against HIV-related discrimination when actionable goals underpinned by concerted efforts. Since the 2011 Political Declaration on HIV and AIDS, calls on Member States to remove HIV-related restrictions on entry, stay and residence, ten countries have removed such restrictions.

While many countries remain reliant on international resources, the response is moving towards sustainability: The majority of global AIDS resources—which were almost US\$ 19 billion in 2012—are now coming from domestic sources in low- and middle-income countries.

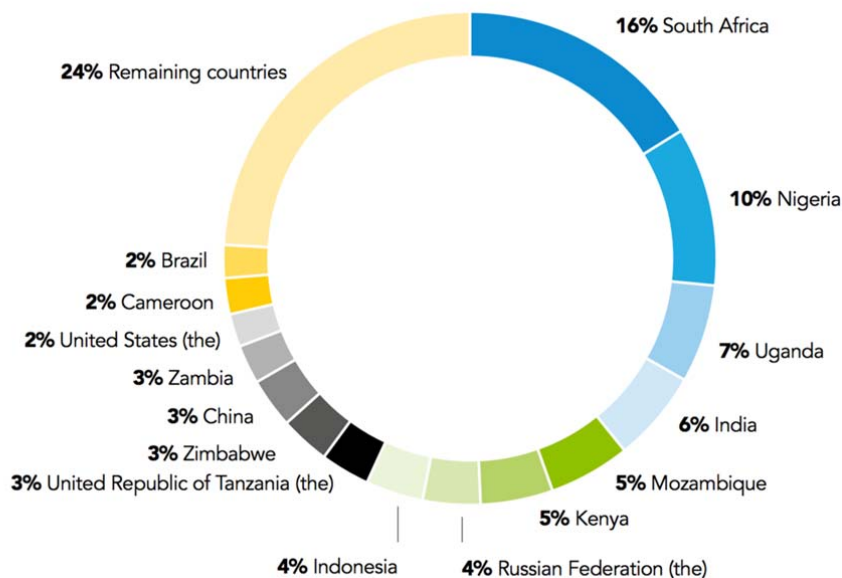


Fig. 5 Proportion of new HIV infections by country, 2013

Gaps in the response: Populations being left behind

¹² <http://www.unaids.org/en/resources/presscentre/featurestories/2014/october/20141027thaipm>

The people who have not yet been able to access HIV testing, information, prevention and treatment services are the most difficult to reach, suggesting that innovative and diverse approaches are needed to sustain and accelerate recent trends. Some populations are at higher risk or lack access to effective services because they are marginalized, others because of harmful laws, policies and gender norms, poverty, legal and social inequalities. Across regions, the populations being left behind vary greatly (Fig. 6), as do the contextual factors that result in their vulnerability and marginalization. The 2014 UNAIDS Gap Report explores issues faced by 12 populations that have been left behind by the AIDS response.

Of the 35 million **people living with HIV** in the world, 19 million do not know their HIV-positive status. While treatment coverage is expanding rapidly, with increased access comes the need to attend to treatment adherence, which poses unique challenges to people living with HIV of all ages across the lifecycle. Globally, levels of adherence are almost universally suboptimal, with evidence suggesting a negative trend over time.

Adolescent girls and young women account for one in four new HIV infections in sub-Saharan Africa. Three of four **children** living with HIV are not receiving HIV treatment. **Prisoners** are much more vulnerable to HIV, tuberculosis and hepatitis B and C – up to 50 times – than the general public, and are often denied access to relevant health services.

Between 40-50% of all new infections worldwide are currently estimated to occur among key populations (sex workers, men who have sex with men, people who inject drugs and transgender people) and their sexual partners. Only about three fifths of countries have risk reduction programmes for **sex workers**, while access to HIV prevention services remains low among **gay men and other men who have sex with men**; 88 countries report that fewer than half of men who have sex with men know their HIV status from a recent test result. Globally, less than 8% of **people who inject drugs** have access to opioid substitution therapy, and 4% of eligible people who inject drugs are receiving ART.

While many countries restrict access to health services for **migrants**, often migrants are simply not able to afford services because of their legal status or income earnings. Yet migrants and their partners are at high risk: In India for example, more than 75% of women testing HIV-positive had a migrant husband.

Many **transgender people** experience social exclusion and marginalization because of the way in which they express their gender identity, and are 49 times more likely to acquire HIV than all adults of reproductive age.

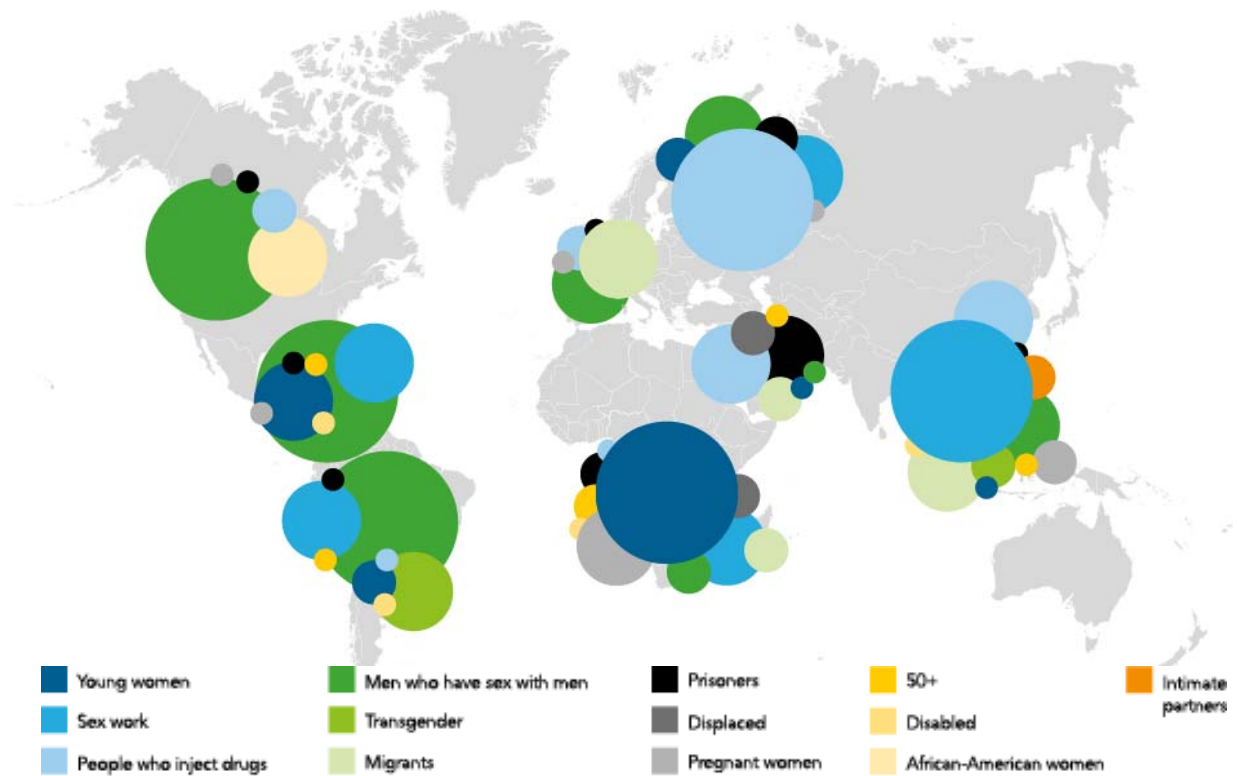
Whether or not they are living with HIV, **people with disabilities** have an unmet need for health and HIV services in order to protect themselves. They represent one of the largest and most underserved populations. The number of people living with HIV in low- and middle-income countries **aged 50 or older** continues to grow, representing 12% of all adult people living with HIV in 2013. However, few HIV strategies in low- and middle-income countries have caught up with this trend.

