



## UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (38)/16.6  
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### **THIRTY- EIGHTH MEETING**

**Date:** 28-30 June 2016

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

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**Agenda item 4.1**

### **Unified Budget, Results and Accountability Framework**

**Performance Monitoring Report: Synthesis**

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**Additional document for this item:**

- i. UNAIDS Performance Monitoring Report 2014-2015 (*UNAIDS/PCB(38)/16.7*)

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

1. *Take note* of the performance monitoring report and continued efforts to rationalize and strengthen reporting, in line with decisions of the Programme Coordinating Board, and based on experience and feedback on reporting;
2. *Look forward* to further streamlined performance monitoring reports based on a simpler structure, fewer outputs and improved indicators in the 2016-2021 Unified Budget, Results and Accountability Framework;
3. *Encourage* external validation and triangulation of data as well as independent evaluations to strengthen performance reporting further;
4. *Urge* all constituencies to contribute to efforts to strengthen performance reporting and use UNAIDS annual performance monitoring reports to meet their reporting needs;

**Cost implications of decisions:** none

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## I. INTRODUCTION

1. UNAIDS Performance Monitoring Report is the primary tool used to report annually to the Programme Coordinating Board (PCB) on achievements against the Unified Budget, Results and Accountability Framework (UBRAF). It is complemented by financial reports prepared based on the International Public Sector Accounting Standards (IPSAS). It is distinct from the reports of the Secretary-General to the General Assembly on AIDS, and UNAIDS global reports on AIDS, which present progress against global AIDS targets and commitments, beyond the contributions of the Joint Programme.
2. The format of this year's report follows last year's report and is based on the decisions of the 34th PCB to provide a consolidated report that captures progress against core indicators as well as expenditures; shows the link to outcomes, goals and targets; distinguishes Cosponsor, Secretariat and joint results; and, using the UBRAF structure, showcases country performance.
3. This report highlights achievements of the UN Joint Programme on HIV/AIDS (UNAIDS) in 2014-2015 at country, regional and global levels 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, lessons learned and future actions.
4. The first part of the report presents progress against the three pillars of the UNAIDS Strategy – revolutionizing HIV prevention;; catalysing treatment, care and support;; and advancing human rights and gender equality for the AIDS response. Thereafter, UNAIDS strategic functions of leadership and advocacy, coordination, coherence and partnerships, and mutual accountability are presented, followed by cross-cutting themes. Future actions are identified before financial information is presented in the final section of the report.
5. As of next year, performance reporting will be based on the final, prioritised and more detailed 2016-2021 UBRAF. The 2016-2021 UBRAF has a simpler structure and fewer outputs than the 2012-2015 UBRAF, which will enable more streamlined and concise reporting. The 2016-2021 UBRAF includes a strong focus on independent evaluations, to complement performance monitoring, with annual evaluation plans and summaries of key evaluations shared with the PCB (see Annex I and II).

## II. PROGRESS AGAINST OUTCOMES, GOALS AND TARGETS

### A. Revolutionize HIV prevention

#### *i. Reducing sexual transmission*

6. Since 2000, there has been steady global progress towards reducing the number of people newly infected with HIV. In 2014, 35% fewer people acquired HIV worldwide (1.9 - 2.2 million), compared to in 2000.<sup>1</sup> However, progress has been slower than hoped. Between 2010 and 2014, the annual number of young people and adults (aged 15+) newly infected worldwide fell by just 8%, with reductions in sexual transmission of HIV

<sup>1</sup> How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response. Geneva: UNAIDS; 2015 ([http://www.unaids.org/sites/default/files/media\\_asset/MDG6Report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf))

falling significantly short of the 2011 Political Declaration target of a 50% reduction by 2015.<sup>2</sup> Almost one fifth of new infections are among females aged 15 to 24, with most new infections being acquired through sexual transmission.

7. In 2015, the UNAIDS Programme Coordinating Board (PCB) approved the UNAIDS Strategy 2016-2021. This Strategy seeks to achieve a focused set of ambitious and people centred goals and targets by 2020 in order to end the AIDS epidemic as a public threat in all places and among all populations by 2030. It focuses on drastically reducing new infections to bend the trajectory of the epidemic. Reducing sexual transmission of HIV is central to achieving the Strategy fast tracking goal of reducing new infections to fewer than 500 000 by 2020. On the implementation side, the Joint Programme conducted a range of initiatives in 2014-2015 that were targeted towards reducing sexual transmission. These include:
- **A strategic focus on key populations and locations:** WHO estimates that key populations and their partners account for 40-50% of all new HIV infections. In 2014, the UNAIDS Fast Track report also identified that key populations living in cities shoulder a disproportionate burden of the global HIV epidemic, as well as being less likely to access prevention and treatment services. WHO rolled out its consolidated key population guidelines in all regions and produced a target setting guide to support countries to plan, develop and monitor services as well as supporting health worker training for providing services for key populations in the AFRO region. The World Bank additionally provided direct technical assistance to help countries improve programme implementation for key populations, including supporting sex worker programmes in six West and Central African countries, as well as strengthening capacity to implement such programmes in others countries in the region, through a regional training event. ILO additionally implemented a Corridor Economic Empowerment Project in partnership with the UNAIDS Secretariat, the Southern African Development Community (SADC), UNFPA, IOM, UNICEF and key civil society partners, to reach vulnerable women along transport corridors in Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe. The project combined increased access to HIV services, entrepreneurial skills and innovative microfinance opportunities and resulted in a 48% and 81% increase in the number of individuals adopting HIV risk reduction strategies in 2014 and 2015. In Sudan, the Allocative Efficiency study conducted by the World Bank in partnership with the Global Fund and UNAIDS led to almost doubling HIV resource allocations, including for treatment, to high priority programmes for key populations. The UNDP and UNFPA led Urban Health and Justice Initiative operating to reduce HIV among key populations supported 42 cities in 2014 and 2015, through technical support on development of strategic plans that incorporate prevention, treatment and access to justice services for key populations - for example in Zambia, five cities were supported to develop Cities HIV and AIDS Investment Plans.
  - **Increasing prevention interventions and availability of prevention commodities:** The updated UNAIDS Strategy includes five targets related to prevention and a set of ambitious programmatic targets that addresses coverage of combination prevention services for key populations and for young people in high HIV prevalence settings. UNFPA remains one of the largest suppliers of condoms and lubricants. In 2014, UNFPA procured over 759 million male condoms, 14.8 million female condoms and just over 10 million sachets of lubricants. In 2015, UNFPA procured and supplied

<sup>2</sup> Invest in HIV prevention. Geneva: UNAIDS; 2015  
[http://www.aidsdatahub.org/sites/default/files/publication/Invest\\_in\\_HIV\\_prevention\\_2015.pdf](http://www.aidsdatahub.org/sites/default/files/publication/Invest_in_HIV_prevention_2015.pdf)

686.8 million male condoms, 14.7 million female condoms and just over 16 million sachets of lubricants. To support the supply of quality assured condoms to countries, the UNFPA/WHO Prequalification programme prequalified four female condom designs and has 26 male condom manufacturers on the prequalified list. In 2015, 97 UNFPA-supported countries reported having a functional logistical system for forecasting and monitoring reproductive health commodities. Of these, 71% experienced no stock-outs of contraceptives, including condoms, in the previous six months, in at least 60% of service delivery points. In order to address supply, the World Food Programme (WFP) and the Global Fund signed a Memorandum of Understanding (MoU) to improve access to HIV-related commodities, through the use of WFP's storage and shipping networks. WFP and the Global Fund's supply-chain partner PFSCM also concluded an agreement for the provision of bilateral logistics services. National CONDOMIZE! campaigns, which are designed to increase knowledge and awareness on use of condoms, address myths and misconceptions about condoms, promote behavior change and reduce stigma, were expanded in nine countries in Sub-Saharan Africa. The campaigns run under the leadership of the Ministries of Health with technical assistance from UNFPA and support from youth organizations, civil society organizations and the private sector. In 2015 these campaigns reached over 360 000 people, distributing 2.7 million male condoms and 90 000 female condoms in a 3.5 day individual campaigns. The global condom push agenda in 2015 included the issuing of a new condom statement, supported a regional condom consultation in ESA, briefed Global Fund in a "condom seminar", developed condom targets and indicators and a condom section in the MDG 6 and WAD reports. The World Bank funded combination prevention in multiple countries, for example through infrastructure and transportation operations such as the Trade and Transport Facilitation Project (covering Botswana, DRC, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe) which finances HIV services scale up. Furthermore, comprehensive condom programming has been expanded in 55 countries. Finally, in Thailand, a UNHCR HIV programme aimed at young refugees was implemented where free condoms were made available in shelters for unaccompanied minors. Through UNHCR, Voluntary Counselling and Testing (VCT) services and confirmatory tests were conducted for refugees and asylum seekers in Egypt and Yemen. Behaviour Change Communication (BCC) programmes focused on sexual reproductive health (SRH) in refugee camps in countries such as Kenya, South Sudan and Tanzania were also implemented by UNHCR.

#### Responding to a transforming epidemic in Eastern Europe and Central Asia



The HIV epidemic in the EECA region is rapidly transforming into one driven by the sexual transmission, which accounts for upwards of 70% of all newly reported cases in many countries. To address this, UNFPA trained 6100 youth leaders on messages promoting condom and lubricant use, including among Roma and Egyptian minority people (Albania, Azerbaijan, Tajikistan, Turkmenistan and Ukraine) and internally displaced persons. This work reached an estimated 250 000 young people. UNFPA also procured and distributed 8 465 600 condoms in Albania, Armenia, Kosovo, Macedonia, Tajikistan, Turkmenistan and Ukraine. In Ukraine, condom promotion messages and knowledge reached 3000 truck drivers. Attitude and practice surveys were conducted among long-distance truck drivers in Moldova and Ukraine, and scoping work undertaken in Turkey. An estimated 20 000-plus sex workers and men who have sex with men were reached by UNFPA-supported nongovernmental organizations in Albania, Bosnia and Herzegovina, Georgia, Kyrgyzstan and Tajikistan.

- **Educating and engaging young people**, particularly women and girls: Through the “All in! Campaign to end adolescent AIDS” the UNAIDS Secretariat, together with UNDP, UN Women, UNFPA, UNICEF, Y+ and The PACT, have built a framework to strengthen participation and catalyse policy change. In 2014-2015, UN Women advocated for empowerment and meaningful engagement of young women and adolescent girls, including those living with HIV, in global and regional decision-making forums, to prevent HIV and mitigate its impact. Meanwhile, UNESCO contributed to the first comprehensive website for adolescents on SRH in Eastern Europe and Central Asia (EECA) “teenslive.info” and, together with UNFPA they also contributed to the scale-up of comprehensive sexuality education (CSE) in over 97 countries throughout the course of 2014-2015, and jointly published a report on the global status of CSE drawing on evidence from 48 countries. The capacities of 21 countries were strengthened through continued follow-up on the Accountability Framework for the UNESCO-led Eastern and Southern Africa Ministerial Commitment on CSE and SRH services, including through the piloting of curricula in six countries, training of curriculum developers in four countries, development of 15 lesson plans to be rolled-out to 18 countries and the launch of an online teacher training course that has already benefitted nine countries. In Zambia, a CSE programme was launched targeting 1.75 million young people and has led to the strengthened capacities of over 12 000 teachers. In 2014-2015, UNICEF supported assessments to improve the quality of counselling provided to adolescent boys during Voluntary Male Medical Circumcision (VMMC) and HIV testing, developing a publication on factors affecting uptake and outcomes of VMMC in adolescents. Meanwhile, the World Bank supported studies showing how Cash Transfers (CT) can reduce sexual transmission for young people as well as financing multiple CT programmes to reach youth. The World Bank additionally modelled the impact of combination prevention on youth in several countries including Namibia and Zimbabwe. In Kenya, the UNAIDS Secretariat, ILO, UNDP and the UN Joint Team supported the development of the 2015 Kenya Strategy on ending AIDS among adolescents and young people. The Strategy addresses economic empowerment and entrepreneurship, employment-related discrimination and an education sector workplace policy, among others. The World Bank also modelled the impact of combination prevention on youth in several countries such as Zimbabwe and Namibia. The Joint Programme’s Interagency Working Group on Key Populations has produced a series of technical briefs focused on the needs and realities of young men who have sex with men, young people who sell sex, young people who use drugs, and young transgender people. The “Have you seen my rights?” campaign also brought together 40 organizations and 60 youth partners, to urge world leaders to make pledges to young people’s sexual and reproductive health and rights (SRHR). UN Women’s “Engagement+Empowerment=Equality” programme mobilized more than 130 young women and girl advocates to engage in design and validation of the All-In assessments in Kenya, Malawi and Uganda.
- **Expanding the evidence base on effective HIV prevention measures** and adopting innovative prevention approaches and technologies: The Joint Programme is adopting innovative approaches to help countries achieve the Fast Track targets of the UNAIDS Strategy 2016-2021. For example, UNFPA collaborated with the UNAIDS Secretariat, World Bank, USAID, ILO, manufacturers, governments and civil society organizations (CSOs) to promote public-private partnerships and address barriers to condom market entry. A coalition named Africa Beyond Condom Donation was formed to create an enabling environment for condom markets to grow in six selected African countries (Botswana, Kenya, Namibia, South Africa, Zambia and Zimbabwe). UNFPA also commissioned a systematic review on the use of personal

lubricants for vaginal and anal sex. The results of the study will lead the discussions during a global consultation on lubricants in 2016 with manufacturers and organizations involved with research on lubricants or provision of lubricants to communities and countries. Prevention technologies were further supported by WHO, which played a leading role in the development of guidance for VMMC procedures, as well as providing support to countries in the development of Pre-exposure Prophylaxis (PrEP) project proposals for funding and ethical approval, with female sex workers, men who have sex with men (MSM), young women, sero-discordant couples and the wives of migrant workers. The World Bank both evaluated and used demand creation strategies to increase VMMC uptake and scale up national VMMC programmes. For example, the Bank is funding large scale operations to improve VMMC service delivery capacities in Botswana and Malawi. The “Quarter for Prevention” campaign was launched at the PCB in October 2015 with the aim to re-energize prevention discussions; provide a space for dialogue about needs, targets and investments; and help reverse declining prevention investment trends. Initial feedback including from the HIV Alliance shows its having an impact.

- **Harnessing Cosponsors’ and other partners’ complementary competencies** to address sexual transmission including among key populations. The Global Prevention Focal Points Group composed by representatives of the WB, UNFPA, WHO, PEPFAR, GF, BMFG, HIV-Alliance and Antwerp University was instrumental to enhance global prevention targets in the updated UNAIDS Strategy 2016-2021. Implementation tools for comprehensive HIV programming for key populations have been developed and launched by UNFPA, for example the MSMIT (for men who have sex with men), was published in 2015 and TRANSIT (for transgender people) was developed in 2015 and will be published in 2016.
8. Despite considerable achievements in 2014 and 2015, the UNAIDS Secretariat and Cosponsors faced a number of challenges in regards to reducing sexual transmission of HIV. Increases in **risky sexual behaviours**, such as multiple sexual partners and declines in condom use were documented in several countries in 2014 - highlighting the fact that education and advocacy on safe sexual behaviours must be strengthened. Whilst significant progress has been made in addressing persistent opposition and misperceptions around CSE, more work needs to be done, notably through engagement of parents, religious and community groups. Steps have already been taken to address this through the production of community engagement materials and consultative meetings with religious communities in the ESA region. In countries where quality CSE has been implemented, **challenges remain in ensuring linkages to youth-friendly SRH and HIV prevention services. A lack of investment in condom and lubricant programming** continues to constrain prevention efforts, while condom accessibility remains a constant struggle in sub-Saharan Africa. Many countries with the greatest burden of HIV remain largely dependent on donor support for condom provision and other prevention commodities. However, in 2013, donors provided only eight male condoms for every man aged 15-49 and one female condom for every eight women of reproductive health aged 15-49. Access to condoms in prisons is even more problematic. While condoms remain the single most efficient method to reduce the transmission of HIV, more efforts are required to enhance women’s, particularly young women’s ability to negotiate safe sex. Evidence shows that women with greater autonomy in decision-making are more likely to negotiate safer sex, have higher HIV-related knowledge and condom use. Further investment in research and development to improve female-controlled prevention methods is also required. The current **pace of take up of VMMC is too slow** to reach overall targets of 80% by the end of 2016. Some countries are transitioning to sustainable services while others are still attempting to accelerate pace of



scale up. **There is a lack of evidence of the value and preferences of PrEP for transgender women and sex workers** and it is not fully supported by end users for people who inject drugs, who felt that it might override priority interventions (e.g. needle-syringe programmes and opioid substitution treatment).

## **ii. Eliminating vertical transmission**

9. In 2014-2015 there was a sea-change in the global effort to end new HIV infections in children and keep mothers alive through prevention of mother-to-child transmission (PMTCT). In 2015, Cuba became the first country to eliminate mother-to-child transmission (MTCT) of HIV, while several others in Asia, MENA, the Caribbean and Europe are poised to follow. The UNAIDS Secretariat, in partnership with WHO, GNP+ and ICW have developed a tool for human rights, gender equality and community engagement aspects of the certification of countries' elimination of mother to child transmission of HIV and syphilis; the first time a public health process of certification of elimination of a disease has looked into human rights considerations as a precondition.
10. Some 85 countries have fewer than 50 children newly infected with HIV each year<sup>3</sup>, while out of the 21 priority countries in sub-Saharan Africa<sup>4</sup>, eleven have reduced the annual number of children newly infected with HIV by at least 60% (compared to the baseline in 2009). Among the countries in sub-Saharan Africa, which account for about 85% of all MTCT, the Global Plan to Eliminate New HIV Infections among Children and Keep their Mothers Alive galvanized political will and led to unprecedented programme expansion. This combination of factors has led to the achievement of significant scale up of maternal treatment.

### **The road to zero HIV infection among children in China**



China has made significant progress in its AIDS response. Rates of mother-to-child transmission of HIV in China fell from 6.7% in 2013 to 6.1% in 2014, leading to calls for China to be the next country certified for the elimination of mother-to-child transmission of HIV. WHO supported the MCH-PMTCT division to update and formulate guidance on: monitoring and evaluating mother-baby pairs for integrated prevention of mother-to-child transmission and guidance to health-care providers; and analysis of the MCH routine database on congenital syphilis to inform which criteria to follow in efforts to eliminate the disease. The national standard operating procedures for early infant diagnosis (EID) were also developed with support from UNICEF. The national assessment of two laboratories and community support for EID in the project sites led to more than 75% of exposed infants receiving EID.

11. With the support of funding under the UBRAF, the UNAIDS Secretariat and Cosponsors have played a critical role in this progress in 2014-2015 by:
  - **Advocating for rights-based policies to prevent HIV in women and their children:** In 2015, UNICEF, UNHCR and Save the Children finalized guidance on the prevention of mother to child transmission (PMTCT) in humanitarian settings. Over 50 Maternal and Child Health Projects across the world were also funded and coordinated by the World Bank in 2014-2015, with the aim of improving access and

<sup>3</sup> How AIDS changed everything. MDG 6: 15 years, 15 lessons of hope from the AIDS response. Geneva: UNAIDS; 2015 ([http://www.unaids.org/sites/default/files/media\\_asset/MDG6Report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/MDG6Report_en.pdf))

<sup>4</sup> Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

coverage of PMTCT, maternal and newborn child health (MNCH) and other SRH services, such as the Health Sector Rehabilitation Support Project in DRC;

- Through the IATT maternal working group, UNICEF and WHO supported the development of tools to help countries **deliver integrated services and retain women in care**;
- **WFP provided food and nutrition support to pregnant and lactating women**, including PMTCT clients and children who may have been exposed to HIV. WFP also continued to integrate its PMTCT activities with comprehensive mother-and-child health and nutrition (MCHN) services to prevent HIV transmission and ensure that mothers and infants have access to growth monitoring, vaccinations, micronutrient supplementation, nutrition assessment, education and counselling, and complementary foods;
- **Promoting access to family planning to prevent unintended pregnancies:** MoUs with the Global Fund and several UN agencies including UNICEF and UNFPA have been signed to ensure better inclusion of reproductive, maternal, newborn, child and adolescent health (RMNCAH) in Global Fund grants - thereby supporting delivery of EMTCT services integrated with SRH, in a number of countries, including Bangladesh, Cote D'Ivoire, Chad, Ethiopia, Mozambique, Nigeria, South Africa, Tanzania, Togo, Uganda and Zambia;
- **Developing normative recommendations that have transformed global thinking:** In 2013, WHO issued a conditional recommendation for all pregnant and breastfeeding women with HIV to start lifelong ART, removing eligibility criteria. This guidance (commonly known as Option B+) has become one of the most widely implemented of all HIV recommendations, adopted by 88% of 144 countries in 2015;
- **Mobilizing resources** from traditional and non-traditional donors was intensified and through intense advocacy in 2014 increased resources for countries were leveraged to support scale up of paediatric ART through the US\$ 200 million PEPFAR/Children Investment Fund Foundation's Accelerating Children's HIV/AIDS Treatment Initiative in 10 high-burden countries. UNAIDS in MENA also mobilized resources from the OPEC Fund for International Development to scale up testing and treatment including in pregnant women, with a focus on six countries;
- **Strategic investments** were made in community engagement and mobilization for eMTCT (incl. traditional and religious leaders) to improve uptake and retention in care. These resources were to demonstrate the value of community-driven models of care support to engage and retain pregnant and breastfeeding women in perinatal care and PMTCT services;
- **Supporting systems and capacity to improve monitoring and evaluation (M&E)** including cascade monitoring: The M&E Option B+ Framework developed by the *Inter Agency Task Team (IATT) on the Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and their Children* contains guidance on improving retention monitoring and strengthening M&E systems for more effective follow-up of mothers and children in HIV care and treatment;
- **Fostering research into novel approaches to optimize drugs, diagnostics and integrated service delivery and working within a broad community of stakeholders and civil society to coordinate country support activities:** UN partners through the IATT have developed an optimal formulary of paediatric ARV formulations which is regularly updated and has been widely taken up in the field.

The optimal formulary is also used by the Global Fund's Paediatric ARV Procurement Working Group to verify country requests to purchase paediatric ARV formulations. Paediatric HIV diagnosis has received a boost with the approval in 2015 of two new technologies for POC infant diagnosis. UNICEF and WHO with the support of UNITAID have also worked together to accelerate in-country uptake of novel point-of-care technologies for infant diagnosis.

12. A number of challenges have been identified that have limited progress to eliminate MTCT. Although antenatal care (ANC) testing and ART coverage is generally high, **coverage in some countries has remained persistently low**. Nigeria in particular has been the focus of past and continuing technical support in an effort to improve their indicators. **Weak procurement and supply management** have resulted in commodity stock-outs especially in high-burden countries where there has been rapid scale up of services. **Retention of women during the post-partum period is poor**, in part due to poor systems for tracking women who may be lost-to-follow-up. This significantly diminishes the potential efficacy of ART for PMTCT. **Underlying weakness in MNCH and other SRH services** continue to compromise the delivery of integrated EMTCT services. **The number of trained health workers and poor infrastructure** especially at the primary level are some of the most significant of these weaknesses. The **level of male partner engagement** continues to be very low. **Stigma, discrimination and gender-based violence** are still barriers preventing clients from seeking and getting the rights-based services they need. **Mandatory HIV testing practices, breakdowns in confidentiality** as well as incidents of **forced sterilization, forced or coerced abortions or forced or coerced contraception** weakens trust in health care systems and further affects access and adherence to eMTCT programmes. **Fully integrating family planning into EMTCT programming**, including for preventing unintended pregnancies in adolescents and young women living with HIV is still not receiving adequate programming attention.

