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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 addresses the implementation of the decisions and recommendations of the Programme Coordinating Board (PCB) of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The report focuses on the implementation of decisions from the 34th and 35th PCB meetings, held in July and December 2014, respectively.

Elements of a decision

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

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I. Context

1. Over the past 15 years, the Millennium Development Goals have driven considerable progress in halting and reversing the AIDS epidemic. Since 2001, new HIV infections have fallen by 38 per cent; new HIV infections among children have fallen by 58 per cent and, for the first time, dropped below 200,000 in the 21 most affected countries in Africa. We have record numbers of people accessing life-saving treatment. Of the 35 million people living with HIV, an estimated 15 million will be on treatment before the end of 2015. Over half (53 per cent) of global AIDS resources now come from domestic sources in low- and middle-income countries. The AIDS response has also contributed to progress on reducing child and maternal mortality, increasing access to services for sexual and reproductive health (SRH), tuberculosis and malaria.

2. Despite this progress, HIV remains a major obstacle to achieving health and development objectives; 1.5 million people died from AIDS in 2013. The world continues to face challenges that will require renewed focus and determination if we are to end AIDS as a public health threat. Reinvigorating prevention as well as a new global push to encourage people to come forward for testing is vital. AIDS deaths are increasing among adolescents and the disease is now the second greatest cause of death globally for adolescents. The World Health Organization (WHO) estimates that between 40 per cent and 50 per cent of all new HIV infections among adults worldwide may occur among key populations and their sexual or needle-sharing partners. At the same time, national responses and international programmes for key populations are inadequate. Programmes for key populations remain precariously dependent on external funding sources. At the same time, non-communicable diseases have become the leading forms of preventable illness, disability and mortality, costing national economies billions of dollars every year. The Ebola crisis also provided a stark reminder of the importance of investing in global health as a matter of human security. Governments need to step up to address the social, political and economic drivers of HIV and ill health overall.

3. In June 2003, the Executive Boards of UNDP and UNFPA, the United Nations Children's Fund (UNICEF) and the World Food Programme agreed that follow-up to UNAIDS Programme Coordinating Board (PCB) meetings be placed on the agendas of their Boards as a regular item.

4. The present report, prepared jointly by UNDP and UNFPA, provides an update on the decisions and recommendations from the 34th and 35th meetings of the PCB, held in June and December 2014, respectively. Issues of particular relevance to UNDP and UNFPA included the AIDS response in the post-2015 development agenda; intellectual property and HIV commodity security; and thematic segments on social protection and people who use drugs.

5. This report also provides an overview of UNDP and UNFPA results in addressing HIV, in the context of broader work on health, human rights and development. More detailed results for both organizations are available in the UNAIDS Unified Budget, Results and Accountability Framework performance report 2014 to the PCB. The oral presentation at the second regular session 2015 will include a synopsis of decisions and recommendations from the 36th PCB meeting held in July 2015.

II. Decisions and recommendations of the Programme Coordinating Board

6. This section gives a brief overview of the PCB decisions relevant to UNDP and UNFPA. Further information on how they are being implemented is included in section III.

HIV and the sustainable development goals

7. While sustainable development goal (SDG) negotiations are still ongoing, there is a growing consensus on a number of elements, including a target on ending the AIDS epidemic by 2030. Other targets in the health sector for universal health coverage and universal access to sexual and reproductive health (SRH) provide an opportunity to strengthen linkages and integration of HIV

responses into broader health policies and programmes. The post-2015 development agenda presents opportunities to promote synergies across development sectors (for example, on reducing inequalities and providing inclusive social protection, education, inclusive and resilient cities and decent work for all), which could all help drive progress towards ending the AIDS epidemic. Achieving the proposed AIDS target under the health SDG will not be possible unless significant progress is made across a number of SDGs. The successes of UNAIDS have been highlighted as a model of how the United Nations system can effectively leverage its diverse resources for high-impact multisectoral programming for SDG implementation.

