

# UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK (UBRAF) PERFORMANCE MONITORING REPORT 2016

**Additional document for this item:**

- i. UNAIDS Performance Monitoring Report: Organizational Reports  
(UNAIDS/PCB (40)/17.6)
- ii. Independent Evaluation of the Partnership between Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (UNAIDS/PCB (40)/CRP3)

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

1. *Take note* of the performance monitoring report and continued efforts to rationalize and strengthen reporting, in line with decisions of the Programme Coordinating Board, and based on experience and feedback on reporting;
2. Urge all constituencies to contribute to efforts to strengthen performance reporting and use UNAIDS' annual performance monitoring reports to meet their reporting needs.

**Cost implications of decisions:** none

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## ACRONYMS

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral medicines
ART	antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CSE	comprehensive sexuality education
CSO	civil society organizations
eMTCT	elimination mother-to-child transmission
ESCAP	Economic and Social Commission for Asia and the Pacific
FAO	Food and Agriculture Organization
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	hepatitis C
HIV	human immunodeficiency virus
HLM	High-Level Meeting
HTC	HIV testing and counselling
IAS	International AIDS Society
IATI	International Aid Transparency Initiative
IATT	Interagency Task Teams
INPUD	International Network of People who Use Drugs
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
LGBTI	lesbian, gay, bisexual, transgender and intersex
MSM	men who have sex with men
NGO	nongovernmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office Of The United Nations High Commissioner For Human Rights
PAHO	Pan-American Health Organization
PCB	Programme Coordinating Board
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMR	Programme Monitoring Report
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
PrEP	pre-exposure prophylaxis
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SOGIE	sexual orientations, gender identity and gender expressions
SRA	strategic results area
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STDs	sexually transmitted diseases
STI	sexually transmitted infection
TB	tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UHC	Universal Health Care
UNAIDS	United Nations Joint Programme on AIDS
UNCTAD	United Nations Conference on Trade and Development
UNGA	UN General Assembly
UNGASS	UN General Assembly Special Session
UNOPS	United Nations Office for Project Services
UNITAID	UN International Drug Purchasing Facility
USAID	United States Agency for International Development
VMMC	voluntary medical male circumcision

**Cosponsors**

ILO	International Labour Organization
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WFP	World Food Programme
WHO	World Health Organization
WB	World Bank

## HIGHLIGHTS

### Leadership and political commitment

1. In 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reinforced its commitment to and leadership of the global HIV response, and AIDS in the Sustainable Development Goals (SDGs) and the 2030 Agenda. The Joint Programme positioned itself to continue to effectively lead the global AIDS response, while promoting shared responsibility and global solidarity, ensuring that no one is left behind.
2. The success of this high-level work was evident in the Political 2016 Declaration on Ending AIDS, adopted during the UN General Assembly High-Level Meeting on AIDS in June 2016. In the following month, the 21<sup>st</sup> International AIDS Conference in Durban (AIDS 2016) provided an important platform for raising awareness on key specific issues such as paediatric treatment and prevention, the need to mobilize political engagement and advocate for a Fast-Tracking approach, and to ensure that HIV remains high on national, regional and global agendas.
3. Despite remarkable progress in the AIDS response, the gains are fragile and UNAIDS continues to encourage decision-makers and stakeholders to be ambitious in their aspirations and actions in 2017 and beyond. Success will require scaling up programmes so people can access the services they need, where they need them and in ways that enable them to use the services. It also involves providing people with the knowledge and means to keep themselves and others free of HIV infection. Similarly, the world must move quickly to reach the 90–90–90 targets, enabling people to know their HIV status and to access and stay on HIV treatment. Building on achievements to date—including increased domestic spending on HIV, prioritization of interventions that deliver the greatest impact, wide use of innovations, and leveraging intersectoral partnerships—countries need to further accelerate their efforts.

### 90–90–90 and prevention

4. In mid-2016, the Joint Programme celebrated a critical milestone in the global response to AIDS, when it announced that 18.2 million people were accessing antiretroviral therapy (ART). The massive expansion of ART in the past 10–12 years, supported by coordinated activities across the Joint Programme, has reduced the global number of people dying from AIDS-related causes, from 2 million in 2005 to an estimated 1.1 million in 2015. Accelerated treatment access continues to underpin the 90–90–90 targets for HIV diagnosis, treatment and viral suppression, as a vital pathway also to reducing new HIV infections to below 500 000 by 2020.
5. With the objective of reinvigorating the HIV prevention agenda, including making it more responsive to the needs of adolescents, young people and key populations, and building political commitment, the Joint Programme launched several landmark initiatives in 2016 and reinforced existing initiatives. For example, the Joint Programme supported countries in identifying the optimal combination of targeted behavioural, biomedical and structural programmes to reach people who are at increased risk of HIV infection. It also continued to promote access to HIV prevention as a right for every person, and supported efforts to ensure that all young people have access to accurate, comprehensive HIV and sexuality education and youth-friendly services. A “quarter for prevention” campaign was launched, aiming to

adequately finance effective prevention programmes. In addition, UNAIDS announced the establishment of a Global Prevention Coalition which in 2017 will bring together political leaders, implementers and advocates to develop a roadmap for achieving the prevention targets in the 2016 Political Declaration on Ending AIDS.

## eMTCT

6. The elimination of mother-to-child transmission of HIV (eMTCT) agenda remained a high priority for the Joint Programme in 2016. With the transition to a post-Global Plan era for eMTCT and the inception of the new framework Start Free Stay Free AIDS Free new pathways have been created to ensure that:
  - all pregnant women have access to antiretroviral (ARVs) medicines;
  - all pregnant women are retained in treatment and care;
  - HIV-exposed infants have access to ARV prophylaxis to prevent infection;
  - human rights and gender equality are upheld in eMTCT efforts; and
  - community engagement is ensured.
7. Given the importance of continued and intensified progress towards the elimination goal, members of the Joint Programme used their comparative advantages to provide various types of support in the delivery of eMTCT services for all elements of the eMTCT effort. Support included adapting the latest eMTCT guidance and developing costed implementation plans, work that was exemplified in the validation of eMTCT in Thailand and other countries in 2016.

## Key populations

8. UNAIDS' 2016 *Prevention gap report* refocused attention on HIV prevention, including for key populations, and enabled the Joint Programme to make an evidence-based case to countries to achieve 90% coverage of prevention services for key populations. At the International AIDS Conference in Durban, the Joint Programme was recognized for its efforts to reach key populations and secure treatment for all. Meanwhile, the Fast-Track approach to end the AIDS epidemic has continued to enhance access to prevention and treatment for key populations, including in cities, in 2016.
9. The UN General Assembly Special Session (UNGASS) on the world drug problem, in April 2016, provided another opportunity for high-level advocacy by the Joint Programme. As a result, UNAIDS policy positions on HIV and drug use were reflected in statements of several Member States. Those statements highlighted for example the need for "evidence-based services ... to help prevent the spread of HIV, hepatitis C, and other preventable diseases", and urged that "law enforcement efforts should focus on criminal organizations—not on people with substance use disorders who need treatment and recovery support services".

## Gender equality

10. The Joint Programme addressed the gender dimensions of the HIV epidemic in 2016 through a range of activities. Those included strengthening evidence on the ways in which unequal gender norms affect women and girls' abilities to avoid HIV infection, and on the need to repeal discriminatory laws and practices. UNAIDS also supported countries in integrating gender equality into national HIV strategies, monitoring and

evaluation frameworks and budgets, and in enhancing leadership and participation of women living with HIV in decision-making.

11. Promoting leadership of women living with HIV was a major advocacy focus for the Joint Programme during 2016. This resulted in young women and networks of women living with HIV taking on greater roles in defining a common agenda and participating meaningfully in HIV policy and programming at national, regional and global levels. This included their active engagement in the 60<sup>th</sup> session of the Commission on the Status of Women, the High-Level Meeting on Ending AIDS, the AIDS 2016 Conference and Women Deliver.

### Human rights, stigma and discrimination

12. The year 2016 was also important for positioning human rights and the quest for zero discrimination at the core of the 2016 Political Declaration on Ending AIDS. To that end, the Joint Programme worked to address human rights and confront stigma and discrimination in legislative and policy frameworks, through technical support, advocacy, collecting evidence, and conducting reviews and assessments. The Joint Programme also targeted discrimination in health care settings through a range of approaches. For example, the Agenda for Zero Discrimination in Health Care was launched in 2016, guiding collective advocacy, leadership, accountability and the implementation of evidence-informed interventions.

### HIV integration

13. Through joint and individual activities, the Joint Programme worked to ensure that people living with, at risk of and affected by HIV have access to integrated services, including for HIV, tuberculosis (TB), sexual and reproductive health, cervical cancer, harm reduction, and food and nutrition support. To that end, the Joint Programme worked with partners to integrate HIV in the programmes of other sectors, including humanitarian responses, the education sector and human rights initiatives.
14. In order to advance HIV-sensitive social protection, the Joint Programme worked collaboratively to include a social protection target in the 2016 Political Declaration on Ending AIDS. The target calls for efforts to “strengthen child and national social protection systems to ensure 75% of people living with, at risk of and affected by HIV, who are in need, have access to HIV-sensitive social protection activities.” As a result, social protection and incentives have become a prominent part of the recommended packages promoted by the Joint Programme on HIV prevention, treatment, care and support.

### Sustainable financing

15. Sustainable financing and investment remains a major challenge for Fast-Tracking the HIV response. The UNAIDS Secretariat estimates that by 2020 the global cost of implementing the Fast-Track approach will be approximately US\$ 26 billion per year in low- and middle- income countries (as per 2015 classification). In 2016, as more countries transitioned towards an increased share of domestic financing for their HIV response, the Joint Programme provided direct technical assistance to support them in defining a sustainable path, maximizing sustainable funding opportunities and minimizing the service disruptions of potentially complex transitions.



16. The *Global AIDS update* and the projected impact and resource needs in the *Fast-Track update on investments needed in the AIDS response* served as the basis for setting time-bound targets in the 2016 Political Declaration on Ending AIDS, which outlined a global framework for the AIDS response for 2016–2020. The World Bank Optima model, an allocative efficiency analysis tool for use in informing public health (including HIV) investment choices, was rolled out in 2016, and enabled the development of more than 10 allocative efficiency studies across 6 regions, and the reallocation of HIV resources to avert new infections.

### Resourcing the Joint Programme

17. The Joint Programme faced serious budget constraints in 2016. Income against the core budget in 2016 fell 25% short of the Board-approved budget. The budget shortfall posed a challenge that significantly affected the capacity of Cosponsors and the Secretariat to deliver the level of support stipulated in the UNAIDS Strategy. The Joint Programme responded by, among others, identifying cost-saving measures, and by sharpening the focus on Fast-Track countries and on specific populations and locations. Efforts to enhance the coherence, coordination and accountability of the Joint Programme continued to ensure confidence of existing and new donors, and supported the mobilization of additional resources.

## INTRODUCTION

18. The Performance Monitoring Report (PMR) presents the performance and achievements of the Joint Programme during 2016—at country, regional and global levels—towards the UNAIDS 2016–2021 Strategy and the global targets agreed to in the 2016 Political Declaration on Ending AIDS. The report also outlines key challenges, lessons learned and future actions.
19. Reporting is based on a review of achievements against 2016–2021 Unified Budget, Results and Accountability Framework (UBRAF) indicators. As per the recommendations of the PCB made at its 38<sup>th</sup> meeting, the PMR 2016 is structured to highlight contributions and results of Cosponsors and the Secretariat, using core and non-core UBRAF funding.
20. Part I of the report is a synthesis of key achievements, challenges and future actions. It reviews progress against the eight Strategy Results Areas (SRAs) of the 2016–2021 UBRAF. Further, detailed information, structured around the 20 UBRAF outputs can be found in Part II of the 2016 PMR (UNAIDS/PCB(40)/17.6). Regional reporting is captured in the next section, after which the UNAIDS Secretariat functions are reported. Financial implementation is presented in the final section of Part I.
21. Part II of the report provides detailed information on the key achievements of Cosponsors and the Secretariat against core and non-core resources, as well as progress against the 20 SRA outputs of the 2016–2021 UBRAF.
22. The 2016–2021 UBRAF emphasizes the need for independent evaluations to complement performance monitoring. In 2016, independent evaluations were done on the UNAIDS technical support facilities, UNAIDS' regional cooperation programme in Eastern Europe and Central Asia, and the partnership between UNAIDS and the Global Fund, which is presented to the Board as a conference room paper (UNAIDS/PCB(40)/CRP1). UNAIDS' evaluation plan for 2017 is included as an Annex.

## STRATEGY RESULT AREAS

### Strategy Result Area 1: HIV testing and treatment

**Strategy Result Area 1: Children, adolescents and adults living with HIV access testing know their status and are immediately offered and sustained on affordable quality treatment**

#### Achievements

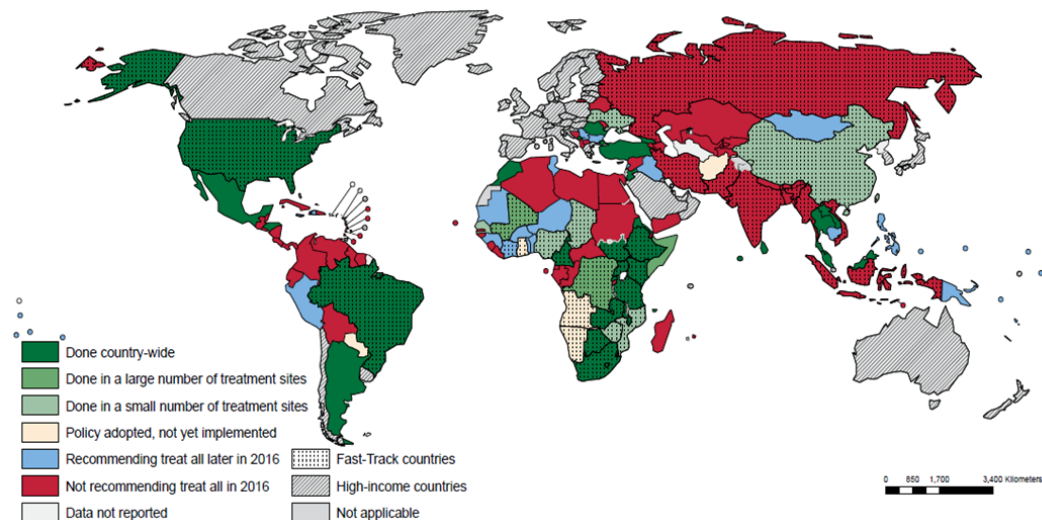
23. In mid-2016 the Joint Programme celebrated a critical milestone in the history of the global response to AIDS, when UNAIDS announced that 18.2 million people were accessing antiretroviral therapy (ART). With the massive expansion of ART in the past 10 years, supported by coordinated activities across the Joint Programme, came a reduction in the global number of people dying from HIV-related causes, from 2 million [1.7 million – 2.3 million] to around 1.1 million [940 000 – 1.3 million] in 2015. Treatment coverage is lower for men than for women living with HIV in every region. Globally 52% of women living with HIV access treatment compared with 40% of men living with HIV. Accelerated treatment access continues to underpin the 90–90–90 targets for HIV diagnosis, treatment and viral suppression, as the pathway to reducing new HIV infections to below 500 000 by 2020.
24. However, challenges towards reaching the 90–90–90 targets remain: for example, in 2016, 40% of people with HIV did not know their HIV positive status. In many countries, critical gaps exist in HIV testing services, and key populations are still not being reached. Treatment access and adherence is a central pillar in the global HIV response and has been successfully promoted, collectively and individually within the Joint Programme, as key to reducing mortality, morbidity and HIV transmission. However more needs to be done. For example, efforts to expand treatment do not sufficiently address gender dynamics, hindering access for both women and men.

*Innovative testing strategies*

25. In 2016 the Joint Programme leveraged results in the acceleration of testing and treatment access, through coordinated action. Updated World Health Organization (WHO) normative guidance ensured that the latest science was applied to treatment policy, with 45 low- and middle- income countries adopting “Treat All” guidelines in 2016 and an additional 31 indicating imminent adoption. The Joint Programme ensured high visibility for testing and treatment at a number of critical events in 2016, including the UN General Assembly High-Level Meeting (HLM) to end AIDS at the UN in New York and at the 21<sup>st</sup> International AIDS Conference in Durban (AIDS 2016), with a particular focus on paediatric treatment. Agencies including WHO, the United Nations Development Programme (UNDP), the World Bank and the United Nations Children’s Fund (UNICEF) joined together to ensure that international financing was unlocked for national treatment programmes, through coordinated collaboration with the Global Fund and the United States President’s Emergency Plan for AIDS Relief (PEPFAR).

**Figure 1: Implementation of the “Treat All” recommendation as of October 2016.**

**Implementation of the "treat all" recommendation among adults and adolescents living with HIV, October 2016**



26. In December 2016, WHO released guidelines on HIV self-testing and assisted partner notification as a supplement to consolidated guidelines on HIV testing services. Both sets of guidance are informing much of the work of the Joint Programme on testing and treatment. The guidance encourages: the routine offer of voluntary assisted HIV partner notification services as part of a public health approach to delivering HIV testing services; and advice on how HIV self-testing and assisted HIV partner notification services can be integrated into both community-based and facility-based approaches and be tailored to specific population groups. A number of critical partnerships that focus on testing and treatment also progressed in 2016, including with the Global Fund, PEPFAR and UNITAID, offering important opportunities for international partners to leverage technical inputs from across the Joint Programme in support of research and implementation.

Percentage of countries with selected HIV Testing Services in place.	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.	2021: 90% 2019: 80% 2017: 70%	All: 47% [45/96] FT: 58% [19/33]
<p>This indicator shows improvements in HIV testing services as a result of advocacy and technical support provided by the Joint Programme.</p> <p>In 2016, 47% of the 96 countries with Joint Programme presence (including 19 Fast-Track countries) reported that the following services are in place:</p> <ul style="list-style-type: none"> <li>■ targeted HIV testing services;</li> <li>■ lay providers HIV testing;</li> <li>■ quality assurance (laboratory) of testing and re-testing before ART initiation;</li> <li>■ HIV partner notification services.</li> </ul>		

27. In partnership with the UNAIDS Secretariat and other Cosponsors, the World Bank is also building evidence around innovative testing and counselling programmes. In South Africa for example, the ART Adherence Guideline evaluation will help the government's decision-making processes on the national roll-out of adherence interventions. The International Labour Organization (ILO) continued to prioritize HIV testing (VCT@WORK Initiative), in the context of an ongoing collaboration with the UNAIDS Secretariat, WHO, UNDP, UNICEF and the United Nations Educational, Scientific and Cultural Organization (UNESCO), to drive up results in the first two 90s of the 90–90–90 targets. A total of 1.2 million workers, families and community members undertook the HIV test in 2016: 17 773 tested positive and were referred to treatment and care services. Cumulatively, 4.1 million have taken an HIV test since the launch of the VCT@WORK Initiative by the ILO Director-General and the UNAIDS Executive Director in June 2013. A total of 104 926 people tested HIV-positive and 103 286 were referred to treatment and care services.

#### *Access to the treatment cascade*

28. WHO, the UNAIDS Secretariat, Futures and the HIV Modelling Consortium created a tool for countries to develop and analyse results from their own cascades. This is enabling an improved understanding of the data quality and gaps. WHO also convened 25 high-burden countries, covering 85% of the epidemic, to establish testing and treatment gaps, analyse cascades and prioritize actions to fill these.
29. Extensive work was carried out in the first half of 2016 to bring all partners and stakeholders together to accelerate the implementation of 90–90–90, focusing primarily on diagnostics, paediatric treatment and human resources for health. The UNAIDS Secretariat also had two strong collaborative partnerships as a platform to advance work on human resources for health and paediatrics with the One Million Community Health Care Workers (1mCHW) and the Government of Côte d'Ivoire, respectively. These close partnerships have helped ensure that advocacy on 90–90–90 is broadly shared, widely disseminated and coherent.

Percentage of countries adopting WHO HIV treatment guidelines.	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.	2021: 80% 2019: 60% 2017: 50%	All:39% [37/96] FT: 64% [21/33]
<p>A central element of the 2016 WHO treatment guidance is the removal of limitations on eligibility for ART among people living with HIV. All people living with HIV, irrespective of age or CD4 cell count, are now eligible for treatment and they should initiate ART as soon after diagnosis as possible. Joint Programme support to countries includes promotion of task-shifting, adherence support and, where relevant, programmes to address nutritional needs of vulnerable groups.</p> <p>In 2016, 39% of 96 countries with Joint Programme presence reported that:</p> <ul style="list-style-type: none"> <li>■ The “Treat All” policy has been adopted;</li> <li>■ Task shifting or task sharing in provision of ART has also been adopted;</li> <li>■ Policies/strategies for ART retention and adherence are in place;</li> <li>■ A programme for nutritional support to people on ART is in place.</li> </ul> <p>Notably, 64% of the Fast-Track countries have adopted the WHO HIV “Treat All” guidelines.</p>		

30. In 2016 the Secretariat and Cosponsors, including WHO, UNDP, the Office of the United Nations High Commissioner for Refugees (UNHCR), the World Food Programme (WFP) and the World Bank, also continued to emphasize the importance of TB/HIV coinfection and people-centred linkages across health and community systems. TB remains a leading cause of death among people living with HIV. Large gaps exist both in diagnosis and treatment of HIV-associated TB. In 2016, WHO undertook an analysis of bottlenecks to scale up key TB/HIV interventions in 20 countries with very high burdens of coinfection. The World Bank led initiatives in South Africa and Swaziland to accelerate access to services for HIV/TB coinfection in 2016 and approved US\$ 122 million worth of financial assistance for TB in several southern African countries with high burdens of TB countries: Lesotho, Malawi, Mozambique and Zambia. UNDP provided support through the Multi-Country Western Pacific HIV/TB grant covering 11 countries in that region.

*[“Just under two years ago, 15 million people were accessing antiretroviral treatment—today more than 18 million are on treatment and new HIV infections among children continue to fall. Now, we must ensure that the world stays on the Fast-Track to end the AIDS epidemic by 2030 in Namibia, in Africa and across the world.”](#)*

Hage Geingob, President of Namibia

#### 90–90–90 for children and adolescents

31. Ambitious new targets for ART coverage for children and adolescents were adopted in the 2016 Political Declaration on Ending AIDS and included in the *Start Free Stay Free AIDS Free* framework launched at the 2016 HLM on Ending AIDS. Addressing HIV testing and treatment among adolescents and children, UNICEF led the ongoing evolution of the “All In” initiative among adolescents, together with the UNAIDS Secretariat, UNFPA, WHO, PEPFAR, the Global Fund and other partners, through “All In” assessments. UNICEF also focused on enhanced HIV case finding among young children, through integrating HIV testing in immunization clinics, children’s sick child platforms and nutrition clinics, as well as introducing new point-of-care technologies for early infant diagnosis to allow for decentralization of HIV testing in infants and timely linkage to treatment services in seven African countries, with

UNITAID support. At a meeting organized in Vatican City by Caritas, the UNAIDS Secretariat and PEPFAR in May 2016, a statement was provided by Pope Francis in support of widening access to HIV testing and treatment services for children. Participants also committed to finding collective solutions, such as multipartner agreements; encouraging increased research on HIV treatment for children; accelerating the process of testing, approving and registering new HIV medicines for children; finding innovative solutions to prevent medicine supply stock-outs; and strengthening health systems.

Percentage of countries adopting quality healthcare services for children and adolescents	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.	2021: 90% 2019: 80% 2017: 60%	All: 51% [49/96] FT: 58% [19/33]
<p>Addressing the gap in ART and care coverage for children and adolescents is a priority for the Joint Programme to Fast-Track the AIDS response with leaving no one behind.</p> <p>In more than half of 96 countries with Joint Programme presence (including 19 Fast-track countries), a strategy to address loss-to-follow-up/adherence/retention issues for children and adolescents is in place. In addition, 32 countries have strategies for identifying older children living with HIV beyond the health sector, for example through linkages with social protection. Furthermore, 75% of countries (48 out of 64) with concentrated epidemic reported that provider-initiated testing and counselling is available for children under five years.</p>		

32. WHO together with the International AID Society (IAS), CIPHER and the Interagency Task Teams (IATT) have developed a research prioritization ranking for clinical and operational research related to paediatrics and adolescence. This will be shared at the Paris IAS conference in July 2017. WHO is supporting the adaptation of the Adolescent-Friendly Health Services and the Differentiated Service Delivery models developed with and for adolescents.

*HIV services in high-burden cities*

33. Through collaboration with the China AIDS Center and China Association for STD-AIDS Prevention and Control, demonstration projects were established in three cities, to explore innovative models for service delivery to adolescents. In all three pilots, partnership has been strengthened with local health providers, community organizations and adolescent networks, and especially key affected populations. In addition, a training manual was developed on adolescent friendly health services with technical support from the UNICEF regional office, WHO and the UNAIDS Secretariat in China. The Secretariat convened a high-level side event during the 2016 HLM in collaboration with the cities of Paris and New York, UN Habitat and the International Association of Providers of AIDS Care, and supported by MACAIDS Fund. Inputs to this side event to the 2016 HLM in New York, were made by the Secretariat, UNDP, UNFPA, WHO and other Cosponsors. UNFPA facilitated sex worker advocacy inputs by the Sex Workers Project of the Urban Justice Center, NYC (<http://sexworkersproject.org/info/>), with a statement on the human rights needs of sex workers.

*[“Fast-Track cities are accelerating their local AIDS responses toward the goal of ending the AIDS epidemic as a public health threat by 2030. Our collaborative city-specific approach and real-time data generation afford us a precise understanding of gaps in city responses, which we are helping to address through targeted strategies to increase HIV testing, prevention, treatment and care.”](#)*

José M. Zuniga, IAPAC President/Chief Executive Officer



34. As part of the joint Secretariat, the United States Agency for International Development (USAID), World Bank programme in West Africa, the World Bank conducted several size estimation and programmatic mapping studies. The studies, such as the one conducted in Côte d'Ivoire for the cities of Abidjan, Bouake and San Pedro, provide programme managers, planners and implementers with the granular level of information needed to Fast-Track services at city level. In partnership with the UNAIDS Secretariat and other Cosponsors, the World Bank additionally conducted an allocative efficiency study in Johannesburg. The study provided epidemic and programmatic projections to 2020 and 2030. The analysis directly responded to the city Fast-Track initiative by assessing past HIV care cascade achievements and future needs to reach the 2020 and 2030 targets.
35. Under the guidance of the UNDG, a human rights dialogue on urbanization was conducted, feeding into the Habitat 3 meeting (<https://habitat3.org/>). Municipal HIV programming and civil society engagement were highlighted as important elements of rights-based urban plans.

*HIV services in humanitarian emergencies*

36. UNHCR and WFP led in addressing HIV in humanitarian contexts, including through the IATT on HIV in Emergencies, with participation from partners including UNICEF, UNFPA, UNODC, the AIDS Alliance, the UNAIDS Secretariat, World Vision and the International Rescue Committee. In 2016, this platform provided thought leadership and technical guidance, advocated for funding and policy outcomes, acted as a coordination mechanism and facilitated country-level partnerships. Joint initiatives in 2016 included: updating the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings; convening a working group on El Niño; working with WHO, OCHA, Food and Agriculture Organization (FAO) and the Special Envoys on El Niño and Climate's team to integrate HIV into Standard Operation Procedures; working with the Global Fund and UNDP to improve supply chains to prevent stock-outs in emergencies; and engaging with the cluster system to integrate HIV into emergency responses. In collaboration with DPKO and UNHCR, The Secretariat led the preparation of a report on the Security Council Resolution 1983, which was sent by the SG to the Security Council in November 2016.

Percentage of countries offering HIV-related services for populations affected by humanitarian emergencies	Targets and milestones	2016 Progress
<p>Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.</p>	<p>2021: 90% 2019: 85% 2017: 80%</p>	<p>All: 77% 74/96 FT: 67% [22/33]</p>
<p>The Joint Programme advocates for the integration of populations affected by humanitarian emergencies within national health systems where possible. Where national governments are unable to do so, the Joint Programme provides HIV-related services directly through partnerships on the ground, including logistical support. Specified HIV services are based on the "IASC Guidance for Addressing HIV in Humanitarian Settings".</p> <p>In 2016, 77% of 96 countries with Joint Programme presence (including 22 Fast-track countries) offered HIV-related services for populations affected by humanitarian emergencies. In 40 of 50 countries, where refugees/migrants are relevant in their epidemic situation, the following services are offered:</p> <ul style="list-style-type: none"> <li>▪ Basic HIV services: HTS, prevention of mother-to-child transmission (PMTCT), treatment; (ART, TB, sexually transmitted infections (STIs);</li> <li>▪ HIV services for key populations;</li> <li>▪ Services for sexual and gender-based violence survivors, including post-exposure prophylaxis.</li> </ul> <p>The same set of services is available in 32 out of 40 countries that consider internally-displaced</p>		

populations as relevant key populations. Finally, in 75% of 44 countries people affected by emergencies (including non-displaced people) reported that food and nutrition support, which may include cash transfers, was accessible to this key population.

37. In South Sudan, UNHCR and WFP engaged in the HIV and TB in Emergencies sub working group, engaging in dialogues on the HIV in Humanitarian Settings Action Plan and the HIV Minimum Service Package. UNICEF worked with International NGOs and the International Organization for Migration (IOM) to reach over 55 000 pregnant women with integrated antenatal care/PMTCT and maternal services in Western State in South Sudan.

*[“The people most affected by conflict and humanitarian emergencies have to shape programmes. They are more than “implementing partners”. Limiting them to this role is a missed opportunity”.](#)*

Liwad Elman, Director of programmes and development  
Elman Peace and Human Rights Centre

38. Intense El Niño conditions in 2016, coupled with multiyear drought, led to a food security crisis that affected an estimated 40 million people in southern Africa. In response to this, WFP advocated for resources and worked with partners to ensure a multisector to this Level 3 Emergency. This global level advocacy work led to a substantial award from PEPFAR to support 225 216 malnourished and food insecure people affected by HIV in five Fast-Track countries. WFP also continues to provide food and nutrition support to vulnerable people, including people living with HIV/TB in emergency and refugee contexts in the Central African Republic, Haiti, Myanmar, South Sudan, Ukraine and in the Lake Chad Basin and the Horn of Africa.

#### *Access to medicines and commodities*

39. Regarding availability, affordability and accessibility of treatment and diagnostics for HIV and coinfections, the Secretariat led a Joint Programme activity that drew on UNDP, WHO and other Cosponsor inputs to generate a synthesis report of existing research and literature on intellectual property-related and other factors. The included access to medicines and other health technologies in the context of the Political Declaration on Ending AIDS; common barriers to accessing HIV-related products; global initiatives that were put in place to overcome these barriers; and global initiatives regarding access to HIV-related products.
40. In 2016 WHO and other Cosponsors developed an updated IATT Formulary and Adult Think Tank Priorities, and conducted price reporting of HIV drugs and diagnostics, providing market information and profiles on benchmarked prices to countries. The 2016 Annual meeting with Pharma/ Diagnostic agencies established global, regional and country-wide forecasting for ARVs and diagnostics. WFP and UNDP remained committed to working together to improve HIV supply chains, exploring new ways to prevent stock-outs in challenging operating environments.
41. In November 2015, the United Nations Secretary General announced the appointment of a High-Level Panel on Access to Medicines. UNDP served as the Secretariat for the High-Level Panel, in collaboration with the UNAIDS Secretariat, developing a report with a simple and powerful message: no one should suffer because he or she cannot afford medicines, diagnostics or vaccines. The report has been welcomed by the Secretary General, several UN Member States and civil society groups and was included in a resolution of the UNGA in December 2016, as well as a 2016 resolution of the Human Rights Council.