The **forcible displacement of people** through conflict or disaster is associated with increased food insecurity, the destruction of livelihoods and resulting poverty. Emergencies can disrupt care and treatment for people already living with HIV, and the negative impact of HIV on their health and livelihoods can increase the severity of the disasters they experience.

Too often people at higher risk or living with HIV face multiple issues—such as being a young woman displaced from home and engaged in sex work, or a gay man who injects drugs. Ensuring that no one

is left behind means closing the gap between people who can get services and people who can't, the people who are protected and the people who are punished.

Fig. 6 The importance of location and population



People living with HIV (children and adults) are included as members of all of the featured populations. They are implicitly included in this map as they must have universal access to services.

Fast-Tracking to 2021: Location, population and innovation

Fast-Tracking will set us on the path towards ending AIDS

The AIDS epidemic can be ended as a global public health threat by 2030. This confidence is based on a combination of major scientific breakthroughs and accumulated lessons learned in scaling up the AIDS response worldwide. Today we know that sustained HIV treatment can dramatically extend the lifespan of people living with HIV and effectively prevent HIV transmission. There are also many proven opportunities for HIV prevention beyond ART, including condom distribution, behaviour change, needle-syringe exchange, voluntary medical male circumcision, school feedings and programmes to empower women, girls and key populations to reduce HIV risk. These have clearly demonstrated their capacity to sharply lower rates of new HIV infections. HIV programmes are further dramatically strengthened when they are combined with social and structural approaches.

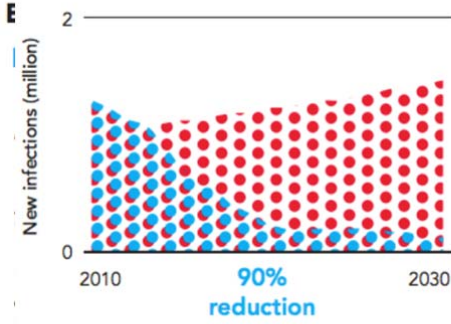
We know what works – but to reach our Fast-Track targets¹³ and set ourselves on a path towards ending AIDS by 2030, countries and their partners will need to significantly ramp up investments, programmes and policy change, and focus on populations, locations and innovation.

Fig. 7 Estimated annual number of new HIV infections and AIDS-related deaths: Comparing the achievement of the Fast-Track Targets and maintaining 2013 coverage levels

¹³ Over the course of 2014, all seven UNAIDS regions completed regional consultations on country and regional target setting. These consultations primarily focused on setting HIV treatment targets for beyond 2015 and also included other AIDS response targets. From these consultations, guided by evidence, modelling and implementation science, a clear call for the Fast-Track targets emerged.

