Executive Board of the United Nations Development Programme, the United Nations Population Fund and the United Nations Office for Project Services

Distr.: General
12 July 2013

Original: English

Second regular session 2013
9 to 13 September 2013, New York
Item 11 of the provisional agenda
Follow-up to UNAIDS Programme Coordinating Board meeting

Report on the implementation of the decisions and recommendations of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS

Summary

The present report, jointly prepared by UNDP and UNFPA, addresses the implementation of decisions and recommendations of the Programme Coordinating Board (PCB) of the Joint United Nations Programme on HIV/AIDS. The report focuses on the implementation of decisions from the 31st PCB meeting, held in December 2012. The report also highlights UNDP and UNFPA contributions in responding to HIV.

Elements of a decision

The Executive Board may wish to take note of the report.

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I. Context

1. In recent years, important progress has been made towards meeting the 2015 targets in the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (A/RES/65/277). The number of people newly infected with HIV in 2011 was down 20 per cent from the 2001 level, reflecting results from a combination of biomedical, behavioural and structural prevention strategies.[1] Access to life-saving antiretroviral treatment had been extended to more than 8 million people in low- and middle-income countries, an increase of 63 per cent since 2009. Achieving zero new HIV infections in children increasingly appears possible: between 2009 and 2011, 24 per cent fewer children acquired HIV.

2. Yet the epidemic is far from over. Globally, HIV remains a leading cause of adult mortality and the largest killer among women aged 15-49 years. In 2011, 34 million people were living with HIV. Despite the overall decline in new infections, 2.5 million people acquired HIV in 2011, including 890,000 young people. Infection rates among young women aged 15-24 were twice as high as those among young men. About half of those who were living with HIV were unable to access treatment.[2] Although new HIV infections and AIDS-related deaths were declining in most regions, they were rising in Eastern Europe and Central Asia and in the Middle East and North Africa. Rates of HIV infection were also well over 40 per cent among key populations in many countries, reflecting insufficient human-rights-based responses for HIV prevention and treatment for these groups. Moreover, the global economic downturn has impacted efforts to mobilize the full funding needed for universal access to HIV prevention, treatment and care services. Since 2008, international investment for the global AIDS response has stalled. Although domestic investment by low- and middle-income countries rose by 15 per cent from 2010 to 2011, to $8.6 billion, many countries still relied heavily on international assistance: 61 countries received more than half their HIV funding from abroad and 38 relied on international sources for 75 per cent or more of funding.

3. The present report, prepared jointly by UNDP and UNFPA, provides an update on the decisions and recommendations of the 31st Programme Coordinating Board (PCB) meeting, held in December 2012. Key issues addressed during this meeting of particular relevance to UNDP and UNFPA include the following: gender-sensitivity of AIDS responses; the launch of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Lancet Commission: From AIDS to Sustainable Health; and strategic investment. The

[1] *Global Report: UNAIDS Report on the Global AIDS Epidemic, 2012.*
[2] Ibid.

present report also provides an overview of UNDP and UNFPA results in addressing HIV. More detailed results are available in the 2012 UNAIDS Performance Monitoring Report to the PCB. The oral presentation during the Executive Board second regular session 2013 will include a synopsis of decisions and recommendations from the 32nd PCB held in June 2013.

II. Programme Coordinating Board decisions and recommendations

Women, girls, gender equality and HIV

4. The midterm review of the implementation of the UNAIDS *Agenda for accelerated country action for women, girls, gender equality and HIV* (UNAIDS/PCB(31)/12.CRP.4) was presented at the 31st PCB meeting in December 2012. The review indicates that many countries have accelerated HIV action for women and girls, with demonstrated progress in 60 per cent of countries. The review identifies common elements for success, including the following: (a) strong political commitment from government, (b) an active and engaged civil society, (c) adequate financial resources, and (d) technical support from the UNAIDS Cosponsors and Secretariat.

5. Key challenges highlighted in the midterm review include the following: (a) inadequate funding to operationalize the agenda for women and girls at the country level, particularly for networks of women living with HIV and women's rights groups; (b) mixed political commitment for gender-transformative AIDS responses; (c) insufficient coordination involving all stakeholders, in particular at the country level; (d) insufficient integration of gender into monitoring and evaluation systems and inconsistency in "knowing the epidemic" from a gender perspective; (e) uneven results from technical support efforts; and (f) variability in the meaningful involvement and inclusion of women at all levels of the HIV response.

6. The PCB recognized the challenge of ensuring sustained funding to address gender inequality and HIV as well as funding to support women's civil-society organizations and networks of women living with and affected by HIV. Underscoring the importance of a continued strategic investment approach to addressing gender together with HIV, the PCB requested UNAIDS to ensure that future guidance and documentation related to strategic investment in the HIV response include gender as an integrated, cross-cutting issue.

UNAIDS and Lancet Commission: From AIDS to Sustainable Health

7. The UNAIDS and Lancet Commission: From AIDS to Sustainable Health was launched at the December 2012 UNAIDS Board meeting. The Commission aims at informing the debate on the post-2015 development agenda and ensuring

continued international commitment to the AIDS response beyond 2015. It brings together global leaders in development, AIDS, health, governance, business and the environment, people living with HIV, youth leaders and senior United Nations officials, including the UNDP Administrator as one of the Commissioners. The findings and recommendations of the Commission will be presented in early 2014 in a special issue of *The Lancet* as well as through social media.