42. Joint Programme advocacy led to the inclusion of a target of 20 billion condoms in the 2016 Political Declaration on Ending AIDS. The target is based in estimates of global condom need. UNFPA and the United States Agency for International Development (USAID) remained the major suppliers of male and female condoms to the developing countries, with around 70% of the commodities going to countries in sub-Saharan Africa. UNFPA continues to manage the prequalification programme for male and female condoms on behalf of and in conjunction with WHO. In 2016, UNFPA prequalified 30 male condom manufacturers and 4 female condom manufacturers. UNFPA also convened a “Partnerships for Impact: Prequalification, Quality Assurance, Quality Control and Post-market Surveillance of Condoms” meeting in 2016, which brought together heads of National Regulatory Authorities responsible for condom regulation and heads of national laboratories responsible for testing condoms from Botswana, Ethiopia, Ghana, Kenya, Namibia, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. As a result, a forum was established for scientific discussions and information sharing to promote the use of personal lubricants with condoms. In addition, the Secretariat led the development of a condom Fast-Track tool to support countries to set realistic needs based and people centred condom targets in line with 2016 Political Declaration on Ending AIDS, leading to the first ever comprehensive condom gap analysis for sub-Saharan Africa, presented in July 2016. The tool was also used to support condom needs estimates done by USAID/PEPFAR in specific countries.

Percentage of countries using a functional logistics management information systems for forecasting and monitoring reproductive health and HIV-related commodities	Targets and milestones	2016 Progress
Data source: UNFPA country offices annual reports	2021: 93% 2019: 90% 2017: 88%	All: 82% [102/125]
<p>This indicator measures the Joint Programme’s support to countries in strengthening systems for procurement, supply chain and commodity management; to prevent stock-outs and ensure sustainable and affordable access to the full range of commodities.</p> <p>In 2016, 82% of 125 countries where UNFPA has a programme, had functional (computerized) logistical management and information system (LMIS) that met at least four of the six following criteria:</p> <ul style="list-style-type: none"> <li>▪ Figures on the distribution of modern contraceptives;</li> <li>▪ Figures on the distribution of essential life-saving medicines;</li> <li>▪ Inventory and monthly consumption data;</li> <li>▪ Information on stocks at all levels of all products;</li> <li>▪ Information on the expiry dates of all products;</li> <li>▪ Information on number of users of each product.</li> </ul>		

43. Examples of other notable individual Cosponsor achievements in this Strategic Results area in 2016 include:
- UNICEF supported a legal review of age of consent laws and policies in 22 countries, combined with a review of ethical, social and cultural barriers in 11 countries, to understand the context behind and the general practice around consent for adolescents;
  - WFP assisted 318 555 people living with HIV, TB patients and their households in 24 countries, through HIV-specific programmes. For example, WFP provided assistance in the form of food support and cash or vouchers to people living with HIV in emergency and refugee contexts in the Central African Republic, Haiti, Horn of Africa, Myanmar, South Sudan, the Lake Chad Basin and Ukraine. WFP also provided technical assistance to a number of governments to integrate food

services into HIV responses, for example through the development of national guidelines on Nutrition Assessment, Counselling and Support;

- The UNDP-Global Fund partnership evolved to span 19 countries and 34 grants. Currently 2 million people are on life-saving ART treatment through the partnership. Thirty-eight million people were tested for HIV and given the opportunity to know their status (with quality counselling support to help them cope with a positive or a negative test result)—an increase of four million in 2016. 700 000 women living with HIV received ART to help prevent HIV infection in their babies;
- WHO headquarters, regions and countries undertook seven joint guideline dissemination meetings that covered all recent guidelines and reached more than 100 countries, nearly 700 programme managers and implementers and resulted in the rapid knowledge transfer and uptake of the ARV guidelines as well as the testing, key populations, hepatitis and strategic information guidelines;
- The World Bank funded major health system strengthening operations and approved funding for HIV testing and treatment as part of broader health projects. For example, in Nigeria, the “Saving One Million Lives” project aims at increasing the utilization and quality of high-impact reproductive and child health interventions, including the provision of HIV counselling and testing during antenatal care. Through its analytical work, the World Bank is also building evidence and providing direct technical assistance to improve the design and implementation of HIV testing and treatment services. For example, in South Africa, an ART South Africa Adherence Guideline evaluation is intended to support the Government’s decision-making process about the national roll-out of adherence interventions;
- UNFPA continued to lead linking HIV with sexual and reproductive health at the legal, policy, health systems and service delivery levels. For example, in Uganda UNFPA directly contributed to 867 404 young people accessing sexual reproductive health (SRH)/HIV services, of whom 37% sought HIV counselling and testing. To increase access to an integrated package of services for young key populations, UNFPA Egypt’s advocacy for HIV prevention among young women resulted in reaching more than 1,134 young sex workers in Cairo and 1,017 in Alexandria through HIV testing and counselling. In Tajikistan, 88% of sex workers and 49% of men who have sex with men were tested for HIV and know their results: in total, 8197 sex workers and men who have sex with men were counselled and tested for HIV. Community members reported improved satisfaction with the HIV testing and counselling services in 2016 compared with previous years;
- UNAIDS Secretariat and UNFPA organized a regional Condom Fast-track workshop in western and central Africa, attended by representatives from 10 countries, as well as civil society organizations and regional partners, following the recommendations of the Global Condom meeting in early 2016.
- The UNAIDS Secretariat partnered with the Government of Côte d’Ivoire in three major events in the bid to advance the 90–90–90 agenda for children. At a ministerial meeting in Abidjan in May 2016, Health Ministers from Africa endorsed a Fast-Track approach for children. This approach called for reaching 95% coverage of ART for both pregnant women and children living with HIV by 2018.

## Challenges

44. **Innovations in HIV testing.** Current costs of rapid diagnostic tests for HIV are high. Advocacy and application of price reduction strategies are needed, including increasing volumes of tests purchased and shaping the market for other products. HIV self-testing approaches need to be developed to reach untested populations with high positivity such as men, young people and key populations.
45. **Treatment and care.** Efforts will need to be made to ensure that “Treat All” is fully implemented in all Fast-Track countries and in the those countries with low ART coverage and high HIV incidence (such as western and central Africa and eastern Europe and central Asia). The introduction of new ARVs such as Dolutegravir and integrase strand transfer inhibitors into countries will need to be done safely, with appropriate monitoring of outcomes and responses. As treatment coverage increases, programmes will need to ensure quality people-centred care. Implementing DSD models can help to build sustainable service delivery programmes. Given that treatment coverage globally for men living with HIV is 40% compared to 52% for women, renewed efforts to reach males are urgently required. Efforts to enhance treatment access and adherence should also address gender-related barriers in access to HIV treatment faced by women and men across their life cycle, with a focus on how gender norms impact female decision-making around uptake. In the current funding environment, it is increasingly challenging to advocate for and address non-medical factors in the HIV epidemic, such as poverty and food insecurity.
46. **Paediatrics and adolescents.** There continues to be limited access to early infant diagnosis, while poor retention in the testing to treatment cascade continues to lead to unacceptable HIV-related mortality, which disproportionately affects infants and young children. Timely treatment initiation and adequate virological suppression are further limited by lack of age-appropriate ARV formulations. Lack of effective service delivery models to retain children in care and ensure positive transition into adolescence is also challenging. Additionally adolescents living with HIV continue to have poor access to HIV services, which are not tailored to their specific needs and challenges, leading to excess mortality, particularly between 14 to 19 years. DSD models for families can improve these outcomes.

## Key future actions

47. Looking to the immediate future, the Joint Programme recognizes the importance of placing further emphasis on HIV testing as the key to unlocking blockages in the 90–90–90 cascade and ensuring the effective use of funding for testing and treatment. A major focus for Cosponsors will be country implementation of WHO policies, through country adaptation and capacity building of national staff and partners. There will also need to be greater support for scaling up the viral load testing and ensuring utilization of results to improve patient outcomes.
48. The Joint Programme will support the scale up and implementation of DSD models for all people living with HIV, including for families, key populations and those affected by humanitarian emergencies.
49. Towards innovation, the Secretariat will also engage the private sector, governmental and international institutions to support access to medicines and bring together new partners such as the African Development Bank and the African Network for Drugs and Diagnostics Innovation.

50. To reduce mortality, the profile of HIV-associated tuberculosis (TB) will need to be raised at global level, to seek enhanced country commitment for eliminating TB deaths among people living with HIV, including through the Global Ministerial Conference on ending TB in the SDG era (in Moscow in November 2017) and the UN General Assembly High-Level Meeting on TB in 2018.
51. Finally, while testing and treatment success requires strong health systems, a well-coordinated multisectoral response is required to ensure all populations and settings are reached in efforts to achieve 90–90–90 targets. For example, efforts by the Joint Programme to enhance treatment access and adherence need to reach overlooked men and address gender-related barriers that women face in accessing treatment across their life cycle.

## Strategy Result Area 2: Elimination of mother-to-child transmission

### Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

#### Achievements

52. In 2016, the eMTCT agenda remained a high priority for the Joint Programme. With the transition to a post-Global Plan era for the eMTCT of HIV and the inception of an innovative new action framework to accelerate action to end AIDS in children, adolescents and young women *Start Free Stay Free AIDS Free*, new pathways were created to ensure that:

- All pregnant women have access to ARVs;
- All pregnant women are retained in treatment and care;
- HIV-exposed infants have access to ARV prophylaxis to prevent infection;
- Human rights and gender equality are upheld in eMTCT efforts, and community engagement is ensured.



*The 3-Frees initiative was launched at the High Level 2016 Meeting. The Frees are linked to the 4-prongs of the Global Plan but articulate a more "lifecycle" approach to PMTC and paediatric/adolescent care and treatment*

#### Comprehensive eMTCT services

53. Given the importance of continued and intensified progress towards the elimination goal, in 2016, members of the Joint Programme, based on their comparative advantage, provided various types of support in the delivery of the range of eMTCT services for all four "prongs" of eMTCT, while also contributing to the adaptation of the latest eMTCT guidance and costed implementation plan.

Percentage of countries implementing latest eMTCT guidance	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.	2021: 100% 2019: 95% 2017: 90%	All: 60% [58/96] FT: 70% [23/33]
<p>Since most countries have already adopted WHO's eMTCT guidance, Joint Programme efforts focus on supporting eMTCT implementation with engagement of networks of women and women living with HIV.</p> <p>In 2016, 60% of 96 countries with Joint Programme presence (23 of which are Fast-Track countries) offered the following services:</p> <ul style="list-style-type: none"> <li>▪ Lifelong treatment for all HIV positive pregnant women;</li> <li>▪ Repeat testing of HIV negative pregnant and breastfeeding women;</li> <li>▪ Partner testing of HIV positive pregnant women in antenatal care settings.</li> </ul> <p>Networks of women, including women living with HIV, are engaged in eMTCT strategy development and service implementation in these countries.</p>		

54. The WHO "Treat All" recommendations for pregnant and breastfeeding women (Option B+) have been adopted by almost all Fast-Track countries. As a result, there

have been significant improvements in ART access for pregnant women living with HIV, as well as gains in reducing MTCT during pregnancy and breastfeeding. However, these successes vary regionally, with much slower progress in western and central Africa, for example. Cosponsors pledged to focus their efforts in 2016 on this region, and reach targets for elimination. Areas for improvement included:

- Interventions to improve diagnosis of pregnant women with HIV;
- Retention of women in the postpartum period;
- Guidance on use of integrase inhibitors during pregnancy and breastfeeding;
- Implementation of enhanced infant prophylaxis recommendations;
- Greater adherence to improve viral load suppression;
- Integrated approaches through the maternal and child health platform; and
- Increased community engagement to support the cascade of care.

*["To ensure children are born healthy is to give them the best possible start in life. It is immensely encouraging to see countries succeed in eliminating mother-to-child transmission of these two diseases."](#)*

Dr Margaret Chan, WHO Director-General

55. Moving forward on the second prong of eMTCT, UNFPA's support for family planning in 2016, through the provision of contraceptives in Fast-Track countries, averted an estimated 5.9 million unintended pregnancies and 20 000 maternal deaths. Benefits of integrated service delivery, including for eMTCT are summarized in Strategic Result Area 8.
56. Addressing prongs three and four of eMTCT in Asia and the Pacific, WHO, WPRO, the South-East Asia Regional Office and UNICEF supported efforts using information communications technologies to strengthen linkages between maternal, newborn and child health (MNCH) and HIV programmes. The work focused on PMTCT and addressed loss to follow-up and strengthened referral mechanisms. In South Sudan, UNICEF continued to support provision of PMTCT services in relatively stable locations across the country, using the maternal and neonatal health platform. A total of 155 233 pregnant women were reached with at least one antenatal care service visit in 2016, and 32 021 pregnant women were counselled and tested for HIV. WFP focuses on pregnant and lactating women, PMTCT clients and children as part its food support activities. This has a positive impact on adherence to PMTCT, as well as on health outcomes for newborn babies. For example, 96% of PMTCT clients receiving WFP food assistance in Ethiopia in 2016 attended all their clinical appointments and 99% of the newborn babies tested were HIV-negative.
57. In 2016, UNHCR advocated for the inclusion in eMTCT services of refugees, asylum seekers and other populations affected by humanitarian emergencies, including both out-of-camp populations and in-camps populations. UNHCR achieved a global PMTCT coverage of 77%, while over 75% of 48 reporting countries achieved PMTCT coverage of over 80%. UNHCR also supported partners to provide eMTCT services in low prevalence settings.
58. In the second half of 2016, UNDP, through its partnership with the Global Fund, provided 77 000 HIV-positive pregnant women with ARV prophylaxis, bringing the cumulative total of PMTCT treatments to 714 000.
59. WHO, the UNAIDS Secretariat, UNFPA and others have supported national efforts that led to the validation of eMTCT of HIV and syphilis in Cuba in 2015, Belarus and Thailand, eMTCT of HIV in Armenia, and eMTCT of syphilis in Moldova in 2016. The WHO-led eMTCT validation process includes assessment of whether eMTCT criteria

have been met in a manner consistent with human rights, gender equality and community engagement considerations.

60. WHO, in collaboration with UNICEF and the IATT for eMTCT, convened a regional meeting, "Gathering knowledge and best practices from B+: the path to treatment for all" in Zimbabwe in August 2016. Meeting participants discussed PMTCT, including new recommendations on infant prophylaxis; validation of eMTCT; and operational considerations on emerging issues for future programming such as viral load monitoring, PrEP in HIV-negative women and integration of TB services within PMTCT. UNFPA, WHO and other partners also updated guidelines on validating the elimination of neonatal HIV and syphilis.
61. In 2016, the IATT on HIV in Humanitarian Contexts continued to work on a distance learning module for PMTCT in emergency contexts. Led by UNHCR, this work will continue in 2017. In Somalia, WFP and UNICEF jointly held a sensitization session on PMTCT for partners, including local nongovernmental organizations (NGOs), the Ministry of Health, the AIDS Commission and regional TB programmes. Participants discussed strategies for ensuring that food support is included in support packages.
62. In partnership with the UNAIDS Secretariat and Cosponsors, the World Bank is helping governments identify funding priorities, which include an analysis of PMTCT. The analysis provides an evaluation of the costs and quality of HIV and SRH service integration, which should expand coverage of eMTCT to more remote locations, improve HTC in pregnant women, as well as family planning and antenatal care in people living with HIV.

## Challenges

63. **Prevention and detection of HIV amongst pregnant and breastfeeding mothers.** Targeted repeat HIV testing, partner HIV testing and selected use of pre-exposure prophylaxis (PrEP) remain a challenge. In many contexts, there is an incorrect assumption that pregnant women do not continue to have sex, understandings of PrEP use during pregnancy are poor, and males seldom attend antenatal care clinics.
64. **Retention of pregnant and breastfeeding women on ART.** Poor retention is due in part to weak support for women during the postpartum period, particularly for younger mothers. Improved management of pregnant women who start ART late in pregnancy or at delivery is needed, through enhanced infant prophylaxis and early use of dolutegravir to rapidly reduce viral load amongst women diagnosed in the third trimester.
65. **Limited access to early infant diagnosis and poor retention in the testing to treatment cascade.** This continues to lead to unacceptable HIV-related mortality, which disproportionately affects infants and young children. Timely treatment initiation and adequate virological suppression are further limited by lack of age-appropriate ARV formulations, limited access to viral load monitoring and treatment options, lack of effective service delivery models as well as lack of understanding of the barriers that retain children in care and ensure positive transition to adolescence.
66. **Lack of focus on unintended pregnancy amongst women.** This remains a challenge in many regions. In fragile settings, health systems are often constrained by limited quality human resources, high staff turnover, weak procurement and supply management systems, and weak community capacity to reduce barriers to service uptake among the vulnerable populations.

67. **Adolescents living with HIV continue to have poor access to services.** Services are not tailored to adolescents' specific needs and challenges, leading to excess mortality particularly among adolescents between the ages of 14 to 19 years. Primary prevention of HIV among adolescents is important for reducing the risk of vertical transmission. Adoption of community-based interventions to reach and retain adolescents, so that they can start and adhere to ART, requires greater attention.

*"[A reduction in new HIV infections among children] shows what is possible through the combined power of science, communities and focused action. PEPFAR is building on this success, driving harder and smarter to prevent HIV infections and end AIDS among children, adolescents and young women through our DREAMS Partnership, Accelerating Children's HIV/AIDS Treatment initiative and other efforts."*

Deborah Birx, United States Global AIDS Coordinator  
and Special Representative for Global Health Diplomacy

### Key future actions

68. *Start Free Stay Free AIDS Free* targets and focus countries will be the main framework of actions for the UN Joint Programme in this Strategy Results Area in 2017 and beyond. Future actions by the Joint Programme will include:
- The UNAIDS Secretariat, together with UNICEF, WHO and other Cosponsors, will promote political advocacy and an accountability framework at country and global levels, and will coordinate with partners to support national strategies to achieve the new, accelerated targets;
  - WHO will formalize the AIDS Free Workplan of the "Three Frees" and initiate implementation activities in focus countries, including ensuring that all countries have adopted a "Treat All" approach for pregnant and breastfeeding women, and have support in place for retention in treatment and care;
  - UNFPA will continue to support eMTCT through integrated service delivery, and partnerships focused on family planning and midwifery;
  - UNICEF will provide technical leadership in the work of the "Start Free" and "AIDS Free" agendas, and will strengthen support to countries in the pre-elimination and elimination phases of eMTCT;
  - Through its various instruments and initiatives, the World Bank will continue to place women and children at the centre of its health agenda by supporting countries in expanding access to essential HIV services;
  - The WFP will continue to support people living with HIV, PMTCT clients and children through its food support activities, specifically targeting those groups where possible and relevant. The WFP will also continue to be actively involved in the Child Survival Working Group to identify programming entry points;
  - UNHCR will support scale-up of eMTCT mother-to-mother support groups in humanitarian settings. It will strengthen access to polymerase chain reaction testing in humanitarian settings, and will roll out UNHCR-completed guidance on PMTCT in humanitarian settings among staff and partners in 2017. UNHCR will also strengthen monitoring systems to enable faster and more accurate collection of data on eMTCT indicators at individual, facility and camp levels.



### Strategy Result Area 3: HIV prevention among young people

**Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV**

#### Achievements

##### *Combination prevention*

69. The theory of change for Result Area 3 calls for strategically targeted combination prevention programmes and emphasizes the increasingly recognized linkages between gender equality, education and positive health-seeking behaviours. To that



*“Hands up for #HIVPrevention mobilized support worldwide, the campaign reached more than 2 million people on Facebook and 64 000 people have engaged through likes, shares and comments. On Twitter, the campaign reached almost 3 million people and UNAIDS campaign tweets were retweeted 12 000 times and liked 9500 times.*

end, the Joint Programme supports countries to identify the optimal combination of targeted behavioural, biomedical and structural programmes to reach those at increased risk of infection, while also recognizing that HIV prevention is a right for everyone and that all young people should have access to accurate, comprehensive HIV and sexuality education and youth-friendly services. The Joint Programme launched several landmark initiatives in 2016, in addition to those already ongoing, with the

objective of reinvigorating the prevention agenda, making it more responsive to the needs of adolescents and young people, and building political commitment. The 2016 HLM was an opportune moment for this, and efforts were made to ensure a high level of youth engagement.

70. Meanwhile, for World AIDS Day 2016, the “Hands-up for Prevention!” campaign, led by the UNAIDS Secretariat in partnership with the *Star Times*, reached millions of people.
71. In 2016, the ILO and partners strengthened country efforts to develop National Strategic Plans and Wellness Standards to enhance combination prevention programmes. In Nigeria, the ILO, the UNAIDS Secretariat, UNICEF and partners provided technical inputs to the development of the draft National Strategic Plan for the Nigeria Business Coalition against AIDS. The Strategic Plan will be launched in 2017. In Swaziland, the ILO and UNDP provided technical support to the Kingdom of Swaziland’s Public Sector HIV/AIDS Coordinating Council to review its workplace standard in order to integrate wellness and disease management issues using Swaziland Standards Authority as a reference. As an outcome, the Standard was reviewed, better aligned to ILO Recommendation No. 200 on HIV/AIDS and adopted through national consultations with the assistance of the ILO.

*Youth health and education needs*

72. The Joint Programme also continues to lead two pioneering campaigns for adolescent and young people’s health: All In to End Adolescent AIDS, and the Eastern and Southern Africa Ministerial Commitment to scale up comprehensive sexuality education (CSE) and access to SRH services for young people. More than 11 Ministries of Health committed to scaling up effective combination prevention packages and called for renewed commitment and accountability. A new global VMMC framework for 2016–2021 was developed and launched during the International AIDS Conference 2016. The UNICEF and UNAIDS Secretariat-led “All In” platform has been instrumental in improving outcomes for adolescents, with a focus on aligning investments and fostering innovations. For example, in 2016 in western and central Africa, a Fast-Track approach was used to strengthen the integration of HIV in national policies on adolescent health and gender-based violence. Six countries conducted bottleneck analyses to identify critical capacity gaps and structural barriers. The findings informed models for community-based HIV testing and counselling and the adaptation of mHealth for HIV response in adolescents. As a result of improved data analysis and assessments, a number of countries have been able to better tailor their national responses and enhance investments for adolescents. This is also possible through the meaningful engagement of young people and adolescents in “All In”.

Percentage of countries with targeted combination prevention programmes in place	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.	2021: 70% 2019: 60% 2017: 50%	<b>All: 32% [31/96]</b> <b>FT: 45% [15/33]</b>
<p>Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well researched and understood local epidemic. Measurements under this indicator cover priority areas of Joint Programme support as part of national combination prevention packages, namely access to male and female condoms and inclusion of life skills-based HIV and comprehensive sexuality education in school curricula.</p> <p>In 2016, only 31 out of 96 countries with Joint Programme presence (15 of which are Fast-Track countries) had all targeted combination prevention programmes in place, namely:</p> <ul style="list-style-type: none"> <li>▪ Quality-assured male and female condoms are readily available universally, either free or at low cost;</li> <li>▪ Gender responsive life skills-based HIV and sexuality education is part of the curriculum in primary schools;</li> <li>▪ Gender responsive life skills-based HIV and sexuality education is part of the curriculum in secondary schools; and</li> <li>▪ Young women are engaged in HIV prevention strategy development and service implementation.</li> </ul>		

73. Key advances have additionally been made through the UNESCO-led Eastern and Southern Africa Ministerial Commitment to scale up CSE and access to SRH services for young people. At the 2016 International AIDS Conference, countries reaffirmed their commitment through the “Let’s Step up and Deliver” call to action. In the United Republic of Tanzania, more than 8,500 pre- and in-service teachers were trained in CSE, and 13 000 CSE and HIV prevention curriculum support materials were distributed in over 1,000 schools, benefiting an estimated 8.6 million school-age children (49% female). To reach out-of-school young people, UNFPA has developed an Eastern and Southern Africa Regional Resource Package on CSE, which has been adopted by Lesotho, Namibia and Zambia. UNESCO is also looking into opportunities to expand the lessons learned of the ESA region Ministerial Commitment on CSE and access to SRH services to western and central Africa. In

2016, a regional conference for representatives from 17 western and central African countries resulted in a call for action to strengthen CSE and access to SRH services.

Percentage of Fast-Track countries that are monitoring the education sector response to HIV and AIDS	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly.	2021: 70% 2019: 60% 2017: 50%	<b>FT: 58% [19/33]</b>
<p>This indicator measures the commitment of countries to monitor the education sector response to HIV and AIDS. At the same time, support to the implementation of monitoring systems is a priority of focus for the Joint Programme, a major player in the area.</p> <p>In 2016, 58% of Fast-Track countries had integrated the core indicator indicators for measuring the education sector response to AIDS in national education monitoring systems, in line with the recommendations of the IATT on Education.</p>		

74. The Joint Programme is committed to helping countries ensure that adolescents and young people have access to the SRH commodities and services they need to prevent HIV infection. Condom programming continues to be a cornerstone of these efforts. The Africa Beyond Condom Donation coalition, initiated by UNFPA in collaboration with USAID and the Reproductive Health Supplies Coalition, brought together a multisector coalition of more than 70 private and public sector groups to meet the bold target of increasing the number of male and female condoms in low- and middle-income countries to 20 billion by 2020. The World Bank and UNDP also support countries to ensure that their combination prevention programmes are optimally targeted for the given country context, and to identify multisectoral cost-sharing strategies.
75. In 2016, WHO organized a meeting and drafted a framework on differentiated service delivery for young and adolescent people, as well as for young key populations. Also in 2016, UNFPA and FHI360 launched the roll-out of the young key populations technical briefs, published by WHO in 2015.
76. The World Bank carried out a quantitative and qualitative study of adolescent SRH in Bangladesh, Burkina Faso, Ethiopia, Nepal, Niger and Nigeria, resulting in improved understanding of adolescent health status and determinants from demand- and supply-side perspectives, as well as a set of recommendations for country-specific policy options. UNHCR worked to increase national capacity to deliver integrated SRH services for marginalized and vulnerable adolescents and young people in humanitarian settings. For example, UNHCR worked in Cameroon, Ethiopia, Ghana, Kenya, Pakistan, Rwanda, South Sudan, Ukraine and Zambia to provide youth-friendly HIV services to adolescents and young people both in and out of camp.
77. The Joint Programme recognizes that efforts to scale up the provision of prevention commodities will be of no use if young people are unable to access them, either due to insufficient supply or because young people do not feel comfortable and safe with their service provider. To address this, the Joint Programme continued to work closely with civil society and young people in 2016 to strengthen youth-friendly services, including services provided by community health workers, mentors and peers, and services targeted to the specific needs of adolescent and young key populations.
78. Access to services and commodities must go hand-in-hand with access to comprehensive sexuality education, which is a core component of any combination

prevention package. A key joint initiative in 2016 and beyond is the update of the UN International Technical Guidelines on Sexuality Education. UNESCO hosted a global technical stakeholder consultation in October 2016 with more than 60 participants. A CSE Advisory Group was established with the UNAIDS Secretariat, UNFPA, UNICEF, UN Women, WHO and UNDP. The updated International Technical Guidance on Sexuality Education will be published in 2017 and will reflect new evidence and good practices, with specific focus on areas such as early pregnancy, puberty, and gender equality.

79. Youth leaders were supported by the UNAIDS Secretariat and Cosponsors to conduct the Youth HLM pre-meeting, hosted by UNFPA at its headquarters in New York. Approximately 25 young people participated in the pre-meeting, where strategies were developed and people had the chance to network.
80. The UNAIDS Secretariat and Cosponsors supported the development and launch of a UNAIDS practical guide to meaningfully engage adolescents in the AIDS response. The guide integrates issues related to gender inequality and outlines strategies to increase the engagement of women and girls in the AIDS response.
81. UN Women and other partners facilitated strategic opportunities for young women and adolescent girls, including those living with HIV, to engage in the key agenda-setting fora. At the High-Level Meeting on AIDS, UN Women and partners facilitated a space for young women advocates to engage in the development of the 2016 Political Declaration on Ending AIDS. With UN Women support, young women advocates, including those living with HIV, engaged in the first-ever 60th Commission on the Status of Women Youth Forum. At the 2016 International AIDS Conference, young advocates called for action on ending early marriages and gender-based discrimination in health care settings, and on promoting the meaningful participation of young women living with HIV.
82. In collaboration with the International Planned Parenthood Federation (IPPF) and the PACT, the UNAIDS Secretariat supported the launch of the fourth phase of ACT!2030, formerly ACT!2015. This youth-led social action initiative engages young people in 12 countries (Algeria, Bulgaria, India, Jamaica, Kenya, Mexico, Nigeria, Philippines, South Africa, Uganda, Zambia and Zimbabwe) on youth-led, data-driven accountability around the SDGs and other relevant agreements or frameworks related to the sexual and reproductive health and rights of young people. Through the "All in to #EndAdolescentAIDS" partnership, the UNAIDS Secretariat supported the PACT to develop an adolescent engagement guide for the HIV response.

## Challenges

83. **Targets and advocacy for prevention.** Despite efforts to set prevention targets and galvanize political commitment for increased investment in prevention, few countries have adopted a meaningful set of national targets that capture their prevention response. Several countries are grappling with conceptualizing and advocating for prevention within a context where treatment advocacy has been dominant and where HIV incidence reductions have been expected to mostly derive from treatment as prevention.
84. **Data for a targeted combination prevention approach.** Another challenge relates to the availability and analysis of the highly granular data, disaggregated by sex and age, that are needed for a targeted combination prevention approach. There is a need to strengthen data collection mechanisms and fill the gaps in knowledge and evidence around young people's health, education and rights. This means ensuring

that systems are in place to collect and analyse data that is disaggregated by sex, age, economic status, and geographical location.

85. **Transition from child to adult services.** In view of the enhanced survival rates of children living with HIV, due to ARVs, it is essential to support their transition to adolescent programmes. Also needed are strategies for improved identification of older, undiagnosed children and adolescents who are living with HIV, and linking them to treatment and care. Supporting HIV-positive young people during the transition from child to adult services calls for improved understanding of the needs of adolescents.
86. **Translating voice to impact.** The vocal participation of young women and adolescent girls, including those living with HIV, does not necessarily translate into impact. Long-term mentoring and institutional support are urgently required to ensure that young women and adolescent girls can meaningfully contribute to the AIDS response.
87. **Financing Fast-Track.** The Joint Programme is unanimous in recognizing the need to radically accelerate progress on prevention. While significant progress has been made, and several new campaigns have been launched, the context of financial uncertainty and staff turnover limited the progress. Despite this, it was a testament to the capacity and resilience of the UNAIDS Secretariat and Cosponsors that efforts have remained on course.

*[“Today’s generation of youth is the biggest in history. If we want a demographic dividend from that generation we have to invest in adolescents now. It depends on all of us breaking down silos and adopting innovative solutions.”](#)*

Seth Berkley, Chief Executive Officer, Gavi, the Vaccine Alliance

## Key future actions

Towards progress on adolescent SRHR and CSE in 2017:

- The updated UN International Technical Guidance on Sexuality Education will be published and rolled-out at country level in multiple language versions. A complementary volume focused on CSE in out-of-school settings will also be developed under the leadership of UNFPA;
- The Joint Programme will continue to support the scale-up quality CSE and access to SRH services for adolescents and young people through follow-up to the Eastern and Southern Africa Ministerial Commitment, and in particular the “Let’s Step up and Deliver” Call to Action and “Roadmap 2020”; and
- UNHCR and Save the Children will develop guidelines on adolescent SRH (adolescent sexual and reproductive health) in humanitarian settings, which will seek to guide humanitarian partners on how adolescent sexual and reproductive health can be better integrated into programming. A research and mapping exercise of existing adolescent sexual and reproductive health services in UNHCR operations will be undertaken to ascertain existing gaps and opportunities for scale up.

Addressing the availability of combination prevention:

- UNICEF will focus on ensuring that programming meets the needs of adolescents living with, affected by and at-risk of HIV, including support for Country Offices to scale up combination HIV prevention interventions and introduce innovations such as PrEP and targeted HIV testing, where appropriate;

- The ILO will continue to prioritize the scale up of combination prevention workplace programmes for vulnerable mobile and migrant workers in identified sectors in high-prevalence locations in sub-Saharan Africa and Asia. The focus is to increase access to HIV services for workers, and build synergies between the supply of commodities, the strengthening of the legal policy framework and improved social protection coverage; and
- The World Bank will continue to focus on evidence building and providing support to the implementation of combination prevention programs through its multisectoral Health, Education, Social Protection and Transport lending portfolio.