### **iii. Preventing HIV among people who inject drugs**

13. According to UNAIDS estimates, there was no significant global decline in the annual number of new HIV infections among people who inject drugs (PWID) between 2010 and 2014. This is largely attributed to the grossly inadequate scale-up of evidence-based HIV strategies for people who inject drugs. In 2014, an estimated 140 000 (112 000 - 168 000) people who inject drugs were newly infected with HIV, people who inject drugs and their sexual partners accounting for around 30% newly infected with HIV outside sub-Saharan Africa.<sup>5</sup> Women who use drugs are particularly vulnerable to HIV, as well as facing multiple forms of discrimination, violence and abuse and having limited or no access to health services. According to UNODC, among 30 countries reporting data on women who inject drugs, the pooled HIV prevalence among women was 13% compared to 9% among men from the same countries. The target of halving the number of people who inject drugs who become newly infected with HIV by the end of 2015 was not met. However, there are important distinctions between different countries and regions that demand closer analysis of these global figures. For example, whilst available evidence indicates that the number of new infections among people who inject drugs have risen in Eastern Europe and Central Asia, in western Europe, where many countries have expanded harm reduction programmes, there is evidence of a decline in new infections among people who inject drugs.

<sup>5</sup> [http://www.unaids.org/sites/default/files/media\\_asset/20160318\\_ten\\_targets\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/20160318_ten_targets_en.pdf)

14. In light of this limited progress, during 2014 and 2015, the Joint Programme has made significant efforts to address various gaps, including:

- **Strengthening advocacy and technical support** to countries to increase access to a comprehensive package of interventions for the prevention and treatment of HIV for PWID: In the 24 UNODC high priority countries for HIV and PWID, support has been intensified to address bottlenecks such as quality and availability of strategic information, increasing countries' capacity on harm reduction (with a specific focus on needle and syringe programmes (NSP), opioid substitution therapy (OST), HIV testing and counselling (HTC) and antiretroviral therapy (ART), increasing the capacity of NGOs and CBOs to advocate for harm reduction and increasing the capacity of law enforcement agencies to support access of PWID to HIV services both within the community and in prisons. The World Bank provided technical assistance to investigate the cost effectiveness, return on investment and impact of harm reduction programmes for PWID, in particular in the Philippines, Malaysia and Vietnam. Through its allocative efficiency studies, the Bank provided evidence for the impact of well targeted prevention programmes for PWID;
- **Addressing the sexual reproductive health (SRH) needs of PWID:** In Albania and Kyrgyzstan, UNFPA worked to reduce sexual transmission between PWID and their partners by supporting their SRH needs. In Ukraine, UNICEF piloted model interventions for PMTCT among pregnant women using drugs through integration of MCH, HIV and drug dependence service. In Eritrea, Sierra Leone and Togo, UNFPA addressed the sexual reproductive health needs of prisoners, including through condom promotion. UNESCO worked with the Government of Indonesia to improve the provision of CSE for young people living in prisons and other closed settings;
- **Supporting in-country legal and policy reforms, towards ending compulsory detention for people who use drugs:** In 2015, support by the UNAIDS Secretariat and UNODC resulted in legal and policy reforms on HIV and drugs in Myanmar, HIV in prisons in Ethiopia as well as on harm reduction and HIV prevention and treatment of prisoners in Nigeria;
- **Empowering community based organizations (CBOs):** Support by UNODC to CBOs resulted in the establishment of new networks of people who inject drugs and in the participation of international, regional and country networks of PWIDs in debates at the High Level Session of the 57th Commission on Narcotic Drugs and, with the support of both UNODC and the Secretariat, to the 35th Programme Coordinating Board. Financial support was provided by UNODC to 350 civil society organisations (CSOs) at country, regional and global levels, to enable them to provide adequate services to people who inject drugs in prison settings and to enable the participation of PWID and harm reduction communities in strategic initiatives;
- **Supporting human rights based policing:** Workshops on "Enhancing Partnerships between Law Enforcement and Civil Society Organizations in the context of Drug Use and HIV" were conducted by UNODC in 30 cities and 21 countries, allowing the participation of around 2100 representatives from law enforcement agencies (LEAs) and CSOs. UNODC also developed a training manual for police on HIV services for PWID, which has been adapted and is being formalised as part of law enforcement officials' training in several countries;

### First methadone maintenance therapy service for people in prisons in Vietnam



Following advocacy and technical assistance provided by UNODC and its partners, the first methadone maintenance therapy (MMT) unit for people who inject drugs in prisons was launched in Viet Nam in 2015. The pilot of MMT services in Phu Son prison marked a milestone for the dedicated and long-term effort of UNODC to increase coverage and quality of HIV prevention, treatment and care in prisons, in partnership with the Government of Viet Nam. In 2015, UNODC provided a series of training courses to build the capacity of prison staff in the two prisons assigned for the pilot phase (Thanh Xuan and Phu Son) to implement the clinical guidelines for the provision of MMT. In total, 80 prison health officers (21 female, 59 male) were trained in MMT service provision in prison settings. In addition, 20 members (14 female, 6 male) of community-based MMT service units were trained. In Phu Son prison a training-of-trainers was provided to 50 peer educators, equipping people living in the prison with knowledge on HIV and AIDS and risks for HIV transmission. UNODC also provided essential equipment (e.g. inventory system) to support piloting the MMT service as well as producing and distributing information, education, and communication materials on HIV prevention in prison settings. Based on the initial results of the pilot, the MMT service is being expanded to other prisons in 2016.

- **Producing normative guidance, best practices documentation and improved strategic information:** Technical briefs and guidance documents have been developed and disseminated by WHO, UNODC, UNDP, UNFPA, UN Women and by the Inter-agency Working Group on Key Populations, on the provision of services in the community and prisons, with a specific focus on HIV and women who inject drugs, young people who inject drugs, NSP in prisons and integration of HIV services for key populations. Technical support has also been provided to adapt international guidance at the country level. UNODC additionally led joint efforts with the UNAIDS Secretariat, WHO, the World Bank and CSOs to improve global data on HIV and injecting drug use, as well as data on HIV and harm reduction services for people who inject drugs. The first ever joint UNODC, WHO, UNAIDS Secretariat and World Bank global estimates on injecting drug use and HIV among people who inject drugs were published in the 2014 World Drug Report. UNESCO, UNODC and the WHO also produced a Global Report on Education Sector Responses to Substance Use among Young People and a Guide for Country-Level Data Collection. For UNGASS 2016, the UNAIDS Secretariat organized and supported early 2016 multi-stakeholder dialogues in 12 countries while UNODC facilitated a scientific consultation on HIV and drug use, which updated the findings developed in 2014.
15. Despite these achievements, major challenges remain such as **poor legal and policy environments and abusive practices and harassment** for people who inject drugs, age-related barriers to access and **lack of gender and age sensitive** harm reduction services, **humanitarian emergencies** in countries where there is high prevalence of injecting drug use and HIV among PWID (particularly Libya, Nepal, Syria and Ukraine) and a **worrying lack of domestic investment** in NSP, OST and ART for people who inject drugs and **in HIV prevention and treatment services in prisons**.

## B. Catalyse the next phase of treatment, care and support

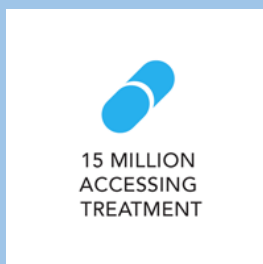
### i. Accessing treatment

16. As a result of sustained global commitment to HIV treatment at the global, regional and country level, by 2015 more than 16 million people living with HIV were on ART, surpassing the global target of 15 million by 2015 and achieving 45% treatment coverage. Between 2000 and 2014, HIV treatment prevented an estimated 7.8 million deaths and access to ART continued to increase in all regions - between 2011 and 2014 alone, ART coverage of people living with HIV more than doubled - though there are regional and population variations. The greatest scale-up occurred in sub-Saharan Africa, however, global treatment coverage among children, adolescents, men who have sex with men and key populations lags behind.
17. In 2014-2015 the following achievements were made by the UNAIDS Secretariat and Cosponsors:
- Inspired by the success of Option B+ for pregnant and breastfeeding mothers and in the face of mounting evidence, **WHO updated the consolidated ARV guidelines to recommend a policy of Treat All** – extending the B+ to all people living with HIV. These updated guidelines incorporate 74 recommendations for prevention and management of HIV in all populations and service delivery guidance to implementing the clinical recommendations. In line with the UNAIDS fast track 90-90-90 targets, WHO has also provided a comprehensive normative framework that guides policies and strategies for HIV diagnosis, treatment and care and outlines priorities for optimizing HIV treatment across the cascade;
  - In 2013, an estimated 1.7 million people living with HIV were affected by emergencies. In 2014-2015 **UNHCR published Guidelines for the Delivery of Antiretroviral Therapy (ART) to Migrants and Crisis affected Persons in Sub-Saharan Africa**. By 2015, global access to ART for refugees on par with surrounding nationals rose to 100%, largely as a result of advocacy with governments. UNHCR continues providing treatment where refugees and other persons of concern lack access, while advocating for inclusive national programmes;
  - UN Women conducted a **Global Review of Women’s Access to HIV Treatment, Care and Support that highlighted gender-specific barriers and facilitators for their treatment access and adherence**. It engaged over 200 women living with HIV from 17 countries and was guided by 14 women living with HIV, acting as a reference group;
  - **UNICEF and WHO convened an Africa regional paediatric and adolescent HIV meeting** through which country roadmaps for scale-up services were developed. Following this meeting, Nigeria was the first country to be supported in developing its national paediatric HIV Acceleration Plan in line with the 90-90-90 targets. UNESCO also supported adolescent treatment literacy, uptake and adherence through the dissemination of the “Adolescent HIV Prevention and Treatment Literacy Toolkit” (ATLT) and the “Big Story Book on Teachers and Learners Living Positively with HIV” in over 10 countries in Eastern and Southern Africa;
  - **The UNAIDS Secretariat and WHO convened a regional meeting with the Government of Algeria to fast-track HIV testing and diagnostics in MENA region** to achieve 90-90-90 targets, which resulted in a Declaration of commitment to

bring commitments to Arab Council of Ministers of Health, Council of Ministers of Health of African Union and the High Level Meeting;

- In partnership with the MAC AIDS Foundation, UNICEF completed piloting of **decentralized paediatric ART through telemedicine in India**, which linked 32 peripheral ART facilities to a Centre of Excellence. Preliminary findings indicate that children and adolescents living with HIV who received care through telemedicine were more likely to initiate ART early and to be retained on treatment;
- **WFP provided food & nutrition support to PLHIV on Antiretroviral Therapy (ART)** in around 23 countries for nutritional rehabilitation and improved treatment outcomes through greater adherence and retention in care. In Congo, Guinea and Myanmar, WFP's food and nutrition interventions for malnourished PLHIV contributed to the achievement of high ART adherence rates. In around 10 countries, a household ration was granted to food-insecure households of malnourished ART clients to minimize sharing of the individual ration amongst family members. WFP also provided food assistance in humanitarian settings (including C.A.R., DRC, Haiti, Malawi, Sierra Leone, South Sudan, Syria and Yemen) to vulnerable individuals and households affected by HIV, through HIV-sensitive and HIV-specific interventions. WFP, the UNAIDS Secretariat and PEPFAR jointly published a programming guide on nutrition assessment, counseling and support (NACS) for PLHIV to advance the comprehensive integration of food and nutrition in HIV treatment, care and support;

#### Joint Programme supports antiretroviral therapy in West and Central Africa



The West and Central Africa region (WCA) Joint UN Regional Team on AIDS (JURTA) advocated and supported countries to adapt the 2013 WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Of the 27 countries from WCA, 21 have fully adopted the recommendations, which have contributed to the scale up of antiretroviral therapy in the African region. By the end of 2014, 41% (10.8 million) of people living with HIV were receiving antiretroviral therapy in the region. This is an exceptional accomplishment, considering that fewer than 11 000 people living with HIV were receiving ART in 2000.

To fast-track paediatric antiretroviral therapy coverage in the WCA region, JURTA intensified its effort by supporting countries to generate evidence for programming. As a result, 11 countries completed the situation analysis of the national paediatric HIV programme. Five of these countries used this study's findings to develop their paediatric treatment acceleration plans with strategic shifts to fast-track paediatric antiretroviral therapy coverage, including: case-finding of HIV-positive children beyond early infant diagnosis (to high-yields entry points); integrating routine HIV testing in children (inpatient); a family-centred approach using index adult on antiretroviral therapy (i.e. implementation of Option B+ approach). In 2014, 5552 children living with HIV were initiated on ART, bringing to 92 558, the number of children on treatment (compared with 87 006 in 2013). This gives a total coverage of 13% of paediatric ART in the region, with a low of 2% in Mauritania and a high of 28% in Gabon.

- As of 1 December 2015, UNDP managed a total of 48 Global Fund grants in 24 countries that are facing challenging operating environments, including many that are crisis countries. Through these grants, **UNDP supported 1.8 million people living with HIV to access ART**, accounting for one in every eight people on treatment globally. Since the start of the partnership, the Global Fund and UNDP have jointly supported countries in saving 2.2 million lives from AIDS, TB and malaria. In six countries, **UNDP has achieved price reduction for preferred ARV regimens to US\$ 100 per year**, which saved US\$ 25 million to put an additional 250 000 people

living with HIV on ART, the equivalent of all HIV patients in the UK, Germany and France combined;

- **UNAIDS Secretariat developed iMonitor+**, a tool which is being used to strengthen community systems, monitor access to and quality of services, as well as informing treatment situation rooms about the realities on the ground, including the barriers to accessing services and stock outs of different commodities. iMonitor+ expanded its use to multiple countries in 2015, including Cambodia, India, Indonesia, the Philippines and Thailand, as well as linking with CSOs;
- **The World Bank provided technical assistance to improve treatment access**, for example using modelling in Zimbabwe to estimate access to and quality of ART services during ART expansions, or evaluating the treatment cascade and adherence to ART in South Africa. The Bank is also funding major health system strengthening operations that aim to increase access to services. For example, the Tanzania Basic Health Services Project aims to assist the Government in improving the equity of geographic access and use of basic health services, including HIV/AIDS, across districts and enhancing the quality of health services being delivered.

18. However, challenges remain. **Delayed ART initiation and lack to follow up** are proving challenging in many contexts. While HIV testing services (HTS) have expanded and the numbers of people initiated on ART are increasing, there is **substantial patient attrition across the cascade of care**. Urgent work from UNAIDS is required to better support treatment uptake, adherence and retention in HIV care, as well as in addressing gender-related barriers that prevent it. Retention in care and ART adherence specifically requires adaptation to different contexts and settings, including those of humanitarian concern. For the UNAIDS 90-90-90 fast track targets to be achieved, **innovation, strengthening of health and community systems and programme quality, more commitment to reduce and remove structural barriers, safeguarding gender equality and human rights and enhancing health equity, as well as sustained funding**, are critical. As with prevention, access to treatment is also hampered by stigma and discrimination because of a person's HIV status, sexual orientation, gender identity or behavior – for instance use of drugs or sex work. Lack of confidentiality, mandatory HIV testing or treatment (without informed consent) and denial of treatment are commonplace violations of prisoners' rights that are deterring them from seeking the health-related services they need. Women and girls face multiple forms of exclusion and discrimination, which poses obstacles in accessing HIV services. Targeted research regarding women's experiences of treatment availability and their decision-making around uptake, and how treatment programmes are impacting women and girls living with HIV is needed.

#### **ii. Avoiding TB deaths among people living with HIV**

19. Significant progress has been made in reducing the incidence of Tuberculosis (TB) among people living with HIV. Between 2005 and 2014, approximately 5.8 million lives were saved through joint efforts to scale up collaborative TB/HIV activities. According to the 2015 WHO Global Tuberculosis Report, TB/HIV mortality reduced by a third in 2014, compared with 2004, which unfortunately fell short of the 50% target set for 2015. However, in 18 of the 41 high TB/HIV burden countries, the 50% target was surpassed. Despite progress being made, TB remains the leading cause of death among people living with HIV, highlighting the ongoing need for intensified action to effectively address the linked epidemics of HIV and TB.



20. The UNAIDS Secretariat and Cosponsors have achieved the following outcomes in 2014-2015 towards addressing Tuberculosis among people living with HIV:

- **Advocacy** at events such as CROI, EECAAC, IAS and the Union conferences helped promote TB/HIV implementation, shape strategies, define research agendas and mobilise resources. The appointment of the Former Ambassador-at-Large and US Global AIDS Coordinator, Dr Eric Goosby, as the UN Special Envoy on Tuberculosis, whose Secretariat is managed by WHO, also helped raise the profile of the linked epidemics of HIV and TB;

#### Decreasing the burden of tuberculosis in East and Southern Africa



The Eastern and Southern Africa (ESA) region remains the most affected by tuberculosis (TB), with an average incidence and prevalence of 367 and 317 cases per 100 000 populations respectively, compared with 300 and 280 per 100 000 populations for the region. At the same time, an average 39% of all incident tuberculosis patients in the ESA region are coinfected with HIV, and HIV is considered the driving force behind the resurgence of TB in the region. Conversely, TB is believed to be the most common cause of death among people living with HIV.

To decrease the burden of TB among people living with HIV, and to decrease the burden of HIV in patients with presumptive and diagnosed TB, WHO has been promoting collaborative TB/HIV activities in member states, including TB screening for all people living with HIV; providing isoniazid preventive therapy to eligible clients; screening and investigations for TB/other diseases; routine HIV testing for all patients with presumptive and diagnosed TB; and antiretroviral therapy for all TB patients living with HIV.

WFP collaborated with ministries of health in Ethiopia, Lesotho, Madagascar, Malawi, Mozambique, Rwanda, Swaziland and Zimbabwe in supporting malnourished TB clients, including HIV-TB coinfected individuals, with a comprehensive nutrition programme that includes nutritional assessment, counselling and, when necessary (based on anthropometric measurement), specialized nutritious food. The most food-insecure TB clients were supported with a household ration for the duration of TB treatment; in-kind in rural areas or voucher plus cash in urban areas. Almost all countries reported a treatment success rate of more than 90%.

- Support provided by the UNAIDS Secretariat, WHO and other key partners focused on the **continued scale-up of collaborative TB/HIV activities** through strengthened joint TB and HIV programming. This was achieved through strategic direction by the Global Fund TB/HIV Technical Working Group, an information note on joint TB and HIV programming and technical assistance to high burden countries for the development of National Strategic Plans (NSPs), joint programme reviews and the development of 42 Global Fund single TB and HIV concept notes;
- **Guidance developed to facilitate diagnosis and fast-track access to lifesaving treatment** has included WHO policy updates on Xpert MTB/RIF and development of recommendations on the use of Lateral Flow Urine Lipoarabinomannan Assay. Support to countries in facilitating the roll-out of Xpert resulted in the procurement of 16.2 million cartridges in 122 eligible countries by the end of 2015. TB/HIV recommendations were also mainstreamed within consolidated guidance on: HIV prevention, diagnosis, treatment and care, including for key populations, HIV testing services, comprehensive care for people who inject drugs and WHO guidance and tools on the management of TB in children;
- To **strengthen monitoring and evaluation and improve the HIV/TB care cascade** for the prevention, diagnosis and treatment of HIV-associated TB, WHO, in collaboration with the UNAIDS Secretariat, PEPFAR and the Global Fund revised the

Guide to monitoring and evaluation for collaborative TB/HIV activities. WHO and the UNAIDS Secretariat continued to ensure the reporting of reconciled, consolidated data on TB/HIV for the WHO Global TB, HIV and UNAIDS reports;

- In East and Southern Africa, the ILO, the UNAIDS Secretariat and IOM, in conjunction with SADC **provided support to countries to draft a Code of Conduct for TB** in the mining sector. Approved by the SADC Council of Ministers and signed by the Heads of State, it reaffirms the principles of the ILO Recommendation on HIV and AIDS (No. 200). The Code is being implemented with World Bank and Global Fund support;
  - UNICEF continued **to focus on the childhood TB/HIV response** through integrated service delivery and community response within maternal and newborn child health platforms, as well as the generation of evidence on the burden of co-infections to inform policy and programmatic shifts. UNICEF achieved this through pilot implementation of HIV/TB adapted community case management in Zambia and completion of paediatric HIV and TB assessments in Ghana and Nigeria;
  - In 2014-2015, WFP **provided food and nutrition (F&N) assistance to TB patients living with HIV** in around 16 countries for improving treatment outcomes and increasing adherence to ART and TB treatment. WFP is the sub-recipient for the provision of F&N support in Global Fund TB grants. In many food-insecure settings, food support (in-kind, cash or vouchers) has served as an incentive to seek out HIV or TB services and improve adherence to treatment. In Tajikistan, where WFP assisted TB clients and their families with food baskets during the six-month course of treatment, interviews conducted during post-distribution monitoring confirmed that WFP's household assistance was an important incentive for people with TB to register and complete the treatment;
  - In 11 countries where **UNDP has managed the implementation of TB grants** - Belarus, Bosnia & Herzegovina, Cuba, El Salvador, Haiti, Kyrgyzstan, Montenegro, Sao Tome & Principe, Syria, Tajikistan and Turkmenistan - the TB case detection rate has exceeded the global target of 70% set for 2015. Six countries that have received support from UNDP have seen a 50% reduction in TB prevalence (Bolivia, Bosnia & Herzegovina, Cuba, Sao Tome & Principe, Syria and Zambia);
  - Through its health system strengthening operations **the World Bank is expanding access to ART for TB patients**. For example in Swaziland, where the objectives of the HIV/AIDS and TB Project is to improve access to and quality of health services, with a particular focus on primary health care, maternal health, HIV treatment and prevention services and TB.
21. Despite this progress, a third of deaths among people living with HIV in 2014 were from TB, representing 390 000 lives lost to a curable and preventable disease. Key factors for high mortality include vertical programming with **lack of coordination or integrated, patient-centred care; poor case detection** (less than half of all HIV-related TB cases were reported in 2014); **suboptimal initiation of ART** among detected HIV-positive TB cases (one in four detected cases did not receive ART in 2014), **poor uptake by countries of isoniazid preventive therapy (IPT)** (23% countries reported in 2014); and **a weak TB/HIV care cascade**.