Strategic investment approaches

8. UNAIDS is supporting countries in taking significant steps to apply strategic investment approaches to national HIV responses to maximize the efficiency, effectiveness and impact of HIV programmes. These experiences are being documented and shared to promote joint learning and South-South collaboration and exchange. With the adoption of a new funding model by the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereafter referenced as the Global Fund), the UNAIDS Secretariat and Cosponsors will also actively support countries during the transition to the new model. This will include support for grant renewals and reprogramming, based on strategic investment opportunities. Further guidance will also be provided on understanding and measuring "critical enablers"—interventions that create an enabling environment for maximizing the effectiveness and efficiency of basic HIV programmes.

III. UNDP and UNFPA transformative results

9. UNDP and UNFPA continue to make significant contributions to the global HIV response, building on and leveraging organizational core capacities to benefit HIV outcomes together with other development priorities. These results cut across the strategic goals of the UNAIDS unified budget, results and accountability framework, as illustrated below.

10. As a Cosponsor of UNAIDS and a partner of the Global Fund, UNDP plays an important role in supporting development outcomes by helping countries to address the social, cultural and economic determinants of HIV and health, in partnership with the United Nations system and other organizations. Since 2008, more than 100 UNDP country offices have supported national responses to HIV and health. Interventions address the development dimensions of HIV, recognizing that action outside the health sector can contribute significantly to improving health outcomes. These efforts have resulted in the following: (a) greater integration of HIV in national development planning and gender-equality programmes; (b) strengthened governance, coordination and legislative and human-rights environments for HIV responses; and (c) strengthened implementation of HIV, tuberculosis and malaria programmes funded by the Global Fund.

11. Recent evaluations of UNDP country programmes provide a positive assessment of its contributions in addressing HIV. They highlight the value-added by UNDP in strengthening national capacity to respond to HIV, creating enabling legal environments, promoting gender equality, enhancing local-level implementation and civil-society engagement, expanding social protection and improving national planning. Successful approaches include the implementation of cross-thematic programmes that address HIV together with key priorities such as advancing gender equality, economic empowerment and access to justice. Collaboration with United Nations partners has strengthened coordinated multi-sectoral support to national HIV and health programmes. Evaluations of UNDP global and regional programmes, 2009-2013, note achievements in capacity development, South-South collaboration and the advancement of cross-practice synergies.

12. The UNFPA contribution to the global HIV response is shaped by its mandate to accelerate progress towards universal access to sexual and reproductive health (SRH), including voluntary family planning and safe motherhood, comprehensive sexuality education (CSE) and advancement of the rights, opportunities and capacities of young people. In 2012, 99 UNFPA country offices reported the provision of significant support to national HIV programmes. UNFPA support focused on HIV prevention and HIV and SRH linkages through: (a) building capacities of young people, women and key population organizations and networks to engage fully in advocacy, policy, planning and programme implementation; (b) building national capacities to prevent HIV and unintended pregnancies in women of reproductive age, contributing to the elimination of mother-to-child transmission (EMTCT); (c) building national capacities to implement quality CSE; (d) increasing access to an integrated package of services[3] for key populations, including young people; (e) ensuring access to neglected commodities and new technologies, including female condoms, as well as increasing access to and utilization of male and female condoms for dual protection; and (f) supporting advocacy to raise awareness and mobilize resources to meet the needs of women and girls in the context of HIV and SRH, including reducing AIDS-related maternal mortality, providing CSE, improving SRH for women living with HIV and ending gender-based violence (GBV).

13. Analysis of the UNFPA 2012 reporting against its strategic plan's development results demonstrates considerable progress on the interventions listed above. Between 2010 and 2012, UNFPA supported 24 countries, exceeding the strategic plan target of 20 countries, in conducting assessments of the linkages between SRH and HIV; it also guided the development and regular updating of

[3]The integrated package includes community empowerment; protection against discrimination and violence; access to condoms and lubricants, SRH services including sexually transmitted infection prevention and treatment, family planning and prevention of unintended pregnancies, abortion and post-abortion care, catch-up hepatitis B virus immunization and community health care services; voluntary testing and counselling; antiretroviral treatment; and harm reduction.

the HIV and SRH linkages online resource pack. UNFPA supported 95 countries (against a target of 85) in strengthening capacities for essential SRH service delivery to young people, including HIV prevention, treatment and care; it also supported 95 countries (against a target of 80) in designing and implementing comprehensive age-appropriate sexuality education and built capacities for providing technical assistance on the design, implementation and evaluation of this education. Additionally, UNFPA worked to enhance human-rights protection and service access for key populations in 80 countries. Between 2010 and 2012, UNFPA supported 27 (against a target of 25) of the 38 UNAIDS priority countries for engaging in programmes that address the HIV-related and SRH needs of sex workers.

14. The following section highlights UNDP and UNFPA results in relation to the goals of the 2011-2015 UNAIDS strategy.

A. Addressing HIV-specific needs of women and girls in at least half of all national HIV responses

15. The midterm review of the UNAIDS agenda for women and girls provided a unique opportunity to track progress, assess barriers and plan for more intensified collective support to countries. Of the 80 countries that launched the agenda for women and girls, 90 per cent had initiated action to better understand their epidemic, context and response from a gender perspective. However, this progress was uneven across areas of the agenda and across and within regions.

16. Following up on its responsibilities in the agenda, UNDP provided technical assistance to 32 countries to integrate gender into national HIV strategies, policies and programmes. Marked improvements were made in the proportion of countries reporting regular participation of networks of women living with HIV in the Committee on the Elimination of Discrimination against Women (CEDAW) processes, namely 33 per cent in 2012, compared with 20 per cent in 2011. UNDP, UNAIDS and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) convened a task force to advise CEDAW on global and emerging trends on gender equality; provided support for strengthening the integration of HIV concerns into CEDAW processes at the country level; and developed a brief for CEDAW on integrating attention to HIV into conflict and post-conflict contexts. UNDP also strengthened policy engagement with the Global Fund to promote the integration of gender into its policies, strategies and programmes. In countries where UNDP is a principal recipient for Global Fund grants, programme outcomes are assessed to significantly contribute to gender equality, including through the establishment of counselling and testing services for pregnant women, services for preventing mother-to-child transmission, and women-friendly health services.