Attempting to translate voice into impact:

- UN Women will continue to identify strategic opportunities for young women and adolescent girls, including those living with HIV, to participate and engage in the key agenda-setting fora and national HIV responses.



## Strategy Result Area 4: Key populations

**Strategy Result Area 4: Tailored HIV combination prevention services are accessible to key populations including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants**

### Achievements

88. During 2016, the launch of UNAIDS' 2016 *Prevention gap report* redirected attention to HIV prevention, with the Joint Programme urging countries to achieve 90% coverage of prevention services for key populations. At the 21<sup>st</sup> International AIDS Conference in Durban, the Joint Programme was recognized for efforts to reach key populations and secure treatment for all. Meanwhile, Fast-Tracking the end of AIDS continued to enhance prevention and treatment for key populations, especially within cities, in 2016—for example, a MAC AIDS partnership mobilized US\$ 1.5 million for key population services in six cities.



89. UNDP, UNFPA, UNODC, the UNAIDS Secretariat, WHO and the World Bank supported global coordination of key population programming via the MSM Global Forum and HIV's global advocacy platform, the Steering Committee on HIV and Sex Work, and the Strategic Advisory Group on HIV and People who inject drugs. Strong focus was placed on implementation tools for HIV programming with key populations and technical briefs on HIV and young key populations. This work included the publication of TRANSIT, final drafting of the IDUIT and uptake of MSMIT and SWIT in all regions. Increased implementation of programmes occurred in partnership with key population global secretariats and local networks, to ensure community-led approaches.
90. UNDP and partners continued follow-up of the Global Commission on HIV and the Law recommendations, through assessment of legal and policy environments in 22 countries and the development of key population action plans in eight countries. Integration of key population services was supported in four regional and 23 country Global Fund grants. UNDP also supported countries in creating enabling environments for LGBTI, including the decriminalization of same-sex relations in Seychelles, national plans and frameworks prioritizing key population interventions in the Dominican Republic, Nigeria and Zambia, and the amendment of Guyana's anti-discrimination act to include Sexual Orientations, Gender Identity and Gender Expressions (SOGIE).
91. UNFPA and partners supported sex worker organizations in 19 countries (including China, India, Malawi, Myanmar and Ukraine) during 2016, including through training of trainers, capacity building and outreach to mobile sex workers and clients. In Kenya, SRH/HIV services were provided to 4,500 sex workers and 500 clients. In collaboration with PACT/Linkages and NSWP/ASWA, the UNAIDS Secretariat

organized regional training on Fast-tracking community-led sex work programming in eastern and southern Africa, involving seven country teams (50/50 mix of sex workers and Government representatives), and regional and global stakeholders.

92. Scale-up of condom programming, including for key populations, occurred in 54 countries.

*[“We can only reach the goal of ending the AIDS epidemic by 2030 if we are serious about HIV prevention. We need to end the isolation and fear that key populations face every day.”](#)*

Laura Londén, UNFPA Deputy Executive Director

93. UNODC and partners advanced global dialogue and advocacy for gender-responsive and equitable HIV programmes for women who use drugs, women in prisons and female partners of men who inject drugs. UNODC, with the International Network of People who Use Drugs, published a guide on gender-responsive services, and strengthened the capacity of community- and prison-based services for women who inject drugs in Afghanistan, Nepal and Pakistan. Police were sensitized and civil society partnerships were built to support HIV services for people who inject drugs, through efforts that included institutionalizing HIV training in police academies in Belarus, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. WHO supported countries in reviewing national drug strategies and programmes, and highlighted the public health rationale for incorporating harm reduction interventions and services within national responses. In eastern Europe and central Asia and in Asia and the Pacific, the World Bank conducted several studies investigating the cost-effectiveness and impact of harm reduction services for people who inject drugs.

Percentage of countries with comprehensive packages of services for key populations defined and included in national strategies	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	<b>MSM, sex workers</b> 2021: 90% 2019: 80% 2017: 70%	<b>MSM, sex workers</b> <b>All: 61% [59/96]</b> <b>FT: 55% [18/33]</b>
<p>The Joint Programme plays a key role in supporting countries to develop comprehensive packages of services for key populations so that services are adequate and targeted. Elements of empowerment of key populations, both as clients and providers of HIV services, are also captured.</p> <p>In 2016, 61% of 96 countries with Joint Programme presence, of which 18 are Fast-Track countries, have comprehensive packages of services for MSM and sex workers defined and included in national strategies. Furthermore, these countries have size and prevalence estimates for these key populations. The key populations are also engaged in HIV strategy/programming and service delivery.</p>		

94. UN Women promoted participation and leadership of women who use drugs and living with HIV in decision-making fora at global and country level. For example UN Women supported the engagement of women living with HIV who use drugs from Indonesia, Kenya, Uganda and Ukraine in the RTI International global conference on ending gender inequalities. It also addressed the nexus of HIV, drug use and violence, with a focus on evidence-based implementation. At the conference, women advocates amplified a global call to scale-up evidence-based interventions implementation, advocacy and funding to address the intersecting issues of HIV, drug use and violence. UN Women also partnered with the Asian Network of People Who Use Drugs to strengthen leadership capacity of women who use drugs and enhance their engagement in national HIV responses, including in Asia. In the United



Republic of Tanzania, UN Women advocated for a woman who used drugs to be appointed as a member of the Harm Reduction Committee in the Temeke District Council to ensure that the specific needs of women who use drugs and are living with HIV are integrated into local harm reduction planning and programming.

95. ILO, the UNAIDS Secretariat and partners, within the framework of the ILO Recommendation on HIV and AIDS, increased access to rights-based Occupational Safety and Health programmes in 2016 for vulnerable establishments in the Asia and Southern Africa regions, and supported economic empowerment programmes. Through partnerships with transport associations and companies. This work reached approximately 12 000 young women and female sex workers along the transport corridors and other hotspots in six nations in Southern Africa: Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe. The ILO, the UNAIDS Secretariat and partners also supported the implementation of combination prevention programmes through strategic partnerships with large private sector groups. For example in India, partnerships were forged with 12 large private sector corporate groups, including Ambuja Cement, Apollo Tyres, Ballarpur Industries Ltd, Crompton & Greaves, Hindustan Unilever Limited, J K Tyres Ltd, Jubilant Organosys Ltd, Pepsico, Sab Millers, Sona Koyo Steering Limited, SRF Group and Transport Corporation of India. These partnerships have increased access to HIV services, workplace policies, condoms, HIV testing and behaviour change communication programmes, reaching millions of workers and their families.
96. The WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* were updated and disseminated, covering health interventions and strategies to address structural barriers to services for key populations. The 2015 WHO *Technical tool for countries to set targets for HIV prevention, diagnosis, treatment and care for key populations* was further used to support national responses for key populations and monitor progress. Countries were supported to assess the treatment cascade for key populations and to differentiate service delivery. Evidence was collected on the effectiveness of harm reduction programmes, illustrating benefits for entire communities via reduced crime and public disorder and increased participation of previously excluded members of the society.
97. UNHCR supported provision of comprehensive HIV services for key populations in humanitarian settings, and reduction of stigma and discrimination in 18 countries. In Nepal, NGOs provided free HIV testing services to key populations, and also worked with out-of-school youth on sex work and sexual behaviours in camps. In Kenya, sex workers, truck drivers and migrants were provided with HIV information, HIV testing services, condoms and positive prevention programmes.
98. PrEP was rolled out in Asia and the Pacific with support from the IATT for young key populations, including in Thailand, which pioneered the use of PrEP for adolescent MSM. In the Islamic Republic of Iran, rapid tests were introduced to youth centres for adolescents who use amphetamine-type stimulants. UNESCO, UNICEF, UNFPA and the UNAIDS Secretariat supported Youth LEAD, a young key population network, to revise the NewGen Asia leadership curriculum for young key populations.
99. UNESCO, UNODC and WHO developed guidance on education sector policy responses to substance use, including for young key population, complementing UNESCO's work on preventing SOGIE-related violence and bullying in schools, which also helped dispel HIV myths and combat HIV-related stigma and discrimination. In Belarus, three distance-learning courses trained over 300 youth workers and educators on HIV and violence prevention among young key populations. In Israel, 50 specialists were trained on preventing violence in schools

and discrimination against children and young people living with HIV. In Brazil, civil society organizations strengthened AIDS responses for young people. In the Congo, 300 adult educators and 260 youth leaders were trained in CSE, reaching 25 000 out-of-school youth, including 285 adolescent refugees who sold sex, who were supported to re-attend school.

100. In partnership with UNDP, the UNAIDS Secretariat and other Cosponsors, the World Bank conducted ten allocative efficiency studies, illustrating the benefits of funding key population programmes. The World Bank also financed comprehensive HIV prevention programmes for key populations in multiple regions through its Health, Education, Social Protection and Transport lending portfolio. In India for example, the World Bank supported safer behaviours among key population and opioid substitution treatment (OST) procurement. In Nigeria, prevention interventions for sex workers were scaled up, while in Burkina Faso the RH Project included results-based financing for key populations.

#### *HIV services for key populations*

101. Action among key populations continued in 2016 with the convening of the first meeting of the new advisory body, the Global Platform to Fast-Track HIV response among Gay men, Bisexual Men and other MSM, in collaboration with MSM Global Forum, WHO, UNFPA, PEPFAR, the Ghana Aids Commission and the Global Fund. The meeting reached consensus on elements required to Fast-Track the HIV response among MSM in 2016–2017. Normative guidance (implementation tools) for HIV programming with key populations were also expanded in 2016. A tool for working with MSM was circulated to UNFPA field offices and to a MSM Global Platform side event at the HLM on Ending AIDS. UNFPA and partners trained MSM civil society organizations and allies in use of the tool in 11 countries. A tool for working with transgender people, TRANSIT, was also published. The sex worker tool was also used to guide programming with sex workers in 31 countries by UNFPA and partners.

*"It is unacceptable that key populations still face stigma, discrimination, and violence, which impede their ability to access quality HIV services. PEPFAR stands firmly and unequivocally with and for key populations, defined by UNAIDS as gay men and other men who have sex with men, transgender people, sex workers, and people who inject drugs, and prisoners, and we are deeply committed to protecting and promoting their health and human rights."*

Deborah Birx, United States Global AIDS Coordinator  
and Special Representative for Global Health Diplomacy

102. To address the needs of people living with HIV and key populations, including MSM, transgender persons and sex workers, the ILO and UNDP in China continued to support the legal aid hotline. A study on the experiences of LGBT communities was undertaken to support the work of the legal aid hotline. In partnership with UNDP, LGBTI-related research was undertaken to support the functioning of the legal aid hotline. UNHCR and UNFPA are working with the Women's Refugee Commission to develop and scale up HIV and reproductive health programming aimed at sex workers in humanitarian settings. Collaboration has also taken place with sex work steering groups, and was reflected in two research studies providing a global mapping of the legal environment relating to sex work and a review of evidence on the characteristics of the online sex industry and innovative interventions.

*Harm reduction package for people who inject drugs*

103. An implementation tool for HIV programming for people who inject drugs has been drafted during 2016 for publication in 2017, with input from International Network of People who Use Drugs, UNODC, UNFPA, WHO, UNDP, the UNAIDS Secretariat and PEPFAR: “Implementing Comprehensive HIV and HCV Programmes with PWID: Practical guidance”. The purpose of the tool is to provide practical advice on implementing HIV prevention, treatment and care programmes for people who inject drugs.

*“The world has taken a step towards a more rational and compassionate approach to people who inject drugs. Countries can only reverse their HIV epidemics by implementing policies and programmes that are proved to work and put people first, including people who use drugs.”*

Michel Sidibé, UNAIDS Executive Director

104. UNODC led the collection of strategic information on people who inject drugs and HIV among people who inject drugs in collaboration with WHO, the UNAIDS Secretariat and the World Bank. Joint efforts enhanced coordination between the relevant United Nations agencies in data collection and analysis, and harmonized global data reviews and reporting, with the involvement of civil society and expert networks. Jointly reviewed estimates also improved the understanding of the quality of current estimates on prevalence of injecting drug use and prevalence of HIV among people who inject drugs, helping to identify country-specific needs for improvement. UNODC, together with the UNAIDS secretariat and UNDP, contributed to and participated in events for the preparation towards the UNGASS on the World Drug Problem “UNGASS 2016 on the World Drug Problem: focus on people, public health and human rights”, in New York, Geneva and Vienna hosted by Permanent Missions of Switzerland, Norway and Colombia.

Percentage of countries implementing in combination the most essential interventions to reduce new HIV infections among people who inject drugs	Targets and milestones	2016 Progress
<p>Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly</p> <p>While the Joint Programme promotes the full set of interventions for PWID (nine components), the four most essential to reduce new HIV infections are needle and syringe programmes (NSP), opioid substitution therapy (OST), HTS and ART, and the expected impact is greatest when these are implemented in combination with sufficient coverage (and quality). Therefore, the UBRAF monitoring captures the implementation of these four elements in combination.</p> <p>In 2016, 31 out of 96 countries with UNAIDS presence (12 of which are Fast-track countries) reported that the full package of PWID intervention is applicable in their epidemic situation. Of these 31 countries, 74% implement the four components of the PWID package (NSP, OST, HTS and ART) in combination. Furthermore, 20% of 96 countries have gender-sensitive HIV needs assessment for PWID.</p>	<p>2021: 60% 2019: 50% 2017: 30%</p>	<p>All: 74% [21/31] FT: 75% [9/12]</p>

105. In partnership with the UNAIDS Secretariat and other Cosponsors, the World Bank conducted several allocative efficiency studies in countries with injecting drug use as the primary HIV transmission mechanism. The studies showed that more funding should be allocated to these programmes in order to reduce new HIV infections. The World Bank also conducted a programme efficiency study in Ukraine to show how HIV programmes for people who inject drugs could be implemented at lower cost.

## Challenges

- 106. Key populations are socially marginalized.** Key populations often experience human rights violations, stigma and discrimination. Efforts to attain 2016 Political Declaration on Ending AIDS goals and targets are impeded in many countries by laws, which criminalize key populations, as well as lack of funding, which has reduced procurement of commodities such as condoms and lubricant, delivery of prevention programmes and capacity building of key population civil society organizations. Although HIV prevalence is high among women who inject drugs, national harm reduction efforts are not gender-sensitive and national drug policies rarely address violence against women who inject drugs, thus limiting the ability of women to prevent HIV and mitigate its impact.
- 107. Discriminatory laws and policies, community norms and practices.** Punitive legal environments and misuse of criminal law often negatively impact health and violate the human rights of key populations. Community norms and practices that discriminate against key populations have resulted in shrinking space for civil society, impacting key populations' ability to self-organize and mobilize responses. Barriers include:
- Punitive laws and limited access to justice;
  - Increased homophobic and transphobic violence;
  - Lack of reporting and responses for assaults;
  - Use of possession of condoms as evidence of sex work; and
  - Lack of service provision for key populations.
- 108. Neglect of young key populations.** These populations are neglected owing to consent, notification and minimum-age requirements, and prosecution of service providers. Demand for adolescent and young key population services is low due to young people's poor risk perception and fear of isolation and stigmatization. Service providers sometimes perceive adolescent key populations as "problematic" and "undeserving" of care. Such barriers contribute directly to increasing new HIV infections among people who inject drugs and HIV prevalence of up to 70% in some sex worker communities in sub-Saharan Africa. Violence against MSM and closure of NGO services creates acute risk in many countries.
- 109. Data and disaggregation.** Limited key population data and lack of disaggregation, limit available information, especially on young key populations. Few countries collect data on homophobic/transphobic violence, violence against women who inject drugs, substance use or sex work among young people. Early prevention efforts often do not take into consideration the needs and challenges of young key populations.

## Key future actions

- 110.** Support will continue for key populations, with further development and roll-out of guidance focusing on implementation tools, consolidated guidance, young key population technical briefs, civil society strengthening and humanitarian settings. Joint action with partners such as PEPFAR and the Global Fund will be strengthened, while key population organizations and advocacy platforms will be supported to facilitate community mobilization and interventions and the prioritization of key populations within national plans and frameworks;
- 111.** Disaggregated data collection will aim to fill gaps in knowledge relating to key populations, including locations, risks and barriers to working collectively and

obtaining HIV services. Monitoring of differentiated interventions will assess the cascade and evaluate new interventions such as PrEP and self-testing.

112. Specific actions by Cosponsors will include:

- UNDP will address legal, policy and practice barriers affecting the rights of key populations. Legislative and policy change will be progressed during national dialogues and via law enforcement agencies to facilitate enabling laws and policies, and key population-oriented national plans or Global Fund grants;
- UNFPA will continue to roll-out comprehensive HIV programmes with key populations via community empowerment, organizational capacity building, addressing human rights abuses and provision of comprehensive SRH/HIV services.
- UNODC will engage people who use drugs and are in closed settings, developing guidance on harm reduction for stimulant users and HIV services in prisons, with a specific focus on gender responsiveness;
- UNHCR and UNFPA will scale up HIV prevention activities with key populations, particularly sex workers, including within humanitarian settings in several countries during 2017. This will include a global review of programmes and increased technical support for all operations, with piloting and scale up of sex work programming in three countries;
- ILO will continue to build strong synergies between increasing access to HIV services, strengthening legal and policy frameworks and increasing access to HIV-sensitive programmes, guided by the principles of Recommendation 200;
- UN Women will promote participation and leadership of women who use drugs and living with HIV in decision-making fora at global and country level;
- The World Bank will continue to support key population HIV programming with specific focus on social assessment and HIV transmission mitigation within its transport sector portfolio;
- The WFP will increasingly address the needs of key populations in humanitarian contexts.

## **Strategy Result Area 5: Gender inequality and gender-based violence**

**Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV**

### **Achievements**

113. The Joint Programme addressed the gender dimensions of the HIV epidemic in 2016 by:

- Building evidence on the ways unequal gender norms influence women and girls' ability to prevent HIV;
- Repealing discriminatory laws and practices;
- Supporting countries in integrating gender equality into national HIV strategies, monitoring and evaluation frameworks and budgets; and
- Enhancing leadership and participation of women living with HIV in decision-making processes.

*Women and girls*

114. In order to address unequal gender norms and other social drivers of HIV, UN Women, UNICEF, WHO, the World Bank, the UNAIDS Secretariat and the WFP supported evidence building on the impact of harmful gender norms on women’s abilities to prevent HIV and mitigate its impact. UN Women commissioned *Key Barriers to Women’s Access to HIV Treatment: A Global Review*, revealing gender-related barriers in women’s treatment access and adherence across their lifecycle, including violence and fear of violence, stigma and discrimination, low treatment literacy, lack of control over resources and care responsibilities. The findings were presented at the 2016 International AIDS Conference and were used to inform efforts to enhance treatment access. The World Bank also conducted studies in sub-Saharan Africa to examine social drivers of transmission in young women, including a trial of conditional and unconditional cash transfers to adolescent girls to determine the impact on retention in school and risk of HIV. In Zambia, the WFP in partnership with the Scaling Up Nutrition Civil Society Network conducted a study to investigate the barriers that hinder adolescent girls’ access to HIV and food services. The barriers included low utilization of HIV testing and counselling services, limited power to negotiate condom use and inadequate behaviour change programmes addressing HIV and food.

Percentage of countries with national HIV policies and strategies that promote gender equality and transform unequal gender norms	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 70% 2019: 60% 2017: 50%	All: 45% [43/96] FT: 45% [15/33]
<p>The Joint Programme provides advocacy, technical advice, legal and policy review and reform and capacity development to promote gender equality and the empowerment of women and girls, including the most vulnerable and marginalized.</p> <p>In 2016, 45% of 96 countries with Joint Programme presence (of which 15 are Fast-Track countries) had national HIV policies and strategies that promote gender equality and transform unequal gender norms with the following elements:</p> <ul style="list-style-type: none"> <li>▪ Assessments of the social, economic and legal factors that put women and girls at risk of HIV are available;</li> <li>▪ Sex- and age-disaggregated data and gender analysis are used in HIV planning and budgeting;</li> <li>▪ Structural and social change interventions to transform unequal gender norms and systemic barriers implemented, including gender-sensitive education curricula and initiatives to engage men and boys.</li> </ul>		

115. UN Women, UNDP and UNFPA helped to integrate gender equality issues into the national HIV strategies in China, Morocco, Sierra Leone, South Africa and Ukraine; design gender equality and HIV operational plans in Malawi, the United Republic of Tanzania and Viet Nam; include gender-responsive indicators in the monitoring and evaluation frameworks in Kazakhstan, Tajikistan and Uganda; advocate for budgeting gender-specific actions in Morocco and the United Republic of Tanzania; and strengthen capacity of the national AIDS councils for gender-responsive implementation in China, Kazakhstan, Tajikistan, the United Republic of Tanzania and Uganda. UN Women led a global expert group meeting on *Putting Gender Justice at the Center of the Fast-Track to End AIDS* with 47 experts, including representatives from networks of women living with HIV, women’s organizations, academia and the UN, which resulted in prioritizing of the need for concerted efforts to advocate and develop strategies to ensure increased and sustainable financing for gender equality priorities in HIV responses and for women’s organizations, including



organizations of women living with HIV, young women, and gender equality advocates. In Malawi, South Africa and the United Republic of Tanzania, UNDP, UNICEF and the World Bank helped to cost cash transfer schemes, targeting young women and adolescent girls to prevent HIV.

116. To support national and local planning to implement Agenda 2030, the Joint Programme supported engagement of women living with HIV in the localization of the SDGs. Unzip the Lips and the International Community of Women Living with HIV-Asia/Pacific, with support from UN Women, UNDP, the UNAIDS Secretariat and other partners, launched and disseminated a video and *Unzipping Agenda 2030 for Key Affected Women and Girls in the HIV Epidemic in Asia and the Pacific*, identifying the opportunities for monitoring and tracking of the progress towards SDGs for women and girls in the context of HIV. UN Women also partnered with the International Community of Women Living with HIV-Global to ensure that over 200 women living with HIV in Belarus, the Democratic Republic of Congo, Kazakhstan, Kenya, Mozambique, Namibia, Russia, Thailand, Ukraine and Zimbabwe are voicing their priorities and engaging with policy-makers to influence localizing SDGs.

117. Promoting leadership of women living with HIV was a major advocacy focus for the Joint Programme and Cosponsors during 2016. UN Women, UNFPA, UNDP, WHO, UNHCR, ILO, UNESCO and the UNAIDS Secretariat's advocacy resulted in greater leadership and mobilization of young women advocates and networks of women living with HIV to define a common agenda and participate meaningfully in HIV policy and programming at national, regional and global levels. This included meaningful



*UNAIDS International Goodwill Ambassador Annie Lennox at the opening of the Women Deliver conference in Copenhagen, Denmark from 16-19 May 2016*

engagement in the 60<sup>th</sup> session of the Commission on the Status of Women, the High-Level Meeting on AIDS, the 2016 International AIDS Conference and Women Deliver. The UNAIDS Secretariat, UNFPA and UNDP also supported a youth engagement strategy for the High

Level Meeting on HIV/AIDS. UN Women supported the Women's Networking Zone at the

International AIDS Conference, a space for women in the Global Village, which resulted in increased visibility of women's organizations and provided women living with HIV with a space to advocate for greater accountability, funding and implementation of actions to advance women's priorities.

118. The UNAIDS Secretariat, ILO and UN Women also invested in the implementation of interventions to promote equal gender norms and enhance women's economic empowerment in the context of HIV. The grantee of the UN Women Fund for Gender Equality in the United Republic of Tanzania economically empowered over 3,000 rural women living with and affected by HIV by developing their business skills and enabling them to launch their own small businesses. Women have been able to increase their incomes, and also reported having more control over decision-making in the household and community. In Uganda, a series of entrepreneurship trainings

developed and delivered by UN Women has equipped young women living with HIV with social and economic skills, and improved their self-esteem and confidence. As a result of mentoring, young women living with HIV not only started their own businesses but also accessed additional government grants for entrepreneurs.

119. The Joint Programme provided Member States with the latest evidence and policy support to advance normative frameworks on HIV that guide national HIV responses. The UNAIDS Secretariat, UN Women, WHO, UNFPA, UNESCO and UNDP's policy support to the Member States contributed to strong gender equality commitments in the adopted 2016 Political Declaration on Ending AIDS, which includes a target to reduce new HIV infections in adolescent girls and young women.
120. In order to address the links between HIV and gender-based violence, UNICEF, the World Bank and UN Women invested in building evidence and implementing initiatives that prevent violence and HIV. UNICEF's longitudinal study in Malawi on reducing gender-based violence, improving SRH and empowering adolescent girls and boys (10–14 years) to realize their rights resulted in evidence-informed intervention to build gender-equitable relationships and transform harmful notions of masculinity and femininity. Through the UN Trust Fund to End Violence Against Women, UN Women supported SASA! implementation in Kenya, Haiti and the United Republic of Tanzania, a community mobilization initiative that engaged men and women and resulted in preventing violence and HIV.
121. To harmonize collection of data in humanitarian contexts, UNFPA, UNHCR and key partners created the Gender-Based Violence Information Management System (GBVIMS). The GBVIMS is an inter-agency partnership between UNFPA, UNHCR, UNICEF, WHO and the International Rescue Committee. Implemented in 25 humanitarian contexts, the GBVIMS is a first attempt to organize management of GBV-related data across the humanitarian community. In addition, UNHCR worked with UNFPA to ensure the implementation of the Minimum Initial Service Package in humanitarian emergencies, including services for the clinical management of rape and sexual violence. This included the provision of post-exposure prophylaxis for survivors of sexual violence, access to HIV prevention, treatment and care, trauma recovery and mental health services.
122. In response to the alarming rates of violence against women in South Sudan, with reports suggesting 475 000 women and girls are at risk, UNDP worked in partnership with the Government of South Sudan, the Global Fund and the IOM to address gender-based violence as part of mental health and psychosocial support programmes, particularly for women displaced by the three-year conflict.
123. The Joint Programme policy support in 2016 resulted in a stronger normative framework on the gender dimensions of HIV/AIDS. For example, UN Women, the UNAIDS Secretariat and other partners' coordinated technical assistance to the Southern African Development Community, as it drafted and tabled the Commission on the Status of Women Resolution on Women, the Girl Child, and HIV and AIDS, resulted in the adoption of the Resolution, which acknowledges women and girls' vulnerabilities in the context of HIV, the importance of securing their sexual and reproductive health and reproductive rights, ending all forms of violence and reducing the burden of care work.
124. UNDP, UNFPA, UN Women, UNICEF and the UNAIDS Secretariat provided technical advice to the countries in the design and costing of the national HIV strategies and Global Fund Concept Notes. UN Women, UNDP and UNFPA helped to integrate gender equality issues into the national HIV strategies in China, Morocco,



Sierra Leone, South Africa and Ukraine, design gender equality and HIV operational plans in Malawi, the United Republic of Tanzania and Viet Nam, include gender-responsive indicators in the monitoring and evaluation frameworks in Kazakhstan, Tajikistan and Uganda, advocate for budgeting gender-specific actions in Morocco and the United Republic of Tanzania, and strengthen capacity of the national AIDS councils for gender-responsive implementation in China, Kazakhstan, Tajikistan, the United Republic of Tanzania and Uganda.

*"At a time when we are entering a new phase in the AIDS response we need to pay particular attention to women, young girls and infants. We need new strategies to stop violence against women and girls, reduce school drop-outs and end forced early marriage."*

Adjoavi Sika Kabore, First Lady of Burkina Faso

125. In 2016, WHO and the UNAIDS Secretariat launched a tool for gender-sensitive monitoring and evaluation of SRH and HIV programmes, to assist countries in strengthening systems for national monitoring and evaluation of HIV and sexual and reproductive health, also piloted by UN Women and WHO/PAHO for 15 countries in 2015. The tool seeks to improve evidence on how gender inequality affects HIV and SRH outcomes and programmatic response, as well as measuring and monitoring gender-based inequities in HIV and SRH outcomes.
126. UN Women, UNFPA, UNDP, WHO, UNHCR, ILO, UNESCO and the UNAIDS Secretariat's advocacy resulted in greater leadership and mobilization of young women advocates and networks of women living with HIV to define a common agenda and participate meaningfully in HIV policy and programming at national, regional and global levels.

#### *Gender-based violence*

127. WHO supported the UNAIDS Secretariat and civil society partners in 2016 to strengthen the capacity of civil society groups to address violence against women in the context of HIV, based on the WHO and UNAIDS 2013 tool. The tool was used to develop an implementation framework (ALIV(H)E) that was used in India, Kenya, Malawi, South Africa, South Sudan and Zimbabwe.
128. UN Women, UNDP, WHO and UNFPA supported design and implementation of the national action plans on gender-based violence in Argentina, Paraguay, Peru and Viet Nam. UN Women and UNFPA's support in Viet Nam resulted in adoption of the 2016–2020 National Thematic Project on Gender-Based Violence Prevention and Response. This is an operational framework for implementing the 2016–2020 National Action Plan on Gender Equality, which includes measures to prevent and address sexual violence and to implement integrated gender-based violence/HIV services.
129. UNHCR worked with UNFPA to provide refresher training to health staff for the clinical management of rape in humanitarian emergencies. UNHCR also worked with the Women's Refugee Commission to address sexual and gender-based violence in humanitarian settings. For instance in India, they conducted an Urban Gender-based Violence Pilot Project. In total, 11 gender-based violence task forces were formed from 4 refugee communities, and 11 trainings were conducted and linkages made with local police, significantly improving the community response to sexual and gender-based violence in the pilot sites.

## Challenges

- 130. Availability of appropriately disaggregated data.** Considerable gaps exist in the availability of data disaggregated by sex, age and other factors, which does not allow for a comprehensive gender analysis to reveal specific gender inequalities that women and girls face in the context of HIV to be addressed by the national HIV responses. For example, work to address various forms of gender-based violence, including in schools, is hindered by a lack of data on the nature, prevalence and impact of such violence on women and girls.
- 131. Lack of financing for structural and social drivers of HIV.** Financing and adequate allocation of budgets for structural and social drivers of the epidemic, particularly the influence of gender inequality is generally lacking in national HIV strategies and/or through Global Fund grant implementation. Sustainable financing for advocacy, mobilizing and institutional strengthening of the networks of women living with HIV also lack funding.
- 132. Ensuring gender-related barriers to treatment are concretely addressed.** Efforts to enhance treatment access and adherence do not consider and address gender-related barriers that women face across their lifecycle and that impact their decision-making around uptake. As countries commence the process of localizing SDGs, there are few mechanisms or spaces secured for women living with HIV to engage and to influence the prioritization process.

Percentage of countries with laws and/ or policies and services to prevent and address gender-based violence.	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 70% 2019: 60% 2017: 50%	<b>All: 43% [41/96]</b> <b>FT: 36% [12/33]</b>
<p>The Joint Programme supports coordinated, integrated action across sectors to build broader coalitions addressing barriers to preventing and addressing violence in the context of HIV, and developing actionable recommendations on how to achieve progress, with particular attention to justice, law enforcement, health, education, labour and social welfare. Measurement questions for this indicator identify elements that are more directly linked to Joint Programme support such as availability of relevant data for evidence-based services; existence of laws and policies addressing gender-based violence; mechanisms to report and address cases of gender-based violence and stronger integration.</p> <p>In 2016, 43% of 96 countries with Joint Programme presence (of which 12 are Fast-Track countries) had laws and/or policies and services to prevent and address gender-based violence with the following components:</p> <ul style="list-style-type: none"> <li>▪ Disaggregated data on prevalence and nature of gender-based violence are available and used;</li> <li>▪ Legislation and/or policies addressing gender-based violence exist;</li> <li>▪ A mechanism to report and address cases of gender-based violence is available, such as special counselling centres, ombudsman, special courts and legal support for victims;</li> <li>▪ HIV, sexual and reproductive health, and gender-based violence services.</li> </ul>		

- 133. Discriminatory laws, policies and practices.** These affect the ability of women, especially young women and adolescent girls, to claim and realize their rights, prevent HIV transmission and mitigate the impact for those already living with HIV. Meanwhile, overburdened health systems are not able to respond adequately to cases of gender-based violence and sexual violence against women and girls, and link the response to HIV services, particularly in humanitarian emergencies settings.