### **iii. Protecting the vulnerable**

22. In 2014-2015, the Joint Programme put social protection (SP) firmly on the global HIV agenda, highlighting its critical role in the success of the AIDS response, addressing social and economic inequalities, HIV risk behaviour and HIV-related stigma and discrimination, all of which are factors that serve to exacerbate marginalization and increase vulnerability to HIV exposure.
23. In order to ensure global understanding of the vital role of social protection, care and support within the HIV response and build the evidence base for effective social protection programming, the UNAIDS Secretariat and Cosponsors have carried out the following work in 2014-2015:
- **UNICEF supported scale-up of sustainable social protection programmes** that enhance HIV prevention, treatment, care and support for vulnerable families and individuals. This included UNICEF dedicating resources for programme scale up, technical assistance, strengthening multisectoral coordination and integration, and community system strengthening;
  - **The UNAIDS Secretariat, with support from Cosponsors and partners, published the HIV and Social Protection Guidance Note and Social Protection Advancing the AIDS response**, a compilation of 10 case studies showing how social protection advances the AIDS response. The Secretariat also organized a number of events, for example with the ILO and the World Bank at the International AIDS Conferences in Africa and Asia Pacific, to create awareness on the new evidence on HIV and social protection;
  - **UNODC supported the establishment of the Prisoner Reintegration and Empowerment Organization (PREO)** that provides social support to ex-prisoners including in facilitating access /continuation of HIV treatment.
  - Following sustained advocacy and positioning of Social Protection, Care and Support (SPCS), the 34th PCB thematic sessions was devoted to addressing the social economic drivers of HIV through social protection. As a result, **cash transfers were included in the package of HIV prevention services for adolescent girls and young women** in UNAIDS' guidance to countries and partners, and USAID/PEPFAR developed a US\$ 210 million, two year project to focus on mitigating the specific vulnerabilities affecting young women in 10 East and Southern African Countries;
  - The World Bank and UNICEF **co-convened the SPCS working group** and had a remarkable two years in terms of positioning social protection in the HIV response. A series of events co-led by the UNAIDS Secretariat, the World Bank and UNICEF further raised the social protection profile in the HIV response and accelerated commitments, as well as resulting in key decisions pertaining to SPCS. Led by the secretariat and the World Bank, a meeting with senior government officials from 7 East and Southern African Countries was organised and generated commitment on scaling up social and structural intervention to prevent the sex transmission of HIV in concerned countries. The Secretariat successfully advocated with the African Union for scaling up social protection to HIV prevention, treatment and impact mitigation in its programs. In Kenya, the ILO, UNICEF, World Bank, SIDA and DFID supported the first National Social Protection Conference where discussions focussed on improving social protection systems. In Cambodia, ILO, UNDP, UNICEF and the UNAIDS Secretariat are jointly advocating for the inclusion of people living with HIV and key affected populations in existing social protection schemes. Led by UNDP, the Joint

Programme undertook a sub-regional study on HIV and Social Protection in Algeria, Djibouti, Egypt and Tunisia, providing a basis for advocating reform of social protection policies to be more HIV sensitive and inclusive of PLHIV;

- The **World Bank is a major source of financing for national social protection systems in over 70 countries**, with increased safety nets for those orphaned or impoverished by AIDS. Programmes include income transfer programmes, social safety net programmes, skills development for poor high risk youth, conditional cash transfer programmes, improving nutrition and health services and childhood education promotion. In 2015, the Bank launched additional Social Protection and Cash transfer projects targeting poor and vulnerable populations, including PLHIV and those most at risk of acquiring HIV, such as the Takaful and Karama Cash Transfer Programme in Egypt;
- **UNDP supported 54 countries in social protection in 2014-2015**. In 35 of these, UNDP worked with governments, development partners, civil society and other stakeholders to make social protection policies and programmes HIV-sensitive. UNDP continued using results from its nation-wide studies on the socio-economic impacts of HIV at the household level in this work. As a result, HIV-sensitive considerations were incorporated into a national survey instrument to identify poor households in Cambodia;
- Since the adoption of ILO Recommendation No. 202 on Social Protection Floors by member States in 2012, **the ILO has furthered the development of policy tools and methodologies to support the implementation of the Social Protection Floor** and the development of Social Protection schemes in 136 countries. Operational linkages are being developed to facilitate access to employment, social inclusion of people living with HIV;
- **UNICEF and the Transfer Project carried out an impact evaluation of cash transfer programmes** in 13 countries. UNICEF and EPRI also convened a south-south learning event, which disseminated initial findings and shared lessons from qualitative and quantitative research that was conducted as part of UNICEF's HIV-Sensitive Social Protection study;
- **WFP has been working closely with governments in a number of countries, including Ethiopia, Somalia and Swaziland, to provide social transfers** to households affected by HIV/TB, which helps to compensate for lost income and increased illness-related expenses and prevent the adoption of negative coping mechanisms, including withdrawal of children from school and missed medical visits. WFP is also reaching HIV/TB-affected individuals and households through HIV-sensitive interventions, such as school feeding programmes, which keep girls in school longer and delay sexual debut, thereby contributing to the reduction of new HIV infections as well as through general food distribution during emergency and lean seasons.

#### Economic strengthening activities for people living with HIV in Ethiopia



In Ethiopia, WFP provided assistance to about 19 200 food-insecure people living with HIV and 50 000 orphans and vulnerable children in 2014; and 29 623 people living with HIV and 56 820 orphans and vulnerable children were provided food assistance.

Food-insecure people living with HIV graduating from clinical nutrition assessment counselling and support services were linked to economic

strengthening activities to enable them to sustainably address their food and nutrition requirements, adhere to their clinic follow-up and treatments, and prevent themselves becoming reinfected. Hence, after conducting vulnerability assessment and situation analysis 19 401 people living with HIV in 2014 and 6499 people living with HIV in 2015 were enrolled for economic strengthening interventions. People living with HIV were encouraged to form and manage their own Village Saving and Loan Associations. Within these associations, participants are encouraged to save and take out loans to start small businesses. There are 1278 associations managed by people living with HIV, with 22 355 members (4387 males and 17 968 females) who are saving, taking loans to add value to the small businesses they are running and repaying regularly. People living with HIV have mobilized US\$ 668 733 in savings.

24. While the AIDS response is becoming more targeted and focused, some interventions – such as those addressing underlying drivers of HIV infection and non-adherence – require improved working with broader development sectors, including child protection and social protection systems and often take a medium 5-10 years to produce results. A further challenge is the fact that the vast majority of evidence on social protection and HIV prevention, treatment, care and support is from sub-Saharan Africa and focuses on young women and girls. **Information on the impacts of social protection among other groups – including key populations is increasing** – and in other HIV epidemic contexts and geographical areas, including the Caribbean and Latin America. **Many operations such as food transfers, asset accumulation, school feeding and general food distribution are not designed specifically for people living with HIV.** While this is the favoured approach and people living with HIV including orphans and vulnerable children are usually covered by such programmes, this means that several factors, such as targeting criteria, stigma and the implementation modality, may inadvertently exclude people living with HIV and affected households, if programmes are not adequately designed. Finally, the UNAIDS 2011 Investment Framework modelling proposed investing 40% in enablers and synergies (15% and 25% respectively) and 60% in basic programmes to effectively enhance the impact of HIV programmes. However, there is **continued under-investment in critical enablers and development synergies**, towards which it is believed that national HIV programmes spend less than 2% of national HIV budgets.

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

### i. Reducing punitive laws

25. From 2010 to 2014, there was an increase in the number of countries reporting the existence of general anti-discrimination laws and mechanisms applicable to sex workers, migrants, people in prison, women and young people. From 2006 to 2015, the number of countries criminalizing same-sex sexual acts fell from 92 to 75. However, the elimination of punitive laws and counterproductive legal and policy frameworks around HIV is far from being achieved. Overly broad prosecutions for HIV non-disclosure, exposure and transmission have been recorded in all regions, while some 72 countries have adopted legislation that specifically allow for HIV criminalization. To advance the commitments of UN Member States in the 2011 Political Declaration on HIV and AIDS and the recommendations of the Report of the Global Commission on HIV and the Law, the Joint Programme undertook the following activities in 2014-2015:

#### National dialogues in Asia-Pacific to review legal and policy barriers to HIV services



With support from the Asia-Pacific Ad Hoc Regional Interagency Team on AIDS (Ad Hoc RITA) on Enabling Legal Environments, national dialogues were held in 21 countries to review legal and policy barriers that either promote or limit access to services. Nine countries – Cambodia, China, Indonesia, Lao People’s Democratic Republic, Malaysia, Myanmar, Nepal, Pakistan and Papua New Guinea – produced national recommendations. These national processes helped governments meet their commitments under High-level Meeting targets and resolutions 66/10 and 67/9 of the UN Economic and Social Commission for Asia and the Pacific (ESCAP), and to take forward recommendations from the Global Commission on HIV and the Law. In January 2015, ESCAP members reported on their progress and renewed their commitment to conduct reviews and dialogues beyond 2015 as part of efforts to eliminate HIV stigma and discrimination.

This regional process delivered national results. In Pakistan, the Sindh Provincial AIDS Law was passed, the first AIDS law in south Asia. China issued a national policy on the health and safety of health-care workers. Recommendations from Indonesia’s process informed programming to remove legal barriers included in the Global Fund concept note. In Papua New Guinea, private members bills to decriminalize sex work and sodomy have been prepared for the 2016 parliamentary session. The consultation in Lao People’s Democratic Republic fed into the revised penal code. Regional analysis of key findings and recommendations on people who use drugs was presented by UNAIDS Secretariat and UNDP at the International Harm Reduction Conference in 2015.

- **Supporting reform of punitive laws, policies and practices:** In September 2015, UNAIDS Secretariat, UNDP and OHCHR led the issuing by 12 UN agencies, including several Joint Programme cosponsors, of a powerful joint statement calling for action on ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI) adults, adolescents and children. Under the leadership of UNDP, the Joint Programme worked with governments and civil society to conduct national dialogues on HIV and the law in 62 countries, including reviewing legal and policy barriers to HIV services for people living with HIV and key populations as well as legal reform for adolescent health and rights. In Pakistan, this contributed to the passage of Sindh’s Provincial AIDS Law and in Bangladesh to a policy recognizing transgender persons. UNDP developed a tool to undertake Legal Environment Assessments (LEAs) and led the undertaking of LEAs in partnership with the joint programme’s co-sponsors and the UNAIDS Secretariat in 52 countries. Follow-up to LEAs saw positive changes, including the government adoption of Chad’s revised HIV law and approval of DRC’s revision to remove criminalisation of HIV transmission;

- The Joint Programme provided advisory support to law development and reform processes in 52 countries. It also supported dialogue for the protection and access to health services for key populations, including a dialogue between OHCHR, the UNAIDS Secretariat and the Inter-American and African Commissions on Human Rights on the protection of the human rights of lesbian, gay, bisexual, transgender and/or intersex (LGBTI) people in Banjul in 2015. The Joint Programme has supported national coalitions in the removal of legal barriers hindering access to HIV services for men who have sex with men (MSM) in 71 countries, sex workers in 74 countries, people who inject drugs in 49 countries and transgender people in 50 countries. UN Country Team intervention led to removal of proposed punitive bills regarding so-called 'gay propaganda' from consideration in Ukraine and deferring similar legislation in Kyrgyzstan, while in Kazakhstan a similar law has been struck down as unconstitutional. Intervention has additionally led to withdrawal of provisions for mandatory HIV testing from amendments to the Public Health Act in Czech Republic, the drafting of a bill recognizing sex work as work in the Dominican Republic, the shelving of punitive legislation in Chad and the release of individuals detained under anti-gay laws in the Gambia and Nigeria;
- Legal review and advocacy by the UNDP and the UNAIDS Secretariat supported ratification of the Arab Convention for HIV Prevention and Protection of the Rights of PLHIV by Djibouti. In Malawi, technical and political opinion has been provided by UN Women to the UNAIDS Secretariat on concerns relating to the Marriage, Divorce and Family Relations Bill, while advocacy to eliminate child marriage and teenage pregnancy resulted in the legal change in age of marriage from 15 to 18 years. The guidance provided also deterred introduction of overly broad criminalization of HIV transmission. In Myanmar, UNAIDS Secretariat and UNODC provided direct support to the government to revise the Law on Drugs (expected to be passed in the coming months). Djibouti became the first Arab country to ratify the Arab Convention on Preventing HIV and Protecting the Right of PLHIV in the region after year long advocacy and support by UNDP and the UNAIDS Secretariat. UNICEF partnered with Southern Africa AIDS Trust (SAT) to address restrictive age-of-consent to health services laws in 22 countries and improve access to HIV services;
- **Strengthening capacity of judiciary, legislature and law enforcement agencies on HIV, human rights and the law:** The UNAIDS Secretariat, WHO, UNODC, UNDP and UNFPA co-sponsored a global dialogue on police and HIV convened by the Law Enforcement and HIV Network (LEAHN) and International Development Law Organization (IDLO) in Amsterdam. UN Joint Teams in 50 countries contributed to building national capacity among law-makers. The ILO, UNDP and UNHCR trained 36 magistrates in Jamaica on the labour rights of people living with HIV, while the ILO trained approximately 300 judges from the Community of Portuguese-speaking countries on labour rights of people living with HIV and key populations, leading to a judgment in a Brazilian labour court in favour of a worker dismissed due to their HIV status. In 2014, the UNAIDS Secretariat filed *amicus curiae* briefs on behalf of the joint programme in cases before Malawi's High Court on constitutionality of laws criminalising homosexuality and in a European Court of Human Rights case challenging Russia's OST ban. In 2015, the Secretariat requested leave to intervene in two high-level cases - the East African Court of Justice case on impacts of Anti-Homosexuality Act in Uganda and a case in Kenya on forced sterilization of women living with HIV;
- **Expanding access to justice and legal literacy initiatives:** UNDP, UNAIDS Secretariat and ILO collaborated to support development of a manual on LGBT workers' rights, published in 2014. UNDP also supported provision of free legal aid

for people living with HIV and key populations through a national network of HIV legal aid centres in China and a regional HIV legal network in nine Eastern European and Central Asian (EECA) countries. UNESCO and UNFPA worked to engage young people in knowing their rights and documenting HIV and SRH-related barriers in Asia Pacific, through the organization of regional meetings and the development of a toolkit for legal/policy advocacy trainings. Building on its nine-country initiative in Africa on women's access to property and inheritance rights in the context of HIV, UN Women strengthened alternative dispute resolution mechanisms and community justice systems, worked to increase legal awareness and literacy for women living with HIV and to strengthen the capacity of community-based organizations, grassroots and paralegals to respond to the needs of women living with HIV. This work included a focus on issues involving gender-based violence, access to land and other economic resources. In Tanzania, after increasing the capacity of local paralegals to address the needs of Maasai women living with HIV, 60 women secured their land plots and 20 others submitted applications to obtain their land titles. In Sudan UNDP supported the Sudanese People Living with HIV Care Association (SPCA) to help successfully access EU funds to conduct legal aid provision and legal literacy activities throughout the country;

- **Reducing stigma and discrimination:** In 2015, 12 UN Agencies issued a Joint UN Statement on Ending Violence and Discrimination against LGBTI People. A global multi-stakeholder meeting was held in November 2015 by the UNAIDS Secretariat in partnership with the Global Health Workforce Alliance (WHO) to mobilize constituencies, resulting in the launch of an Agenda for Zero Discrimination in Health care, with a time-bound Action Plan. A regional workshop held in WCA brought together over 50 government, civil society, CSO, TSF and UN staff members from 10 countries, resulting in the "Dakar Declaration on scaling up the HIV response, realizing the human rights and full access to services for everyone in West and Central Africa" in which participants committed to specific actions in their respective countries to advance evidence-informed and rights-based programmes in national HIV responses. With Joint Programme support, in August 2015, a Regional Declaration and targets for Zero Discrimination in Latin America and the Caribbean were adopted in Brazil, guiding country-level target setting efforts;
- **Securing high level commitment to human rights at the core of the HIV response:** The UNAIDS Secretariat secured the adoption of Resolution 30/8 on Contribution of the Human Rights Council (HRC) to the high-level meeting on HIV/AIDS in 2016, calling for the panel at the 31st session of the HRC to mark 20 years of International Guidelines on HIV and Human Rights and provide critical inputs to the High Level Meeting. The resolution was led by Brazil and co-sponsored by over 80 countries;
- **Producing guidance documents, tools and knowledge products:** The UNAIDS Secretariat, WHO, the Global Network of People living with HIV (GNP+) and International Community of Women living with HIV (ICW) developed a tool for human rights, gender equality and community engagement aspects of certification of countries' elimination of mother to child transmission of HIV and syphilis. UNDP published guidance documents on undertaking LEAs and national dialogues. UNDP also developed a guidance document for UN Staff titled, 'Preventing and Responding to HIV-related Human Rights Crises' with the UNAIDS Secretariat, UNFPA, UNODC, ILO, UNHCR, UNICEF and the Global Fund. The UNAIDS Secretariat published the Gap report in 2014, focusing on key populations left behind in the HIV response in 2013. The MDG 6 and World AIDS Day reports were also developed, documenting effective fast-track interventions that work to end AIDS.



26. Despite UN Member States' commitments in the 2011 Political Declaration, **an increasing number of countries worldwide are debating and implementing punitive laws**, policies and practices. Punitive laws remain in place against sex workers, men who have sex with men and people who use drugs in many countries. **Lack of domestic resources, limited quantitative data and insufficient focus on key population** programming perpetuates discrimination and limits the effectiveness of responses. Even where positive change has been achieved, laws and policies must be continuously monitored since **positive changes can be reversed** when new political leadership gains power or from societal pressure. Limited availability of quantitative data on the impact of punitive legal environments, stigma and discrimination on investments and access to HIV services hinders efforts to insert HIV sensitive programming into NSPs, national investment cases, Global Fund concept notes and M&E frameworks.

***ii. Eliminating HIV-related travel restrictions***

27. The work of the International Task Team on HIV-related Travel Restrictions has established evidence that travel restrictions do not protect public health, and further stigmatize people living with HIV. Furthermore, the 2011 Political Declaration on HIV and AIDS made the elimination of restrictions on entry, stay and residence based on HIV status a target in global efforts to reach zero discrimination. Since 2011, 14 countries, territories or areas have removed or have officially clarified that they do not apply such restrictions.
28. To further progress towards eliminating restrictions on entry, stay and residence based on HIV status, the UNAIDS Secretariat and Cosponsors have carried out the following work in 2014-2015:
- **The Joint Programme developed a roadmap, meeting paper and agenda** for a proposed interregional dialogue on travel restrictions and universal access to health and HIV services between Asia and MENA region countries. ILO developed a supporting strategy document for the meeting and circulated to labour sector partners in both regions. Consequently, joint HIV teams in both regions agreed to hold a technical working group meeting in collaboration with the Arab league in 2016;
  - In some Pacific Islands states - Marshall Islands, Samoa and Solomon Islands - **legal reviews and policy notes on travel restrictions were developed in 2014-2015**. In the Solomon Islands, the process has advanced to the point of a review of the Medical Form for long-term entry, stay and employment being conducted, resulting in the approval of a new form, where HIV has been excluded from mandatory testing, thus effectively contributing to lifting of travel restrictions;
  - In 2015, **the UNAIDS Secretariat provided technical and advocacy support** that was critical to the removal or clarification that there are no restrictions on entry, stay and residence on the basis of HIV status in Belarus, Chinese Taipei and Lithuania. It is expected that a similar confirmation from Paraguay is forthcoming in 2016. Repeated advocacy with Russia yielded the first results – based on the Constitutional Court decision and relevant European Court of Human Rights (ECHR) precedents, immigration law has been amended to grant stays to foreign citizens with HIV that have family residing legally in Russia
  - **UNAIDS also engaged in dialogue with the Government of the Republic of Korea and civil society** regarding concerns that they retain policies and practices that constitute HIV-related restrictions on entry, stay and residence. The UNAIDS Secretariat provided technical opinion to the Convention on Elimination of all forms of

Racial Discrimination (CERD) when it heard a case of a foreign language teacher subjected to mandatory HIV testing for residency purposes. The CERD decision in May 2015 found that such testing violated human rights;

- In Iraq, Yemen, Jordan and Syria refugees, migrants and asylum seekers are subject to mandatory testing upon arrival as well as upon renewal of identity cards, whilst in Lebanon only migrants are subject to mandatory testing. During 2014 and 2015 **UNHCR and the Joint Programme continued to work with governments to advocate for the lifting of such mandatory testing** as well as access to asylum procedures and protection from expulsion and refoulement for refugees, asylum seekers and other populations of concern living with and affected by HIV. Additionally, in 2014, UNHCR together with the US-based NGO Organisation for Refugees, Asylum and Migration (ORAM), held LGBTI asylum-seeker and refugee protection training events on Claims to Refugee Status based on Sexual Orientation and/or Gender Identity with UNHCR offices and partners in Cameroon, Ethiopia, Chad, India, Jordan, Kenya, Malaysia, Senegal and Uganda.

#### Arab Convention for HIV Prevention tackles HIV-related travel restrictions



Removing travel restrictions for people living with HIV is one of the articles of the Arab Convention for HIV Prevention that was adopted by the Arab Parliament in 2012. During 2014 and 2015, UNDP continued advocacy efforts with countries in the region to ratify the convention, which sets the basis for a regional, legally binding framework for removing travel restrictions. In November 2015, UNDP with the Arab League and UNAIDS Secretariat convened a regional technical consultation on the Arab Convention, attended by representatives from justice and health ministries in Algeria, Bahrain, Djibouti, Egypt, Kuwait, Morocco, Sudan, Somalia and Tunisia. The consultation elaborated a road map for the ratification of the Arab Convention at the national level. UNDP will continue working with national parliaments through its work on inclusive political processes to ensure the next generation of parliamentarians is sensitized and informed about the importance of protecting the human rights of people living with HIV.

29. At the end of 2015, **35 countries, territories, and areas still imposed some form of restriction** on entry, stay and residence based on HIV status. While this number is far lower than the original 59 countries, territories and areas identified in 2008, there is still a strong need for further action, including high level advocacy, to ensure the elimination of these laws, regulations and policies wherever they exist. **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, including decisions issued by UN treaty bodies, finding that **discriminatory practices still persist in countries that have ostensibly removed travel restrictions** - for example, the Republic of Korea's continued imposition of HIV testing on foreign English teachers despite having officially repealed existing restrictions. Government and civil society partners in the MENA region face considerable obstacles in moving the travel restrictions agenda forward as a stand-alone issue. Broader health issues need to be considered in advocacy efforts against travel-restrictions, as with the Ebola or Zika outbreaks and related travel advisories.

#### **iii. Addressing HIV-needs of women and girls**

30. Gender inequalities as well as gender-based violence continue to undermine progress towards realizing global AIDS targets, placing women and girls at higher risk of HIV

infection, impeding their access to HIV prevention, treatment and care services and increasing their vulnerability to institutional violence, such as forced or coerced abortion or forced sterilization. Women and girls currently bear a disproportionate burden of the global HIV epidemic. In sub-Saharan Africa, in 2014, women accounted for 59% of people living with HIV, while they represent 51% worldwide. The statistics are particularly alarming when looking at young women and adolescent girls. 56% of all people aged 15–24 years old who became newly infected and 62% of those 15–19 years old who acquired HIV in 2014 were female.

#### The Algiers Call for Action



The partnership between the Regional Arab Network Against AIDS (RANAA) and the Arab League, signed in December 2014 with UNAIDS Secretariat support, has been instrumental in advancing gender equality in the region. As part of the Arab AIDS Strategy and the post-2015 development agenda, the Arab League, UNAIDS Secretariat, UN Women and the Government of Algeria organized a high-level meeting of women leaders on gender equality and HIV in November 2014. This resulted in the Algiers Call for Action, urging all Arab state governments and intergovernmental bodies to include a commitment to ending the AIDS epidemic within the post-2015 development agenda – ensuring no one is left behind – through rights-based and gender-transformative action on the social, political and economic determinants of HIV.

