

2008 UNAIDS Annual Report

Towards Universal Access



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CONTENTS



Foreword	4
Status of the AIDS epidemic	7
Chapter 1: mobilizing leadership and advocacy	11
Chapter 2: strategic information and policies	18
Chapter 3: surveillance, monitoring and evaluation	33
Chapter 4: civil society engagement and partnerships	38
Chapter 5: resource mobilization and needs	42
Cosponsor highlights	45
Financials	61

Foreword

Last year was a year of leadership, consolidation, partnership and transition. It was a year in which the hard work of previous decades came together to produce tangible and measurable results. Yet the hard-won gains are fragile and call for a renewed commitment and leadership by the United Nations system.

There has been substantial progress in delivering HIV services to millions of people, especially in low- and middle-income countries. Last year the goal of the “3 by 5” campaign—to have 3 million people on antiretroviral treatment—was finally realized. By the end of 2007, the annual number of new HIV infections had fallen from 3 million in 2005 to 2.7 million. New infections among children have dropped, thanks to the scale-up of services to prevent mother-to-child transmission. Young people in many parts of the world are waiting longer to become sexually active, are having fewer sexual partners or are using condoms. Millions of children orphaned by AIDS now have access to social support and protection.

World leaders increasingly admit that the needs of the people most at risk of acquiring HIV—men who have sex with men, sex workers, their clients and injecting drug users—need to be included in the AIDS response. In 2008, more and more countries made efforts to ‘know their epidemic’ and chose evidence-informed approaches based on human rights.

In short, countries are beginning to take seriously the goal of meeting their universal access targets for HIV prevention, treatment, care and support.

We need to recognize success, but we must not forget the challenges that still need to be overcome. AIDS is not over yet. For every two people starting treatment, five people are newly infected with HIV. The waiting lines for people needing immediate treatment are increasing, and each day children are orphaned and their survival threatened.

The challenges facing the response to AIDS are exacerbated by the current global financial and economic crisis. The crisis will affect all countries, with a serious and disproportionate impact on the poorest, and could leave 80% of the world’s population without a social safety net.

But we must remain optimistic.

In 2006, the world made a historic commitment at the United Nations aimed at the goal of universal access to comprehensive prevention programmes, treatment, care and support. The achievement of universal access will remain the fundamental priority for UNAIDS. Universal access goals can become a reality.

By achieving these goals, we can clearly contribute to the Millennium Development Goals and the broader development agenda. I have seen the demand for universal access. I have seen political will. And I have seen the successes that people newly on treatment are achieving in the far corners of the world. They are making universal access a reality.

I see the AIDS movement as an opportunity. We cannot work on AIDS in isolation. We must

UNAIDS will be guided by five principles in supporting countries to reach their universal access goals.

- ▶ We will stand with people living with, or affected by, HIV.
- ▶ We will mobilize greater investments, while increasing their impact and sustainability.
- ▶ We will renew accountability and focus on country results, particularly where progress is lacking.
- ▶ We will put science, technology and data to work.
- ▶ We will expand and optimize strategic partnerships and networks.

leverage the results of the AIDS response across the economic, social and political spheres.

Whether it is through an invigorated attempt to stop the sexual transmission of HIV, highlighting and addressing homophobia, decriminalizing the transmission of HIV, promoting human rights, amplifying the voices of people living with HIV, or treating tuberculosis and saving mothers and their babies, I want to lead by asking this: "Is what we are doing improving lives?"

In order to achieve further progress, it is essential to take steps to address specific gaps in the response to the epidemic, as well as the social, political and structural constraints that limit results. In the coming years the UNAIDS Outcome Framework for saving lives will be informed by the following nine priority areas:

- ▶ Reducing sexual transmission of HIV.
- ▶ Preventing mothers from dying and babies from becoming infected with HIV.
- ▶ Ensuring that people living with HIV receive treatment.
- ▶ Preventing people living with HIV from dying of tuberculosis.
- ▶ Protecting drug users from becoming infected with HIV.
- ▶ Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS.
- ▶ Stopping violence against women and girls.
- ▶ Empowering young people to protect themselves from HIV.
- ▶ Enhancing social protection for people affected by HIV.

A more in-depth description of these priority areas can be found in the UNAIDS document *Joint Action for Results: UNAIDS Outcome Framework 2009–2011*.

Following the historic G20 summit in March 2009, UN Secretary-General Ban Ki-moon made clear the importance of turning the economic crisis into an opportunity for a sustainable future.

Most countries have set universal access targets for 2010 that are ambitious and that reach real people. For countries to reach the specific targets they have set, an investment of US\$ 25 billion will be required in 2010: US\$ 11.3 billion more than we have available today.

If we reach the country-defined targets in 2010, approximately 6.7 million people will be on treatment. More than 70 million pregnant women will be screened and receive prevention of mother-to-child transmission services. Twenty million men who have sex with men, 7 million sex workers and 10 million people who inject drugs will receive HIV prevention services. Seven million orphans will be supported. Together, over the next two years, the result will be 2.6 million new HIV infections and 1.3 million deaths averted and HIV incidence cut by nearly 50%.

I have set out an ambitious agenda.

We have an actionable vision.

We have one priority: universal access.

We know that the AIDS response is an opportunity to achieve the Millennium Development Goals.

We know what investments are needed.

We have focused principles to guide us.

Our actions invigorate us.

I believe that together we can do this.

Let us accelerate our efforts.

*Together we **will** do it,*



Michel Sidibé
Executive Director





Photo UNAIDS / P. Viro



Photo UNAIDS / P. Viro

Status of the AIDS epidemic

In November 2007, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) published data showing that HIV prevalence has stabilized, even though the number of people living with HIV continues to rise. The following year, a joint UNAIDS, United Nations Children’s Fund (UNICEF) and WHO report announced that 3 million people living with HIV were accessing antiretroviral therapy—an unprecedented increase of 1 million from the previous year and a 10-fold increase from five years earlier.

A global snapshot: declining new infections and deaths, expanding needs

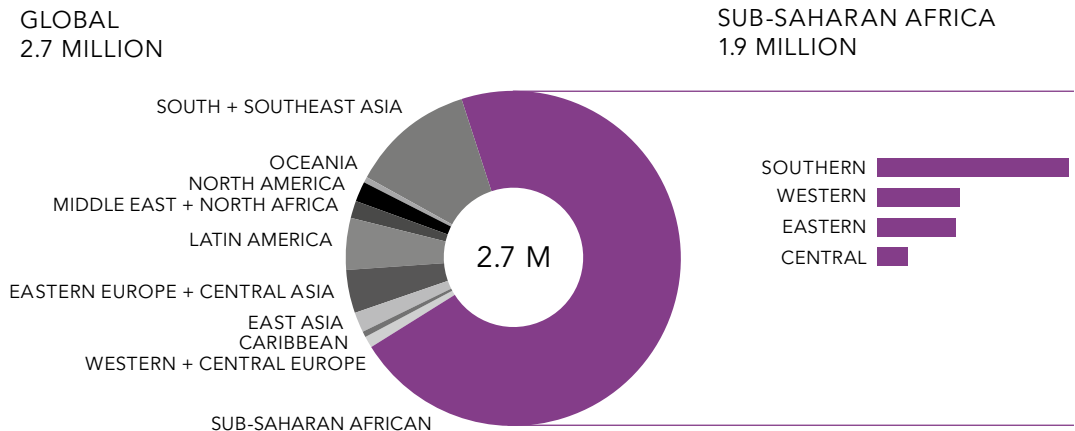
As reported in mid-2008, an estimated global total of 33 million (30.6–36.1 million) people were living with HIV. An estimated 2.7 million (2.2–3.2 million) individuals were newly infected and 2.0 million (1.8–2.3 million) died of AIDS-related illnesses in 2007 (Figure 1). HIV estimates for the end of 2008 will be available in November 2009.

An estimated 22.0 million (20.5–23.6 million) people living with HIV, or 67% of the global total,

live in sub-Saharan Africa, where the epidemic is most severe. Almost one third of all new HIV infections and AIDS-related deaths worldwide occur in this region. It is noteworthy that in the worst-affected African countries, the highest levels of new infections are found among women and girls.

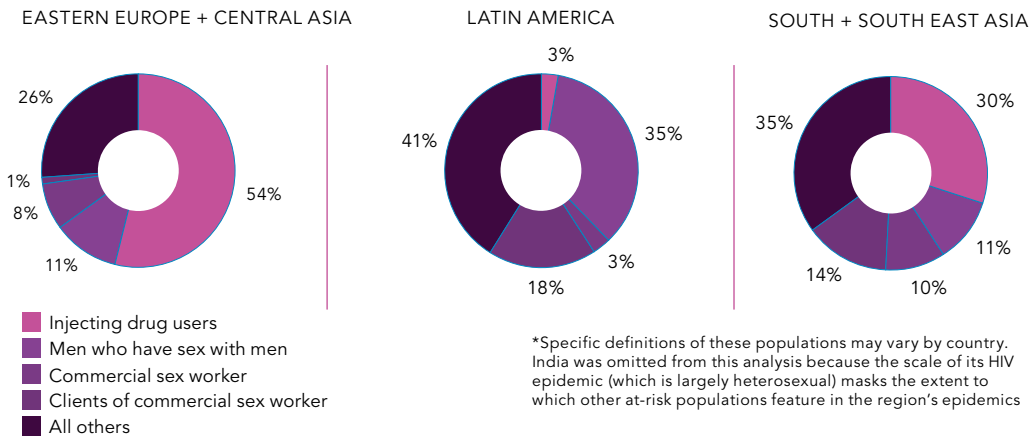
The HIV epidemic is not homogeneous—it affects different populations living in each region in different ways (Figure 2). Women account for 60% or more of new HIV infections in sub-Saharan Africa; in other regions men represent the majority of new infections and of people living with HIV. Globally, across all populations, adolescents and young adults are most likely to be exposed to HIV.

FIGURE 1: GLOBAL DISTRIBUTION OF NEW HIV INFECTIONS, 2007



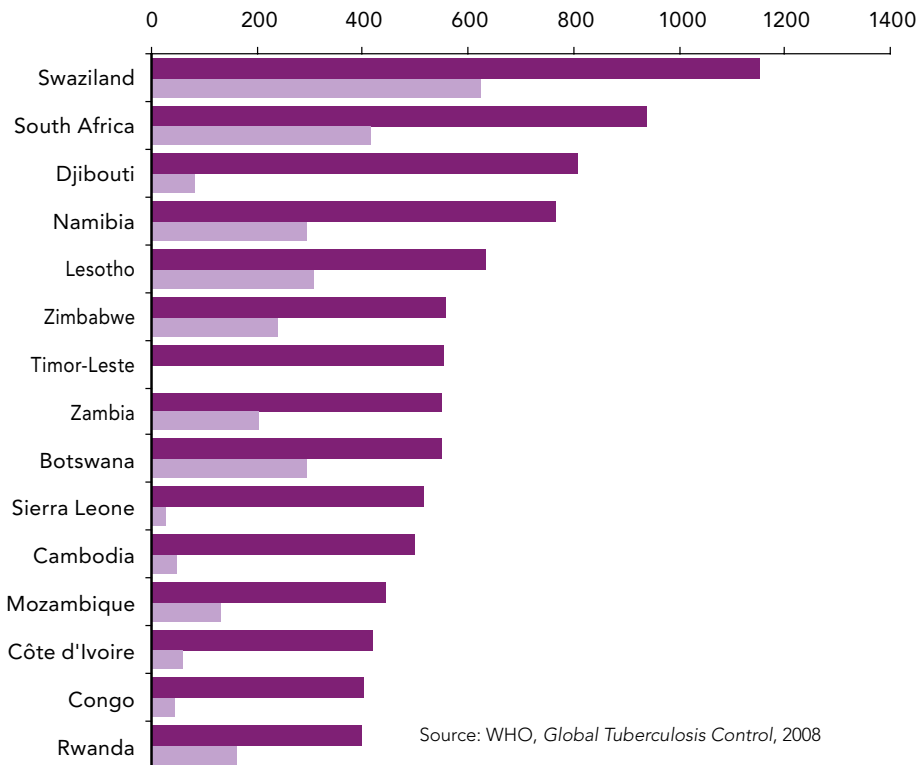
Source: 2008 Report on the Global AIDS Epidemic, UNAIDS.

FIGURE 2: ESTIMATED PROPORTIONS OF HIV INFECTIONS IN DIFFERENT POPULATION GROUPS* BY REGION, 2007



Source: AIDS Outlook/09, UNAIDS.

FIGURE 3: FIFTEEN COUNTRIES WITH THE HIGHEST ESTIMATED TUBERCULOSIS INCIDENCE RATES PER CAPITA (ALL FORMS; DARK PURPLE BARS) AND CORRESPONDING INCIDENCE RATES OF HIV-POSITIVE TUBERCULOSIS CASES (LIGHT PURPLE BARS), 2006



Source: WHO, Global Tuberculosis Control, 2008

In sub-Saharan Africa, heterosexual sex is the dominant mode of transmission, but many infections are occurring in other key populations at higher risk of exposure to HIV—especially among men who have sex with men, a population that is often overlooked or not acknowledged by policy-makers. In Malawi, for example, HIV prevalence among men who have sex with men is estimated at 21%, a tragically high figure greater even than the estimated national prevalence of 14.1%.

In other regions, the epidemic is similarly diverse. In Latin America, for example, men who have sex with men are at high risk of HIV infection, with significant risks faced also by sex workers and their clients and people who inject drugs. Asian epidemics are characterized by high levels of infection and risky behaviours among injecting drug users and sex workers and their clients. Use of contaminated injecting equipment remains the primary source of new infections in eastern Europe and central Asia, but a growing proportion of new infections is heterosexually transmitted.

Towards universal access—promising progress, enduring challenges

Reports received from 147 countries show promising progress towards achieving the universal access goals. Access to antiretroviral therapy rose by 47% and reached 3 million adults (2.7–3.28 million) living in low- and

middle-income countries. This resulted in the first decline in the number of annual AIDS-related deaths since HIV was first recognized in the 1980s. Paediatric antiretroviral therapy coverage increased nearly threefold between 2005 and 2007. The percentage of HIV-infected pregnant women receiving services to prevent mother-to-child transmission increased from 15% in 2005 to 33% in 2007.

Declines in HIV prevalence observed among young pregnant women in several high-prevalence countries in Africa suggest that HIV prevention efforts in the region may be resulting in significant changes in sexual behaviour.

However, many challenges remain. About 70% of people who needed antiretroviral therapy in 2007 did not have access to it. A continuing lack of comprehensive and integrated coverage for people living with HIV and coinfecting with tuberculosis continues to hamper the prevention and treatment of both diseases (Figure 3).

For every two people who started antiretroviral therapy, five individuals were newly infected with HIV. Only 40% of young people between the ages of 15 and 24 demonstrated accurate and comprehensive knowledge about HIV. Nearly two thirds of countries reported having policies that impede the access of key populations to HIV services. Eighty-five per cent of children orphaned or made vulnerable by HIV in 11 high-prevalence countries lived in households that received no assistance.



Photo UNAIDS

Chapter 1: mobilizing leadership and advocacy

Strong leadership and redoubled advocacy efforts are necessary if the target of making universal access a reality is to be achieved. Working with key stakeholders and organizations of influence, including governments and civil society, and engaging with parliamentarians, in 2008 UNAIDS remained at the forefront of global efforts to address stigma and discrimination, promote universal access goals and champion a global AIDS response that is evidence-informed and grounded in human rights.

Advocacy to sustain the global AIDS response in the context of the global economic downturn

In 2008, the world economy experienced a series of economic shocks that continue to reverberate. In the currently challenging financial environment, sustaining an effective AIDS response will require strong leadership and innovative and focused advocacy. The certainty of some prior funding commitments must now be in doubt; failure to meet these commitments, given the increasing number of people infected and the growing need for antiretroviral therapy, could adversely affect the lives of millions.

In 2008, UNAIDS continued to promote universal access goals and advocate on behalf of people living with HIV, their families, their loved ones and the communities in which they live. Progress towards universal access has been strong in some areas, but patchy in others. Nonetheless, 2008 was a year of consolidation, transition and change. Several global events, including the United Nations (UN) General Assembly High-level Meeting on AIDS and the XVII International AIDS Conference, held in Mexico City, provided an opportunity to advance the agenda for accelerating the global AIDS response.

High-level Meeting on AIDS

At the 2008 UN General Assembly High-level Meeting, held on 9 and 10 June in New York, General Assembly President Srgjan Kerim, UN Secretary-General Ban Ki-moon, several heads of State, more than 80 ministers, senior officials and representatives of international organizations and civil society met to review progress towards the targets set out in the 2001 *Declaration of Commitment on HIV/AIDS* and the 2006 *Political Declaration on HIV/AIDS*. At the meeting, the Secretary-General outlined work done and identified challenges in a report based on 147 national progress reports submitted to UNAIDS at the end of 2007.

Although a few countries reported having already achieved some of their universal access targets, a significant proportion indicated that they did not have the human and financial resources to achieve their targets by 2010. A number of donor countries committed to increase their financial assistance for HIV programmes, with the aim of supporting a transition from an emergency response to one that takes account of the need for sustained, predicted long-term funding.

Participants recognized that the AIDS epidemic was not over in any terms and remains both a public health issue *and* a development

issue—one that requires a response that remains sensitive to cultural context. They affirmed that HIV programmes and services strengthen health systems. Delegates also discussed the necessity of promoting human rights and focusing on gender to implement an effective response.

Throughout the two-day event, delegates called for greater accountability, particularly in relation to expenditure of funds. Participants also highlighted the need to adapt HIV prevention programming to local contexts and lamented the lack of effective programming directed towards key populations. Civil society organizations and a number of countries continued to push for the decriminalization of certain behaviours and the lifting of travel restrictions on people living with HIV.

Participants reaffirmed the coordinating role of UNAIDS as critical to the achievement of global commitments and called upon the organization to strengthen HIV prevention programmes to better reflect local realities and to provide support for the expansion of treatment programmes. Many lauded the recent dramatic increase in the number of people receiving treatment, but warned that if HIV prevention efforts were not stepped up these successes would be difficult to maintain.

Ahead of the UN General Assembly High-level Meeting, UNAIDS, heads of government, business leaders, activists and UN delegates convened for the First HIV/TB Global Leaders Forum to discuss the health, socioeconomic and human security impacts of the epidemics.

XVII International AIDS Conference, Mexico City

Between 3 and 8 August 2008, 22 000 participants attended the XVII International AIDS Conference for five days of spirited exchange, scientific debate and advocacy. HIV and human rights organizations from around the world called for vastly greater attention to be given to populations at higher risk of contracting HIV.



Photo UNAIDS / Agencialibre foto

They also worked hard to let the world know that HIV is not over and that it continues to claim millions of lives each year and remains the world's most damaging infectious disease.

Mobilizing under the theme of Universal Action Now!, many delegates called for a renewed commitment from the international community to strengthen the scale-up of HIV prevention, treatment, care and support programmes worldwide and to work towards achieving the Millennium Development Goals, which include the goal of halting and reversing the spread of HIV by 2015. Providing antiretroviral therapy, addressing HIV-related stigma and discrimination, strengthening health systems, searching for an HIV vaccine, as well as responding to broader human rights issues for people living with HIV, were some of the other topics discussed at the conference, the first to be held in Latin America.

