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**26<sup>th</sup> Meeting of the UNAIDS Programme Coordinating Board**  
Geneva, Switzerland  
22-24 June 2010

**The Unified Budget and Workplan  
Synthesis Report for 2008-2009**

**Additional documents for this item:**

- i. 2008-2009 Financial Report (*UNAIDS/PCB(26)/10.4*)
- ii. Interim financial management update for the 2008-2009 biennium for the period 1 January 2009 to 31 March 2010 (*UNAIDS/PCB(26)/10.6*)
- iii. 2008-2009 UBW Performance Report Supplement (*UNAIDS/PCB(26)/10.CRP.1*)

**Action required at this meeting - the Programme Coordinating Board is requested** to review and provide comments on the report and advise on ways of further strengthening of performance monitoring of UNAIDS.

**Cost implications for decisions:** *none*

## I. Introduction: Monitoring the performance of the Joint Programme

1. This report to the Programme Coordinating Board summarizes key findings regarding UNAIDS achievements under the Unified Budget and Workplan (UBW) for 2008-2009. This report focuses on overall achievements of the Joint Programme as a whole. A separate conference room paper accompanies this report, providing additional information on achievements in 2008-2009, detailed financial information, and descriptions of achievements by individual Cosponsors and the Secretariat.
2. The period covered by this report was one of unprecedented achievements in the global HIV response, as well as extraordinary challenges. During 2008 alone, the number of people in low and middle-income countries on antiretroviral therapy rose by more than 1 million, constituting a 10-fold increase in treatment coverage in only five years.<sup>i</sup> Scale-up of services to prevent mother-to-child transmission – which had lagged in earlier years – also accelerated, with 45% of pregnant women living with HIV receiving prophylactic antiretroviral drugs in 2008.<sup>i</sup> Globally, the rate of new HIV infections continued to slow, with the number of new HIV infections in 2008 17% lower than in 2001.<sup>ii</sup>
3. During the 2008-2009 biennium, the world experienced a severe economic and financial contraction. Although definitive data on financial resources for 2009 are not yet available, surveys by UNAIDS suggest that national responses in many countries are now suffering as a result of the economic downturn.<sup>iii</sup>
4. To maximize the effectiveness, strategic focus and accountability for results, the Joint Programme developed and implemented a new strategic framework: the 'Outcome Framework 2009-2011, Joint Action for Results', a collaborative approach to achieve specific results in ten Priority Areas. Through intensified collaboration and programmatic focus, UNAIDS and its partners took action to help achieve the outcomes necessary to stem the HIV epidemic. The Priority Areas identified in the Outcome Framework are critical to the achievement of universal access to HIV prevention, treatment care and support.
5. Progress in these ten Priority Areas will also be critical to achievement of the Millennium Development Goals (MDGs). The 2008-2009 biennium was the first to occur beyond the halfway mark for attainment of the MDGs. As a multisectoral, cosponsored programme that includes health, development, sector-specific, and financing agencies, the Joint Programme itself reflects the degree to which the HIV response cuts across the broad array of MDGs. As the United Nations Secretary-General himself underscored in his latest report to the General Assembly on progress in the HIV response, there is a synergistic relationship between the HIV response and the broader development agenda.<sup>iv</sup> Gains in reducing HIV incidence, HIV-related morbidity and mortality, and the epidemic's broader socioeconomic impact support global efforts to reduce poverty and hunger, promote women's equality and human rights, ensure universal education, and generate broad-based improvements in health outcomes. Conversely, achievements across the full array of MDGs support HIV-focused initiatives to reduce HIV risk and vulnerability, deliver essential HIV treatment and care, bolster critical national systems, and promote innovative partnerships for health.
6. At the national level, the Outcome Framework enables the UN to strengthen and refocus its response to achieve results. The Outcome Framework builds on previous efforts to align the agendas of UNAIDS Cosponsors and the Secretariat to mandate clear deliverables, maximize impact, use comparative strengths, and support national

priorities. The Priority Areas in the Outcome Framework form the core of a new UNAIDS strategy, which was requested by the Programme Coordinating Board in its review of the report and recommendations of the Second Independent Evaluation.

## II. Implementing the UNAIDS Outcome Framework: Achievements in Priority Areas in 2008-2009

7. All members of the Joint Programme have committed to intensify collaboration, strategic focus, and country-level action to achieve results for people in ten Priority Areas which make up the Outcome Framework. Using this Framework, this section identifies available data on progress in each of these Priority Areas in 2008-2009 and summarizes key contributions by the Joint Programme in each respective area.
8. To permit a more extensive review of achievements under the 2008-2009 UBW, a separate conference room paper has been submitted to the Programme Coordinating Board linking investments and results.
9. In line with the agreed approach in the Unified Budget and Workplan Performance Monitoring Framework for 2008-2009, descriptions of achievements in each priority area include two components. The first summarizes results to date for the overall HIV response, relying primarily on data derived from standardized data sources, including the 2009 *AIDS epidemic update*<sup>ii</sup>, the 2009 progress report on *Universal Access*<sup>i</sup>, information submitted by countries on core indicators developed for monitoring implementation of the 2001 Declaration of Commitment on HIV/AIDS, and global tuberculosis surveillance figures compiled by the World Health Organization. The second notes specific contributions by UNAIDS towards these overall results, drawing from reporting mechanisms specified in the 2008-2009 Unified Budget and Workplan, including UNAIDS country reports and standardized monitoring reports submitted by individual Cosponsors and the Secretariat on agreed UBW indicators.

### ***Reduce sexual transmission***



### **Overall progress in this Priority Area**

10. Significant strides have been made in slowing rates of sexual transmission of HIV in some countries. In five countries where two recent national household surveys were

conducted, HIV incidence is on the decline, including statistically significant reductions in the Dominican Republic and Tanzania and among women in Zambia.<sup>v</sup> Globally, the annual number of new HIV infections in 2008 was more than 20% lower than in 1996.<sup>ii</sup>