EASTERN AND SOUTHERN AFRICA

New HIV infections

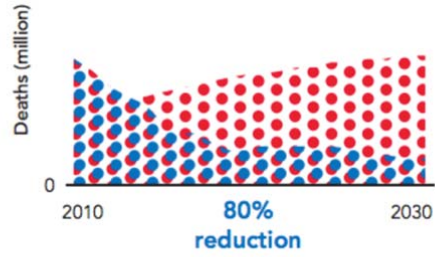


New HIV infections

- Ambitious targets
- Constant coverage

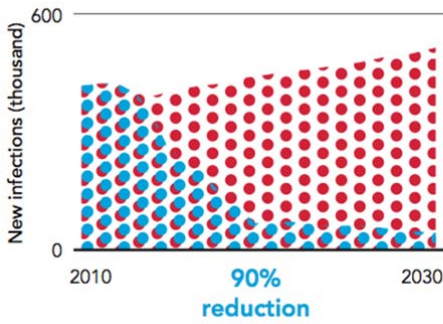
AIDS-related deaths

- Ambitious targets
- Constant coverage

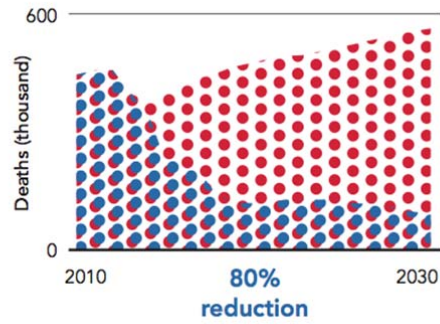


WEST AND CENTRAL AFRICA

New HIV infections

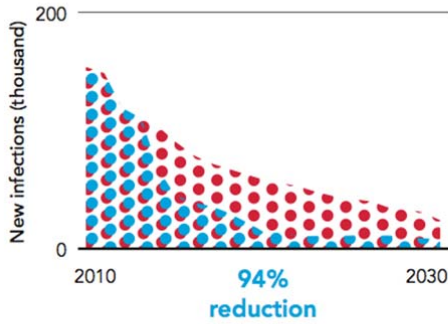


AIDS-related deaths

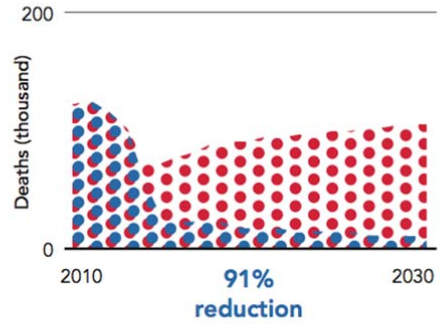


CARIBBEAN

New HIV infections

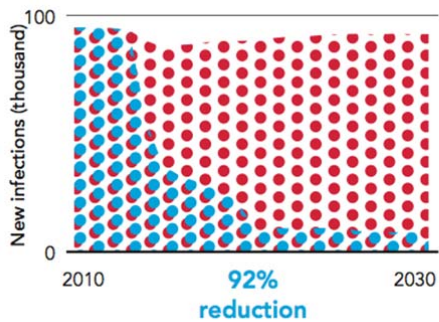


AIDS-related deaths

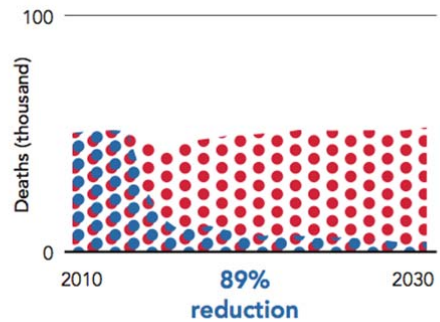


LATIN AMERICA

New HIV infections



AIDS-related deaths



What will it take to Fast-Track the AIDS response?

There will be no ending AIDS without putting people first, without ensuring that people living with and affected by the epidemic are part of a new movement. Without a people-centred approach, we will not go far in the post-2015 era.

So what will it take to Fast-Track the response and how do we close the gap between the people moving forward and the people being left behind? Drawn from areas of consensus over the last several months of regional, thematic and virtual consultation as well as ongoing discussion within the Joint Programme, an illustrative set of opportunities and innovations for accelerating progress are presented below:

- **Going granular:** Data-driven responses must prioritize the areas where the new HIV infections are highly concentrated, and identifying the places where services are lacking, not reaching or not being sustained among the people in need. Data collection methods that map behavioural risks, such as high rates of injecting and syringe-sharing, as well as rates of sexually transmitted infections can help to localize responses in relatively small, discrete areas that could be serviced with HIV treatment and prevention packages (such as needle and syringe programmes, opioid substitution therapy, ARV, TB and hepatitis C treatment). Going granular will demand improvements in data collection with an emphasis on **disaggregating data** to reveal and address the situation of different population groups.
- Understanding why populations continue to be left behind and adequately monitoring progress on reaching them – including by supporting **participatory research and data collection by representatives** from networks of key populations.
- Seizing the potential of new (or under-utilized) **Programmatic, Scientific and Leadership opportunities and innovation**. Such opportunities include self-testing; transforming delivery systems through community systems strengthening; PrEP; Community leadership and city leadership initiatives. For the latter, mobilizing local leaders, including Mayors, to champion “going granular” by demanding and implementing city-specific interventions will be critical.
- In the face of growing inequality, more forcefully leveraging the AIDS response to reduce vulnerability, creating more resilient communities. **Economic empowerment and inclusive HIV-sensitive social protection** offer proven approaches to preventing new HIV infections, improving access to services and supporting treatment adherence – with important multiplier effects on broader health, nutrition, education, and gender equality.
- **Addressing gender inequality, harmful gender norms and guaranteeing the rights of women and girls** so that they can protect themselves from HIV, and women living with HIV can gain greater access to services, including by amplifying the voices of women in decision-making, addressing the intersections between HIV, sexual and reproductive health and rights (SRHR) and violence against women, engaging boys and men, and promoting access to justice for women living with and affected by HIV, including their access to property and inheritance rights.
- **Empowering civil society:** Civil society organizations currently receive only 1% of global AIDS funding. UNAIDS proposes this proportion be increased to at least 3% to effectively leverage the role and contributions of community- and peer-led civil society organizations. The leadership of people living with HIV, particularly women, and other key populations is continually cited as the critical – yet inadequately resourced and supported – ingredient to effective and sustainable AIDS responses.

- **HIV-related stigma and discrimination** constitute among the most pervasive impediments to progress in countries. In addition to addressing the overall legal and policy environments and ensuring access to justice, concerted efforts must be made to address stigma and discrimination in health-care settings, in the media and in partnership with faith-based organizations.
- Addressing the **heightened vulnerability of young people** (particularly in the context of the largest youth generation the world has ever seen). Removing **social and legal barriers** and other bottlenecks in services delivery that prevent young people from accessing comprehensive sexuality education and sexual and reproductive health services.
- Ensuring **clearer accountability for front-loading investments**, achieving financial sustainability and mobilizing resources from both traditional and emerging development partners, innovative as well as domestic sources.
- While consolidating significant gains, **enhancing focus on under-performing countries, areas and cities**, for example, address bottlenecks, stagnating pace of progress and lost ground in several countries in implementing the Global Plan to Eliminate New HIV Infections Among Children and Keep their Mothers Alive.
- In the context of the new development agenda, demonstrating that **sustainability is at the heart of the Strategy. Programmatically**, this means focusing on service continuity and integration (e.g. with SRHR, hepatitis, TB, MNCH, cervical cancer and other NCDs), systems strengthening, supporting growing efforts to link risk-informed health, development and humanitarian action, and empowering marginalized groups. **Financially**, this means pursuing new ways of working with national treasuries, Global Fund, PEPFAR, the World Bank and others while devising financial sustainability transition compacts.
- New **ways of working with the private sector** must be explored, moving beyond corporate social responsibility and convincing private partners that investing in the AIDS response is good business practice.
- Sustainability will be further achieved through identifying '**entry points**' provided by the **SDGs** where the AIDS response has and can be a pathfinder, including:
 - Pursuing multisectoral solutions to **address shared determinants** (e.g. SRHR, child protection and education, social protection, nutrition, local medicines production, reducing gender-based violence and drug and alcohol dependence); and
 - Negotiating and delivering **global public goods** – including disease surveillance systems; research and development; overcoming IP/trade barriers to affordable, quality medicines; the global norm of health as a political and economic priority; and the activism role of civil society.