## Key future actions

134. Key future actions to be undertaken by the Joint Programme will include:

- UN Women, UNDP, WHO, UNFPA, World Bank and UNAIDS Secretariat will continue integrating gender equality and women's empowerment commitments in national HIV strategies, including gender-responsive actions, budgets and monitoring frameworks. UN Women and UNFPA will continue rolling out the UN Essential Services Package for Women and Girls Subject to Violence and implementing the Minimum Initial Services Package;
- UN Women will convene experts on gender-responsive budgeting and financing for gender equality to support the development and dissemination of guidance on financing for gender equality within the HIV response, including strategies for advocacy to support greater investment in networks and organizations of women living with HIV;
- UNICEF, UN Women, UNESCO, UNFPA, UNDP and UNAIDS Secretariat will promote the engagement of women, young women and adolescent girls, including those living with HIV, in the design and implementation of national HIV responses and Global Fund Concept Notes. The Joint Programme, under UNESCO leadership and in collaboration with UNFPA and UN Women, will launch the updated UN International Technical Guidance on Sexuality Education;
- UNDP, UNICEF, UNESCO, UN Women, ILO, UNFPA, UNHCR, WHO and the UNAIDS Secretariat will scale-up evidence-based initiatives that prevent gender-based violence and HIV, strengthen the management of rape cases and HIV prevention, including in the humanitarian context and addressing the drivers of gender-based violence.

## Strategy Result Area 6: Human rights, stigma and discrimination

**Strategy Result Area 6: Punitive laws, policies, practices; stigma; and discrimination that block effective responses to HIV are removed**

### Achievements

135. 2016 was an important year for positioning human rights and zero discrimination at the core of the 2016 Political Declaration on Ending AIDS and ensuring a rights-based approach. To that end, the UNAIDS Secretariat supported a panel on HIV and human rights at the March 2016 session of the Human Rights Council (HRC), which established formal links between the HRC and the June 2016 HLM on ending AIDS in New York. The UNAIDS Secretariat also organized a side event at the HRC September 2016 session, which reported back on challenges and successes in featuring human rights within the 2016 Political Declaration on Ending AIDS.

136. The Joint Programme and its Cosponsors undertook considerable work in 2016 to address human rights and confront stigma and discrimination within legislative and policy frameworks, through technical support, advocacy, evidence, reviews and assessments. For example, UNDP supported work around legislation in a number of countries. In Mozambique, it supported the development of an HIV Law that was passed during 2014. Ghana's Parliament passed the Ghana AIDS Commission Bill into law in 2016, with UNDP support in the development of the Bill and subsequent advocacy efforts with lawmakers for its passage. In the Seychelles, the National Assembly voted to decriminalize sex between men by removing Section 151 from its Penal Code (Amendment) Act in May 2016. This stemmed from, among other contributing factors, a Legal Environment Assessment conducted with UNDP support, which had strongly recommended decriminalizing adult consensual sexual

activity as part of efforts to strengthen the national response to HIV. UNDP also completed and validated Legal and Policy Environment Assessments in Burkina Faso and Gabon.

137. Assessments and reviews of HIV-related laws and policies were conducted in Bhutan, Lao PDR and Pakistan, building on a collaboration between UNDP, the UNAIDS Secretariat and Economic and Social Commission in Asia and Pacific, to support more than 20 countries in addressing legal and policy barriers that hinder effective responses to HIV. With support from UNDP and other Cosponsors and partners, 18 countries in sub-Saharan Africa reported results related to strengthening legal and policy environments for sexual and reproductive health, HIV and TB. The UNAIDS Secretariat also provided evidence and support in cases of HIV-related travel restrictions in six countries, while in cooperation with UNDP, UNFPA, UNODC and other Cosponsors, the UNAIDS Secretariat provided comments and expertise in developing or amending relevant laws in Lao PDR, Myanmar, Papua New Guinea, the Russian Federation, South Africa, Tajikistan and Turkmenistan.

138. UNFPA, UNICEF, UN Women, UNDP and the UNAIDS Secretariat supported efforts to implement laws to end child marriage in sub-Saharan Africa. Following the adoption of the Marriage, Divorce and Family Relations Bill that raised marriage age from 15 to 18 years, with UN Women's support, Malawi's Constitution was amended to align the marriage age with the Bill. Furthermore, UN Women supported the Paramount Chiefs as they developed a unified by-law framework to guide implementation and monitoring of the gender equality, gender-based violence and HIV laws and policies, including the Bill and new Constitutional amendment, at the community level.

Percentage of countries positively addressing laws and/or policies presenting barriers to HIV prevention, treatment and care services	Targets and milestones	2016 Progress
<p>Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly</p>	<p><b>2021:</b> progress in 20% of countries from 2019</p> <p><b>2019:</b> progress in 20% of countries from 2017</p> <p><b>2017:</b> progress in 20% of countries from baseline</p>	<p><b>With the exception of four countries (Brazil, Cuba, South Africa and Uruguay) in a sample of 96 countries, all had some law or policy that present barriers to delivery of HIV prevention, testing and treatment services.</b></p>
<p>This indicator measures progress in addressing or repealing laws and/or policies that present barriers to HIV prevention, treatment and care services, disaggregated by area of discrimination. The Joint Programme is a major player (providing advocacy/technical support and more) in supporting countries to identify and repeal or reform discriminatory laws and policies. Progress on reforms of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support is enabled in many instances by the support of the Joint Programme.</p> <p>In 2016, nearly all countries with Joint Programme presence, except the four countries listed above had some laws or policy that present barrier to delivery of HIV prevention, testing and treatment services. The six most common laws (43% to 58% of 96 countries) relate to:</p> <ul style="list-style-type: none"> <li>● Bans or limits on distribution of condoms in prison settings;</li> <li>● Restrictions to adolescent access to HIV testing or treatment without parental consent;</li> <li>● Lack of alternatives to imprisonment for nonviolent minor drug-related crimes</li> <li>● Bans or limits on needle and syringe programmes and/or OST for people who inject drugs, including in prisons settings;</li> <li>● Criminalization of same-sex behaviours, sexual orientation and gender identity; and</li> <li>● Criminalization of HIV non-disclosure, exposure or transmission.</li> </ul>		

139. Addressing human rights and drug use, UNDP and the International Centre on Human Rights and Drug Policy at University of Essex initiated a project to develop human rights guidelines on drug policy in partnership with UN Member States, international organizations, civil society groups and others. Meanwhile, the UNODC Executive Director made a statement condemning the extrajudicial killing of suspected drug traffickers in the Philippines. UNODC, as part of the joint UN Country team on punitive approaches and violations of human rights, developed a Guidance for Community-based Assessment, Treatment, and Care for People Affected by Drug Use and Dependence, adopted by the Dangerous Drugs Board.

*"We are motivated to fight AIDS because we know that every child deserves care, every person deserves treatment and all vulnerable groups deserve protection from stigma and abuse. Tolerance and awareness help stop AIDS. Speaking out protects life."*

Ban Ki-moon, UN Secretary General

140. The Joint Programme and Cosponsors also targeted discrimination in healthcare settings through a range of approaches in 2016. The Agenda for Zero Discrimination in Health Care was launched in 2016 by the UNAIDS Secretariat and WHO, and it is guiding collective advocacy, leadership, accountability and implementation of evidence-informed interventions. For example, in Egypt, WHO supported the

government in developing a national policy to address stigma and discrimination in healthcare settings against people living with HIV. The policy identifies forms of discrimination faced by people in healthcare settings and articulates the right of people living with HIV to health care, as well as the ethical duties of healthcare providers, both within and outside health care settings, to provide adequate and equal care. Meanwhile, in Jamaica, UN Women worked with the



*The Agenda for Zero Discrimination in Health Care supports a vision for a world where everyone, everywhere, enjoys health services without discrimination and where the health workforce is empowered to provide discrimination-free services to all.*

National Family Planning Board to provide gender mainstreaming training to healthcare workers, which resulted in reduced stigma and discrimination against women living with HIV in the healthcare setting and positive outcomes in treatment access and adherence. The UNAIDS Secretariat also launched EqualHealth4All, a virtual platform for sharing evidence, tools and best practices with over 120 members from more than 50 organizations, including governments, civil society, the United Nations, professional healthcare associations and donors. A reference paper on Eliminating Discrimination in Healthcare was produced and an e-repository ([www.zeroHIVdiscrimination.com](http://www.zeroHIVdiscrimination.com)) improved the dissemination and use of tools to assess and address HIV-related discrimination in health care.

141. In 2016, UNAIDS Secretariat filed three amicus curiae briefs: one in the East African Court of Justice on the Uganda now-defunct Anti-Homosexuality Act, one on coercive



sterilization in the High Court of Kenya, and one on mandatory HIV testing for foreign language teachers in Korea with the Human Rights Committee.

*Legal and policy reforms*

142. UNAIDS Secretariat has been convening partners such as HIV Justice Worldwide, OHCHR, Amnesty International, and leading efforts to address misuse of criminal law and its impact on health, including through developing a global scientific statement on HIV criminalization and a workshop on the intersectionality of misuse of criminalization at AIDS 2016.
143. In South Africa, contributing to the generation of knowledge, the ILO, UNAIDS Secretariat and partners made significant inputs into the process of drafting a book focussing on AIDS and the law in South Africa. The ILO was requested to moderate a panel discussion during the launch of the book, published by Nexis Lexis in July 2016.
144. In the South Governorate of Yemen, UNHCR with the UNAIDS Secretariat and the National AIDS Programme advocated for the end of mandatory testing of refugees and asylum seekers. As a result of this, in 2016, mandatory testing for refugees and asylum seekers was halted during asylum procedures, and refugees living with HIV were able to successfully renew their identity cards.

*Access to justice and enforcement of rights*

145. In Malawi, UN Women, in collaboration with the UNAIDS Secretariat and UNICEF, led coordinated support for a court case against Eric Aniva, a man living with HIV, who publicly admitted to engaging in sexual cleansing practice with 104 women and girls as young as 12 years-old. Aniva was sentenced to 24 months under the provisions of the Gender Equality Act. It was the first time the Act had been used in a court.
146. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) is a powerful instrument for articulating, advocating and monitoring women’s human rights. With UN Women, UNDP and UNFPA’s support, women living with HIV input to country reporting on CEDAW. In Ukraine, women living with HIV, sex workers and women who use drugs presented the shadow report to the CEDAW Committee. In Viet Nam, the network of women living with HIV contributed to the development of the monitoring framework of the 2015 CEDAW Concluding Comments.

Percentage of countries with mechanisms in place providing access to legal support for people living with HIV	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 70% 2019: 65% 2017: 60%	<b>All: 54% [52/96]</b> <b>FT: 61% [20/33]</b>
<p>Joint Programme efforts to strengthen institutions, systems and legal environments will specifically focus on ensuring protection for people living with HIV, key populations, women, girls and other vulnerable groups. In particular, the Joint Programme supports the implementation of mechanisms to record, address and to promote legal access for cases of HIV-related discrimination, and it prioritizes HIV-sensitive training programmes on human rights and non-discrimination laws for law enforcement personnel and members of the judiciary and national human rights institutions.</p> <p>In 2016, 54% of 96 countries with Joint Programme presence (of which 20 are Fast-Track countries) had mechanisms in place that provide access to legal support for people living with HIV, with the</p>		

following features:

- Mechanisms to record and address cases of discrimination in relation to HIV;
- Mechanisms to provide promote access to legal support (e.g. free legal services, legal literacy programmes) for HIV-related issues including gender-based discrimination (e.g. dispossession due to loss of property and/or inheritance rights in the context of HIV);
- HIV-sensitive training programmes on human rights and non-discrimination laws for law enforcement personnel and members of the judiciary and members of national human rights institutions.

147. The Eastern and Southern Africa Ministerial Commitment helped inform a study by UNFPA on the harmonization of the legal environment on adolescent SRH in the region, with UNESCO providing technical input. Recommendations include decriminalizing consensual sex between adolescents, introducing legislative reforms to address age of consent limitations for testing and treatment, and providing young people with rights-based, age-appropriate, gender-sensitive CSE, among others.

148. The UNAIDS Secretariat and IDLO have supported efforts in the United Republic of Tanzania and Uganda to develop a cadre of lawyers that is committed and equipped with the knowledge and skills to support human rights-based responses to HIV, in order to scale up access to legal services.

#### *Eliminating HIV healthcare discrimination*

149. In line with the call of the SDGs to address inequalities and discrimination that leave people behind, and in light of the evidence that discrimination continues to occur in health care settings, the UNAIDS Secretariat and the WHO Global Health Workforce Alliance in March 2016 launched an Agenda for Zero Discrimination in Health Care. The Agenda aims to bring together relevant stakeholders to work towards a world where everyone everywhere is able to receive or provide health care without discrimination. The Agenda prioritizes action to secure political leadership and commitment, scale up implementation of what works to eliminate discrimination, and enhance accountability.

Percentage of countries with measures in place to reduce stigma and discrimination in health settings	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 60% 2019: 50% 2017: 40%	All: 29% [28/96] FT: 39% [13/33]
<p>Stigma and accompanying discrimination are widely recognized as significant barriers to HIV prevention, treatment and care services reaching those who need them most. The Joint Programme supports the development of improved measurements of scope, nature and impact of stigma and discrimination in the health sector, and efforts to document them. It provides quality support to health care professionals to reduce and ultimately end HIV-related stigma and discrimination in health care settings, including by adding gender-sensitive stigma and discrimination reduction notions in pre-and in-service training. The Joint Programme promotes legal, policy and programmatic actions and redress mechanisms to eliminate HIV-related stigma, discrimination and violence in healthcare settings, including forced sterilization and coerced abortion among women living with HIV.</p> <p>In 2016, 29% of 96 countries with Joint Programme presence (of which 13 are Fast-Track countries) had measures in place to reduce stigma and discrimination in health setting with the following elements:</p> <ul style="list-style-type: none"> <li>▪ An up-to-date assessment on HIV-related discrimination in the health sector (either through the Stigma Index or another tool);</li> <li>▪ Health care workers pre-and in-service training which includes gender-sensitive stigma and discrimination reduction, with specific attention to the sexual and reproductive health and rights of women living with HIV in all of their diversity and throughout their lives;</li> <li>▪ Measures in place for redress in cases of stigma and discrimination in the health sector.</li> </ul>		



150. In Nigeria, working through the UN Joint Team on Gender, Human Rights and Key Populations (which comprises the UNAIDS Secretariat, ILO, UNDP, UNODC and other UN agencies), the ILO provided technical input to the draft National HIV Stigma Reduction Strategy. Following the passage of the HIV and AIDS (Anti-Discrimination) Act in 2014, the National AIDS Control Authority began the process of developing an AIDS Stigma Reduction Strategy. The purpose of the Strategy is to align the efforts of stakeholders in addressing HIV-related stigma and discrimination in various health and non-health settings, and to bring about synergies. Advocacy was undertaken in 2016 to reduce stigma and discrimination in state hospitals and health facilities. Key topics included discriminatory attitudes towards people living with HIV among health workers; mandatory HIV testing before surgery and during pregnancy; denial of treatment; refusal of admission to the hospital: refusal to operate or assist in clinical procedures; and physical isolation in the wards for people living with HIV.
151. In South Sudan, the WFP, the UNAIDS Secretariat, the Ministry of Health and the Network of People living with HIV (SSNeP+) completed a Stigma Index and Vulnerability Survey among people living with and affected by HIV and AIDS. The goal of the survey was to establish a baseline for HIV-related stigma and discrimination among people living with HIV to inform programming, policy and advocacy efforts. A striking finding was that people on ART are more food insecure than people living with HIV who are not yet on treatment. This is a worrying finding as people who are food insecure are less likely to adhere to their treatment, and strong adherence is essential for treatment success for both TB and HIV.

## Challenges

152. **Stigma and discrimination against key populations remain serious barriers to effective HIV responses worldwide.** Despite UN Member States' commitments in the 2016 Political Declaration on Ending AIDS, an increasing number of countries worldwide are debating and introducing punitive laws, policies and practices. In many countries, punitive laws remain in place against sex workers, MSM, transgender people and people who use drugs. There has also been a shrinking of civil society space and encroachment on the rights and freedoms of civil society on the basis of public health or security rationales. Discriminatory laws and harmful practices continue to hamper women and girls' abilities to confront HIV and mitigate its impact. Increasing legal literacy of both informal justice community leaders and women, particularly those living with HIV, is critical in advancing women's security and rights. In South-East Asia the number of people in compulsory detention centres is not decreasing. Lack of domestic resources, limited quantitative data and insufficient focus on key population programming perpetuates this discrimination and limits the effectiveness of responses.
153. **Translation of international standards into action.** Although many international standards have been set regarding HIV, human rights and the law, it remains a challenge to enforce those standards with protective laws and law enforcement, and increased access to justice.

## Key future actions

154. Key areas of focus for the Joint Programme in 2017 will include:

- Positioning HIV-protections in rights bodies, building bridges among communities;
- Challenging the misuse of criminal law;
- Advancing zero discrimination in health care;
- Strengthening human rights at the country level, including through coordination of responses to HIV-related human rights crises;
- Partnering to develop a global scientific statement to influence HIV criminalization; and
- Responding to *amicus curiae* requests, leveraging law firm support and addressing the shrinking of civil society space and its impact on the AIDS response.

Specific actions by Cosponsors will include:

- UNDP will commission a formal stock-taking exercise in 2017 to assess the impact of the report of the Global Commission on HIV and the Law. In partnership with UN Member States, international organizations, civil society groups and academia, UNDP will also continue to develop human rights guidelines on drug policy in 2017;
- UNHCR is planning to scale up regional activities to address protection concerns for people living with HIV, including the continuation of mandatory testing for HIV in four countries in the Middle East and North Africa;
- UN Women will invest further in supporting legal literacy and promoting increased access to legal aid services for women and girls, in particular those living with HIV, as a strategic HIV prevention and impact mitigation strategy;
- In 2017, UNODC will roll out a training manual for police academies on HIV service provision for people who inject drugs and a guide for civil society organizations to improve cooperation with police, in seven high-priority countries for HIV and people who use drugs;
- UNDP will address legal, policy and practice barriers affecting the rights of key populations. Legislative and policy change will be promoted during national dialogues and via legal environment assessments to facilitate enabling laws and policies and key population-oriented national plans and Global Fund grants.

## Strategy Result Area 7: Investment and efficiency

### Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

#### Achievements

155. Sustainable financing and investment remains a major challenge for Fast-Tracking the HIV response. UNAIDS Secretariat estimates that by 2020, the global price tag for the Fast-Track will be at least US\$ 26 billion per year in low- and middle- income countries (per 2015 classification). In a context of reduced international funding, improving financial sustainability and efficiency of investments is vital, as well as improved programme effectiveness. It is also essential to take into account broader trends in development assistance and in health sector to ensure the long-term sustainability of national responses. As more countries transition to an increasing domestic financing for their AIDS responses, the support of the Joint Programme for cross-sectoral integration is helping to maximize sustainable funding opportunities and minimize the service disruptions of a complex transition.
156. A key challenge for sustainability is the space HIV prevention and treatment services will find under the Universal Health Coverage (UHC) umbrella and multisectoral funding frameworks. The World Bank, WHO and UNDP, as well as the Secretariat, have therefore been providing global guidance, direct technical assistance and funding to help countries define a sustainable path. In 2016, the World Bank and WHO, together with the Government of Japan, the Global Fund and the African Development Bank, launched *UHC in Africa*, which provides an overview of UHC and identifies areas, including HIV, that are critical for achieving improved health outcomes. The World Bank and WHO also released *Tracking Universal Health Coverage* to assess countries' progress towards UHC, while the World Bank finalized a series of four country studies, *HIV/AIDS and Universal Coverage financing in Africa*, to help the governments of Côte d'Ivoire, Kenya, Nigeria and the United Republic of Tanzania assess the financial sustainability of HIV interventions within the context of UHC. UNDP launched a project with the Government of Japan to support cross-sectoral cofinancing for health and UHC in seven sub-Saharan African countries. UNDP also strengthened partnerships on tobacco control and noncommunicable diseases, leading to the creation of global joint programmes with WHO.

#### *Efficiency and effectiveness of AIDS response*

157. The Joint Programme also leveraged its collective expertise in 2016 to ensure a more sustainable cross-sectoral approach and benefit from opportunities arising from service delivery integration. For example, UNICEF used its community-level work around the world to demonstrate the potential for more efficient use of human resources. In 2013, only 10 of the 21 Global Plan countries applied HIV task-shifting or delegation of HIV-related medical services from doctors to nurses and community health care workers. In 2016, through UNICEF's "proof of concept" approach, all 21 countries were applying task-shifting to manage HIV among pregnant women, mothers and their infants. Meanwhile, the WFP worked to highlight the importance of addressing emergencies, structural drivers and food as critical parts of the HIV response. This global and regional level advocacy work led to an approximate US\$ 22 million commitment from PEPFAR to support malnourished and food insecure people living with HIV in Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe.

<b>Percentage of countries with up-to-date HIV Investment cases (or similar assessing allocative efficiency) that is being used.</b>	<b>Targets and milestones</b>	<b>2016 Progress</b>
<p>Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly</p>	<p>2021: 80% 2019: 70% 2017: 60%</p>	<p>All: 48% [46/96] FT: 55% [18/33]</p>
<p>The Joint Programme is a major provider of technical assistance to countries to develop quality investment cases or similar exercises to improve allocative efficiency at country level. The Joint Programme is also a main provider of technical assistance for strengthening the monitoring system in countries.</p> <p>As part of national monitoring and evaluation frameworks, the Joint Programme supports countries to track and analyse HIV expenditures per funding source and beneficiary population using the National Aids Spending Assessment (NASA), or other integrated tools. Spending data provide decision makers with strategic information that allow countries to mobilize resources, have a stronger accountability and a more efficient and effective programme implementation. However, there is need to promote the institutionalization of these type of tools for the regular use in the country planning cycles. In 2016, 48% of 96 countries with Joint Programme presence (of which 18 are Fast-Track countries) had up-to-date HIV Investment cases (or similar assessing allocative efficiency with the following components:</p> <ul style="list-style-type: none"> <li>▪ A computerized monitoring system that provides district level data on a routinely basis including key HIV service delivery variables (ART and PMTCT);</li> <li>▪ The country tracks and analyses HIV expenditures per funding source and beneficiary population;</li> <li>▪ Country allocations are based on epidemic priorities and efficiency analysis (investment case or similar).</li> </ul>		

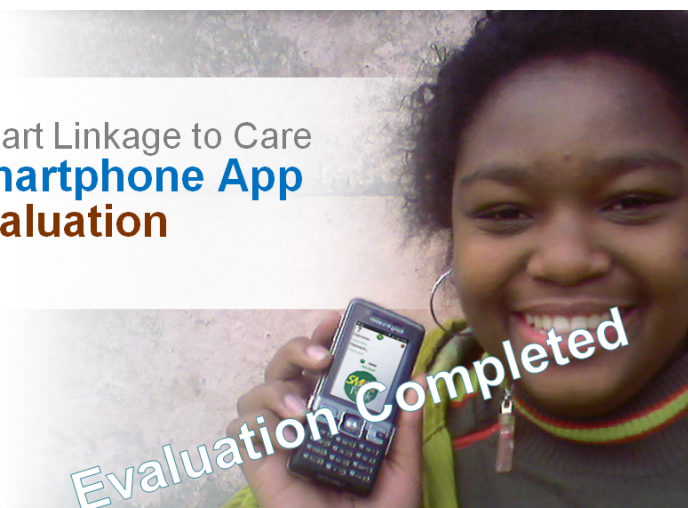
158. Joint Programme technical assistance additionally contributed to improving the effectiveness of the response. For example, UNICEF, in partnership with WHO, led on the adoption of a more efficacious and simpler ART regime. Thanks to coordinated advocacy and demonstrations of how to implement at lower costs, 21 of the eMTCT Global Plan countries adopted the policy. UNFPA supported the implementation of comprehensive male and female condom programming that ensured maximum effectiveness for condom interventions. In 2016, 54 countries implemented all four steps of the implementation phase as recommended by UNFPA. The WFP and the London School of Hygiene and Tropical Medicine also completed a study on the investment returns of food-based interventions for ART patients in eastern and southern Africa. The findings suggested that investment in ending hunger could contribute to improved treatment adherence and retention in care.

#### *Technological and service delivery innovations*

159. The Joint Programme also pursued innovative mHealth strategies in 2016 and developed new tools to improve the efficiency of the response. For example:

- The WFP used innovative technologies to collect and manage data on its programmes and beneficiaries as well as for resource mobilization. One such innovative platform is mobile vulnerability analysis and mapping, which is used in South Sudan, among other countries, to capture data on HIV/TB programme attendance, food deliveries and distribution, as well as nutrition assessment, counselling and support indicators;
- UNICEF utilized mobile technologies to stimulate demand and monitor service utilization. For example U-Report, a social messaging tool that encourages adolescents and young people around the world to speak out on issues that affect them has over 2.4 million registered users and is live in over 25 countries;

- As part of its Solar for Health initiative, UNDP is scaling up the use of solar panels in health facilities as part of Global Fund implementation support, providing electricity to primary health care clinics offering ART in Zimbabwe and health warehouses in Zambia;
- WHO made progress on several work streams on innovation, including treatment optimization, differentiated service delivery (differentiated service delivery) models, HIV monitoring and diagnostics, HIV testing, PrEP and innovations for voluntary medical male circumcision;
- The World Bank provided financing for multiple projects fostering eHealth innovations. For example the “eGabon” project, which aims to improve availability of information to support service delivery. The World Bank also provided evidence for the use of innovative tools, for example with the evaluation of a smartphone app in a randomized controlled trial in South Africa;
- The Secretariat has been promoting innovation in UNAIDS strategic information products and is collaborating with private sector on integration of community data into national monitoring and evaluation systems. A new SMS platform was developed with Orange: the Mobile Training Every Where (MTEW) platform.



*The World Bank conducted an evaluation of the Smartphone App, which is being used by patients in South Africa to access their personal health information.*

160. Collaborating with the UNAIDS Secretariat and other Cosponsors, the World Bank worked on more than 10 allocative efficiency studies across the six regions in 2016.

161. In coordination with the UNAIDS Secretariat, the Bank also completed additional impact evaluation studies, such as the second phases of the ART adherence study in South Africa.

Percentage of countries with scale-up of new and emerging technologies or service delivery models.	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 60% 2019: 50% 2017: 40%	All: 35% [34/96] FT: 48% [16/33]
<p>The Joint Programme promotes innovation in HIV service delivery, including e-health and mobile health for comprehensive sexuality education, HTS, ARV case monitoring, and other priority health services. By fostering partnerships among communities, government agencies, health providers and the private sector, the Joint Programme encourages countries to develop and use innovative prevention technologies and examine broader HIV testing methods. The list of new technologies in the indicator measurements are directly linked to Joint Programme support and may vary over the period of the UBRAF based on contextual changes and innovation.</p> <p>In 2016, 35% of 96 countries with Joint Programme presence (of which 16 are Fast-Track countries) had scale-up of new and emerging technologies or service delivery models, such as:</p>		

- Social media/information and communication technologies;
- e-health and/or m-health tools for priority HIV services;
- Diagnostics for rapid diagnosis, combined HIV/syphilis and for monitoring of viral suppression.

162. In November 2016, WHO convened a consultation with a number of stakeholders on the application of HIV differentiated service delivery models for specific populations and settings, with a focus on pregnant and breastfeeding women, children, adolescents and key populations. This led to the development of key considerations for families and key populations for differentiated service delivery. WHO additionally supported Kenya, South Sudan and Zimbabwe to integrate these key considerations into their National Operational Manuals for Differentiated Service Delivery. In 2016 WHO started work to review the safety and efficacy data on next-generation PrEP products, including the dapivirine vaginal ring, which is being considered by the European Medicines Agency under a collaborative process with WHO known as Article 58. WHO is actively involved with partners working on long-acting PrEP and is collating evidence and experiences from oral PrEP programmes to support rapid effective implementation of long-acting PrEP, if and when products are shown to be safe and effective.

*["Under the Fast-Track approach the world is driving down costs quickly to close the gap between people who have services and people being left behind. Urgently and fully funding and front-loading investments will save lives and lead us to ending the AIDS epidemic by 2030."](#)*

Michel Sidibé, UNAIDS Executive Director

163. In partnership with the UNAIDS Secretariat and other Cosponsors, the World Bank conducted several studies in 2016 that provided additional evidence for the use of innovative tools and approaches in the HIV response. Studies include the evaluation of a smartphone app in a randomized controlled trial conducted by the Bank in urban Johannesburg. As part of the ART adherence study conducted in South Africa, the World Bank also tested several service delivery modalities for decentralized medication provision, including:

- Adherence clubs (as an efficient mechanism for ART clients' drug refill);
- The Central Chronic Medicine Dispensing and Distribution scheme;
- The Central Dispensing Unit scheme.

## Challenges

164. **Dependency on external funding.** This remains a challenge, along with the transition to domestic financing mechanisms. UNAIDS, UNDP, World Bank, the UNAIDS secretariat and other partners provide vital inputs to countries in this transition. Although more integrated approaches provide clear opportunities, 168 other SDG targets also require resources (projected at US\$ 3.5 to 5 trillion per year). Persistent issues around intersectoral coordination and intragovernmental incentive conflicts are noticeable challenges.

165. **Implementation, translation and scale up.** Implementing funding re-allocations, translating technical efficiency knowledge into actions and reaching full-scale implementation at the desired coverage levels are also major challenges. Additional technical support is needed to help countries implement the recommendations and ensure maximum impact.

**166. Ensuring continuity of online technologies.** For M-health, a key challenge is ensuring continuity of use of internet/cloud/mobile-based platforms, since access to Wi-Fi is not easy and data can be costly. UNESCO is looking into options to offer an offline version of its CSE courses, which can be delivered from a CD-ROM, thereby bypassing the need for Internet access. Data is also still lacking in emergency contexts.

**167. Inclusion and capacity development of networks of people living with HIV.** Networks of people living with HIV have vastly different capacities. In some settings, they have substantial knowledge gaps on the SDGs. Some others have already established a strong foothold in the SDGs implementation, but require more tailored policy guidance and support. As the countries embark on the SDGs localization, it is essential to sustain robust investment in building capacity and disseminate good practices on integrating people living with HIV priorities into the national policies, programmes, actions, budgets and accountabilities.

### **Key future actions**

168. Key future actions by the Joint Programme will include:

- UNICEF will continue to provide support to countries in the collection, analysis and use of age- and sex-disaggregated data to sharpen HIV programmes for children and adolescents. UNICEF is committed to the development of a social and community accountability mechanism to reinforce broad community engagement around adolescent priorities;
- UNDP's focus is on supporting the implementation of three global programmes for low and middle-income countries: (1) cross-sectoral cofinancing; (2) catalyzing multisectoral action on noncommunicable diseases; and (3) strengthening implementation of the WHO Framework Convention on Tobacco Control to achieve the SDGs. The three programmes seek to strengthen intersectoral coordination and include specific approaches to finance development priorities such as HIV and related co-morbidities;
- UN Women will continue to advance meaningful participation of people living with HIV and ensure sustainable spaces are established for people living with HIV to voice their priorities and advocate for actions, budgets and accountability frameworks;
- The World Bank will maintain a strong focus on sustainability, efficiency and effectiveness. In support of domestic budget planning, Global Fund concept notes and COP planning processes, the World Bank will launch a new series of allocative and implementation efficiency studies, with a priority on Fast-Track countries and countries transitioning towards domestic funding for their HIV response;
- UNFPA will continue to support advocacy efforts of key populations for claiming their human rights, reducing violence and increasing access to SRH/HIV services.