UNAIDS contributions in this Priority Area in 2008-2009

11. In the 2008-2009 biennium, the Joint Programme spearheaded advances in strategic information to inform evidence-based strategies to prevent sexual transmission. UNAIDS supported epidemiological syntheses covering at least 27 countries, as well as epidemiological and behavioural studies on key populations, such as transport workers in Georgia, sex workers in Indonesia, indigenous people in Guyana, refugees in East and Southern Africa, and vulnerable populations in the Middle East and North Africa region. Support provided to 58 countries through the AIDS Strategy and Action Plan (ASAP) service assisted in the development and implementation of strategies that respond to documented epidemiological trends and address sexual transmission, with formal ASAP reviews of national plans reported for 18 countries.
12. Building on the expanded base of strategic information, the Joint Programme produced new tools to assist countries in implementing well-planned, optimally effective prevention programmes, including significant components addressing sexual transmission. UNAIDS initiated a multi-stakeholder process to formalize a glossary of HIV prevention interventions, with the aim of facilitating improved monitoring and evaluation, strengthened service quality, and more rational decision-making. The Joint Programme also worked with the UNAIDS Prevention Reference Group to develop a formal definition and operational guidance document for planning, implementing and monitoring combination HIV prevention programmes.
13. Normative guidance issued by UNAIDS on HIV prevention significantly influenced country-level action around sexual transmission. Eighty-five of 88 countries surveyed reported making use of UNAIDS' practical guidelines for intensifying HIV prevention. Policy guidance and technical support was provided in 70 countries to accelerate integration of HIV programmes in the world of work, and 31 countries benefited from support to incorporate the world of work in national HIV strategies. In 2008-2009, all UNAIDS refugee operations had access to HIV information, education and communication materials, and the majority of them had taken steps to integrate HIV information systems in their HIV and AIDS programmes.
14. UNAIDS also took steps in 2008-2009 to strengthen the relevance, accessibility and effectiveness of HIV prevention for people living with HIV, again including important components on sexual transmission. In April 2009, UNAIDS and the Global Network of People Living with HIV convened a global consultation, which resulted in the formulation of a new approach to HIV prevention. Known as "Positive Health, Dignity and Prevention," this approach calls for holistic efforts to involve people living with HIV in prevention programmes and intensify action to protect and promote their human rights, combat stigma and discrimination, and link prevention efforts to stronger action to ensure access to treatment and care.
15. Studies documenting the ability of circumcision to reduce female-to-male sexual HIV transmission by 60% led UNAIDS to intensify its normative guidance and technical support to priority countries to implement circumcision services as a critical component of their HIV prevention plans. All 13 priority countries for the scale-up of adult male circumcision services for HIV prevention conducted situation analyses, and several finalized national guidelines to accelerate access to voluntary circumcisions. Kenya aims to ensure ready access to male circumcision services for

all who desire it by 2013, while Zambia has established a target of circumcising 250,000 men annually. These efforts were assisted by operational guidance for scaling up male circumcision, produced in 2009. The Joint Programme also made progress towards developing a research agenda on circumcision, including such issues as service delivery, community and advocacy.

16. Global advocacy, technical guidance and commodity procurement supported condom use to prevent sexual transmission of HIV. Partners within the Joint Programme distributed at least 50 million female condoms in 2009, including 36.2 million in sub-Saharan Africa (compared to 21.1 million in 2008). Seventy-five countries implemented on-line tools to expand condom access, and 89 countries made use of standardized software for forecasting and procurement of contraceptives.
17. The 2008-2009 biennium also witnessed the emergence of an important new research focus for HIV prevention – evaluation of the potential of antiretroviral therapy to prevent new infections by lowering community-level viral load. In November 2008, a modelling exercise undertaken by scientists working for the Joint Programme concluded that universal voluntary HIV testing for all adults, on average once a year, followed by immediate antiretroviral therapy after diagnosis, might accelerate the transition in generalized epidemics from the endemic stage to ultimate elimination of HIV.<sup>vi</sup> In 2009, a consultation involving more than 100 leading experts resulted in recommendations for future research to evaluate the potential of antiretroviral therapy for HIV prevention.
18. UNAIDS continued and strengthened its longstanding efforts to integrate HIV prevention and sexual and reproductive health services. The Joint Programme supported the translation and dissemination of a rapid assessment tool for linking HIV and sexual and reproductive health services into Arabic, French, Russian and Spanish. Support was also provided for a meta-analysis by Cochrane Review Group of studies assessing linkages between HIV and sexual and reproductive health, and case studies on service integration were developed from Haiti, Kenya and Serbia. Intensive technical support was provided to stakeholders in at least ten countries to improve linkages to sexual and reproductive health services. UNAIDS developed key policy and programmatic actions to strengthen linkages between sexual and reproductive health and HIV programmes for populations in humanitarian crisis situations.

***Prevent mothers from dying and babies from becoming infected with HIV***



### Overall progress in this Priority Area

19. Although mother-to-child HIV transmission has been virtually eliminated in high-income countries, children accounted for one in six new HIV infections worldwide in 2008, underscoring the urgent need to accelerate the effective use of life-saving tools to protect newborns from infection. At the same time that prevention services in antenatal settings are brought to scale, intensified efforts are required to protect the health and well-being of pregnant women and mothers living with HIV. Preventing mothers from dying of HIV is not only central to the HIV response, but vital to accelerate progress towards Millennium Development Goal 5, which envisages a 75% reduction in the maternal mortality rate by 2015.
20. In 2008-2009, major progress was achieved in expanding access to services to prevent mothers from dying and babies from becoming infected with HIV. The number of countries with a national scale-up plan with population-based targets for services to prevent mother-to-child transmission rose from 34 in 2005 to 70 in 2008.<sup>i</sup> Coverage of antiretroviral regimens to prevent mother-to-child transmission reached 45% in 2008, compared to 10% in 2004.<sup>i</sup> Expanded access to services to prevent mother-to-child transmission has averted an estimated 200,000 new infections among newborns over the past 12 years.<sup>ii</sup> Access to PMTCT for refugees increased from 57% in 2007 to 75% in 2009.<sup>vii</sup>

### UNAIDS contributions in this Priority Area in 2008-2009

21. Normative guidance by the Joint Programme helped guide country-level action to prevent mothers from dying and babies from becoming infected with HIV. In 2009, new guidelines on prevention of mother-to-child transmission were issued. These guidelines call for earlier initiation of antiretroviral therapy in pregnant women, longer provision of antiretroviral prophylaxis, and post-natal administration of antiretroviral prophylaxis to prevent newborns from contracting HIV through breastfeeding. In addition, a paediatric care programming framework was launched to promote the integration of paediatric treatment into national health systems. Guidance on infant feeding and HIV in the context of refugees and displaced populations was also published.
22. To further accelerate progress in preventing newborns from becoming infected, UNAIDS spearheaded regional meetings and situation assessments to accelerate the scaling-up of prevention programmes. An eight-country review of national experiences found significant progress in accelerating facility- and population-based coverage of services to prevent mother-to-child transmission. UNAIDS supported a project to estimate unit costs to implement services to prevent mother-to-child transmission and to provide paediatric HIV care in five countries. Pilot projects to intensify partnerships for prevention of mother-to-child transmission were launched in Côte d'Ivoire and the Democratic Republic of Congo. An experts consultation on operational research in Washington DC mapped planned research projects to accelerate implementation of prevention of mother-to-child transmission, identified gaps, and agreed on priority operational research questions for 2010-2011.
23. The Joint Programme supported the UN Secretary-General's meetings with 17 pharmaceutical and diagnostic companies, which resulted in commitments for further investments in research and development of new HIV medicines for resource-limited settings. Assessments of procurement and supply management were conducted in eight countries in West and Central Africa. These activities included the aim of ensuring a continuous and reliable supply of commodities for the prevention of mother-to-child transmission.