17. In East and Southern Africa, UNFPA strengthened the capacity of HIV gender focal points from 15 countries to promote delivery on the agenda for women and girls. UNFPA also supported a high-level mission of 10 government and civil-society representatives from eight countries to South Africa to learn from the Ministry for Women, Children and People with Disabilities, which had progressed in implementing the agenda for women and girls. UNFPA supported country-level initiatives to increase knowledge and to change the attitudes and behaviour of men to support gender equality. For example, the Turkish armed forces implemented an SRH programme for men. In the Middle East and North Africa, UNFPA supported the development of a training toolkit on men’s and boys’ engagement for women's empowerment. In addition, the UNFPA Arab States Regional Office supported a “10 days of activism” campaign in September 2012, led by the Youth Peer Education Network (Y-PEER), a group of more than 500 non-profit youth organizations. Y-PEER was pioneered by UNFPA. The regional campaign focused on gender equality and human rights and mobilized young people in all countries of the region, under the theme “nothing for us without us”. In Egypt and Lebanon, UNFPA supported the "Let’s Talk” campaign, aimed at raising awareness about the HIV-specific needs of young women. In Jordan, UNFPA supported activities to raise awareness among young Syrian men and women in the Za’tri refugee camp.

18. UNDP support to networks of women living with HIV and for the integration of human rights and gender equality into national and decentralized HIV planning processes has led to improvements in gender equality and women’s empowerment. For example, in the Central African Republic, El Salvador, Gambia, Guinea, Madagascar and Myanmar, programmes helped to strengthen the leadership of women living with HIV and built the capacity of women’s networks to respond to HIV. In El Salvador, training was provided both to thousands of women community leaders on promoting HIV prevention and to thousands of men on addressing gender equality and masculinity. In the United Republic of Tanzania, all staff of the National AIDS Council were trained on issues related to human rights and gender, resulting in a reported increase in the number of people accessing user-friendly services.

19. Putting human rights, equity and gender equality at the centre of the HIV response requires a major shift in the coverage, content and resourcing of HIV programmes. All countries applying investment approaches in the coming years need to incorporate action on the critical enablers of gender, human-rights and legal environments. Implementing the agenda for women and girls remains a priority, including supporting stronger collection, analysis and use of sex- and age-disaggregated data to inform programmes; finalizing and rolling out the integrated package of tools to support gender-transformative assessment, planning, implementation and evaluation, along with strengthening the

engagement of women and girls in these processes; and fortifying linkages between gender and HIV work.

20. UNFPA promotes the integration of HIV in maternal, newborn and child health and family planning services for people living with HIV. These key linkages, especially EMTCT, are supported by most of UNFPA country-level programming. To advance national understanding on the status of SRH and HIV linkages at the policy, systems and service-delivery levels, UNFPA and partners — the UNAIDS Secretariat, the World Health Organization (WHO), International Planned Parenthood Federation, Global Network of People Living with HIV/AIDS, International Community of Women Living with HIV/AIDS and Young Positives — have supported countries in implementing the rapid assessment tool for SRH and HIV linkages, strengthening national capacity to scale up linked and integrated SRH and HIV programmes (see http://www.srhhivlinkages.org/content/en/rapid_assessment_tool.html).

21. UNFPA supported 39 countries (18 in 2012) in completing SRH and HIV linkages assessments. Country summaries highlight the lessons learned, recommendations and the way forward. A total of 17 impact assessments were undertaken with the first round of countries that implemented the rapid assessment. UNFPA continued to support seven African countries benefiting from European Union funding to strengthen linkages and integration.

22. With the launch of its family planning and adolescent and youth strategies, along with maternal health and commodities initiatives, UNFPA will seize opportunities to accelerate progress in linking SRH and HIV. Integration will remain a key to success. The new strategic plan, 2014-2017, calls for strengthening those linkages by promoting the delivery of an integrated package of services and scaling up the outreach to marginalized groups of women, girls, young people, and key populations

B. Ensuring a goal of zero tolerance for gender-based violence

23. The midterm review of the agenda for women and girls notes progress in addressing GBV. Since the launch of the agenda for women and girls, 82 per cent of reporting countries had taken action to highlight GBV as a concern or to address it in the context of HIV. For example, with support from UNDP and UNFPA, Lesotho established one-stop centres for multisectoral services to address the needs of survivors of GBV. Sri Lanka successfully integrated HIV into national advocacy and communication under the UNiTE campaign to end violence against women, as called for by the agenda for women and girls.

24. However, accelerated efforts are needed to address critical linkages with HIV. Of countries that launched the agenda for women and girls, 61 had health policies to address GBV. However, one third of these lacked data available on links between GBV and HIV. In 2012, 11 countries initiated messaging to address violence against women in "information, education, communication" strategies. In Africa, by 2010, 36 countries had already included messaging to address violence against women, but in other African countries progress was limited.