At the conference UNAIDS distributed its recently published 2008 *Report on the Global AIDS Epidemic*, which pointed to significant progress in reducing new HIV infections and AIDS-related deaths in the past two years. The Secretariat also called for a renewed commitment to the human rights of populations at higher risk and for a redoubling of efforts to promote combination prevention. The latter is

based on sound epidemiological evidence that there is no one ‘magic bullet’ for helping people avoid exposure to HIV.

The biennial International AIDS Conference is the world’s largest HIV forum and is organized by the International AIDS Society, together with a series of partners, including UNAIDS. The next conference will be held in Vienna in July 2010.

Second Eastern Europe and Central Asia AIDS Conference

In May UNAIDS supported the second Eastern Europe and Central Asia AIDS Conference, which took place in Moscow. The theme, Accelerating Access to HIV Prevention, Treatment and Care for All, highlighted the fact that within eastern Europe and central Asia new HIV infections occur primarily among injecting drug users and men who have sex with men.

The aim was that political and community leaders, scientists and other researchers, people living with HIV and representatives of civil society from across the region would take stock, share best practices and mobilize action in response to the challenges posed by the AIDS epidemic. The Russian Federation was the largest financial supporter of the conference, which featured a Youth Village—a community dialogue space to increase the visibility of HIV issues among young people and to promote youth involvement in addressing HIV in eastern Europe and central Asia.

15th International Conference on AIDS and STIs in Africa

At the 15th International Conference on AIDS and STIs in Africa, which was held in Dakar, high-level delegates, civil society representatives and technical experts from across Africa and elsewhere gathered for discussions under the theme Africa’s Response: Face the Facts. A notable event on the programme was a gathering of First Ladies of Africa, who discussed

stigma towards people living with HIV as well as the need to halt its spread. Their panel discussion on the HIV response was moderated by Michel Sidibé, former UNAIDS Deputy Executive Director.

Evidence-informed leadership

Governance and leadership were high on the UNAIDS agenda throughout 2008. Two independent commissions on AIDS, one in Africa and one in Asia, reviewed the state of the epidemic in their respective continents and called upon leaders to accelerate prevention and treatment efforts.

The Independent Commission on AIDS in Asia

In June 2006 UNAIDS initiated the establishment of the Independent Commission on AIDS in Asia to examine the HIV epidemic in the region from a socioeconomic perspective, going beyond the public health context. Nine leading economists, scientists, civil society representatives and policy-makers from across the region were appointed to the commission, which is led by Professor C. Rangarajan, Chief Economic Adviser to the Prime Minister of India. In their 2008 report, *Redefining AIDS in Asia—Crafting an Effective Response*, launched on 28 March and presented to the UN Secretary-General Ban Ki-moon on 26 March, the commissioners recommended that high-impact interventions such as HIV transmission prevention programmes focus on key populations and stated that the provision of antiretroviral therapy constitutes the core of the HIV response across Asia. It also made a compelling case for a region-wide strategy based on the particular features of the HIV epidemic in Asia and proposed a comprehensive programme that ensures 80% coverage for prevention services, directed towards supporting members of key populations and treatment and care services.

Securing our Future: final report from the Commission on HIV/AIDS and Governance in Africa

Throughout 2008, UNAIDS worked closely with the Commission on HIV/AIDS and Governance in Africa. In 2003, former UN Secretary-General Kofi Annan established the Commission under the leadership of the Executive Secretary of the UN Economic Commission for Africa, K.Y. Amoako, assisted by 20 commissioners. On 9 June 2008, the commission presented its final report, *Securing our Future*, to UN Secretary-General Ban Ki-moon. The report includes an analysis of findings and a series of key recommendations, including that there needs to be a refocus on prevention, that children infected or orphaned by HIV should be provided with adequate treatment and care and that African governments should improve their expenditure systems to meet HIV response standards and to increase donor confidence.

Advocacy for increased political commitment

In 2008, the UNAIDS Secretariat undertook several high-level advocacy missions to Botswana, China, the Democratic Republic of the Congo, the Dominican Republic, Egypt, Ethiopia, India, Jordan, Mali, Mexico, the Russian Federation, Senegal, South Africa, Thailand, Uganda, Ukraine and the United Republic of Tanzania. The aim was to elicit stronger political, financial and programmatic commitment to the AIDS response by engaging with people living with HIV groups and civil society, as well as soliciting both bi- and multilateral support, including with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

UNAIDS continued to work closely with the administration of the United States of America and members of Congress to sustain funding for AIDS. Former US President George W. Bush signed the Tom Lantos and Henry J. Hyde United

States Global Leadership against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008. This legislation replaces and extends the previous act by five years and expands it threefold to US\$ 48 billion, effectively expanding the reach of the US President's Emergency Plan for AIDS Relief (PEPFAR).

The UNAIDS Secretariat also played an important role at the Community of Portuguese Speaking Countries (CPLP) Heads of States Summit, which took place from 24 to 25 July in Lisbon. The summit occurs every two years and is an opportunity to review progress made and to improve cooperation between CPLP member States on political, economic, social and cultural issues. Former UNAIDS Deputy Executive Director Michel Sidibé participated in the CPLP summit as a keynote speaker at the Civil Society Forum on Health Affairs.

A new initiative by the former President of Botswana, Festus Mogae, brought together African leaders to unite around HIV prevention efforts, particularly those that involve a 'combination approach'.

Supporting national AIDS responses

UNAIDS worked with its Cosponsors and partners to develop the capacity of national AIDS authorities to lead a multisectoral response and to provide guidance to strengthen the capacity of national AIDS authorities to conduct national programme reviews. This included developing a guidance paper on joint reviews of national AIDS responses.

UNAIDS supported the development of multi-sectoral national strategic and action plans through support for the AIDS Strategy and Action Plan initiative developed by the World Bank. It developed programme reviews that led to the development of evidence-informed, costed national plans and promoted the implementation of the Country Harmonization and Alignment Tool (CHAT) to gauge the level of harmoniza-



Photo UNAIDS

tion and alignment at the country level. CHAT has also become integrated as part of a wider joint review process. UNAIDS supported the integration of HIV issues into national development processes, such as poverty reduction strategies and budgetary frameworks, which included strengthening the participation of AIDS stakeholders in formulating national development plans or poverty reduction strategies.

At the global level, UNAIDS and partners have informed and shaped the broad harmonization and alignment agenda by participating in, and engaging with, the Accra High-level meeting on Aid Effectiveness and by sharing UNAIDS experience and lessons learned. It is engaging with the International Health Partnership+ (IHP+) by offering UNAIDS expertise, in particular with the development, coherence and function of the Joint UN Teams on AIDS, with the aim of informing the development of IHP+ institutional frameworks and strategies, such as the

country health teams. UNAIDS continued to support the implementation of Global Task Team recommendations and coordinated the Oversight Reference Group.

Strengthening the UN response to AIDS

In 2008, UNAIDS began to work with partners to find new ways to streamline work at the country level. This included consolidating all UN activities into one cohesive UN response to HIV by improving the functioning of the Joint UN Teams on AIDS. A toolkit was designed to assist UN country teams to develop and implement a unified programme of support for the national AIDS response.

UNAIDS provided technical and financial support to the UN Theme Groups and Joint UN Teams on AIDS to better assist national governments to address key areas of the national AIDS response. The Secretariat also provided strategic

input to the various efforts on UN reform of the United Nations Development Group. It participated in the revision of the Common Country Assessment and United Nations Development Assistance Framework (UNDAF) guidelines and developed and piloted a performance assessment tool to assess how the AIDS component of the UNDAF was performing compared with other national priorities.

In order to improve the quality of advocacy and communication on the part of the Joint UN Teams on AIDS and key stakeholders, UNAIDS developed a communications paper and plan.

Photo UN



Change in leadership at UNAIDS—Michel Sidibé appointed new Executive Director of UNAIDS

In late 2008 Michel Sidibé was appointed as the Executive Director of UNAIDS by the UN Secretary-General Ban Ki-moon. On

1 January 2009 he took over from Dr Peter Piot and will be leading UNAIDS as it moves into a new phase of work and development.

Special Envoys

Successful advocacy efforts often draw on the popular appeal of celebrities and other figures well known in public life. In 2008, the UN Secretary-General's Special Envoys ensured that AIDS remained high on the list of international priorities. UNAIDS Special Envoys Sir George Alleyne (Latin America and the Caribbean), Professor Lars Kallings (eastern Europe and central Asia), Ms Elizabeth Mataka (Africa) and Dr Nafis Sadik (Asia and the Pacific) continued to meet with governments and to engage with all sectors—private, public and civil society—in order to promote the human rights of all people living with HIV, including women, men who have sex with men, injecting drug users and other key populations.

UNAIDS Goodwill Ambassadors and special representatives

UNAIDS currently works with eight international high-profile personalities from the worlds of art, sport and entertainment in their roles as UNAIDS International Goodwill Ambassadors. During 2008 they undertook a variety of activities, ranging from field missions, to panel discussions, to football games to support the advocacy work of UNAIDS. An example is the

Sport uniting the world against AIDS

Sport can provide the perfect conduit to a mass audience to send messages about how to avoid becoming infected with HIV, where to get tested and how to access treatment. In 2008, UNAIDS strengthened ties to leading sports associations and celebrities. UNAIDS Special Youth Representative Michael Ballack captained a team in the Goal4Africa all-star benefit football match held at Allianz Arena in Munich, Germany, on 12 July 2008 in honour of Nelson Mandela's 90th birthday. Afterwards he spoke at a press conference about the importance of using sport as a platform to empower young people in the response to AIDS. Ballack also joined forces with a fellow footballer, Togolese national Emmanuel Adebayor, to feature in the UNAIDS campaign *Uniting the World against AIDS*. The International Cricket Council reaffirmed its commitment to partner with UNAIDS to bring messages of HIV prevention to young people in countries where the sport is popular.

Pakistani rock star Salman Ahmad's participation in the Global Insight Summit at the Jackson Hole Film Festival alongside UN Secretary-General Ban Ki-moon advocating for the entertainment industry to show greater involve-

ment in the AIDS response. Other ambassadors undertook field trips to Madagascar, Mexico and Ukraine. Each and all of the Goodwill Ambassadors show great commitment to help UNAIDS move forward the AIDS response.

Artists against AIDS helps fight stigma and discrimination in the Russian Federation

Art has always had the power to move individuals in ways that statistics and facts cannot. On 11 November 2008 UNAIDS in the Russian Federation launched the initiative Artists against AIDS, the aim of which was to decrease stigma and discrimination against people living with HIV while raising funds for an orphanage that cares for HIV-positive children. Twenty-three artists, including several well-known Russian painters as well as artists from Greece, Spain, Ukraine and the United States of America, contributed their works for the exhibition and sale, which was held at the Central House of Artists in Moscow. More than 200 guests attended the exhibition's opening ceremony, including representatives from the private sector, the artistic and diplomatic communities, and governmental and nongovernmental organizations.

In the Russian Federation about 440 000 cases of HIV infection are officially registered; however, many Russian and international experts believe that the actual number of people living with HIV in the country could be closer to one million. Injecting drug use remains the main mode of transmission. In recent years the percentage of women living with HIV has grown: in 2007, 44% of all new cases of HIV infection were among women.

The number of children born to women living with HIV has also increased. Even though preventive therapy makes it possible to reduce a newborn's risk of infection to a minimum, mother-to-child transmission of HIV continues to occur in children during pregnancy, labour and delivery, or while breastfeeding.



Global Coalition on Women and AIDS

Founded in 2004 to respond to the specific and growing needs of women living with HIV, in 2008 the coalition embarked on a new strategic direction to strengthen its advocacy in support of national AIDS responses and to expand its membership base. Chief among its aims is to provide assistance to country-level partners to strengthen strategic and operational plans around women, girls and AIDS. It will do this by creating a worldwide network of partners to share technical knowledge, collaborate on tools, carry out research and provide the support for capacity-building needed by national organizations to advance work in the field and by assisting national AIDS commissions to develop road maps to strengthen national AIDS strategies and plans. The coalition Secretariat is housed at UNAIDS in Geneva.

Among other efforts, the Global Coalition on Women and AIDS supported ground-breaking research in Pakistan on female partners of men who inject drugs, which has major implications for harm reduction programmes globally.



Photo UNAIDS / P. Viro

Chapter 2: strategic information and policies

In order to be effective, national HIV responses need to be tailored to the unique economic, social and geographic context of a particular country. Governments therefore require access to sound, timely and strategic information to enable them to adopt policies and programmes that are evidence-informed and grounded in human rights.

Human rights, gender and law

The global commitment to universal access is grounded in long-recognized international human rights frameworks. Whether it was advocating for equal inheritance rights for women or encouraging governments to repeal discriminatory and stigmatizing legislation, in 2008 UNAIDS continued to promote the human rights of all people living with, or affected by, HIV.

At the 2008 High-level Meeting, UNAIDS reported that a growing number of countries have adopted laws to protect people living with HIV from discrimination. However, in 2007, one

third of countries still lacked laws and regulations to prohibit HIV-based discrimination.

A number of countries have enacted overly-broad laws that criminalize HIV transmission and exposure. UNAIDS has expressed concern that such laws risk undermining both public health and human rights. Although often motivated by a desire to prevent HIV transmission by deterring high-risk behaviour, such laws largely fail in this aim and risk perpetuating and reinforcing HIV-related stigma. The UNAIDS Secretariat believes that enacting HIV-specific laws and broadly applying these to broad categories of behaviour perpetuates an image of people living with HIV as dangerous and undeserving of

social support. This is at odds with human rights principles and hinders an effective response.

In 2008, the UNAIDS Secretariat significantly strengthened its relationships with parliaments and parliamentarians and coproduced (with the Inter-Parliamentary Union and the United Nations Development Programme (UNDP)) *Taking Action against HIV*, a handbook designed to assist parliamentarians to advocate, mobilize resources and promote human rights.

It also teamed up with partners to map a series of programmes in 56 countries. The aim was to support human rights through an analysis of national AIDS strategies, associated action plans, successful Global Fund Round 6 and 7 grant proposals and other planning documents. Programmes identified include legal support, legal audits/law reform, 'know your rights' campaigns, human rights training for key service providers, stigma and discrimination reduction and those that address violence against women.

The Secretariat also provided input to HIV legislation developed by the Southern Africa Development Community and commented on draft HIV laws in eight countries. In close collaboration with partners, UNAIDS produced a policy brief concerning the criminaliza-

tion of HIV transmission in time for the 2008 International AIDS Conference. It also undertook a priority needs assessment examining problematic national HIV laws in western and central Africa and worked with partners to organize a regional capacity-building workshop designed to explore HIV legal frameworks. Participants included government officials and civil society.

Since countries continue to restrict the travel of individuals living with HIV, UNAIDS convened the International Task Team on HIV-related Travel Restrictions. The team is made up of over 40 members from governments, civil society and international organizations, including the International Labour Organization (ILO), UNDP, the Office of the United Nations High Commissioner for Refugees (UNHCR) and WHO (all of which are UNAIDS Cosponsors). The aim is to develop recommendations and eliminate HIV-related restrictions on entry, stay and residence. The UNAIDS Secretariat, with WHO and the Office of the United Nations High Commissioner for Human Rights (OHCHR), convened a public forum—webcast live and archived online—in honour of the life and legacy of Jonathan Mann and of the 60th anniversary of the Universal Declaration

Mainstreaming AIDS in development processes

Sustaining a long-term response requires investing in measures to build durable capacity in many low- and middle-income countries. For example, while sub-Saharan Africa accounts for two thirds of all people living with HIV, only 3% of the world's health-care providers live in the region. Evidence from Haiti, Rwanda and other countries also reveals that the creation of new HIV-specific services can improve provision of other services not directly related to HIV, such as immunizations, tuberculosis and malaria control measures, sexual and reproductive health services, and maternal and child health care. HIV service scale-up is also helping to empower patients and engage communities in patient education, health-care advocacy and initiatives to promote patient adherence to therapy and to improve medical outcomes. Achieving and sustaining universal access to HIV prevention, treatment, care and support depends on robust, well-functioning health systems.

Although vital for an effective long-term response, health is only one of the many national systems that must be bolstered to ensure success in containing HIV epidemics. Sustainable progress will also depend on stronger, durable capacity in other sectors of society, including social services and the education and labour sectors.

of Human Rights. Participants underlined the ongoing need for attention to human rights in the response to the epidemic.

The UNAIDS Secretariat continued to promote in 2008 key technical resources in the area of human rights and law, including *Reducing HIV Stigma and Discrimination: a Critical Part of National AIDS Programmes*; *Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV* (published with the Canadian HIV/AIDS Legal Network); and the *Handbook on HIV and Human Rights for National Human Rights Institutions* and the *International Guidelines on HIV/AIDS and Human Rights* (both published with OHCHR).

Increasing access to HIV treatment

From 2003 to 2007 the world witnessed an unprecedented push to boost access to treatment

for millions of people living with HIV in some of the world's poorest countries. In 2008, a joint UNAIDS/UNICEF/WHO report revealed that the number of individuals receiving antiretroviral therapy rose from one million in 2005 to three million at the end of 2007.

However, by the end of 2008 the deepening financial crisis raised concerns about whether efforts to achieve universal access to prevention, treatment, care and support by 2010 could be sustained in the face of possible reductions in donor funding. In 2007, 55 countries reported that fewer than 25% of adults and children in need of antiretroviral therapy received it. To date, only one third of those who need antiretroviral therapy in low- and middle-income countries are receiving it. Throughout 2008 UNAIDS continued to advocate for the expansion of treatment provision to all people in need living with HIV. In this respect access is an issue, as is

Supporting the Global Fund

UNAIDS has a close partnership with the Global Fund in several areas, including supporting the Fund's full grant cycle—from the development of AIDS grant proposals, to programme implementation, to monitoring and evaluation.

In 2008, UNAIDS and the Global Fund signed a memorandum of understanding to collaborate to strengthen the global response to AIDS and to accelerate progress towards universal access to HIV prevention, treatment, care and support.

UNAIDS provides the Global Fund with strategic knowledge, policy advice and technical expertise on AIDS to ensure that the funds are spent effectively. The Technical Support Facilities cover the entire project cycle of the Global Fund grant implementation.

Grant proposals: UNAIDS assists the country coordinating mechanisms as needed in developing AIDS proposals for consideration by the Global Fund. It also strengthens country coordinating mechanisms by ensuring the meaningful participation of civil society.

Programme implementation: UNAIDS provides the technical support needed to implement AIDS programmes funded by the Global Fund and works with country coordinating mechanisms to resolve implementation bottlenecks.

Monitoring and evaluation: UNAIDS supports the Global Fund in monitoring and evaluating the performance of its grantees through strengthening the capacity of principal recipients and subrecipients to report on grant implementation.

Phase 2: UNAIDS assists countries in the second renewal of grants phase.

the quality of medicines available in low- and middle-income countries.

A programming framework to guide and assist countries to expand prevention, care and treatment for children was developed—PEPFAR and UNICEF are now moving towards implementation in the field. In 2008, 17 high-burden countries began to initiate HIV testing for high-risk infants. WHO revised the global paediatric antiretroviral therapy guidelines to accommodate important new evidence that shows that children benefit from earlier diagnosis and treatment. Three paediatric fixed-dose combinations were added on the children's essential medicines list.

To stop people living with HIV dying of tuberculosis, the “3 Is” policy (intensive case finding, isoniazid preventive therapy and infection control) in tuberculosis/HIV coinfection was

proposed. Global guidelines for post-exposure prophylaxis for HIV infection were also released.

Intensifying HIV prevention

Throughout the year, UNAIDS pushed to bring HIV prevention back onto the international agenda and continued to promote ‘combination prevention’ that is evidence-informed and grounded in human rights.