24. Support was provided to the US President's Emergency Plan for AIDS Relief to develop a user-friendly toolkit commodities for prevention of mother-to-child transmission, partnerships with the Clinton Foundation helped achieve price reductions for antiretrovirals in Kyrgyzstan and Panama, and support was provided to UNITAID's expansion of assistance to nine additional countries for the purchase of key commodities and diagnostics. Commodity purchases by UNAIDS partners in 2008 alone to support services to prevent mother-to-child transmission exceeded US\$ 68 million. Latin American and Caribbean countries also joined with UNAIDS Cosponsors and the Secretariat to undertake a joint initiative for the elimination of mother-to-child transmission of HIV and syphilis in 2008.
25. Technical support for resource mobilization and programmatic scale-up aided dozens of countries in expanding access to HIV prevention for mothers and newborns in 2008-2009. UNAIDS assisted in the development and inclusion of initiatives to prevent mother-to-child transmission in Global Fund proposals of such countries as Papua New Guinea and the Democratic Republic of Congo, and 18 countries translated global recommendations for prevention of mother-to-child transmission in national plans following joint missions by the Inter-Agency Task Force. Focused support for scale-up of services to prevent mother-to-child transmission was provided in 13 countries. In collaboration with partners, the Joint Programme finalized ten country best practice evaluations in 2008 of programmes to prevent mother-to-child transmission. More than 20 countries received technical support to integrate food and nutrition into programmes to prevent mother-to-child transmission.
26. In connection with its work on the prevention of mother-to-child transmission, UNAIDS in 2008-2009 intensified efforts to promote appropriate care and treatment for mothers. For example, support by the Joint Programme aided all high-burden countries in Eastern and Southern Africa to expand antiretroviral access for the help of pregnant women as a component of scaling-up services to prevent mother-to-child transmission.

### ***Ensure that all people living with HIV receive treatment***



#### *Overall progress in this Priority Area*

27. The rapid expansion of HIV treatment access in resource-limited settings represents one of the singular achievements of global health and development in modern times. The number of people in low and middle-income countries receiving antiretroviral



therapy reached more than 4 million by December 2008, reflecting adult treatment coverage of 43% (compared to 3 million on treatment, or 33% coverage in 2007).<sup>i</sup> The number of children under 15 years of age and receiving antiretroviral therapy reached approximately 275,700 by the end of 2008, a 3.5-fold increase over 2005.<sup>i</sup> Particularly noteworthy progress was achieved in expanding treatment access in Eastern and Southern Africa – the most heavily affected sub-region – where treatment coverage among adults reached 49% as of December 2008.<sup>i</sup> Additionally, from 2007 to 2009 the number of refugees with access to antiretroviral treatment increased from 44% to 87%.<sup>vii</sup>

28. Advances in treatment access are estimated to have saved 1.4 million lives since 2004, including 1.1 million in sub-Saharan Africa.<sup>ii</sup> The average cost of first-line antiretroviral regimens declined by 10-40% between 2006 and 2008, although second-line regimens remain significantly more expensive.<sup>i</sup>

#### UNAIDS Contributions in this Priority Area in 2008-2009

29. Revisions to normative guidance by the Joint Programme in 2008-2009 aimed to improve medical outcomes by encouraging optimal timing for the initiation of antiretroviral therapy. Relying on the most recent scientific evidence, the Joint Programme revised international treatment guidelines to recommend earlier diagnosis and initiation of treatment of HIV, use of safer regimens that are more easily tolerated, and expanded laboratory testing to improve HIV diagnosis, treatment and care. Normative guidance for health sector interventions was also either launched or revised in several areas, including HIV testing and counselling; integrated HIV prevention, treatment and care; procurement and supply management; and HIV drug resistance surveillance.
30. UNAIDS continued its work to strengthen national systems for procurement and supply management of medicines and diagnostics. With an eye towards ensuring continuous treatment access and build national capacity for sustainability, the Joint Programme joined with key procurement partners to support a coordinated, international initiative on commodity procurement and to develop minimum volume commodity guarantees. Technical support strengthened supply chain management in at least 24 countries, and country partners benefited from the launch of a procurement and supply management handbooks and the harmonization of procurement and supply management indicators.
31. Extensive capacity-building assistance strengthened national health systems to support the expansion and sustainability of HIV treatment programmes. More than 90 countries have developed policies to address human resource shortages through task-shifting, with 63% of sub-Saharan African countries having such policies in place. Seventy-five countries benefited from capacity-building to adopt enabling trade and health policies, with patent examiners in 22 countries receiving training to promote examination of pharmaceutical patents from a public health perspective. Technical support was provided to 44 countries to facilitate use of flexibilities in the TRIPS intellectual property accord to promote accelerated access to essential medicines. Support was also provided for a meeting focused on reducing impediments to rational procurement of laboratory items. These and other interventions to strengthen national health systems not only benefited the HIV response, but generated ancillary benefits for the health-related Millennium Development Goals (MDGs 4-6).
32. Investments by the Joint Programme in the generation and dissemination of strategic information supported national efforts to bring HIV treatment to scale and to maximize

efficiency of treatment programmes. Reports on transaction prices for antiretrovirals and diagnostics enabled countries to benefit from most favourable pricing available for HIV treatment commodities. HIV resistance surveillance is now operational in countries throughout the world – including 15 in sub-Saharan Africa – providing policy-makers with information relevant to antiretroviral forecasting and the monitoring of strategies to promote treatment adherence. Efforts were launched in 2008-2009 to establish an online global database on antiretroviral toxicities.

33. With UNAIDS recommending the implementation of provider-initiated testing and counselling to supplement other testing approaches, major gains were reported in expanding knowledge of HIV status in 2008-2009. The number of reporting countries with national HIV testing and counselling policies increased from 70% in 2007 to almost 90% in 2008. In 39 low- and middle-income countries reporting, the number of HIV tests performed more than doubled between 2007 and 2008, while the number of sites delivering HIV testing and counseling services rose by 35% in 66 high-burden countries. A policy statement on provider-initiated HIV testing and counselling in health facilities was issued for refugees and internally displaced persons. Despite clear progress, an estimated 60% of people living with HIV remained undiagnosed in 2008.
34. The Joint Programme intensified efforts to expand treatment access for children living with HIV, which is critical not only to achieve international HIV-specific commitments but to accelerate progress towards Millennium Development Goal 4's goal of reducing childhood mortality. In 2008-2009, support was provided for the assessment and documentation of optimal mechanisms for effective, reliable and sustainable systems for early infant diagnosis, including reviews in four countries that yielded promising findings on programme effectiveness. UNAIDS launched a programming framework for prevention, diagnosis care and treatment for infants and children, undertook joint reviews of paediatric care and prevention of mother-to-child transmission in five African countries, and recalculated epidemiological estimates for the number of children needing treatment in order to facilitate more accurate and ambitious target-setting.
35. More than 30 countries received technical support to facilitate integration of food and nutrition programming in national antiretroviral treatment initiatives. Support was provided in a number of countries regarding inclusion of fortified blended foods in support of food-by-prescription programmes and HIV care and treatment. In about 30 countries, UNAIDS provided technical support for the development of monitoring and evaluation efforts for HIV-focused food and nutrition. In collaboration with the Global Alliance for Improved Nutrition, the Joint Programme supported analytical research to inform integration of food and nutrition initiatives in HIV treatment programmes, and a food-by-prescription landscape paper was launched in 2009 along with the first phase of programme reviews in Kenya and Rwanda. A programme evaluation in Zimbabwe found that nutritional support improves antiretroviral adherence and leads to marked weight gain among programme participants.
36. The Joint Programme worked to expand the evidence base for action to ensure effective treatment and care. Generic tools for operational research were developed, focusing on such topics as HIV testing and counselling and antiretroviral adherence. Support was also provided for focused research to simplify clinical and laboratory monitoring, validate algorithms for infant diagnosis, and site monitoring to identify factors associated with the emergence of drug resistance.