25. UNFPA, UNDP and partners provided technical and financial support to 36 countries to integrate attention to GBV in national HIV strategies and plans and to engage men and boys in preventing violence. A consultation organized by the UNAIDS inter-agency working group on women and girls in 2012, in partnership with the ATHENA Network, MenEngage Alliance and Sonke Gender Justice, built on global consultations convened in 2010 and 2011. The consultations successfully addressed the intersections of gender equality and HIV, including the following: (a) championing women's rights in the context of HIV; (b) addressing the HIV needs of women and girls; (c) enhancing efforts to integrate into HIV responses a focus on GBV as a cause and consequence of HIV; and (d) actively engaging men and boys in challenging constructions of masculinity that exacerbate the spread and impact of HIV. Six countries (Angola, Malawi, Mozambique, South Africa, United Republic of Tanzania and Zimbabwe) reviewed their national HIV and gender policies and plans, assessing strengths and weaknesses for addressing GBV and engaging men and boys. The country action plans will strengthen cross-cutting attention to gender equality, GBV and the engagement of men and boys in national planning processes and forthcoming national HIV strategies and plans.

26. UNFPA, UNDP and WHO organized a global consultation on sex worker-led initiatives to address violence against sex workers. Agreement was reached on identifying a new standard to successfully capture evidence-based best practices in addition to more traditional forms of evidence, which tend to be dependent on medical and quantitative data.

27. UNFPA continued the development of an initiative to increase humanitarian actors' capacity to develop and manage multisectoral GBV prevention and response programmes. This initiative includes a multiple language e-learning course and user manual; a regionally adaptable in-person training curriculum; and a web-based community of practice. To date, more than 400 actors have completed the course and rated it highly. Complementing the e-learning course is a guide with additional case studies, best practices and activities.

28. UNAIDS will continue to support countries for collecting and analysing country-level information about the linkages between GBV and HIV and using

this information to influence global and national advocacy so that more development actors become aware of the linkages. Further technical guidance and support will be provided for integrating the elimination of GBV into national HIV strategies and plans.

C. Reducing sexual transmission of HIV by half, including among young people, men who have sex with men and transmission in the context of sex work

29. Getting to zero new HIV infections will require substantial reductions each year in sexual transmission, which accounts for the overwhelming majority of new infections. Despite favourable trends in sexual behaviour in many countries and new biomedical prevention strategies, the pace of progress is insufficient to reach the global goal of halving sexual transmission by 2015. This underscores the urgency of intensified action to reach zero new infections and will require effective combinations of behavioural, biomedical and structural strategies. These efforts should be applied intensively across the whole population in generalized epidemics and for the most affected populations in concentrated epidemics.

National strategic planning

30. UNDP has supported the development and review of multisectoral national strategies and programmes to respond to HIV in more than 30 countries, including Bahrain, Chad, Ecuador, Gambia, Guinea, Guyana, India, Kenya, Malawi, Malaysia, Sao Tome and Principe, United Republic of Tanzania and Zambia. In Kenya, the Government was supported to generate strategic information on sectoral assessments, such as the first national assessment of the impact of HIV in the informal sector. Support was also provided to plan and budget for HIV. As a result, all ministries currently allocate budgets for HIV. In Turkmenistan, UNDP, together with other United Nations organizations, provided coordinated support to national counterparts to develop a national HIV programme, 2012-2016. This strategy includes, for the first time, the treatment of HIV; it also provides a framework for HIV surveillance. Support was also provided to develop a detailed plan of action for the strategy, considered a major breakthrough. In Malaysia, support was provided for the development of the national HIV/AIDS strategic plan, 2011-2015, with the Ministry of Health. In Ecuador, support was provided for the development and planning of the national policy on HIV with UNAIDS, in coordination with CARE and the Global Fund. As a result, the country developed a multisectoral strategic plan focusing on needs of affected populations and identifying priority sectors for a multisectoral response.

31. Assisting countries in their efforts to achieve the Millennium Development Goals (MDGs) remains a top priority for UNDP, including through implementation of the MDG acceleration framework in 45 countries, with national partners and United Nations country teams. Examples include the development of a MDG acceleration action plan for HIV and tuberculosis in the Republic of Moldova and an HIV-specific plan for Ukraine. The plans will assist both countries in ensuring that their HIV responses are more targeted, cost-effective and sustainable.

Comprehensive sexuality education and youth leadership

32. An estimated 40 per cent of new adult infections in 2011 were in young people (15-24), bringing the number of young people living with HIV to 5 million. However, there has been progress as HIV prevalence in young people 15-24 fell by 27 per cent from 2001 to 2011. This global trend was driven by significant declines in prevalence among young people in all regions, except in Eastern Europe and Central Asia, where prevalence rose by 20 per cent.

33. In 2012, UNFPA supported 70 countries in designing and implementing comprehensive age-appropriate sexuality education, including capacities for providing technical assistance on design, implementation and evaluation of CSE. In collaboration with the United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNICEF regional teams, UNFPA supported the review of national curricula in 10 East and Southern Africa countries and built the capacity of 200 teachers-curriculum developers and civil-society partners. As a result, Lesotho, Swaziland, Uganda, the United Republic of Tanzania and Zambia revised their curricula.

34. UNFPA and partners supported the empowerment of 200 youth leaders from 54 countries to advocate for their issues through a knowledge- and skills-building conference preliminary to the 2012 International AIDS Conference. The youth leaders developed a declaration laying the foundation for how youth organizations, networks and activists would collaborate, mobilize and make their voices heard over the next years to reach the 2015 goals of the Political Declaration on HIV and AIDS. HIV was also identified at the Bali Youth Multistakeholder Meeting in March 2013 as one of seven key themes. The meeting communiqué calls for “universal access to affordable, quality healthcare and youth-friendly services that are sensitive to young people’s sexual and reproductive health and rights, especially those living with HIV”.

Condom programming

35. Condom use is a critical element of combination prevention and one of the most efficient technologies available to reduce the sexual transmission of HIV.