In 2008, UNAIDS promoted and defined combination prevention in a special guidance aimed at stakeholders, donors and implementers. It calls for a combination of prevention approaches, tailored specifically to the unique conditions found in different communities and countries. This in turn requires that countries undertake credible surveillance, monitoring and



evaluation activities in order to identify where transmission is occurring, who becomes infected and why. In 2008, UNAIDS supported and provided guidance for an expert review of the science and policy rationales behind combination prevention—the results of which were widely disseminated through a special issue of the *Lancet* medical journal.

In 2008, UNAIDS finalized the development of a taxonomy of prevention activities that was widely lauded by AIDS service organizations and AIDS programmes. The intention is to provide a consistent definition of all activities undertaken under the description of ‘prevention’ in order to strengthen the evidence base, which may inform future developments in the field.

UNAIDS published and disseminated a short version of *Practical Guidelines for Intensifying HIV Prevention*. The Secretariat also developed quality standards for HIV prevention aimed at the mass media and developed an electronic toolkit of HIV prevention resources and planning guidance targeting national and subnational HIV programme managers. The latter will be launched in 2009.

In 2008, the United Nations Population Fund (UNFPA) led efforts to advocate increasing the supply of and demand for male and female condoms. The UNFPA-led Global Condom Initiative, an effort to prevent HIV and unintended pregnancies through comprehensive male and female condom programming, continued in 55 countries. With the assistance of UNAIDS, 20 countries drafted national condom strategies. For the third consecutive year, access to female condoms increased dramatically, reaching a record 33 million female condoms distributed in 2008.

A number of countries with high HIV prevalence and a low proportion of circumcised males are taking steps to introduce or expand adult male circumcision services. Studies have shown that being circumcised reduces the risk of female-to-male sexual transmission by approximately 60%.

In partnership with the Joint Learning Initiative on Children and AIDS, the Secretariat developed and disseminated global guidance briefs targeting young people, with a closer focus on children.

Prevention of mother-to-child transmission of HIV

Prevention of HIV transmission from a mother to her baby while in the womb, during birth or through infant feeding requires a comprehensive package of services that includes preventing primary HIV infection in women, preventing unintended pregnancies of women living with HIV, preventing transmission from pregnant women living with HIV to their infants and providing care, treatment and support for women living with HIV and their families. There is a 30% risk of HIV transmission from a HIV-positive mother to her child during pregnancy or delivery or via breastfeeding. This risk is significantly reduced when the mother and child are given antiretroviral therapy, but reports submitted in 2008 suggested that in 2007 only an estimated 34% of pregnant HIV-positive women in need were receiving such treatment.

Changing recommendations with regard to the optimum time to begin treatment means that assessment of needs could change radically. However, preventing mother-to-child transmission of HIV can be accomplished at low cost, and achieving even a small increase in the percentage of women reached and of new infections prevented will have a significant impact on the progress of the epidemic.

HIV and tuberculosis: a joint approach brings benefits

UNAIDS started 2008 with a major advocacy effort around World TB Day (24 March) to raise awareness about the heavy burden of tuberculosis felt by people living with HIV. The Executive Director launched the WHO *Global TB Control Report* with the WHO Director General, the

Executive Director of the Global Fund and the UN Secretary-General's Special Envoy to Stop TB.

Michel Sidibé, then Deputy Executive Director, sent all UNAIDS country offices country-specific data on the tuberculosis situation among people living with HIV and on the national HIV/tuberculosis response. He encouraged country staff to collaborate with the national tuberculosis programme manager in national World TB Day events.

Meeting in April in Chiang Mai, Thailand, the UNAIDS Programme Coordinating Board considered tuberculosis for the first time. A full-day thematic session brought in expertise and experience from around the world to highlight the importance of addressing tuberculosis within the global AIDS response and the benefits of collaborating with the tuberculosis community in scaling up towards universal access. As a result, the Board recognized

The road to health: HIV prevention in the transport sector

For years research has pointed to the fact that truck drivers and other transport workers remain disproportionately vulnerable to HIV infection. This is largely due to the transient and often solitary nature of their work. In 2008, the World Food Programme (WFP) embarked on an innovative initiative designed to ensure that transport personnel are made aware of the risks and vulnerabilities of life on the road.

In 2006, WFP teamed up with the distribution company TNT to launch the North Star Foundation at the Clinton Global Initiative. The aim was to promote the notion of 'responsible transport' by providing workers with basic health care and the information and services necessary to prevent HIV and other sexually transmitted infections. What began as a pilot project—a drop-in wellness centre for transport workers at the Mwanza border crossing in Malawi—is today a vibrant alliance that involves the global health community, national governments and the business sector.

The wellness centres, which are housed in refitted shipping containers, offer services free of charge. All are open during the hours most convenient for truckers: usually in the evenings when they park for the night.

In 2008, the four-million strong International Transport Workers' Federation officially joined with WFP, TNT and UNAIDS to create a network of health access points along the major transport corridors in Africa. With support from strategic partners, including the British and Dutch governments, Chevron and the Walvis Bay Corridor Group, North Star opened four new wellness centres, in addition to the two that already existed. On average, health-care staff in the centres see 35 visitors a day. Most request HIV prevention information, condoms, counselling, testing and treatment for sexually transmitted infections and other illnesses.

Today, new wellness centres are operating in Namibia, South Africa and Zambia, as well as at the original sites in Malawi and Swaziland. The UK Department for International Development provided funds to WFP Kenya and UNAIDS to establish three more centres along the Mombasa–Kampala corridor. North Star has also received funds from Family Health International/USAID to establish more than 20 centres in eight east African countries over the next three years. By 2013, 85% of the corridors in east and southern Africa will offer HIV prevention services to mobile transport workers and sex workers.

State-of-the-art technology designed to link the wellness centres together and enable real-time access to data and enhanced monitoring began rolling out late in 2008. In the future, visitors will be issued with a smartcard 'health passport' that contains personalized information that will enable speedy access to treatment anywhere within the system.

the urgent threat that tuberculosis, especially drug-resistant tuberculosis, poses to people living with HIV and requested UNAIDS, Cosponsors and countries to collaborate with partners to improve the prevention, diagnosis and treatment of tuberculosis among people living with HIV.

In June UNAIDS co-organized the first HIV/TB Global Leaders' Forum at the UN in New York, which brought together heads of government, public health and business leaders, heads of UN agencies and activists to discuss the impact of the interlinked epidemics of tuberculosis and HIV. The *Call for Action on HIV/TB* stressed the need to drastically reduce the number of deaths due to HIV/tuberculosis coinfection. This was presented to the UN General Assembly High-level Meeting on AIDS.

Throughout the year, UNAIDS has been working with Cosponsors and partners, including civil society, to integrate tuberculosis into the multi-sectoral response to AIDS. UNAIDS, WHO and the United Nations Office on Drugs and Crime (UNODC) jointly published *Policy Guidelines for Collaborative TB and HIV Services for Injecting and other Drug Users—an Integrated Approach*, and ILO and UNAIDS have been working with WHO to integrate tuberculosis prevention, diagnosis and treatment into workplace HIV programmes.

Women and girls

Gender inequalities continue to increase the vulnerability of women and girls to HIV infection. In sub-Saharan Africa, 14 women are infected for every 10 males. In addition to increasing access to HIV prevention services for women and girls, UNAIDS is encouraging countries to redouble efforts to address vulnerability. Throughout 2008, UNAIDS continued to promote the human rights of women and girls and to push for implementation of services that directly correspond to their needs—be it access to integrated reproductive health services, or challenging discriminatory laws and practices that contribute to HIV transmission.

In 2008, UNAIDS Special Envoys Ms Elizabeth Mataka and Dr Nafis Sadik focused on gender and the feminization of HIV. Both lobbied against the perpetuation of harmful practices and spoke out against commercial sexual exploitation and the trafficking of women and girls.

In 2008, UNFPA worked with other UNAIDS Cosponsors to accelerate the scale-up of prevention of mother-to-child transmission services by providing a basic package of HIV services in maternal health-care settings and for sexual and reproductive health for women living with HIV and by linking maternal health services with other sexual and reproductive health services. UNFPA and partners also completed two additional National Report Cards on HIV prevention for girls and young women. The Report Cards, now numbering 25, chart the progress in meeting HIV global commitments and offer recommendations designed to enhance prevention strategies and services for young women and girls.

Investing in Women and Girls was the theme of the International Women's Day (9 March), which had a specific focus on country-level financing for gender equality. The priority theme of the 52nd session of the Commission on the Status of Women, which concluded on 7 March 2008, was Financing for Gender Equality and the Empowerment of Women. UNAIDS delivered a statement to the commission to draw attention to the links between gender inequality and increased vulnerability to HIV infection among women and adolescent girls and to call for ensuring greater and more sustainable financing for gender equality.

UNHCR led the UNAIDS family in strengthening its HIV programmes targeting displaced persons in Africa, particularly women and girls. The organization focused on improving reproductive health, public health and nutritional services, specifically with regard to scaling up family planning services, safe motherhood, obstetric care and sexual and gender-based violence services.



Photo UNAIDS / P. Viroit

Women and AIDS

In 2008, UNAIDS enhanced its support to national partners to strengthen national AIDS programmes to better meet the needs of women and girls. UNAIDS undertook an 'internal mapping' of Secretariat capacity and needs on gender and AIDS to ascertain areas of relative strength and weakness.

UNAIDS lent its expertise to assessing national strategic plans and encouraging greater recognition of the gender dimensions common in both concentrated and generalized epidemic contexts. The Global Coalition on Women and AIDS worked with three major financing institutions—the Global Fund, PEPFAR and the World Bank—to better harmonize their emerging strategies on gender and HIV.

Interagency action

The UNAIDS Secretariat supported UNDP as the Cosponsor designated to draft the UN gender guidelines and report back to the Programme Coordinating Board in April and December. UNAIDS produced a background paper on *Caregiving in the Context of HIV and AIDS*, together with partners, for the Commission on the Status of Women, for which the UNAIDS Executive Director gave one of the keynote speeches. UNAIDS also undertook a request for proposal to build the capacity of regional technical service providers to support countries in incorporating activities on gender and AIDS into Global Fund proposals and implementation plans.

Support for action in countries

In 2008, UNAIDS raised US\$ 3 million for the establishment of a gender window in programme acceleration funds, supported the Women in Trials initiative and contributed to the Social Drivers Group symposium on Sex, Rights and the Law, to be held in early 2009. UNAIDS was also central to the launch of the Caribbean Coalition on Women and AIDS. The coalition brings together women from a diversity of backgrounds pledged to vigorously ensure gender-responsive policy and programming in the Caribbean in order to reduce all aspects of female vulnerability to HIV and to ensure universal access to prevention, care and treatment services. Its mandate is to advocate and take action to reduce the vulnerability of women and girls to HIV by: (i) building awareness of the gendered causes and consequences of the epidemic; (ii) increasing the voice and visibility of women; and (iii) strengthening women's influence in supporting gender-responsive programming and policy-making.

Support for the Global Fund

In 2008, the Global Coalition on Women and AIDS supported countries by convening a meeting of civil society technical service providers to discuss integrating gender with sexual and reproductive health services and to share best practices for proposal development. The coalition also participated in: reviewing proposals for Global Fund Round 8 applications from a gender perspective; producing (with WHO) technical briefs on gender for Global Fund Rounds 8 and 9; and providing technical inputs to the Global Fund gender strategy. It also participated in the selection committee for the Global Fund Gender Champion.



Photo UNAIDS / P. Virot

Teaching acceptance: educating children living with HIV in Namibia and the United Republic of Tanzania

In 2008, UNESCO commissioned a review of best practices in tandem with an exploratory study undertaken in two countries—Namibia and the United Republic of Tanzania—to better understand how the education sector should support HIV-positive children attending school.

Researchers found that, by far, children reported that stigma and discrimination were their greatest obstacles. Every child living with HIV interviewed in both countries described the negative consequences of disclosing his or her HIV status. All told researchers how much safer they felt by keeping silent. Stigma was described as “more killing” than the disease itself.

Study researchers found that the HIV information shared in schools was often “depersonalized and remote from the needs of the individuals infected and affected by the disease”. Associated with this sense of denial and silence is a lack of effective communication regarding sex or reproductive health. In many schools, children felt that the subject was treated “flippantly”.

However, researchers also found that the school environment has the potential to offer important social and developmental support. Families of HIV-positive children are often in crisis and not always able to provide for a child’s needs. Teachers and peers can often step in to bridge the gap—if properly trained. Furthermore, many HIV-positive children live in residential homes rather than family settings. Thus, the school becomes an important adjunct to institutional care.

The report authors also argued that gaps in data and a lack of research are masking the extent to which schools are failing HIV-positive children. However, reduced school fees and expanded lunch programmes for orphaned children, as well as those living with HIV, suggest that the situation is slowly getting better.

The UNESCO report concludes that equitable, accessible and quality education for all children can improve the quality of life of millions of children living with HIV.

Orphans

Since the epidemic began to spread, approximately 15 million children—80% of whom live in sub-Saharan Africa—have lost one or both parents to AIDS. In order to provide for these children, countries will need to strengthen their child welfare and child protection systems. In 2008, WFP led the UNAIDS effort to provide vulnerable children with in-school meals and take-home rations. Enhancing the food security of vulnerable children and their families helps to prevent new infections. During the same year, the United Nations Educational, Scientific and Cultural Organization (UNESCO) continued to expand the reach of EDUCAIDS, the Global Initiative on Education and HIV & AIDS, established in 2004. In 2008, more than 4500 copies of EDUCAIDS technical materials (published in all UN languages, as well as Portuguese) were made available to partners in the response in over 100 countries.

The UNHCR [ninemillion.org](http://www.ninemillion.org) campaign (<http://www.ninemillion.org>) advocated for a healthy and safe learning environment for nine million refugee children by 2010, including access to programming designed to reduce vulnerability to HIV.

Young people

UNFPA led the effort to reach young people by supporting youth networks, including Y-Peer, the Youth Peer Education Network, which operates in 39 countries globally. An evaluation of Y-Peer in eight of these countries concluded that the project had fulfilled its aim and had been successful in creating youth networks and in promoting greater awareness of sexual and reproductive health issues among young people. It also found that Y-Peer has strengthened the capacity of country-level youth and of sexual and reproductive health services.

Universal access for socially marginalized populations

Universal access goals cannot be achieved without providing appropriate services and support to *all* people in need, regardless of sexual orientation, gender, occupation or location. In many countries less than 10% of prevention expenditure is directed towards marginalized populations. If this funding disparity continues, it could seriously impair the overall effectiveness of the response and offend against a basic principle of the global response: that of equity.

The UNAIDS Secretariat, UNESCO and the Social Change Communication Working Group held a satellite meeting to discuss the social drivers of HIV transmission, including gender inequality, violence against women, criminalization of sex work, injecting drug use and same-sex sexual intercourse.

Men who have sex with men

UNAIDS and its Cosponsors continued to focus on men who have sex with men—people who are often both neglected in HIV programming and who are highly likely to be exposed to HIV. In 2008, UNAIDS supported a pre-conference affiliated event at the XVII International AIDS Conference in Mexico City organized by the Global Forum on MSM and HIV entitled the Invisible Men: Gay Men and other MSM in the Global HIV/AIDS Epidemic. The Secretariat also partnered with the Foundation for AIDS Research (amfAR) on its men who have sex with men initiative, worked with Cosponsors to map activities and developed a UNDP-led action plan on HIV prevention aimed at the same population.

UNESCO led the UNAIDS effort to work with international and national nongovernmental organizations to reduce transmission of HIV and other sexually transmitted diseases and to improve the sexual health of men who have sex with men in Asia and the Pacific. This joint effort aims to improve the awareness, knowledge

and skills of peer and outreach workers and health-care providers working with men who have sex with men. It also promotes collaboration, information-sharing, strategic planning and standard setting among the range of partners working with men who have sex with men.

In 2008, UNESCO and partners developed a reference manual entitled *Peer and Outreach Education for Improving the Sexual Health of Men who have Sex with Men*. The manual was developed through a consultative process engaging a wide range of organizations and technical experts. Topics covered include (among many others): sexuality, relationships, HIV and other sexually transmitted infection prevention, antiretroviral therapy, substance abuse and positive prevention. To date, the manual has been translated into a number of local languages and adapted through collaborative workshops with local nongovernmental organizations and community-based organizations in China, the Lao People's Democratic Republic, Myanmar and Thailand. Additional translations have been undertaken into Urdu (Pakistan), Bahasa (Indonesia) and Vietnamese. Adapted versions have been made available through multidonor support for all outreach workers working with men who have sex with men in Cambodia, the Lao People's Democratic Republic, Myanmar, Pakistan, Thailand and Viet Nam, and in parts of China, Indonesia and Malaysia.

Injecting drug users

In many countries injecting drug users are people at high risk of exposure to HIV and are often viewed by workers in the response to AIDS as 'hard to reach'. Since injecting drug use is often associated with poverty and illegal activities, many drug users do not access prevention or treatment services. In 2008, UNAIDS, with the support of the UN Reference Group on HIV and injecting drug use, released new estimates of HIV among injecting drug user populations. It also supported publishing a legal and policy review on impediments to harm reduction programmes in South

Asian countries. With the support of UNODC, an opioid substitution therapy programme was launched for the first time in Asia's largest complex of prisons, at Tihar, India.

UNODC worked to make more effective provision of HIV services for female prisoners and drug users in the community: countries assisted include Afghanistan, India, Iran (Islamic Republic of), Nepal and Pakistan. UNODC produces an array of publications designed to draw attention to the negative impact of HIV on women in prison settings and supported the Positive Women Network, which is designed to develop more appropriate interventions to facilitate outreach to the regular partners of male injecting drug users.

Security and humanitarian response

Displaced populations

UNAIDS and its Cosponsors place special emphasis on providing HIV services to individuals and families living in war-torn countries worldwide. In 2008, HIV services in refugee settings dramatically increased, with provision of antiretroviral therapy and prevention of mother-to-child services for refugees in need reaching 75% and 68%, respectively. However, important programmatic and policy challenges remain when it comes to reaching emergency-affected populations. The failure of many national strategic plans and donor grants to prioritize services for migrants, refugees and internally displaced persons is also a major stumbling block.

As a UNAIDS Cosponsor, UNHCR ensured access to HIV prevention, treatment, care and support for its focus populations. For refugees, voluntary counselling and testing rates improved from 60% to 70%, while access to antiretroviral therapy increased from 44% to 75%. In 2008, UNHCR published a new five-year strategic plan (2008–2012) to support, promote and implement HIV policies and programmes for refugees, internally displaced persons and other persons of concern. WFP continued to address

the food and nutritional needs of people living with HIV affected by conflict or natural disaster, including non-displaced populations. WHO facilitated further expansion of confidential voluntary counselling and testing and antiretroviral therapy services, including for returnees, while UNDP and UNFPA integrated important HIV elements into disarmament, demobilization and rehabilitation services. Cosponsors provided capacity-building on HIV prevention, care and treatment in emergencies and carried out research to improve the evidence base.