## ***Prevent people living with HIV from dying of tuberculosis***



### *Overall progress in this Priority Area*

37. Although tuberculosis (TB) remains a leading cause of death among people living with HIV – with between 450,000 and 620,000 individuals with HIV/TB co-infection dying in 2008<sup>viii</sup> – promising progress was reported in 2008-2009 in the effort to prevent people living with HIV from dying of TB. Globally, TB incidence appears to have peaked in 2004, and funding for TB control activities from all sources rose to more than \$2.4 billion in 2009 (compared to less than \$2.2 billion in 2007).<sup>viii</sup> The number of TB patients who knew their HIV status increased to 1.4 million in 2008 – from 1.2 million in 2007 – and at least 75% of TB patients knew their HIV status in at least 50 countries, including 11 in Africa.<sup>viii</sup> The number of HIV-positive people screened for TB more than doubled in 2008, rising to 1.4 million from 600,000 in 2007.<sup>viii</sup>

### *UNAIDS contributions in this Priority Area in 2008-2009*

38. UNAIDS worked to build the evidence base for more strategic action to address HIV/TB co-infection. The Joint Programme supported four country assessments to review the integration of HIV and TB services and sponsored capacity-building activities to support development of strategic roadmaps to address HIV/TB co-infection in 30 countries. Seven countries used a step-by-step guide for integrating TB into HIV workplace programmes, while 19 countries received capacity-building support for collaborative HIV/TB programmes. Five Asian countries benefited from technical support to integrate management of HIV/TB co-infection in national HIV programmes. In Swaziland alone, support assisted the implementation of HIV/TB activities in 24 business enterprises.
39. Working in collaboration with the TB/HIV working group of the Stop TB Partnership, the Joint Programme helped promote the concept of the 'Three I's for HIV/TB', a package of interventions - including Intensified TB case finding (TB screening), Isoniazid preventive therapy and Infection control - that aim to reduce the burden of TB among people living with HIV. UNAIDS also supported publication of numerous

articles on HIV and TB, addressing such topics as multi-drug resistance, the economic impact of antiretroviral therapy, and the role of rifabutin.

40. Global meetings facilitated or convened by UNAIDS in 2008-2009 greatly accelerated momentum to address HIV/TB co-infection. UNAIDS provided extensive technical and logistical support for the first Global Leaders' Forum on HIV/TB, hosted by Jorge Sampaio (UN Secretary-General's Special Envoy to Stop TB) prior to the UN High Level Meeting on HIV/AIDS in June 2008. The Joint Programme also helped organize a special meeting on HIV/TB research in Cape Town to coincide with the 5<sup>th</sup> International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention. A multi-stakeholder global meeting generated a model for the decentralized provision of antiretrovirals to co-infected patients, and monitoring and evaluation guidelines for HIV/TB collaborative activities were revised.
41. Intensified efforts in 2008-2009 focused on the provision of nutrition and/or food support in programmes to address HIV/TB co-infection. In Sudan alone, more than 200,000 patients enrolled in TB treatment received 3,757 metric tons of food support through the Joint Programme.

### ***Protect drug users from becoming infected with HIV***



#### Overall progress in this Priority Area

42. There are an estimated 15.9 million people who inject drugs worldwide, and up to 3 million are infected with HIV<sup>ix</sup>, with a global median HIV prevalence among people who inject drugs of 13%.<sup>i</sup> In five countries (Indonesia, Kenya, Myanmar, Nepal and Thailand), more than one in three people injecting drugs are infected.<sup>i</sup> The highest concentrations of HIV-positive injecting drug users are in Eastern Europe, East and South East Asia, and Latin America.
43. Although several countries in recent years have taken steps to expand HIV prevention and treatment services for people who use drugs – including China, Pakistan and Ukraine – access to such services remains far too limited in light of the epidemic's heavy burden on this population. Globally, only two needle syringes per injecting drug user are distributed per month, only 8 percent of injecting drug users receive opioid substitution therapy, and only 4 percent of HIV-positive injecting drug users receive antiretroviral therapy.<sup>x</sup>

UNAIDS contributions in this Priority Area in 2008-2009

44. In 2008-2009, the Joint Programme significantly intensified its support for strong national responses to HIV among people who inject drugs. The Joint Programme published a technical guide for target-setting for universal access to HIV prevention, treatment and care for people who inject drugs, which also defined an essential package of nine interventions for a comprehensive programme for drug users. Technical guidance on collaborative HIV/TB services for people who use drugs was developed, as were a policy brief on voluntary HIV testing in prisons, guidance for pharmacological treatment of opioid dependence, and a guide for managing the scale-up of programmes for drug users. A toolkit to combat trafficking in persons was disseminated in more than 80 countries.
45. The Joint Programme complemented support for programmatic scale-up with intensified assistance to ensure the existence of an enabling environment for HIV programmes for people who use drugs. Legislative review and analysis was supported in six countries in Central Asia, leading to legislative amendments in three countries. In South and Southeast Asia, the Joint Programme supported legislative reviews in 15 countries. A review of compulsory drug treatment centres in Asia was undertaken. With support from the Joint Programme, the Secretary-General's special AIDS envoy for Eastern Europe and Central Asia, Professor Lars Kallings, continued to focus on harm reduction and discrimination against people who use drugs, including participating in key regional meetings.
46. Programmatic scale-up for people who use drugs was supported in more than 50 countries. To accelerate progress in addressing the HIV-related needs of people who use drugs, the Joint Programme provided technical support to civil society partners in more than 65 countries regarding expansion of opioid substitution therapy and engagement in national and regional strategic planning bodies. An evaluation of support in Estonia, Latvia and Lithuania found that the project had accelerated the development of national consensus on harm reduction and contributed to expanded access to opioid substitution therapy. The Joint Programme supported harm reduction activities for injecting drug users among refugees in Afghanistan, Bangladesh, Iran, Myanmar and Nepal, and among returnees in Afghanistan.
47. Civil society groups in more than 40 countries benefited from capacity-building assistance to reduce stigma and discrimination towards people who use drugs. Advocacy, policy guidance and technical support facilitated inclusion of people who use drugs in Nepal's national HIV strategy, as well as incorporation of gender-sensitive harm reduction services in the HIV strategy in India. Regional and sub-regional harm reduction Knowledge Hubs were supported in Iran, Lebanon, Lithuania and Morocco, with the aim of developing regional capacity on harm reduction. With the goal of driving evidence-informed policy development and implementation in Central Asia, support was provided for seven international conferences on rights-based harm reduction issues, five regional workshops, two regional conferences and six national meetings. In the Russian Federation, more than 150 police officers received harm reduction training in five regions.
48. Intensified efforts supported policy development, programming and research relating to HIV in prison settings. A review on the evidence of effectiveness of interventions for HIV prevention, treatment and care in prisons was disseminated and supported advocacy efforts to promote evidence-based prison policies and programmes. More than 58 countries were aided in the development, translation and dissemination of technical guidance documents on HIV in prisons. In Latin America and the Caribbean, participants from 20 countries attended a regional consultation on HIV

and prison settings, generating recommendations for improvement in inclusive HIV-related programming. In Kenya, inmates and staff in 20 prisons received HIV training, while law enforcement and drug control officials in Myanmar were supported to address human trafficking and HIV. The Joint Programme supported inclusion of HIV/TB services in prison settings in six countries and sponsored a seminar on the topic in Indonesia that was attended by 110 prison officials and non-governmental organizations. Collaborative support to the Indian Ocean Commission led to the establishment of a regional advocacy network on HIV in prisons.