UNFPA estimates that only nine donor-provided male condoms were available for every man aged 15-49 years in sub-Saharan Africa in 2011 and one female condom for every 10 women aged 15-49 years in the region. Less is known about the procurement of condoms by low- and middle-income countries directly. In 2011, the donor community procured approximately 3.4 billion male condoms and 43.3 million female condoms compared to the estimated annual need of 10 billion condoms to cover all risky sex acts.

36. The 2012 report on the Global Programme to Enhance Reproductive Health Commodity Security (RHCS) highlights that in 2011 UNFPA expended $32 million to provide commodities, including $9.3 million on condoms, and $44 million for funding capacity development, including logistics management and human resources to support country programme implementation. Improved reproductive health commodity stock control and quality management, including for condoms, was achieved via regional training in the use of "Access RH" software, attended by reproductive health commodity managers from Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Reported stock-outs were reduced to 2 per cent. An electronic network among practitioners in RHCS and comprehensive condom programming from Cambodia, Indonesia, Lao People's Democratic Republic, Myanmar, Philippines and Timor-Leste was formed for South-South collaboration in forecasting, procurement and distribution.

37. Eighty-six countries are scaling up the UNFPA 10-step strategic approach to comprehensive condom programming.[4] Four countries (Guatemala, Jamaica, Kenya and Paraguay) developed new condom strategies; and Burundi developed a national male and female condom policy. Through capacity-building workshops, 18 Latin American and Caribbean countries and 12 East and Central African countries drafted 2013 action plans to scale up comprehensive condom programming in 2013. The CONDOMIZE! Campaign (http://www.thecondomizecampaign.org) advocates for increased condom access and demand, with a strong focus on community development and participation. The campaign had high visibility at the 2012 International AIDS Conference opening ceremony through its video. The UNAIDS Executive Director highlighted condoms and the campaign in his opening speech. This resulted in major media coverage, re-energizing community organizations to boost their condom promotion programmes and requests to roll out the campaign at country level.

38. A mini-survey was conducted in 17 priority countries to support the development of country-level programmes targeting young people's access to condoms. Malawi and Swaziland were supported to develop 2013 action plans

[4] UNFPA, *Comprehensive Condom Programming: A guide for resource mobilization and country programming*, 2011.

and strategies for demand creation for condoms for young people. The drafts will be finalized in 2013 following additional behavioural and sociocultural research to better understand attitudes, beliefs, condom knowledge and practices that put young people at risk of unintended pregnancy and HIV. In both countries, skill-building workshops on condoms for young people strengthened the capacity of about 100 government officials, non-governmental organization (NGO) service providers and peer educators.

Key populations at higher risk

39. Reaching a higher proportion of key populations with HIV prevention, treatment and care is critical if the world is to halve sexual transmission by 2015. Currently, programmes to reach key populations account for approximately 4 per cent of HIV expenditure globally. UNAIDS recommends an increase in expenditure to 14 per cent by 2015. The lack of domestic funding for key populations jeopardizes sustainability of the response. Addressing community empowerment, improving access to acceptable health services and redressing human-rights violations need to be significantly scaled up with the requisite funding.

40. UNAIDS has developed important guidance documents and strategic information to support human-rights-based and evidence-informed national policies and programmes. UNFPA, UNDP, the World Bank and the Johns Hopkins School of Public Health partnered in groundbreaking research and economic analysis on global epidemics among female sex workers and men-who-have-sex-with-men (MSM), which found that female sex workers are 14 times more likely to acquire HIV, and MSM 19 times more likely, than the general community, including in high-burden countries. The results include critical data for countries on the cost-effectiveness of investing their HIV resources in key populations to avert the most infections. UNDP, UNFPA, WHO, the UNAIDS Secretariat and the Network of Sex Work Projects have developed guidelines on the "prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries". UNDP, UNFPA, WHO, UNAIDS Secretariat, the United States Agency for International Development (USAID), Centers for Disease Control (CDC), Global Fund and partners finalized the operational guidelines for monitoring and evaluation of HIV Programmes for Sex Workers, Men Who Have Sex with Men and transgender people. UNFPA, the UNAIDS Secretariat and the Asia-Pacific Network of Sex Workers launched the HIV and sex work collection: innovative responses in Asia and the Pacific.

41. The emphasis on the meaningful participation of key populations at global, regional and country levels is effectively shaping normative guidance, strategic information, capacity development and programming. Supporting capacity development of community-led organizations of sex workers, MSM and

transgender people has resulted in stronger engagement of key populations. UNFPA supported the Global Network of Sex Work Projects (NSWP) to strengthen the African Sex Worker Alliance and the Sex Worker's Rights and Advocacy Network (SWAN) of Central and Eastern Europe and Central Asia. UNDP led the establishment of the Eurasian Coalition on Male Health and supported the strengthening of advocacy in African Men for Sexual Health and Rights (AMSHeR).

42. Working at the municipality level represents a key opportunity for prioritizing interventions to have a major impact on reducing new HIV infections. Local governments are uniquely positioned to coordinate efforts to address inequalities affecting key populations. UNDP and UNFPA supported 25 cities in 20 countries to develop and implement municipal plans and strategies for and with key populations. The "Urban Health and Justice Initiative" aims at developing the capacity of community-led organizations to promote and protect health and human rights and develop greater access to and acceptance of HIV (and legal) services. The initiative has begun to yield important results. The UNDP local governance programme supported the city governments in Cebu and Davao (the Philippines) to pass local anti-discrimination ordinances. Odessa (Ukraine) developed and introduced a system of clients' monitoring of HIV prevention, treatment, care and support services aimed at key populations. The city of Kigali (Rwanda) developed a comprehensive strategic plan for HIV prevention, treatment, care and support (2013-2016) inclusive of key populations. The Governments of Thailand and China adopted city-based HIV and MSM strategies.