In 2008, UNHCR led the UNAIDS effort to conduct operational research among displaced populations and strengthened its HIV information system. UNHCR continued to fully integrate HIV indicators into its health-facility-based health and HIV information systems, with comprehensive information on HIV prevention, access, care and treatment indicators. In collaboration with the respective ministries of health, UNHCR coordinated a UNAIDS assessment focusing on HIV among internally displaced persons in the Central Africa Republic and in Sri Lanka and conducted a behavioural surveillance survey in Namibia and sentinel surveillance in refugee settings that included host populations in Kenya, South Sudan and Uganda. UNHCR

also undertook qualitative assessments in several refugee camps in Thailand and led the UNAIDS effort to improve access to HIV prevention, care and treatment programmes. Prevention of mother-to-child transmission service coverage increased from 57% in 2007 to 63% in 2008, confidential voluntary counselling and testing from 60% to 70% and antiretroviral therapy for refugees from 44% to 75%.

In 2008, WFP promoted 'responsible transport' by ensuring that personnel responsible for moving and delivering WFP food aid to impoverished communities are given access to HIV transmission prevention information, condoms and services for HIV and other sexually transmitted infections.

UNAIDS and the International Federation of the Red Cross and Red Crescent Societies renewed their collaboration agreement to work together to scale up efforts for universal access to HIV prevention, treatment, care and support services worldwide. The partnership, which covers a three-year period from 1 January 2009 to 31 December 2011, will focus on two main issues: addressing stigma and discrimination related to HIV and maximizing HIV prevention, treatment, care and support efforts during humanitarian crises.

Police in India commit to support community AIDS responses

Since police forces all over the world interact on a daily basis with people at higher risk of acquiring HIV, involving them in the response can have an impact disproportionate to their numbers. In 2008, UNAIDS in India proposed to the Ministry of Home Affairs to consider the value of enhancing cooperation and proactive support between the police and the agencies working with people at higher risk of exposure to HIV. With support from the police, the protection of community workers, their outreach and successful implementation of measures such as condom distribution and needle exchange programmes are now more assured.

In order to enhance awareness, the Ministry of Home Affairs, in partnership with UNAIDS, organized four regional conferences for newly identified officers for nongovernmental organization coordination who would facilitate the implementation of a strategy designed to target HIV programming for uniformed services in all states. The events were an opportunity to sensitize the state police leadership as well as representatives of health departments and state AIDS control societies to plan HIV transmission prevention initiatives in police departments together through new strategies evolved by the Ministry of Home Affairs.

Uniformed services

The UNAIDS Cosponsors made progress in 2008 in strengthening AIDS responses within the context of security, uniformed services and humanitarian crises. Key achievements include working with the armed forces to coordinate the AIDS response through the Global Task Force on Uniformed Services and AIDS and to establish and strengthen military networks in western and central Africa, Southern African Development Community countries and Latin America and the Caribbean.

The Secretariat established a network on AIDS and police in Asia and the Pacific while building up Cosponsor capacity in an effort to implement AIDS programmes for the uniformed services in countries. UNAIDS also coordinated a three-year UN system-wide work programme funded by the UK Department for International Development for HIV in emergencies and managed the implementation of new Irish funds for the same thematic area. In 2008, it co-chaired the Inter-Agency Standing Committee HIV Task Force, which revised its HIV guidelines.

Technical support facilities—supporting implementation

Supporting international partners and national governments

UNAIDS' five Technical Support Facilities work to improve country and regional access to timely, high-quality, short-term technical assistance. Together, the facilities cover more than 90 countries and are managed by a number of independent organizations. They serve HIV communities in two important ways: first, they offer rapid, reliable high-quality technical assistance and, second, they engage in a wide-ranging capacity development programme that builds consultant skills and assists country partners in managing the technical assistance they procure. The special nature of the facilities lies in their emphasis on local and regional consultants (so strengthening capacity), the South–South collaborations in which they engage and their continuing efforts to promote local ownership of initiatives and strategies.

The facilities have been increasingly involved in supporting the implementation of Global Fund grants, monitoring and evaluation activities and developing the capacity of grant recipients to

plan, budget and implement large-scale grants. Throughout 2008 the facilities supported the expansion of HIV services through technical support for all regions working through Joint UN Teams on AIDS and the Global Implementation Support Team. An indication of the value and success of this work may be seen in that those country partners that received technical support through a Technical Support Facility mobilized over US\$ 800 million and reported a 70% success rate for Global Fund Round 8 grant proposals, compared with an overall success rate of 49%.

National vigilance and flexibility are required with regard to HIV treatment. With support from international technical agencies and donors, countries need to evaluate the emergence of resistance to antiretroviral drugs, monitor drug toxicities, anticipate the need to make available alternative antiretroviral drugs and regimens and integrate HIV services with tuberculosis services. However, the risk of duplication of service



Photo UNAIDS / P. Virot

provision remains a serious concern. To that end, UNAIDS encourages and facilitates the harmonized and collaborative delivery of technical assistance that supports local and national plans. In order to do so, throughout 2008 Technical Support Facilities were active in actively building partnerships and fostering coordination at different levels, covering different perspectives and with a variety of stakeholders.

In 2008 the five Technical Support Facilities provided over 12 000 days of technical assistance: notable achievements include the following:

- ▶ Facilities in southern and eastern Africa engaged with the newly established Technical Hub for Africa of the International AIDS Alliance.
- ▶ The Technical Support Facility for South-East Asia and the Pacific focused on building consulting skills among HIV-positive experts. It held two workshops on managing a professional AIDS consulting business for consultants from HIV-positive communities, drug users and sex workers; in total, they trained 33 consultants from 11 countries in the region.
- ▶ The Technical Support Facility for western and central Africa formalized partnership arrangements with regional training institutions, such as the Ghana Institute of Management and Public Administration and the Centre Africain d'Études Supérieures en Gestion (CESAG), to build capacity among consultants in support facility priority areas and to widen their consultant database.
- ▶ Technical Support Facilities increasingly collaborated by sharing and developing course materials, attending each other's training courses, providing input to the review of the capacity development programme and offering consultant referrals.
- ▶ The Technical Support Facility for eastern Africa delivered 96 technical assistance working days to the AIDS Strategy and Action Plan and the World Bank for the development of Global Fund proposals for South Sudan and the Great Lakes Initiative on AIDS.
- ▶ The '70% success group' is another example of partnership and harmonization. This interagency coordination process was established during the preparations for the Global Fund Round 8 to improve the scope, level and coordination of technical support for submissions of HIV proposals to the Fund.



Photo UNAIDS

Chapter 3: surveillance, monitoring and evaluation

To understand the ever-changing nature of the HIV epidemic and the impact of the response demands robust and sensitive national monitoring, evaluation and surveillance systems. UNAIDS works with countries and other partners to build surveillance, monitoring and evaluation systems that can provide credible evidence. We provide direct assistance through more than 60 UNAIDS in-country monitoring and evaluation advisers to improve expertise and to develop the skills necessary to collect, analyse and interpret data.

The epidemiology of HIV

HIV prevalence estimates can only be as accurate as the HIV surveillance data that are used to generate them. The quality of data depends on the frequency and timeliness of data collection, whether the populations under surveillance are the correct ones to provide an accurate picture, the consistency of the site/locations and groups measured over time and the coverage and representation of the groups covered.

Surveillance

Throughout the year, UNAIDS continued to disseminate up-to-date scientific recommendations on improvements in data gathering and analysis methodology based on the latest scientific and surveillance data. It published several scientific papers on the latest estimation methodology (in the *Sexually Transmitted Infections* journal) and on the epidemiology of HIV among young people in southern Africa in the *British Medical Journal*. UNAIDS also provided updated recommendations about how best to conduct surveillance among children.

Detailed individual country estimates for the number of people living with HIV, national HIV prevalences and AIDS-related deaths were published in 2008. A series of updated country

Epidemiological Fact Sheets was published that, for the first time, featured time trends of epidemiological indicators.

In 2008, UNAIDS assisted the governments of 14 countries in eastern and southern Africa and in western Africa to develop AIDS strategies based on solid and detailed epidemiological evidence. As well as enabling countries to collect data and interpret them, UNAIDS also assisted countries to undertake 'incidence by mode of transmission' analyses to provide them with the information necessary to respond more effectively to the epidemic as it unfolds in their particular country context.

In Uganda, for example, researchers discovered that an estimated 43% of new infections occur among married or cohabiting couples. This finding directed policy-makers to focus more closely on strategies designed specifically to prevent HIV transmission between intimate partners; that is, counselling for couples and programmes to encourage individuals to avoid concurrent partnerships and/or to reduce their number of sexual partners.

The incidence by mode of transmission model serves to identify exposure/risk groups in which new infections can be expected in order to help plan interventions. The exercise divides the total population on the basis of their transmission

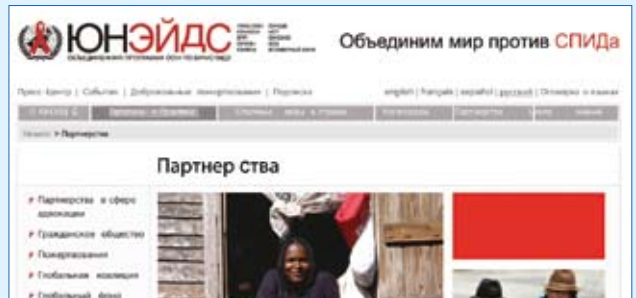
unaids.org

In March 2008 French, Spanish and Russian language versions of the UNAIDS global website were launched, making all UNAIDS web content available for the first time in four official languages of the Secretariat. This step enables UNAIDS to reach a wider audience across the globe, giving many more Internet users access to data about the AIDS epidemic, key resources and the latest HIV news.

During 2008 the global website, www.unaids.org, published over 220 news stories from the Secretariat and its Cosponsors, as well as government and civil society partners, on a wide range of topics, including analysis of issues, reviews of latest publications and policy documents and coverage of international conferences and forums.

The UNAIDS website continued in its role as the go-to source for the latest epidemiological data and statistics on the status of the AIDS epidemic with the publication of the 2008 *Report on the Global AIDS Epidemic*.

Audiences include community members, policy-makers, civil society, researchers, media, advocates, practitioners and researchers. The number of unique visitors to the site has grown steadily, reaching more than 175 000 in November 2008.



Print publications

An effective global response to AIDS depends upon planners and practitioners having access to and taking action on understandable and accurate information. Every two years UNAIDS publishes its authoritative updated assessment, the *Report on the Global AIDS Epidemic*, which provides essential statistical data and text detailing and discussing important issues. In 2008 the Report was published on the UNAIDS website and, for the first time, on a flash drive ('memory stick') supplied to delegates at the XVII International AIDS Conference. Printed copies were also distributed worldwide. The Content Management Team at UNAIDS managed more than 175 new titles in 2008, usually in multilanguage editions, ranging from small items such as leaflets and posters to much larger multipart works. Team members were also responsible for administering all the translation needs of the Programme. In the area of social responsibility, the Team is just one group within the Secretariat working to help UNAIDS become a 'greener' organization. To contribute to reducing environmental impact in the area of print publication, Team members undertook research and developed a policy on paper sourcing and quality. Additionally, whenever possible print runs have been reduced and preliminary research was undertaken for a feasibility study on sourcing print and paper regionally or nationally.



risk, including men who have sex with men, injecting drug users, sex workers and their clients and people with heterosexual partners. It also considers transmission through unsafe injections and blood transfusions. The exercise helps countries to more effectively focus prevention efforts.

The Secretariat also assisted countries to build local epidemiological capacity through a series of training workshops in key countries, including Botswana, the Democratic Republic of the Congo, India, Kenya, Malawi and Zambia.

Simplifying and harmonizing indicators for monitoring programmes

In order to determine what is working in the response, and why, researchers need to monitor and evaluate the impact of HIV programmes and services. In 2008, an external evaluation was undertaken of UNAIDS efforts to build country capacity of monitoring and evaluation. Preliminary findings reveal a number of areas in which national monitoring and evaluation systems had quantifiably improved since the initiation of the Programme. The results will be published in 2009.

In 2008, UNAIDS worked with partners to simplify the set of indicators used to monitor and evaluate the response. Through the Monitoring and Evaluation Reference Group, UNAIDS led the process of selecting a set of 40 critical indicators designed to monitor multisectoral responses, which all international partners subsequently agreed to. This represents a huge step forward in partner harmonization and a significant step in reducing the set of more than 500 indicators that have been proposed by various institutions since the beginning of the epidemic. Now national AIDS committees are able to choose from this smaller list and improve the quality and relevance of data collection.

The Monitoring and Evaluation Reference Group has also developed a set of objective

measurable criteria by which indicators should be assessed. A tool for assessing indicator quality, based on these standards, has been developed and is currently being field-tested by national monitoring and evaluation programmes in three countries.

Strengthening human resource capacity for monitoring and evaluation

In collaboration with Tulane University, UNAIDS has developed a knowledge, skills and competencies framework for monitoring and evaluation staff. This framework can be used to select staff and assess monitoring and evaluation staff capacity. It also formed the basis for the 3rd Biennial Global Monitoring and Evaluation Training, which was organized in Bangkok in October 2008. The event attracted participants from more than 60 countries.

New tools to support monitoring and evaluation

At the 12th annual meeting of the UNAIDS Monitoring and Evaluation Reference Group, a number of technical working group products were endorsed by the group, including the indicator guidance for UNGASS 2010 reporting, a framework for monitoring and evaluation among populations at higher risk, an Internet-based indicator registry, an indicator standards tool and a multi-agency monitoring and evaluation systems assessment tool.

Data are of little use unless they can be shared. In 2008, UNAIDS launched the Country Response Information System, version 3 (www.cris3.org), a tool designed to manage national HIV data. CRIS3 enables national AIDS authorities to store and share HIV data with national and international counterparts. CRIS3 was designed to accommodate the reporting needs of different donors, such as the Global Fund, PEPFAR and others, thus reducing the in-country burdens of reporting.

Strengthening monitoring and evaluation systems in South Africa

As national HIV programmes and associated projects expand, so too does the necessity of ensuring accountability and results reporting. These depend on strong monitoring and evaluation systems that produce high-quality and useful data.

South Africa is experiencing high rates of HIV/tuberculosis coinfection. As part of the response, the National Department of Health received a Global Fund Round 2 grant to strengthen the national and provincial capacity for HIV/tuberculosis-related prevention, treatment, care and support. Owing to the emergence of multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB), the country coordinating mechanism proposed to reallocate a majority of the Phase 2 budget to the upgrading of MDR-TB and XDR-TB centres throughout the country.

In Phase 1 the programme had strong results in areas such as targets for HIV testing of tuberculosis patients, tuberculosis screening of HIV-positive patients and referrals for antiretroviral therapy and intermittent preventive therapy for tuberculosis. However, performance against indicators tied directly to Global Fund financing was less than satisfactory, particularly with regard to monitoring and evaluation and the management of grant activities.

The Global Fund did not approve Phase 2 extension but did highlight a number of conditions that would need to be met. In response, the South African National AIDS Council asked the UNAIDS Technical Support Facility for Southern Africa for assistance to facilitate a monitoring and evaluation systems strengthening exercise.

A two-day training workshop involving 31 health-care professionals (including monitoring and evaluation officers and programme managers) from the Provincial and National Department of Health was held. Activities centred around the completion of a monitoring and evaluation systems strengthening tool designed to strengthen accountability and improve country systems. Participants were able to complete action plans and identify and discuss bottlenecks, inefficiencies and shortages, including staff shortfalls. The end result? The Global Fund released Phase 2 funding for the South Africa HIV/tuberculosis programme.

Africa: men who have sex with men and injecting drug users

Until very recently, concentrated epidemics among injecting drug users and men who have sex with men had largely gone unrecognized in much of Africa. This was in part owing to stigma and to a kind of collective denial.

Today, researchers recognize that a varying proportion (depending on the overall size of the epidemic) of all new infections occurs among these populations. Indeed, although the absolute numbers of people with these behaviours appear small, the estimated prevalence and incidence among injecting drug users and men who have sex with men are worryingly high.

In Unguja, in the United Republic of Tanzania, men who have sex with men had an estimated HIV prevalence of 12.3%. In Malawi, HIV prevalence among men who have sex with men was estimated at 21%, compared with the national prevalence of 14.1%. In two cities in south-western Nigeria, the story was similar to Malawi's: HIV prevalence was found to be 13.4%, or 3.5 times higher than the national prevalence, among men who have sex with men. In Kenya, the estimated HIV prevalence among injecting drug users was 42.9%, and 12.4% in South Africa.

Without efficient monitoring and evaluation systems, vulnerability among these key populations might have gone unrecognized.



Photo UNAIDS

Chapter 4: civil society engagement and partnerships

A meaningful engagement with civil society at all levels is an absolute prerequisite for a successful HIV response; this is particularly the case for groups made up of and promoting the rights of people living with HIV. In 2008, UNAIDS continued to build partnerships with all sectors of civil society and assisted many in overcoming barriers to effective involvement in the universal access movement, including governance challenges, infrastructure issues and financing.

Working with civil society

Civil society plays a key role in the global response to the AIDS epidemic. As the 2008 UN General Assembly High-level Meeting in New York illustrated, important strides have been made in strengthening community engagement with the response. In order to more strongly represent all sectors involved in the HIV response, throughout 2008 UNAIDS continued to play an important convening and supporting role, working with many different organizations in the sector, listening to and learning from individuals with a wealth of experience and ideas to strengthen the international response.

In addition to maintaining and strengthening established working relationships during 2008, the Partnerships Unit of the UNAIDS Secretariat took the initiative to implement a new focus on strengthening work with Francophone organizations.

The People Living with HIV Stigma Index

Much of what we know about the stigma attached to HIV and the resulting discrimination against people living with the virus is anecdotal or fragmented. To address this lack of evidence, a measurement tool, the People Living with HIV Stigma Index, was developed by the International Planned Parenthood Federation (IPPF), as the lead partner, in collaboration with the Global Network of People Living with HIV (GNP+), UNAIDS and the International Community of Women Living with HIV/AIDS (ICW). The tool was developed in collaboration with community leaders, activists, researchers and human rights advocates around the world. During 2008 the important process of preparing for the roll-out of the index commenced by strengthening the capacity of networks of people living with HIV and building in-country partnerships. UNAIDS Regional Support Teams and UNAIDS country

coordinators, as well as regional partners of IPPF, ICW and GNP+, worked together to provide training in using the tool. From 50 countries across Asia, the Pacific, Africa, the Caribbean and Latin and South America, 87 HIV-positive people, representing 66 organizations, were trained as trainers or team leaders.

Living 2008: the Positive Leadership Summit

UNAIDS supported, and some members of the Secretariat participated in, an important meeting—HIV+ Monaco. The meeting was a landmark in the history of the people living with HIV movement, enabling 40 leading advocates to reflect on how they could unite around a single advocacy agenda and collaborate strategically with people living with HIV networks so as to enhance the contribution of people living with HIV in addressing the epidemic and ensuring that their human rights are not ignored. HIV+ Monaco was followed by a three-month e-consultation process to further develop content and gather evidence for discussion at Living 2008: the Positive Leadership Summit, held just prior to the XVII International AIDS Conference.

The Communication Facility

UNAIDS is unique among UN organizations in that civil society in the form of representatives of nongovernmental organizations sit on its governing body, the Programme Coordinating Board. The Board is composed of representatives of 22 governments from all geographic regions, the 10 UNAIDS Cosponsoring organizations and five representatives of nongovernmental organizations elected on a regional basis. The UNAIDS Programme Coordinating Board nongovernmental organization delegation is the first civil society delegation formally represented on a UN governing board.

In an effort to further enhance the participation of civil society in policy decision-making at the global level, the delegation has created

the Communications Facility, an independent mechanism that will strengthen the capacity of the delegation to bring forward a unified and consolidated message from their constituencies to the Board meetings of UNAIDS.