31. The Joint Programme has made significant contributions to addressing the gender dimensions of AIDS epidemics, by improving integration of gender equality and human rights into national HIV strategies and plans, strengthening human rights and policy frameworks in support of women's rights - especially women living with HIV and from key populations - and supporting greater leadership by women living with HIV. Further contributions in 2014-2015 have included:

- **Building gender-responsive HIV policies:** Enhanced technical guidance and tools developed by the Joint Programme and other partners strengthened national HIV strategies and Global Fund concept notes by increasing attention to gender equality, women, adolescents, girls and key populations. Used by more than 40 countries, the implementation of the UNAIDS Gender Assessment Tool enabled governments and CSOs to generate strategic information to be used in integrating gender equality and women's rights issues into national HIV responses. A Technical Working Group established by UN Women and co-convened with the Global Fund - with participation by UNDP, UNFPA, WHO, donors and CSOs - commissioned and disseminated a menu of evidence-informed interventions on gender-transformative programming to integrate gender equality issues into Global Fund concept notes. The World Bank provided key evidence in support of gender-transformative HIV strategies, financing studies to examine social drivers of transmission in young women and developing tools to allow examination of drivers of sexual risk for vulnerable girls. Beyond technical assistance and evidence, the World Bank financed multiple targeted actions through its operations, for example in Zambia where it is financing a project to increase women and adolescent girls' empowerment and their access to quality reproductive, child and maternal health services including HIV services. Overall, the Joint Programme helped to integrate gender-responsive actions into the national HIV strategic plans in 30 countries and into the Global Fund concept notes in 13 countries. UN Women, WHO and the UNAIDS Secretariat increased capacities of M&E staff from HIV programmes in 15 countries on gender-sensitive M&E for HIV/AIDS; since then, four countries have integrated gender equality into their M&E

frameworks. UN Women and the UNAIDS Secretariat invested in the localization of the National HIV Strategic Plan in six counties, which are prioritizing actions and budgets to address HIV-specific needs of women. In Uganda, a similar effort has resulted in the Global Fund concept note prioritizing ending gender-based violence and removing discriminatory laws and practices that contribute to women and girls' vulnerability to HIV, with the total budget of US\$ 2.3 million allocated for this work in 2015-2017;

- **Empowering and engaging adolescent girls and young women:** UNICEF, UNFPA, UN Women and other Cosponsors supported national partners in producing data examining social vulnerability of adolescents and young women in order to better address their needs in HIV prevention strategies and new NSPs in Cambodia, Kenya and Mozambique, through youth-friendly, integrated HIV-SRH services. UN Women successfully advocated for gender-transformative national HIV strategies that highlight the HIV-specific needs of adolescent girls and young women and engaged these constituencies in planning and decision-making processes in Cambodia, Kenya, Mozambique and Uganda. In Kenya, UN Women and other Cosponsors supported the development of the Operational Plan for Ending AIDS among Adolescents 2015-2019, launched by the President in 2015. An initiative by ILO, the UNAIDS Secretariat and South African Development Community in East and Southern Africa (ESA) empowered young women and girls in the informal economy by integrating entrepreneurial skills and economic enhancements, including access to loans, into HIV services. In Zambia, the percentage of young women who reported using a condom during their last sex 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 these women. Such outcomes provide concrete evidence on how addressing the socio-economic determinants of HIV can reduce the vulnerability of young women. UNDP supported similar initiatives in Djibouti and Egypt and convened an expert partners meeting to identify a strategy for strengthening legal and policy frameworks that protect and promote the rights of young women and adolescent girls, focusing on child marriage, inconsistent and punitive age of consent laws and harmful practices. UNESCO, UNFPA and UN Women additionally launched a joint programme to empower adolescent girls and women through education, under the framework of the "Better Lives Better Future" Global Partnership. The first phase of this joint programme will target six countries (Nepal, Pakistan, Mali, Niger, South Sudan and Tanzania) and preliminary plans for country-level activities include a strong focus on life skills and CSE;
- UNAIDS Secretariat, The African Union Secretariat and Ministers of Gender launched "**Empowering young women and adolescent girls: Fast- Tracking the end of the AIDS epidemic in Africa**". This forms part of the mobilization and political engagement towards the CSW 60 and HLM 2016, to ensure integration of HIV/SRHR, focus on an inclusive human rights perspective, including women and girls in conflict and post conflict settings in line with the African Union Declaration on Women's Right to Health;
- **Strengthening legal environments for gender equality and human rights:** Legal analyses and reform efforts highlighted the relationship between HIV vulnerability and harmful cultural and gender norms and focused on removing discriminatory provisions and affording greater protection to women including from key populations in personal status laws, domestic violence and sexual offences acts, social protection policies and HIV decriminalization laws. UNDP, the UNAIDS Secretariat, WHO and UN Women supported 69 countries to review and revise discriminatory laws, policies

or practices that put women and girls at risk of HIV and hinder effective HIV responses. UNDP, the UNAIDS Secretariat, UNFPA and UN Women also continued to work on improving access to justice for women in plural legal contexts as well as 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. With UN Women's support and advocacy, a marriage, divorce and family relations bill was also adopted, which increased legal age for marriage from 15 to 18 years. The 2013 Eastern and Southern Africa Ministerial Commitment for CSE and SRH services, led by UNESCO, also includes a target to reduce early and unintended pregnancies by 75% and eliminate child marriage by 2020. In Malawi, UN Women advocacy resulted in adoption of the Marriage, Divorce and Family Relations Bill that now increases a marriage age from 15 to 18 years; and of the by-laws and/or action plans by Paramount Chiefs to enforce the Bill. UNDP convened a strategy meeting to advance the Global Commission on HIV and the Law's findings on child marriage, punitive age-of-consent laws and harmful practices;

- **Championing women's leadership and participation:** 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. The International Conference on Population Development (ICPD), Beijing+20 regional reviews and the International AIDS Conference in 2015 all resulted in recommendations that included women's and girls' HIV-related needs and priorities. The UNAIDS Secretariat, UNDP and UN Women also facilitated women living with HIV networks to participate in Committee on the Elimination of Discrimination Against Women (CEDAW) reporting processes and to connect with other women's organizations in order to shape a more inclusive human rights and gender equality agenda for post-2015. UN Women, the UNAIDS Secretariat, UNESCO and UNFPA provided extensive policy support to the Southern African Development Community in developing a draft resolution on "Women, the Girl Child and HIV and AIDS" in preparations for the 60<sup>th</sup> session of the Commission on the Status of Women. Through its Fund for Gender Equality and the UN Trust Fund to End Violence against Women, UN Women provided more than US\$ 3.5 million in grants to civil society organizations that address issues related to political and economic empowerment of women, including those living with HIV and interlinkages of violence and HIV. Grantees were able to pilot promising approaches, replicate good practices and engage communities. The Joint Programme supported 65 countries in engaging women living with HIV, including young women and adolescent girls, to participate in decision-making processes, including the development of HIV NSPs and Global Fund Concept Notes. Botswana, on behalf of the United Nations Member States that are members of the Southern African Development Community, introduced a draft resolution at the 60<sup>th</sup> CSW session; it was subsequently adopted by consensus on March 24 2016 after member states negotiations.

32. **The lack of or limited use of sex- and age-disaggregated data and evidence** linking HIV/STIs and gender equality continues to undermine target-setting, development, implementation, monitoring and financing of gender-responsive policies and programmes, as well as the identification of gaps in services. **Harmful practices and discriminatory laws and policies** continue to have a negative impact on women and girls. **Stigma and discrimination**, including on the basis of age, sexual orientation and gender identity, sex work and drug use, continue to hamper HIV responses. **Strengthening participation and voice of women living with HIV**, particularly young

women and adolescent girls, does not necessarily translate into impact – since women and gender advocates may still lack the adequate authority and capacity needed to influence. Long-term institutional support, seats in decision-making and coordinating bodies and access to funding is urgently needed to strengthen the capacities of networks of women living with HIV and particularly those working at the community level and with the most marginalized and excluded groups of women. **National HIV responses continue to some extent to reflect gender biases** in policies, programmes, institutions and budgets. These trends must be reversed in order to ensure equal access and benefit for women, men, girls, boys, transgender men and transgender women. This can be achieved through sustained investment in research and evidence on social and structural drivers, as well as political advocacy and improved technical knowledge. Programming to address HIV prevention, treatment, care and support for women and girls is often considered to be in competition with, rather than linked and related to, programming and support for key populations. A gender equality perspective increases the understanding of the needs of women and men, girls and boys and transgender people, whether they are sex workers, intimate partners of sex workers, men or women who inject drugs, LGBT or female partners of men who have sex with men.

#### **iv Stopping gender-based violence**

33. Violence against women remains an unacceptable and serious human rights violation in all regions of the world. An estimated one in three women around the world have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner at some point in their lives. Indeed, globally, 35% of women have experienced physical or sexual violence at some point in their lives, which has been linked with women's increased vulnerability to HIV. Women who have experienced intimate partner violence are 50% more likely to be living with HIV. Women living with HIV are more likely to experience intimate partner violence in addition to violence from family members, the community and within institutional settings, including coerced abortion and forced sterilization. Child marriage is a risk factor for intimate partner violence and girls under 18 who marry are more likely to experience violence within marriage than girls who marry later. Whereas the practice of child, early and forced marriage is declining globally, there are still 700 million girls worldwide who were married before their eighteenth birthday.

#### **Joint Programme actions against gender-based violence in Eastern Europe and Central Asia**



To address the increased risk of sexual assault and other forms of gender-based violence (GBV) in the context of the military conflict in Ukraine, UNICEF procured post-exposure prophylaxis kits to support women exposed to GBV. Care providers were sensitized to better recognize GBV and support affected women and girls.

UNESCO's regional work on GBV prevention was built on UNESCO's global strategy to stop school-related gender-based violence and homophobic bullying.

The UN agency supported the sensitization of more than 150 educators in Kazakhstan, Kyrgyzstan, Russia and Tajikistan on sexual rights and GBV, and approaches to prevention and response. Three training modules on violence prevention, efficient communication and prevention of discrimination against people living with HIV were integrated in teacher training curricula in Kyrgyzstan, with 100 schools benefiting.

In Albania, Bosnia and Herzegovina, Moldova, Serbia and Tajikistan, UNFPA supported health ministries to strengthen their GBV response, including sexual violence, through technical assistance to develop/update national guidelines, manuals and resources packages in accordance with Women against Violence Europe (WAVE) guidance. Specific training curricula on the health response to GBV commenced in Moldova, and 60 primary health-care staff in three municipalities in Kosovo were trained

on WAVE application. Legislation protecting the rights of women in family settings was adopted in Turkmenistan, while training among front-line providers on the linkages between HIV and gender-based violence were undertaken in Armenia, Kazakhstan and Serbia.

34. In 2014-2015 the Joint Programme made the following achievements in addressing gender-based violence in the context of HIV:

- **Strengthened evidence on gender based violence (GBV) and HIV linkages:** In Latin America, UN Women supported a CSO, Gestos, to produce a Guide for Monitoring the Inclusion of Violence Against Women at the National Level of the AIDS Response. Five country reports were prepared and will be used by networks of women living with HIV to advocate for stronger integration of GBV/HIV issues into the national HIV responses in 2016. UNESCO and UN Women also led the development of global guidance on addressing school-related gender-based violence (SRGBV). UNICEF and UNESCO published the first-ever review of SRGBV in the Asia Pacific region and worked with UN Women to develop infographics in 13 languages for advocacy through the region. The UNAIDS IATT on Education conducted a research project on SRGBV including focus group discussions with teachers in Bolivia, the MENA region, Philippines, Senegal, South Africa and Ukraine. An EECA regional guide for educators was also developed on preventing SRGBV and a study on SRGBV in the Arab States Region was undertaken. UNESCO also supported specific efforts to address SRGBV, focusing on gender non-conforming and LGBTI youth, through the development of a global report and regional research in Asia Pacific, Latin America and Eastern and Southern Africa. In 65 countries, the Joint Programme strengthened the evidence base on human rights violations faced by women, girls and women living with HIV as well as key populations (sex workers, women who inject drugs, transgender people); the intersections of HIV and different forms of gender-based violence (GBV); limitations for women who are the victims of gender based violence to accessing justice; as well as what works programmatically in health care, educational and community settings to respond to violence against women. UNDP conducted research on violence against sex workers in Indonesia, Myanmar, Nepal and Sri Lanka, together with UNFPA and civil society partners. This research was recognized for its excellence through the prestigious Robert Carr Award at the International AIDS Conference in Melbourne, Australia in 2014;
- **Improved integration of GBV into HIV National Strategic Plans and of HIV into GBV National Action Plans (NAPs):** Better evidence on violence against women and girls, including those living with HIV and from key populations, has sharpened and ensured evidence-informed national policy and programmatic responses in different epidemic settings. Technical and capacity support to national AIDS coordinating authorities and ministries of gender resulted in strengthened HIV-GBV linkages in HIV NSPs and NAPs on ending gender based violence in at least 16 countries. In Indonesia, an action plan was developed to respond to evidence on violence against sex workers and advocate for its inclusion in the new HIV NSP. In Cambodia, joint advocacy by the UNAIDS Secretariat, UN Women and UNDP ensured that the issue of violence against women living with HIV, women among key populations and LGBT were integrated into the NAP on Ending Violence Against Women. In Nigeria, UN Women facilitated adoption of the National Plan of Action on GBV/HIV 2015-2017 in support of the implementation of the Violence Against Persons (Prohibition) Act to prosecute various forms of violence (including female genital mutilation) and establish a protection mechanism for survivors. WHO, OHCHR, UN Women, the UNAIDS Secretariat, UNDP, UNFPA and UNICEF published a joint interagency statement, eliminating forced, coercive and otherwise

involuntary sterilization with guiding principles for the prevention and elimination of coercive sterilization and recommendations for legal, policy and service-delivery actions;

- **Strengthened public health approach to prevention and response to violence against women and girls:** The Joint Programme strengthened the public health approach to prevention and response to violence against women and girls through improved guidelines, which integrated HIV prevention, treatment and care services and capacity development of Ministries of Health, other relevant ministries (such as women's or gender ministries) and the UN. 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 that was subsequently rolled out in Uganda and Cambodia. In 2015, it was rolled-out in Cambodia and Uganda. The World Bank funded GBV prevention programmes through operations such as the Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project, which provided support to the Democratic Republic of Congo, Republic of Burundi and Republic of Rwanda. Such regional operations typically involve additional support for cross country knowledge sharing, regional training and advocacy. The UNAIDS Secretariat, in collaboration with Together for Girls, launched the "Every Hour Matters" Global Campaign to raise awareness on the post-rape care services and its link to HIV prevention.

35. Despite these achievements, there continues to be **insufficient political will, institutional support and capacity to address GBV**, in addition to a lack of systematic and comparable age- and sex-disaggregated data and use of existing evidence on ending GBV and its implications for HIV. Many countries have **little or no domestic budget 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. **Comprehensive knowledge about HIV also remains unacceptably low**, especially among adolescent girls. Given the high levels of coerced sex experienced by young women, **better programming for violence prevention, comprehensive sexuality education, condom use and negotiation skills are needed** to increase HIV knowledge and skills to prevent HIV.

### III. STRATEGIC FUNCTIONS AND RELATED THEMES

#### ***1. Leadership and advocacy***

36. UNAIDS has built the vision, momentum and foundations of political support to end AIDS as a public health threat by 2030. The UNAIDS 2016–2021 Strategy adopted by the PCB in October 2015 is a bold call to action to Fast Track the AIDS response, accelerating efforts and frontloading investments, to reach people being left behind. UNAIDS leadership on the Fast Track and ending AIDS agenda has been well acknowledged across the AIDS and global health fields and the 90-90-90 targets have been enthusiastically embraced as the cornerstone of efforts to end the AIDS epidemic. Building up to this, the UNAIDS Secretariat and Cosponsors continued to work together in 2014-2015 to develop their individual and collective role in leadership and advocacy for the AIDS response, including:

- On World AIDS Day 2014, mayors from around the world came together in Paris, France and joined UNAIDS, the United Nations Human Settlement Programme (UN-



Habitat) and the International Association of Providers of AIDS Care (IAPAC) in signing the 2014 Paris Declaration to **put cities in the Fast-Track to ending the AIDS epidemic**, through a set of commitments. Those commitments include achieving the UNAIDS 90–90–90 targets, which will result in 90% of people living with HIV knowing their HIV status, 90% of people who know their HIV-positive status on antiretroviral treatment and 90% of people on treatment with suppressed viral loads, keeping them healthy and reducing the risk of HIV transmission.

- The Joint Programme **supported countries and Fast-Track cities** (as a follow up to the 2015 Paris Declaration) to set milestones for 2020 and develop action plans. The new UNAIDS reference document entitled Fast-Track—update on investments needed in the AIDS response explains improvements to the investment model with critical new inputs from the revised 2015 World Health Organization guidelines on HIV treatment. Other inputs include new evidence that projects lower costs for HIV medicines and supplies particularly in high burden countries that will further offset the increased investment associated with expanded treatment coverage.
- **The UNAIDS Secretariat serves as the Secretariat of the Diagnostics Access Initiative** and leads an advocacy working group, bringing unprecedented energy and coordinated action to a long-neglected component of the response: laboratory medicine. UNAIDS advocated for secure and affordable supplies of essential medicines and showed the leading role that the AIDS community can play in overcoming trade barriers to access to essential medicines. For instance, promoting the creation of a new African Union Commission’s Technical Committee on the Pharmaceutical Manufacturing Plan for Africa and a joint India-Africa cooperation framework on HIV and health commodity security. In 2015, a global agreement was signed with Roche to sharply lower prices of early infant diagnosis of HIV;
- The UNAIDS Secretariat provided **political and strategic support to the Champions for an AIDS free Generation** and brought together OAFRA and the First Lady of China on the margins of the Forum on China-Africa Cooperation in 2015 to launch the Africa-China Campaign on an AIDS Free Generation. Advocacy efforts to engage emerging leaders and influencers in the AIDS response include actress Charlize Theron, Kweku Mandela, grandson of Nelson Mandela and singers and songwriters Nico and Vinz who mobilized and launched a social media campaign to end AIDS : #GenEndIt. The engagement of young influencers and celebrities resulted in significant media coverage for the AIDS response. Zendaya, an American artist is now part of ProTESTHIV, an initiative that brings together people from all over the world to promote HIV testing;

**Asia Pacific champion parliamentarians pledge to increase domestic investment and advance human rights in AIDS response**

Continuing partnership between Asian Forum of Parliamentarians on Population and Development (AFPPD) and UNAIDS Secretariat has resulted in creating number of champion MPs and also promoted dialogues with parliamentarians, politicians, and civil society organizations (CSOs) for collective efforts for a scaled-up and effective AIDS response with a special focus on key populations, addressing stigma and discrimination and improving legal and policy environment and increased domestic resources for a sustainable AIDS response at present and in the future for ending the AIDS epidemic in the Asia-Pacific region by 2030.

- UNAIDS **secured the adoption of a resolution at the Human Rights Council** that calls for a panel discussion on the challenges and progress on the human rights aspects of the AIDS response. The UNAIDS Secretariat, together with OHCHR,

convened the first dialogue of the Inter-American and African Commissions on Human Rights on protection of LGBTI rights in November 2015. Working with governments, civil society and other stakeholders, it played a key role in a number of countries towards creating an enabling environment, protect human rights of people living with and affected by HIV and reducing HIV-related stigma and discrimination. In Nigeria and Gambia, for instance, UNAIDS Secretariat and civil society activists secured the release of more than 20 individuals who had been detained on charges of conducting same sex relations;

- **UNAIDS continued advocating against travel restrictions**, by presenting evidence on their ineffectiveness and on the fact that they violate the right to freedom of movement and non-discrimination. In 2014 and 2015, Australia, Andorra, Belarus, Chinese Taipei, Comoros, Lithuania and Tajikistan either confirmed removal of HIV-related travel restrictions or clarified that there are no restrictions in their countries, territories and areas;
- On September 2015, **twelve UN agencies released an unprecedented joint statement calling for the upholding of rights for LGBT adults, adolescents and children**. In 2015, the MDG 6 and World AIDS Day reports compiled evidence on key populations, while several initiatives were undertaken to address their needs. For instance, the UNAIDS Secretariat advanced the MSM prevention agenda by documenting best practices and operationalizing WHO's Guidelines on HIV and STI Prevention and Treatment among MSM. The MSMIT - (A tool for implementing comprehensive HIV and STI programmes with men who have sex with men) is a UNFPA publication, jointly with WHO, UNDP, the UNAIDS Secretariat, the World Bank, USAID and PEPFAR, creating a global advocacy platform and mobilizing private sector dating apps;
- The political leadership of the UNAIDS Secretariat, UN Women and UNDP with the League of Arab States resulted in the **development and endorsement of the Arab AIDS Strategy in March 2014** and the Council of Arab Health Ministers following up the implementation of the strategy in all Member States in the following year;
- **UNAIDS' Secretariat's efforts on gender balance in the workplace** and its emphasis on career development opportunities for women continue to receive significant recognition through the UN SWAP report and in the Report of the Secretary-General on the Improvement in the Status of Women in the UN System. With the gains made in 2015, including the establishment of a gender equality marker against all work plans across the UNAIDS Secretariat and a financial target for expenditures in support of actions that address gender equality and women's empowerment as a principal objective, UNAIDS Secretariat continue to be one of the leaders in the UN system on the issue;
- UNAIDS Secretariat continued its leadership role to provide strategic information, producing epidemic data and extensive strategic analysis. helping countries and partners drive a more strategic, focused, evidence-informed approach to planning and monitoring. New modelling of location-specific epidemics resulted in a list of 200 cities with relatively high levels of HIV prevalence, laying the foundation for the Fast-Track Cities Strategy. Other areas for which strategic information provided help were: gender inequalities and violence against women and girls; national reviews of HIV strategic plans; development of HIV Investment Cases and Country Concept Notes to mobilize financial resources from the Global Fund under the New Funding Model; and projection of investment needs to end HIV by 2030. UNAIDS Secretariat increasingly

made use of new technology in 2014-2015, including for population-location responses and data visualization. This included the introduction of UNAIDS Treatment Situation Room technology, a modelling tool that projects trends based on actual programme data from the most-recent 24 months. The UNAIDS Treatment Situation Room provides an up-to-the-minute estimate of the number of people living with HIV receiving antiretroviral therapy in low- and middle-income countries.

37. While progress has been made in the AIDS response, gains are fragile and reversible and focus on AIDS must be maintained as part of the post-2015 development agenda. **Budget reductions and political issues** in donor countries have made it challenging for UNAIDS and partners to sustain funding for the global AIDS response. Small budgets will challenge the implementation of previously agreed agendas and actions including for networks of people living with HIV and key populations, as well as funding support to civil society organisations, particularly for service delivery and advocacy. **Uncertainties regarding future financing for the AIDS response and market dynamics that could potentially imperil the availability of affordable antiretroviral medicines** are a significant challenge to achieving the 90-90-90 targets. It is also essential that UNAIDS meets the evolving needs on the type and quality of data (location, population granularity) and the resources required for data collection and processing.
38. Together with governments, people living with HIV, civil society and other partners, the Joint Programme will continue to lead the AIDS response, calling for greater ambition and more effective, rights-based and gender-sensitive responses, which leave no one behind. Support will be mobilized at the High Level Meeting (HLM) on AIDS, and other regional and international conferences and platforms.

#### **ii. Coordination, coherence and partnerships**

39. Addressing the Joint Programmes responsibilities under UBRAF and the 2011 Political Declaration in developing coordination, coherence and partnerships, the UNAIDS Secretariat and Cosponsors carried out the following work in 2014-2015:
- **UNAIDS promoted awareness on the benefits, breadth and depth of integration.** The Secretariat actively participated in high level discussions on integration, education, global health governance, public-private partnerships, financing for development and global health security. A consultative review paper on indicators to measure integration and a guidance note for national programmes on how to pursue integration at country level were prepared;

#### **Economic and Social Council (ECOSOC) resolution cites UNAIDS**

A leader in the global AIDS response, with impact across broader health, development, rights and gender outcomes, the unique strengths of UNAIDS have been recognized by ECOSOC through its 2013 and 2015 Resolutions: "(...)the Joint Programme offers the United Nations system a useful example, to be considered, as appropriate, of enhanced strategic coherence, coordination, results-based focus, inclusive governance and country-level impact, based on national contexts and priorities" (ECOSOC resolution, E/2015/L-5, p.8)

- **The new UNAIDS 2016-2021 Strategy, adopted in 2015, provides a solid foundation for re-energizing and re-positioning HIV prevention.** Examples of UNAIDS-led progress on the HIV prevention agenda, in coordination with partners, civil societies and communities include the global agenda for increased condom use, the PreP agenda and enhanced focus on HIV prevention efforts for women and girls.