8. The PCB expressed its support for the proposed AIDS target in the SDGs and has called for HIV-sensitive indicators throughout the SDGs. Support was also expressed for continued efforts to 'take AIDS out of isolation' and integrate HIV with health and development more broadly, though board members also urged that efforts should be made to ensure that AIDS is not obscured or deprioritized in the post-2015 development agenda. UNDP and UNFPA have followed up on this through providing, together with the United Nations Statistical Commission, technical expertise to Member States to formulate indicators that address the multiple dimensions of HIV.

UNAIDS strategy 2016-2021 and fast-track targeting

9. Given the strong support for ending the AIDS epidemic by 2030, the PCB has asked for the development of an updated UNAIDS strategy for 2016-2021, to drive progress towards ambitious fast-track targets (see figure 1).

Figure 1. UNAIDS fast-track targets

10. The UNAIDS Secretariat has led a consultation process to support the update and extension of the UNAIDS strategy, 2010-2015. Multi-stakeholder consultations have been held online and at the global and regional levels. Initial feedback from the consultations indicates consensus around a number of priorities: inequality and exclusion; gender equality and human rights; reinvigorating prevention; confronting emerging challenges to scale up treatment; empowering young people; and investing in strengthening community and health systems.

11. Coherence with the SDGs is central to the development of the strategy. This is being assured though a number of ways: alignment of priorities; targets and indicators; and ensuring the joint programme is 'fit for purpose' to support the ambitious scope and vision of the SDGs. The strategy and the accompanying Unified Budget, Results and Accountability Framework will be presented for endorsement at the 37th PCB meeting in October 2015.

Intellectual property and HIV

12. At the 35th PCB meeting, the non-governmental organization delegation presented a report, which focused on the impact of intellectual property in the quest to ensure access to affordable, high-quality HIV treatment for all people living with HIV. Board members expressed their concern about continuing high prices, especially for second-line and third-line antiretroviral treatments, and noted that more affordable prices will be required to achieve the 90-90-90 treatment target. They also expressed concern regarding the exclusion of many middle-income countries from voluntary licensing agreements and other schemes to lower drug prices. Board members cited the need to strike an appropriate balance between intellectual property rights and access to medicines and stated that UNAIDS is well placed to guide the work of countries in this regard.

13. The PCB urged UNAIDS to intensify technical support to countries to address intellectual property-related and other barriers to expanding access to HIV treatments and diagnostics. It asked UNAIDS to intensify its coordination with key partners, including the World Trade Organization and the World Intellectual Property Organization on issues relating to public health, intellectual property and trade. The Board also asked UNAIDS to collaborate with relevant partners to further develop price-reduction mechanisms to increase access to quality-assured HIV treatments and diagnostics.

Social protection and HIV

14. The 34th PCB organized a special thematic session focusing on HIV and social protection. Discussions showed that social protection addresses structural factors that increase vulnerability to HIV. There is a growing body of evidence demonstrating that it is an effective intervention for HIV prevention, treatment, care and support; and an increasing range of experiences has shown how social protection programmes benefit people affected by or living with HIV, including young women and key populations. For example, achievement of the 90-90-90 treatment target will require support for transport, free antiretroviral therapy, food and nutrition, and housing for many people living with HIV.

15. The session concluded that combining the movements on ending the AIDS epidemic, extreme poverty and inequality would present unprecedented opportunities for a reinvigorated AIDS response. A research agenda that lays out the pathways to social inclusion, social protection and equitable economic growth in different geographic and political settings, as well as HIV epidemic contexts is needed and will be an important step towards joint action on ending AIDS, extreme poverty and inequality. The PCB requested UNAIDS to work with partners to develop and strengthen national social protection systems.

HIV and people who inject drugs

16. The thematic session of the 35th PCB addressed the issue of HIV among people who inject drugs. An estimated 12.7 million people inject drugs worldwide, approximately 13 per cent of whom are living with HIV. Injecting drug use is found in nearly every country; it is a significant driver of the HIV epidemic, particularly in Europe and Central Asia. This population accounts for 5-10 per cent of all new HIV infections worldwide, and for 30 per cent of new infections outside sub-Saharan Africa. Presentations showed evidence on harm reduction as a way to reduce HIV transmission among people who inject drugs and to increase access to HIV prevention, treatment, care and support. They also revealed that harm-reduction programmes are highly cost-effective.