This Communications Facility was established on 2 April 2008 with the recruitment of a consortium comprising the World AIDS Campaign and health and development networks, with funding provided by UNAIDS. Under the leadership of the Programme Coordinating Board nongovernmental organization delegation, the Communications Facility plans to work in two ways: it will ensure that the broad and diverse community voices are heard and influence the development of international policies that meet their needs; it will also better inform civil society about the decisions and recommendations adopted at the global level by the Programme Coordinating Board by developing and distributing a variety of information materials.

Working with faith-based organizations

UNAIDS continues to work with faith-based organizations to support their work with those living with, and affected by, HIV. With global constituencies of many millions of believers, leaders of faith-based organizations and communities are particularly influential: speaking out responsibly about HIV can have a powerful impact that reaches far beyond their immediate communities.

In April 2008, UNAIDS, in collaboration with UNFPA, hosted an initial consultation that included representatives of faith communities, people living with HIV and UNAIDS Secretariat and Cosponsor partnership staff, to develop a draft UNAIDS strategic framework for the engagement of religion and faith-based organizations in the response to HIV.

A three-day ecumenical pre-conference session with the theme Faith in Action Now! was held

Interfaith action for AIDS in Guyana

UNAIDS worked with the National AIDS Programme Secretariat of the Ministry of Health in Guyana to convene a national conference on faith and HIV. The aim of the conference was to establish a national coalition of faith leaders of all denominations in Guyana to address HIV-related stigma and discrimination. At the opening of the Guyana National Faith and HIV Conference, faith leaders from the Hindu, Christian, Islamic, Rastafarian and Baha'i faiths agreed to move from commitment and rhetoric to action by endorsing the Guyana Faith and HIV Declaration.

in Mexico City ahead of the International AIDS Conference. UNAIDS led a workshop for faith-based organizations, in collaboration with the Ecumenical Advocacy Alliance, to elicit inputs on the UNAIDS strategy on religion and faith-based organizations. During the global AIDS conference, UNAIDS led a skills-building workshop, which was packed to capacity, on working with faith-based communities; this will be something to build upon in future years.

In a historic UNAIDS-supported initiative by Hindu religious groups, over 70 prominent faith leaders from across India came together to commit to incorporating HIV information into their religious education and training of future faith leaders and to including AIDS in their discourses, rituals and festival celebrations. Senior Hindu religious leaders agreed to join the national effort to reverse the spread of HIV at the first meeting of the Faith in Action Hindu Leaders Caucus on HIV/AIDS, which took place from 1 to 2 June 2008. Religious leaders also committed to working with UNAIDS and the national AIDS control programme to increase HIV awareness among young people and to end stigma and discrimination against people living with HIV.

Partnerships with labour and the private sector

Ministries of labour, employers and workers and their representatives all have a significant stake in promoting successful HIV prevention, care, treatment and support measures. In 2008, building

partnerships with labour and the private sector became a more prominent feature of the work of UNAIDS. A series of partnerships was initiated during the course of the year.

In 2008, the UNAIDS-supported World Economic Forum Global Health Initiative released the first report on business coalitions at the 2008 annual meeting in Davos, Switzerland. The report is an in-depth study of the activities of business coalitions and will help define how they can better support the private sector in responding to AIDS. Business coalitions on AIDS have emerged as an effective platform for the private sector response to the epidemic.

Although some companies are already addressing AIDS in the workplace, others simply do not know how to mitigate risk, despite being fully aware of the impact that HIV can have on operations. Business coalitions are emerging to fill the gap and provide the private sector with the expertise necessary to effectively address AIDS in the workplace.

Business coalitions act as a voice for the private sector, often through representation on national AIDS committees and by interacting with other key stakeholders. They support the business response to AIDS through advocacy and the design, development and implementation of workplace programmes.

In 2008, the Ethiopian Business Coalition against HIV/AIDS (EBCA), the GTZ Engineering Capacity Building Program, the World Bank Institute and the Rapid Results Institute implemented a pilot programme to achieve rapid

results within businesses in Ethiopia in 100 days. In March and April 2008, 180 members of staff from 12 companies, together with six members of EBCA, attended workshops on the rapid results approach for their business HIV programmes. The trainings gave the company teams—management and employees—an opportunity to identify HIV focus areas, set ambitious targets and develop workplans.

UNAIDS and the Brazilian Business Council on HIV–AIDS Prevention (CEN) convened a regional workshop of business coalitions and initiatives in Latin America and the Caribbean in São Paulo, Brazil, from 6 to 8 October to recognize the critical role that the private sector plays in the response to HIV, exchange experiences and

discuss challenges and opportunities. It was the first inter-regional meeting of business coalitions.

UNAIDS and UNICEF Regional Support Teams for Latin America signed a cooperation agreement with the Lions Club International in Central America. The cooperation agreement will allow the organizations to join forces in the response to HIV, with the goal of promoting universal access to HIV prevention, treatment, care and support, as well as sexual health education and information initiatives, in Central America.

UNAIDS continues to work with trade unions through campaigning in partnership with the World AIDS Campaign. The global unions were very active in supporting the 2008 World AIDS Day theme: Lead. Empower. Deliver.

The hotel industry's response to AIDS

Since it can reach such a large and diverse audience of clients and staff, the hotel industry is a key player in the response to AIDS. The International AIDS Conference attracted approximately 20 000 delegates and 2000 journalists from all over the world. UNAIDS and the Mexican hotel industry launched an HIV prevention campaign entitled the Life Initiative—Hotels Addressing AIDS. Aimed at hotel guests and staff to raise awareness about HIV prevention and non-discrimination against people living with HIV, the initiative promoted the development of sustainable long-term HIV workplace policies and programmes in hotels.

Private sector role in affordable medicines

Partnerships with pharmaceutical companies and private health-care providers are critical to a unified and cohesive response to AIDS. The UN Secretary-General Ban Ki-moon, together with senior officials from the UN system, met with 17 research-based and generic pharmaceutical and diagnostic companies to review progress in strengthening efforts to expand access to HIV services in low- and middle-income countries. Companies committed to further invest in the research and development of new HIV medicines suitable for poor settings and in reliable and affordable diagnostic technologies.

The World AIDS Campaign

The UNAIDS partnership with the World AIDS Campaign remains important and allows us to campaign jointly with various constituencies (i.e. networks of people living with HIV, labour, business, youth, faith-based organizations, etc.) working from the community level right up to the highest governmental levels. Together with the World AIDS Campaign, UNAIDS has continued to design and develop printed and electronic campaigning materials for use by staff and external partners. The 2008 campaign packet included three posters and six postcards, with additional materials available online.



Chapter 5: resource mobilization and needs

In 2008, donor agencies and countries earmarked US\$ 13.8 billion to support the global AIDS response, an increase of nearly 40% from 2007. That same year, the global financial markets experienced a series of adverse events that could affect funding in 2009. Resources for HIV must be seen as investments, not expenditures. AIDS programmes are delivering results and saving lives. There is a continued need to invest in the AIDS response.

Resources available in 2008

In 2008, global financing for AIDS reached its highest level ever—US\$ 13.8 billion (Figure 4). At the close of 2008, domestic expenditures accounted for the largest financing source (52%), followed by direct bilateral cooperation (31%), multilateral institutions (12%) and the philanthropic sector (5%). Out-of-pocket spending by affected individuals and their families account for nearly US\$ 1 billion.

Many of the most-affected countries are increasing the use of their own resources. The per capita domestic public expenditure in sub-Saharan countries was six times more than in other parts of the world, after adjusting for income levels. In July 2008, ahead of the G8 meeting in Hokkaido, Japan, UNAIDS, together with the Kaiser Family Foundation, released a report showing that assistance to AIDS

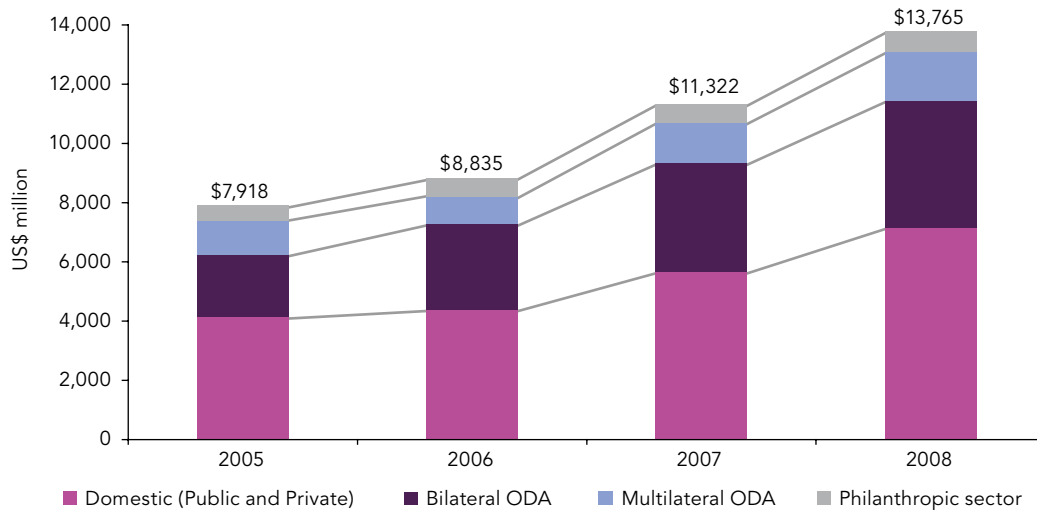
programmes from donor governments to low- and middle-income countries is being driven by a subset of G8 members and notably some non-G8 countries such as Australia, Ireland, the Netherlands and Sweden.

Most of the resources available are invested in the health sector. It is estimated that about 85% of resources were spent on health services related to HIV, including health systems strengthening.

Tracking expenditures

Understanding how finances move from the funding source to actual expenditure is an essential part of monitoring and evaluating the AIDS response. Funding sources include affected-country governmental budgets, bilateral and multilateral assistance agencies,

FIGURE 4: INVESTMENTS AVAILABLE FOR AIDS



Source: *What Countries Need*, UNAIDS.

international foundations and charities, households and the commercial sector.

In an effort to track expenditures, UNAIDS helps low- and middle-income countries monitor the way in which investments are used. In 2008, 80 countries completed national AIDS spending assessments using a tracking tool developed by UNAIDS. UNAIDS also gave assistance in strengthening the capacity of countries to undertake these assessments, which have highlighted the gaps in investments being made, especially for HIV prevention programming.

The UNAIDS Secretariat undertook several collaborative projects with the Kaiser Family Foundation and the Organisation for Economic Co-operation and Development/Development Assistance Committee to determine the resources available for HIV in 2008 and to prepare projections for 2009.

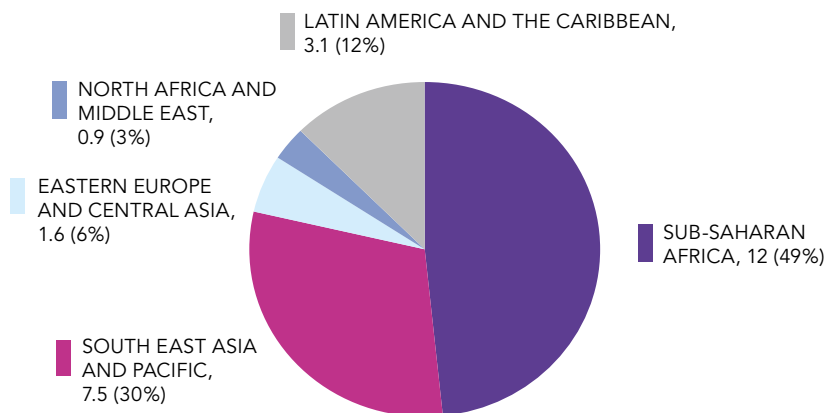
Foundations and international nongovernmental organizations play a major role in supporting and financing the AIDS response. In collaboration with the European Funders Group and the Funders Concerned about AIDS, a study was undertaken to

measure support from the European and US philanthropic sector. The study found that AIDS-related philanthropic giving in 2007 rose to US\$ 444 million from US-based bodies and to €114 million (approximately US\$ 168 million) from philanthropic bodies based in Europe. The UNAIDS Secretariat also worked with the HIV Vaccines and Microbicides Resource Tracking Working Group (a collaborative effort of UNAIDS, the International AIDS Vaccine Initiative and the AIDS Vaccine Advisory Committee). In its latest report, the working group estimated that investments in HIV vaccines and microbicides reached US\$ 1.2 billion in 2007.

Estimating future resource needs

The AIDS response requires long-term sustained financing. In 2008, UNAIDS undertook a study to estimate the new investment needs for the AIDS response following the release of the 2007 estimates of people living with HIV. The findings were published in early 2009 in a report entitled *What Countries Need: Investments Needed for 2010*. The findings focused on the investment required to meet the universal access targets

FIGURE 5: REGIONAL BREAKDOWN OF INVESTMENTS NEEDED (US\$ BILLION)

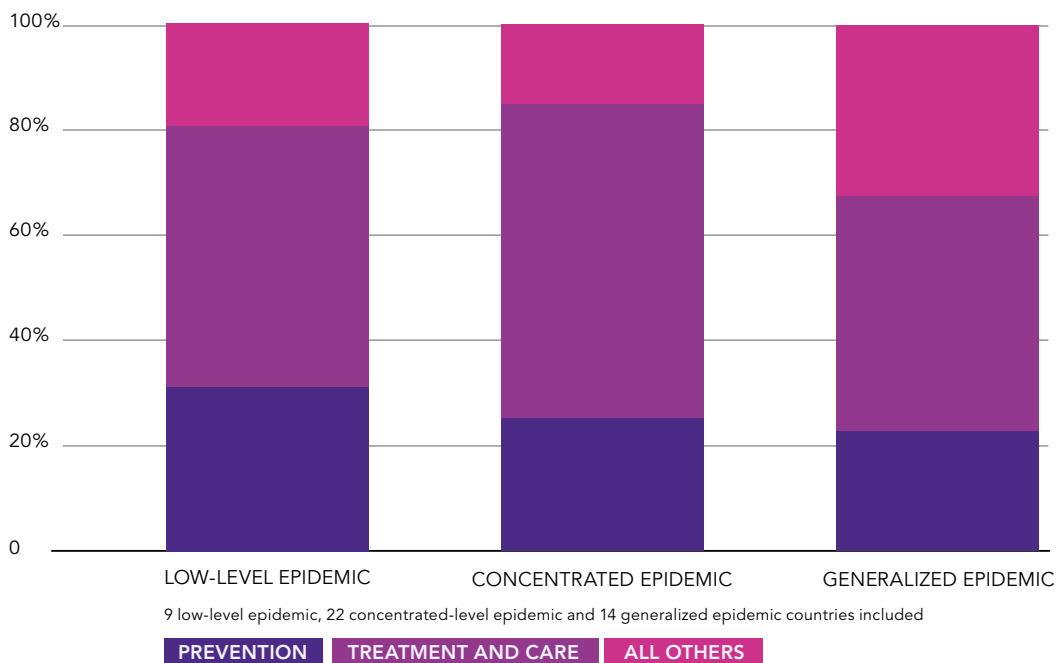


Source: *What Countries Need*, UNAIDS.

set by countries for 2010 (Figure 5). UNAIDS estimates that US\$ 25 billion will be required to mount an effective AIDS response in low- and middle-income countries by 2010. Of this, approximately US\$ 11.6 billion will be required for prevention programming and US\$ 6.9 billion for provision of treatment (Figure 6 shows the distribution of spending in 2006).

Domestic public sources will supply an estimated one third of the investment needed globally, while the remaining two thirds will require external investment. Most of the external assistance will be provided to low-income countries, particularly the highest-prevalence countries of sub-Saharan Africa.

FIGURE 6: DISTRIBUTION OF HIV SPENDING ACCORDING TO SPENDING CATEGORY AND TYPE OF EPIDEMIC, 2006



Source: 2008 *Report on the Global AIDS Epidemic*, UNAIDS.

Cosponsor highlights



Office of the United Nations High Commissioner for Refugees (UNHCR)

HIV, refugees, internally displaced populations and other persons of concern

In 2008, UNHCR published a five-year Strategic Plan for HIV and AIDS (2008–2012) to support, promote and implement HIV policies and programmes for refugees, internally displaced persons and other persons of concern. In accordance with the provisions of the Unified Budget and Workplan, the plan outlines the overall objectives, main strategies and key indicators to address HIV within the context of the UNHCR mandate to protect its persons of concern.

Together with partners, UNHCR improved access to HIV prevention, care and treatment programmes in 2008. Prevention of mother-to-child transmission service coverage increased from 57% in 2007 to 63% in 2008, voluntary counselling and testing from 60% to 70% and antiretroviral therapy for refugees from 44% to 75%. HIV programmes in Africa were likewise strengthened. This led to improved reproductive health, public health and nutritional services for UNHCR persons of concern, specifically with regard to scaling up family planning services, safe motherhood, obstetric care and sexual and gender-based violence services. UNHCR is supporting HIV programmes targeting returnees in eight countries in Africa and one in Asia. The organization also provided packages with information about HIV prevention and the availability of services for repatriates transiting

through returnee areas. In 2008, UNHCR continued to focus attention on HIV prevention, with specific attention given to populations at higher risk residing in Asia, the Americas, Europe and the Middle East and North Africa.

UNHCR also organized regional capacity-building training, which included training focusing on HIV protection and programming in the Americas and, in eastern Europe, on HIV vulnerability among internally displaced persons, refugees and Roma. Anti-stigma and discrimination activities and rights-based advocacy activities intensified in Europe, the Middle East, North Africa and the Americas. The organization and partners also developed and disseminated a number of new information, education and communication materials.

UNHCR continued to advocate for the inclusion of refugees, asylum seekers and internally displaced persons in individual country national strategic plans and developed brief action sheets for the Joint UN Theme Groups on HIV and AIDS to support efforts to ensure that persons of concern are included. The UNHCR [ninemillion.org](http://www.ninemillion.org) campaign (<http://www.ninemillion.org>) continued to advocate for a healthy and safe learning environment for nine million refugee children by 2010, including access to programming designed to reduce vulnerability to HIV.

To ensure evidence-based programming, UNHCR conducted operational research in displacement settings and strengthened its HIV information system. The agency continued to fully integrate HIV indicators into its health-facility-based health and HIV information systems, with comprehensive information on HIV prevention, access, care and treatment

indicators. In collaboration with the respective ministries of health, UNHCR coordinated an interagency assessment focusing on HIV among internally displaced persons in the Central Africa Republic and in Sri Lanka and conducted a behavioural surveillance survey in Namibia and sentinel surveillance in refugee settings that included host populations in Kenya, South Sudan and Uganda. UNHCR also undertook qualitative assessments in several refugee camps in Thailand.

In 2008, UNHCR conducted an evaluation of the implementation of the 2005–2007 strategic plan on refugees, HIV and AIDS. Results indicate that essential HIV prevention interventions such as protection and assistance coverage improved in refugee operations overall. However, the assessment also revealed that many countries have yet to include refugees and internally displaced persons in their HIV national strategic plans in Global Fund funding proposals.

To strengthen programmes and to fill gaps, UNHCR published various publications, including *Guidance on Infant Feeding and HIV in the Context of Refugees and Displaced Populations*, *Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations* (with WHO), a *Manual for Conducting HIV Behavioural Surveillance Surveys among Displaced Populations and their Surrounding Communities*, *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities* (with WHO and UNAIDS) and a guidance brief for *HIV Interventions for Young People in Humanitarian Emergencies* (in collaboration with the UNAIDS Interagency Task Team on Young People). UNHCR has also finalized a *Policy Statement on HIV Testing and Counselling* for refugees, internally displaced persons and other persons of concern to UNHCR.