A new joint *UNFPA, WHO and UNAIDS Secretariat position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy*, targets and indicators were developed as well as briefings and advocacy. The community of men who have sex with men were engaged to a greater extent in the SE Asian regional response, and PrEP was scaled-up in Latin America in partnership with UNITAID. Focused support was provided to PEPFAR DREAMS and the All-in! initiatives, best practices documented, guidance on cash transfers issued, and a consultation held to explore the potential and reach of new media for young people;

- **UNAIDS leveraged champions**, goodwill ambassadors, political and technical actors, government officials, PEPFAR and other partners and community voices (including of traditional and religious leaders) to strengthen awareness on AIDS and to move the AIDS response forward;
- UNAIDS **facilitated high-level political and technical collaboration** on eMTCT, to increase access to and use of PMTCT services. The Secretariat and WHO **partnered in the initiative to formally certify and validate countries which achieve eMTCT of HIV and syphilis**. Human rights and community engagement indicators/tools were included for the first time in a disease elimination validation process (in partnership with ICW and GNP+);
- UNAIDS **continued to implement 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. More than 700 civil society organizations are implementing the agenda. Gender assessments were implemented in over 30 countries across regions, with close collaboration with members of the Joint Programme and the Global Fund, using UNAIDS' Gender Assessment Tool to assess countries' epidemic, context and responses from a gender perspective, inputting strategic recommendations in national processes (NSP reviews and development) and Global Fund concept notes.
- The Secretariat **catalysed leadership of UN and regional bodies on HIV and human rights**. In 2015, in Banjul, Gambia, for example, it co-convened the first dialogue between OHCHR and Inter-American and African Commissions on Human Rights on the protection of LGBTI rights. The Secretariat has supported Human Rights programming in national responses through regional capacity building in the Caribbean, Eastern Europe and Central Asia, as well as in Western and Central Africa. A Dakar Declaration on scaling up the HIV response, realizing the human rights and full access to services for everyone in WCA was developed and endorsed;
- The UNAIDS Secretariat and the Global Health Workforce Alliance have **launched an Agenda for Zero Discrimination in Health Care**, convening key Governments, civil society organizations, professional healthcare associations and development partners. The agenda supports a vision for a world where everyone, everywhere, enjoys health services without discrimination and where the health workforce is empowered to provide discrimination-free services to all.
- With civil society and other partners, UNAIDS **supported campaigns, events and released publications to enhance the youth movement for the AIDS response**. In December 2015, in partnership with IPPF and Sonke Gender Justice, UNAIDS conducted a global consultation on rights, roles, responsibilities of men and boys, reaching agreement on the core elements required to Fast-Track the HIV response among men and adolescent boys, which were encompassed in a Platform for Action;

### Technical Support Facilities

The Technical Support Facilities (TSFs) continued to deliver concrete results in 2014-2015, particularly, in terms of helping countries meet resource mobilization needs. Across three regions (Asia Pacific, East and Southern Africa and West and Central Africa), the TSFs provided technical support for the development of 56 global Fund Concept Notes. More importantly, over 90% of the Concept Notes have been successful and these have helped over US\$5 billion of funding for an investment of a little under US\$4 million from the UNAIDS Technical Assistance Funds (TAF). Almost three-quarters of TSF assignments over the last two years have had a GF process component focus. In support of this, the TSFs have mobilized significant TS for 62 countries for their “upstream” efforts or the essential building blocks in developing robust Concept Notes. These included nearly 30 National Strategic Plans (NSPs) for example in Côte d’Ivoire, Burkina Faso, Malawi, Angola, South Sudan, India, Afghanistan and Myanmar as well as provincial plans (in Pakistan). In addition, organizational strengthening and country dialogue engagement plans for Key Populations (KPs) in Indonesia, Côte d’Ivoire, Uganda and regional Asia have been developed as well as several modes of transmission studies and estimates (Mali, Chad, Uganda) and monitoring and evaluation frameworks (Benin, Kenya, Cambodia). There has also been over 20 investment cases developed in countries such as South Africa, Tanzania, Bangladesh, Botswana, Namibia, Solomon Islands and several Nigerian states. (*Refer to Annex 2 for more information about the TSFs*).

- UNAIDS Secretariat ensured continuous engagement and dialogue with civil society on the Fast-Track agenda, including through social media. A network of 15 000 professional HIV communication practitioners was engaged to promote Fast-Track at country level;
  - The Global Fund strategic framework (2017-2022) is aligned to the UNAIDS Fast Track Strategy and its ambitious targets. **UNAIDS worked closely with partners to support an effective roll out of the Global Fund New Funding Model.** The Secretariat has continued to enhance the abilities of countries with Global Fund grant implementation, as well as on transition and sustainability planning.
40. Sustainability, incorporating both programmatic and financial aspects, has rapidly become an evolving priority for many stakeholders including PEPFAR, Global Fund and UNAIDS. **As there are different perceptions and definitions, working together has its challenges.** UNAIDS is ideally positioned to use its convening power to bring different actors around the table and to advance the agenda. **Some dichotomy still exists between “prevention” and “treatment”** and countries are struggling to balance the policy advice from different actors and to translate the concept of population and location into concrete programme action. More guidance will greatly help countries to design more effective programmes. The participatory regional reviews of Country Operational Plans, convened by PEPFAR, presented an opportunity for improving dialogue between partners (governments and civil society, multilateral partners, PEPFAR agencies), and enhancing alignment and joint impact.

### iii Mutual accountability

41. UNAIDS is among the first in the UN system to align its 2016-2021 Strategy with the Sustainable Development Goals (SDGs). Likewise, the Strategy is aligned with the cycles of UN Funds and Programmes as required by the Quadrennial Comprehensive Policy Review (QCPR). The UNAIDS Secretariat led an inclusive consultative process with global, regional and virtual dialogues on both the Strategy and the UBRAF with Member States, civil society, Cosponsors and other partners. The UBRAF remains an innovative accountability framework and an instrument to catalyze country level action against AIDS. Lessons learned from the 2012-2015 UBRAF have been considered in the development of the 2016-2021 UBRAF to ensure a clearer, simpler structure, a stronger

link between resources and results and improved reflection of regional differences and priorities.

42. The UNAIDS Secretariat undertook the following actions in 2014-2015 towards improving mutual accountability in the AIDS response:

- **Continued coordination and facilitation of the Joint Programme implementation** to maximize synergies across Cosponsors and the Secretariat at global, regional and country levels. Governance mechanisms, inter-agency bodies and key platforms were leveraged to facilitate Joint Programme delivery on the 10 global AIDS targets of the 2011 United Nations Political Declaration on HIV and AIDS and strategic positioning of AIDS in the post 2015 development agenda. In 2015, the UNAIDS Secretariat, organized four Programme Coordinating Board (PCB) and four Committee of Cosponsoring Organizations (CCO) meetings to deliver decisions that position the AIDS response and the Joint Programme in the post 2015 period;
- In 2015, a **UNAIDS evaluation policy** was drafted. The Policy sets out the concepts, purpose and intended use of evaluations; outlines guiding principles, norms and standards for evaluation and clarifies roles and responsibilities. An evaluation plan – to operationalize the policy, was also developed for 2016 – and UNAIDS will report on its implementation in 2017 (refer to Annex 1). The evaluation policy highlights partnerships with UNAIDS Cosponsors and it will become the basis for independent evaluations performed jointly with Cosponsors to assess collaborative HIV efforts.
- 2015 was declared the “International year of Evaluation” by the United Nations Evaluation Group (UNEG) and the 2016-2021 UBRAF was designed to offer a broad range of monitoring and evaluation tools allowing a more comprehensive picture and triangulation of data. In particular, there are stronger provisions for independent evaluation as well as more rigorous inclusion of external perspectives. Case studies, in-depth reviews and evaluations will be carried out systematically over the next UBRAF period and complement indicator reporting, and they will cover the entire work of the Joint Programme.
- **Two global annual performance peer reviews of the Joint Programme** were conducted in March 2014 and April 2015. The reviews considered achievements, challenges, lessons learned and key future actions of the Joint Programme in all thematic areas. This is a key internal accountability mechanism, which directly influences future actions across the Joint Programme;
- The Joint Programme Monitoring System (**JPMS**) to record and track progress on **UBRAF results was further improved** and used to collect data from country, regional and global levels on an annual basis. The data collected is analysed and presented to the Programme Coordinating Board (PCB) annually in the UNAIDS Performance Monitoring Report (PMR) and other supplementary reports. The UNAIDS Secretariat is responsible for leading the preparation of the PMR, which serves as the primary tool to assess the performance of the Joint Programme and meet the accountability requirement of stakeholders.
- Indicator-based reporting is supplemented by case studies, in-depth assessments and other reviews, including progress and achievements against 2015 HLM global AIDS targets and resources spent. The Investing for Results web portal - refined in 2015 (<https://results.unaids.org/>), complements paper-based reporting to the PCB by providing regularly updated programmatic and financial information;

### **Mutual accountability within the Joint Regional Team on AIDS in WCA (JURTA)**

Mutual accountability in the West and Central Africa region was reinforced through the implementation of UBRAF 2012–2015 and since 2012 through the annual reporting using the JPMS as the data collection tool. The JPMS has served as a catalyst in helping the UN JURTA members to become familiar with the UBRAF, the division of labour, individual and joint deliverables, and regional budget allocations. An improved knowledge of the UBRAF by Cosponsors at the regional level contributed to the identification of synergies and joint actions. Starting in 2013, JURTA's workplans were increasingly aligned with UNAIDS corporate results frameworks: thematic working groups (young and key populations, eMTCT, procurement and supply management, HIV in humanitarian settings) developed and implemented workplans directly linked with UBRAF outcomes, outputs and joint deliverables. In 2014, the Secretariat also developed tools to assist JURTA decision-making, follow-up and monitoring: the first an Excel dashboard compiling the JURTA master workplan, the regional UBRAF budget allocations and the regional coverage of JURTA member organizations in WCA countries; the second a recommendation and decision follow-up matrix reviewed at quarterly meetings.

- **UNAIDS has made a crucial contribution to the ECOSOC Dialogue process and Chief Executive Board (CEB) discussion on the longer term positioning of the UN development system and UN fit for purpose**, in the context of the post-2015 agenda. The ECOSOC Dialogue process has been mandated by member states through the 2012 QCPR, to ensure the UN development system is able to best support countries to deliver on sustainable development priorities in the post-2015 era. UNAIDS' contribution to the dialogue has included input into multiple meetings and documents as well as participation in workshops and panels. Within this process, UNAIDS' enhanced strategic coherence, coordination, results-based focus, inclusive governance and country level impact have been cited as positive examples for the UN system. UNAIDS has also been cited as a potential 'business model' for future UN system development, particularly with regard to greater participation of non-state actors in programming and governance and partnership approaches. UNAIDS has also been involved in the ongoing UN 'fit for purpose' discussions through the Chief Executive Board (CEB). Going forward, there will be an opportunity to further advance UN fit for purpose discussions and UNAIDS' positioning within this, through the UNDG ASG Advisory Group and the Working Groups under its aegis;
- **UN SWAP was institutionalized**: UN SWAP is a UN-wide accountability framework to accelerate mainstreaming of gender equality and women's empowerment in response to Economic and Social Council (ECOSOC) conclusions of 1997/2. In 2015, the UNAIDS Secretariat Gender Equality Marker was developed in line with the UN-SWAP requirements and applied to all of the 2016-2021 UBRAF workplans and budget allocations across the Secretariat. A UNAIDS Secretariat Gender Action Plan simultaneously sets out targets to monitor gender balance and enable a supportive culture for all staff in the UNAIDS Secretariat;
- **UNAIDS Secretariat Human Resource Strategy has been updated** to deliver on the UNAIDS Strategy 2016-2021 and respond to the challenges of the next five years. The updated HR Strategy is based on four pillars: inspiring collective leadership; investing in people; strengthening UNAIDS Secretariat performance culture; and ensuring an enabling workplace;
- **UNAIDS Secretariat along with the Cosponsors continue to implement IPSAS**, international best practice of accounting standards for use by public sector entities around the world. Its adoption has improved the quality and comparability of financial reporting and consequently, the governance of the Joint Programme;

- A Risk Management Committee was established and improved internal oversight of all expenditures maintained. A tool called iTrack was deployed to enhance quality assurance of contracting and an annual consolidated procurement plan was developed. Travel ceilings were introduced and regularly monitored;
  - **UNAIDS Secretariat continued to adopt innovative and cost-effective ways of working with technology.** This includes roll-out of “Cloud” and move to Google, having a single global contact system and a global service provider for country connectivity and revitalising the IT governance structure. This has been a ground breaking move for UNAIDS Secretariat and a clear example of innovation in action. The new Google system was used efficiently for the development of the 2016-2021 UBRAF and the workplanning process.
  - **An Ebola Task Force was established with cross-Secretariat participation** to monitor and take timely action to protect staff and their families in the concerned countries and to steer regional and country-level full embedment in Ebola-related developments and decision-making.
43. The global challenges the world has attempted to grapple with in 2015, from the Ebola outbreak to the migration crisis, climate change and the conflict in Syria, simultaneously underscore the necessity of an effective United Nations and existing barriers to progress. **Political and economic challenges persist in mobilizing sufficient resources for the AIDS response, including the Joint Programme.** In particular, competing priorities in major donor countries have placed downward pressure on official development assistance generally and specifically for HIV.

#### **iv Close the resource gap**

44. In 2015 global resources available for HIV are forecasted to have reached US\$ 21.7 billion, almost meeting the 2011 global target for HIV investments of US\$ 22 - 24 billion annually. Domestic resources surpassed international ones for the fifth year running. The projected investments needed to successfully Fast Track the end of the AIDS epidemic by 2030 are US\$ 26.2 billion. Dependence on international aid remains considerable among low-income countries where domestic sources (public and private) account for only 10% of resources, compared to 22% in lower-middle-income countries and 84% in upper-middle-income countries.

#### **Resource mobilization efforts in Peru**

**A total of US\$ 17.9 million raised for HIV prevention and key populations:** UNAIDS Secretariat provided technical and financial support in elaborating proposals to mobilize resources for HIV prevention and key populations.

**HIV concept note for the GFATM:** UNAIDS Secretariat participated in the steering committee of designing the proposal, national dialogues and hired two consultants to incorporate the key populations perspective in the concept note. In addition, UNAIDS Secretariat and WHO provided technical assistance to prepare the focalization strategy of the proposal (hotspots). The HIV concept note was submitted by the Country Coordinating Mechanism (CCM) in September, and approved by the Technical Review Panel in November. A total of US\$ 12.5 million has been granted by the Global Fund. The project is focused in strengthening prevention strategies (mobile teams, combination prevention) targeting transgender, MSM and indigenous populations. It will include test and treat for trans and indigenous populations.

**The first phase of a multicounty proposal** of US\$ 5.9 million for implementing a demonstrative study on combination prevention and PrEP in Peru was approved by UNITAID: UNAIDS Secretariat provided



technical assistance in preparing and negotiating the proposal with MoH. Proposal includes initially Peru, Brazil and Argentina (and Mexico and Ecuador were interested in being included in a second phase), but the project was approved for Brazil and Peru only. The MoH of Peru and MoH of Brazil lead the proposal; in the case of Peru, the project will be implemented with Cayetano Heredia University as Principal Recipient. Between December and June 2016, Brazil and Peru should prepare the detailed proposal for starting implementation afterwards.

45. The UNAIDS Secretariat and Cosponsors worked towards closing the resource gap in the following ways in 2014-2015:

- **Ending AIDS by 2030:** In 2014, UNAIDS projected the resource needs to end AIDS by 2030. The process was consultative, including consultation with experts, modellers, regional representatives and main partners, including people living with HIV and affected communities themselves, on defining global aspirational targets to end AIDS and the model to be used. Validation of global inputs by 36 countries that bear 90% of burden of disease and spending through regional consultations in East and Southern Africa (ESA), West and Central Africa (WCA), Asia Pacific (AP), Latin America (LA) and the Caribbean (CAR), as well as a series of consultations with civil society were carried out. The 2015-2030 resource needs were estimated for 116 low and middle income countries;
- In 2015, UNAIDS Secretariat additionally **produced desk-reviews of fiscal space analysis** for 28 countries which account for almost 90% of the new annual HIV infections. Similarly, fiscal space analysis and funding option studies have been conducted in SADC and East African Community countries. The World Bank, working with IMF colleagues, developed an HIV fiscal liability analysis framework and conducted financial sustainability analyses in Cote d'Ivoire, Indonesia, Kenya, Swaziland and Zambia. The World Bank developed a financial sustainability diagnostic tool for assessing sustainability of national HIV programmes and help governments develop a strategy of HIV financial sustainability, including HIV-UHC integration. The World Bank along with the UNAIDS Secretariat and the Global Fund also organized regional workshops for allocative efficiency and sustainability modelling in Eastern Europe and Central Asia and West and Central Africa. UNAIDS Asia Pacific Regional Support Team (RST) initiated the process to take stock of the investment cases processes and their impact on national HIV funding and policies in several countries, together with exploring principles of allocative efficiency, greater integration of HIV financing into Universal Health Coverage (UHC) financing schemes and smooth transitioning from donor funding to countries' self-reliance. UNAIDS RST ESA in collaboration with World Bank, the Global Fund and PEPFAR have established a regional Advisory Committee on implementation efficiencies and sustainable financing;
- The UNAIDS Secretariat and the World Bank **convene the HIV Economics Reference Group (ERG)** and its respective technical working groups. The group advised on the global resource needs estimates for ending AIDS by 2030, positioning HIV into the UHC efforts as well Global Fund sustainable financing and transitioning policy and Equal Access Initiative, allocative efficiency (AE) and programme effectiveness; and costing and technical efficiency. In the context of the ERG, the World Bank produced an inventory of HIV AE tools, which provides guidance to countries on which allocative efficiency tools to use in which context;
- Chaired by the UNAIDS Secretariat, the ERG technical working group on Sustainable HIV Financing, has **identified four domains for HIV financial sustainability:** metrics for fair share in HIV financing between countries and donors, within countries

and within donors, strategies to translate the metrics into increased domestic and international resource envelopes, integration of HIV into national health budgets and schemes as well as smooth and managed transitions from donor financing to domestic financing for HIV. The group has looked at opportunities and limitations of integrating HIV into domestic financing schemes, overviewed experiences of donor-country arrangements for smooth transition to domestic financing and identified criteria for country donor compacts. A Task Force on Resource Tracking for HIV has been established and several agreements have been reached for standardization of classification and methodologies between different tools;

- **Evidence, strategic information, guidance and tools informing country and donor agendas have been produced and distributed by the Secretariat and the World Bank.** AIDS financing and economic analyses have been at the centre of several UNAIDS flagship reports – including the MDG 6 How AIDS changed everything report, the resource needs estimates (2014 update), the fiscal space analysis and funding options for 28 fast track countries. UNAIDS has studied the relationship between critical enablers and ART coverage/AIDS mortality to determine their impact in the HIV epidemics. A 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 Assessments, which will connect resource tracking with performance and outcomes of interventions also allowing the monitoring of the efficiencies of the response.

46. Despite the increase in domestic investments for HIV, **a resource gap remains to meet the goal of ending AIDS by 2030**, although this gap should diminish with the implementation of the Fast Track strategy. AIDS funding dependency continues to be high especially in low- and lower-middle-income countries, where approximately 46 out of 128 countries depend on international contributions for more than 75% of their responses.

47. **The flattening and potential decline of HIV external funding beyond 2015** is one of the most important challenges to closing the resource gap. This challenge concerns not only low-income countries, historically dependent on foreign aid, but also an increasing number of countries recently transitioning into a higher income bracket and now classified middle- and upper middle-income countries in the Eastern Europe and Central Asia region, Latin America and the Caribbean. These countries face challenging environments that threaten the feasibility of completely financing the HIV response with domestic public resources after the Global Fund and other bilateral and multilateral projects concluded in 2015, hence threatening the sustainability of the AIDS response and the achievements made to date. Often, **lack of adequate HIV resources is heightened by inefficiencies at different levels**. Even while the global target of mobilizing between US\$ 22-24 Billion by 2015 was nearly met, resources are not always allocated in the most efficient manner. Prevention services for key populations continue to show a chronic and deep underfinancing, thus leaving these populations behind and delaying progress in averting HIV infections and AIDS related deaths. Despite access to the voluntary procurement services for all Global Fund grantees, a number of countries in Africa, Latin America and the Caribbean and Eastern Europe **pay above the norm prices for antiretroviral drugs and HIV diagnostic tests**, due mostly to inappropriate forecasting, inefficient tendering procedures, trade agreements or small regional markets.

#### v. Strengthen HIV integration

48. The AIDS response has strengthened health systems and made substantial gains towards integrating HIV and broader health services, as well as non-health programmes. More than 90% of countries reporting to UNAIDS at the end of 2014 stated that HIV had been mainstreamed into broader development frameworks, while 70% reported being on track to achieve national integration commitments. While strides have been made in eliminating parallel systems, countries are however at different stages with HIV integration. The greatest level of integration of services provided at facility level has been reported between: HIV counselling and testing and sexual reproductive health services (SRH); HIV counselling and testing and tuberculosis; ART and tuberculosis; and prevention of mother to child transmission (PMTCT) and keeping mothers alive, with antenatal care and maternal and child health - with 82% of reporting countries indicating that many facilities are providing integrated PMTCT and antenatal care/maternal and child health services. Limited integration of services at the facility level is however reported between HIV services and chronic non-communicable diseases (NCDs).

#### **HIV integration in the Latin America region**

Countries in the Latin America region have endorsed a regional plan of action proposed by WHO for the prevention and control of viral hepatitis 2016–2021, including integration with established HIV interventions. In particular, action will be undertaken to include hepatitis B virus (HBV) as a candidate for eliminating mother-to-child transmission, together with HIV and congenital syphilis. Also, coinfection with either HBV or hepatitis C is increasingly used as a criterion for priority access to treatment programmes.

Integration of HIV and tuberculosis (TB) services continues to progress, especially the systematic offer of HIV testing services to TB patients (up to 74% in 2014) and provision of antiretroviral therapy among new TB/HIV cases (63% in 2014). Reporting of TB screening among people living with HIV continues to be problematic. It has been reported for 56 856 people living with HIV in clinical care, while provision of isoniazid preventive therapy occurred in 28 556, confirming a rising trend over recent years, although representing a modest coverage in absolute terms. On the other hand, provision of cotrimoxazole preventive therapy covered 52% of TB/HIV coinfections, according to WHO's *Global TB report 2015*.

The priority implementation of the dual elimination initiative for mother-to-child transmission of HIV and syphilis has positioned HIV services firmly within antenatal care, maternal, newborn and child health (MNCH), sexual and reproductive health and family planning packages. It has also generated an opportunity to improve antenatal care and MNCH, specific components of health information systems. As a consequence of the high-level advocacy, supported by the accurate documentation of progress and achievements, the Latin America region recognizes effective HIV services as a marker of quality for MNCH care, a critical step towards their integration and sustainability.