Towards the 2016-2021 Strategy Framework

Our vision of the three zeros – zero new HIV infections, zero discrimination and zero AIDS-related deaths – will continue to guide everything that we do. The SDG target of “ending the AIDS epidemic by 2030”¹⁴ provides a concrete milestone to be endorsed by UN Member States on the way to reaching the three zeros. The Fast-Track initiative has further laid out interim targets for 2020:

- Fewer than 500 000 new HIV infections
- Fewer than 500 000 AIDS-related deaths
- Everyone everywhere lives a life free from HIV-related discrimination

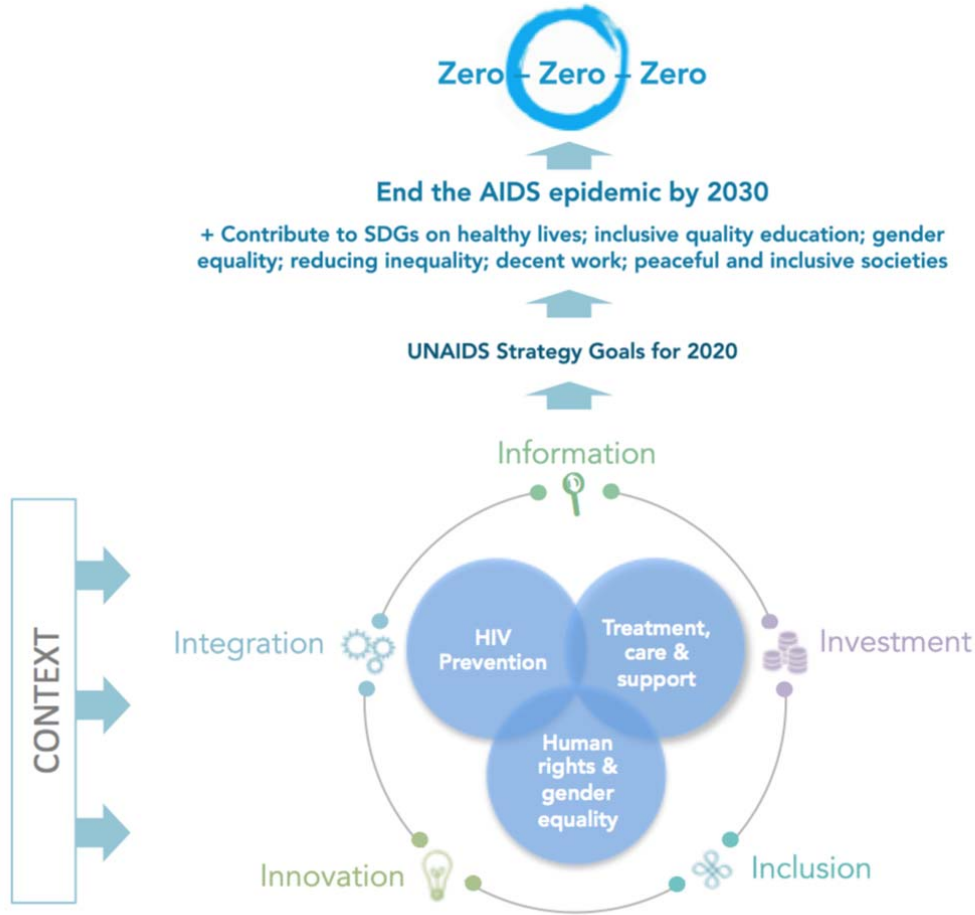
These three layers of goals and targets (see Fig. 8) provide the overarching framework for the UNAIDS 2016-2021 Strategy. The 10 Goals that were set by the 2011-2015 Strategy (see Annex 1) and subsequently adopted and adapted by the 2011 UN Political Declaration will also be updated to match the Fast-Track ambitions.

The next strategy will maintain the three strategic directions of the UNAIDS Strategy 2011-2015 – these are at the heart of global AIDS response and directly linked to our vision of the three zeros. The three Strategic Directions, (1) Prevention; (2) Treatment, care and support, and; (3) Human rights and gender equality, provided the organizing framework in the 2011-2015 Strategy. Goals for 2015, objectives and impact areas were arranged under each (see Annex 2).

In light of recent trends and developments, lessons learned and calls from stakeholders throughout consultations, it is proposed that the three Strategic Directions be complemented and reinforced by five cross-cutting themes: Information, Innovation, Integration, Inclusion and Investment. When considering the critical areas for accelerated progress, as presented on pages 20-21, these five cross-cutting themes continually reappear. They will serve to capture critical functions that support progress on a number of goals, and break down false dichotomies among the three Strategic Directions. The cross-cutting areas provide more direct opportunity to connect to and drive progress across the SDGs. Most importantly, the cross-cutting themes can offer clear operational guidance on the “how” – supporting countries to implement and scale-up for greater impact.

¹⁴ The 34th Meeting of the PCB provisionally defined ending the AIDS epidemic as a public health threat by 2030 as: “The rapid reduction of new HIV infections, stigma and discrimination experienced by people living with HIV and vulnerable populations and key populations, and AIDS-related deaths by 90% of 2010 levels, through evidence based interventions to include universal access to HIV prevention, treatment, care, and support, such that AIDS no longer represents a major threat to any population or country.”

Fig. 10 Proposed UNAIDS Strategic Framework for 2016-2021



Regional dimension. While all countries and stakeholders will be accountable to collectively reach the global goals set for 2020, UNAIDS needs a “geo-smart” strategy that supports the articulation of differentiated strategies in cities, fragile settings, middle-income countries, high-impact countries, or under-performing countries. One innovative aspect of updating the strategy can thus be to reflect the regional specificity of priorities and actions. A regional dimension to the strategy further recognizes the increasingly influential role of regional institutions in promoting stronger ownership, mutual accountability, and regional cooperation, and addressing areas that require inter-country collaboration e.g. strengthening pharmaceutical regulatory mechanisms; bundled commodities purchasing and delivery, and; migration. Throughout regional consultations, the proposal of including a regional dimension in the strategy has garnered significant support.