UNHCR continued to address the interlinkages between HIV and sexual and gender-based violence. Standard operating procedures are in place for sexual and gender-based violence

response. UNHCR supported the integration of HIV prevention activities for women and girls that include sexual and gender-based violence responses in 75 countries and provided training and support on clinical management of rape, with more emphasis on health and psychosocial response. UNHCR strengthened community services to assist with the reduction of HIV vulnerability among women and to improve programmes for sexually transmitted infections and rolled out post-exposure prophylaxis in the southern Africa region.

UNHCR increased collaboration with the other Cosponsors: UNFPA for the provision of HIV prevention commodities, reproductive health, clinical management of rape, HIV prevention and response for young people, and HIV and sex work in humanitarian settings; WFP for food security and nutrition for persons of concern, including innovative ways to prevent and treat anaemia; WHO for mental health and substance abuse among conflict-affected and displaced populations. Other collaborations occurred with OCHA and the humanitarian cluster leads to ensure that HIV is a cross-cutting issue among all clusters. UNHCR also worked with Regional AIDS Initiatives in Africa (the Great Lakes Initiative on AIDS and the IGAD Regional AIDS Partnership Program) to ensure access to comprehensive HIV prevention, treatment, care and support to persons of concern. UNHCR is a member of the Inter-Agency Standing Committee HIV Task Force and was an active member of the International Task Team on HIV-related Travel Restrictions. UNHCR advocated strongly to ensure that HIV-related restrictions on entry, stay and residence should not result in the denial of the right to seek asylum, the right to be protected from refoulement or other rights applicable to refugees and asylum seekers.

UNHCR supported HIV workplace programmes in 50 countries, targeting UNHCR staff members and the staff of its implementing partners.

As part of the advocacy effort to improve HIV programming and interventions in humanitarian settings and to share experiences, UNHCR presented analysis of data, including lessons learned and operational research results, during the XVII International AIDS Conference in Mexico and at the 15th International Conference on AIDS and STIs in Africa.



United Nations Children's Fund (UNICEF)

Children and AIDS

Through the Unite for Children, Unite against AIDS initiative, UNICEF, UNAIDS and partners joined forces to feature children more prominently on the global AIDS agenda. In 2008, the initiative's call for action resulted in strengthened partnerships and produced measurable results with regard to the prevention of mother-to-child transmission, the provision of paediatric care and treatment, the prevention of HIV infection among adolescents and the protection and support of children affected by AIDS. The annual progress report *Towards Universal Access—Scaling up Priority HIV/AIDS Interventions in the Health Sector* (WHO, UNAIDS, UNICEF), as well as the third annual *Stocktaking Report on Children and AIDS* (UNICEF, UNAIDS, WHO and UNFPA) 2008, revealed that, despite obstacles, significant progress has been made towards the achievement of the universal access goals.

By the end of 2007, 33% of pregnant women living with HIV received antiretroviral therapy, compared with only 10% in 2004. A series of UNICEF/WHO-led interagency task team joint technical missions that focused on the prevention of HIV infection of pregnant women, mothers and their children successfully accelerated country-level efforts. A UNICEF-commissioned study confirmed that beneficiary countries significantly improved access to prevention of mother-to-child transmission programming

both within health-care settings and at the community level. In addition, the involvement of UNICEF in the Global Fund and UNITAID, along with its participation in over 80 UN joint country AIDS teams, and country-level planning processes with stakeholders such as PEPFAR, has leveraged funds and policy change based on best practice and normative guidance.

A dramatic expansion of paediatric care and treatment is occurring in every region of the world, with the most significant gains in sub-Saharan Africa. By December 2007, almost 200 000 children under the age of 15 received antiretroviral therapy. Moreover, 2008 also saw the development of new evidence-based guidelines highlighting the necessity of early diagnosis and access to treatment and care for HIV-positive infants. UNICEF and partners worked to build national capacity for the early diagnosis of HIV in infants alongside the concomitant expansion of access to cotrimoxazole, a low-cost, effective and critical intervention that can delay or prevent serious illness in HIV-positive infants. During that same year, UNICEF procured US\$ 68.7 million worth of HIV-related commodities, including antiretroviral drugs, tests for HIV and other sexually transmitted infections and other paediatric treatments.

The 4th Global Partners Forum on Children Affected by AIDS, held in October 2008, established an evidence-based consensus that emphasizes investing not only in children affected by AIDS, but all vulnerable children. Investments include increasing access to basic services, ensuring appropriate alternative care and providing social support and protection from abuse and neglect. In sub-Saharan Africa, 35 countries completed the revised orphans and vulnerable children Policy and Planning Effort Index Survey. By 2007, 31 countries had carried out orphan and other vulnerable children situation analyses—a 58% increase compared with the number undertaken in 2004. In the same region, 15 countries have adopted a specific

policy on orphans and vulnerable children or have ensured that general policies cover their needs. UNICEF is leading the Monitoring and Evaluation Working Group of the Interagency Task Team on Children and HIV and AIDS and has completed a monitoring and evaluation national indicator guidance, which is designed to be a standard for all partners.

Worldwide, a renewed emphasis on prevention presented an important opportunity to ensure that adolescents and young people benefit from prevention efforts that take local realities into consideration. It is now well documented that adolescents and young people living in low-prevalence countries with concentrated epidemics face a heightened risk of acquiring HIV. In partnership with the London School of Hygiene and Tropical Medicine, UNICEF collected disaggregated data examining behaviour among boys and girls at high risk of exposure to HIV in seven countries located within central and eastern Europe and the Commonwealth of Independent States. Results are now being shared with stakeholders for appropriate follow-up. In 2008, national HIV strategies increasingly focused on young people—as demonstrated in west and central Africa, where 22 countries included young people in their national HIV strategic plans.

Solid evidence points to the fact that girls and young women remain disproportionately vulnerable to HIV infection in sub-Saharan Africa. In 2008, UNICEF commissioned an in-depth analysis of domestic and household survey data from five sub-Saharan countries. The study found a significant association between a young woman's HIV status and the number and age of her partners.



World Food Programme (WFP)

Nutrition, food security and HIV

WFP is the world's largest humanitarian agency and provides food assistance to approximately 86 million people living in the world's poorest countries. As the UN agency responsible for dietary and nutritional support within the UNAIDS Division of Labour, WFP relies on innovation, speed and organization to provide food and nutritional support to people living with, and affected by, HIV.

WFP provides food assistance to individuals receiving treatment for tuberculosis or HIV in order to improve adherence with the treatment among those who live on the very edge of survival. Nutritional support can help with recovery and can mitigate negative drug side-effects. WFP helps to ensure that national and community-level HIV programmes include gender-responsive nutritional components and contributes to research on the efficacy of specially-formulated food products for people living with HIV.

WFP is also working to prevent HIV infection and to strengthen national AIDS responses through advocacy, guidance and technical support for nutrition and food security.

In 2008, high food prices compromised the food security and nutritional status of millions of the world's most vulnerable people. At the same time, the expansion of antiretroviral therapy in countries with high rates of food insecurity led to greater demands for food support. In 2008, WFP supported HIV prevention, treatment and care in 20 of the 25 countries with the highest HIV prevalence. Overall, WFP supported HIV and tuberculosis programmes in 50 countries

worldwide; 2.2 million individuals benefited, 52% of whom were women and girls.

Countries receiving food and nutrition support for antiretroviral therapy programmes increased from 16 in 2006 to 26 in 2008. Within the same period, the number of countries supporting home-based care activities decreased from 13 to 8, indicating that food and nutrition are increasingly being recognized as critically necessary to the success of treatment expansion efforts. WFP continues to refine efforts to become more responsive to programme needs and to ensure that limited resources are used wisely in order to achieve the desired outcomes.

WFP and partners care for and protect vulnerable children by providing in-school meals and take-home rations. By protecting the food security of vulnerable children and their families, WFP is helping to prevent new infections; for example, food supply may reduce the possibility or necessity of women and girls selling sex. Furthermore, WFP is also committed to engaging in 'responsible transport' by ensuring that personnel responsible for moving and delivering WFP food aid to impoverished communities are given access to prevention information, condoms and services for HIV and other sexually transmitted infections.

WFP enjoys two notable private sector partnerships: one focused on enhancing nutritional support for people living with HIV and the other promoting HIV prevention in the transport sector. WFP and the Dutch chemical group DSM are collaborating on the development of a number of innovative products specially designed to boost the nutritional status of malnourished people living with HIV. WFP and the global express delivery company TNT are working with the International Transport Workers' Federation and UNAIDS to increase access to HIV prevention services through a network of conveniently located drop-in health centres targeting mobile transport workers.



United Nations Development Programme (UNDP)

Placing AIDS at the centre of development efforts

UNDP supports national partners to address development challenges and achieve the Millennium Development Goals. In 2008, UNDP implemented programmes to strengthen the links between the HIV response and broader development efforts. In order to advance towards the achievement of universal access and the Millennium Development Goals, UNDP prioritized programmes to promote HIV-related human rights alongside initiatives to increase attention to women, girls and gender equality. The programme also implemented initiatives to reduce stigma and discrimination and to address HIV among men who have sex with men and transgender populations. In addition, UNDP supported country partners to more effectively coordinate both national and local HIV responses and to strengthen the implementation of Global Fund programmes.

Through a joint programme with the World Bank and the UNAIDS Secretariat, UNDP led efforts to support 23 countries in sub-Saharan Africa, the Caribbean and eastern Europe to integrate HIV responses into poverty reduction strategy papers and national development planning and implementation. The programme resulted in the greater integration of HIV responses within sector and district planning and in national planning and budgeting processes. In addition, UNDP developed a conceptual framework that identified key strategic approaches for more effective HIV mainstreaming in low-prevalence environments.

In 2008, UNDP also supported reviews of laws to promote and protect the human rights of individuals living with HIV and provided support

to national partners to respond to the proposed criminalization of HIV transmission in some sub-Saharan countries. Technical support was provided for parliamentarians representing all Arab countries to assist in the development of a draft Arab convention to protect the rights of people living with HIV. In Asia, the UNDP assessed laws relating to sex work, trafficking and the property and inheritance rights of women. UNDP collaborated with the UNAIDS Secretariat to convene and support the UNAIDS Reference Group on HIV and Human Rights and the International Task Team on HIV-related Travel Restrictions.

To address the issue of gender equality, a global interagency working group was created to coordinate and accelerate UNAIDS and UNIFEM support and to develop guidance designed to promote the implementation of gender action throughout country AIDS programmes. In the Asia-Pacific region, UNDP, in collaboration with the UNAIDS Secretariat and UNIFEM, led the development of *Women and HIV in the Asia-Pacific Region: a Development Practitioner's Guide*. Technical support was also provided to integrate and programme gender into national HIV strategies and to implement initiatives that will promote the inheritance and property rights of women. UNDP and partners also conducted research into the spousal transmission of HIV in Asia and established initiatives designed to reduce the vulnerability of migrant women and to economically empower women living with HIV.

To highlight the role of stigma and discrimination as barriers to the HIV response, UNDP launched a Regional Human Development Report, *Living with HIV in Europe and the CIS*, which drew attention to the human cost of social exclusion. In the Arab States, UNDP worked with national programmes operating in eight countries to increase the capacity of Muslim and Christian religious leaders to address HIV-related stigma and discrimination.

In 2008, UNDP also provided support to community-based organizations and national and local groups of people living with HIV in

order to strengthen leadership and organizational capacity, to collaborate with governments and to more effectively engage in the AIDS response. UNDP also worked with governments and other stakeholders to develop policy guidance to promote effective partnerships between networks of people living with HIV and governments.

UNDP hosted the Red Ribbon Award community dialogue spaces at various international and regional AIDS conferences to create platforms for mutual learning and engagement with global and regional policy-makers. It also provided financial support and helped to build the capacity of community-based organizations in 32 countries.

In 2008, UNDP helped strengthen the governance of national and decentralized AIDS responses through initiatives designed to build the capacity of national, district and municipal authorities to coordinate and implement AIDS programmes in east and southern Africa. A coordination secretariat was established to promote experience-sharing and sub-regional cooperation among national AIDS authorities in west and central Africa, and assessment studies were conducted that identified challenges and highlighted good practices that promoted effective leadership and coordination. UNDP also assisted governments to build country capacity to enable trade and to strengthen health policies and legislation. This included supporting patent examiners in Africa and Latin America to help assess pharmaceutical patents from a public health perspective in addition to initiatives designed to improve literacy about the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS Agreement) and access to treatment in Asia. Through a partnership with the Global Fund, UNDP intensively supported 29 countries to improve the management, implementation and oversight of Global Fund grants and to strengthen the financial and procurement capacity of principal recipients and subrecipients. As a result of these efforts, notable results were achieved in supporting national strategies for HIV prevention, treatment and impact mitigation.



United Nations Population Fund (UNFPA)

Linking sexual and reproductive health and HIV

Since most HIV infections are sexually transmitted or associated with pregnancy, childbirth or breastfeeding, UNFPA offers an integrated approach to the delivery of sexual and reproductive health and HIV policies, programmes and services. Strengthening these linkages is widely acknowledged to be critical to achieving the Millennium Development Goals. In the context of the multiple universal access goals (to reproductive health and to HIV prevention, treatment, care and support), UNFPA advocacy and programming efforts concentrate on preventing HIV infection and ensuring the provision of sexual and reproductive health services to those living with HIV. UNFPA focuses primarily on women and young people, who are both vulnerable to HIV and often overlooked in prevention efforts.

Strengthening national capacity and ownership through effective partnerships is an essential element of the UNFPA strategy. In 2008, UNFPA supported the institutional strengthening and technical capacity-building of UNFPA country offices and United Nations country teams. This resulted in the recruitment of over 120 national HIV focal points in 65 countries as well as regional and subregional HIV advisers. UNFPA's enhanced HIV capacity has had a significant impact on prevention, including through comprehensive condom programming and strengthened internal linkages within its core mandate of sexual and reproductive health. Support for regional and national key population organizations has bolstered progress in the AIDS response in the areas of women, young people and HIV and sex work.

UNFPA provided technical assistance to more than 40 countries to incorporate the interlinkages of population dynamics and reproductive health, youth, gender and HIV in national development frameworks, action plans and regional and national strategies. A 2008 external review of UNFPA's efforts to support national responses to HIV concluded that the scope, intensity and quality of UNFPA's contribution to HIV prevention programming have undergone a significant positive shift in the past three years. This has increased UNFPA's credibility and heightened expectations with regard to national, international and UN partners.

UNFPA played a key role in the XVII International AIDS Conference, held in Mexico City, and in the 15th International Conference on AIDS and STIs in Africa, held in Dakar. UNFPA supported 600 young people from 41 countries to actively participate in the conferences. Thoraya Obaid, the UNFPA Executive Director, participated in a session that examined the links between gender-based violence and HIV and attended the inaugural meeting of Latin American and Caribbean Ministers of Health and Education to discuss sexual and reproductive health education, including HIV prevention.

UNFPA hosted special events featuring young people and highlighted the need to make the global response to HIV more gender equitable in a bid to encourage world leaders attending the United Nations General Assembly High-level Meeting on AIDS to increase efforts to meet the needs of women and youth living with HIV and to more effectively integrate sexual reproductive health into the AIDS response. During the meeting, UNFPA also launched a booklet that features real-life HIV prevention success stories from around the world.

As part of UNFPA's efforts to promote evidence-informed tools to strengthen linkages between sexual and reproductive health and HIV, UNFPA and partners developed, published and disseminated several reports, including the *Rapid*

Assessment Tool for Sexual & Reproductive Health and HIV Linkages: a Generic Guide. The assessment tool has already been utilized to facilitate the development of country-level action plans in Uruguay and in Pacific island countries. Over 60 countries in all regions have received capacity-building training and have expressed an interest in implementing the tool.

Furthermore, UNFPA and its partners released *Linkages: Evidence Review and Recommendations*, which confirmed the benefits of linking policies, systems and services for HIV and sexual and reproductive health. Two case studies, *Gateways to Integration: a Case Study from Haiti* and *Gateways to Integration: a Case Study from Kenya*, offer in-depth examples of how this can be accomplished.

UNFPA continued to advocate to increase the supply of and demand for male and female condoms. The UNFPA-led Global Condom Initiative, an effort to prevent HIV and unintended pregnancies through comprehensive male and female condom programming, continued in 55 countries. With UNFPA's assistance, 20 countries drafted national condom strategies and are now working to develop five-year costed operational plans, with identified funding and a specified division of labour among implementing partners. For the third consecutive year, access to female condoms increased dramatically, reaching a record of 33 million female condoms supplied in 2008. Comprehensive condom programming is part of the UNFPA commitment to global reproductive health commodity security.

UNFPA continued its efforts to increase access to comprehensive sexual and reproductive health and HIV information, education, skills and services for young people in and out of school, especially those most vulnerable. Strategies included: mobilizing effective coordination mechanisms at the global, regional and country levels; capacity-building; the development of policy and programme guidance tools; and support and advocacy for youth involvement and participation. Under UNFPA leadership,

the Interagency Task Team on HIV and Young People clarified its Terms of Reference and expanded its membership beyond the UN to include selected youth networks and associations, bi- and multilateral donors, civil society and foundations. In an effort to clarify roles, and within the context of young people as a whole, the interagency task team also adapted the UNAIDS Technical Support Division of Labour. The seven Interagency Task Team Global Guidance Briefs on HIV and Young People outline specific actions necessary to guide an effective response to HIV among young people in areas such as education, the workplace and humanitarian emergencies.

UNFPA continued to support youth networks, including Y-Peer, the Youth Peer Education Network, which operates in 39 countries globally. An evaluation of Y-Peer in eight of these countries concluded that the project has successfully accomplished its aim: to create youth networks, to improve knowledge of sexual and reproductive health issues among young people and to strengthen the capacity of country-level youth and of sexual and reproductive health services.

UNFPA and partners completed two additional National Report Cards on HIV prevention for girls and young women. The Report Cards, now totalling 25, chart the progress in meeting global commitments to HIV and offer recommendations designed to improve HIV prevention strategies and services targeting young women and girls.

Advocacy continues in an effort to accelerate prevention of mother-to-child transmission service provision scale-up, with a specific focus on a basic package of HIV services in maternal health-care settings, sexual and reproductive health for women living with HIV and linking maternal health services with other sexual and reproductive health services. In 11 countries, UNFPA provided technical support through the regional training of trainers workshops aimed at further integrating prevention of mother-to-child transmission services into primary and

maternal health care. As one of 20 members of the Interagency Task Team on Prevention of Mother-to-child Transmission, UNFPA pushed for strengthened data collection, monitoring and evaluation, including the development of a family planning indicator to be used during prevention of mother-to-child transmission service provision.

The *UNAIDS Guidance Note on HIV and Sex Work*, which outlines an evidence and rights-based three-pillar approach, was revised and agreed to by the UNAIDS Cosponsors. Country-level programming focusing on HIV and sex work is taking place in more than 60 countries and more than a dozen regional, sub-regional, national or local consultations involving governments, UNAIDS Cosponsors and the Secretariat, and civil society were supported in all regions of the world.