49. The Joint Programme actively promoted and supported integration efforts in line with the Division of Labour. In 2014-2015, at the global level, efforts focused on advocacy on the benefits of an integrated approach to achieve the MDGs; on increasing awareness of the breadth and depth of integration; supporting efforts leading to better tracking and monitoring of achievements at country level; as well as 'taking AIDS out of isolation' and connecting HIV to the broader post-2015 development agenda. Salient examples of efforts undertaken at the global level include:
- The IATT on the Prevention and Treatment of HIV Infection in pregnant women, mothers and children **supported, monitored and tracked country-led implementation of the Global Plan** to eliminate HIV among children by 2015 and keep mothers alive. By the end of 2015, new paediatric infections were halved in the countries with 90% of global new HIV infections in children. An estimated 85

countries were also within reach of elimination, with fewer than 50 new infections among children each year;

- The Interagency Working Group on sexual reproductive health and rights (SRHR) and HIV Linkages **developed the SRHR and HIV Linkages Compendium: Indicators and related assessment tools**, as well as a country level index of indicators for measuring progress in HIV and SRHR, which was applied in 60 countries;
- **Health sector strengthening, with a focus on human resources (HR) for health**, was developed via global guidance on promising HR practices, produced through the IATT. Efforts were also made to harmonize Frontline and Community Health Workers (CHW) through the development of the CHW Framework for Partner Action. Countries that evolved CHW programmes include Ethiopia, Kenya and Uganda;
- The UN Interagency Task Force (UNIATF) on the prevention and control of NCDs **promoted better linkages between HIV and NCDs services**, as reflected in the UN Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs. UNAIDS offices in Mozambique and Sri Lanka have participated in the UNIATF joint missions to support governments and UN Country Teams (UNCTs) scale up their response to NCDs in the past year;
- **Accelerated and intensified support was provided to countries in the development of investment cases** that make the case for strategic investments, enhance the efficiency and effectiveness of service delivery and sustainable financing. Integration of HIV services with other health services was a key strategy that countries have utilized in their investment cases to scale up HIV and other health services.

50. According to reports submitted by countries that conducted reviews, there are numerous challenges, constraints and lessons learnt in the integration process, including **the need for diverse approaches for different contexts, upfront investments in health systems strengthening, workforce training and quality assurance**.

#### **vi. Support multisectoral national AIDS plans**

51. To support countries to develop better strategic plans and implement them more efficiently, the UNAIDS Secretariat and Cosponsors achieved the following results in 2014-2015:

- **New generation guidance and analytical tools:** Working with UN partners, the Global Fund and United States Government, the World Bank used several tools, including the Optima HIV analysis and optimization tool, to support HIV allocative efficiency (AE), epidemic scenario and financial commitment analyses. More than 15 AE analyses were implemented or initiated in all six regions. These studies led to improved national strategies focusing on high-impact programmes to minimize new infections and deaths. For example, in Sudan where the AE study led to almost doubling HIV resource allocations, including treatment, to high priority programmes for key populations. The UNAIDS Secretariat, the World Bank, UNDP and the Global Fund also convened a regional consultation to advocate for an investment approach in the EECA region. Seven countries in the region developed HIV investment cases and a strong partnership between the World Bank, UNDP, WHO and the Global Fund was established to provide financial and technical support to the countries in this process. Through the global HIV Economics Reference Group, the World Bank

produced an inventory of HIV AE tools, which provides guidance to countries on which allocative efficiency tools to use in which context.

#### **Joint Programme's support for the multisectoral nature of national AIDS plans**

The Joint Programme supported the multisectoral nature of national AIDS plans by providing expertise, guidance and advocacy across the broad sectoral competencies they each represent, bringing a much needed focus in AIDS planning on issues such as gender, education, drugs and humanitarian challenges.

For example, by financing and supporting programs that focus on the multisectoral determinants of health, such as HIV/AIDS and education, transport, gender, and social protection, the World Bank helps reduce poverty and promote equity. Many of its development projects in the Latin America region (LA) have HIV components. For instance, in Central America, education project in Nicaragua and Honduras include improving student's knowledge of and how to prevent HIV, and social protection programs in Mexico and Dominican Republic include people living with or at risk for HIV. Moreover, the World Bank is supporting studies in Bolivia and Belize to investigate the levels of homophobia in these countries that impact supply and demand sides of service delivery for key populations. Such studies addressing social factors that affect effective HIV responses contribute to the World Bank's overall support for multisectoral national AIDS responses and plans.

Finally, the Joint Programme will continue its efforts to improve the multisectoral nature of national AIDS plans with focus on the sustainability of the response. Investment case studies are being developed or planned in multiple countries, and the Joint Programme is working to improve the evidence, tools and technical support available for governments.

- **Technical support for more effective HIV strategic planning:** The World Bank supported countries to better integrate HIV financing requirements into Universal Health Coverage schemes and provided actuarial support to realize this integration. The World Bank also supported efforts to improve the efficiency of HIV programmes in Ukraine, Kenya, Lesotho and Zambia. The efficiency analyses led to identification of areas where countries could deliver the same programmes for lower costs, for example in Ukraine where the analyses showed up to 30% lower cost. The World Bank, working with IMF colleagues, also developed an HIV fiscal liability analysis framework and conducted financial sustainability analyses in Swaziland, Zambia, Kenya, Cote d'Ivoire and Indonesia. WB has developed a financial sustainability diagnostic tool for assessing sustainability of national HIV programmes and helped governments develop a strategy of HIV financial sustainability, including HIV-UHC integration. The UNAIDS Gender Assessment Tool was also implemented in 40 countries, providing strategic information to help develop and/or review NSPs and Global Fund concept notes. UN Women's Advocacy Kit "Championing Gender Equality in the HIV Response" documents strategies for integrating gender equality into policies. UN Women and other co-sponsors supported integration of gender equality into NSPs in 30 countries and in 13 Global Fund concept notes. The UNAIDS Secretariat and UNDP worked closely with the League of Arab States and Saudi Arabia and other Member States to provide political and technical support to develop the Arab AIDS Strategy. A series of consultations, workshops and technical validation meetings were organized and high level advocacy was conducted at regional and global level for the endorsement of the Arab AIDS Strategy by the Council of Arab Ministers of Health which took place in March 2014. UNAIDS Secretariat and WHO also supported 10 countries in MENA to update their NSPs and align them with Fast Track targets and the Arab AIDS strategy. Finally, the UNAIDS Secretariat provides technical support through the Technical Support Facilities to countries for investment analysis and strategic planning;

- **Better data for better HIV strategic planning results:** UNDP and WHO supported 20 countries on strengthening and integrating national policies and programmes addressing HIV, GBV and harmful use of alcohol. Subsequent country-level results include research, policy reform and multisectoral coordination. UN Women commissioned a Global Review of Women's Access to HIV Treatment, Care and Support to identify gender-related and structural barriers that could inhibit women's access. The findings revealed persistent gender-related barriers in women's treatment access and adherence across their lifecycle, as well as gaps in sex-disaggregated data collection. More investment is needed to document women's experiences of treatment availability and their decision-making around uptake, as well as how treatment programmes are impacting women and girls living with HIV. The UNAIDS Secretariat supported a number of countries in the development of sub-national estimates. More granular knowledge of the epidemic allows countries a more strategic approach to allocate resources for maximum impact. The World Bank supported multiple multisectoral national AIDS plans and responses. It initiated a regional TB/HIV in the Mines Initiative in the Southern African mining sector and activities have been undertaken in Zimbabwe to develop tools and gather data to support HIV and SRH service integration. Knowledge products were also developed highlighting the success of Kenya and Namibia in implementing a multisectoral HIV response. In South Sudan, UNESCO ensured that the recently developed national HIV strategy stipulates the role of the education sector to deliver comprehensive sexuality education (CSE) and educate about prevention and care, which led to planned development of an education sector strategy on CSE.

52. **Translating strategies into full scale implementation at the desired coverage levels** is the biggest challenge facing this area of work. **Funding re-allocations also remain a challenge.** Longer term technical support is needed to help countries realize, on the ground, the HIV programme funding reallocations that are needed for maximum impact. **Dependency on external funding** and the transition to domestic financing mechanisms is especially challenging.

## IV. CROSS-CUTTING THEMES

### *i Address HIV in humanitarian emergencies*

53. In 2014-2015 more people than ever before were affected by humanitarian emergencies around the world. In 2013, when figures were last published, 314 million people were affected by emergencies, of which 67 million people were displaced by natural disasters and conflicts. Of these, 1.7 million were people living with HIV of whom, almost 1.4 million people (82%) were in Sub-Saharan Africa. Many were displaced, lacking access to essential HIV services and suffering as a result of shortages that could have been avoided. Migration and displacement are major issues affecting people's health, including reducing their access to HIV prevention, treatment, care and support services. In 2011, the Security Council adopted the Resolution 1983, which broadened the HIV and AIDS agenda in peacekeeping operations to address violence in conflict and post-conflict situations and drew the attention to the vulnerability of women and girls. The factors that determine HIV transmission during humanitarian emergencies are complex: existing gender inequalities may be further exacerbated, sexual gender-based violence and sexual exploitation may increase, and essential health services can be disrupted during crises. The Secretary-General's Global Study on progress in implementing Resolution 1325 underscored that gender inequality, exacerbated by conflict, contributes to increased risk of HIV among women and girls: that they have less access to prevention information; face greater barriers to negotiate safer sex due to unequal power dynamics; and represent the overwhelming majority of survivors of sexual gender-based violence (SGBV), requiring greater intervention and care. Work carried out in 2014-2015 by the UNAIDS Secretariat and Cosponsors to address HIV in humanitarian emergencies included:

- UNHCR and the WFP **continued co-convening the IATT on addressing HIV in Emergencies** in 2014-2015, working on advocacy briefs to integrate HIV in the clusters and conducting face-to-face meetings in January 2014 in Rome and January 2015 in Geneva;
- **Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis affected Persons in sub-Saharan Africa** were developed by UNHCR, in partnership with 14 agencies and published in 2014;
- UNHCR additionally worked with WHO, WFP, UNICEF and the UNAIDS Secretariat to **develop a guidance brief on the need for continuity of a minimum HIV programme in the context of Ebola**;
- During 2015, UNICEF, UNHCR and Save the Children finalized **guidance on prevention of mother to child transmission (PMTCT) in humanitarian settings**. The document includes two parts: (1) review of lessons learned; (2) guidance note of key considerations for integrating PMTCT in emergencies.
- **A Thematic Segment on HIV in Emergencies was held during the 36th UNAIDS Programme Coordinating Board (PCB)**. This event was successful in boosting the visibility of HIV in emergencies and communicating the risks associated with neglecting this issue in funding and programming decisions. Decision points as a result of the segment were adopted during the 37th PCB;
- WFP, UNHCR and PCB NGO's **ensured the importance of access to HIV services for populations affected by emergencies**, strategic information, funding, food and

nutrition, SGBV, preparedness, logistics, Health Travel Cards, cross-border activities and key populations were included;

- During 2015 UNHCR **provided updated data on the inclusion of refugees/migrants** for National Strategic Plans and Global Fund (GF) grants.
- To inform the operationalization of the Global Fund's Emergency Fund, UNHCR, WFP, UNICEF, the UNAIDS Secretariat, UNDP and IOM **contributed to 10 country-specific case studies highlighting the impact of emergencies on service continuity**;
- With support from UN Women, in Central African Republic and South Sudan, a **SGBV prevention and response programme was implemented in refugee camps** to increase the capacity of health care workers to provide support to survivors and prevent HIV transmission. UN Women also worked to strengthen capacity of South Sudan's security sector on SGBV and HIV. In Mali, more than 5500 security sector personnel received support to improve awareness on gender equality and women's empowerment during conflict, including on SGBV/HIV;
- WFP and the Global Fund **signed an MoU to use WFP's logistics capabilities** to deliver commodities during emergencies, while WFP and PFSCM (Global Fund's supply-chain partner) concluded a Global Framework Agreement for the provision of bilateral services. WFP also continues to provide last-mile delivery services to UNFPA and concluded a Framework Agreement for the provision of bilateral logistics services;
- In West and Central Africa, the Joint UN Regional Team on AIDS successfully **advocated for the inclusion of HIV activities in the Sahel regional strategy** across Inter Agency Working Groups (IAWGs);
- UNHCR and UNFPA provided **technical support for responses to the European refugee crisis**, while UNFPA, UNHCR and Women's Refugee Commission carried out assessments on health and protection of refugee women and girls, including assessing HIV risk.

#### **HIV response amid conflict in Ukraine**

Ukraine is experiencing instability and insecurity. The HIV response in 2014–2015 and partners' support were challenged by internal and external political, economic and social factors, aggravated by the armed conflict in the east of the country particularly in Crimea. This is the territory mostly affected by HIV and tuberculosis (TB), with 25% of all registered people living with HIV (33 000), 25% of people living with HIV on treatment (13 000) and the biggest population of people who inject drugs (45 000) in the Donetsk and Lugansk regions. As a result of the conflict, in these regions 40% of the dispensary HIV group and 40% of those people living with HIV on treatment remain in non-government controlled areas. HIV testing decreased by 30% in the non-controlled areas, and the opioid substitution therapy programme there and in Crimea was suspended, affecting 1600 clients in total.

Despite the volatile situation, UNAIDS remained committed to the Joint UN Programme of Support (JPS) and humanitarian assistance, advocating for proper positioning of HIV, human rights and protection of key populations in the changing national agenda. JPS funding increased from a planned US\$ 1.87 million to US\$ 5.71 million, including humanitarian fundraising. The Joint Team has been involved in shaping new national development priorities in public health and mobilizing donor support, as well as helping the country meet the political, humanitarian and emergency challenges.

Mitigating the risk of interrupted antiretroviral therapy (ART) and scaling it up to national targets remained a



priority for the Joint Team. Global Fund grant savings were reprogrammed to meet the challenge of ART interruption due to national procurement failures, and a 300% devaluation of the national currency. The UN facilitated dialogue between national partners and donors, including the Global Fund, the United States Government, Netherlands, France and Germany, on providing HIV prevention, opioid substitution therapy, ART and TB services in the conflict zones. PEPFAR funding was mobilized to cover the gap in the national ART scale-up targets. As a UN assistance response to stagnating drug procurement, a memorandum of understanding was signed with the Government for temporary measures via international organizations; UNDP for TB drugs and HIV commodities, and UNICEF for antiretroviral drugs. In order to arrange this, 19 normative acts were changed by the Government with Joint Team expert support.

54. However, challenges remain. **HIV is not typically seen as a priority in humanitarian contexts**, especially in areas where prevalence is low. Yet, stock-outs remain a challenge in humanitarian settings. **Greater efforts are needed to prevent SGBV** and promote integrated services for girls and women survivors of SGBV, including those living with HIV, in the context of conflict and post-conflict. This includes a need for strengthened partnerships between the security sector, the Ministries of Gender Equality and the Ministries of Justice. Enhanced capacity on strategic planning and longer-term advocacy of networks of women living with HIV needs to be strengthened. Existing **monitoring systems and sex- and age-disaggregated data on addressing HIV in emergencies is limited**. In addition, inclusion of HIV related data is not consistent in rapid assessments; for instance, data on patients requiring continuation of ART in the immediate aftermath of an emergency is not easily available. **There is often weak capacity in countries with fragile health systems** to be able to respond to emergencies. This compounds the problem and makes it harder to respond.

**ii Integrate food and nutrition within the HIV response**

55. In 2014-2015, actions undertaken by the UNAIDS Secretariat and Cosponsors towards integrating food and nutrition within the HIV response included the following:
- **Global advocacy:** In 2015, WFP, as the lead of the Inter Agency Task Team (IATT) on Food and Nutrition (F&N), held meetings to define goals for 2016 in three areas: 1) El Niño; 2) linkages between non-communicable diseases and food and nutrition; and 3) maternal and child health and nutrition and HIV. WFP, through the IATT on F&N, also created a Sub-Working Group on South Africa and hosted a stakeholder meeting at the University of Western Cape, where members of the government, academic and UN communities shared insights from integrating nutrition and HIV in South Africa. WFP in collaboration with UNAIDS Secretariat and PEPFAR organised a consultation on the Role of Food and Nutrition in the HIV response at the UNAIDS Secretariat. The consultation shared emerging evidence on HIV Food and Nutrition and provide inputs in the goals and targets of the new UNAIDS Strategy. WFP additionally worked with the UNAIDS Secretariat, an NGO delegation, 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 in the 35th PCB Decisions points on the thematic sessions on Addressing the social structural drivers of HIV through social protection. WFP also contributed to the inclusion of food and nutrition issues in the decision points for the PCB thematic on HIV in Emergencies at the 37<sup>th</sup> PCB. Additionally, WFP and other UN agencies developed an advocacy and guidance brief on the need to maintain a minimum HIV programme during Ebola outbreaks.
  - **Strengthening the evidence base:** WFP coordinated the publication of eight peer-reviewed papers on food security and the role of food and nutrition in adherence to

care in an AIDS and Behaviour supplement. WFP also coordinated the publication of a chapter on Nutrition, Food Security, Social Protection and health systems strengthening for HIV programming in a book called 'Food insecurity and public health';

- **Implementing effective programmes:** In 2015, WFP operated HIV-specific interventions in 17 High Impact Countries and supported governments in sustainably addressing the F&N needs of PLHIV and TB patients in 21. WFP, WHO, and the UNAIDS Secretariat, in collaboration with PEPFAR, finalized and published a food and nutrition programming guide on Nutrition Assessment, Counselling and Support (NACS) for adolescents and adults living with HIV (in English and French). WHO additionally released guidelines for nutritional care and support for patients with Tuberculosis and incorporated nutrition assessment and counselling in the 2015 update of the ARV guidelines. UNESCO supported the launch of the Focusing Resources on School Health M&E toolkit – with a focus on HIV, school health and nutrition – which was shared with Ministries of Education (MoEs) throughout the EECA region and is expected to help schools and other educational institutions to standardize health programmes;

#### Food provision for PMTCT clients

In Ethiopia, providing food for prevention of mother-to child transmission (PMTCT) clients significantly increased the number giving birth at health facilities. Of exposed infants born to PMTCT clients on food assistance, 99.1% were reported to be HIV-free. In 2015, end of year outcome data also indicated that among PMTCT clients provided with food assistance, 100% of babies were born at health facilities, 94% had a birth weight greater than 2.5kg and 95.5% of mothers regularly attended their PMTCT clinic appointment. Ethiopia also continued to implement an economic strengthening programme to improve livelihoods for people living with HIV, and HIV-sensitive social transfers for orphans and vulnerable children.

- **Building partnerships:** WFP has collaborated with DSM, Wageningen University and University of Pretoria in the development of a drinkable, fermented maize-based product for treatment of malnutrition among adults, in particular HIV/TB patients. Pre-sensory and sensory testing was conducted in 2014-2015. Future steps include research on satiety and acceptability. WFP, the UNAIDS Secretariat and the Global Fund participated in joint missions in 2014 and 2015, providing technical assistance in integrating food and nutrition into HIV/TB NSPs, protocols and/or Global Fund grants in several countries. For example, WFP provided an urgent airlift of HIV medicines on behalf of the Global Fund to prevent a critical stock out. UNESCO supported the development of school health policies in Zimbabwe, Zambia, Swaziland and Malawi, commissioning a consultancy to assist MoEs and other stakeholders to embed HIV education within the school health and nutrition policy and programming framework. The “Nourishing Bodies, Nourishing Minds” partnership between WFP, UNICEF, UNESCO and partners in the private sector continued for improved, integrated access to health care, nutrition and education for underserved children. The three-year pilot phase focused on four countries with high levels of malnutrition and low levels of schooling – Haiti, Mozambique, Niger and Pakistan – countries which also shoulder a significant HIV burden. The UNICEF, UNFPA and WFP partnership delivers food and nutrition interventions and SRH education side-by-side to improve nutrition and health outcomes (including HIV/AIDS) for adolescent girls. In 2015, WFP formalized a partnership with the South African non-governmental organization Kheth’Impilo on enhancing the knowledge base for community-based approaches to improving HIV treatment and health outcomes. Through its partnership

with North Star Alliance, WFP provided services along transport corridors at 30 road wellness centres in 12 countries that account for many new HIV infections.

- **Capacity development:** successes included a nutrition and HIV capacity building course for WFP Senior Managers, jointly developed with the Institute for Development Studies in 2014 as well as joint course with NYU in 2015 on the system approach to health, food security and nutrition for heads of programmes to build the capacity of WFP's staff and share the latest developments in nutrition and HIV. WFP, WHO, the UNAIDS Secretariat, PEPFAR, and the Global Fund are updating the WFP/PEPFAR joint toolkit (2009) assisting countries to integrate food and nutrition support in Global Fund proposals with a draft document ("Thinking Strategically about Nutrition") to guide nutrition investments in the context of HIV/TB. WFP continues to support governments in strengthening their social protection mechanisms and making them more HIV-sensitive.

56. Constraints and challenges in this area have continued to affect progress. An ongoing challenge for the integration of food and nutrition in the HIV response remains **the lack of attention at global and country level** to sustaining treatment success through improved adherence to ART treatment and retention in care. This impacted the ability to ensure adequate funds for food and nutrition activities within HIV/TB-specific funding mechanisms that prioritise provision of treatment. As a result, many countries faced resource shortfalls for food and nutrition interventions, forcing temporary discontinuation of this vital adherence support.

### **iii Scale up HIV workplace policies and programmes**

57. The Joint Programmes' work in the area of scaling up HIV workplace policies and programmes in 2014-2015 has included:

- **The VCT@WORK Initiative:** Launched in June 2013 by the ILO Director General and UNAIDS Executive Director and implemented throughout 2014 and 2015, the VCT@WORK Initiative was focussed on 36 countries, in collaboration with Ministries of Labour, Employers' organizations, Workers' organizations, the UNAIDS Secretariat, WHO, UNESCO, UNICEF, UNDP, the membership of the IATT on Workplace Programmes, networks of people living with HIV, CSOs and over 200 country partners. The VCT@WORK initiative was launched to concretely contribute to closing the treatment gap by generating demand for HIV testing among vulnerable workers and linking those who test positive to treatment and care services. To facilitate a rights-based approach to HIV testing, the ILO, in collaboration with GNP+ and the membership of the IATT, developed an operational guide to promote human rights principles during the implementation of the VCT@WORK Initiative. Over 2014-2015, approximately 4.3 million workers (1 971 645 men, 1 092 884 women and 31 190 others) were reached and 2.5 million (1 532 859 men, 843 791 women and 24 020 others) from different sectors were mobilized to test for HIV. A total of 66 715 tested positive (39 268 men, 19 872 women and 594 others) and referrals to treatment and care services were reported for 65 156 workers (38 761 men, 19 345 women and 594 others);
- **Laws and policies:** In Ukraine, the UNDP and ILO supported the amendment of the Labour Code of Ukraine through tailored advocacy. In November 2015, the Ukrainian Parliament adopted the amended labour code, which states that it is forbidden for "any discrimination in the workplace, including violation of the principle of equal rights and opportunities, both direct and indirect restrictions of workers' rights based on race, colour, political, religious and other beliefs, sex, gender identity, sexual

orientation, ethnic, social and foreign origin, age, health, disability, **HIV and AIDS**, family and property status, family responsibilities, and location". In policy development, ILO supported Jordan, Lebanon and Syria to have the National Policy on HIV/AIDS and World of work integrated in their National HIV/AIDS strategic plan. In East and Southern Africa, the ILO, the UNAIDS Secretariat, SADC and IOM, provided support to draft the SADC code of conduct for TB in the mining sector. The code has been approved by the SADC Council of Ministers and signed by the Heads of State. The code of conduct, which addresses the need of Mining workers, is aligned with the ILO Recommendation on HIV/AIDS (No. 200) and other ILO Conventions;

- **Programmes:** In 2014, the Regional Office of UNFPA for Eastern Europe and Central Asia launched a regional initiative "Silk Road: HIV/STI prevention and safe behaviour among truck drivers as clients of sex workers", in collaboration with ILO. The programme creates a less risky environment for sex workers while strengthening access to services and commodities for long distance truckers;
- **Generating Evidence:** To generate evidence on what works in HIV and AIDS workplace programmes, the ILO in partnership with Human Sciences Research Council (HSRC), the HIV/AIDS, STIs and TB Research Programme (HAST), the Research Programme and the Social Aspects of HIV/AIDS Research Alliance (SAHARA) network from South Africa, National AIDS Commissions, Business coalitions, Employees of employer Organizations, Workers organizations, Organizations of people living with HIV, NGOs, GIZ, the Swedish Workplace HIV and AIDS Programme (SWHAP), UNAIDS Secretariat and UNDP, conducted a 10-country comprehensive study focussing on 66 workplaces in the public and private sectors as well as the formal and informal economy, to investigate what works in achieving good outcomes in HIV and AIDS workplace programmes. The findings have been extensively disseminated to country stakeholders and is informing the implementation of HIV workplace programmes targeted at vulnerable mobile and migrant workers in 15 countries;
- **Capacity Building:** To strengthen the capacity of national HIV workplace experts, the ILO in partnership with the UNAIDS Secretariat, UNICEF, WFP, WHO, GBC Health, GNP+ and others, trained 109 senior National HIV Workplace and Social Protection Specialists from 53 countries between 2013 and 2015, through the integrated multidisciplinary course titled "HIV and AIDS and the World of Work: a prevention and social protection perspective" at the International Training Centre in Turin. An independent impact assessment of the course (among beneficiaries) concluded that: 57% respondents said the training course led to the development of HIV workplace policies at national/sectoral levels; and 65% respondents said that the training helped them to mainstream other chronic illnesses, such as TB, into their HIV policy and/or programmes, among others. In Thailand, UNESCO, ILO and Youth LEAD supported the Thailand Service Workers Group (SWING) to develop an English as a Second Language syllabus for male and transgender sex workers, with the objective of improving financial, health and safety outcomes. The course has reached over 300 people, enabling them to better negotiate with their clients for safer health outcomes.