17. Board members emphasized the importance of the 2016 United Nations General Assembly special session on drugs as an opportunity to rethink international approaches to drug use. Grounding approaches to drug use in human rights, public health and development were emphasized. Board members and observers said that civil society has a critical role to play as full and equal partners in preparing for the special session. Board members expressed concern about the future of harm-reduction programming in many middle-income countries.

III. UNDP and UNFPA transformative results

18. The proposed post-2015 development agenda is ambitious and complex. Achieving the SDGs will require a strategic approach that harnesses key synergies across the goals and delivers shared gains. As the PCB has called for HIV integration across the SDGs, this section highlights the achievements of UNDP and UNFPA, structured according to the SDG areas that are most relevant to their respective roles in the AIDS response.

19. Progress on AIDS, health and development is interdependent. The AIDS response and efforts to promote health and development confront many shared obstacles, including inequalities, conflict, fragility, social exclusion and poverty. Working at the intersection of AIDS and key SDGs, addressing overlapping vulnerabilities and yielding multiple shared gains, so that common obstacles to HIV, health and development are addressed, is an effective way to progress on AIDS and simultaneously achieve other SDG targets.

20. The strategic plans of both UNDP and UNFPA make a corporate commitment to addressing the HIV epidemic as well as its causes and consequences. The vision outlined in the UNDP strategic plan, 2014-2017 (supporting countries to eradicate poverty while simultaneously reducing inequalities and exclusion) is needed to effectively address HIV. Recognizing the wide-ranging social and economic impact of HIV and the synergy between health and sustainable development, the UNDP strategic plan addresses HIV as a cross-cutting issue highlighted in two substantive areas of work: adopting sustainable development pathways and strengthening inclusive, effective democratic governance.

21. The UNFPA strategic plan, 2014-2017 aims to achieve universal access to SRH, the realization of reproductive rights and the reduction in maternal mortality. UNFPA focuses its work on family planning, maternal health, and HIV with an emphasis on adolescents, youth and women. This is enabled by efforts on human rights, gender equality and population dynamics.

End poverty in all its forms everywhere

22. There is a complex relationship between HIV, poverty and economic inequalities. AIDS can worsen poverty and there are strong associations between economic inequality and HIV vulnerability. UNDP supports over 50 countries in social protection. In several of these countries, including the Dominican Republic, India, Indonesia, Jamaica, Thailand and Uruguay, support was provided for HIV-sensitive social protection programmes. In India, this included support for the creation of the second state-level transgender welfare board. UNDP published a discussion paper on cash transfers and HIV prevention that analyses the evidence on cash transfers and HIV prevention, explores key issues, and offers strategies for moving forward policy, programmes and research in this area.

23. UNDP, together with the London School of Hygiene and Tropical Medicine and the STRIVE research consortium have developed an innovative approach to the cross-sectoral financing of structural interventions. UNDP and the Economic Policy Research Institute have developed course materials to introduce cross-sectoral financing approaches to policymakers in sub-Saharan Africa and demonstrate its applicability to cash transfers for HIV prevention, among other areas.

24. UNDP is carrying this work forward by developing operational tools for sensitizing cash-transfer programmes to HIV prevention, and supporting countries to integrate HIV-sensitive social protection into Global Fund grants and concept notes. UNDP is working with Member States in Latin America and the Caribbean to identify strategic engagement opportunities on social protection for HIV and health.

Ensure healthy lives and promote well-being for all at all ages

25. As more people living with HIV access treatment and live longer, they require a range of health services throughout their life cycle, in addition to antiretroviral treatment. UNFPA and UNDP are supporting health sectors to meet these evolving needs. A push for health equity through

universal health coverage is critical for leaving no one behind in the AIDS response. Universal health coverage can focus greater attention on promoting health equity, improving service quality, ensuring financial and social security, strengthening health and community systems, building coherence across different health areas and addressing the social and economic determinants of health. The AIDS response has promoted innovation in the way health services are funded and delivered, presenting good practices for implementation across the health goal. UNDP and UNFPA are supporting more integrated health-sector approaches to HIV.