43. UNFPA supported 80 countries to develop and/or implement programmes on HIV-prevention services for female, male and transgender sex workers. In-reach training addressing stigma, discrimination and HIV risk and the vulnerability of key populations continues to have an impact, with a substantial increase in the number of UNFPA country offices that are programming strategically in this area. Ongoing financial and technical support for capacity strengthening of the Global Network of Sex Work Projects (NSWP) and its regional and country-level networks and organizations resulted in the participation of sex workers in developing policies, guidance, tools and programmes and in international forums. UNFPA financial and technical assistance to the International AIDS Conference Kolkata Hub for Sex Workers, Kolkata, India, helped enable the hub to become the largest gathering of sex workers in the world to discuss programming advice on HIV and sex work.

44. In Asia and the Pacific, UNDP is the regional technical assistance provider for two multi-country Global Fund HIV programmes for MSM, covering Afghanistan, Bangladesh, Bhutan, India, Indonesia, Malaysia, Nepal, Pakistan, Philippines, Sri Lanka and Timor-Leste. Support was provided for the

development of proposals along with technical support for grant implementation. Both programmes are community-led and aim at responding to the HIV-related needs of MSM. This technical assistance role has also been used to leverage resources and increase partnerships to address discriminatory laws, stigma and discrimination including, in six countries, strengthening the capacity of national human-rights institutions to address human-rights violations related to HIV, sexual orientation and gender identity.

45. “Getting to zero” also means keeping HIV rates low. Scaling up human-rights-based approaches for HIV prevention and treatment for key populations is essential. UNDP and UNFPA will continue to work together on scaling up the Urban Health and Justice Initiative in municipalities with high or growing rates of HIV and on enhancing the empowerment of community-led organizations and networks of MSM, sex workers and transgender people.

D. Eliminating vertical transmission of HIV and reducing AIDS-related maternal mortality by half

46. According to the *Global Report: UNAIDS Report on the Global AIDS Epidemic 2012*, new pediatric infections declined from about 560,000 in 2003 to about 330,000 in 2011, a 43 per cent reduction. Some countries, including Burundi, Kenya, Namibia, South Africa, Togo and Zambia, achieved at least a 40 per cent reduction. More effective regimens have been adopted to stop new infections in children and keep mothers alive. Experience with simplifying treatment options for women, including ensuring that antiretroviral treatment is initiated and maintained for life (Options B and B+), indicates that treatment coverage can increase dramatically, including for women with more advanced disease.

47. The UNFPA scale-up towards EMTCT through the SRH/maternal neonatal health care platform is guided by the *Global plan towards the elimination of new HIV infections among children and keeping their mothers alive* (the *global plan*) and *Preventing HIV and unintended pregnancies: strategic framework, 2011-2015* (*strategic framework*) (see http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_jc2137_global-plan-elimination-hiv-children_enpdf and http://www.unfpa.org/public/home/publications/pid/10575).

48. Capacity was strengthened in seven countries (Ethiopia, Kenya, Malawi, Swaziland, Uganda, United Republic of Tanzania and Zambia) on programming on Prongs 1 and 2,[5] utilizing the strategic framework in support of the global plan

[5] There are four prongs of EMTCT. They include: (a) prong 1 - primary prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum/natal care and other health and HIV

and addressing GBV in the context of EMTCT programming. Each country developed an action plan with associated technical support requirements. UNFPA and its partners also developed an H4+/FP2020/EMTCT[6] harmonization framework and joint workplan. To enable measurement of progress towards linking SRH and HIV, a review was undertaken of existing indicators and tools to identify a set that will measure SRH and HIV linkages and integration at the policy, systems and service-delivery levels to assess outcomes and impact. Work is advancing towards field-testing 17 potential indicators in the second half of 2013. Achieving the goal of eliminating vertical transmission will require the strengthening of local capacity to decentralize management and service provision; support to implement the new 2013 consolidated antiretroviral treatment guidelines and other key guidelines, such as those related to infant feeding; and continued support to countries to strengthen linkages between maternal and neonatal child health, SRH and HIV, with an emphasis on meeting the family planning and other SRH needs of women living with HIV.

E. Ensuring universal access to antiretroviral treatment for people living with HIV who are eligible for treatment and reducing tuberculosis deaths among people living with HIV by half

49. By the end of 2011, antiretroviral treatment was available to an estimated 8 million people in low- and middle-income countries. Antiretroviral treatment coverage remained higher for women (68 per cent) than for men (47 per cent). Almost half of tuberculosis patients living with HIV received antiretroviral treatment. Scientific evidence shows that providing antiretroviral treatment has important prevention benefits: giving antiretroviral treatment to people earlier in their disease progression not only drastically reduces the risk of tuberculosis disease and mortality but also helps limit HIV transmission. These benefits imply that up to 25 million people could be considered eligible for antiretroviral treatment. Universal access to treatment is already within reach for several countries. The United Nations targets of reaching 15 million people on antiretroviral treatment and reducing tuberculosis deaths among people living with HIV by 50 per cent by 2015 are within reach, but renewed efforts are critical to achieving this goal.

50. As a partner of the Global Fund, UNDP has, since 2003, supported more than 40 countries in implementing large-scale HIV, tuberculosis and malaria programmes, focusing on countries facing capacity or governance challenges. By

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service delivery points, including working with community structures; and (b) prong 2 - providing appropriate counselling and support to women living with HIV to enable them make an informed decision about their future reproductive life, with special attention to preventing unintended pregnancies.