Close

By committing to Fast-Track the AIDS response, countries, regions, and the global community have demonstrated an unprecedented level of ambition, hope and dedication. Reaching the proposed Strategy goals is possible - but will require us to collectively respond to several fundamental questions. We have identified those posed at the opening of this paper as a good starting point:

1. How will developments – global and regional – impact the epidemic and response in countries and at the sub-national level over the coming years?
2. Who is being left behind and why? Where are the main challenges and gaps? What achievements in addressing challenges to date should be expanded and built upon?
3. In order to reach the Fast-Track targets, what should be the strategic priorities in the response?
4. What will need to change in support of those priorities? What are the “game-changers” – in terms of policy and law reform, funding, resource allocation, partnerships, service delivery, empowering civil society, science and innovation, and links with other health and development efforts?
5. How can the opportunity of the new Sustainable Development Goals be optimized in the Strategy – what linkages, policy coherence and collaborative action must be pursued?
6. What are the most critical ways in which the UNAIDS Joint Programme can support efforts to end AIDS as a public health threat by 2030?

By collectively exploring and defining the answers to these questions, and translating them into an actionable Strategy, together we can set the world on course to Fast-Tracking the AIDS response, and ending the epidemic by 2030.

Annex 1. Ten UNAIDS Goals for 2015, set by the UNAIDS 2011-2015 Strategy

- 1 Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work
- 2 Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half
- 3 All new HIV infections prevented among people who use drugs
- 4 Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment
- 5 TB deaths among people living with HIV reduced by half
- 6 People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support
- 7 Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half
- 8 HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions
- 9 HIV-specific needs of women and girls are addressed in at least half of all national HIV responses
- 10 Zero tolerance for gender-based violence

From the 2011 UN General Assembly Political Declaration on HIV and AIDS:

- 11 Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22-24 billion in low- and middle-income countries

Annex 2. CURRENT Strategic directions, objectives and impact areas of the UNAIDS Strategy 2011-2015

| VISION STRATEGIC DIRECTIONS | ZERO NEW HIV INFECTIONS Revolutionize HIV prevention | | | ZERO AIDS-RELATED DEATHS Catalyse the next phase of treatment, care and support | | | ZERO DISCRIMINATION Advance human rights and gender equality for the HIV response | | |
|-----------------------------------|---|--|---|---|---|--|---|---|--|
| OBJECTIVES | To generate political commitment on how and why people are getting infected | To mobilize communities to demand transformative change | To direct resources to epidemic hot spots | To ensure that people living with HIV can access treatment | To strengthen national and community systems to deliver services | To scale up access to care, support and social protection services | To support countries in protecting human rights in the context of HIV | To advance country capacity to reduce stigma and discrimination | To ensure that national programmes address the needs of women and girls |
| IMPACT AREAS | Leaders positively incentivized to make the right decisions | Young people empowered to redress harmful social norms | Strategies emphasize priority prevention programmes | Better drugs and point-of-care tools developed | Capacity of community systems to deliver integrated services expanded | Care and support services adapted to diverse needs | Key populations empowered to claim their rights | People living with HIV mobilized as forces of change | Programmes that support women and girls across the full range of their lives implemented |
| | Political and legal barriers mapped and addressed | Positive Health, Dignity and Prevention approaches scaled up | Innovative and effective prevention approaches introduced and scaled up | Major non-drug-related cost savings identified and achieved | Country capacity for registering of medicines and using TRIPS scaled up | HIV-sensitive social transfers embedded into national programmes | Guidance on protective social and legal environments in HIV context disseminated | Data collection with people at higher risk of HIV infection strengthened and put to use | Programmes to counter gender-based violence implemented |
| CORE THEMES | <p>Inclusive, country-owned sustainable responses</p> <ul style="list-style-type: none"> ■ Build and strengthen lasting local institutional capacity ■ Mobilize national leaders to allocate funding, including domestic, to those at the highest risk of infection with the most cost-effective interventions <p>People at the centre of the response</p> <ul style="list-style-type: none"> ■ Promote the leadership and capacity of peer-led organizations and networks of people living with and affected by HIV and at higher risk of HIV infection in designing, implementing and evaluating HIV responses at the global and national level <p>Synergies between the HIV response and broader Millennium Development Goals and human development efforts</p> <ul style="list-style-type: none"> ■ Generate collaboration between various networks and movements promoting health and development causes ■ Leverage resources for implementing appropriate, equitable and cost-effective approaches to integrating programmes and services | | | | | | | | |

Annex 3: Progress and Gaps towards UNAIDS 10 Strategy Goals for 2015

| GOALS | PROGRESS (2013; Baseline 2009) | GAPS |
|---|--|---|
| Sexual transmission of HIV reduced by half, including among young people, MSM and transmission in the context of sex work | <ul style="list-style-type: none"> ➤ New adult infections continue to decline in most parts of the world: 10% since 2009/10. 1,900,000 new infections, 47% in females ➤ Nearly half of the adults living with HIV in sub-Saharan Africa know their status ➤ Highly effective biomedical tools have emerged | <ul style="list-style-type: none"> ➤ Adult key populations¹⁵ account for 40-50% of new infections. Prevalence among SWs is 12x greater than women overall; Among MSM about 19x greater than men generally. A better allocation of resources to target KP is needed. ➤ 15 countries account for more than 75% of new HIV infections; HIV burden varies greatly by location and population ➤ In some regions young women and girls at higher risk than male peers. 80% of young women living with HIV are in SSA ➤ Challenges in implementation and insufficient access to quality Comprehensive Sexuality Education and SRH services for adolescents and young people ➤ VMMC scale up slow; More evidence on what works to scale up is needed ➤ Sexual transmission among stimulant non-injecting drug users is critical. |
| All new HIV infections prevented among people who use drugs | <ul style="list-style-type: none"> ➤ HIV prevention programmes for people who inject drugs have shown results when such services are made available and community-led | <ul style="list-style-type: none"> ➤ 12.7 million people inject drugs and 13% of them are PLHIV; HIV prevalence is 22 times higher among people who inject drugs than the general population ➤ Programmatic coverage is low, particularly among prison populations ➤ Numerous countries retain punitive policy and legal frameworks/practices which discourage individuals from seeking health and social services ➤ HIV prevalence among women injecting drugs higher (13%) than men (9%) |
| Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half | <ul style="list-style-type: none"> ➤ 43% reduction of new HIV infections in children ➤ Among 21 highest-burden countries, eight countries reduced infections by 50% or more ➤ PMTCT coverage increased from 33% to 68% - and with more efficacious regimens ➤ Down to 7,500 maternal deaths from AIDS¹⁶ | <ul style="list-style-type: none"> ➤ Need for scale-up of other prevention strategies e.g. primary HIV prevention for women and access to contraception, other family planning services ➤ Greater efforts needed to link pregnant women and children to services, and continuity of care for women on ART through breastfeeding ➤ 30% of countries have yet to integrate PMTCT in MNCH or SRH services ➤ Lack of child-friendly regimens |