## Strategy Result Area 8: HIV and health service integration

### Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

#### Achievements

169. The UNAIDS Strategy 2016–2021 aspires to reach 75% of people living with, at risk of and affected by HIV, with HIV-sensitive social protection activities. Meanwhile, implementation of the 2030 Agenda for Sustainable Development calls for an integrated approach across the social, economic and environmental pillars of development. The Joint Programme worked collaboratively to include a social protection target in the 2016 Political Declaration on Ending AIDS, which calls for strengthening child and national social protection systems to ensure 75% of people living with, at risk of and affected by HIV, who are in need, have access to HIV-sensitive social protection activities. As a result, social protection and incentives have become a prominent part of the recommended packages promoted by the Joint Programme on preventing HIV, treatment, care and support.

170. To that end, in 2016, the UNFPA-WHO led interagency working group on SRH and HIV linkages developed infographic snapshots detailing SRH/HIV linkages. These snapshots summarize progress in mainstreaming HIV within broader SRH services and identify opportunities for programme planning and resource mobilization. They are complemented by a SRHR/HIV Linkages Index, which provides the first-ever composite score for measuring country progress towards achieving a linked response to SRHR and HIV. It can be used to:

- Track progress of how well a country is linking SRHR and HIV;
- Increase understanding of SRHR and HIV linkages;
- Support advocacy for improved linkages;
- Deepen knowledge on the drivers and effects of SRHR and HIV linkages; and
- Highlight data gaps.

171. The World Bank also continued to place a strong focus on health system strengthening in 2016, with funding and analytical support provided to decentralization and integration of HIV-related services into primary health care centres and SRH. UNESCO supported the decentralization and integration agenda through support to develop and refine multisectoral strategies for life-skills-based HIV and CSE, including in 12 countries in Latin America and the Caribbean.

Percentage of countries with social protection strategies and systems in place that address HIV	Targets and milestones	2016 Progress
<small>Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly</small>	2021: 70% 2019: 60% 2017: 50%	<b>All: 63% [60/96]</b> <b>FT: 67% [22/33]</b>
The Joint Programme supports scale-up of sustainable, HIV-sensitive and evidence-informed social protection programmes and strengthens national social protection floors. It works to ensure that social protection programmes reach those living with and affected by HIV, and advocates for increased investment and provides guidance and support for implementation of HIV-sensitive measures to address the needs of orphans and vulnerable children.		
In 2016, 63% of 96 countries with UNAIDS presence (of which 22 are Fast-Track countries) had social protection strategies and systems in place that address HIV and cover: <ul style="list-style-type: none"> <li>▪ People living with HIV and affected by HIV; and</li> </ul>		

- Orphans and vulnerable children.

Furthermore, 46% of those countries (including 15 Fast-Track countries) had national health insurance (or social health insurance), life or critical illness insurance that cover people living with HIV. Social protection programmes, such as safety nets and livelihood interventions, are provided to men and women living with HIV and affected by HIV in 49 countries (of which 19 are Fast-Track countries).

172. The Joint Programme also worked to ensure that people living with, at risk of and affected by HIV were empowered through HIV-sensitive national social protection programmes in 2016, including cash transfers. This was done at country level through advocacy, technical support, and implementation of social protection activities. At the global level, the Social Protection IATT, led by the World Bank and UNICEF, with support from the UNAIDS Secretariat, continued to raise the profile of social protection in the HIV response and provided technical support, oversight and advocacy on HIV and social protection.
173. The UNAIDS Secretariat, with support from ILO, PEPFAR, UNDP, UNICEF, WFP, WHO, UNICEF, the World Bank other entities developed a HIV and Social Protection Assessment Tool, which will be used for quick assessments of existing social protection programmes and their sensitivity to the AIDS response at country level. The tool has already triggered implementation of HIV and Social Protection Assessments in at least six African countries as well as operationalization of social protection targets. The UNAIDS Secretariat, with support from UNICEF and UNFPA, additionally continued to collaborate with PEPFAR on programming for addressing the social and economic drivers of HIV through social protection, care and support, economic empowerment and access to education for adolescents in 10 DREAMS project countries in Africa (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia, and Zimbabwe).
174. UNICEF's HIV programme on social protection led to improved access to social services for children without caregivers and for poor households with children in 2016. In the past year, in partnership with the Joint Programme and others, UNICEF led the design of tools and guidance to support countries that undertake comprehensive assessments, in a bid to strengthen national responses to AIDS in adolescents. These analytical tools have helped countries to identify equity and performance gaps that limit the impact of investments in adolescent programming, as well as adolescents at greatest risk of infection, illness and death, such as those who are typically excluded from services or live in areas with poor service performance. In addition, the tools can also help to identify bottlenecks that contribute to ineffective HIV prevention, treatment, and care.
175. The ILO's Global Flagship Programme on Building Social Protection Floors for All was launched in 2016. Technical support was provided to support the step-by-step development of nationally defined social protection floors. Tailored support to extend Social Protection programmes to cover vulnerable populations, including people living with HIV, is ongoing in Cambodia, Cameroon, India, Indonesia, Kenya, Nigeria Rwanda, South Africa, the United Republic of Tanzania, Viet Nam and Zambia.
176. Access to sustainable livelihoods and economic resources are crucial for women living with HIV. UN Women and partners therefore worked together to improve opportunities for people living with HIV to access sustainable livelihoods and economic resources.
177. The WFP continued to contribute to the empowerment of people living with HIV through its HIV-sensitive social protection programmes in 2016. It did so by

supporting national governments in designing, implementing and evaluating cost-effective food security-sensitive safety net and social protection mechanisms for people living with HIV and other vulnerable populations, including in fragile and challenging operational contexts.

*“The cost of inaction is extremely high. Individual communities are where the work gets done. There is no ending AIDS without us.”*

Marama Pala, International Indigenous Working Group on HIV/AIDS and Co-Chair of the Stakeholder Task Force

#### *Decentralization and integration of HIV-related services*

178. Prior to the HLM on Ending AIDS in June 2016, with support from the Secretariat, WHO convened a Ministerial panel discussion, chaired by UN Special Envoy on TB, Eric Goosby, which elicited important commitments on delivery of integrated care from the Ministers of high-burden countries (Ethiopia, Nigeria and South Africa) in order to end TB deaths among people living with HIV. At the Women Deliver conference in Copenhagen, WHO, in collaboration with the UNAIDS Secretariat and the Global Fund convened a symposium on the “Female face of communicable diseases”, where participants discussed the importance of TB, HIV and other communicable diseases in women’s health and best approaches for a holistic and integrated healthcare delivery model, from policy to care recipient level.
179. UNESCO and the WHO have been enhancing joint efforts on the promotion of health and well-being. UNESCO participated in a 2016 meeting on promoting intersectoral and interagency action for health and well-being in the WHO European Region and will be collaborating with WHO to support the development of a practical manual for the implementation of evidence informed violence prevention in schools. In August 2016, the World Bank and WHO, together with the government of Japan, Japan International Cooperation Agency, the Global Fund and the African Development Bank launched “Universal Health Coverage in Africa: A Framework for Action”, which provides a big-picture view of UHC in the region and identifies key areas that will be critical to achieving better health outcomes. These include financing, service delivery, targeting vulnerable populations, mobilizing critical sectors and political leadership.

#### *HIV-sensitive social protection*

180. The World Bank, UNICEF and the UNAIDS Secretariat worked together to bring social protection, including cash transfers, care and support into global public policy dialogue, successfully advocating for the inclusion of a social protection target in the UNAIDS Strategy 2016–2021, 2016 Political Declaration on Ending AIDS and the 10 Fast-Track Commitments. This advocacy has led to the widespread acknowledgement and application of social protection as a key HIV prevention, treatment and mitigation approach for adolescent girls and young women, people living with HIV, at risk and affected by HIV.

Percentage of countries delivering HIV services in an integrated manner	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 80% 2019: 70% 2017: 65%	All: 65% [62/96] FT: 64% [21/33]

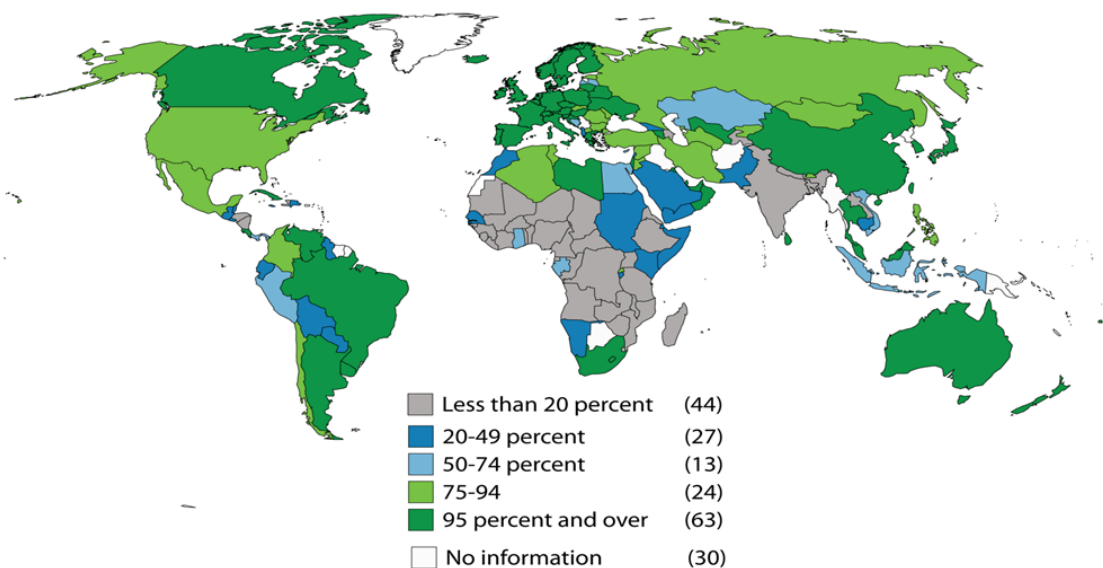
The Joint Programme promotes collaboration across national health programmes for delivery of integrated services, to promote systems strengthening and policies that support linkages. The Joint Programme supports countries to assess and monitor progress on HIV programme decentralization and integration; advocates and provides operational guidance and technical support for integrating services. It supports countries to embed the AIDS response in efforts to achieve Universal Health Coverage.

In 2016, 65% of 96 countries with Joint Programme presence (of which 21 are Fast-Track countries) were delivering services in an integrated manner, i.e. a client can receive services in one facility (in a single visit) for multiple interventions such as:

- HIV, sexual and reproductive health, and gender-based violence services;
- HIV and TB;
- HIV and antenatal care.

181. The Joint Programme has collaborated with Oxford University, London School of Hygiene and Tropical Medicines, Columbia University, University of North Carolina and others to generate cutting edge evidence on the impact of social protection and different combination of social protection, cash transfers, cash incentives, care and support on HIV prevention and treatment. The evidence informs the design and implementation of UNAIDS and partners including the DREAMS programme particularly on the social protection, cash and care components. This evidence and its policy application continues to be shared in UNAIDS Secretariat, UNICEF World Bank and Housing Works organized Global Research Network on Social Protection and Social Drivers Annual meeting, supported by the Social Protection, Care and Support working group.

182. The ILO and the World Bank inaugurated the Global Partnership for Universal Access to compile Social Protection experiences to highlight the feasibility of social protection in developing countries. In Indonesia, the ILO and UNAIDS Secretariat supported the National AIDS Commission to establish a task force to ensure coverage of people living with HIV and key populations under the national social protection scheme. The task force has been transformed into a working group that will continue to monitor the implementation of the scheme. In Nigeria and Zambia, the ILO, UNICEF and the UNAIDS Secretariat are members of the UN Group on Social Protection and provided technical input to the Social Protection policy with a view to make the policies HIV sensitive.



*National Social Protection Floors: to reach all people living with HIV, health protection must be universal and based on legislation. Globally, in more than 70 countries, less than half of the population is covered.*

*Source: Social Protection for All: Ending AIDS by 2030, Panel Discussion, 25 May, Geneva]*

183. In El Niño-affected countries, WFP supports people living with HIV/TB and their families to compensate for the loss of income-earning potential. In Zimbabwe, WFP food assistance reached over one million beneficiaries, including orphans and vulnerable children and people living with HIV. In Ethiopia, WFP worked with PEPFAR to provide nutritional assessment, counseling and support, social safety nets and economic strengthening services to people living with HIV, orphans and vulnerable children and PMTCT clients. Engagement in economic strengthening activities has proven to be a robust predictor of improved retention to HIV care, adherence to ART, access to health services and health-related quality of life.

## Challenges

184. **Lack of financial resources.** This is a major challenge for integration of HIV and health services and social protection, including task-shifting to communities. The Sustainable Development agenda calls for multidisciplinary action; the Joint Programme is a prime example of implementing the SDGs through partnerships and integration, providing a coordinated and multisectoral response to a major global health and development challenge. Channelling funding through UBRAF has been instrumental in making these linkages across the response and the SDGs, however limited funding to the UBRAF could have long standing consequences, such as reduced opportunities to integrate HIV in UHC schemes and lack of support for civil society organizations. For example, while social protection programmes for young women and adolescent girls provide financial security and help keep girls in school, this work is rarely complemented with gender-transformative initiatives that address power relations, expand young women's access to and control over economic resources, or increase women and girls' knowledge, skills and ability to negotiate safer sex.

185. **Under representation in HIV programmes.** Key populations, as well as adolescents, people living with HIV and TB patients, remain underrepresented in HIV programmes. Lack of capacity to target the specific needs of these groups could reduce the effectiveness of social protection and other programmes in promoting adherence and retention to care and treatment, which can ultimately lead to the need for more expensive second and third line ART. Furthermore, without adequate support from the Joint Programme, governments may not possess the means or expertise to implement the required social protection programmes for people living with HIV and other vulnerable groups at risk of acquiring HIV. This could be particularly harmful in countries dealing with humanitarian emergencies.

186. **Intensified advocacy, strategic information and technical and capacity building support.** The Joint Programme needs to intensify advocacy, generation of strategic information and technical and capacity-building support to mobilize social protection strategies to reduce HIV vulnerability, enhance the impact of HIV services and strengthen the response. Strategic information on the barriers to uptake of health services for people living with HIV should feed into the design or adjustment of social protection programmes at the country or community level.

## Key future actions

187. The Joint Programme will continue to ensure that people living with, at risk of and affected by HIV have access to integrated services, including for HIV, TB, SRH, harm reduction and food support. Strengthening national health systems will be prioritized through integration of community service delivery with formal health systems and supporting countries with differentiated service delivery.

188. The Joint Programme will also continue to link social protection to UHC scale-up and support HIV-sensitive social protection programmes at country level. Identifying ways to support the Global Fund and PEPFAR's commitment to social protection in the AIDS response will remain a priority. The Joint Programme will also continue to work with political leaders to increase demand for HIV-specific social protection programmes.

189. Specific future actions by the Joint Programme will include:

- UNICEF will continue to build evidence and overcoming operational challenges to implement HIV-sensitive programmes;
- WFP will finalize and disseminate the results of the study on investment returns of food-based interventions for ART patients in eastern and southern Africa jointly with the London School of Hygiene and Tropical Medicine;
- ILO will prioritize work with Member States to scale up HIV-sensitive national Social Protection Floors;
- UNDP will examine synergies outside of the health sector and multiple disease outcomes;
- UN Women will economically empower women and girls, particularly those living with and affected by HIV;
- UNESCO and WHO will support the development of a practical manual on evidence informed violence prevention in schools;
- WHO will disseminate the Key Considerations and the updated Decision Framework for Differentiated Service Delivery for Families and Key Populations;
- The UNAIDS Secretariat will support four countries to conduct HIV and social protection assessments; and
- UNFPA and the World Bank will provide funding and technical assistance for HIV integration and mainstreaming into health services, in particular integration with SRH services.

## SECRETARIAT CONTRIBUTIONS

190. This section provides an overview of achievements, challenges and future actions by the UNAIDS Secretariat, organized against the five Secretariat functions outlined in the 2016–2021 UBRAF. More detailed information on achievements, challenges and future actions under the UNAIDS Secretariat’s organizational functions can be found in Part II of this report.

*“The global community is united in its resolve to end the AIDS epidemic within the framework of the Sustainable Development Goals. This meeting is laying the groundwork for future progress in creating healthier outcomes for everybody affected by HIV and building stronger societies prepared for future challenges.”*

Mogens Lykketoft, President of the United Nations General Assembly

### S1: Leadership, advocacy and communication

191. In 2016, the UNAIDS Secretariat focused efforts on reinforcing leadership and commitment to the global AIDS response within a changing and challenging international environment. Numerous missions and country visits were undertaken, meeting and working with Heads of State, Ministers of Health and Finance and other key government, national and civil society partners, to promote UNAIDS’ call for the acceleration of the global response, shared responsibility and global solidarity, ensuring no one is left behind. The success of this high-level work was evident in the powerful 2016 Political Declaration on Ending AIDS, adopted during the HLM on AIDS in June 2016.

Percentage of countries with HIV strategies that reflect Fast-Track	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 100% 2019: 90% 2017: 80%	<b>All: 61% [59/96]</b> <b>FT: 58% [19/33]</b>
<p>The UNAIDS Secretariat aims to establish an inclusive, results-driven global agenda for the strategic directions outlined in the UNAIDS 2016–2021 Strategy. It raises awareness, mobilizes political engagement, and advocates and builds commitment for Fast-Tracking the AIDS response to end the epidemic by 2030.</p> <p>In 2016, 61% of 96 countries with Joint Programme presence (including 19 Fast -Track countries) had HIV strategies that reflect the Fast-Track approach:</p> <ul style="list-style-type: none"> <li>▪ The country strategy reflects the population/location principle;</li> <li>▪ The country strategy adopts all 10 Fast-Track targets that apply;</li> <li>▪ The country strategy focuses on increasing the percentage of domestic funding on the AIDS response</li> </ul>		

192. Focused attention on HIV prevention and treatment was also a leadership and advocacy priority for the Secretariat in 2016. The UNAIDS Secretariat supported WHO efforts to expand access to treatment through the 90–90–90 targets and its associated work streams. It provided leadership, guidance and support for the development of diagnostic and forecasting tools to implement WHO HIV treatment guidelines and to advocate for increased treatment coverage for people living with HIV. An internal Executive Directive to all Secretariat staff was issued, pushing for the scale up of five combination prevention pillars in all countries. Furthermore, UNAIDS Secretariat announced the establishment in 2017 of a Global Prevention



Coalition, to develop roadmap towards achieving the 2016 Political Declaration on Ending AIDS targets. The Secretariat additionally worked to ensure that leadership for AIDS is empowered to shape transformative, human rights and gender equality based responses. For example, the Secretariat initiated strategic dialogue with key partners on related challenges of misuse of criminal law across population groups.

## **S2: Partnerships, mobilization and innovation**

193. Against the backdrop of significant resource constraints, in 2016 the UNAIDS Secretariat strengthened dialogue with governments, communities and other stakeholders and stepped up its partnership approach with key donors and partners. The Secretariat also made progress in engaging new strategic partners, including within the private sector and civil society. For example, the UNAIDS Secretariat engaged the private sector, academics and foundations, during an HLM side event on financing the end of AIDS, which explored practical steps to generate AIDS-related investment.

194. The Secretariat has been spearheading innovation and sustainability for advancing HIV-related human rights, including through leveraging *pro bono* legal support for Joint Programme and the AIDS response. For example, through Memoranda of Understanding with global law firms which resulted in almost half million pounds of donated legal services at local, regional and international levels.

195. The Secretariat and WHO have been key convenors of the Agenda for Zero Discrimination in Health Care, providing a joint frame for coordinated multisectoral action to end intersectional discrimination. The Secretariat supported civil society-convened events and conferences on HIV-related human rights issues (e.g. the “HIV is not a crime” training academy) throughout 2016, highlighting UNAIDS policies and related data, and supporting advocates in their efforts to promote an enabling environment for an effective response. The Secretariat supported young women’s engagement, training and leadership in global policy spaces, including the HLM Task Team, Women Deliver, CSO HLM hearing, Commission on the Status of Women youth pre-conference and HLM on ending AIDS. In 2016, the UNAIDS Secretariat and Cosponsors also focused on ensuring that the new Global Fund Strategic Framework 2017–2022 was in alignment with the UNAIDS Fast-Track Strategy to end AIDS by 2030 and the SDGs. This work supported effective collaboration and partnership, and supported the Global Fund in the development of strategic investment approaches based on the Investment Framework, as well as in efforts to operationalize its human rights and gender equality objective, including through catalytic funding.

## **S3: Strategic Information**

196. Through its extensive strategic information work, the UNAIDS Secretariat provides an evidence-based, global perspective on the HIV response, equipping decision makers with the tools to engage constructively. In 2016, the Secretariat played a key role, not only in mapping and preparing analysis of strategic information products but in highlighting areas of innovation and mapping different audiences of strategic information products.

197. Data was compiled and analyses were conducted for a number of flagship reports in 2016, including the *Do no harm global AIDS update* report, the *Prevention gap report*, the *Toward an AIDS-free generation* report and the *Life cycle approach to AIDS* report. Additional analyses were conducted to influence UNAIDS policy

positions and priority issues. For the first time the Joint Programme was able to report on progress towards the 90–90–90 targets at the regional level. An update on the investments needed to end AIDS as a global public health threat by 2030 and to finance the Fast-Track approach was developed in parallel with the UNAIDS Strategy and SDG target 3.3. This resource analysis update used the WHO 2015 ART guidelines and included the costing of a streamlined model of care which imply significant efficiencies and improved programme effectiveness, lower ARVs prices, and used updated service provision data and updated unit costs compared to the 2014 earlier estimates.

198. The strategic information contained in the *Global AIDS update report* and the projected impact and resource needs in the *Fast-Track update on investments needed in the AIDS response report* served as the basis for setting time-bound targets in the 2016 Political Declaration on Ending AIDS, the global framework for the AIDS response during 2016–2020.

*"It is a critical time to coordinate and Fast-Track the effort to end AIDS. We can contain and reverse the AIDS epidemic through a coordinated response. I strongly believe we can and must and will make AIDS history."*

Kenneth Cole, amfAR Chair and a leading fashion designer

#### **S4: Coordination, convening and country implementation support**

199. The Secretariat facilitates and coordinates support to countries, sub-national locations and cities to address gaps and programme implementation challenges in order to reach Fast-Track and HLM targets to end AIDS by 2030. Working closely with Cosponsors, partners and academia, examples of Secretariat support to countries in 2016 included:

- Identification of gaps and provision of specific solutions to challenges that impede the delivery of impactful and inclusive prevention and treatment services;
- Political and technical support to make a "case" for focus, programme optimization and accelerated service delivery;
- Prevention of and response to HIV-related human rights crises in over 20 countries by backstopping UN Country Teams and civil society partners in emergency responses;
- Data collection and reporting on UN support to governments to achieve HIV targets;
- Resource mobilization guidance - international and domestic;
- Integration of innovation in service delivery and strategic information;
- Programme sustainability and transition planning;
- Development of new guidance to implement Fast-Track in cities, outlining required actions to accelerate the HIV response and to reach Fast-Track targets;
- Formulation of Joint UN Plans for 2016 in coordinating Joint Team support; and
- External review of three Technical Support Facilities, assessment of potential alternative business models and development of the prioritization framework for technical support.

200. The Secretariat, supported by a USAID grant through the Office of the U.S. Global AIDS Coordinator (OGAC), provided support to 30 countries in Global Fund grant

request and implementation, which facilitated US\$ 1.5 billion in grant funding; supported Fast-Track actions in 35 countries for prioritized programmes, which led to the development of evidence-based strategic documents, policies and plans and the accelerated implementation of the 2016–2021 UNAIDS Fast-Track Strategy (e.g. in West and Central Africa, 11 countries were supported in developing transition and sustainability plans). This support produced the following results:

- 27 Principle Recipients and sub-recipients strengthened their capacities for effective operational and financial management of the Global Fund grants;
- 10 Country Coordinating Mechanisms improved their oversight of Global Fund grants;
- 23 countries developed new national strategic plans and/or revised existing ones in line with the 2016 Political Declaration on Ending AIDS and the Fast-Track Strategy, while two of those countries extended such planning to the subnational level covering five states/provinces;
- 13 countries conducted investment analysis at the national level and two countries conducted this analysis at the subnational level in five states/provinces, leading to policy changes such as test and offer and/or optimized investments;
- 17 countries were supported in developing concept notes for the Global Fund’s new funding cycle;
- 8 countries started innovative service delivery models (e.g. community service delivery, differentiated models of care); and
- 11 countries developed transition and sustainability plans for their HIV responses.

201. In 2016, improved cooperation between UNAIDS Country Directors and PEPFAR teams in countries helped advance joint work plans and coordination at the country level. The regional reviews of COPs convened by PEPFAR in 2016 have significantly improved dialogue between partners, thereby enhancing alignment and joint impact. Support has also been provided to the Global Fund initiative to scale up human rights programmes in 20 countries and produce evidence of health impacts, in addition to support to development of concept notes and investment cases for Global Fund support in countries as outlined above.

Percentage of countries that have a functioning Joint Team.	Targets and milestones	2016 Progress
Data source: 2016 JPMS country reports Data is currently under validation process. Final result may vary slightly	2021: 90% 2019: 90% 2017: 90%	All: 50% [48/96] FT: 73% [24/33]
<p>The UNAIDS Secretariat convenes and coordinates Joint UN Teams on AIDS and implementation of Joint UN Programmes of Support on HIV at country and regional level. This indicators measure the percentage of countries that have functioning Joint Teams and highly performing Joint Programmes.</p> <p>Half of the 96 countries with UNAIDS presence (of which 24 are Fast-Track countries) had a functioning Joint Team which has the following elements:</p> <ul style="list-style-type: none"> <li>▪ All Cosponsors present in the country are represented in the Joint Team (with the exception of World Bank which has a different working model; and</li> <li>▪ The Joint Team is implementing the Joint UN Programme of Support on HIV and AIDS.</li> </ul>		

## **S5: Governance and mutual accountability**

202. The UNAIDS Secretariat made extensive efforts in 2016 to secure the necessary resources to continue delivery of Joint Programme's shared mission, vision and strategy at a time of considerable financial constraints and pressures on the budget.

*"The unique UNAIDS model has shown that the United Nations can deliver as one, under one budget and results framework."*

Laila Bokhari, State Secretary, Ministry of Foreign Affairs, Norway

203. The Secretariat undertook an organizational repositioning process in 2016 to ensure the UNAIDS Secretariat is fit for purpose, demonstrates effectiveness and efficiency for optimal implementation of the UNAIDS Strategy, the 2016 Political Declaration on Ending AIDS and the SDGs, within a financially constrained context. Following the repositioning process, the Secretariat continues to actively monitor staffing levels and efficiencies in their deployment. The Secretariat also achieved the target of becoming an International Aid Transparency Initiative publisher in 2016.

204. Intensive engagement with Cosponsors strengthened coherence across the Joint Programme on the UNAIDS Strategy and key issues notwithstanding the difficult financial situation. The second Financing Dialogue also provided an opportunity to strengthen partnerships and dialogue with existing and potential new donors and other partners on mobilizing funding for UNAIDS.

205. The Secretariat emphasized innovation in 2016, including reducing costs. The Performance and Learning Management system was reconfigured in line with the updated performance management policy; new courses were added and ongoing training was provided to groups and individuals to complete all required phases of the performance management cycle.

206. The Secretariat's efforts on gender balance in the workplace and its emphasis on career development opportunities for women also continued to receive significant recognition in 2016. The Gender Action Plan was updated and extended to March 2018.

## Illustrations of Secretariat contributions

### *HIV testing and treatment*

The UNAIDS Secretariat provided technical support and coordinated a strategy to integrate community testing into overall testing services in line with the 90–90–90 targets and in support of WHO HIV testing guidance. It provided support for cities to Fast-Track the HIV response and strengthen service delivery; for example, in developing a protocol for implementing testing and treatment and community counselling for key populations in India.

Financial support was provided to scale up HIV testing in South Africa to achieve the “first 90” target (by 2020, 90% of all people living with HIV will know their HIV status). Project funding had two elements: preparing the new HIV testing strategy and campaign, launched in April 2016, and documenting the success and lessons learned from the previous campaign.

In addition to activities culminating in the launch of the global initiative to end paediatric AIDS, the Secretariat convened meetings and events that built on existing global forums to push the 90–90–90 agenda. During the HLM on Ending AIDS, the Secretariat convened two successful events on human resources for health and paediatrics. The AIDSinfo online resource was upgraded to include more subnational data and treatment cascades.

UNAIDS Secretariat organized three events to advance the 90–90–90 agenda for children. At a meeting in Abidjan in May 2016, African Ministers of Health endorsed a Fast-Track approach for children calling for 95% coverage of ART for pregnant women and children living with HIV by 2018. Stakeholders in paediatric HIV treatment gathered in New York for the high-level meeting and then in Durban at a special session at AIDS 2016 to launch a global push to end paediatric AIDS by 2020.

On 5 December 2016, Health Ministers from nine African countries joined UNAIDS, PEPFAR and other development partners in Geneva to demonstrate leadership in ending AIDS among adolescents and preventing new HIV infections among children by 2020 under the *Start Free Stay Free AIDS Free* framework

The rapidly expanding global commitment to Fast-Track targets, particularly in key cities and major urban areas, was endorsed in the 2016 Political Declaration on HIV and AIDS. The Secretariat convened a high-level side event attended by 160 delegates to highlight the leadership role of cities in the HIV response and showcase urban innovations to achieve the Fast-Track targets. Held in collaboration with the cities of Paris and New York, UN Habitat and the International Association of Providers of AIDS Care, and supported by MAC AIDS Fund, it brought together mayors and city leaders, civil society and partners.

The *Cities ending the AIDS epidemic* report launched during the HLM provided evidence from more than 30 cities on progress towards 2020 targets. It demonstrates the commitment and leadership role of cities and testifies to the strategies, actions and achievements in implementing the Paris Declaration. Continued political mobilization around the Fast-Track Cities initiative has resulted in more than 200 cities signing the Paris Declaration on ending the AIDS epidemic, pledging their commitment to achieving the 90–90–90 targets and addressing disparities in access to basic services, social justice and economic opportunity.

Another Secretariat side-event during the HLM—“HIV and security: past, present and future”—strengthened the HIV and humanitarian action agenda in the 2016 Political Declaration on Ending AIDS. The Middle East and North Africa Regional Office provided guidance on prioritizing essential services in countries affected by humanitarian emergencies, critical in a region experiencing humanitarian crises that are causing massive displacement of people, and consequent strains on resources and health services. The regional office is working with the Global Fund, UN agencies and other partners to position HIV within the humanitarian response in affected countries, including through the Global Fund’s special initiative, the Middle East Response.

A meeting with BRICS countries (Brazil, Russian Federation, India, China and South Africa) on access to medicines and regional trade agreements was held in Goa, prior to the high-level meeting on ending AIDS. In their declaration, leaders emphasized cooperation in research and development of local pharmaceuticals and diagnostic tools for access to safe, effective and affordable medicines.

UNAIDS Secretariat established formal liaison with the African Development Bank on access to medicines. The Africa liaison office focused on developing-country initiatives, such as China-Africa partnerships, local manufacturing and trade in medicines.

### ***Elimination of mother-to-child transmission***

A Global Plan (towards eliminating new HIV infections among children by 2015 and keeping their mothers alive) progress report documented the advances towards reducing paediatric infections, relied on the validation process led by WHO and UNICEF. The Secretariat finalized the human rights, gender equality and community engagement tool for validating eMTCT, and contributed to the work of the global validation advisory committee that resulted in four countries being validated in 2016.

The Secretariat supported Thailand’s effort to achieve certification for eMTCT, providing technical support in preparing the national elimination report. It was substantively involved in the validation process. Thailand became the first country in Asia to be certified by WHO as having eliminated MTCT of HIV and syphilis.

### ***HIV prevention among young people***

An executive directive issued at the end of 2015 provided UNAIDS staff with guidance to Fast-Track HIV combination prevention as a core priority.

In 2016, UNAIDS released *Get on the Fast-Track: the life-cycle approach to HIV*, highlighting among other things, adolescence as a dangerous time for young women.