[6]This abbreviation represents the harmonization of plans of the organizations addressing the same or similar issues, based on UNAIDS, *Global Plan towards the Elimination of New HIV Infections among Children and Keeping Their Mothers Alive*, 2011.

the end of 2012, 1 million people in 25 countries were receiving life-saving antiretroviral treatment through UNDP-managed Global Fund programmes. When serving as an interim principal recipient, one of the most important roles is to support the long-term sustainability of national programmes and to enable national entities to assume the management of grants. As a result of its efforts, UNDP has exited from the role of principal recipient in 23 countries since 2003, including nine countries in 2011 and 2012.

51. In 2012, UNDP continued to strengthen a systematic approach to enhancing the capacity of national entities both to manage grants and to ensure smooth and timely transitions, using measurable milestones. Contributions to capacity development were reinforced through the roll-out of a "capacity development toolkit to strengthen national entities to implement national responses for HIV & AIDS, tuberculosis and malaria". Produced on the basis of best practices from comprehensive capacity-development efforts in Zambia and Zimbabwe, the toolkit provides a systematic approach to strengthening national partners' systems for programme management and implementation. Country teams, in countries as diverse as Belize, Haiti, Mali, Montenegro, Tajikistan and Uzbekistan, are utilizing the toolkit to enhance capacity development for national partners.

52. Between 2003 and 2012, UNDP-managed programmes contributed to reaching 12 million people with HIV counselling and testing, with 1.6 million people receiving treatment for sexually transmitted infections, 230,000 women benefiting from services to prevent mother-to-child transmission of HIV, and 120,000 HIV-positive people receiving treatment for tuberculosis and distribution of 520 million condoms.

53. UNDP, in partnership with UNFPA, has supported the Global Fund in shaping its strategies on gender equality and on sexual orientation and gender identity. In 2010, research spearheaded by UNDP on human-rights issues in the context of the Global Fund, helped influence the Global Fund Board in its strategy-development process. The Global Fund's strategy framework, 2012-2016, incorporates the promotion and protection of human rights as one of its five key objectives. In 2012, UNDP supported the Global Fund Board and secretariat in developing an implementation plan for this strategy to enhance the Fund's ability to advocate with countries on the importance of human rights in delivering tangible HIV, health and development results. This included appropriate attention to issues of human rights and key populations in the new funding model.

54. Ongoing support will be provided to countries as they transition to the Global Fund's new funding model. They will be supported in adopting strategic investment approaches that give attention to gender, key populations and human rights. They will also be supported in anchoring their Global Fund applications

not only in national health strategies but also, more broadly, in national development and poverty-reduction strategies, and in national budget processes and expenditure frameworks.

F. Addressing people living with HIV and households affected by HIV in all national social-protection strategies and providing access to essential care and support

55. The unprecedented increase in people initiating HIV treatment has been followed by an acceleration of social-protection efforts and growing recognition of the importance of health-service integration and community mobilization. Such initiatives can directly mitigate the social and economic impacts of the HIV epidemic on the most vulnerable households and key populations, caregivers and vulnerable children.

56. The mainstreaming of the HIV response into social-protection programmes and financial modelling has helped create and sustain initiatives that advance HIV prevention, treatment, care and support. In India, as a result of UNDP support to mainstreaming efforts towards increased social protection, more than 400,000 people living with HIV have benefitted from central and state schemes. These experiences have been shared with Cambodia, Indonesia, Papua New Guinea and Thailand for appropriate adaptation, based on household-impact assessments of HIV. In Kyrgyzstan, technical and financial support was provided for the development of state policy on HIV prevention and for improving the system of receiving social allowances for people living with HIV to avoid stigma and discrimination—a mechanism considered a best practice by the Government. In Zambia, support resulted in increased national budgetary allocations to health, commitment to establish an AIDS fund and incorporation of a national health-insurance scheme for public workers, to commence in 2013. In Belarus, support was provided for the elaboration of the HIV sustainability plan to provide funding for high-impact interventions on HIV. In Burkina Faso, a study on income and expenditure related to HIV resulted in governmental commitment to increase annual contributions from the national budget. In Thailand, the Thailand International Development Cooperation Agency, Ministry of Public Health, Ministry of Foreign Affairs and the National Health Security Office are working with Cambodia, Indonesia, Myanmar and the Philippines to address universal health-care coverage with respect to HIV, sharing innovative and pro-poor approaches.

57. There is a need for sustained political commitment to addressing HIV in the context of greater integration of health programmes, as well as increased mobilization of domestic resources for HIV responses. UNDP will continue to support countries in identifying solutions for optimal funding and integration. This will include promoting dialogue at the country level among ministries of

health, labour, social welfare, justice, gender, social development, planning and finance to identify ways in which inclusive social protection, care and support can contribute to HIV and health outcomes. UNFPA is committed to strengthening the integration of HIV response into its SRH programming, as is evident in the integrated results framework of the new strategic plan, 2014-2017.

G. Reducing by half the number of countries with punitive laws and practices that block effective responses and eliminating HIV-related restrictions on entry, stay and residence in half of all national HIV responses

58. Stigma, inequality (particularly gender inequality) and exclusion continue to drive the HIV epidemic, as do legal environments that do not protect against HIV-related discrimination and that criminalize key populations at risk. For this reason, the PCB organized a thematic session on non-discrimination in December 2012, highlighting the importance of achieving zero discrimination.

59. In 2011-2012, the Global Commission on HIV and the Law examined the impact of law on HIV responses. UNDP, as convener of the Commission, supported evidence-based research to inform its findings and recommendations. This included convening seven regional multi-stakeholder dialogues on HIV, human rights and law and publishing 18 working papers with in-depth analyses of key issues addressed in the Commission's groundbreaking report. The final report and resources are available in English, French, Portuguese, Russian and Spanish and have been downloaded more than 10,000 times since the launch of the report in July 2012. The findings are being used by United Nations partners, civil-society and government officials to discuss gaps in laws, non-implementation of protective laws, and legal frameworks for better HIV responses. The Commission report also provides a blueprint for the legal review of commitments in the 2011 Political Declaration on HIV and AIDS.