### **Building capacity of unions and private sector to implement HIV workplace policies in the Caribbean**

In the Caribbean region, the ILO supported ministries of labour, workers' unions and the private sector to implement HIV workplace policies. In Trinidad and Tobago, jointly with the Minister of Labour, the ILO provided technical training to government and civil society staff to promote and develop programmes from a wellness approach, including HIV testing and treatment, prevention of HIV and noncommunicable diseases (NCDs) and drugs and tobacco, healthy nutrition, stress and stopping violence at work. As a result, the Ministry of Labour, with the support of the Ministry of Health and organizations from civil society, provided guidance for 20 workplaces from the public and private sector on developing HIV and wellness programmes. These reached 423 workers with sensitization and information sessions on HIV and noncommunicable diseases; at the same time, HIV and NCD testing services were provided to 779 workers. Additionally, in Haiti, the ILO supported the manufacturing sector to develop and adopt an HIV workplace policy. As a result, more than 7500 workers will receive HIV prevention and care services.

Besides training and promoting activities, the ILO provided technical support to workers' unions in Dominican Republic on integrating HIV-related clauses in workplace collective agreements. Two enterprises concluded negotiations of new agreements by including such clauses and more are expected to follow suit when agreements are renegotiated.

58. One major challenge is **how to exponentially increase the number of women and men workers voluntarily undertaking VCT** within the context of their workplaces while addressing their concerns about confidentiality. Lessons from the VCT@WORK Initiative show that strong management commitment and support to HIV programmes, confidentiality and job security make it easier for workers to test in the workplace. Another key challenge is about **“normalising” HIV testing**. HIV testing will exponentially increase if workers have total control of when and where to take the test. If workers can purchase self-testing kits and test at their own convenience, this will contribute towards significantly increasing the proportion of workers who know their HIV status. This approach will help make HIV testing more routine and less stigmatized. **The low perception of risk to HIV in many countries with concentrated epidemics** makes many workers feel they don't need to take an HIV test. **Limited funding** for scaling up the VCT@WORK Initiative is also a major challenge.

#### **iv Ensure high-quality education for a more effective HIV response**

59. Achievements by the UNAIDS Secretariat and Cosponsors towards ensuring high quality education for a more effective HIV response in 2014-2015 have included:
- **A global review of comprehensive sexuality education (CSE)** was produced by UNESCO and UNFPA examining the evidence-base for CSE and its positive impact on sexual reproductive health outcomes, including reduced rates of HIV, STIs and unintended pregnancy. 31 African countries were **supported to integrate core HIV indicators** in their “Education Management Information Systems” through three workshops led by UNESCO in 2015. Each country drew a roadmap for integration of the indicators in the Annual School Census and School-Based Survey;
  - UNESCO, UNFPA and UNICEF **supported a CSE assessment in Bhutan, China and Thailand** and data collected from over 15 000 students, teachers and principals will be used for curriculum revision. UNESCO additionally supported the analysis and dissemination of an evaluation on implementation of the 2008 Mexico Declaration “Prevention through Health”, and produced a Spanish-language publication on concepts, approaches and competencies in CSE. In Ukraine, over 2 million students (grades 1-7) benefitted from updated “Basics of Health” textbooks which were revised

through UNESCO support to provide comprehensive information on SRH and life skills;

- **The Joint Programme also sought to enhance the quality of CSE through teacher training.** In the context of the ESA Commitment on CSE and SRH services for young people, over 80 000 in-service and 67 000 pre-service teachers have been trained. In Zambia alone, a new CSE programme targeting 1 750 000 young people has benefitted over 12 000 teachers. An estimated 85 000 young people in Burundi, Cameroon, Chad, Congo, Gabon and DRC received improved CSE through UNESCO ICT-based teacher training and ICT-based teacher training reached over 26 000 educators in EECA;
- **Efforts have focused on using media and ICTs for the provision of youth-friendly CSE** and SRH information. More than 100 000 young people benefited from the first comprehensive website for adolescents on SRH in the EECA region (teenslive.info) through support from UNESCO. Available in Russian, Ukrainian and Romanian, it is visited daily by 150 people. Through the Shuga partnership, UNICEF, PEPFAR, MTV and UNAIDS Cosponsors supported the provision of CSE information to over four million young people through TV and radio programmes in Tanzania, Kenya, DRC, Lesotho, South Africa and Cameroon;
- **The Joint Programme is also leading efforts to address homophobic and transphobic violence and bullying in schools.** In 2014, UNESCO organized a LAC regional consultation on homophobic and transphobic bullying in schools with participants from 11 countries, and has since developed a regional report “Towards Inclusion and Safety in Schools in Latin America”; In Cambodia, the ILO and UNESCO partnered to roll out income generation tools with the Ministry of Education, Youth and Sports for programmes to reach young key populations in- and out-of-school. UNESCO and UNDP supported the first-ever Asia-Pacific regional review of SOGI-related school bullying and violence.

#### **Quality education for an effective HIV response in the Middle East**

As part of its regional programme on Health and HIV Education and in its efforts to promote quality education for girls and boys in safe learning environments, UNESCO Beirut launched in November 2014 a regional study on School-Related Gender-Based Violence (SRGBV) in the Arab region, with a focus on SRGBV in school and teacher policies, as well as teacher education and training. The study aimed to enhance knowledge on SRGBV in general, and in the Arab region in particular, and to make policy and capacity building recommendations, specifically with respect to school and teacher policies, teacher codes of conduct, and their role in the response to SRGBV.

Moreover, UNFPA Lebanon collaborated closely with the Faculty of Educational Sciences at University Saint Joseph and the French Cultural Institute to promote reproductive health education, including HIV/AIDS, in francophone schools. A seminar and 5 training workshops were carried out at the Faculty in a four-day course in which more than 110 teachers from Egypt, Jordan, Lebanon and Oman participated. This included a panel discussion on comprehensive sexuality education, as well as guidance on how to develop and evaluate RH education projects including on HIV/AIDS, life skills and participatory education methods.

- The World Bank **supported more than 70 programmes across regions to increase retention in and quality of secondary education**, such as the Quality Improvement programme targeting girls in Afghanistan. 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 and support healthy lifestyles;

- **WFP's school feeding platform was used to provide SRH education**, since educated young people, especially girls, enjoy better health and can make more informed choices for themselves and on behalf of their families and future children. WFP-supported school feedings drove attendance in a number of countries, including Republic of Congo, Ghana, Ethiopia, Lesotho, Myanmar, Swaziland and Zambia. 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.
60. The SDGs have brought an enhanced awareness of the importance of the education sector (SDG4), and its linkages to all the other SDGs, notably SDG3 on health. Yet **scarce resources**, both human and financial, mean that many school health needs will go unmet. Moreover, **where resources do exist they tend to be focussed on meeting basic knowledge-level targets** often leaving little to build the capacity of educators to foster the skills of learners on the range of issues concerning HIV and sexuality education. **Some teachers may lack the skills for their own health in the first place**. While many resources have been devoted to teacher training in the past 15 years, these have often been piecemeal and disconnected from a wider supportive policy and administrative environment. This means that **efforts are not sustained**. Further, the **high degree of attrition in the profession** means that teacher training initiatives cannot be stand-alone; they must be a recurring priority.

#### **v Men who have sex with men, Sex Workers and Transgender Populations**

61. Transgender women are among the populations most affected by HIV, being 49 times more likely to acquire HIV than other adults of reproductive age, while the impact of HIV on transgender men is yet to be established. Globally, gay men and men who have sex with men (MSM) are 19 times more likely to acquire HIV while HIV prevalence among sex workers is 12 times greater than among the general population. That said, HIV prevention programmes for men who have sex with men, sex workers and transgender people have shown results when services are made available and are community-led. For example, increased access to antiretroviral therapy, in combination with other HIV prevention services, is driving down new HIV infections.

##### **Joint Programme support for key populations in Latin America**

As a result of UNAIDS support, Latin America governments have been provided with the knowledge and tools to improve their HIV response at national and regional levels, and within specific populations. For instance, the World Bank is supporting projects related to HIV risk, infection and service delivery in key populations in Latin America, including Argentina, Belize, Bolivia, Brazil, Colombia and Mexico. Technical assistance included analyses of the contribution of key populations to national epidemics and the impact of prevention programmes for these populations, including sex workers and men who have sex with men. Studies have been undertaken in Belize and Bolivia to investigate the levels of homophobia that impact the supply and demand of service delivery for key populations. WHO promoted documents developed on comprehensive care for men who have sex with men and transgender people in countries of the Latin America region, and activities related to combination prevention for key populations have been emphasized.

62. HIV prevalence among sex workers globally has declined modestly since 2011 in several regions, including sub-Saharan Africa, but in 2014 it remained 12 times greater than that of the general population.<sup>6</sup> In 2014-2015, the Joint Programme made significant

<sup>6</sup> [http://www.unaids.org/sites/default/files/media\\_asset/20160318\\_ten\\_targets\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/20160318_ten_targets_en.pdf)

contributions towards meeting the needs of key populations in the HIV response. The UNAIDS Secretariat, UNDP, UNFPA, UNODC, the World Bank and WHO worked with the Global Fund, MEASURE Evaluation, PEPFAR and other partners to support 42 countries in preparing for size estimations and programmatic mapping of key populations for better tailored national and city-level responses. 14 countries have completed the research. Further work in this area by the Joint Programme in 2014-2015 included:

- The Joint Programme developed and rolled out **guidance documents to support national policies and programmes for MSM, sex workers and transgender populations**:. For example, WHO released Consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations, which were endorsed by the Joint Programme. The Implementing Comprehensive HIV/STI Programmes with Sex Workers tool (the SWIT), was rolled out by UNFPA and others in Eastern Europe, Central Asia, Asia Pacific and Caribbean regions. Sessions on the SWIT and other key population resources were conducted at ICASA 2015, Zimbabwe. World Bank, 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”, while UNDP produced a paper on legal barriers to HIV prevention for sex workers. Following the success of the SWIT tool, work progressed on development and publication of implementation tools for the other key populations. The MSMIT (for men who have sex with men) was published in 2015. The TRANSIT (for transgender people) was finalized, and will be published in 2016. A joint UN statement on ending violence and discrimination against LGBTI people was published in 2015;
  - The Joint Programme invested in strengthening the **capacity of key populations’ organizations, including MSM, sex worker and transgender organizations** to enable global coordination, advocacy and effective participation in policymaking and service provision;
  - WFP continued its partnership with the North Star Alliance **to expand access to services for migrant workers, sex workers and communities surrounding transport corridors** through 30 Road Wellness Centers in twelve countries across Africa;
  - To support **overcoming stigma and violence**, UNESCO promoted the right to education for all learners by supporting the education sector to address and prevent violence and discrimination on the basis of sexual orientation and gender identity (SOGI). Research has been undertaken in the Asia Pacific, Latin America, Eastern Europe and Central Asia, and East and Southern Africa regions. UNESCO published a regional report Towards Inclusion and Safety in Schools in Latin America and published the first-ever review of SOGI-related violence in schools in the Asia Pacific region. Advocacy campaigns were held at regional (“Purple My School”) and national level in Thailand (“School Rainbow”) and China (“Friendly Campus”, “Be Myself”), and the hashtag #WeAreRainbow reached 1.8 million on Twitter;
  - UNDP supported successful efforts in DRC to **prevent the passing of legislation that would harm key populations**. In Chad, the engagement of the UNAIDS Secretariat resulted in a draft penal code provision to criminalize same-sex sexual relations not being passed. The ILO carried out the PRIDE study in Argentina, Hungary, South Africa and Thailand, examining the nature of discrimination that
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LGBT workers encounter in formal and informal employment, as well as good practices in countering these challenges;

- UNFPA developed a strategic partnership with AIDS fund Netherlands, with the goal of scaling up interventions for sex workers in priority countries with concentrated HIV epidemic, including Morocco and Tunisia;
- UNAIDS MENA partnered with the International AIDS Alliance and USAID in the development of the MSM toolkit targeting project managers and peer educators.

63. However, **legal restrictions and barriers to accessing key populations hinder effective HIV responses**. Community empowerment remains a central approach to reducing marginalization and HIV risk in key populations. Mobilization of key population networks is vital for HIV responses to be effective and rights-based. A variety of **service providers need to be sensitized to the needs and rights of key populations**, in order to increase delivery of effective, professionally competent, rights based and gender sensitive services. **More advocacy, supportive laws and policies, and resources** for community-led responses are required. **Partnerships need to be strengthened** between local government and communities to facilitate community-led programming with key populations. **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. Linked to this is the challenge that **the vast majority of funding for key populations programmes comes from international donors**. There is an urgent need to increase domestic funding for these programmes overall, and in particular in middle-income countries where Global Fund resources are decreasing.

#### ***vi Address the HIV-related needs of young people***

64. Young people, particularly young women and girls, bear an enormous burden of the HIV epidemic. In fact, young people (15–24 years old) accounted for 34% of the new HIV infections among people aged 15 years and older globally in 2014.<sup>7</sup> Joint achievements of the Joint Programme in 2014–2015 in support of programming with and for young people in response to ending the AIDS epidemic by 2030 have included:

- The Joint Programme, together with non-UN partners, including youth organizations, **launched the global All In! initiative** on adolescents, mobilizing action to end the AIDS epidemic in adolescents. The Joint Programme and partners have supported 25 countries to initiate programme assessment and data-driven planning exercises focused on adolescents. Assessments have been guided by technical guidance documents and tools developed by UNICEF and partners, to identify priority adolescent populations, locations and interventions to fast track the adolescent response. A synthesis report was also developed based on lessons from in the first five country assessments, to facilitate learning and replication in additional countries. UN Women mobilized 130 young women and adolescent girls advocates in Kenya, Malawi and Uganda to influence design and validation of the All In! country assessments. UN Women also contributed to the All In! Global Consultation on Adolescents' Engagement to ensure that gender equality aspects are on the agenda of the consultation and that adolescent girls are equally represented;

<sup>7</sup> [http://www.unaids.org/sites/default/files/media\\_asset/20160318\\_ten\\_targets\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/20160318_ten_targets_en.pdf)

### All In movement in the Caribbean

Adolescents continue to be infected and HIV/AIDS related diseases represent the second cause of mortality among adolescents. As a response to this alarming situation, the global All In movement that is about ending the epidemic among adolescents by 2030 was launched in 2 countries in Caribbean : Jamaica and Haiti with support from the UNAIDS Regional Support Team and thanks to a high level of commitment from national authorities and strategic partners. For example, the All in movement was successfully launched in Haiti under the leadership of the First Lady and the Ministries of Health, Education, Justice and Social Affairs. Most important was the participation of young people and the signature of a chart by governmental authorities, civil society, UN partners and funding agencies. The chart indicated key actions to be implemented by stakeholders in the near future in favor of young people either to prevent the epidemic or to protect those already living with HIV.

Moreover, UNFPA's interventions in the region resulted in the improvement of regional systems for the delivery of Comprehensive Sexuality Education (CSE) in 6 countries through the development and implementation of a sexual and reproductive health (SRH) training methodology and manual social work and public health university students; capacity building for teachers and guidance counsellors CSE Instruction and in the delivery of adolescents SRH services; capacity building of peer leaders and youth advocates along with support for their active participation in national adolescents SRH advocacy. Besides, capacity of youth leaders and youth-serving organizations in 7 Eastern Caribbean countries were strengthened for HIV, sexual and reproductive rights and rights advocacy, through a sub-regional consultation in November, 2014 organized by the UNAIDS Regional Support Team in collaboration with UNESCO and UNFPA.

- The Inter-Agency Working Group on Key Populations **developed technical briefs on young key populations** to advance discussions and action on health services and programmes for young men who have sex with men, young transgender people, young people who inject drugs and young people who sell sex – all taking into account considerations of adolescents under the age of 18. UNFPA supported first global meeting of YKPs from indigenous communities and conducted assessments need of YKPs in EECA;
- UNICEF support led to Thailand's declaration **permitting children under 18 to access HIV testing** without parental consent;
- In Asia and the Pacific, the Joint Programme **contributed to the Youth LEAD's NewGen Leadership Programme** to highlight gender equality aspects of the HIV response for adolescent girls and young women as well as ensuring equal representation and engagement of adolescent girls and young women. In Kenya, the UNAIDS Secretariat, UN Women and UNICEF supported the development of the Operational Plan for Ending AIDS among Adolescents 2015-2019;
- Guided by new data on the impact of PrEP, together with WHO and UNAIDS, UNICEF led a **global consultation in Vancouver** in 2015 to consider the clinical, ethical and operational issues associated with implementing oral PrEP among sexually active, high risk, older adolescents aged 15-19. The resulting report will serve as key input to new WHO global implementation guidance on PrEP which will outline approaches to effectively deliver PrEP to adolescents, as part of a prevention package;
- The World Bank **contributed funding and analytical studies on prevention for young people** through social protection research and programmes as well as VMMC. The World Bank also modelled the impact of combination prevention on youth in several countries such as Zimbabwe and Namibia;

- **The Inter-Agency technical task team for young people in MENA developed the Regional Framework of Joint Strategic actions for young people** in MENA (2016-2017). This Regional Framework is a collectively agreed compilation of key strategic priorities and actions responding to the needs of young people in the region. In MENA, UNFPA helped to scale up capacity building interventions in the key area of HIV response for young people including Master trainers in Y-Peer emergency and humanitarian response training focusing on HIV;
- The UNAIDS Secretariat and UNFPA **co-led the adolescent health work stream** of the Secretary General's Global Strategy on Women's, Children's and Adolescents' Health;
- UNAIDS Secretariat, UNFPA and UNICEF supported an analysis on legislations and policies that affect the **access of adolescents and young people to SRH and HIV services** in 17 Latin American countries. This analysis evidenced the negative impact of laws and policies that impede access of adolescents and youth to a wide range of prevention, treatment, care and support services related to SRH and HIV, including access to HIV VCT and treatment, commodities and CSE.
- **Comprehensive Sexuality Education (CSE):** An accountability framework was developed to track progress of the 21 countries that are part of the East and Southern Africa (ESA) Ministerial Commitment to scale-up CSE. Significant steps have been made in the areas of curricula development and teacher training. UNESCO convened a West and Central Africa regional workshop with stakeholders from 17 countries resulting in a call for action and country roadmaps to improve delivery of education on HIV, SRH and GBV for young people. An estimated 85 000 young people in Burundi, Cameroon, Chad, Congo, Gabon and RCA received improved CSE as a result of UNESCO ICT-based teacher training in the region. UNFPA supported 73 countries to align their CSE programmes with international standards. Through the 'Have you seen my rights?' Campaign, the UNAIDS Secretariat, UNFPA, The PACT, IWHC and Restless Development supported young people's participation in intergovernmental negotiations to advocate for CSE and access to youth friendly services, along with the roll-out of 60 national consultations. To close the gap in evidence-based advocacy, UNFPA put together 50 global, regional and national CSE' experts to strengthen the flow of communication and provide concrete case studies and analysis of what has worked. Jointly with UNESCO, the UNAIDS Secretariat worked to ensure CSE was included in the agenda of the World Education Forum. In Niger, WFP integrated nutrition and SRH in a pilot project to break the intergenerational cycle of malnutrition by equipping adolescents with life skills, an understanding of the importance of nutrition and education, and encouragement to delay marriage and childbearing. In Zambia, WFP has successfully rolled out the Home Grown School Feeding programme to 22 districts in predominantly rural areas where WFP has provided hot nutritious meals in 2308 schools;
- **Youth Engagement:** UNICEF, UNFPA and the UNAIDS Secretariat jointly convened a consultation on the use of mHealth and ICT to support youth engagement for HIV prevention. This included working with a global C4D Network to formulate recommendations based on current practice to strengthen the impact of mHealth tools and ICT on HIV prevention results for adolescents and youth. UN Women successfully advocated for gender-transformative national HIV strategies that include HIV-specific needs and priorities of adolescent girls and young women and engaged these constituencies in planning and decision-making processes in Kenya, Mozambique, Uganda and Cambodia.

65. The **global response to HIV largely neglects young key populations, including young women and girls**. As a result, **access and availability of SRH and HIV services for young people remains low**. Governments and donors **fail to adequately fund research, prevention, treatment and care for young key populations**, while HIV service-providers are often **poorly equipped to serve young key populations**. **Stigma and discrimination remain high** and youth programme staff may in some cases lack the sensitivity, skills and knowledge to work specifically with key populations.

## V. FUTURE ACTIONS

66. The review of achievements, challenges and lessons learned in the implementation of the UBRAF identified a number of future actions for UNAIDS. These include:

- **Intensify support to the implementation of Fast-Track in countries and cities** based on evidence, local epidemics and contexts, and progress against targets;
- **Harmonize and improve the collection and use of sex- and age-disaggregated data, expand existing databases and the use of strategic information;**
- **Advocate for increased international and domestic investments, optimal allocation of resources, integration and sustainability** of HIV financing;
- **Support mobilisation of funding for civil society** and scale up of community responses as an essential element of improving service delivery;
- **Support young people, especially adolescent girls and young women** acquire the knowledge, skills and means needed to remain free of HIV and violence;
- **Invest in leadership and capacities of networks of women living with HIV** and engage women's rights groups to strengthen participation of women in the response;
- **Support initiatives to engage men and boys to challenge harmful gender norms**, towards supporting gender equality and ending all forms of violence;
- **Review and revise the approach to address stigma and discrimination** related to key populations and other groups left behind to counteract current concerning trends;
- **Expand collaboration with the private sector** to strengthen HIV awareness, expand services, and identify new resources for financing of the AIDS response;
- **Strengthen policy coherence and strategies to expand HIV testing and improve treatment** uptake, adherence and retention;
- **Encourage emerging economies** to provide leadership on Fast-Track and support their role in advancing South-South and triangular cooperation;
- **Continue to leverage the experience of the Joint Programme and build closer ties with key partners**, such as the Global Fund and PEPFAR;
- **Continue effective coordination and collaboration across all areas of the Division of Labour** among the Cosponsors and Secretariat;
- Conduct **independent evaluations** and in-depth **reviews in critical areas and disseminate findings** to inform policy and programmatic actions.