The Secretariat organized two events focusing on the *Quarter for Prevention* message during the 2016 high-level meeting on ending AIDS and the International AIDS Conference (AIDS 2016). Those attending highlighted opportunities to increase investments for new prevention programmes and encouraged increased condom provision and education, PrEP and VMMC, along with empowering youth and key populations.

The Secretariat supported a review of 106 youth scholarship applications to the Women Deliver initiative, financially supported six, and engaged young AIDS activists and those involved in SRHR.

Youth organizations were supported to encourage young people and adolescents to take



part in the HIV response and key events, such as the HLM on Ending AIDS, strengthening their advocacy for policy change. Working with PACT, a global coalition of 25 youth networks, a youth engagement strategy was developed. Sessions at AIDS 2016 revised PACT's objectives and explored cooperation between organizations. An adolescent engagement guide and age of consent advocacy pack were developed, as well as youth participation study.

### ***HIV prevention among key populations***

During AIDS 2016, the Secretariat was recognized for its efforts to reach out to key populations and to support increased access to treatment for all. The Secretariat delivered the key populations atlas, an online tool that offers detailed strategic information on these groups. UNAIDS feedback to PEPFAR has shaped the revised approach to developing and reviewing country operational plans, strengthening PEPFAR's partnerships with countries and improving its reach to community-level organizations of key population groups.

The Secretariat prepared the flagship report *Do no harm: health, human rights and people who use drugs*, which includes newly released strategic information and key messages to advocate for an appropriate response for these groups.

The Secretariat engaged actively in the preparations for the UNGASS on the world drug problem in April 2016, including briefings with Member States. UNAIDS policy positions on HIV and drug use were reflected in statements which made specific reference to the need for "evidence-based services ... to help prevent the spread of HIV, hepatitis C, and other preventable diseases", and that "law enforcement efforts should focus on criminal organizations—not on people with substance use disorders who need treatment and recovery support services".

### ***Gender inequality and gender-based violence***

A progressive 2016 Political Declaration on HIV and AIDS for women and gender equality resulted from several initiatives, including advocacy with the International Women's Health Coalition. Guidance on Fast-Tracking HIV prevention among adolescent girls and young women, a snapshot on women and girls, and two papers (*Children, adolescent girls and young women: preventing new HIV infections*; and *Breaking the silo: empowering adolescent girls and young women to access integrated health care services*) were produced.

UNAIDS developed a compendium of concise advocacy briefs to summarize and standardize 36 country gender assessment reports, enabling national governments, civil society and affected communities to easily identify priority areas for discussion and ensure a gender-transformative response to the TB and HIV epidemics.

Collaboration with Together For Girls, the global public-private partnership to end violence against children, led to the launch of the Every Hour Counts campaign, a call to ensure post-rape care. The campaign led to a panel discussion at the 60th session of the CSW, and community representatives and rape victims speaking out on the issue. A call to action and advocacy toolkit was developed for the campaign and shared with countries for use in their own national efforts to end violence against women and girls.

### ***Human rights, stigma and discrimination***

The 2016 Political Declaration on Ending AIDS states explicitly the importance of all human rights as an objective and means to end AIDS. It contains an unqualified reference

to the applicability of human rights treaties and norms in the HIV response and a section devoted to human rights, committing states to end violence and discrimination, review and reform laws that perpetuate stigma and discrimination, and scale up human rights programmes. The strong human rights foundation is in part due to the contribution of the Human Rights Council, through panel and summary report supported by the Secretariat.

The Secretariat has continued to position human rights at the core of the AIDS response through political processes and human rights bodies. Together with WHO, the Secretariat has led the Agenda for Zero Discrimination in Health Care, which is bringing stakeholders together for coordinated and multisectoral actions to ensure that everyone everywhere is able to receive and provide health care without discrimination. The Agenda has leveraged political leadership, through the 2016 HLM to End AIDS, the Human Rights Council, the Special Rapporteur on the Right to Health, the World Health Assembly and other fora. The Secretariat and WHO also convened other UN agencies for an interagency statement on eliminating discrimination in health care, to be launched in 2017. To scale-up implementation of effective interventions, a platform ([www.zeroHIVdiscrimination.com](http://www.zeroHIVdiscrimination.com)) was created to disseminate tools to assess and address HIV-related stigma and discrimination. A virtual community of practice enhances knowledge transfer and coordination. Actions are underway in several regions to strengthen accountability and implementation of effective actions to reduce discrimination in health care.

Throughout 2016, the Secretariat supported preventing and responding to HIV-related human rights crises in over 20 countries. The Secretariat provided expertise in developing or amending laws in the Lao People's Democratic Republic, Papua New Guinea, Tajikistan and Turkmenistan.

The Secretariat coordinated the response to the human rights crisis in the United Republic of Tanzania relating to LGBTI and sex workers, and responded to human rights crises and shrinking space for Tanzanian and Indonesian civil society. It engaged with Czech public health authorities to discourage criminal charges against men who have sex with men living with HIV who had a sexually transmitted infection in the past 12 months.

The Secretariat facilitated cooperation between developing countries to advance human rights. A report was launched on the first dialogue between the Inter-American and African human rights commissions, the Office of the United Nations High Commissioner for Human Rights and UNAIDS on protecting the rights of LGBTI people.

With Secretariat support, Armenia, Belarus, the Republic of Moldova and Thailand have been validated by WHO for the elimination of MTCT of HIV and/or syphilis, with due consideration given to the absence of grave or systematic human rights abuses in eMTCT efforts and government due diligence in addressing them.

### ***Investment and efficiency***

UNAIDS Secretariat leadership focused on positioning the global HIV response in a changing and challenging international environment. Advocacy with Heads of State and Governments, Health and Finance Ministers, and other key national and civil society partners promoted bold commitments to support UNAIDS' call for an accelerated global response, shared responsibility and global solidarity.

Fast-track and strategic investment approaches for domestic and international spending were developed. The Secretariat estimated resource needs and identified appropriate

options for sustainable financing schemes. It made extensive efforts to secure resources to fund the UBRAF, and continues to work on financial sustainability, transition and efficiency planning, including allocative and technical efficiency in countries. It also supports development and analysis of investment cases and transition assessment tools.

To strengthen and assess the effectiveness, efficiency, relevance and sustainability of UNAIDS in eastern and southern Africa, an evaluation has been initiated in collaboration with the Swedish International Development Cooperation Agency.

The Joint Programme brings an evidence-based, global perspective to issues, helping decision-makers focus HIV programmes on approaches that will reach those most affected by the epidemic and have the most impact. The Secretariat played a key role in preparing and analysing strategic information products, highlighting areas of innovation, and mapping their audiences. A proposal on innovation and exploration of resource mobilization options, including new approaches and funding sources was developed. Other innovations, including on reducing costs, such as UNAIDS apps and the contact system, UNAIDS Connect.

Other examples of innovation in the area of strategic information include proactive data analysis, new tools, shifting focus to measuring impact, developing scenarios and using granular programme data. In-kind contributions via crowdsourcing were secured to develop a dashboard for visualizing global AIDS monitoring indicator data in an online tool. UNAIDS situation rooms in Geneva and Kenya were used for a real-time data approach and gap analysis, using service delivery statistics in countries (e.g. District Health Information System 2). The Secretariat also worked with the private sector to integrate community data into national monitoring and evaluation systems and situation rooms.

The Secretariat coordinated the development of proposals from six cities to Fast-Track the HIV response and to strengthen service delivery.

### ***HIV and health services integration***

The Secretariat leveraged UNAIDS' role in Pink Ribbon Red Ribbon (the partnership to expand the availability of cervical cancer screening, treatment and breast care education, especially for women living with HIV) as a leading example of how the AIDS response can be a force for integrating and improving women's health. The Secretariat expanded its gender-related work with the Together for Girls organization, with a focus on sexual violence against girls.

UNAIDS Secretariat led the development of a social protection assessment tool, triggering HIV and social protection assessments in six African countries and the initiation of operationalization of social protection targets.

The Secretariat produced a document on Fast-Tracking social protection to assist governments, policy-makers, and social and development practitioners intensify efforts to integrate HIV and social protection to end AIDS.

The Secretariat also supported mainstreaming HIV into social protection programmes, particularly access for people living with HIV and key populations. In Cambodia, it worked to increase advocacy by people living with HIV and key populations on access to information, quality health, social protection services and human rights. In Zambia, with UNAIDS assistance, HIV-sensitive social protection services were introduced and social

cash transfers to adolescents piloted in four districts.

## **Challenges and key future actions**

207. Fast-tracking the response in order to end the AIDS epidemic by 2030 requires that we keep pace with a fast-changing world. This includes responding to the difficult resource context; bringing AIDS out of isolation; addressing complacency and lack of prioritization, increasing conservatism, continuing discrimination, shrinking space for civil society, insufficient access to services and commodities; and suboptimal use of data and evidence. The 2030 Agenda for Sustainable Development rests on a commitment to leave no one behind. Governments pledged to reach each goal and target “for all nations and peoples and for all segments of society” and to “reach the furthest behind first”. The future actions articulated below focus on rising to the challenges in front of us. Reaching the unreached requires overcoming legal, policy and regulatory barriers, social barriers (including stigma and discrimination that too often keep people living with HIV, and in particular key populations, in the shadows) as well as capacity barriers (challenge of scaling approaches to reach all in need), all of which hinder access to services.

208. Building on the UNAIDS 2016–2021 Strategy and recommendations of the Global Review Panel, the Secretariat’s key future actions in response to each challenge are briefly set out below. Six transformational shifts set out in the UNAIDS Strategy underpin our approach: (1) front-loading investments; (2) focusing on the locations, populations and interventions that will deliver the greatest impact; (3) catalyzing innovation for people who need it most; (4) leveraging global and regional political institutions and leadership for more targeted, sustainable and accountable responses; (5) launching a new era of intersectoral partnerships to address the determinants of vulnerability, including discrimination and gender inequality; and (6) recommitting to the GIPA principle (greater involvement of people living with HIV) and people-centred accountability.

### ***Keeping pace with the world***

209. In order to keep up with the scale and pace of change in today’s world, the Secretariat will focus on adapting what it does (as set out in the UNAIDS 2016–2021 Strategy) and how it works (in line with recommendations set out in the Global Review Panel).

210. Two monumental demographic shifts have taken place in recent years that pose challenges and opportunities in the AIDS response: urbanization and the youth bulge. Over half of the global population now lives in cities. Meanwhile, there are more young people between the ages of 10 and 24 today than at any other time in human history and almost 9 out of 10 of them (89%) live in less developed countries. In the world’s 48 least developed countries, most people are children (under age 18) or adolescents (ages 10 to 19 years).

211. The approach of the Secretariat reflects this changing reality. With a strong focus on population and location, the Secretariat is developing and promoting tools that help to focus the response on areas and populations where incidence is highest and programme gaps are largest. This involves galvanising action at the city level and mobilising networks of city leadership globally to advance the response and end the AIDS epidemic in their cities. Regarding the youth agenda, UNAIDS is continuing to engage young people in the response and will strengthen and support young

people's organizations and networks to tackle the root causes that keep putting young people at risk of HIV, through three pillars of action: challenging harmful policies, advancing youth participation in decision-making and community responses, and strengthening our partnerships, through decentralized coordination, use of social media, crowdsourcing technical expertise, and crowd-funding.

212. The Secretariat will focus on supporting countries to remove barriers to implementation, and on connecting and convening coalitions of communities, governments, health providers and the private sector to promote diverse participation in the processes to scale up evidence-based interventions and deliver innovations that have impact, including in HIV prevention technologies, in HIV testing methods, such as peer-assisted testing and self-testing, and the scale up of advanced service models. The Secretariat will work with countries to drive progress towards the 90-90-90 treatment targets and scale-up prevention efforts including through the Global Prevention Coalition and the *Start Free Stay Free AIDS Free* partnership. The Secretariat will convene a broad range of partners to address intersectional discrimination and cross-sectoral structural determinants, as misuse of criminal law.

213. To achieve these objectives the Secretariat will support countries to innovate HIV service delivery, through diverse means such as the use of modern information technology, and community-led service delivery, and it will promote transferable lessons of the AIDS response in the context of the SDGs. Lastly, the Secretariat will strengthen its advocacy for the continued development and rapid implementation of effective HIV-related medicines and technologies, and ensuring their availability, accessibility, quality and affordability.

### **Resources**

214. Insufficient human and financial resources limit the ability of the global community to meet anticipated needs in the response. The UNAIDS Strategy sets the broad direction of travel with these two result areas: AIDS response is fully funded and efficiently implemented based on reliable strategic information; and people-centred HIV and health services are integrated in the context of stronger systems for health. Front-loading investments until 2020 will enable the world to ensure a sustainable AIDS response. To close the funding gap, the Secretariat will take a multi-pronged approach. Notably, the Secretariat will: advocate for increased domestic resources and increased targeted international financing; mobilize partnerships for innovative, new sources of financing and integration in national financing schemes (eg. UHC, social protection programmes); promote the use of global resource needs and generate updated estimates to inform country and global responses; and support countries to develop transitional plans and remove bottlenecks [financial management] for gradual transition to domestic financing (in countries where applicable).

215. The Secretariat will support efforts to improve strategic investment decisions and implementation efficiencies to achieve sustainable country results, in collaboration with key partners, including the World Bank, the Global Fund and PEPFAR.

216. The Secretariat will strengthen its efforts to optimize effective and efficient AIDS responses at national and sub-national level, including through: (1) influencing strategic investments, effective and efficient NSPs, including impact assessments; (2) promoting increased capacity and scale through efficiency and innovative service delivery; and (3) integrating financing targets in sustainability frameworks.

217. Furthermore, the Secretariat will sharpen its focus on systems for health. If the world is to double the scale of the response, systems for health must be strengthened, with enhanced models of community response and service delivery. The AIDS response has highlighted the need for community health workers to improve and sustain health care access. UNAIDS is working to help mobilize efforts to create 2 million community health worker jobs in Africa, an effort that will have an impact far beyond the AIDS response.

### ***Complacency and prioritization***

218. There is a common perception that the AIDS epidemic is no longer an urgent global health challenge. With a slew of global challenges to overcome and new crises emerging constantly, AIDS is part of an overcrowded and underfunded sustainable development space. When resources do go to the AIDS response, they are not always prioritized in the most effective way that will lead to the strongest results.

219. The UNAIDS Secretariat will continue to refine and strengthen its messaging and communications, striking a fine balance between hope (ending the AIDS epidemic is possible) and reality check (AIDS is not over and huge amounts remain to be done). The Secretariat will highlight and bring to scale community responses and reinvigorate GIPA at the core of its work and communications. The Secretariat will do more to highlight critical challenges and where we are failing and need to do more, bringing data to highlight gaps and combat denialism. We will do more to use data to underpin political advocacy to mobilize new leadership.

220. The Secretariat will catalyze leadership from a broad range of sectors to address links and build political urgency and multisectoral coalitions for action. It will bring together actors from governments, civil society, the private sector, as well as elected officials and others to share lessons and help others build responses around the SDG agenda.

### ***AIDS out of isolation***

221. While significant progress has been made, the AIDS response needs to further adapt to and integrate itself within the SDG environment. Simultaneously, critical elements of the AIDS response must be embedded into the wider health system (e.g. in UHC initiatives, action to address AMR) and inform approaches to emerging epidemics and broader sustainable development (e.g. education, social protection, labour, justice, etc).

222. The UNAIDS Secretariat is making efforts to both integrate ending AIDS as part of the SDGs and to bring lessons from the AIDS response to spur progress on the SDGs. Key actions include: promoting collaboration across national health programmes for integrated service delivery and for policies that support such links; promoting the integration of HIV care with primary health care services as well as with sexual and reproductive health, maternal and child health, and STIs and NCDs; calling for multisectoral action to tackle stigma and discrimination in health care; advancing national plans to decentralize and bundle services for TB, hepatitis, mental health and other health issues, as well as procurement; supporting countries' capacity to roll out such integrated interventions; guiding integration of food and nutrition support with HIV and TB treatment and HIV, hepatitis and TB services with harm-reduction strategies for people who inject drugs. For example, the UNAIDS Secretariat is strengthening collaboration and coordination with the Stop TB Partnership—particularly on high-level advocacy, political leadership and accountability—to advance integrated approaches, sustainability, country ownership

and domestic funding to address both diseases in national and regional plans and strategies and Global Fund processes.

### ***Suboptimal use of data and evidence***

223. The suboptimal understanding and use of the power of data and evidence to drive results is stalling progress in the response. UNAIDS is home to the most extensive and disaggregated data collection available on the HIV epidemic and its response. The UNAIDS Secretariat will continue to build evidence and provide technical expertise to help decision-makers, programme managers and funding partners in achieving maximum impact toward the UNAIDS Strategy targets.
224. The Secretariat will focus on improving the use of data by enhancing capacity-building support to significantly increase the availability of high-quality, timely and reliable data that are disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts. It will support countries to collect and use information on the epidemic and response to produce results (with attention to humanitarian emergency contexts, given the challenges in obtaining accurate data on AIDS HIV responses in such settings). UNAIDS will work to strengthen capacity at national and sub-national levels, including reinforcing and enhancing capacity in Fast-Track countries, to routinely use the available data for policy and programme development, implementation and management.
225. The Secretariat will promote comprehensive and evidence-based responses to address the “Three Zeroes” through NSPs and investment cases. It will work with countries to influence and shape Global Fund grants, and to ensure that strong data and evidence underpin the alignment of Global Fund grants and major bilateral programmes, and support achievement of national Fast-Track targets.
226. The Secretariat will contribute to the development of new evidence and the formulation and rapid introduction of new guidance in country programming. The Secretariat will promote and develop new approaches to data analysis and its use for programme policy, design and implementation. On the data collection side, the Secretariat will promote innovations including collecting sub-national and facility-based data, developing evermore granular epidemiological estimates and increasing the availability of real-time data through community monitoring and the use of new technologies such as crowdsourcing.
227. The Secretariat will further advance its strategic investment approach, providing countries with the tools and analytical support to ensure optimal resource allocation in accordance with the epidemic priorities and to maximize multiplier effects across broader health and development issues. The Secretariat will support countries to conduct allocative efficiency analysis and guide the implementation of recommendations to reduce costs and enhance the reach and impact of HIV prevention, treatment, care and support activities. There will be continued engagement with the Global Fund Board and Secretariat to define and implement strategies, policies and approaches informed by strategic information and Fast-Track guidance provided by UNAIDS.

### ***Increasing conservatism, and prevalent stigma and discrimination***

228. While on the one hand, governments have made commitments to eliminate inequalities and discrimination as preconditions for achieving the SDGs, simultaneously there are regressions in advancing human rights in many parts of the



world. There is an increasing focus on national sovereignty, while various cultural, religious and public security arguments are used to justify discrimination, and encroachment on rights and freedoms. Discrimination in health care settings occurs in all countries and takes many forms. It violates the most fundamental human rights protected in international treaties and in national laws and constitutions and often disproportionately affects marginalized and stigmatized populations.

229. The Secretariat will continue to convene a broad range of partners for comprehensive multisectoral responses challenging entrenched stigma and discrimination. It will place particular focus on eliminating discrimination in health care, including by supporting stronger routine monitoring of stigma and discrimination in health care settings, engagement of communities in accountability mechanisms, as well as evidence-informed programmes to eliminate discrimination and reduce stigma in health care (e.g. Thailand's experience now being replicated in Lao PDR, Myanmar and Viet Nam). To improve the availability of data about the experiences of discrimination among people living with HIV, as well as the empowerment and meaningful participation of networks of people living with HIV in responding to these challenges, the Secretariat will continue to support the roll out of the revised Stigma Index. The Secretariat will enable the critical contributions of communities, civil society organizations, professional healthcare associations, faith-based organizations in eliminating discrimination in health care. The Secretariat will also continue to document and share evidence of negative impact of stigma and discrimination, and of programmes that work as well as existing partnerships and efforts, for a cohesive evidence-informed response. Advocacy for accountability for discrimination in health care will continue to be a priority for the Secretariat.
230. In recognition that the Fast-Track approach requires putting human rights principles, into practice, the Secretariat will support implementation of its guidance, and will support the roll-out of Global Fund catalytic funding for scaling up the UNAIDS-recommended key programmes to reduce stigma and discrimination and increase access to justice. The Secretariat technical guidance on gender-sensitive AIDS responses, and its support to programmes for and by key populations will be translated into action via the respective catalytic funding streams of the Global Fund.
231. The Secretariat will continue to convene the Joint Programme and partners, and to support civil society in responding to HIV-related human rights crises. It will catalyze efforts across movements to address the misapplication of criminal law that impedes access to services, and will support the links between science and law for enhanced legal and policy reform, and access to justice. The Secretariat will also continue fostering partnerships with private law firms and universities to leverage innovative and sustainable access to justice strategies in HIV-related cases.
232. The Secretariat will continue to speak out for and work with marginalized communities to identify their needs and ensure that AIDS responses are tailored to them. It will assist governments, civil society organizations and other HIV actors in addressing diverse gender and human rights issues in national HIV, human rights and gender plans in all countries. The Secretariat will intensify political advocacy on human rights, legal and policy reform to change perception of and policies on key populations, and will reinvigorate engagements with the United Nations human rights bodies, as well as regional and national human rights mechanisms, for stronger accountability.

### ***Shrinking space for civil society***

233. Linked to the increase in conservative rhetoric and policies, the space in which civil society operates is being restricted in many parts of the world. Silencing these voices and preventing their constructive engagement in policy-making and programme implementation will do serious damage to the AIDS response and will undermine the world's ability to deliver on the Agenda 2030. As recognized in the 2016 Political Declaration on Ending AIDS, civil society continues to have a central role in ending the AIDS epidemic.
234. In response to this challenge, the Secretariat is working to further enable civil society partners (including community and grassroots organizations led by people living with HIV and other key populations, women, young people and faith-based actors) to take central parts in designing, implementing and monitoring the response. Enabling civil society partners to play these roles requires support in the realms of funding, capacity building, service delivery and more.
235. With regard to funding, the Secretariat will advocate for strategic funding for civil society to perform their crucial documentation of impact, advocacy, strategic information gathering, demand creation and service provision roles. It will work with partners to build and strengthen policies, systems and mechanisms for sustainable public sector financing of civil society and communities. The Secretariat will support community systems strengthening through Global Fund grants for service delivery scale up and to enhance quality of care. It will support policies and processes that allow for domestic resources to be allocated to civil society, including through social contracting.
236. In terms of capacity building and expanding space for civil society participation, the Secretariat will increase its support for organizational capacity building and informed participation in decision-making platforms at the global, regional and national levels. The Secretariat will continue to nurture and grow the engagement of young people. It will work with IPPF and the PACT to provide young people with the tools and knowledge to enable them to create youth-generated evidence for advocacy on policy reform. This is one element of a broader effort the Secretariat will undertake to support civil society in tracking and monitoring progress against the 2016 Political Declaration on Ending AIDS.
237. The Secretariat will support the establishment and strengthening of systems, structures and processes to provide space and enable civil society and communities (including the most marginalized) to engage as equal partners in country and donor policy and programmatic processes, both in the AIDS response and in broader health and development. The Secretariat will also address crises faced by key populations in a timely and effective manner, including cases of human rights crises.
238. The Secretariat will foster collaboration between civil society and governments to identify, adapt and scale up innovative models of community-based, community-led service delivery, including through social contracting as a mechanism to get resources directly to communities. The Secretariat will advocate for the professionalization of civil society and community-based organizations as service providers and support regulatory frameworks that allow for decentralization of health services.
239. Furthermore, the Secretariat will bring its convening role to link movements and forge new alliances for stronger collective results across the SDGs. The Secretariat will strengthen well-established collaborations and develop new partnerships with

complementary movements when possible. For example, it will work with stakeholders responding to the increasing burden of noncommunicable diseases in order to provide new opportunities for joint efforts that address the links between HIV, noncommunicable diseases and ageing. UNAIDS will leverage momentum and consolidate commitment by supporting regional and global platforms that bring together young women, governments, women's rights organizations, women living with HIV, and the wider AIDS and women's movements.

***Reaching people left behind***

240. Ending the AIDS epidemic will be impossible if people continue to be left behind. The 2030 Agenda is underpinned by a commitment to reach those people who are furthest behind first and this approach must be operationalized in the AIDS response.

241. Highlighting communities' role as leaders in the response, the Secretariat will collaborate with networks of communities that are being left behind, in particular people living with HIV and other key populations. It will aim to identify priority areas for advocacy, as well as innovations in service delivery that can be adapted from context to context and scaled up. The Secretariat will foster collaboration between civil society and governments to identify, adapt and scale up innovative models of community-based, community-led service delivery. It will pay particular attention to service models that are tailored to reach people and communities that are left behind. The Secretariat will mobilize networks to expand community- and facility-based care as an essential component of rapidly scaling up service delivery and support the collection of data. This work will include support for developing best practice models of service delivery and support to address bottlenecks at the community level, such as transforming gender norms and ending gender-based violence. UNAIDS will support strengthening legal frameworks to enable communities to engage legitimately in service delivery.

## REGIONS

### Asia and the Pacific

#### Achievements

##### *HIV testing and treatment*

242. Tailored technical support was provided to countries by WHO and the Joint Programme, for the adoption of the latest WHO guidance to treat all, irrespective of CD4 count, as well as for scaling up innovative HIV testing approaches, including community based testing. Currently, almost all countries in Asia and the Pacific have adopted the WHO “Treat All” guidelines, with India, Indonesia, Papua New Guinea and Viet Nam expected to revise their national protocols soon. China, India, Nepal, Philippines, Thailand and Viet Nam have additionally updated their HIV testing guidelines to include community-based testing by lay providers.

#### Support to Fast-Track Countries

Three Fast-Track priority countries in Asia and the Pacific (China, India and Viet Nam) have established community-based HIV testing pilot sites, with Joint Programme technical support.

243. The UNAIDS Secretariat and WHO regional offices also provided technical support for the assessment and strengthening of case-based surveillance systems to support 90–90–90 cascade monitoring in Indonesia, Myanmar, Papua New Guinea, Philippines and Viet Nam.

##### *eMTCT*

244. In 2016, WHO, the UNAIDS Secretariat and UNICEF supported the validation of eMTCT in Thailand, which became the first country in Asia and the Pacific to be certified for eMTCT of HIV and syphilis. In September 2016, WHO, UNICEF and the UNAIDS Secretariat extended support to China for the National Consultation on the Triple Elimination of MTCT of HIV, Syphilis and Hepatitis B, and supported efforts for eMTCT validation in Maldives and Sri Lanka, as well as initial discussion on subnational level elimination in India. A Progress Review Report and Road Map towards the eMTCT of HIV and syphilis was finalized and shared with partners, while technical support was also offered to countries on scaling up access to early infant diagnosis.

*"By investing in strong maternal and child health care and national AIDS prevention measures, Thailand has demonstrated there are ways to protect children from the global AIDS pandemic response. Thailand's achievement inspires its neighbours to greater action. There are still 21 000 infants who are born with HIV each year in the Asia-Pacific region, and more than 200 000 children who are growing up with HIV."*

Karin Hulshof, Regional Director, UNICEF East Asia-Pacific Region

##### *HIV prevention among key populations*

245. Together with the UNAIDS Secretariat, UNODC developed and launched the regional Trainer's Manual on Community-based Services for People Who Use Drugs, providing community workers with skills to engage in outreach and service provision among people who use drugs, from harm reduction services to screening and

assessment for dependency. UNAIDS Secretariat also partnered with UNODC to document community-level interventions and strategies that support transition away from the use of compulsory detention in selected countries in Asia.

#### *Gender inequality and gender-based violence*

246. Throughout the region, numerous activities were conducted in 2016 to prevent sexual and gender-based violence, notably by strengthening community-based protection and engaging all actors to end violence against women. UNESCO published the Connect with Respect curriculum tool for teachers to address gender-based violence in schools, together with Plan International, UNICEF, UN Girls' Education Initiative,

#### **Training of trainers for women living with HIV leaders**

A regional training of trainers among leaders of women living with HIV networks from China, Indonesia, Thailand and Viet Nam was conducted by the Joint Programme in 2016, with further country-level training, mentoring and coaching support provided in China, Indonesia and Viet Nam.

UN Women and UniTE. A regional consultation was also convened by UNFPA, UNESCO, UNICEF, UN Women and WHO, to discuss the importance of integrating gender and power into CSE advocacy and programming and protecting children and adolescents from child marriage and gender-based violence. UN Women and the International Community of Women Living with HIV additionally developed

the "International Community of Women Living with HIV Feminist Leadership School Programme" to strengthen feminist leadership and advocacy skills among women living with HIV. UNDP, in partnership with the Asia Pacific Network of People Living with HIV (APN+) and the UNAIDS Secretariat, supported initiatives in Nepal and Cambodia to empower women and people affected by HIV to protect their rights in health care settings. UN Women, together with UNFPA, the UNAIDS Secretariat and UNDP, additionally developed and disseminated a regional policy and programme guidance *HIV and gender-based violence: preventing and responding to linked epidemics in Asia and the Pacific*.

#### *HIV prevention among young people*

247. The Asia-Pacific Inter Agency Task Team on Young Key Populations, which includes UNICEF, UNESCO, UNFPA and the UNAIDS Secretariat, supported mentorship programmes to address young people's lack of opportunities to participate effectively in national AIDS responses. The UNAIDS Secretariat and UNICEF also supported Youth Voices Count's "Ignite" mentorship programme for young gay and other men who have sex with men and transgender persons, enabling young mentees from nine countries to access grants for small-scale projects in their countries. The IATT has developed and piloted a legal advocacy toolkit that aims to capacitate youth-led and -serving civil society organizations to understand the legal and policy barriers that young people face in accessing SRHR services and advocate for their removal.

#### *HIV and health services integration*

248. By financing and supporting programmes that focus on the multisectoral determinants of HIV, such as education, gender and HIV-sensitive social protection, the World Bank supported institutional development and capacity building for the HIV response, with increased access to health and social protection services for people living with HIV and most at risk of acquiring HIV. In 2016, the World Bank was financing 27 health system strengthening projects and 10 social protection projects in the region.

*Investment and efficiency*

249. The Economic and Social Commission in Asia and Pacific and the UNAIDS Secretariat undertook a Comparative Analysis of Selected National AIDS Investment Cases in Asia and the Pacific. National partners are using this to inform their work to increase domestic financing and the efficient use of resources, particularly on prevention programming for key populations. It has also informed the development of a regional initiative by the Asia-Pacific Coalition on Male Sexual Health “Sustainable HIV Financing in Transition (SHIFT)”, including the identification of project sites and countries.

*Human rights, stigma and discrimination*

250. The UNAIDS Secretariat, UNFPA and UNDP provided country-level technical assistance to create more enabling legal environments, including in China, Indonesia and Pakistan, where punitive laws continue to hamper the AIDS response. In addition, they supported multistakeholder dialogues on HIV, the law and/or legal environment assessments. This work resulted in proposals for legal and policy reforms to strengthen HIV responses, revisions to address legal barriers and strategies to strengthen implementation of protective laws. A sub-regional training by UNDP and the Asia-Pacific Forum of National Human Rights Institutions helped to build the capacity of Human Rights Commissions and civil society representatives from six countries in South Asia to protect the human rights of key populations, and will be expanded to South-East Asia and the Pacific in 2017. With UNDP support, “The Time Has Come” training package, developed jointly with WHO to reduce stigma and discrimination against LGBT people in healthcare settings, was adopted into national HIV training programmes in 6 countries: Bhutan, Indonesia, India, Nepal, the Philippines, and Timor-Leste. UNDP-supported trainings of trainers in 12 countries, reaching 400 health care providers in 2016 and almost 1,500 since 2014.

**UNHCR’s harm reduction work in Pakistan**

In coordination with other Cosponsors, UNHCR has taken advantage of its presence in the field to support development and implementation of local innovative initiatives. For example, in Quetta, Pakistan, a long-standing UNHCR partner providing harm reduction and detoxification services to PWIDs initiated a wide range of actions to address HIV-related stigma and discrimination in healthcare. The establishment of a detoxification centre in Quetta city reached 9,354 PWIDs with HIV testing services and distributed 71 840 syringes and 79 818 condoms.