¹⁵ Sex workers and their clients, men who have sex with men, transgender people and people who inject drugs and their sexual partners

¹⁶ Due to adjustments in calculation it is not possible to compare estimates over time

| | | |
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| <p>Universal access to ART for people living with HIV who are eligible for treatment</p> | <ul style="list-style-type: none"> ➤ On track to reach the goal: 13.6 million people on ART as of June 2014 ➤ AIDS-related deaths decreased by 25% (1.5 million deaths) | <ul style="list-style-type: none"> ➤ 38% of adult PLHIV on ART compared to 24% of children ➤ Little is understood and researched regarding women's access and adherence to treatment across entire lifecycle, their experiences of treatment access, availability, and their decision-making around uptake ➤ Considerable variation in ART access within and among regions ➤ Need for greater attention to both uptake and adherence support measures ➤ Lack of access to 2nd and 3rd line drugs |
| <p>TB deaths among people living with HIV reduced by half</p> | <ul style="list-style-type: none"> ➤ TB-related deaths among PLHIV declined by 33% worldwide since 2004 | <ul style="list-style-type: none"> ➤ TB is still the leading cause of death among PLHIV (360 000 deaths) ➤ People with HIV/TB on isoniazid therapy is a fraction of those in need ➤ 50% of countries have either fully integrated HIV and TB services or strengthened joint service provision |
| <p>People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</p> | <ul style="list-style-type: none"> ➤ A trend towards integration of HIV with diverse systems and sectors is apparent ➤ Good country examples of HIV-sensitive social protection programmes, eg India and Tanzania ➤ Strong evidence on impact of Cash Transfers for HIV Prevention, Treatment and Care | <ul style="list-style-type: none"> ➤ Social protection care and support for PLHIV is underfunded and fragmented, and limited in scope and coverage ➤ Data on the level at which social protection instruments are HIV sensitive not ready available ➤ Orphans school attendance rate is still lower (90%) than for non-orphans ➤ Broader social protection schemes beyond cash transfers should be considered for implementation |
| <p>Countries with punitive laws and practices around HIV transmission, sex work, drug use or homoy that block effective responses reduced by half</p> | <ul style="list-style-type: none"> ➤ Work goal has substantially increased political commitment, partnerships, and evidence informed programmes to remove punitive laws and reduce stigma and discrimination ➤ Evidence-base on impact of punitive laws on HIV has been expanded | <ul style="list-style-type: none"> ➤ The number of countries with obstacles to effective responses has not fallen (60%). Criminalization of key populations remains widespread. ➤ Discriminatory treatment of people living with HIV remains common in multiple facets of life, including access to health care |
| <p>HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</p> | <ul style="list-style-type: none"> ➤ Since 2011, 10 countries removed restrictions | <ul style="list-style-type: none"> ➤ 38 countries have travel restrictions ➤ Middle East and North Africa region continues to have the highest number of countries that impose HIV-related travel restrictions |

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| <p>HIV-specific needs of women and girls are addressed in at least half of all national HIV responses</p> | <ul style="list-style-type: none"> ➤ Above 80% of countries report that gender issues are included in their Multisectoral HIV Strategies, with 50% having an earmarked budget ➤ | <ul style="list-style-type: none"> ➤ Gender inequalities and harmful gender norms continue to contribute to HIV-related vulnerability ➤ Lack of sex- and age-disaggregated data undermines development, implementation and financing of gender-responsive policies and programmes ➤ Allocation of earmarked budget dedicated to gender equality and women's empowerment remains inadequate, causing lags in implementation ➤ 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 ➤ Reports from all regions of forced or coerced sterilization of women with HIV |
| <p>Zero tolerance for gender-based violence</p> | <ul style="list-style-type: none"> ➤ More than 80% of countries have a policy, law or regulation to reduce violence against women | <ul style="list-style-type: none"> ➤ Lack of systematic and comparable, sex- and age-disaggregated data collection and use of evidence on the linkages between HIV, gender inequality and GBV ➤ Intimate partner violence is prevalent in all regions – although with large ranges/variations while multi-sectoral and coordinated national response to GBV remains a challenge ➤ Other forms of violence and harmful practices persist in the countries that influence women and girls' abilities to confront HIV ➤ Violence against sex workers is prevalent |
| <p>Close the global AIDS resource gap and reach annual global investment of US\$22-24 billion in LMICs (2011 UNGA Political Declaration Target)</p> | <ul style="list-style-type: none"> ➤ US\$ 19.1 billion invested in AIDS programs in low- and middle-income countries: just over a 10% increase from 2011 | <ul style="list-style-type: none"> ➤ Lower-middle and low-income countries contribute 22% and 10% of AIDS investments from domestic sources ➤ HIV expenditures require significant efficiency reallocation and cost containment to become investments and thus gain return of investment greater than 1. |

Sources: GARPR Report 2013; GAP Report 2014; MTR 2013

Annex 4: Select contributions of the Joint Programme to global progress towards the 10 Goals of the UNAIDS 2011-2015 Strategy¹⁷