## VI. FINANCIAL INFORMATION

67. 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 in 2014-2015. Expenditures are presented in several ways in order to facilitate comparison between the projected estimated resources and actual expenditures.
68. The Joint Programme achieved close to 100% implementation against the core budget in the 2014-2015 biennium. This was matched by equally successful leveraging of other AIDS funding, in total US\$ 3.69 billion which represents 96% of the original projection of other AIDS funds. Two-thirds of the total biennial spending went to High Impact Countries (HICs) while the rest of countries with UNAIDS presence received 29%. This is consistent with the Joint Programme's focus and commitment to distribute resources where the biggest impact on the epidemic can be achieved. Global level expenditure was kept at 8%, slightly more than the original 7% projection for the biennium.
69. Biennial spending was also in line with programmatic projections. Of the strategic directions, prevention received the biggest share at 53%. Of the strategic functions, leadership and advocacy received the biggest share, equivalent to 42%.
70. The summary tables and graphs shown in this section are supplemented by the more detailed core expenditure reporting by UBRAF output and other AIDS fund expenditure at the level of strategic goals and functions.

**Table 1: Overview of UNAIDS Cosponsor and Secretariat 2014-2015 spending (US\$)**

Funding type	Estimated resources 2014-2015	Breakdown (in %)	Expenditure and commitments 2014-2015	Breakdown (in %)
Core	484,820,000	11%	477,293,500	11%
Other AIDS funds	3,832,820,000	89%	3,688,085,200	89%
<b>Grand Total</b>	<b>4,317,640,000</b>	<b>100%</b>	<b>4,165,378,700</b>	<b>100%</b>

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

Funding level	Estimated resources 2014-2015	Breakdown (In %)	Expenditure and commitment 2014-2015	Breakdown (In %)
Global level	201,410,000	42%	193,969,100	41%
30+ HICs	125,405,000	26%	135,849,200	28%
Other countries	158,005,000	33%	147,475,200	31%

GRAND TOTAL	484,820,000	100%	477,293,500	100%
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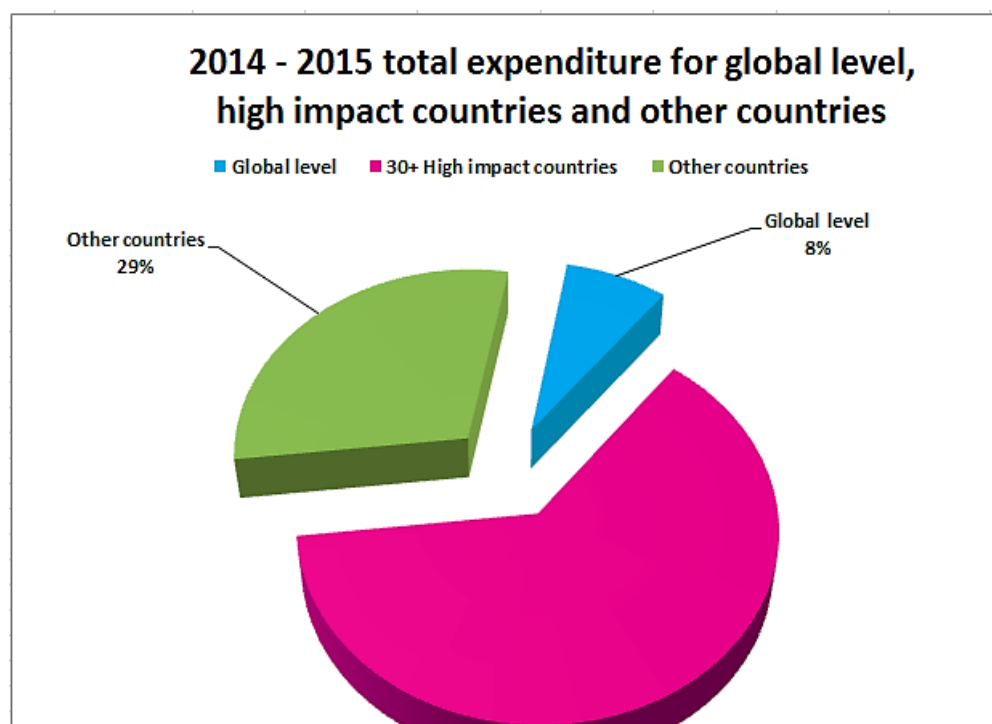
**Table 3: Core expenditure by strategic direction (US\$)**

Strategic Direction	Estimated resources 2014-2015	Breakdown in US\$	Expenditure and commitments 2014-2015	Breakdown in US\$
Prevention	79,102,000	48%	85,559,900	53%
Treatment, care and support	47,539,000	29%	45,132,900	28%
Human rights and gender	37,885,000	23%	30,146,500	19%
Grand total	164,526,000	100%	160,839,300	100%

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

Strategic Direction	Estimated resources 2014-2015	Breakdown in US\$	Expenditure and commitments 2014-2015	Breakdown in US\$
Leadership and advocacy	131,642,000	41%	132,318,000	42%
Coordination, coherence and partnerships	105,118,000	33%	99,646,000	31%
Mutual accountability	83,634,000	26%	84,490,200	27%
Grand total	320,394,000	100%	316,454,200	100%

**Figure 1: 2014-2015 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 2014-2015	%	Projected Resources 2014-2015	Expenditure 2014-2015	%	Projected Resources 2014-2015	Expenditure 2014-2015	%
<b>UNHCR</b>	9,800,000	9,800,000	100%	16,500,000	41,702,900 <sup>8</sup>	253%	26,300,000	51,503,100	196%
<b>UNICEF<sup>9</sup></b>	24,000,000	22,396,700	93%	198,000,000	191,827,700	97%	222,000,000	214,224,400	96%
<b>WFP</b>	9,800,000	9,125,900	93%	197,153,000	79,182,500	40%	206,953,000	88,308,400	43%
<b>UNDP</b>	17,200,000	16,362,400	95%	520,000,000	637,878,900	123%	537,200,000	654,241,300	122%
<b>UNFPA</b>	21,000,000	19,765,600	94%	106,106,000	117,629,700	111%	127,106,000	137,395,300	108%
<b>UNODC</b>	11,500,000	11,500,000	100%	29,076,000	22,905,000	79%	40,576,000	34,405,000	85%
<b>UN Women</b>	7,600,000	7,392,700	97%	26,704,000	28,607,100	107%	34,304,000	35,999,800	105%
<b>ILO</b>	10,900,000	10,712,200	98%	17,126,000	12,673,800	74%	28,026,000	23,386,000	83%
<b>UNESCO</b>	12,400,000	12,010,000	97%	13,850,000	20,828,200	150%	26,250,000	32,838,200	125%
<b>WHO</b>	35,000,000	34,337,600	98%	169,029,000	167,023,700	99%	204,029,000	201,361,300	99%
<b>World Bank</b>	15,400,000	15,400,000	100%	2,494,276,000	2,307,861,700	93%	2,509,676,000	2,323,261,800	93%
<b>Secretariat</b>	310,220,000	308,490,300	99%	45,000,000	59,963,900	133%	355,220,000	368,454,200	104%
<b>Grand Total</b>	<b>484,820,000</b>	<b>478,311,500</b>	<b>98%</b>	<b>3,832,820,000</b>	<b>3,688,085,200</b>	<b>96%</b>	<b>4,317,640,000</b>	<b>4,165,378,700</b>	<b>96%</b>

\* Includes actual expenditures and commitments

<sup>8</sup> In 2014-2015, UNHCR's non-core expenditure exceeded its projected resources due to the dramatic increase in global displacement levels during the UBRAF cycle, matched by the organization's sustained commitment to ensure that HIV services are available to populations affected by new emergencies as soon as possible.

<sup>9</sup> UNICEF 2014-2015 expenditure is based on latest (unaudited) expenditures which reflect estimated expenditure by strategic goals in the UBRAF.

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

Organization	Global	HICs	AP	CAR	EECA	ESA	LA	MENA	WCA	TOTAL
UNHCR	3,138,200	24,574,400	2,552,500	-	2,042,600	3,172,700	900,000	11,095,200	4,027,500	51,503,100
UNICEF	10,130,500	115,866,000	28,321,300	4,722,000	6,792,700	22,522,600	5,484,600	4,784,100	15,600,100	214,224,400
WFP	2,726,900	66,125,700	186,800	93,600	2,426,300	3,998,600	589,700	2,712,500	9,448,300	88,308,400
UNDP	24,426,900	490,931,900	17,337,700	10,684,000	48,979,000	4,260,800	5,189,300	24,352,000	28,079,400	654,241,300
UNFPA	31,303,200	72,945,900	2,222,200	1,427,100	5,037,600	5,676,300	7,068,200	6,850,600	4,864,000	137,395,300
UNODC	2,690,400	22,737,500	2,716,600	66,300	2,624,000	364,100	712,300	2,315,900	178,200	34,405,000
UN Women	4,776,000	17,917,600	3,311,100	654,700	1,570,100	1,870,700	1,825,900	2,079,000	1,995,100	35,999,800
ILO	6,940,800	14,011,500	293,700	55,700	2,300	459,800	928,000	71,800	622,600	23,386,000
UNESCO	4,399,900	20,159,400	1,307,100	241,100	647,400	3,886,400	689,700	183,200	1,323,900	32,838,200
WHO	56,716,000	63,382,800	23,728,400	2,382,900	13,096,800	9,790,500	4,978,200	11,550,300	15,735,300	201,361,300
World Bank	11,289,700	1,617,945,000	203,478,900	27,963,400	141,344,900	40,501,100	105,587,400	48,270,800	126,880,800	2,323,261,800
Secretariat	161,181,800	86,305,300	26,624,700	6,264,600	15,411,700	25,125,100	11,528,800	8,988,600	27,023,800	368,454,200
<b>Grand Total</b>	<b>319,720,300</b>	<b>2,612,903,000</b>	<b>312,081,000</b>	<b>54,555,400</b>	<b>239,975,400</b>	<b>121,628,700</b>	<b>145,482,100</b>	<b>123,254,000</b>	<b>235,779,000</b>	<b>4,165,378,700</b>

*\*includes actual expenditures and commitments*

*[Annexes follow]*



## Annex 1: UNAIDS Evaluation Plan 2016

UNAIDS 2016-2021 Strategy result area	UBRAF 2016-2021 reference outputs	Evaluation title	Purpose of the evaluation	UN Partners (in case of joint evaluation )	Type of evaluation (thematic, country, etc.)	Planned evaluation completion date	Estimated cost (US\$)	Source of funding
AIDS response is fully funded and efficiently implemented based on reliable strategic information	Efficiency and effectiveness of national AIDS responses improved (7.2)  Coordination, coherence and convening (S.4)	<b>Mid-term review of the Technical Support Facilities for Eastern and Southern Africa, West and Central Africa, and Asia Pacific</b>	The main purpose of the evaluation is to determine effectiveness, relevance, efficiency and sustainability of the Technical Support Facilities (TSFs).  The evaluation will also examine the UNAIDS structure used to guide and monitor the work of the TSF. This will include the division of labour between UNAIDS Country Offices, UNAIDS Regional Support Teams and UNAIDS HQ in Geneva.	N/A	Programme evaluation	Mid 2016	60,000	UNAIDS – non core
AIDS response is fully funded and efficiently implemented based on reliable strategic information	Effective and inclusive partnerships for impact and sustainability (S.2)	<b>Evaluation of the UNAIDS programme in Eastern Europe and Central Asia</b>	The main purpose of the evaluation is to determine effectiveness, relevance, efficiency and sustainability of UNAIDS support to countries in Eastern Europe and Central Asia.	UN Joint Teams in relevant countries	Programme / geographic evaluation	End 2016	60,000	UNAIDS – non core
AIDS response is fully funded and efficiently implemented based on reliable strategic information	Effective and inclusive partnerships for impact and sustainability (S.2)	<b>Evaluation of results and effectiveness of the UNAIDS-Global Fund partnership</b>	The main purpose of the evaluation is to determine effectiveness, relevance, efficiency and sustainability of UNAIDS collaboration with the Global Fund to Fight AIDS, TB and Malaria (GFATM).	GFATM DFID	Functional evaluation	End 2016	75,000	UNAIDS core

## Annex 2: Summary of Mid-term Review of UNAIDS Technical Support Facilities

This report details the findings of an independent mid-term review (MTR) of the current Technical Support Facilities (TSFs) which were contracted in 2014 and given an initial two-year contract (from mid-2014 to mid-2016) with the possibility of a two-year extension. The purpose of the MTR was to determine:

- Effectiveness: How well are the TSFs meeting their mission of providing quality technical support (TS) to country partners and capacity building to manage the local and regional epidemic response?
- Relevance: How well are the TSFs design, mission, and service provision meeting the needs of regional clients and stakeholders?
- Efficiency: How well are the TSFs and UNAIDS using available resources to meet their mission?
- Sustainability: To what extent will the benefits of TSF support continue when UNAIDS support is no longer available and how can improved sustainability be optimized?

The TSF modality was established by UNAIDS in 2005 as regionally based mechanism to facilitate the provision of quality assured, flexible and demand driven TS to strengthen regional and national HIV responses within those regions most highly impacted by the HIV/AIDS epidemic. In addition to TS the TSFs also work to strengthen the capacity of country partners to manage AIDS programmes effectively, assist in the professional development of national and regional consultants and encourage a harmonized and collaborative approach to the delivery of TS amongst development partners.

The TSFs operate as out-sourced, separate entities managed by external organizations on a contractual basis. The current structure follows a 2011 review and comprises three TSFs in Eastern and Southern Africa, West and Central Africa and Asia Pacific. Collectively the TSFs manage and deliver demand-driven TS across 70 countries in these regions. The current contract holders are the ICI Santé led consortium (West and Central Africa - WCA), Mott MacDonald (Eastern and Southern Africa - ESA) and the International Planned Parenthood Federation (Asia Pacific - AP). The Asia Pacific TSF also covers the South Asia region.

The TSFs serve government ministries and departments, National AIDS Committees (NACs), Global Fund (GF) grantees and Country Coordinating Mechanisms (CCMs) and civil society organizations (CSOs). Types of support and services provided include epidemic assessment, strategy development, resource mobilization, programme implementation and systems strengthening, civil society strengthening, governance and monitoring and evaluation (M&E).

The MTR was conducted by a consortium of three independent consultants contracted by UNAIDS following a Request for Proposal (RFP) process. The evaluation team employed a mixed-methodology approach (qualitative and quantitative data) to build an evidence for findings through a comprehensive literature review, in-depth interviews of TSF clients and key stakeholders and field visits including country visits, discussions with UNAIDS RST personnel and visits to TSF offices in Dakar (Senegal), Johannesburg (South Africa) and Kuala Lumpur (Malaysia) which allowed for a comprehensive review of the TSF processes.

The TSFs have continued to perform well over the current contract period. They continue to work closely with UNAIDS Country Offices (UCOs) and have been effective in meeting the short-term technical support (STTS) needs of country and regional partners.

Under the current contract period there has been a strong focus on providing services in

response to the advent of the Global Fund (GF) New Funding Model (NFM) that was introduced in 2013. This shifted funding from a project-based to an allocation-based approach with the aim of greater certainty and predictability of grant support. This has focused much of the TSF assistance across all regions on supporting countries in developing the “building blocks” of the response – specifically the development of National Strategic Plans, Investment Cases and funding proposal Concept Notes. Almost three-quarters of TSF assignments over the last two years have had a GF process component focus. Through these processes the TSFs globally have contributed to the unlocking of over \$5 billion in new grant funding over the current contract period for an investment of a little under \$4 million from the UNAIDS Technical Assistance Funds (TAF). Over 62 countries have been assisted in these upstream activities supporting national planning, programme costing and proposal development. Demand for TSF services remains high and the TSFs remain high volume programmes averaging over 100 assignments per annum, significantly higher than other like type STTS providers.

The TSFs have provided important leverage for UNAIDS. Advantaged by being seen by country and regional partners as honest brokers and being supported by the UNAIDS global technical architecture, the TSFs are important agents for the UNAIDS policy agenda at country level. TSF technical support has been able to leverage UNAIDS capacity to facilitate and stimulate policy and strategy dialogue around key cross cutting issues (gender, human rights, stigma and discrimination) towards creating a more enabling environment for prevention, testing and treatment services. TSF-provided TS has also enabled UNAIDS to advocate for and facilitate the genuine participation of civil society (CSOs) and community based organizations (CBOs) in particular, in the response. The TSF and UNAIDS relationship is mutually reinforcing. UCOs and Regional Support Teams (RSTs) play a critical technical backstopping role to TSF consultants at the field level. Technical backstopping of consultants is a critical quality control measure to ensure acceptable standards of performance and delivery of quality outcomes and products. Clear demarcation and definition is needed of the roles of UCOs, RSTs and the TSFs in collaborating to support the delivery of TS to further improve its effectiveness.

Whilst the TSFs remain effective in responding to demand driven requests for STTS, the rapidly changing landscape of the HIV response with the Sustainable Development Goals (SDG) integration of HIV into the broader health agenda and a shift from an emergency response to a longer-term focus on health systems is creating new demands and opportunities for TSF services. These changes are occurring against a backdrop of donor retreat, particularly in the Asia Pacific region, as a number of countries transition towards graduation from Global Fund and donor assistance. To remain relevant and to better position the TSFs to stay ahead of the curve in response to these environmental changes and new emerging needs, the TSF model needs to evolve. This will require the TSFs to pivot towards a more proactive setting to remain agile in their response to new grant implementation demands and supporting the UNAIDS Fast Track agenda to rapidly scale up prevention, testing and treatment service coverage. Better policy alignment of TSF TS focus with the UNAIDS Fast Track Strategy, which aims to end the epidemic by 2030 through the rapid scale up of prevention, testing and treatment services, will require an increasing focus on supporting grant implementation where TSF TS can affect programme services and quality.

There was a strong consensus among all stakeholders in all regions that the *raison d'être* for TSFs, which are at the core of the UNAIDS technical support strategy, remains valid and continues to respond to the needs of country partners. However, with the changes in the broader, rapidly evolving environment within which the TSFs function, this demand-driven model has limitations in anticipating TS needs. There is a desire by country partners to see greater engagement with the TSFs in an iterative process on how the TSFs can best

respond to their new and emerging TS needs. This new setting is envisaged through a strategic partnership approach that builds upon ongoing relationships with key strategic partners – the GF Secretariat, USAID and the United States President’s Emergency Plan for AIDS Relief (PEPFAR), CSOs and CBOs, key populations (KPs) and priority country partners – to identify the critical, high-value niche areas, building on existing TSF subsector strengths as well as new areas of work, where UNAIDS and the TSFs can be most effective in supporting efforts to scale up prevention, testing and treatment. This will allow the TSFs to build on existing relationships with regional and country partners, and leverage off the UNAIDS global architecture and strong working relationships with other TS providers, to define areas where TSF TS can be best directed towards embedding and operationalizing the UNAIDS Fast Track agenda.

There is an important role for UNAIDS at a global level in opening dialogue with key partners to set the needed policy groundwork as the basis for country level collaborations which define where the interests of partners, such as PEPFAR, USAID’s Grant Management Solutions (GMS), the International HIV/AIDS Alliance (IHAA) and, in West and Central Africa, Expertise France intersect with those of the TSFs. This partnership model should include improved access to qualified expertise, stronger working relationships with country stakeholders, and more efficient service delivery through closer collaboration with key development partners.

The TSFs remain efficient and a number proxy indicators highlight that the TSFs compare well against other like-type outsourced STTS modalities. All the TSFs are lean, light touch organizational structures employing on average nine persons. On a comparison of average fee rates the TSF-AP has the lowest daily average fee rate of all STTS providers with a range across the TSFs of US\$ 410- US\$ 571. The TSFs also compare favourably to other outsourced contracted service providers on the overhead cost ratio of total programme costs, with a range across the TSFs of 29-38% compared to GMS which presently operates at 46%. A key comparative advantage of the TSFs is their ability to mobilize experts quickly. All TSFs are able to mobilize within 21 days, on par with the much larger GMS programme and far quicker than other providers.

Whilst the TSFs remain largely efficient in their operation, there are also some process improvements that can further improve efficiency and lower operating costs. These can partially be realized through employing a strategic partnership approach that will yield better efficiencies from closer coordination and shared resources with development partners. Some efficiency will be gained from better configuration and use of TSF services, particularly the elimination of current low value functions. There is a strong appetite from other development partners to explore cost-sharing and cost-reduction initiatives including co-location, common databases and sharing of capacity development costs. The TSFs would also benefit from a common fee rate ceiling policy which will help contain some of the inflationary effects of high demand specialized expertise.

Some improvements are also possible in the quality assurance process chain, particularly quality at exit. There is an opportunity to make better use of the rich technical knowledge and insights gained from TSF assignments by harvesting and disseminating this information. This knowledge has value for analyzing trends in TS provision and forecasting TS needs, supporting analytical tools development and providing thought leadership on how future TS could be provided more effectively and efficiently. It also has potential value in informing UNAIDS and GF policy development given the unique position of TSF TS in supporting national responses and interpreting GF processes. Better knowledge management will also support improved quality control of consultant performance.

Repositioning the TSFs to shape demand and map and respond to emerging areas of need in grant implementation, whilst retaining capacity to respond to ongoing GF process compliance requirements, will help build more sustainable outcomes from TSF TS. The current model, with its urgency of mobilization and short input duration carries inherent risks in the speed of process. A more collaborative, planned and coordinated approach in a market where comparative advantage and natural divisions of labour between TS providers can be better exploited will enhance the quality and sustainability of TS services.

It is anticipated there will be a surge in demand for STTS in 2017 driven by the coalescing of new GF proposal development and commencement of grant implementation. This is anticipated to place increased demand and expectation on the TSFs. There will be a need to replenish the consultant databases to respond to needs identified through the strategic partnership dialogue process with development and country partners. Some of the anticipated areas of demand for TS support in grant implementation may include cross cutting areas such as financial and programme management, monitoring and evaluation, programme costing and national resource mobilization as well as specific technical areas. UNAIDS and the TSFs could also play a key leadership role in supporting sustainability and transition planning. Transition planning is presently poorly formulated and UNAIDS is seen by other development partners as being well placed to lead on these important issues. Furthermore, the GF current draft strategy emphasizes the need for a differentiated country approach with promotion and protection of gender and human rights and supporting the meaningful engagement of KPs. These are constituencies which go beyond a HIV focus but are areas where UNAIDS and the TSFs can provide support and add value.

There are alternative business models that could be considered to support the transformation to a strategic partnership model and the potential for a more independent financial setting. These include a centralized, single TSF mechanism, a shared cost model, a panel system and in-sourcing some TSF functions to UNAIDS. The type of organization where the TSF is nested is highly influential on the prospects to evolve to meet this increased functionality and move towards greater financial sustainability. Any moves towards transforming the TSF business model needs to ensure that its core values and advantages remain part of any new model including the ability to mobilize high quality expertise quickly; its independence and neutrality as an honest broker of TS; and strong knowledge of the Global Fund processes and requirements.

A transition pathway will be needed to move from the current modality to an alternative. Given the anticipated increase in demand for TSF services in the short term, as grant implementation needs and the new Concept Note window coalesce for a number of client countries, dramatic structural change would not be ideal prior to 2018.

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