### ***Reduce HIV transmission among men who have sex with men, sex workers and transgender people***



#### *Overall progress in this Priority Area*

49. Available evidence indicates that men who have sex with men experienced elevated risk of HIV infection in all regions. Globally, surveys from 35 countries generated a median estimated HIV prevalence among men who have sex with men of 6% in 2008, with significantly higher prevalence reported in surveys in some countries (e.g., 26% in Colombia, 25% in Ghana, 29% in Myanmar, 22% in Senegal).<sup>1</sup> In many high-income countries, a resurgence of new infections among men who have sex with men is worsening national epidemics that earlier appeared to be under control.<sup>2</sup> HIV prevention coverage for men who have sex with men remains inadequate, with only 27% of this population being reached by HIV prevention services in 26 countries that reported data for 2008.<sup>1</sup> Surveys also indicate that transgender communities confront considerable HIV risks, with their access to culturally appropriate services diminished by widespread stigma, discrimination and social marginalization.
50. Country surveys suggest that at least 3% of the world's sex workers are living with HIV, with HIV prevalence in 2008 exceeding 30% in at least four African countries.<sup>1</sup> Important strides have been made in expanding sex workers' access to HIV prevention services, although sex workers continue to confront considerable barriers to meaningful service access, including legal frameworks that reinforce their social marginalization, harassment by law enforcement, and an acute shortage of non-judgmental, client-friendly service channels.

#### *UNAIDS contributions in this Priority Area in 2008-2009*

51. UNAIDS partners played leading roles in a global initiative to develop the UNAIDS Action Framework for men who have sex with men and transgendered populations. A



regional strategy on men who have sex with men was launched in Latin America, and support was provided for the launch of a network of men who have sex with men in the Russian Federation. Peer education manuals for men who have sex with men were developed to accelerate programme development and implementation in Cambodia, Mongolia and Thailand. The Joint Programme supported a multi-country research project to identify barriers to treatment for HIV-positive men who have sex with men, as well as a separate study in seven countries to understand enabling factors for sound policy and programming for men who have sex with men. UNAIDS provide continued support to the Asia Pacific Coalition on Male Sexual Health, including the costing of a regional prevention strategy for men who have sex with men, and hosted a project officer from the Pan Caribbean Partnership Against AIDS to galvanize increased programmatic focus in the region.

52. The Joint Programme significantly strengthened its support for sound, rights-based HIV responses for sexual minorities. UNAIDS partners convened a global consultation in September 2008 to help define interventions and clarify the role of the health sector in bringing HIV prevention and treatment services to scale for men who have sex with men. Regional consultations were held in Asia and the Pacific, Europe, Latin America and the Caribbean, and sub-Saharan Africa, with the goal of identifying region-specific epidemiological trends and strengthening regional and national responses.
53. Normative guidance and technical support accelerate programmatic planning and policy development regarding men who have sex with men. Sixty of 88 countries reporting made use of UNAIDS guidelines on HIV and sex between men in 2008-2009. Financial and technical support was provided to 12 countries to catalyze the establishment of rights-based HIV policies and programmes.
54. The Joint Programme provided technical and financial support to over 20 countries on developing policies and programmes for lesbian, gay, bisexual and transgender individuals. This included support to the first national conference of gay, lesbian, bisexual, transvestite and transgender people in Brazil, and development of a Guidance Note on Refugee Claims relating to Sexual Orientation and Gender Identity. UNAIDS provided technical support for a seven-country regional Global Fund proposals addressing HIV among men who have sex with men and transgender populations in the Caribbean and South Asia, resulting in the approval of the first successful regional Global Fund MSM project.
55. UNAIDS energetically opposed national efforts to institutionalize discrimination against men who have sex with men. The Secretary-General's special AIDS envoy for Latin America and the Caribbean (Sir George Alleyne) particularly stressed the need to combat homophobia in his regional advocacy.
56. With surveys indicating that one in five sex workers in sub-Saharan Africa are living with HIV, UNAIDS took steps to strengthen its leadership on HIV prevention for sex workers. The UNAIDS Guidance Note on HIV and Sex Work was launched, calling for intensified evidence- and rights-based approaches, endorsed by the Committee of Cosponsoring Organizations and embraced by a broad array of partners in the field. Building on momentum from the guidance note, the Joint Programme established a UN Advisory Group on HIV and Sex Work, co-chaired by the Network of Sex Work Projects, that includes UN organizations and sex worker networks throughout the world.
57. The final report of the Commission on AIDS in Asia, delivered to the Secretary-General in March 2008, stressed the epidemic's burden on sex workers and their



clients in many epidemics in the region and called for concerted action to strengthen HIV prevention efforts focused on sex work. In Asia, the Joint Programme supported or facilitated important advances in efforts to promote rights-based, evidence-informed responses to HIV and sex workers. A national consultation in Pakistan led to the production of the first national strategic framework on sex work and HIV; a national forum in Bangladesh brought together sex workers, government ministries, NGOs, and police and law enforcement representatives; in China, consultations on HIV and sex work led to the development of numerous national and sub-national approaches to improved HIV programming for sex workers; and in Thailand new approaches to reach non-establishment based sex workers were developed.

58. Capacity-building support benefited sex worker organizations in at least four regions, and a new training module for HIV and sex work was developed. In Peru, the Joint Programme supported the training of police officers and health officials to enhance their ability to provide appropriate services to sex workers. The Joint Programme also supported the transgender community and partners to develop guidelines for multisectoral work with transgender population in the context of sex work and HIV.
59. UNAIDS supported the development of a Caribbean-specific approaches to HIV and sex work, which included intensive capacity-building activities for sex worker organizations in Antigua and Guyana, and sub-regional consultations among sex worker organizations. In 2008-2009, the Joint Programme intensified its support for established sex worker networks and organizations in sub-Saharan Africa, and the establishment of health and legal services for sex workers in several countries. Support was provided for seven focused studies on HIV and sex work in four countries. Technical and funding support to develop interventions in humanitarian crisis situations for HIV and AIDS and sex work was provided in 19 countries.
60. Extensive in-reach training with UN partners improved the UN system's capacity on HIV and sex workers, men who have sex with men, transgender populations and injection drug users. With the inputs of these groups, UN staff from 19 countries in the Arab states and in Asia and Pacific participated in trialling of the training materials. The Joint Programme supported the scale-up of sex worker-friendly services in Egypt. Altogether, UNAIDS partners reported activities on HIV and sex work in at least 65 countries, a significant increase from the previous biennium. This was achieved through strong partnerships with global, regional and national sex worker networks and organizations.

***Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS***



*Overall progress in this Priority Area*

61. Recently, important advances have been made in promoting and protecting the human rights of people living with or affected by HIV. Several countries – including the Czech Republic, South Korea and the USA – have taken steps to remove HIV-related travel restrictions. In 2009, the High Court in New Delhi, India, struck down a law criminalizing sexual contact between persons of the same sex.
62. Yet despite such progress, human rights violations continue to undermine efforts to prevent people from becoming infected. More than 30 countries have enacted HIV-specific laws that criminalize HIV transmission or exposure, and over two dozen countries have used non-HIV-specific laws to prosecute individuals on similar grounds. Even as a growing body of data has documented elevated HIV prevalence among men who have sex with men in all regions, a number of countries have undermined effective HIV prevention for this vulnerable population by either enacting or considering legislation to criminalize same-sex sexual conduct. Scores of countries prohibit or limit access to proven harm reduction services for people who use drugs.

*UNAIDS contributions in this Priority Area in 2008-2009*

63. Through advocacy, policy guidance, and technical support, UNAIDS in 2008-2009 strengthened its efforts to ensure the removal of punitive laws, policies, practices, stigma and discrimination. Fifty-eight of 85 countries surveyed reporting using UNAIDS policies on removing criminalization of HIV transmission in the 2008-2009 biennium. Sixty-two countries received technical support for the development and implementation of gender-responsive and rights-based HIV policies and programmes. Joint UN Teams in more than 30 countries provided technical support to address human rights barriers to an effective HIV response, including removal of legal provisions criminalizing HIV transmission and facilitating improved access to justice for people affected by the epidemic. Pilot programmes for the reduction of stigma and discrimination in humanitarian settings were launched in five countries. The Joint Programme supported the development of an Arab Parliament convention, endorsed in 2009, on promoting and protecting the rights of people living with HIV. The Joint Programme also conducted a baseline review on the level of integration of key programmes to reduce stigma and discrimination and increase access to justice in 56 countries. Additionally, UNAIDS advocated for changes in legislation in four

countries in Eastern Europe for refugees and asylum seekers related to mandatory testing.

64. Through advocacy, strategic information, and use of its global convening role, UNAIDS contributed to the above-noted progress in removing discriminatory travel restrictions. UNAIDS helped convene an International Task Team on HIV-related Travel Restrictions, which issued findings and recommendations that were jointly accepted by the board of the Global Fund and the UNAIDS Programme Coordinating Board. UNAIDS mapped international travel restrictions and also joined with partners to publish a booklet describing the factual basis for the campaign to eliminate travel restrictions for people living with HIV.
65. Organizations of people living with HIV received capacity-building support and leadership development assistance in 45 countries. Policy guidance was published to promote closer working partnerships between people living with HIV, governments and civil society. Working with the Global Network of People Living with HIV, UNAIDS supported 30 countries in the rolling-out of the People Living with HIV Stigma Index, which provides a toolkit to measure and characterize HIV-related stigma and to detect related trends.
66. With the aim of ensuring that existing legal protections are adequately enforced, the Joint Programme invested considerable effort towards educating and sensitizing key actors in the judicial system. A groundbreaking meeting on HIV and the law for more than 30 high-level judges from 15 countries in sub-Saharan Africa led to the adoption of a Statement of Principles on HIV and the Judiciary. More than 180 labour judges in nine countries were trained in effective implementation and enforcement of laws to protect the human rights of people living with HIV. To further facilitate effective enforcement of HIV-relevant human rights provisions, human rights and gender competencies of constituents in the world of work were strengthened in more than 50 countries.
67. In 2009, UNAIDS concluded the first discussion in the process to adopt the International Labour Standard on HIV/AIDS and the world of work. Governments, Employers and Workers contributed to the draft text of the Standard. The engagement of these groups towards the development and finalization of the International Labour Standard is contributing to addressing stigma and discrimination based on peoples' real or perceived HIV status, and helping to create a supportive environment for comprehensive and gender-sensitive HIV programming.
68. Addressing and overcoming stigma and discrimination is vital in the response, and must take care to address cultural diversity. UNAIDS led intensive efforts to consolidate networks of faith-based partnerships at the regional level, which culminated in the establishment of the first Global Interfaith Network for Population and Development. The UNAIDS Strategic Framework for Partnership with Faith-based Organisations was released.
69. More than 4,000 religious leaders from 19 countries in the Arab region were trained as trainers on HIV, gender and human rights to create a supportive environment for people living with HIV. In total 100,000 religious leaders were reached. A tool was developed by UNAIDS that helped review discriminatory language in policies and practices in more than 400 municipalities in Africa and Asia and the Pacific.

## ***Meet the HIV needs of women and girls and stop sexual and gender-based violence***



### *Overall progress in this Priority Area*

70. Violence against women increases women's vulnerability to HIV and undermines the global campaign to reach agreed gender equality milestones by 2014 under Millennium Development Goal 3. In a four-country study, nearly one in four women reported that their first episode of sexual intercourse was forced. According to surveys in Bangladesh, Ethiopia, Peru, Samoa, Tanzania and Thailand, between 40% and 60% of women report having been physically or sexually abused by their partners.

### *UNAIDS contributions in this Priority Area in 2008-2009*

71. In 2008-2009, the Joint Programme worked to build the evidence base for action in reducing violence against women and to drive consensus in the field on future programmatic directions. UNAIDS conducted a systematic review of evidence on effective interventions to reduce violence against women. A meeting on violence against women convened by UNAIDS helped build consensus on the way forward for programmatic approaches to address violence against women and HIV.

72. UNAIDS worked to expand programming to combat violence against women. In nine countries, support was provided to implement multi-stakeholders initiatives to prevent violence against women. UNAIDS collaborated with partners to implement a four-country pilot initiative to prevent sexual violence against girls. The Joint Programme supported implementation of a domestic violence act in Zimbabwe. The Secretary-General's Special AIDS Envoy for Africa (Ms Elizabeth Mataka) emphasized the role of harmful cultural practices in her advocacy on the feminization of the epidemic in the region. Similarly, Dr Nafis Sadik, the Secretary-General's Special AIDS Envoy for Asia and the Pacific, continued to advocate for women's reproductive rights and women's empowerment as essential components of effective HIV prevention. The Joint Programme collaborated with partners in developing and refining national indicators in Sierra Leone and Uganda to prevent gender-based violence.

73. UNAIDS partners intensified joint advocacy and programming to reduce female genital cutting. Through the end of 2009, 12 countries were participating in the joint initiative, an increase of five during the 2008-2009 biennium. Data from diverse countries – including Egypt, Ethiopia, Kenya and Senegal – suggest that such efforts are bearing fruit, as the prevalence of female genital cutting is on the decline.
74. The Joint Programme's efforts to prevent violence against women and girls are situated within the broader emphasis on addressing the epidemic's gender dimensions. UNAIDS consulted with 87 organizations in 76 countries to develop the "UNAIDS action framework addressing women, girls, gender equality and HIV." Policy guidance on essential actions to reduce women's vulnerability to HIV was published in English, Spanish and French, and normative guidance and technical support was provided to 42 countries on integrating national gender and HIV strategies. UNAIDS provided Programme Acceleration Funds to 35 countries to support enhanced work on women and girls in national HIV strategies. The Universal Access Now! Initiative was launched in ten countries to strengthen efforts to integrate key gender actions into national AIDS strategies and plans and key HIV actions into national gender equality plans.