UNITED NATIONS
Office on Drugs and Crime

United Nations Office on Drugs and Crime (UNODC)

Injecting drug use, prisons, human trafficking and HIV

In 2008, UNODC strengthened its emphasis on making HIV policies and programmes more gender responsive through developing and expanding HIV prevention, treatment and care services for women prisoners and women drug users in the community (e.g. in Afghanistan, Iran (Islamic Republic of), Nepal and Pakistan). In India, UNODC supported the Positive Women Network and other self-help groups to develop more appropriate interventions to facilitate outreach to regular partners of male injecting drug users. UNODC continued to draw attention to the devastating and wide-ranging impact of HIV on women in prison settings. In Iran (Islamic Republic of), UNODC supported the

ministry of health in developing a guideline on gender-sensitive HIV services.

In Viet Nam, UNODC assisted in revising the law on drugs, with the aim of incorporating a public health perspective on drug dependence, including an article on harm reduction. In South Asia, UNODC supported publishing a legal and policy review on impediments to harm reduction programmes in the region. In Nepal, UNODC scaled up opioid substitution therapy services and supported the inclusion of harm reduction components in the National AIDS Action Plan 2008–2011, engaging the drug user community. In Bangladesh, UNODC advocated and facilitated the approval of the methadone maintenance programme and the International Narcotics Control Board approval process to produce methadone locally. In Afghanistan, UNODC promoted the provision of opioid substitution therapy among all relevant governmental counterparts.

In the Russian Federation, UNODC provided training to drug control officers on an international legal framework to support both needle and syringe programmes and opioid substitution therapy and provided training for law enforcement officers to reduce the stigmatization of people living with HIV, drug users and sex workers. In Estonia, Latvia and Lithuania, UNODC supported the development of evidence-based national AIDS programmes through an extensive consultation process. In central Asia, UNODC assisted authorities to undertake legislative amendments to enhance prevention activities. UNODC also conducted a regional workshop on the legal ramifications and management of opioid substitution therapy, launched substitution therapy services in Turkmenistan, expanded substitution therapy access in Azerbaijan, Kyrgyzstan and Uzbekistan and facilitated the introduction of therapy in Tajikistan. In Mauritius, UNODC facilitated the implementation of methadone substitution therapy, a pilot needle and syringe programme

and inclusion of the needs of migrant populations in the national AIDS strategy.

In 2008, UNODC significantly expanded its HIV programmes in prisons in the Middle East, North Africa and sub-Saharan Africa. UNODC advocated for policy and legislation changes in prisons, provided technical support in more than 15 countries and supported HIV situational analyses in 10 countries. The development of country-specific HIV training materials for prison settings was supported in the Baltic States, Cape Verde, India, Indonesia, Iran (Islamic Republic of), Malaysia, Mauritius and Nepal. UNODC raised human rights concerns related to compulsory drug treatment centres and advocated for a review of the long-term detention of drug users in compulsory drug detoxification centres. In India, an opioid substitution therapy programme was launched for the first time at Tihar, Asia's largest complex of prisons.

In Kenya, UNODC supported the development of the National AIDS Strategic Plan and the Kenya Joint UN Programme of Support on AIDS (2007–2012). In Botswana, Lesotho, Malawi, Mozambique, Seychelles, South Sudan, Swaziland, Uganda, the United Republic of Tanzania and Zambia, UNODC provided technical assistance to several national authorities and civil society organizations.

One hundred and twenty delegates, from civil society organizations and ministries of health and justice, from 20 countries met and agreed on a Latin American HIV in prisons framework that had 20 recommendations for a regional strategy. The Central American and the Andean (Bolivia (Plurinational State of), Chile, Colombia, Ecuador, Peru and Venezuela (Bolivarian Republic of)) networks on HIV in prisons were established and a declaration on HIV in prison was endorsed.

In Indonesia, UNODC assessed the extent to which HIV services were available for people vulnerable to human trafficking. In India, in partnership with other organizations, UNODC

successfully advocated for the review and modification of the Immoral Traffic (Prevention) Amendment Bill, which would have hindered sex workers from accessing HIV prevention services. In Brazil, UNODC supported the implementation of the National Plan of Action against Trafficking in Persons. In Central America, UNODC integrated the Safe Mobility Toolkit as part of the implementation of a regional project to strengthen national and regional capacity against trafficking of persons.

In 2008, guidelines and toolkits developed, translated and disseminated by UNODC with its partners included: *HIV and AIDS in Places of Detention*; a technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users; a policy brief on injecting drug use and HIV; an evidence for action technical paper about policy guidelines for collaborative tuberculosis and HIV services for injecting and other drug users; and a briefing paper on HIV, women and prisons. As part of its ongoing efforts to prevent HIV associated with human trafficking, UNODC published the second edition of the *Toolkit to Combat Trafficking in Persons*, which included guidance concerning HIV and trafficking of persons. UNODC distributed the toolkit to a variety of practitioners in more than 80 countries, including judges, service providers, border guards, law enforcement agents, prosecutors and policy-makers.

UNODC, on behalf of the UNAIDS family, organized the 2nd Informal Inter-country Consultation on HIV Prevention and Care among Injecting Drug Users and in Prison Settings, which was attended by representatives of national criminal justice and drug control authorities, national AIDS programmes and civil society organizations from 52 countries.

In 2008, UNODC continued to support the Reference Group to the United Nations on HIV and Injecting Drug Use. A review of the global epidemiology of injecting drug use and

HIV was completed based on extensive systematic search of the available peer-reviewed and other literature. Key findings were published in the *Lancet* and globally disseminated for policy-makers and expert bodies.



International Labour Organization (ILO)

AIDS in the workplace

“Since the training I write my judgements involving HIV/AIDS with confidence, knowing I am doing the right thing, that it is acceptable and within international norms, practice and standards”, says a high court judge in Malawi. “I am also a great advocate to my fellow judges on total elimination of HIV/AIDS discrimination, not only in the workplace but everywhere in our society”.

In 2008, at the request of governments and authorities responsible for labour courts and industrial tribunals, ILO trained over 140 labour judges and magistrates on issues relating to HIV discrimination.

ILO collaborated with partners to assist governments to create a legal-policy environment designed to enable the HIV response in a number of key countries. The organization also helps the industrial sector and individual enterprises to develop workplace policies and programmes. In 2008, ILO continued to advise member States to integrate HIV provisions into labour law as well as into workplace strategy responses. During that same year, ILO responded to requests from 19 member States for assistance in revising laws or developing national/sectoral policies.

The application of labour laws and regulations in most countries is guided and supported by the labour inspectorate. During 2008, ILO helped to train 70 labour inspectors to develop and imple-

ment HIV policies and programmes, which they will then guide and monitor.

ILO also assisted various ministries and employer and worker organizations and enterprises in 70 countries to develop and implement HIV policies at the workplace, sector and national levels. More than 660 enterprises participated. Some 256 enterprises agreed to add a number of new HIV workplace policies, including the integration of HIV and general worker wellness programmes, into occupational safety and health programmes. In 2008, ILO strengthened its tuberculosis programme in order to promote worker access to national tuberculosis programme outreach efforts. In Swaziland, more than 24 enterprises report tuberculosis–HIV activities. The ongoing emphasis on prevention was increasingly linked to livelihood support for people affected by HIV. Several countries, including China, India and Nepal, developed and established social protection measures, income-generating opportunities and employment programmes for people living with HIV.

As well as assisting member States to identify those sectors and workplaces that put personnel at higher risk of HIV exposure, ILO has responded to requests for assistance to lessen or prevent the vulnerability of certain groups of workers, especially migrants. ILO also helps countries and individual businesses to focus interventions accordingly. The two strategies often intersect, because certain industries, for example construction, mining and agriculture, employ large numbers of migrants. In 2008, ILO collaborated with partners to protect the health and rights of migrant workers and their families in over 13 countries all over the world. In eastern Europe, for example, ILO/AIDS joined up with the ILO Special Action Programme to Combat Forced Labour to include HIV prevention in existing pre-migration training. The initiative targets female migrant workers leaving Armenia, Azerbaijan, Georgia, the Republic of Moldova and Ukraine. ILO also participated in the launch of another major programme for

migrant workers in China with the support of film star Wang Baoqiang, himself a former migrant construction worker.

Protecting the rights and improving the working conditions of health workers is an ILO priority and is part of its strategy to support health system strengthening and the achievement of universal access. Last year, ILO collaborated with WHO to implement the *Joint ILO/WHO Guidelines on Health Services and HIV/AIDS* by providing technical support to countries across all regions. ILO and WHO supported the Uganda Medical Association when it undertook a caring for carers information-sharing workshop to introduce the guidelines to 60 health professionals and to address concerns about working conditions, issues of stigma and discrimination, access to confidential voluntary counselling and testing, prevention of mother-to-child transmission, antiretroviral therapy and tuberculosis care. In 2008, ILO and WHO also published joint guidelines on post-exposure prophylaxis to prevent infection and to preserve the health of workers following accidental exposure to HIV.

Throughout 2008, the work of ILO was guided and strengthened by the development of a new international labour standard on HIV in the world of work. Two reports have been prepared to date. For the first report, published in January 2008, ILO assembled the most comprehensive compilation to date of national laws and policies relating to HIV (now on the ILO/AIDS website). For the second report, ILO received and analysed questionnaire data from more than 250 respondents: 136 member States, 64 employers' organizations and 69 workers' organizations. The intention of the data-gathering exercise, which will be discussed at the International Labour Conferences in June 2009 and June 2010, is to strengthen the development of national HIV workplace policies as part of national AIDS strategies and programmes.

In his message on World AIDS Day 2008, Juan Somavia, the ILO Director-General,

drew attention to the links between the global economic crisis and the HIV epidemic. During his address, he recommitted to promoting gender equality and to supporting initiatives to provide jobs, protection and life-saving information.



United Nations Educational, Scientific and Cultural Organization (UNESCO)

Supporting comprehensive education sector responses to HIV

UNESCO is the UN agency tasked with promoting education worldwide. It is also the designated lead organization focusing on the education sector response to HIV and HIV prevention among young people in education institutions.

In 2008, UNESCO scaled up its efforts to enhance national capacity for comprehensive education sector responses to HIV by supporting workshops in the Arab States, central Asia, eastern Europe, the Caribbean, Latin America and sub-Saharan Africa. With the participation of ministries of education, UNAIDS Cosponsors and civil society counterparts, including networks of people living with HIV, UNESCO supported approximately 20 countries. Four new regional HIV and AIDS advisers, one based at the UNAIDS Regional Support Team for Eastern and Southern Africa in Johannesburg, South Africa, and the others in the UNESCO Bangkok, Moscow and Santiago regional and cluster offices, are playing a major role in mobilizing resources at the country level and coordinating support for HIV programming and strategic planning.

In 2008, UNESCO continued to expand the reach of EDUCAIDS, the Global Initiative

on Education and HIV & AIDS established in 2004. This included enhanced programming in eastern and southern Africa, the region most severely affected by the AIDS epidemic. In Angola, Lesotho, Namibia and Swaziland, intensified programming is expected to reach 100 schools, 1000 pre- and in-service teachers and 100 000 students by the end of 2009. More than 4500 copies of EDUCAIDS technical materials (available in all UN languages, as well as Portuguese) were made available to governments, UNAIDS Cosponsors and civil society counterparts in over 100 countries. An external evaluation, initiated in October 2008, is analysing whether EDUCAIDS has achieved its objectives and is identifying lessons to inform future action.

In 2008, UNESCO education and HIV resource centres located in seven offices and institutes joined together to establish the HIV and AIDS Education Clearinghouse. With interfaces in English, French and Spanish, the Clearinghouse currently contains more than 4000 resources. UNESCO produced its second *Library on HIV and AIDS Materials*, a CD-ROM featuring 180 links to UNESCO institutes and country and regional offices. UNESCO has also developed technical materials addressing the education needs of HIV-positive students in Namibia and the United Republic of Tanzania, school-centred care and support materials for eastern and southern Africa and an HIV prevention education information kit for schoolteachers.

In 2008, UNESCO partnered with the Global Advisory Group (made up of eight international experts with complementary technical experience) to move forward with programmes focusing on education on sex, relationships and HIV and sexually transmitted infections and produced a draft outlining international guidelines on these issues. These guidelines will be field-tested in at least six countries in 2009.

Finally, the UNAIDS Interagency Task Team on Education, a network of more than 30 UNAIDS Cosponsors, bilateral partners and civil society organizations that supports education sector

responses to HIV, continued its efforts to improve coordination and harmonization. In 2008, the interagency task team published four country case studies (on Jamaica, Kenya, Thailand and Zambia) designed to assess progress. The task team also developed a toolkit to support development partners to mainstream HIV in the education sector. It also continued its efforts to enhance understanding of, and commitment to, the role of education in the AIDS response, share information and partner with other stakeholders by participating in a wide range of advocacy efforts.



World Health Organization (WHO)

Strengthening the health sector response to AIDS

During 2008, WHO continued to structure its HIV programme of work around five strategic directions: HIV testing and counselling; HIV prevention in the health sector; HIV treatment and care; strengthening health systems for HIV; and HIV strategic information.

During 2008, WHO developed monitoring and evaluation guidelines to support the scale-up of HIV testing and counselling services in countries, with a particular focus on provider-initiated testing and counselling. WHO is giving priority to capacity-building for HIV testing and counselling, including the integration of provider-initiated counselling and testing into Integrated Management of Adult and Adolescent Illness training materials. WHO developed region-specific training manuals and policy frameworks, including for the eastern Mediterranean, European, South-East Asian, western Pacific and American regions, and provided technical assistance to 92 countries to implement WHO/UNAIDS provider-initiated testing guidelines. Tools on HIV testing and counselling services for specific populations and

settings, including prison settings and children, were developed and implemented. Operational research on HIV testing and counselling in sub-Saharan Africa continued to be supported.

In the same year, WHO intensified its work on the prevention of sexual transmission of HIV, with a particular focus on key populations at higher risk. WHO normative male circumcision guidance and tools were included in an electronic clearing house that was launched in association with UNAIDS, the AIDS Vaccine Advocacy Coalition and Family Health International. WHO, working with partners (UNAIDS, UNFPA, UNICEF and PEPFAR), held a regional consultation on male circumcision and HIV prevention in Africa and provided technical assistance to 11 countries in sub-Saharan Africa to develop and implement national male circumcision policies and programmes. A guidance document on integrated HIV prevention in the African region was developed. WHO also launched a programme of work on health sector programmes for HIV prevention and treatment for men who have sex with men and transgender people. This included global and regional (Europe and the western Pacific) expert consultations to develop an essential package of HIV services for men who have sex with men. Work was also undertaken to: integrate male–male sex issues into Integrated Management of Adult and Adolescent Illness and sexually transmitted infection treatment tools; incorporate men who have sex with men as a sentinel population in HIV and behavioural surveillance and HIV case reporting guidelines; integrate HIV prevention for populations at higher risk in national HIV plans in the eastern Mediterranean region; and promote anti-homophobia campaigns and male sexual health in the American region. In addition to its continued support for 100% condom use programmes in sex work settings, WHO undertook reviews of HIV prevention in sex work settings in sub-Saharan Africa and Europe and organized country missions to Burkina Faso, Côte d'Ivoire and Swaziland.

WHO continued to collaborate with UNODC and UNAIDS on HIV prevention, treatment and care for drug users and in prison settings. WHO finalized guidelines on: the pharmacological treatment of opioid dependence; HIV care and treatment for people who inject drugs in Asia and the Pacific; the management of opioid dependence and common health problems of drug users in South-East Asia; and target setting for universal access for injecting drug users.

In 2008, WHO issued new policy guidance on collaborative HIV and tuberculosis services for injecting drug users and HIV testing and counselling in prison settings. It also assessed the compulsory treatment of drug users in Cambodia, China, Malaysia and Viet Nam. WHO Harm Reduction Knowledge Hubs continued to operate in Europe (Lithuania), and the three Eastern Mediterranean Knowledge Hubs (Iran (Islamic Republic of), Lebanon and Morocco) provided training to some 1500 health workers. As well as supporting 22 countries to develop clinical protocols and training for opioid substitution therapy, WHO helped to strengthen civil society organizations working on harm reduction through the Middle East and North Africa Harm Reduction Association.

In 2008, WHO worked with UNICEF and other partners to accelerate the scale-up of prevention of mother-to-child transmission of HIV services. WHO held an expert consultation to review new evidence on the use of antiretroviral drugs for the prevention of mother-to-child transmission. In collaboration with UNICEF, WHO produced a joint reporting tool to harmonize prevention of mother-to-child transmission data collection. WHO also provided technical support to 66 countries—particularly to nine countries in sub-Saharan Africa. The elimination of paediatric HIV continues to be the goal of regional programmes in Europe, the Americas and Asia and the Pacific. The Integrated Management of Adult and Adolescent Illness/Integrated Management of Pregnancy and Childbirth training course on prevention of

mother-to-child transmission was finalized and adapted for use in the African region.

During 2008, WHO increasingly focused on the potential role of antiretroviral drugs to prevent HIV transmission. The organization promoted the implementation of joint WHO/ILO guidelines on post-exposure prophylaxis and workplace HIV programmes and continued to monitor ongoing clinical trials on pre-exposure prophylaxis and microbicides. WHO also undertook a mathematical modelling exercise to look at the potential impact of universal voluntary HIV testing and counselling and immediate antiretroviral therapy on HIV transmission in generalized epidemics, which was published in the *Lancet*.

In 2008, WHO continued to support the scale-up of antiretroviral therapy in 71 countries. WHO revised its paediatric antiretroviral therapy guidelines, which include new recommendations regarding paediatric formulations, when to test, when to start antiretroviral therapy and what regimens to use. WHO added new paediatric formulations to the WHO list of essential medicines and developed a framework for scaling-up paediatric care. A report was produced on antiretroviral therapy failure and strategies for switching antiretroviral regimens. In the European region, Integrated Management of Adult and Adolescent Illness guidelines on patient monitoring were updated. WHO also prioritized the integration of HIV and tuberculosis services with the launch of the “3 Is” guidance (isoniazid preventive therapy, intensified tuberculosis case finding and infection control) and support for the HIV/Tuberculosis Global Leaders Forum held in association with the UN High-level Meeting on HIV/AIDS. WHO supported 13 African countries to develop HIV/tuberculosis collaboration action plans. A regional training package was adapted for the training of community health-care workers on HIV prevention, treatment, care and support, including HIV/tuberculosis.

In 2008, WHO launched the *Second Global Progress Report on the Health Sector Response Towards Universal Access* in association with UNICEF and the UNAIDS Secretariat. *Country Epidemiology Fact Sheets* were updated in association with the UNAIDS Secretariat. WHO coordinated with partners in data collection and validation, including with UNAIDS for UNGASS indicators, UNICEF on prevention of mother-to-child transmission, the Global Fund and PEPFAR. The Second Generation Surveillance guidelines were updated and support was provided to 93 countries for strengthening their HIV surveillance. Implementation of the HIV Drug Resistance Surveillance Strategy continued.

WHO undertook various activities to strengthen health systems to support HIV service scale-up. The AIDS Medicines and Diagnostics Service continued to provide information on HIV-related medicines, diagnostics and other commodities, including through the Global Price Reporting Mechanism and other databases. Antiretroviral drug forecasts for 2008–2010 were released. Thirty countries were supported in the development of procurement and supply management plans. In the area of human resource development, policy guidelines were developed to increase health-care workers' access to tuberculosis and HIV services, guidelines on task shifting were released, regional workshops on human resource planning were conducted and six country case studies were completed. In health systems financing a costing module was developed to integrate HIV priority interventions into AIDS Strategy and Action Plan tools.