**Challenges**

251. Chronic bottlenecks that continue to hamper the scale-up of effective programmes include the criminalization of key populations, stigma and discrimination (particularly in health care settings), lack of innovation in service delivery, and the slow pace of adapting and introducing new technologies. Punitive approaches by some governments and shrinking civil society space are also hindering progress on the rights of key populations. This is limiting the capacity of key populations to mobilize funding for rights and evidence-based responses to AIDS, as well as hampering their meaningful engagement in policy and programme processes.

252. Programmes targeting key populations are still heavily dependent on external funding. Safeguards need to be in place and a strong investment in capacity building and technical assistance for resource mobilization is required to manage declines in international funding. Efforts are required to respond to young people’s poor knowledge on HIV prevention and inaccessibility of health services. Parental consent and harmful social norms act as an additional barrier for access by young people to

HIV, SRHR and harm reduction services in many countries. Also, underlying gender barriers need to be addressed to scale up and reach women and girls in need of services. Recent analysis showed that the proportion of new infections among low risk populations is growing in several mature epidemics.

*"We understand that the fight against AIDS requires concerted efforts from the whole of society — especially the media. We have a key role to play to ending AIDS."*

Cai Mingzhao, President of Xinhua News Agency,  
holder of the UNAIDS Leaders and Innovators Award in recognition  
of his leadership as a media partner and his contribution to the AIDS response

### **Key future actions**

253. The Joint Programme will undertake the following future actions:

- Explore social media as a platform to further reach young key populations with HIV prevention information and linkage to service delivery;
- Develop a how-to tool in integrating HIV services into the essential package of services of national UHC schemes;
- Seek to introduce and scale up new service delivery models, including community-based HIV testing, active case finding and management, differentiated care model as well as community-based treatment alternatives and services for people who use drugs;
- Continue to advocate and offer technical support for the reanimation of combination prevention, including introduction of PrEP to ensure effective responses especially among MSM;
- Together with the UNODC and other relevant Cosponsors, continue to promote a health centred and human rights-based approach to drug policy, and promote the right to services for people who use drugs.



## 2016 expenditure for Asia and the Pacific

Organization	Core expenditure (in US\$)	% Fast-Track countries	Non-core expenditure (in US\$)	% Fast-Track countries
UNHCR	176 250	70%	1 868 110	22%
UNICEF	527 184	46%	6 767 038	46%
WFP	142 079	38%	1 293 500	25%
UNDP	451 919	30%	3 324 876	70%
UNDP GF Grants			7 190 611	0%
UNFPA	520 312	33%	1 502 492	68%
UNODC	717 984	89%	276 638	47%
UN Women	261 094	67%	1 774 335	51%
ILO	369 430	86%	828 022	91%
UNESCO	391 387	82%	2 100 634	67%
WHO	1 242 649	59%	7 794 817	49%
World Bank	869 292	83%	1 638 902	68%
Secretariat	13 073 208	42%	5 937 909	61%
<b>Grand total</b>	<b>18 742 788</b>		<b>42 297 884</b>	

## Eastern and southern Africa

### Achievements

#### *HIV testing and treatment*

254. During 2016, the Joint UN Regional Team on AIDS in East and Southern Africa supported the roll-out and implementation of the 2015 WHO HIV Testing and Treatment Guidelines in all 21 eastern and southern Africa countries, with 14 Fast-Track countries in the region implementing the 2015 guidelines by end of 2016. Ten countries were additionally supported to further domesticate and accelerate roadmaps on paediatric and adolescent treatment. Advocacy for innovative approaches in HIV testing was also carried out, with promising practices identified in the region.

#### **UNICEF provides technical support in East and South Africa**

UNICEF East and Southern Africa Regional Office provided technical and programming support to Ethiopia, Kenya, Malawi, Mozambique, United Republic of Tanzania, Uganda and Zimbabwe on point-of-care diagnostics, including south-south exchanges and learning, review of the national point-of-care plan in Kenya and support for the development of an implementation toolkit for countries.

255. Eastern and southern Africa experienced a severe drought in 2015—2016, with the El Niño-induced drought phenomenon adversely affecting the health and food

security of the region's population. People living with HIV were particularly affected, as shown by the high ART default rates (up to 32% in Malawi) and the increases in malnutrition (up to a four-fold increase for moderate malnutrition in the first quarter of 2016). The 2016 Lesotho Vulnerability Assessment Committee report showed that 9.1% of people living with HIV were moderately underweight and 8.4% severely underweight. In response to these El Niño effects and the gaps in addressing the food security-related needs of the people living with HIV, the WFP intensified its programmes to address food security of vulnerable populations including those affected and living with HIV.

#### eMTCT

256. *Start Free Stay Free AIDS Free* brought together a coalition of partners in 2016 to build on progress achieved under the *Global Plan towards eliminating new HIV infections among children by 2015 and keeping their mothers alive*. The Joint Programme convened experts and implementers from 20 countries in the region to share knowledge and drive further acceleration of Option B+, supporting 15 countries with national PMTCT reviews and/or development of post-Global Plan strategies. Seven countries were supported to improve understandings of the link between PMTCT and drought, and strengthen their programming in response. The World Bank supported nine concessional lending operations in the region, focusing on reproductive, maternal, newborn and child health and PMTCT, using results-based financing to improve the utilization and quality of reproductive health services, including PMTCT. UNICEF and WHO also co-convened a regional meeting on Option B+ to support country delegations to review and consolidate learning on Option B+ implementation. UNICEF supported the planning, implementation and country participation for this meeting, and shared the outcomes with all 21 Country Offices in the region

#### HIV prevention

257. Under the "All In" Initiative, partners provided technical and coordination support to 10 countries to complete data assessments that influenced national HIV and adolescent policies and programmes, including prevention for at-risk adolescents and young people. Agencies were successful in supporting country teams and governments to organize the first annual adolescent and young people consultations on HIV and other adolescent and young people issues. The Joint Programme, including UNESCO, the UNAIDS Secretariat, UNFPA, UNICEF and RECs, additionally supported the implementation of the ESA Commitment, an important platform for advocating for positive health outcomes for young people in the region. In November 2016, Members of Parliament from the region committed to complementing the work of national Ministries of Education, Youth and others.

258. The UNFPA Regional Office commissioned a multicountry study to assess the applicability of the total market approach to allow commodities, including condoms, to be specifically targeted. Targeting would ensure "free-to-user" public sector condoms reach the socially excluded urban and rural poor; socially

#### Condom manufacturing familiarization tour by UNFPA and UNAIDS Secretariat in Botswana

UNFPA Johannesburg (East and Southern Africa Regional Office), in partnership with the Botswana Country Office, conducted a familiarization tour to a condom manufacturing company based in Gaborone, Botswana. The company has since been connected to UNFPA Procurement Service Branch for possible entry into the prequalification programme. Efforts to have a South African-based condom manufacturing company pre-qualified are at an advanced stage, in a bid to improve availability of condoms in the region.

marketed and other subsidized condoms go to the populations that can afford cost-sharing and commercial condoms go to those that can afford to pay for higher price. This work requires realignment of supply chain management. Studies were completed for four countries in 2016 (Kenya, Madagascar, the United Republic of Tanzania and Uganda).

#### *HIV prevention among key populations*

259. In partnership with the African Sex Worker Alliance, the Joint Programme convened a South-South capacity building programme to accelerate effective country-level programme management and implementation for sex workers in the region. The meeting focused on strategies to accelerate the roll out of SWIT. The Joint Programme supported the examination and documentation of the rise in regular and irregular migration across the region, highlighting the need for a tailored response to meet changing risk profiles.

#### *HIV prevention among young people*

260. Together with UNFPA, the UNAIDS Secretariat, WHO and UNICEF supported countries to better understand the situation of adolescents and HIV. The assessments have supported countries to mobilize around adolescents and HIV, assess programming effectiveness for adolescents and young people at-risk of HIV and adolescents living with HIV. In Ghana, WFP and UNFPA are working towards the inclusion of adolescent sexual and reproductive health in the take-home rations for girls, with the aim of improving girls' attendance and education outcomes.

#### **UNICEF programme for young key populations**

UNICEF strengthened programming for young key populations in eastern and southern Africa, collecting evidence in Kenya, Malawi and the United Republic of Tanzania, and integrating young key population interventions with broader adolescent programming. In Indonesia, the Network of Young Key Populations expanded the HIV-LOLIPOP (Linkages of Quality Care for Young Key Populations) demonstration project in three further sites, addressing parental consent barriers.

#### *Gender inequality and gender-based violence*

261. The Commission on the Status of Women has been instrumental in promoting women's rights and shaping global standards on gender equality and the empowerment of women. The groundwork, extensive lobbying and convening mandate of the Joint UN Regional Team on AIDS in ESA resulted in a unified and balanced approach among Southern African Development Community Member States at the Commission on the Status of Women@60, including the presentation and adoption of the SADC Resolution.

#### *Human rights, stigma and discrimination*

262. The Joint Programme (including UNFPA, UNICEF and UNDP) focused on strengthening leadership in the region by scaling up political engagement to address human rights violations, gender-based inequity, gender-based violence, harmful social norms and other structural barriers hampering access to HIV testing services, treatment and other services. Strategic partnerships were established with countries and regional institutions, leading to the development of a study on human rights and HIV. This high-level political engagement culminated in the adoption by SADC Parliamentarians of a Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage. UNDP supported the writing of the position paper on the bill, reviewed the final draft bill, and was invited to make remarks at the

launch of the Act in Maseru at the SADC Parliamentary Forum. Constructive engagement on controversial and sensitive matters was further promoted through a human rights regional think tank.

*“The Kenyan government, in partnership with UNAIDS and other development partners, is committed to the Fast-Track approach to ending AIDS as a public health threat by 2030. We must catalyse investments across different sectors, with a focus on cost-effective and socially inclusive programmes, if we are to succeed.”*

Cleopa Mailu, Kenya’s Cabinet Secretary for Health

### *Investment and efficiency*

263. One of the main results for 2016 has been the publication of the eastern and southern Africa Sustainable Finance Analysis, for which the groundwork commenced in 2015. Individual countries will use this analysis as a framework to develop an Action Framework for minimum implementation of better service delivery for people on the ground, ensuring no one is left behind.

#### **World Bank’s Optima allocative efficiency studies**

The Joint Programme, led by the World Bank, completed several Optima allocative efficiency studies in Malawi and Zambia in 2016, as well as an allocative efficiency study for the city of Johannesburg and analyses of the HIV care cascade. A TB allocative efficiency study was also launched in South Africa.

### *HIV and health services integration*

264. Support was provided to institutionalize and scale-up SRH-HIV integration in 2016, leading to an end of programme evaluation that indicated an improvement in SRH and HIV outcomes in pilot health facilities, including in antenatal care coverage and contraceptive use), and an increased number of women tested for HIV. Twenty health system strengthening projects were also supported in the region, facilitating access to services and integration of SRHR and HIV services.

### **Challenges**

265. The diversity of locations of members of the Joint UN Regional Team on AIDS in the region poses a challenge for effective coordination, while funding cuts to Cosponsors have limited their flexibility and ability to deliver fully. Funding uncertainty compels the Joint UN Regional Team on AIDS to conduct business in a more coordinated, strategic manner.

266. The ESA Commitment, while applauded as a huge success at the regional level, requires government ownership and allocation of resources to realize results at country level. Thus far levels of ownership and domestication of the commitment have varied across the region.

267. In 2016, about half of the eastern and southern Africa countries were also responding to an El Niño-induced drought, which had adverse effects on health and food security. Many national El Niño programme responses were not adequately sensitive to food security, HIV and gender issues.

268. Key populations are often marginalized due to punitive legal frameworks and policies, impacting service availability and accessibility. National programmes, policies, plans and strategies often do not address the needs of key populations, leading to poorly tailored implementation.

*"The United Nations has a vision to transform the world through the 2030 Agenda for Sustainable Development. Ending the AIDS epidemic as a public health threat by 2030 is among the Sustainable Development Goals. The South African Department of Health is committed to this goal and achieving a long and healthy life for all South Africans."*

Dr. Aaron Motsoaledi, South African Minister of Health

### **Key future actions**

269. Future actions by the Joint Programme will include:

- Reviewing, revising and strengthening the structure and capacity of the Joint UN Regional Team on AIDS in eastern and southern Africa through alignment of work and work plans around the Regional Priorities, as well as strengthening Agency contributions and participation in Joint UN Regional Team on AIDS in eastern and southern Africa activities;
- Supporting national systems through the revision and strengthening of emergency preparedness plans, ensuring the integration of strategic information for HIV programming;
- Strengthening national capacities to improve HIV testing and treatment coverage in the region, through supporting countries in adopting and expanding innovative and community-based approaches and addressing the issues of HIV and migration;
- Maintaining the momentum towards the eMTCT of HIV through the rapid scale-up of Option B+ for pregnant adolescent girls and women living with HIV, and retention and follow-up of mother-baby pairs throughout the breastfeeding period;
- Expanding comprehensive and integrated gender-responsive HIV services, sexuality education in and out of schools, as well as improving prevention and treatment service uptake;
- Supporting countries adopting a human rights-based, gender-responsive, public health approach to ensure equitable health access to services of people living with HIV and people left behind, including their full inclusion in national HIV planning and programming.

## 2016 expenditure in eastern and southern Africa

Organization	Core expenditure (in US\$)	% Fast-Track countries	Non-core expenditure (in US\$)	% Fast-Track countries
UNHCR	952 600	100%	12 960 076	98%
UNICEF	861 885	66%	42 143 078	80%
WFP	790 694	88%	13 886 000	87%
UNDP	1 112 272	80%	3 541 914	90%
UNDP GF Grants		0%	170 917 544	100%
UNFPA	988 639	64%	13 020 315	69%
UNODC	536 610	100%	3 585 875	100%
UN Women	463 342	100%	2 383 782	82%
ILO	741 663	100%	1 681 530	100%
UNESCO	534 028	92%	4 232 174	75%
WHO	1 094 052	73%	7 837 801	82%
World Bank	1 738 585	100%	1 466 386	93%
Secretariat	20 298 877	75%	9 963 080	26%
<b>Grand total</b>	<b>30 113 247</b>		<b>287 619 555</b>	

## Eastern Europe and central Asia

### Achievements

#### *HIV testing and treatment*

270. In 2016, WHO mobilized European Member States to adopt an HIV Action Plan aimed at revising national strategies to accelerate and transform the HIV response to reach the 90–90–90 targets. WHO and the Secretariat were also proactively engaged in the development of a long-awaited national AIDS strategy in Russia, which was adopted by the government in October 2016. The fifth Eastern Europe and Central Asia AIDS Conference (Moscow, March 2016) adopted an outcome document which gave a broad vote of approval to the UNAIDS Fast-Track approach and called for ending AIDS in the region by 2030.

#### **Delivering ARV drugs in Ukraine**

In Ukraine, the Joint Programme brought ARV drugs into non-Government-controlled areas for people living with HIV who were depending on humanitarian support. Between October 2015 and December 2016, UNICEF, with funding from the Global Fund Emergency Fund, delivered more than 40 tonnes of ARV drugs and HIV diagnostic commodities to those areas, enabling 11 000 people living with HIV (including 300 children) to continue receiving ART and 30 000 pregnant women to be tested for HIV. The WFP supported more than 11 100 food-insecure people with three monthly rounds of food assistance, addressing food security-related needs of vulnerable groups and thus minimizing disruption of treatment of food-insecure people living with HIV, who show low adherence to ART.



*“The remarkable achievements of these countries in eliminating HIV and syphilis transmission to infants underscore the importance of robust maternal health services. Only by offering pregnant women integrated HIV and syphilis care as part of a rights-based, comprehensive package of sexual and reproductive health services, including family planning, can we truly keep the mother–baby pair alive and thriving.”*

Dr Babatunde Osotimehin, UNFPA Executive Director

#### eMTCT

271. WHO and the Secretariat were instrumental in the validation of eMTCT of HIV and/or syphilis in three countries (Armenia, Belarus and Moldova) in 2016.

#### *Human rights, stigma and discrimination*

272. Building on momentum created in 2015, the Joint Programme continued advocating to Member States in eastern Europe and central Asia to support human rights-based and gender-sensitive provisions in the outcome documents of the UNGASS on Drugs (April 2016) and the HLM on ending AIDS in New York in June 2016. First rounds of Stigma Index research were conducted in three Central Asian countries. Ombudspersons in Russia and Ukraine have taken up HIV-related discrimination in health care as a human rights issue.

#### *Investment and efficiency*

273. The Joint Programme played a key role in helping national counterparts obtain additional resources, optimize spending of available resources, implement donor-funded programmes and prepare for uninterrupted provision of services when major donor grants expire. For example, the Secretariat, World Bank, UNODC, UNDP, UNFPA, and WHO, in collaboration with the Global Fund, convened stakeholders from 12 countries to develop action plans on the basis of allocative efficiency analysis accomplished in 2015 using the Optima Model (Vienna, February 2016). The meeting enabled participants to develop recommendations for approaches and practices that need to be scaled up to Fast-Track national AIDS responses by 2020, or that need to be scaled down or discontinued.

#### *HIV prevention among key populations*

274. In 2016, the Joint Programme remained instrumental in building capacity of civil society groups representing key populations at risk of HIV, including helping participate in important national and international policy fora. For example, UNDP, UNFPA and the UNAIDS Secretariat provided technical support to the European Coalition on Men's Health to develop a successful concept note that raised €3.1 million from the Global Fund to scale up evidence-informed, age- and gender-sensitive combination prevention programmes for gay and other men who have sex with men and transgender in Armenia, Belarus, FYR Macedonia, Georgia and Kyrgyzstan.

#### **UN Women capacity building efforts for women living with HIV in Ukraine**

UN Women developed the leadership capacity of the Ukrainian Network of women with HIV, equipping them with skills to: become deputy chairwomen of Coordinating Councils on HIV/TB in three regions of Ukraine; co-author an alternative report on Ukraine's implementation of CEDAW for marginalized groups of women, including women living with HIV; and participate in society hearings and plenary sessions of the HLM on AIDS. Women living with HIV, sex workers and women who use drugs presented their shadow report to the CEDAW Committee.



### *HIV prevention among young people*

275. In 2016, the Joint Programme used innovative approaches to reach out to young people in eastern Europe and central Asia with a comprehensive prevention message. UNESCO supported ICT-based solutions for non-formal sexuality, HIV prevention and treatment education and testing promotion among young people across the region. Since 2015, more than 1.5 million people were reached through the OK.RU\TEST platform as part of the UNAIDS regional HIV testing campaign “Concerns Even Those Who Are Not Concerned”. Over 350 000 parents in Armenia, Belarus, Kazakhstan, Russia and Ukraine were also reached through the UNESCO supported “Mama Mia! Being a parent of an adolescent!” project, which provided guidance on how to effectively communicate with adolescents to raise HIV awareness, reduce risk-taking behaviour, promote healthy lifestyles and develop safe, non-violent relationships.

*“HIV prevention is important for the Commonwealth of Independent State countries. More needs to be done to leverage national responses.”*

Talantbek Batyraliev, Chairperson of the Commonwealth of Independent States Health Council meeting, Minister of Health of Kyrgyzstan

### **Challenges**

276. Until the armed conflict in eastern Ukraine is resolved, more than 11 000 people living with HIV in nongovernment controlled areas will be at risk of interruptions in treatment. Available stocks of ARV drugs in Donetsk and Lugansk regions were expected to run out in June 2017. In response to this extended humanitarian need, UNICEF has obtained in-principle approval for additional Global Fund Emergency Funds, which will allow continuing access to ART for 11 000 patients and enrolment of an additional 5,000 people in treatment in 2017.

277. Lack of political will and societal support prevents undermines SRH and HIV education. In some contexts, restrictive policies make open discussion about sexuality, diversity and non-discrimination of LGBT impossible in educational settings and fuel gender-based violence and homophobia, which have an adverse effect on HIV prevention among key young populations. An important challenge in the transition from Global Fund to domestic financing of AIDS responses is the ability of central and local governments to fund or purchase HIV services from NGOs. To facilitate that process, UNDP developed fact sheets about legislative frameworks and practices of NGO social contracting in Belarus, Kyrgyzstan, Moldova, Tajikistan, Ukraine and Uzbekistan. It also assisted Governments in Belarus and Tajikistan to develop roadmaps for implementation of jointly prioritized interventions by civil society, government and partners.

## **Key future actions**

278. Future actions by the Joint Programme in eastern Europe and central Asia will include:

- Continued high level advocacy to ensure that governments take on commitments to the AIDS response that are commensurate with UNAIDS Fast-Track 2020 targets, including selected municipal governments in cities with a high HIV burden;
- Promotion of innovative and targeted HIV testing and counselling programmes that reach out to key populations, young people and employees;
- Support for the provision of HIV prevention and care in humanitarian emergencies;
- Strengthening of mechanisms to ensure access to affordable and high-quality medicines and commodities;
- Advocacy for and mobilization of resources and provision of technical support to expand evidence-based equitable interventions for key populations, including a comprehensive package of harm reduction for people who inject drugs;
- Mobilization and enhancement of capacities of relevant constituencies to eliminate all forms of HIV-related stigma and discrimination (including in health care) and discrimination against learners living with HIV in educational settings, to address and prevent all forms of gender-based violence;
- Strengthened sustainability of the AIDS response, with a focus on supporting actions that promote the transition to greater domestic HIV financing.

## 2016 expenditure in eastern Europe and central Asia

Organization	Core expenditure (in US\$)	% Fast-Track countries	Non-core expenditure (in US\$)	% Fast-Track countries
UNHCR		0%	503 717	35%
UNICEF	274 811	30%	3 182 031	30%
WFP	50 161	0%	1 148 500	75%
UNDP	486 768	20%	945 274	20%
UNDP GF Grants		0%	17 238 921	0%
UNFPA	765 497	7%	1 108 897	5%
UNODC	265 670	18%	846 388	75%
ILO	138 216	100%	280 506	98%
UN Women	219 930	24%	438 000	39%
UNESCO	223 919	70%	86 473	38%
WHO	694 119	32%	1 224 232	38%
World Bank	144 882	60%	345 032	5%
Secretariat	4 832 371	20%	2 952 198	0%
<b>Grand total</b>	<b>8 096 344</b>		<b>30 300 169</b>	

## Latin America and the Caribbean

### Achievements

#### *HIV testing and treatment*

279. The PAHO 2016–2021 Plan of Action for Prevention and Control of HIV and STIs was developed with governments, civil society and partner organizations in 2016 and approved by Member States in September 2016. The Plan is in line with the WHO Global Health Strategy and the UNAIDS Fast-Track Strategy, and aims to accelerate progress towards ending AIDS and STIs as a public health threat in the region by 2030.

#### **ILO promotes 90–90–90 in the private sector**

During 2016, ILO promoted the private sector's contribution to the 90–90–90 strategy by enabling access to HIV-related services in the workplace in Central America and the Caribbean. Through technical advice and co-investment with its stakeholders (government, employers and workers organizations), ILO also promoted the establishment of public-private partnerships between private sectors and Ministries of Health to increase access to HIV-related services among mobile populations and in rural areas.

## eMTCT

280. In 2016, 18 of 42 countries with national eMTCT plans reported data compatible with the dual elimination of MTCT of HIV and syphilis. Along with PAHO, UNICEF contributed to eMTCT validation tools updating, development of virtual assessment and validation criteria, and adoption of cluster approach to eMTCT validation in small Caribbean island and territories.

## HIV prevention among young people

281. A regional study was conducted by UNFPA, the UNAIDS Secretariat, UNICEF and UNDP to examine legal barriers to services and serve as an important tool for evidence-informed advocacy. UNFPA and the International Youth Organization for Ibero-America also published the study “Investment in Youth: Is it a reality?” to examine public social expenditure on youth in four countries in Latin America. The study will inform policy dialogue around the demographic dividend, sustainable development and the need for greater and more targeted investment in youth, including in SRH rights and CSE. UNESCO's “Out in the Open” campaign additionally supported technical and political processes around school-related gender-based violence and SOGIE. More than 25 countries, including several Fast-Track countries, affirmed the call for action.

### All In initiative in Brazil

In 2016 UNICEF guided the implementation of the “All In” initiative to prevent new HIV infections among adolescents in Brazil, Haiti and Jamaica. Meanwhile, in Haiti, the Joint Programme supported the establishment of a multisectoral platform on adolescent health, leading to an increase in HIV testing among adolescents, with improved links to treatment services for HIV positive youth.

## Gender equality and gender-based violence

282. UN Women designed a strategy on HIV for 2016–2017, highlighting linkages between violence against women and girls and vulnerability to HIV, as well as the need for integrated policies, plans and services for prevention, care and support around HIV and violence. National Women’s institutions and local governments recognized violence against women, gender-based violence based and gender inequalities as drivers of the HIV epidemic, and included them in legislation and strategic plans. Advocacy activities were also developed, with the support of civil society organizations and the public sector, as well as international cooperation, to advocate for a comprehensive approach that follows UNAIDS guidelines, best practices and the UN Women Strategy on HIV.

*“Limited access to health care and education, coupled with systems and policies that do not address the needs of young people, are obstacles that block adolescent girls and young women from being able to protect themselves against HIV, particularly as they transition into adulthood.”*

Lorena Castillo de Varela, First Lady of Panama  
and UNAIDS Special Ambassador for AIDS in Latin America

## HIV and health services integration

283. In partnership with academia and research institutes, the WFP developed methodologies to collect and provide important information regarding the food security status of people living with HIV and its relationship with ART adherence in the Dominican Republic, El Salvador, Guatemala and Panama. As a result of these

studies, nutrition indicators and food interventions are being included in national HIV plans, protocols and guidance in a number of countries in the region.

#### *Investment and efficiency*

284. The World Bank finalized epidemic and allocative efficiency analysis in Argentina, Colombia, Mexico and Peru based on the Optima model, which established HIV investments and informed prioritization decisions in resource constrained environments. Additional studies contributed to improving sustainability and efficiency of the regional response, including a cost-benefit analysis of Peru's HIV programme and a regional cost-benefit analysis to be disseminated by the UNAIDS Secretariat. Together with Cosponsors, the Secretariat initiated discussions towards development of a HIV Sustainability framework.

#### **PrEP study in Brazil with UNICEF's support**

UNICEF supported Brazil in defining the scope of a multicountry PrEP demonstration study, including models for service delivery, and became a member of the Regional Task Force on PrEP convened by PAHO and Cayetano Heredia University.

Colombia, Mexico and Peru based on the Optima model, which established HIV investments and informed prioritization decisions in resource constrained environments. Additional studies contributed to improving sustainability and efficiency of the regional response, including a cost-benefit analysis of Peru's HIV

#### *Human rights, stigma and discrimination*

285. A National Dialogue on HIV and the Law was convened in Guyana in 2016, with participation from civil society organizations and line ministries, recommending law reform to address stigma and discrimination and the creation of a Human Rights Commission. In addition, surveys on discrimination and homophobia were conducted in Bolivia and Belize.

#### **UNDP's gender-based violence study in the Caribbean**

UNDP completed a study on gender-based violence in Barbados, El Salvador, Haiti and Trinidad and Tobago. Approximately 55 sex workers, men who have sex with men and transgender women were trained in data collection and interviewing techniques. Preliminary findings show that discriminatory laws and policies continue to legitimize homophobic and transphobic social environments, fuelling violence directed at key populations.

### **Challenges**

286. Reduced external funding for HIV prevention, research and programme evaluation is proving challenging, in addition to reduced resources and budget under the UBRAF for Cosponsors operating in the region.
287. Meanwhile a rise of political positions delegitimizing SRHR and gender equality have been observed in the region, with attacks mainly focused on CSE programmes. In addition, most data related to adolescents and HIV is desegregated for the 15–24 year age group, providing insufficient information on the epidemic amongst adolescent boys and girls aged 10–19 years. The Joint Programme is also experiencing difficulties in calling attention to HIV among women in the region, given the strong focus on key populations in Latin America and the Caribbean.
288. A reappearance of syphilis infection in the general population in some countries, coupled with a lack of appropriate guidance tools for reporting, is holding back eMTCT. Reinfection of pregnant women due to lack of treatment of sexual partners and failure to use barrier contraceptives is also proving to be a challenging issue.

## Key future actions

289. Future actions by the Joint Programme will include:

- Optimization of services with a focus on combination, prevention and intervention, particularly PrEP and self-testing among high risk key populations;
- Strengthened partnerships with academia and research institutions to develop joint fundraising efforts, with the aim of supporting the generation of evidence;
- Focus on improving the sustainability and efficiency of countries' HIV response, through support for application and follow-up on policy recommendations from Optima studies and their use in Global Fund concept notes;
- Support for national HIV programmes through other sectors, such as infrastructure, transport, education, social protection and social inclusion;
- Dissemination of gender-based violence study results and support for networks and organizations of key populations in preventing and responding to gender-based violence;
- Improvement of access to HIV detection and treatment without interruption regardless of migratory status or change of residence. This includes raising awareness on HIV, with an emphasis on indigenous populations and LGBTI people, and working with immigration detention centres, to establish and/or improve access to health services through Safe Spaces Networks.

## 2016 expenditure in Latin America and Caribbean

Organization	Core expenditure (in US\$)	% Fast-Track countries	Non-core expenditure (in US\$)	% Fast-Track countries
UNHCR		0%	203 489	33%
UNICEF	332 208	0%	708 657	41%
WFP	304 926	0%	109 000	0%
UNDP	370 757	35%	812 138	20%
UNDP GF Grants			11 700 435	50%
UNFPA	467 577	43%	1 963 495	1%
UNODC	242 989	52%	49 772	59%
UN Women	228 664	47%	1 770 826	39%
ILO	142 599	77%	197 096	50%
UNESCO	249 315	65%	893 601	68%
WHO	231 223	19%	1 703 513	19%
World Bank	144 882	40%	603 806	51%
Secretariat	9 777 469	23%	284 023	59%
<b>Grand total</b>	<b>12 492 609</b>		<b>20 999 851</b>	

## Middle East and North Africa

### Achievements

#### *HIV prevention among key populations*

290. Continued advocacy and technical support by the UNAIDS Secretariat, WHO, UNODC and the World Bank in the region in 2016 has resulted in a better understanding of the HIV epidemic and response. Understanding that more than 95% of all new adult infections were among key populations and their partners has influenced the focus of HIV prevention programmes, and this is reflected increasingly in National Strategic Plans and Global Fund grant applications. People who inject drugs and gay and other men who have sex with men comprise just under half of the new infections among adults in the region. In light of this, UNODC, UNAIDS Secretariat and WHO worked together at the regional level to prepare countries for the UNGASS on Drugs.
291. Meanwhile, the UNAIDS Secretariat worked with partners to develop and launch the men who have sex with men toolkit for enhanced outreach and rights-based programming. The World Bank supported additional analysis and dissemination efforts for the Sudan Optima study. This informed strategic prioritization of the countries' Global Fund concept notes. The Sudanese Government increased the allocation to HIV prevention programmes for key populations (female sex workers and gay and other men who have sex with men) from 7% of total HIV spending in 2013 to 29% (budget allocations for 2015–2017).

#### *HIV testing and treatment*

292. Following the Algiers declaration for Fast-Tracking HIV testing, technology innovations and community testing, UNAIDS Secretariat and Cosponsors, most notably WHO, provided technical support to countries for implementation, which translated into an increase in community testing and adoption of test and offer policies in countries such as Algeria, Iran and Morocco. The UNAIDS Secretariat supported six countries in implementing the OPEC Fund for International Development grant for increasing access to HIV community testing and ART.
293. UNHCR supported the continuation of comprehensive HIV prevention services and access to testing and treatment services including community-based adherence support for populations affected by humanitarian emergencies in eight countries in the region. UNHCR also supported interventions with sex workers, including for averting the risk of deportation and for HIV and STI prevention programmes. UNHCR completed an assessment of the current health and protection services provided to key populations (sex workers, women and girls at-risk, and men who have sex with men) and the provision of technical support to improve appropriateness, coverage and quality of health and protection services, including improving monitoring and evaluation systems.