### ***Empower young people to protect themselves from HIV***



#### *Overall progress in this Priority Area*

75. With young people under age 25 accounting for an estimated 40% or more of incident HIV infections worldwide, the need to strengthen efforts to empower young people to protect themselves from HIV remained urgent in 2008-2009. Some encouraging trends were reported during the biennium. Declining HIV prevalence among young women in parts of Zambia and in Botswana, as well as reported changes in young people's risk behaviours in South Africa, suggested that HIV prevention efforts may be showing results for young people in parts of Southern Africa where HIV is now endemic.<sup>ii</sup> The percentage of young people with accurate and comprehensive knowledge about HIV has modestly increased in most African countries where multiple surveys have been conducted, and there appears to be a trend towards later initiation of sexual activity in several African countries.<sup>xi</sup>



76. While promising, these trends remain insufficient to dramatically alter the epidemic's trajectory. The percentage of young people with comprehensive HIV knowledge – approximately 40% – remains far shy of the 95% target in the 2001 Declaration of Commitment on HIV/AIDS.<sup>xi</sup> In sub-Saharan Africa, young girls continue to be at particular risk, as they experience a risk of becoming infected that is several times higher than for boys their own age.<sup>xi</sup>

UNAIDS contributions in this Priority Area in 2008-2009

77. UNAIDS provided extensive advocacy and technical support to accelerate HIV prevention programming for young people in the last biennium. The Joint Programme co-sponsored a meeting of health and education ministers from the Latin America and Caribbean region that resulted in a pledge to implement multisectoral strategies to provide comprehensive school-based sexuality education. To translate the declaration into action, UNAIDS launched situation analyses of sexuality education in 15 countries. The Joint Programme also released international technical guidance to set new international benchmarks for standards in sexuality education, as well as to assist education, health and other authorities develop and implement school-based sexuality education programmes and materials. Global Guidance Briefs on HIV prevention, treatment, care and support among young people were also developed and disseminated.
78. Extensive efforts by the Joint Programme focused on maximizing the effective utilization of schools to support HIV prevention and reduce young people's vulnerability. Through EDUCAIDS (the Global Initiative on Education and HIV & AIDS) and other initiatives, UNAIDS intensified activities to strengthen HIV programming in schools, including the launch of a toolkit for mainstreaming HIV responses in education sectors and the development of regional strategic frameworks for HIV and education in Asia and the Pacific, Eastern Europe and Central Asia, and the Arab States. Seven countries in southern Africa were assisted to mainstream HIV interventions for in-school care and support for young people.
79. Stakeholders from seven countries in Eastern Europe received technical assistance that led to national AIDS strategies and operational plans to implement evidence-based prevention interventions for most-at-risk adolescents. Intensive advocacy resulted in important legal reforms in Eastern Europe and Central Asia, including an official proposal in Ukraine to lower the age of access to voluntary testing and counselling. In Eastern and Southern Africa, 120 technical assistance missions supported accelerated implementation of prevention programming with and for adolescents; results of these efforts include a new "hot spot" focus on preventing programming for young people in three high-prevalence districts in Lesotho, as well as the development of new youth-focused prevention strategies in Malawi, South Africa and Tanzania. Countries in Eastern Europe and Central Asia and in Eastern and Southern Africa received technical support for development of monitoring and evaluation workplans for HIV programmes for young people. In Zimbabwe, training in youth-friendly services was provided to more than 300 nurses and more than 400 young peer educators, while sensitivity training on sexual and reproductive health issues was delivered to more than 2,500 school principals and 1,500 teachers in Uzbekistan.
80. UNAIDS undertook numerous efforts to build the capacity of young people to participate in the HIV response. Four regional workshops covering 27 countries built the capacity of youth-led organizations and national ministries to increase involvement of men and boys in HIV prevention programming. Support was provided to more than 600 young people to facilitate their participation in key international

meetings, including the International AIDS Conference in Mexico City. With the support of the Joint Programme, HIV awareness activities were integrated into school feeding programmes in the Central African Republic and Sierra Leone.

81. To build a strong evidence base for action, in-depth analyses of household survey data were conducted in five African countries, finding a significant association between young women's HIV status and the average number and age of their sexual partners. A separate data analysis from eight countries found that sexual debut prior to age 15 increased the likelihood that young women would be HIV-positive. The Joint Programme also supported behavioural surveillance of children and adolescents living on the streets in Egypt, generating baseline data for focused interventions. An assessment of the needs of vulnerable young people was also undertaken in three urban centres in Peru.
82. UNAIDS supported peer education and capacity building initiatives for HIV prevention among young people in humanitarian situations in 60 countries, including activities to combat malnutrition, anaemia and micronutrient deficiencies among children. In Colombia, a joint HIV prevention and response strategy was developed in collaboration with the civil society and the government.

### ***Enhance social protection for people affected by HIV***



#### *Overall progress in this Priority Area*

83. Extensive evidence, much of it commissioned or generated by UNAIDS Cosponsors, demonstrates that cash transfer programmes and other social protection strategies have the capacity to significantly mitigate the epidemic's impact.<sup>xi</sup> However, progress in protecting children and adults affected by the epidemic continues to lag. Although most high-prevalence countries have strategies in place to support children orphaned or made vulnerable by the epidemic, few national programmes reach more than a small minority of such children.<sup>xi</sup>



UNAIDS contributions in this Priority Area in 2008-2009

84. In 2008-2009, UNAIDS intensified its efforts to galvanize greater commitment and action to address the needs of children and adults affected by the epidemic. Targeted missions to donor capitals focused on developing a technical consensus on future actions needed to bring the HIV response to scale. UNAIDS also assisted countries to integrate food and nutrition services within their national social assistance systems, for example for orphans and vulnerable children as well as for people living with HIV.
85. In 2008, the Fourth Global Partners Forum on children affected by AIDS established an unprecedented global consensus regarding a firm evidence base for children affected by AIDS. In response, the Inter-Agency Task Team on children and HIV/AIDS work to strengthen country-level programmes for affected children.
86. In 2008-2009, UNAIDS supported the scaling-up of child-sensitive social protection programmes in 29 countries, including 20 that are implementing cash transfers or undertaking studies regarding the feasibility of such initiatives. Fifteen countries were supported in the development of specific policies on children orphaned or made vulnerable by AIDS. In at least 15 countries, the Joint Programme supported the provision of nutrition and food and support in programmes for children orphaned or made vulnerable by the epidemic. Formal guidance was issued to assist countries in developing and implementing monitoring and evaluation systems for children-focused HIV programmes. UNAIDS partners focused special efforts towards reinvigorating school-based care and support programmes for children affected by AIDS. UNAIDS also supported national strategy development on livelihoods and social protection for orphans and vulnerable children, a group for whom food and nutrition remain an important component of care and support.
87. Building the evidence base for action to support children, the Joint Programme supported national situation assessments regarding children affected by AIDS in China, Indonesia and Malaysia, with findings used to implement action plans and inform funding proposals. National assessments in eight countries in Eastern and Southern Africa supported the development of social protection frameworks, laws and structures to support and protect children.
88. In 2008-2009, UNAIDS strengthened its efforts to support people living with HIV through expanded employment opportunities. Pilot projects were supported in 17 countries to create employment opportunities through micro-finance initiatives, and networks of people living with HIV and other stakeholders in 17 countries received technical support for the development of social protection schemes and income-generating initiatives for people living with HIV. Seven countries in Africa and Asia received guidance and support to extend social security schemes to people living with HIV, including the implementation of new policies in India to ensure that women who have been widowed by AIDS can access widows' pensions even if they are below the standard age of eligibility.
89. Country-level studies of the epidemic's impact in the private, informal and transport sectors were conducted in ten countries. The Joint Programme also supported a review of 70 studies on the epidemic's socioeconomic impact, with the goal of supporting the development of improved impact mitigation strategies.
90. UNAIDS facilitated costing reviews and vulnerability profiling exercises to ensure food and nutrition services were better integrated in national systems. For example in Zambia, a mobile delivery and tracking system has been developed that innovatively