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| <p>Sexual transmission of HIV reduced by half, including among young people, MSM and transmission in the context of sex work</p> | <p>The Joint Programme reinforced the importance of location and population for effective prevention by mapping gaps and populations left behind. It led analyses and reviews of national responses to contextualize global findings; promote evidence-informed combination prevention and integrate new technologies. In 2013, WHO pre-qualified the first nonsurgical circumcision device for adults and considerable gains were made in scaling up Voluntary Medical Male Circumcision. The World Bank supported allocative efficiency studies in 15 countries, which helped improve the focus on high-impact programmes for key populations. UNDP and UNFPA have supported 26 cities covering five regions to develop innovative municipal HIV Action Plans addressing the needs of key populations. UNESCO-led efforts to advance education for HIV prevention and sexual and reproductive health issues have yielded promising results. UNFPA re-energized condom programming and addressed gaps in availability through national CONDOMIZE! campaigns in 5 countries, and procurement of 1.1 billion male condoms and 21 million female condoms. In 2014, UNICEF and the UNAIDS Secretariat, with engagement of all Cosponsors, initiated the All In! agenda, aimed at reducing new HIV infections among adolescents by at least 75% and reducing HIV-related mortality by 65%. WFP's school feeding programmes drive girls' attendance and pre-empt the adoption of negative coping mechanisms that increase the risk of HIV infection, such as transactional sex.</p> |
| <p>All new HIV infections prevented among people who use drugs</p> | <p>UNODC placed HIV and drug use at the heart of its global agenda, and led UNAIDS to support an increase in access for women and men who inject drugs to harm reduction services including in prisons. The Joint Programme provided guidance on preventing HIV transmission among people who inject drugs, including those under 18 or in prisons. Legislative guidance and policy analyses contributed to legal reforms for drug-related services in Azerbaijan, Cambodia, Uzbekistan and Vietnam. Law enforcement officers were trained in 18 countries on supportive practices to enable access to harm reduction services.</p> |
| <p>Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half</p> | <p>The Joint Programme leads the global campaign to eliminate new HIV infections among children. The Global Plan to Eliminate New HIV Infections Among Children and Keep their Mothers Alive, co-led by the UNAIDS Secretariat and PEPFAR, has united countries around a single objective, mobilized science and innovation, accelerated country level action and strengthened accountability. UNICEF and WHO co-lead the Secretariat of the 32-partner Inter-Agency Task Team that coordinates technical assistance, guidance and tools development, and tracking of progress on the Global Plan. WHO's improved global guidance (life-long treatment or Option B+ which provides that pregnant women with HIV should be maintained on treatment for life) made interventions more effective in averting new infections. At country level, the Joint Programme provides extensive technical assistance to ensure that national plans are in place, resources available, approaches integrated – including with nutrition to retain mothers in care – and decentralized and local capacities improved.</p> |

¹⁷ 2011-2013; Information from 2014 has been included but it is incomplete.

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| <p>Universal access to ART for people living with HIV who are eligible for treatment</p> | <p>The Treatment 2015 initiative was launched in 2013 by the UNAIDS Secretariat, WHO, the GFATM and PEPFAR to accelerate treatment scale-up and intensify financial and technical support to 30 countries that account for 90% of the global unmet need for treatment. In 2013, WHO issued consolidated treatment guidelines and supported countries to adapt and implement them. These guidelines are having tremendous impact on access to quality treatment services. UNHCR provided treatment to refugees while lobbying for their inclusion in national programmes. WFP provided nutrition support to malnourished people living with HIV on ART in 22 countries to increase treatment uptake and adherence. In 2014, UNDP-supported Global Fund programmes helped 1.4 million people access life-saving ART. ILO and UNAIDS launched the VCT@WORK Initiative to scale up HIV testing in high impact countries, reaching to date approximately 700,000 women and men workers.</p> <p>The Joint Programme is instrumental for children and key populations to access HIV testing and treatment by continuous advocacy, specific guidance and increased allocation of resources, including via the GFATM. In 2013, UNICEF, with WHO and EGPAF launched Double Dividend to expand testing and paediatric ART through greater integration with maternal and child survival programming in high burden countries.</p> |
| <p>TB deaths among people living with HIV reduced by half</p> | <p>Norms, standards and tools continue to be developed by the Joint Programme. WHO TB/HIV policy was disseminated to 49 countries via workshops and joint TB and HIV programming was undertaken through Global Fund processes. Collaboration with governments and stakeholders brought progress in including food and nutrition in HIV and TB strategies. WFP's HIV and TB operations in 2012 & 2013 reached an estimated 2.9 million beneficiaries.</p> |
| <p>People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support</p> | <p>The Joint Programme strongly advocated for strengthening HIV integration with other health and development sectors and supported countries to maximize and synergize on the AIDS response achievements. WHO's 2013 consolidated treatment guidelines promote improved integration of services such as HIV and TB; PMTCT and ANC; and reproductive, maternal, new-born and child health.</p> <p>The Joint Programme has worked to bring social protection and structural drivers into global policy dialogue, led evidence-based advocacy for HIV-sensitive social protection, facilitated research, and provided technical support to government, civil society and private sector to expand coverage and depth. In 2012-13, with total funding for social protection reaching almost US\$ 15 billion and a new Strategy for Africa, the World Bank played a key role in strengthening national systems and integrating HIV across social protection schemes. The World Bank also strengthened the evidence base for the use of HIV-sensitive cash transfers to reduce sexually transmitted infections. WFP provided food assistance to offset economic shocks of HIV-affected households, linking to broader social protection platforms and economic strengthening activities. UNICEF is working with governments and partners across Africa to scale up the coverage of national social protection programmes to reduce HIV infection among adolescents, keep adolescents on treatment, and increase the resilience of poor and vulnerable households and children affected by HIV.</p> |