During 2008 WHO assisted 85 countries to plan and implement their national HIV programmes, including through the AIDS Strategy and Action Plan process. WHO published the umbrella guide *Priority Interventions: HIV/AIDS Prevention, Treatment and Care in the Health Sector* to help countries develop evidence-based policies and programmes. Countries were supported to

apply for and implement Global Fund HIV grants, including the provision of support to 50 countries in developing Round 8 HIV applications. WHO produced an operational manual for the delivery of HIV prevention, treatment and care in primary health-care centres and launched the WHO Network for HIV and Health in the western Pacific region to improve coordination and capacity to deliver technical support to countries.



The World Bank

Supporting efforts to protect evidence-informed and strategic HIV investments

The World Bank has continued to support countries to compile and analyse data on their epidemics and to align national policies and programmes accordingly. Specifically, through the AIDS Strategy and Action Plan service hosted on behalf of UNAIDS, the Bank supported the development of evidence-informed, prioritized and costed strategic plans for 29 countries across Europe, the Middle East, Asia, Africa, Latin America and the Caribbean. A global programme of capacity-building workshops developed for practitioners complemented this work. The aim was to better understand and

manage the strategic planning processes. The Bank continued to support progress towards universal access by participating in joint reviews of national AIDS programmes and providing US\$ 600 million for 95 projects covering 80 countries, much of which is being channelled to civil society organizations.

The UNAIDS architecture has presented important opportunities for the Bank to partner with others. Examples of joint efforts include work done in concert with UNDP to incorporate AIDS into poverty reduction strategy papers, as well as partnership with the UNAIDS Secretariat on the Economic Reference Group.

In collaboration with other UNAIDS Cosponsors, the World Bank supported the finalization of a harmonized framework for monitoring and evaluation assessments, building on the conceptual framework of the 12 components. Furthermore, the broad-based response has supported the integration of HIV into health system strengthening initiatives, mainstreaming of HIV in key sectors such as transport and education, innovative work on reducing stigma and discrimination, improving procurement and supply chains and strengthening governance.

At the end of 2008, the Bank initiated work to limit the fallout of the global financial crisis and on mitigating the negative impact on national HIV programmes around the world.

Financials



Introduction

The UNAIDS Unified Budget and Workplan (UBW) represents United Nations (UN) reform in action. It is a unique mechanism within the UN system that unites in a single two-year strategic framework the coordinated AIDS work of 10 agencies of the UN system and the UNAIDS Secretariat. It seeks to catalyse an extraordinary, accelerated response to the global AIDS epidemic, transforming the decisions of the UNAIDS Programme Coordinating Board into action on the ground.

The UBW includes a breakdown of the expected results and resource needs of each Cosponsor, the Secretariat and interagency activities. The activities of each relate to one or more of the UNAIDS seven principal outcomes.¹ These principal outcomes reflect the overarching priorities in the global effort to move towards universal access to HIV prevention, treatment, care and support. The 2008–2009 UBW articulates broad activities by each Cosponsor and the Secretariat, as well as joint interagency activities that will support achievement of individual principal outcomes and key outputs. The UBW also includes agreed principles and processes that further harmonize the work of Cosponsors and the Secretariat.

In comparison with previous biennia, the 2008–2009 UBW has a simplified and strengthened results-based orientation. The aim is to provide

a better platform for results-based management, reporting, accountability and transparency across the Joint Programme. Identifying key strategic challenges and opportunities in the global response, the UBW clarifies the specific contributions of each Cosponsoring organization and the Secretariat. The result is a coordinated strategic plan to maximize effectiveness.

Funds made available for the 2008–2009 Unified Budget and Workplan

UNAIDS is fully funded from voluntary contributions. During the financial year under review, operating revenue of US\$ 249.6 million was made available for the core resources of the UBW for 2008–2009. Twenty-seven governments contributed 98.3% of this amount, and the World Bank contributed 1.6% of this amount. The remaining 0.1% is made up of miscellaneous income, including funds received from public institutions and private contributors other than governments, miscellaneous donations and honoraria received. In addition to this amount, financial revenue (primarily interest earnings) of US\$ 4.3 million was received and apportioned during the reporting year, bringing the total revenue available for the UBW for 2008–2009 to US\$ 253.9 million. Table 1 provides details of the revenue recognized towards the 2008–2009 UBW for the year ended 31 December 2008.

¹ The 2008–2009 Unified Budget and Workplan has adopted the nomenclature of the Development Co-operation Directorate of the Organisation for Economic Co-operation and Development, basing the structure of the Unified Budget and Workplan on outcomes and outputs.

Table 1: Unified Budget and Workplan—details of revenue for the year ended 31 December 2008 (in thousands of US dollars)

Voluntary contributions	Funds received towards the 2008-2009 Unified Budget and Workplan
Governments	
Andorra	38
Australia	2 369
Belgium	4 717
Bulgaria	5
China	100
Denmark	10 097
Finland	11 682
France	1 775
Germany	2 726
Greece	1 415
Ireland	9 034
Japan	2 430
Liechtenstein	24
Luxembourg	3 933
Monaco	156
Netherlands	48 517
New Zealand	1 935
Norway	25 907
Poland	48
Portugal	301
Russian Federation	500
Spain	5 829
Sweden	38 822
Turkey	1 000
Switzerland	4 219
United Kingdom of Great Britain and Northern Ireland	15 361
United States of America	52 275a/
	245 215
Cosponsoring organizations	
World Bank	4 000
Other	
Miscellaneous	354
Total	249 569
Other revenue	
Interest	4 348
GRAND TOTAL	253 917

a/ Represents balance of 2007 US letter of credit of US\$ 22.3 million and US letter of credit for 2008 of US\$ 30 million not yet called forward.

Non-Unified Budget and Workplan funds

Non-UBW resources amounting to US\$ 35.2 million were made available to UNAIDS to provide support for a number of global, regional and country activities and a number of interagency-managed activities that are not included in the UBW and that do not specifically fall under any Cosponsor's mandate. In addition to this amount, financial revenue (primarily interest earnings) of US\$ 1.8 million was received and apportioned during the reporting year, bringing the total revenue available for non-UBW resources to US\$ 37.0 million. Details of the sources of these funds are given in Table 2.

Funds expended and encumbered² under the Unified Budget and Workplan for 2008–2009

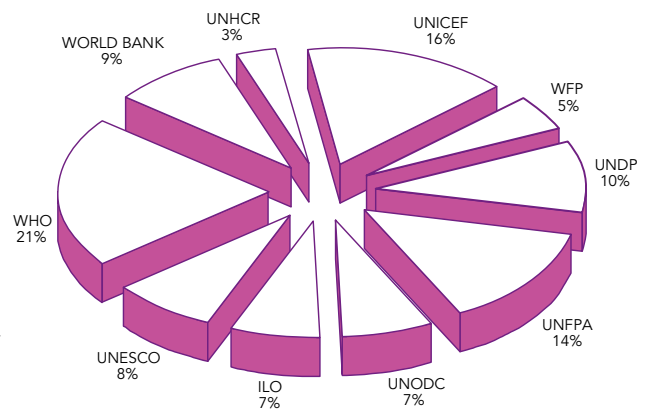
During the period 1 January to 31 December 2008, expenses and encumbrances (including transfers to Cosponsors) totalling US\$ 263.5 million were incurred against the budget of US\$ 484.8 million approved for the 2008–2009 UBW, which corresponds to a financial implementation rate of 54.4%. The total expenses and encumbrances (including transfers to Cosponsors) were distributed as follows:

- ▶ US\$ 99.2 million was transferred to Cosponsors for the implementation of their AIDS activities contained in the UBW;
- ▶ US\$ 74.8 million was expended and encumbered for interagency activities;
- ▶ US\$ 89.5 million was expended and encumbered for Secretariat activities and staff.

(i) Funds transferred to Cosponsors

As at 31 December 2008, financial transfers made to Cosponsors amounted to US\$ 99.2 million. These transfers represent 74% of the Cosponsors' share under the UBW for 2008–2009. Compared with previous biennia, the portion of the Cosponsors' UBW share transferred at the beginning of the biennium was increased, in order to enable the start-up and implementation of UBW activities. Information on the proportion of transfers made to individual Cosponsors versus total transfers, together with the amounts transferred against each of the agreed principal outcomes, is shown in Figure 7 and Table 3.

FIGURE 7: COSPONSORS' SHARE OF FUNDS TRANSFERRED FOR THE YEAR ENDED 31 DECEMBER 2008



² Encumbrance is a firm commitment for goods and/or services that have not yet been delivered.

Table 2: Non-Unified Budget and Workplan resources—details of revenue for the year ended 31 December 2008 (in thousands of US dollars)

Voluntary contributions	Funds received towards non-Unified Budget and Workplan activities 2008-2009
Governments	
Australia	5 477
Austria	617
Canada	83
Denmark	2 296
France	518
Germany	52
Greece	157
Ireland	2 690
Italy	90
Japan	263
Luxembourg	(265) a/
Netherlands	313
Norway	88 b/
Russian Federation	600
Spain	1 107
Sweden	4 423
United Kingdom of Great Britain and Northern Ireland	5 715
United States of America (USAID)	5 242
	29 468
Cosponsoring organizations	
UNHCR	223
UNICEF	79
UNDP	1 107
WHO	209
	1 618
Other	
AWARE	30
Bill & Melinda Gates Foundation	2 825
BM Creative Management Ltd	10
CARICOM	50
Constella Futures	11
Ford Foundation	100
Geneva Global Inc.	27
Germany, GTZ	487
Global Fund	259
Organization of Petroleum Exporting Countries	200
UNCERF	38
UNEP	25
UNIFEM	22
Miscellaneous	3
	4 086
Total	35 172
Other revenue	
Interest	1 828
GRAND TOTAL	37 000

a/ Represents net revenue for 2008 of US\$ 3 025 718 less pass-through funds of US\$ 3 290 464.

b/ Represents net revenue for 2008 of US\$ 448 579 less pass-through funds of US\$ 360 425.

Table 3: Cosponsors' approved allocations and funds transferred for the year ended 31 December 2008 (in thousands of US dollars)

	Principal outcome	Approved allocations	Funds transferred	Balance	Percentage implementation
		(a)	(b)	(c)	(d) = (b/a)
1	Leadership and resource mobilization	8 100	6 025	2 075	74%
2	Planning, financing, technical assistance and coordination	25 071	18 783	6 288	75%
3	Strengthened evidence base and accountability	17 251	12 787	4 464	74%
4	Human resources and systems capacities	45 036	33 681	11 355	75%
5	Human rights, gender, stigma and discrimination	11 470	8 570	2 900	75%
6	Most-at-risk populations	8 550	6 413	2 137	75%
7	Women and girls, young people, children and populations of humanitarian concern	19 192	12 893	6 299	67%
	Total	134 670	99 152	35 518	74%

(ii) Expenses incurred against interagency resources

Interagency activities include joint initiatives by more than one Cosponsor and/or the Secretariat. These activities typically focus on cross-cutting activities that help to strengthen the multisectoral AIDS response. During the year under review, US\$ 61.0 million was expensed and US\$ 13.8 million was encumbered for interagency activities out of a biennium budget allocation of US\$ 152.2 million,³ which together represents a financial implementation rate of 49%. Further details of the funds expensed and encumbered under interagency activities are shown by principal outcome in Table 4.

(iii) Expenses incurred against the Secretariat budget

During the year ended 31 December 2008, US\$ 81.7 million was expensed and US\$ 7.9 million encumbered against the Secretariat

biennium budget of US\$ 192.9 million, which together represents a financial implementation rate of 46%. The total amount expensed and encumbered includes US\$ 38.1 million for staff costs and US\$ 51.5 million for activities. Further details of the funds expensed and encumbered by the Secretariat are shown by principal outcome in Table 5.

Funds expensed and encumbered under non-Unified Budget and Workplan resources for 2008–2009

During the year ended 31 December 2008, a total of US\$ 34.7 million was expensed and US\$ 5.0 million was encumbered against non-UBW resources, as detailed in Table 6. Table 6 also presents: (i) an overview of the total non-UBW resources (column c), including funds carried over from 2007, that have been made available to programme activities under this component; and (ii) the amount of funds expensed and encumbered during the year ended 31 December 2008.

³ The interagency budget includes a provision of US\$ 100 million for the salaries of the interagency country staff (UNAIDS country coordinators and advisers on monitoring and evaluation, partnership development and social mobilization) and operational costs for 83 UNAIDS country offices and related investment in IT field connectivity.

Table 4: Interagency resources approved allocations, expenses and encumbrances for the year ended 31 December 2008 (in thousands of US dollars)

Principal outcome	Approved allocations	Expenses	Encumbrances a/	Total	Balance	Percentage implementation
	(a)	(b)	(c)	(d) = (b+c)	(e) = (a-d)	(f) = (d/a)
1 Leadership and resource mobilization	81 427	37 354	4 764	42 118	39 309	52%
2 Planning, financing, technical assistance and coordination	54 931	20 831	8 898	29 729	25 202	54%
4 Human resources and systems capacities	579	500	-	500	79	86%
5 Human rights, gender, stigma and discrimination	13 718	2 116	154	2 271	11 447	17%
7 Women and girls, young people, children and populations of humanitarian concern	1 595	167	12	179	1 416	11%
Total	152 250	60 968	13 829	74 797	77 453	49%

a/ Encumbrance is a firm commitment for goods and/or services that have not yet been delivered.

Table 5: Secretariat approved allocations, expenses and encumbrances for the year ended 31 December 2008 (in thousands of US dollars)

Principal outcome	Approved allocations	Expenses	Encumbrances a/	Total	Balance	Percentage implementation
	(a)	(b)	(c)	(d) = (b+c)	(e) = (a-d)	(f) = (d/a)
1 Leadership and resource mobilization	128 482	847	4 274	60 121	68 361	47%
2 Planning, financing, technical assistance and coordination	27 410	12 349	1 934	14 283	13 127	52%
3 Strengthened evidence base and accountability	13 270	5 038	793	5 831	7 439	44%
5 Human rights, gender, stigma and discrimination	4 668	3 528	297	3 825	843	82%
6 Most-at-risk populations	7 540	1 465	239	1 704	5 836	23%
7 Women and girls, young people, children and populations of humanitarian concern	11 530	3 431	347	3 779	7 751	33%
Total	192 900	81 659	7 884	89 543	103 357	46%

a/ Encumbrance is a firm commitment for goods and/or services that have not yet been delivered.

Table 6: Non-Unified Budget and Workplan resources—funds available, expensed and encumbered. Summary by source of income for the year ended 31 December 2008 (in thousands of US dollars)

Source of income	2006-2007 carry-over	Funds received in 2008 a/	Total funds	Expenses	Encumbrances b/	Total	Percentage implementation
	(a)	(b)	(c) = (a+b)	(d)	(e)	(f) = (d+e)	(g) = (f/c)
Voluntary contributions and other income							
Andorra	11	-	11	-	-	-	-
Australia	3 148	5 948	9 096	3 169	1 369	4 538	50%
Austria	153	146	299	220	2	222	74%
Belgium	298	-	1 298	834	-	834	64%
Canada	85	83	168	90	2	92	55%
Denmark	784	2 296	3 080	362	-	362	12%
Finland	936	-	1 936	99	3	102	5%
France	1 360	518	1 878	92	-	92	5%
Germany, including GTZ	867	539	1 406	757	86	843	60%
Greece	-	157	157	10	-	10	6%
Ireland	2 754	2 690	5 444	950	111	1 061	19%
Italy	10	90	100	6	-	6	6%
Japan	876	263	1 139	641	29	670	59%
Luxembourg	10 342	(265)	10 077	1 246	215	1 461	14%
Ministry of the Flemish Community, Belgium	917	-	917	533	22	555	61%
Netherlands	387	313	700	366	326	692	99%
New Zealand	224	-	224	65	129	194	86%
Norway	1 991	88	2 079	794	1	795	38%
Russian Federation	339	600	939	815	-	815	87%
Spain	1 152	1 107	2 259	1 283	10	1 293	57%
Sweden	5 961	4 423	10 384	4 614	406	5 020	48%
United Kingdom of Great Britain and Northern Ireland	6 735	5 715	12 450	7 265	1 059	8 324	67%
United States of America (CDC)	2 173	-	2 173	-	-	-	-
United States of America (NHI)	17	-	17	-	-	-	-
United States of America (USAID)	295	5 242	5 537	3 224	202	3 426	62%
AWARE	-	30	30	-	-	-	-
Bill & Melinda Gates Foundation	2 497	2 825	5 322	2 211	700	2 911	55%
BM Creative Management Ltd	-	10	10	9	-	9	90%
CARICOM	66	50	116	39	-	39	34%
Commission of the European Communities	75	(30)	45	1	-	1	2%
Constella Futures	-	11	11	-	-	-	-
Ford Foundation	426	100	526	45	-	45	9%



Table 6: (continued) Non-Unified Budget and Workplan resources—funds available, expensed and encumbered. Summary by source of income for the year ended 31 December 2008 (in thousands of US dollars)

Source of income	2006-2007 carry-over	Funds received in 2008 a/	Total funds	Expenses	Encumbrances b/	Total	Percentage implementation
	(a)	(b)	(c)=(a+b)	(d)	(e)	(f)=(d+e)	(g)=(f/c)
Geneva Global Inc.	-	27	27	-	-	-	-
Global Fund	47	259	306	120	-	120	39%
International Labour Organization	15	-	15	1	-	1	7%
John Hopkins University	6	-	6	-	-	-	-
Johnson & Johnson Products Inc.	12	-	12	1	-	1	8%
Merck & Company Inc.	296	-	296	38	-	38	13%
National Agency for AIDS Research	23	-	23	13	-	13	56%
Organization of Petroleum Exporting Countries	1 064	200	1 264	121	88	209	17%
Rupert Everett	25	-	25	25	-	25	100%
Southern African Development Community	44	-	44	-	-	-	-
Stanford University	10	-	10	-	-	-	-
UNCERF	-	38	38	3	-	3	8%
UNDP	96	1 107	1 203	688	58	746	62%
UNEP	-	25	25	-	-	-	-
UNESCO	116	-	116	-	-	-	-
UNFIP	230	(230)	-	-	-	-	-
UNFPA	10	-	10	5	-	5	50%
UNHCR	13	223	236	1	-	1	-
UNICEF	26	79	105	37	7	44	42%
UNIFEM	-	22	22	-	-	-	-
United Nations	20	-	20	-	-	-	-
UNODC	15	-	15	1	-	1	7%
UNOPS	108	-	108	98	-	98	90%
WFP	15	-	15	1	-	1	7%
WHO	148	209	357	98	-	98	27%
World Bank	34	-	34	3	-	3	9%
Special PCB allocations	29 349	-	29 349	6 441	-	6 441	22%
Miscellaneous	26	3	29	1	-	1	3%
Interest and other	4 947	3 404	8 351	1 623	161	1 784	21%
Programme support costs (PSC)	-	-	-	(4 330)	-	(4 330)	-
Total	83 572	38 315	121 887	34 729	4 986	39 715	33%

a/ Includes revenue, refunds to donor and savings on prior period unliquidated obligations.

b/ Encumbrance is a firm commitment for goods and/or services that have not yet been delivered.

UNAIDS is an innovative joint venture of the United Nations, bringing together the efforts and resources of the UNAIDS Secretariat and ten UN system organizations in the AIDS response. The Secretariat headquarters is in Geneva, Switzerland—with staff on the ground in more than 80 countries. The Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Contributing to achieving global commitments to universal access to comprehensive interventions for HIV prevention, treatment, care and support is the number one priority for UNAIDS. Visit the UNAIDS website at www.unaids.org

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