[\[On World AIDS Day\] “we celebrate determination, perseverance and progress driven by a highly multisectoral, inclusive response. “\[Partnerships and the prioritization of youth and innovation\]are critical for the achievement of the interconnected Sustainable Development Goals.”](#)

Eric Overvest, United Nations Resident Coordinator in Algeria



294. The UNAIDS Secretariat supported the endorsement of the resolution for ending AIDS passed by the Council of Arab Ministers of the Health during a visit of the UNAIDS Executive Director. The UNAIDS Secretariat coordinated with Arab missions and developed a briefing note for national advocacy, supported civil society organizations to develop a regional HLM position paper, and ensured the participation of key networks in the 2016 HLM on ending AIDS. As a result, for the first time, the League of Arab States addressed the UNGASS and expressed their commitment to Fast-Track the AIDS response through increased investment and regional solidarity. UNAIDS Secretariat and the League of Arab States mobilized regional media leaders to support the implementation of the Arab AIDS Strategy and the 2016 Political Declaration on Ending AIDS. Religious leaders were also mobilized and they endorsed calls for action and the Roadmap through coordinated support from UNAIDS Secretariat, UNDP, UNFPA and other Cosponsors, and the League of Arab states.

#### *Gender inequality and gender-based violence*

295. To enhance evidence-based planning on gender-based violence and HIV, UN Women, in partnership with Promundo, launched a survey in Egypt, Lebanon, Morocco and Palestine to explore men and women's attitudes on major issues relevant to gender relations, gender equality and gender-related vulnerabilities, including HIV.

296. UNAIDS Secretariat led a regional campaign on stigma and discrimination and on addressing vulnerability of women. This included working with the Regional Goodwill Ambassador, law enforcement agencies, regional gender forums and the Women Leaders Conference in the United Arab Emirates. UNDP and IDLO supported the engagement and clustering of civil society organizations providing legal aid services for people living with HIV and key affected populations in the region. The result was the establishment of the Middle East Network for Legal Aid, which will support networking, knowledge sharing between civil society organizations, capacity building and documentation of violations of rights that face people living with HIV and key populations.

297. Meanwhile, UNHCR and its partners developed projects to prevent and respond to sexual and gender-based violence through providing medical and psychosocial services as well as protection and legal services to refugees. This included the provision of post-exposure prophylaxis to survivors of sexual assault. UNHCR successfully undertook immediate advocacy to prevent the deportation of HIV positive refugees in at least one county in the region. Affected refugees were provided access to treatment, medical and psychosocial social support until a durable solution was found.

#### **Sexual and gender-based violence awareness in Syria**

In Syria, 90 000 women and girls, boys and men were reached with over 3,000 sexual and gender-based violence awareness prevention events and programmes. UNHCR further supported the establishment of 70 community-based committees, serving 175 000 beneficiaries in addition to the initiation of 70 prevention and response advocacy interventions.

#### *HIV and health services integration*

298. The Joint Programme, led by UNDP, systematically advocated with the governments of Algeria, Djibouti, Egypt, Sudan and Tunisia for people living with, at risk of and

affected by HIV to access social protection benefits. In Algeria, people living with HIV received social protection benefits through 346 decentralized service points. In Egypt, blanket subsidies are being adapted to achieve more direct support to the most vulnerable people, including people living with HIV, through two recently developed cash transfer programmes, Takafol and Karama. In Tunisia, where 85% of the population are covered by social protection programmes, the Joint Programme worked to remove stigma and discrimination that prevented people living with, at risk of and affected by HIV, to allow them access to social protection benefits. In Sudan, the government has decided to include people living with HIV in its social health insurance programme.

## Challenges

299. The concentration of HIV infections among key populations at higher risk of HIV remains a major challenge for national programmes in the region. Some countries have gradually expanded their reach to these populations. However, the required rapid increase in coverage of prevention, testing and treatment is challenging since homosexuality, sex work and drug use continue to be stigmatized and criminalized.
300. The reduction of UBRAF and other HIV funding has severely impacted regional and country capacity to effectively integrate HIV interventions into other sectors. Moreover, many countries in the region are affected by political instability and acute or protracted emergencies. Accordingly, priorities have shifted and communicable diseases such as HIV receive less attention and support. In addition, the rapidly changing political and social environment continues to challenge the AIDS response due to the ongoing or escalating crisis in many countries in the region. Investments are required to sustain past efforts made in those countries while at the same time providing services for refugees, internally displaced persons and other conflict-affected populations. Protection concerns are still paramount for populations affected by humanitarian emergencies, living with and affected by HIV, while mandatory testing for HIV is still a reality in the region.

## Key future actions

301. Future actions by the Joint Programme will include:
- Strengthening coordinated efforts on advocacy and technical support for integration of HIV services in broader relevant health, community and humanitarian programmes;
  - Supporting countries to better understand their epidemics, focus efforts on key locations and populations, reviewing their national strategic plans and Global Fund applications;
  - Enhancing strategic and operational planning and capacity building of national programmes to accelerate access to care and treatment;
  - Capacity building of national partners in harm reduction services;
  - Supporting PMTCT and HIV prevention among adolescents and investing in identifying entry points for HIV mainstreaming. Specific focus will be placed on improving evidence related to risks and vulnerabilities of adolescents and young people;
  - Strengthening the focus on tackling stigma and discrimination and promoting human rights, including by strengthening protection efforts for displaced people living with HIV and by advocating for an end to mandatory testing for HIV;
  - Providing support to the Y-PEER Regional Centre and reinforcing the capacity, engagement and contribution of young people to HIV prevention with a focus on those who are most at-risk and vulnerable.

## 2016 expenditure in Middle East and North Africa

Organization	Core expenditure (in US\$)	% Fast-Track countries	Non-core expenditure (in US\$)	% Fast-Track countries
UNHCR	341 150	0%	5 192 618	1%
UNICEF	174 083	34%	2 240 472	34%
WFP	128 520	0%	692 000	0%
UNDP	247 172	10%	634 868	25%
UNDP GF Grants		0%	13 309 489	28%
UNFPA	209 088	0%	3 952 715	0%
UNODC	308 159	15%	197 496	0%
UN Women	24 765	0%	793 343	0%
ILO	16 457	0%	19 950	0%
UNESCO		0%	96 669	0%
World Bank	339 500	21%	2 472 832	11%
WHO		0%	86 258	0%
Secretariat	3 699 883	9%	597 401	0%
<b>Grand total</b>	<b>5 488 777</b>		<b>30 286 111</b>	

## West and central Africa

### Achievements

#### *HIV testing and treatment*

302. In 2016, nine countries were supported to adopt the “Treat All” policy and update of national guidelines for testing, prevention and treatment. Meanwhile, three countries introduced innovative point-of-care diagnostic machines to monitor viral load for quality treatment among patients on ART and to increase access to early infant HIV diagnostics in hard to reach areas. Six countries launched National Acceleration Plans (2016–2018) for paediatric and adolescent ART with aggressive case finding, using a family-centred approach with linkages to ART and strengthening of monitoring and evaluation systems.

#### **Joint UNICEF and WHO work on HIV testing in western and central Africa**

In West and central Africa, UNICEF and WHO worked together in 2016 to support countries to introduce innovative HIV testing and referral approaches for children outside PMTCT sites, including case finding, using the adult patient index to identify older children and adolescents.

### eMTCT

303. ARV coverage among pregnant and breastfeeding women in the region plateaued at 48% in 2016. The use of lifelong ART for pregnant and breastfeeding women living with HIV (Option B+) is now effective in all countries in the region. The regional roadmap for accelerating eMTCT and paediatric ART was revised and technical support provided to five countries, to revise their eMTCT plans in line with the 2016 Political Declaration on Ending AIDS. Advocacy through the involvement of Africa's First Ladies' has served to champion *Start Free Stay Free AIDS Free*.

304. Through evidence-based advocacy and sustained quality technical assistance for programme scale-up, UNICEF in collaboration with the Joint Team and partners, supported adoption of a sub-regional initiative to accelerate eMTCT and HIV paediatric care and treatment in the Economic Community for Central African Countries Ministries of Health.

#### Western and central Africa has lower number of new infections among children

The region recorded its lowest number of new HIV infections among children aged 0–14 years in six years. The biggest reduction in new HIV infections (75% or greater) was recorded in Togo (80%), Guinea (80%), Cabo Verde (79%), Burkina Faso (77%) and Sierra Leone (75%). Among countries with high HIV burden, the Democratic Republic of Congo had the biggest reduction (63%), followed by Chad (48%), Ghana (40%), Cameroon (37%), Cote d'Ivoire (25%) and Nigeria (18%).

### HIV prevention among young people

305. Joint UN Regional Team on AIDS initiated several joint actions to support young people in 2016, especially young women and adolescent girls' access to combination prevention services and empowering them to protect themselves from HIV. Multicountry momentum was built through the "All In" initiative in eight countries. Data was also triangulated from multiple sources on adolescents, to identify priority interventions for young people, address their critical capacity gaps and structural challenges to achieve impact for young people. To achieve the 90–90–90 targets, the ProTest HIV strategy was launched in Gabon, where adolescents and young people took ownership of the campaign and demanded youth-friendly services. UNICEF and UNFPA supported four countries to address the sexual and reproductive health and rights of teenage girls as a means to Accelerate Action to End Child Marriage.

### HIV prevention among key populations

306. Joint UN Regional Team on AIDS, led by the UNAIDS Secretariat, organized a capacity building workshop for the mapping and size estimation of key populations in 20 countries, to strengthen national programmes for these populations. The World Bank, the UNAIDS Secretariat and USAID organized a regional workshop to support implementation of sex worker programmes. The Regional Platform for Key Populations held a knowledge sharing meeting in Yaoundé, Cameroon, to improve programming. Joint UN Regional Team on AIDS, via UNODC, met with the Drug Demand Reduction Focal point, Economic Community of West African States Regional Action Plan to Address the Growing Problem of Illicit Drug Trafficking, Organized Crimes and Drug Abuse in West Africa to advocate for inclusion of strategic HIV activities for drug users into the drug control master plan and national hepatitis policies. Based on the programmatic mapping methodology, in 2016 the World Bank completed two mapping studies of female sex workers in Cameroon and Côte d'Ivoire. The World Bank also provided direct implementation support to female

sex worker programmes in Niger and Nigeria to improve the design and roll out of intervention packages.

#### *Gender inequality and Gender-based violence*

307. The joint UN Regional Team on AIDS, through UN Women, UNESCO, UNICEF and Plan International, supported countries in joint programming to address school-related gender-based violence in Cameroon, Senegal and Togo (2016–2018), with Ministries of Education and other Government departments. Advocacy was undertaken on Child Marriage and its impact on the SRH of girls and migrants. The joint UN Regional Team on AIDS also collaborated with the African Union on ending child marriages. Joint UN Regional Team on AIDS, led by UNHCR and the WFP, also developed a toolkit for mainstreaming and managing HIV-related issues within humanitarian crises, prioritizing access to treatment and services, and addressing food security-related issues and gender-based violence.

#### *Investment and efficiency*

308. The World Bank, in partnership with the UNAIDS Secretariat, provided technical support to the National AIDS Commissions of Côte d'Ivoire, Senegal and Togo to conduct optimization and efficiency studies. The final reports for Côte d'Ivoire and Senegal have been shared with country partners. These studies were instrumental in the reprogramming of Global Fund resources for Côte d'Ivoire. They also informed the prioritization of interventions and resource allocation in Senegal and Togo, on investing for greater sustainability of their AIDS responses. In addition, the World Bank and the UNAIDS Secretariat organized a regional training course on how to conduct HIV allocative efficiency analysis utilizing the Optima model.

#### **Technical support facility in Nigeria**

Technical support from the UNAIDS technical support facility provided to Nigeria for the development of investment cases for six states. These strategic documents are aimed at helping stimulate state-level investments in the AIDS response and ensure sustainability.

#### *HIV and health services integration*

309. Towards the attainment of UHC and taking AIDS out of isolation, service integration and joint programming between communicable and noncommunicable diseases has been fostered through joint planning and cosponsoring of activities. WFP trainings on nutritional assessment, counselling and support strengthened the capacities of 478 health care workers in seven countries for patients' enrolment, distribution of monthly food rations, patients' monitoring, and stock management. The World Bank supported 25 concessional lending operations in West Africa, focusing on health system strengthening and UHC, and provided funding and technical assistance to facilitate HIV and health service integration.

#### **Challenges**

310. Inadequate funding through the UBRAF and other sources of funding seriously challenged the work of Cosponsors and the Joint UN Regional Team on AIDS in 2016. There is also inadequate access to key interventions and programmes for people living with HIV in western and central Africa, compounded by the slow adaptation of innovative technologies, such as HIV self-testing and PrEP in the region. Inadequate decentralization and integration of HIV testing and treatment, and limited investment in differentiated models of care and in the establishment of

community-based service delivery models are also challenges. Frequent stock-outs of HIV commodities (ARVs, condoms, reagents etc) and fragile health systems, due to limited qualified human resources, weak procurement and supply management systems, and barriers to services utilization, especially for key populations, are also proving problematic.

311. High stigma and discrimination continue to be challenges, especially for key populations and persons living with HIV. Similarly, gender inequalities and gender-based violence continue to make girls and young women more vulnerable.

*[“The Organisation of African First Ladies against HIV/AIDS strongly believes that in moving towards the Fast-Track Targets we must ensure that no young girl or boy is left behind. We must address the needs of young people, especially young girls, ending gender inequality and other factors that increase their vulnerability to HIV.”](#)*

Lordina Mahama, First Lady of Ghana

### Key future actions

312. Future actions by the Joint Programme will include:

- Strengthening regional partnerships and initiating a massive resource mobilization drive from traditional and non-traditional sources, including domestic funding;
- Using granular data for prioritization, evidence-based planning, strategic investment and strengthening monitoring and evaluation systems;
- Implementing the western and central Africa emergency “catch-up” plan and providing technical support to countries to remove implementation bottlenecks and improve PMTCT and ART cascades to achieve impact;
- Supporting national procurement systems and supply chain management to reduce stock-outs of HIV medicines and commodities;
- Supporting countries in introducing and optimizing HIV self-testing in national HIV testing strategies with a focus on male partners and high-risk older adolescents;
- Launching a systematic review and policy analysis on adolescent key populations, and expanding the number of countries that use investment approaches to adjust and improve their programmes on HIV prevention among adolescent and young key populations.

**2016 expenditure in western and central Africa**

Organization	Core expenditure (in US\$)	% Fast-Track countries	Non-core expenditure (in US\$)	% Fast-Track countries
UNHCR	629 000	78%	8 061 035	56%
UNICEF	630 893	57%	30 231 589	57%
WFP	441 703	23%	9 745 500	0%
UNDP	296 606	30%	1 333 896	35%
UNDP GF Grants		0%	13 758 354	100%
UNFPA	547 820	46%	1 010 935	15%
UNODC	173 639	100%		0%
UN Women	247 811	100%	2 133 745	63%
ILO	221 855	100%	651 708	96%
UNESCO	293 037	64%	500 996	69%
WHO	815 449	81%	6 412 746	53%
World Bank	579 528	65%	1 207 612	73%
Secretariat	16 595 533	44%	3 670 952	18%
<b>Grand total</b>	<b>21 472 874</b>		<b>78 719 068</b>	



## PARTNERSHIPS FINANCIAL INFORMATION

**Table 1: Overview of 2016 AIDS spending by funding source (US\$)**

Funding source	2016 Available fund (in US\$)	Breakdown (%)	2016 Expenditure (in US\$)	Breakdown (%)
Core	203 538 143	27%	179 159 004	25%
Non-core	551 622 118	73%	543 089 724	75%
<b>Grand total</b>	<b>755 160 261</b>	<b>100%</b>	<b>722 248 728</b>	<b>100%</b>

**Table 2: Core expenditure by strategic result area (US\$)**

Strategy Result Area	2016 Available core fund (in US\$)	Breakdown (%)	2016 Core Expenditure (in US\$)	Breakdown (%)
HIV testing and treatment	12 603 504	26%	9 906 809	25%
Elimination of mother-to-child transmission (eMTCT)	1 793 476	4%	1 294 722	3%
HIV prevention among young people	8 406 441	17%	7 014 236	18%
HIV prevention among key populations	7 455 367	15%	7 647 808	19%
Gender inequality and gender-based violence	5 166 806	11%	3 881 217	10%
Human rights, stigma and discrimination	3 822 507	8%	2 510 887	6%
Investment and efficiency	3 355 966	7%	2 796 392	7%
HIV and health services integration	5 824 076	12%	4 267 381	11%
<b>Grand total</b>	<b>48 428 143</b>	<b>100%</b>	<b>39 319 452</b>	<b>100%</b>

**Table 3: Core expenditure by Secretariat function (US\$)**

Organizational function	Budget (in US\$)	Breakdown (in %)	Expenditure (in US\$)	Breakdown (in %)
Leadership, advocacy and communication	42 109 000	27%	38 329 782	27%
Partnerships, mobilization and innovation	27 108 000	17%	22 196 770	16%
Strategic information	23 544 000	15%	21 240 009	15%
Coordination, convening and country implementation support	28 570 000	18%	24 958 754	18%
Governance and mutual accountability	33 779 000	22%	33 114 237	24%
<b>Grand total</b>	<b>155 110 000</b>	<b>100%</b>	<b>139 839 552</b>	<b>100%</b>

**Table 4: Core and non-core expenditure by organization (US\$)**

Organization	CORE			NON-CORE			TOTAL		
	2016 Available funds	Expenditure 2016	%	Projected resources 2016	Expenditure 2016	%	Projected resources 2016	Expenditure 2016	%
UNHCR	2 450 000	2 450 000	100%	30 240 500	30 530 000	101%	32 690 500	32 980 000	101%
UNICEF	6 129 026	4 499 175	73%	95 108 475	93 609 002	98%	101 237 501	98 108 177	97%
WFP	3 113 736	2 612 444	84%	27 757 000	27 757 000	100%	30 870 736	30 369 444	98%
UNDP	5 137 834	4 138 872	81%	11 650 000	11 973 681	103%	16 787 834	16 112 553	96%
UNDP GF grants				212 750 000	235 136 246	111%	212 750 000	235 136 246	111%
UNFPA	5 845 472	5 255 173	90%	55 353 576	34 652 934	63%	61 199 048	39 908 107	65%
UNODC	3 107 551	3 107 551	100%	8 661 100	5 362 096	62%	11 768 651	8 469 647	72%
UN Women	2 426 041	1 627 880	67%	13 354 500	10 540 667	79%	15 780 541	12 168 547	77%
ILO	2 882 924	2 800 678	97%	7 500 000	4 600 587	61%	10 382 924	7 401 265	71%
UNESCO	3 448 377	2 434 731	71%	13 160 000	10 787 996	82%	16 608 377	13 222 727	80%
WHO	9 403 811	6 265 779	67%	50 738 971	40 320 500	79%	60 142 782	46 586 279	77%
World Bank	4 483 371	4 127 169	92%	5 347 996	5 597 996	105%	9 831 367	9 725 165	99%
Secretariat	155 110 000	139 839 552	90%	20 000 000	32 221 019	161%	175 110 000	172 060 571	98%
<b>Grand total</b>	<b>203 538 143</b>	<b>179 159 004</b>	<b>88%</b>	<b>551 622 118</b>	<b>543 089 724</b>	<b>98%</b>	<b>755 160 261</b>	<b>722 248 728</b>	<b>96%</b>

**Table 5: 2016 Expenditure by region (US\$)**

Organization	Global	AP	EECA	ESA	LAC	MENA	WCA	Grand total
UNHCR	2 091 954	2 044 360	503 717	13 912 676	203 489	5 533 768	8 690 035	32 980 000
UNICEF	10 034 247	7 294 222	3 456 842	43 004 963	1 040 865	2 414 555	30 862 482	98 108 177
WFP	1 636 861	1 435 579	1 198 661	14 676 694	413 926	820 520	10 187 203	30 369 444
UNDP	2 554 093	3 776 795	1 432 042	4 654 186	1 182 895	882 040	1 630 502	16 112 553
UNDP GF grants	1 020 893	7 190 611	17 238 921	170 917 544	11 700 435	13 309 489	13 758 354	235 136 246
UNFPA	13 850 325	2 022 804	1 874 394	14 008 954	2 431 072	4 161 803	1 558 755	39 908 107
UNODC	1 268 427	994 622	1 112 058	4 122 485	292 761	505 655	173 639	8 469 647
UN Women	1 428 910	2 035 429	657 930	2 847 124	1 999 490	818 108	2 381 556	12 168 547
ILO	2 112 233	1 197 452	418 722	2 423 193	339 695	36 407	873 563	7 401 265
UNESCO	3 620 491	2 492 021	310 392	4 766 202	1 142 916	96 669	794 033	13 222 727
WHO	14 723 344	9 037 466	1 918 351	8 931 853	1 934 736	2 812 332	7 228 195	46 586 279
World Bank	900 000	2 508 194	489 914	3 204 971	748 688	86 258	1 787 140	9 725 165
Secretariat	80 377 668	19 011 117	7 784 569	30 261 957	10 061 492	4 297 284	20 266 485	172 060 571
<b>Grand total</b>	<b>135 619 446</b>	<b>61 040 672</b>	<b>38 396 513</b>	<b>317 732 802</b>	<b>33 492 460</b>	<b>35 774 888</b>	<b>100 191 942</b>	<b>722 248 728</b>

**Table 6: Core expenditure by category (US\$)**

Agency	Staff costs	Contractual services, consulting	General operating costs	Direct financial contribution	Equipment and supplies	Travel	Training	Programme support costs	Total expenditures	Encumbrances (commitments)	Total 2016 Expenditures, encumbrance:
UNHCR	276 171	159 243	31 669	1 627 126	110 036	11 079	74 396	160 280	2 450 000	-	2 450 000
UNICEF	3 787 326	24 633	199 219	41 613	1 579	111 135	-	333 240	4 498 745	431	4 499 176
WFP	1 165 434	217 470	495 556	143 204	-	430 500	-	160 280	2 612 444	-	2 612 444
UNDP	1 421 063	1 107 123	195 796	79 921	-	241 836	556 906	313 274	3 915 919	222 953	4 138 872
UNFPA	2 522 455	732 402	1 071 877	58 355	16 644	464 371	-	389 069	5 255 173	-	5 255 173
UNODC	2 677 504	9 836	39 934	346	-	121 401	-	199 431	3 048 453	59 098	3 107 551
UN Women*	122 046	393 821	15 241	-	-	99 335	-	140 741	771 183	330 656	1 101 839
ILO	2 300 356	79 919	7 825	-	-	40 135	50 241	322 202	2 800 678	-	2 800 678
UNESCO	1 706 071	264 843	9 828	244	23 283	89 583	26 875	133 908	2 254 635	180 096	2 434 731
WHO	4 771 587	682 988	94 571	83 318	83 779	194 868	-	354 667	6 265 779	-	6 265 779
World Bank	768 665	754 353	15 009	277 000	1 471	315 224	4 524	192 500	2 328 746	1 798 423	4 127 169
<b>Grand total</b>	<b>21 518 679</b>	<b>4 426 631</b>	<b>2 176 526</b>	<b>2 311 127</b>	<b>236 792</b>	<b>2 119 465</b>	<b>712 942</b>	<b>2 699 592</b>	<b>36 201 754</b>	<b>2 591 658</b>	<b>38 793 412</b>

\*UN Women's expenditures against the carry-forward balance from 2015 are not included

**Table 7: Expenditure by Strategy Result Area (US\$)**

Strategy Result Area	Core (in US\$)	Non-core (in US\$)	Grand total (in US\$)
<b>Strategy Result Area 1: HIV testing and treatment</b>			
UNHCR	1 868 000	18 928 600	20 796 600
UNICEF	971 164	40 206 309	41 177 473
WFP	1 075 424	7 500 500	8 575 924
UNDP	548 538	1 436 842	1 985 380
UNDP GF Grants		66 092 350	66 092 350
UNFPA	133 068	244 834	377 902
UNODC		214 483	214 483
UN Women	25 600	200 000	225 600
ILO	727 908	804 771	1 532 679
UNESCO	92 053	393 504	485 557
WHO	3 652 054	15 013 986	18 666 040

Strategy Result Area	Core (in US\$)	Non-core (in US\$)	Grand total (in US\$)
World Bank	813 000	919 159	1 732 159
<b>Subtotal SRA 1</b>	<b>9 906 809</b>	<b>151 955 338</b>	<b>161 862 147</b>
<b>Strategy Result Area 2: Elimination of mother-to-child transmission</b>			
UNICEF	934 401	11 320 489	12 254 890
WFP	42 845	4 570 000	4 612 845
UNFPA	37 556	550 783	588 339
WHO	279 920	4 533 963	4 813 883
World Bank		534 800	534 800
<b>Subtotal SRA 2</b>	<b>1 294 722</b>	<b>21 510 035</b>	<b>22 804 757</b>
<b>Strategy Result Area 3: HIV prevention among young people</b>			
UNICEF	962 271	11 993 531	12 955 802
WFP	59 983	2 500 000	2 559 983
UNDP	52 115	359 210	411 325
UNDP GF Grants		40 672 216	40 672 216
UNFPA	2 814 823	17 061 431	19 876 254
UNODC		107 242	107 242
UN Women	136 810	954 810	1 091 620
ILO	669 952	767 251	1 437 203
UNESCO	1 744 331	5 149 983	6 894 314
WHO	292 951	3 719 431	4 012 382
World Bank	281 000	822 199	1 103 199
<b>Subtotal SRA 3</b>	<b>7 014 236</b>	<b>84 107 304</b>	<b>91 121 540</b>
<b>Strategy Result Area 4: HIV prevention among key populations</b>			
UNICEF	822 158	8 239 969	9 062 127
UNDP	737 375	2 514 473	3 251 848
UNDP GF Grants		30 504 162	30 504 162
UNFPA	1 563 328	5 899 464	7 462 792
UNODC	3 107 551	4 343 298	7 450 849
ILO	251 215	635 802	887 017
UNESCO	115 067	533 276	648 343
WHO	707 945	6 724 855	7 432 800

Strategy Result Area	Core (in US\$)	Non-core (in US\$)	Grand total (in US\$)
World Bank	343 169	909 159	1 252 328
<b>Subtotal SRA 4</b>	<b>7 647 808</b>	<b>60 304 458</b>	<b>67 952 266</b>
<b>Strategy Result Area 5: Gender inequality and gender-based violence</b>			
UNHCR	360 000	7 327 200	7 687 200
UNICEF	262 437	148 579	411 016
WFP		465 000	465 000
UNDP	781 452	2 394 736	3 176 188
UNDP GF Grants		26 691 141	26 691 141
UNFPA	41 254	2 378 728	2 419 982
UNODC		160 863	160 863
UNW	1 381 920	8 094 610	9 476 530
ILO	652 954	745 873	1 398 827
UNESCO	345 200	4 000 655	4 345 855
WHO		861 815	861 815
World Bank	56 000	225 000	281 000
<b>Subtotal SRA 5</b>	<b>3 881 217</b>	<b>53 494 200</b>	<b>57 375 418</b>
<b>Strategy Result Area 6: Human rights, stigma and discrimination</b>			
UNHCR	222 000	4 274 200	4 496 200
UNDP	1 541 721	2 993 420	4 535 141
UNDP GF Grants		25 420 135	25 420 135
UNFPA	323 907	521 766	845 673
UNODC		536 210	536 210
UN Women	83 550	1 291 247	1 374 797
ILO	259 162	778 892	1 038 054
UNESCO	80 547	317 874	398 421
WHO		2 558 028	2 558 028
<b>Subtotal SRA 6</b>	<b>2 510 887</b>	<b>38 691 772</b>	<b>41 202 659</b>
<b>Strategy Result Area 7: Investment and efficiency</b>			
UNICEF	109 349	2 149 041	2 258 390
WFP	36 504		36 504
UNDP	259 450	1 317 105	1 576 555

Strategy Result Area	Core (in US\$)	Non-core (in US\$)	Grand total (in US\$)
UNDP GF Grants		7 626 040	7 626 040
UNFPA		531 840	531 840
WHO	716 089	4 339 270	5 055 359
World Bank	1 675 000	1 116 119	2 791 119
<b>Subtotal SRA 7</b>	<b>2 796 392</b>	<b>17 079 415</b>	<b>19 875 807</b>
<b>Strategy Result Area 8: Investment and efficiency</b>			
UNICEF	437 395	19 551 084	19 988 479
WFP	1 397 688	12 721 500	14 119 188
UNDP	218 221	957 894	1 176 115
UNDP GF Grants		38 130 202	38 130 202
UNFPA	341 237	7 464 088	7 805 325
ILO	239 487	867 998	1 107 485
UNESCO	57 533	392 704	450 237
WHO	616 820	2 569 152	3 185 972
World Bank	959 000	1 071 560	2 030 560
<b>Subtotal SRA 8</b>	<b>4 267 381</b>	<b>83 726 182</b>	<b>87 993 563</b>
<b>Secretariat functions</b>			
S1	38 329 782	10 492 710	48 822 492
S2	22 196 770	7 488 914	29 685 684
S3	21 240 009	3 220 892	24 460 901
S4	24 958 754	9 812 992	34 771 746
S5	33 114 237	1 205 511	34 319 748
<b>Subtotal Secretariat functions</b>	<b>139 839 552</b>	<b>32 221 019</b>	<b>172 060 571</b>
<b>Grand total</b>	<b>179 159 004</b>	<b>543 089 724</b>	<b>722 248 728</b>

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2016–2021 UBRAF Results	Key achievements in PMR I	Key achievements in PMR II
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## Annex 1: UNAIDS Evaluation Plan 2017

UNAIDS 2016–2021 SRA	UBRAF 2016–2021 reference outputs	Evaluation title	Purpose of the evaluation	UN Partners	Type of evaluation (thematic, country, etc.)	Planned evaluation completion date	Estimated cost	Source of funding
SRA 3, 4 and 6	Outputs 3.1, 4.1, 6.2	Independent Evaluation Strengthening Faith Community Partnerships for Fast-Track	The main purpose of the evaluation is to provide UNAIDS and partners important lessons and actionable recommendations that can be used to guide implementation of the Initiative and similar activities for further replication. The evaluation should determine to what extent the Initiative has achieved the results that it was intended to achieve or that it could reasonably have been expected to achieve within the timeframe and what challenges were faced – what worked and what did not work.	n/a	Programme	End 2017	70,000 USD	UNAIDS non-core
Across SRA (focus on SRA 4, 5 and 8)	Across outputs	Independent Evaluation of UNAIDS Regional Programme: “Expanded Accelerated AIDS Response towards HLM Targets and Elimination Commitments in Eastern and Southern Africa Region, 2013– 2017”.	<p>End of Project Evaluation to assess whether Regional Support Team for Eastern and Southern Africa is achieving impact through its programme titled “Expanded Accelerated AIDS Response towards HLM Targets and Elimination Commitments in ESA Region 2013–2017”.</p> <p>The evaluation focuses on effectiveness and impact of the programme. The evaluation investigates areas under the four programme outcomes highlighted below. The fifth objective focuses on management and accountability which is cross-cutting across the four programme outcomes.</p> <ol style="list-style-type: none"> <li>1. HIV is maintained on the political, development and health agendas and</li> </ol>	n/a	Programme	End 2017	115,000 USD	UNAIDS non-core

UNAIDS 2016– 2021 SRA	UBRAF 2016– 2021 reference outputs	Evaluation title	Purpose of the evaluation	UN Partners	Type of evaluation (thematic, country, etc.)	Planned evaluation completion date	Estimated cost	Source of funding
			<p>key global, regional and national HIV commitments are implemented.</p> <ol style="list-style-type: none"> <li>2. Countries' planning, programming and decision making is based on high quality strategic information.</li> <li>3. People who are left behind, (focusing on adolescents and young people, women, girls, sex workers, men who have sex with men, people who inject drugs, migrants) have equitable access to comprehensive HIV services.</li> <li>4. Countries have sustainable resources for their HIV responses.</li> <li>5. Management and accountability.</li> </ol> <p>The evaluation covers the implementation and results of the programme during the period June 2013 to December 2016.</p>					

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