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| <p>Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half</p> | <p>In addition to global high-level advocacy and policy statements, joint action was undertaken in 84 countries to advance the recommendations of the Global Commission on HIV and the Law, convened by UNDP on behalf of UNAIDS. The Joint Programme has helped countries draft legislation and policies, based on public health evidence and human rights principles, and convened consultations on laws, including in the context of key populations and young people. Dialogues on HIV and the law were held in 49 countries, with the Joint Programme helping 65 countries undertake legal environment assessments and reviews. UNAIDS and partners developed advocacy and guidance materials. Fifty countries completed the PLHIV Stigma Index, which has promoted and informed national dialogue on improving legal and social environments for effective AIDS responses. In 2014 WHO released recommendations of evidence-based, targeted HIV policies and programmes focused on all five key population groups currently identified as the groups most vulnerable to HIV. ILO published an HIV handbook for judges, magistrates, lawyers and parliamentarians from 50 countries. Capacity building led to national legislative and HIV workplace policy reviews in dozens of countries.</p> |
| <p>HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions</p> | <p>The Joint Programme has a) identified where travel restrictions exist, b) carried out high-level advocacy to lift such restrictions, and c) provided concrete technical assistance for the removal of the discriminatory provisions. In several countries, the UNAIDS Secretariat created momentum for the removal of restrictions and built partnerships that were able to carry the issue forward.</p> |
| <p>HIV-specific needs of women and girls are addressed in at least half of all national HIV response</p> | <p>The Joint Programme implemented the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in more than 90 countries and produced strategic guidance on gender and HIV. A review of the Agenda found that “nearly two thirds of countries strengthened gender equality within their AIDS responses, and gains were made in fostering political commitment and developing an evidence base for policies and programmes”. More than 700 civil society organizations are implementing the Agenda. By supporting women networks, UNDP, UN Women and the UNAIDS Secretariat help women living with HIV to influence HIV planning and implementation and increase their access to justice. Since 2011, UN Women has supported several sub-Saharan African countries to improve legal and property inheritance rights for women and girls living with HIV with clear results in the increase in availability and accessibility of legal services. UNFPA helped build consensus on best practices for protecting and supporting the adolescent girl-child.</p> |
| <p>Zero tolerance for gender-based violence</p> | <p>Activities on Gender Based Violence (GBV) are wide-ranging. In 2011, the UN Security Council adopted Resolution 1983 on preventing HIV and GBV in conflict settings – an agenda driven by UNAIDS. It helped document the linkages between HIV and GBV using social media to raise awareness; evidence and technical support on the linkages between GBV, food security and HIV (WFP); advocacy and country efforts to address GBV in the context of sex work (UNDP, UNFPA). The UN Women Gender Equality Fund provides direct grants to CSOs, which have forged effective partnerships addressing intersections of violence against women and HIV at the community level. The IATT on Education, led by UNESCO and in collaboration with UN Women and UNGEI, is advancing evidence and research on school-related gender-based-violence and producing regional and global guidance to assist national stakeholders in developing educational policies and practices that promote safe schools for all young people. UNFPA and partners published an Asia-Pacific assessment of the impact of violence against sex workers on HIV risk and engaged multiple sectors in response to this. UNICEF in collaboration with CDC and PEPFAR conducted studies in a number of countries on violence against children to inform national plans.</p> |

Annex 5. Multistakeholder Consultation on UNAIDS 2016-2021 Strategy: Progress to date and next steps

The UNAIDS 2016-2021 Strategy, as well as the [Unified Budget, Results and Accountability Framework](#), (UBRAF) is being developed through an inclusive process. The process includes multistakeholder consultations at the regional and global levels, in-person and online. Short notes on each of the consultations will be available as conference room papers for the 36th Meeting of the UNAIDS Board in July 2015.

Regional consultations

All UNAIDS Regional Support Teams as well as the New York and Washington DC Liaison Offices and partners have led consultations in their regions.

Asia & Pacific

- 30 January; Bangkok, Thailand. This consultation took place in the framework of an intergovernmental meeting on AIDS convened by ESCAP which brought together representatives of member states, civil society, young people and Cosponsors.

Latin America

- The RST hosted a multi-phase and multi-level consultation over the course of one month, including sub-regional and national in-person consultations and through the use of several virtual consultation platforms.

Middle East & North Africa

- MENA hosted eight national consultations, a virtual regional consultation and an in-person regional consultation in partnership with the League of Arab States, which brought together representatives of member states, civil society and governments.

Caribbean

- 16 March; Kingston, Jamaica. This event brought together participants representing CARICOM and OECS member states, the judiciary, academia, the private sector, civil society, young people and Cosponsors.

Eastern & Southern Africa

- 23 March; Johannesburg, South Africa. This full-day consultation convened people living with HIV, and representatives from government and municipalities, NGOs including networks of key populations and youth networks, academia, the private sector, donors and other development partners, and the United Nations family. The high level consultation followed three constituency-specific consultations.

Western & Central Africa

- 1-2 April; Dakar, Senegal. This two-day event brought together high-level government, civil society and UNAIDS representatives. This high level event followed several country- and regional-level discussions and consultations.

Eastern Europe & Central Asia

- 6-8 April; Minsk, Belarus. UNAIDS facilitated this regional consultation for partners in EECA, in partnership with the Government of Belarus.

North America

- 13 March; Washington DC, United States. UNAIDS U.S. Liaison office convened this consultation with U.S. civil society, hosted by the Global AIDS Policy Partnership and with support from the Federal AIDS Policy Partnership (FAPP).
- 18 March; New York, United States. The UNAIDS New York Office convened New York-based stakeholders from civil society, academia, think tanks and the private as well as Cosponsors in a one-day consultation on the UNAIDS Strategy.

Western Europe and Other Countries

- 26-27 March; Montreux, Switzerland. Hosted by the Government of Switzerland, this consultation engaged representatives from several Western European Member States, civil society and international organizations in partnership with UNAIDS.

2) Virtual Consultations

From March 23-April 2, UNAIDS launched a global virtual consultation to encourage an open and interactive discussion including with stakeholders who might otherwise not be reached. The virtual consultation generated a lively debate with more than 280 inputs, with participants representing more than 50 countries and submissions in 5 languages. The virtual consultation included significant representation from many communities including people living with HIV, members of key populations and young people.

A second virtual consultation is planned for July, with a focus on the first draft of the Strategy.

Submissions will remain visible on the site, which will also host the second consultation. Link: <http://www.unaidsstrategy2021.org/>