60. In following up the Global Commission's recommendations, UNDP supported national partners to initiate action to advance human rights and improve social, legal and policy environments relating to HIV in more than 80 countries[7], including 31 UNAIDS high-impact countries. Multi-stakeholder national dialogues were supported in 20 countries, in addition to assessments of legal environments in 51 countries. This support has resulted in constructive dialogues between governments and civil society, national coalitions advocating for relevant law reform, and an increasing number of parliaments actively promoting reform proposals. For example, in Kenya, with UNDP support, the Government and various constituencies for the first time convened to discuss key human-rights and legal issues that affect HIV (First National Symposium on HIV, Law and Human Rights, 2012) as well as dialogue on criminalized groups, such as injecting drug

[7]Information on implementation of the Commission's recommendations is available at: www.hivlawcommission.org.

users, MSM and sex workers. In Myanmar, UNDP supported the review of laws affecting HIV-positive persons and supported civil-society organizations, leading to overall improvements in the situations of HIV-affected people. In Malawi, an HIV legal assessment generated evidence to inform HIV laws, addressing the human rights of people affected by HIV, including sexual minority rights, to establish a rights-based legal framework. In Kyrgyzstan, as a result of UNDP support for the elaboration of substantial amendments related to the rights of persons living with HIV, the ombudsman now includes HIV issues in annual plans, providing a platform for protecting people affected by HIV.

61. In partnership with United Nations organizations and civil society, UNAIDS will continue to support governments in conducting national dialogues aimed at building coalitions to catalyse HIV-related law reforms. This will be done to facilitate country-level action on improving legal environments. Special attention will be given to UNAIDS priority countries and to those where an opportunity exists to change the legal environment for more effective and efficient HIV responses.

IV. Conclusion

62. At its 32nd meeting in June 2013, the PCB considered the results of the first year of implementing the UNAIDS 2012-2015 unified budget results and accountability framework (UBRAF) and was asked to approve the budget for the second biennium of UBRAF (2014-2015). The development of the new budget was guided by key requirements and principles of General Assembly resolution 67/226 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system (QCPR). These include a focus on specific goals, results-based planning and budgeting, strengthened joint work, improved effectiveness and more transparency. In particular, the development of the new budget reflected the need for enhanced system-wide coherence and strengthened accountability for results and impact. It also reflects a response to QCPR calls for ongoing efforts to streamline procedures and to lower transaction costs. To support this, UNDP and UNFPA will ensure alignment of the HIV-related components of their 2014-2017 strategic plans and results frameworks with the UNAIDS strategy and accountability framework, as directed by the UNDP/UNFPA/UNOPS Executive Board in decision 2011/41 (adopted at the second regular session 2011) and reaffirmed subsequently at the Board’s second regular session 2012.

63. The June 2013 PCB meeting also focused on addressing AIDS in the post-2015 development agenda. To inform Member States in the open working group and the High-level Panel, UNDP put in place a project, “Building the post-2015 development agenda: open and inclusive global consultations”, under a United Nations Development Group (UNDG) umbrella. The objective was to help realize

the Secretary-General's vision that discussions about the post-2015 agenda be open and inclusive, in line with United Nations principles. The project entails supporting: (a) a large number of (up to 100) national dialogues on post-2015, (b) 11 thematic meetings on issues selected by UNDG and (c) an ambitious social-media platform for outreach to all citizens and concerned stakeholders. Complementary to this, UNFPA would continue to work with and empower civil-society, youth-led organizations and other partners towards ensuring that the post-2015 development agenda includes the health needs and rights of women and adolescents (aged 10-19 years). This includes enabling advocacy that all women and girls must be empowered to make free and informed choices regarding their sexuality and reproduction, protecting themselves from HIV and other sexually transmitted infections; and that adolescents must enter into adulthood healthy and without sexual or reproductive health problems, including unwanted or unsafe pregnancy and delivery, and free of HIV and other sexually transmitted infections.

64. Even with intensified efforts, it is unlikely that all the targets of the 2011 Political Declaration on HIV and AIDS will be achieved by 2015. While acknowledging the remarkable progress made since the outset of the millennium, the UNAIDS Cosponsors and Secretariat are united in their commitment to following through on the goals that remain to be achieved. At the April 2013 meeting of the Committee of Cosponsoring Organizations[8] all heads of agency confirmed their commitment to strategic use of the next 1,000 days to accelerate their efforts and push forward on the MDGs and to support a post-2015 framework that tackles the unfinished business of the MDGs. This must necessarily take into account the important lessons learned from the Joint Programme model, namely, that HIV must be addressed not only from a health perspective but also from other perspectives, including the need to address gender and other inequalities, governance, population dynamics and education. UNAIDS will continue to support countries in applying strategic investment approaches in all three key elements of HIV responses: basic programme activities; critical enablers; and synergies with development sectors. Addressing the unfinished agenda post-2015 does not mean, however, that UNAIDS will continue "business as usual." Getting to zero will require intensified and focused action to tailor responses to country-level specificities, to reach the hardest-to-reach groups and to ensure that human rights and gender are at the heart of all UNAIDS action.

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[8]The UNAIDS Committee of Cosponsoring Organizations serves as the forum for executive heads of cosponsoring organizations to consider matters of major importance to UNAIDS and to provide input into its policies and strategies.