uses mobile phones to register beneficiaries and streamline secure delivery of food and livelihood interventions.

### **III. Conclusion**

91. In 2008-2009, UNAIDS made concrete contributions to the global response, helping strengthen and accelerate an unprecedented scaling-up of national responses to AIDS. UNAIDS served as a central source of strategic information and normative guidance, continued its role as the world's leading advocate for an exceptional AIDS response, facilitated the engagement of critical sectors and communities, intensified and streamlined its technical support to country partners, and helped mobilize vital resources for the response. With the goal of enhancing the Joint Programme's strategic focus and effectiveness for results, UNAIDS transitioned to an Outcome Framework that provides for intensified leadership and action in ten priority areas.
92. This report – along with the more detailed conference room paper that accompanies it – reflects the Joint Programme's ongoing commitment to accountability and transparency. This commitment is further reflected through strengthened efforts in this regard in the current 2010-2011 UBW. In line with the directions of the Programme Coordinating Board following its review of the Second Independent Evaluation, UNAIDS is taking additional steps to clarify its mission and strategic direction, simplify its budgeting and work planning, and permit all stakeholders to link resources allocated to the Joint Programme to specific results for people.

#### IV. Financial Reports

**Table 1: 2008-2009 UBW Core and Supplemental Budgets and Expenditure**

Agency	Budget	Expenditure
UNHCR	6,400,000	6,400,000
UNICEF	20,800,000	20,462,078 <sup>*</sup>
WFP	7,000,000	7,000,000
UNDP	13,760,000	13,760,000
UNFPA	18,200,000	18,199,982 <sup>*</sup>
UNODC	9,500,000	9,500,000
ILO	9,500,000	9,606,316
UNESCO	10,600,000	10,060,598 <sup>*</sup>
WHO	26,500,000	25,910,820 <sup>*</sup>
World Bank	12,410,000	12,356,628 <sup>*</sup>
Secretariat	192,900,000	191,668,000
Interagency <sup>§</sup>	157,250,000	155,488,000
<b>Total</b>	<b>484,820,000</b>	<b>480,412,422</b>

<sup>\*</sup> Remaining balance to be counted against 2010-2011 UBW allocation. The total expenditure represents the actual level reported by Cosponsors for the reporting period. It is lower than the amount reported in the Financial Report (PCB(26)10.4), where Cosponsor allocations are reported as fully expended.

<sup>§</sup> Contains Contingency, which was utilized in implementing Interagency activities.

**Table 2: 2008-2009 UBW Cosponsor Supplemental and Global/ Regional Budgets and Expenditure**

Agency	Cosponsor Supplemental <sup>1</sup>		Cosponsor Global/ Regional Resources <sup>2</sup>		Estimated Cosponsor Country-level Resources <sup>3</sup>
	Budget <sup>4</sup>	Expenditure	Budget <sup>3</sup>	Expenditure	Expenditure
<b>UNHCR</b>	1,320,000	1,346,213	7,845,000	7,215,000	945,001
<b>UNICEF</b>	33,408,000	18,356,006	38,493,000	1,069,961	367,768,188
<b>WFP</b>	1,600,000	10,230,586	14,051,000	2,200,000	249,033,963
<b>UNDP</b>	21,700,000	6,147,116	12,000,000	19,397,659	365,217,422
<b>UNFPA</b>	38,800,000	37,364,241	28,590,000	17,195,510	83,454,443 <sup>5</sup>
<b>UNODC</b>	39,600,000	46,379,891	13,200,000	8,607,079	5,014,396
<b>ILO</b>	16,000,000	10,138,911	4,400,000	3,832,326	11,999,965
<b>UNESCO</b>	12,500,000	5,621,986	11,500,000	6,159,965	18,596,032
<b>WHO</b>	71,600,000	37,894,943	31,200,000	21,914,700	65,168,691
<b>World Bank</b>	11,135,000	14,227,000	23,457,000	21,181,000	434,400,000
<b>Total</b>	<b>247,663,000</b>	<b>187,706,893</b>	<b>184,736,000</b>	<b>108,773,200</b>	<b>1,601,598,101</b>

<sup>1</sup> Indicates resources funded by voluntary contributions raised by Cosponsors.

<sup>2</sup> Indicates resources allocated from Cosponsor's own core resources through their regular budget financed by voluntary or assessed contributions.

<sup>3</sup> Additional resources raised by Cosponsors or from cosponsor's own core resources outside the UBW for work at country-level.

<sup>4</sup> Budgets were compiled by Cosponsors in 2007 as best estimates of anticipated funds, including from voluntary fundraising, for 2008-09. In some instances Cosponsors channelled funds from their Supplemental and Cosponsor UBW budgets to their Country-level Resources which, while formally outside the UBW, are included here to provide a more complete picture of Cosponsor implementation.

<sup>5</sup> Does not include figures from most of UNFPA's country offices in Africa.

## References

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- <sup>i</sup> WHO, UNAIDS, UNICEF (2009). *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*.
- <sup>ii</sup> UNAIDS, WHO (2009). *AIDS epidemic update*.
- <sup>iii</sup> UNAIDS, Impact of the global financial and economic crisis on the AIDS response, 25<sup>th</sup> meeting of the UNAIDS Programme Coordinating Board, December 2009, UNAIDS/PCB(25)/09.26.
- <sup>iv</sup> United Nations General Assembly (2010). *Report of the Secretary-General on progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS*. A/64/735.
- <sup>v</sup> Hallett TB et al. (2010). Estimates of HIV incidence from household-prevalence surveys. *AIDS* 24:147-152.
- <sup>vi</sup> Granich RM (2009). Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. *Lancet* 373:48-57.
- <sup>vii</sup> UNHCR (2010). *47th Standing Committee Report*.
- <sup>viii</sup> WHO (2009). *Global Tuberculosis Control 2009*.
- <sup>ix</sup> Mathers, B. et al. (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372: 1733-1745.
- <sup>x</sup> Mathers, B. et al. (2010). HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional and national coverage, *Lancet* 375:1014-1028.
- <sup>xi</sup> UNAIDS (2008). *Global report on the AIDS epidemic*.