- **Linking HIV and sexual and reproductive health**

26. SRH is inextricably linked to HIV. The Programme of Action of the International Conference on Population and Development committed the world to universal access to SRH, including HIV services. Though high-impact initiatives (Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive; Every Woman Every Child; and Family Planning 2020), UNFPA plays a leading role in promoting SRH and HIV linkages at policy, systems and service levels.

27. At the policy level, UNFPA is setting the agenda on SRH and HIV integration. A think piece (from a UNFPA-led task group of The UNAIDS and Lancet Commission: Defeating AIDS, Advancing Global Health) linking HIV and sexual and reproductive health rights (SRHR) in the post-2015 development agenda contributed to discussions on integrating SRHR in the SDGs. To strengthen monitoring of 'elimination of mother-to-child transmission' integration into SRH services, as part of the Inter-agency Working Group on SRH and HIV Linkages, together with WHO, International Planned Parenthood Federation, the UNAIDS Secretariat, UNFPA co-developed the *SRH and HIV Linkages Compendium: Indicators and Related Assessment Tools*, which includes two new pilot-tested integrated service delivery indicators. Seven countries provided support to operationalize them. The indicators have now been accepted and included in the UNAIDS Indicator Registry. An index of SRH and HIV integration is being developed in 2015, which will further strengthen the evidence base for policy advocacy.

28. At the systems level, UNFPA supported 14 countries to develop costed integrated national SRH action plan in 2014. In Mozambique, UNFPA supported the Ministry of Health to strengthen SRH and HIV integration through guidelines developed for HIV and family-planning service integration. In Uganda, backed by the President and the First Lady, UNFPA supported a costed implementation plan emphasizing the integration of family planning and HIV, focusing on maternal health and teen pregnancy, and the identification of high-burden districts to target for SRH and HIV services integration.

29. At the service delivery level, UNFPA is supporting countries to provide high-quality, rights-based SRH and HIV services. UNFPA support to Malawi resulted in an increased uptake of women and their partners in mother-to-child transmission services, and increased capacity of 136 health workers to deliver integrated SRH and HIV services. In Gambia, Guinea and Togo, health service providers were trained and commodities supplied to deliver integrated SRH and HIV services.

30. UNFPA remains the largest supplier of both male and female condoms to developing countries. In 2014, UNFPA procured 780 million male and female condoms for developing countries needing these commodities the most, mainly in sub-Saharan Africa. It reenergized its work on comprehensive condom programming, which had been implemented in 52 countries by 2014. The CONDOMIZE! campaign was expanded to Botswana, Swaziland and Togo; in the three countries, with mass social mobilization of volunteers, government and media, six million male and female condoms were distributed and six million people were educated through entertainment, newspapers and television.

31. The CONDOMIZE! campaign helped to attract participants to the testing and counselling drives in Botswana, Ethiopia, South Africa and the United Republic of Tanzania sites. These drives resulted in the largest number of people ever undertaking HIV testing and counselling during an

eight-hour period: 7,750 people across the four sites. The results are now included in the Guinness Book of Records.

- **Collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria**

32. As one of the major sources of financing for HIV and other health programmes, the Global Fund to Fight AIDS, Tuberculosis and Malaria is a strategic partner for both UNDP and UNFPA.

33. UNDP managed 50 grants from the Global Fund in 25 countries and one regional programme covering seven countries in South Asia, with expenditures totalling $412 million in 2014. UNDP contributions are currently helping 1.4 million people access life-saving antiretroviral treatment, equal to one in eight people on HIV treatment in low- and middle-income countries. Six countries (the Plurinational State of Bolivia, Islamic Republic of Iran, Kyrgyzstan, Sao Tome and Principe, Tajikistan and Zambia) have decreased the incidence of malaria by 75 per cent with support from UNDP. Thirteen countries (Angola, Belarus, Belize, Bosnia and Herzegovina, Cuba, El Salvador, Haiti, Kyrgyzstan, Montenegro, São Tomé and Principe, Syrian Arab Republic, Tajikistan and Turkmenistan) have exceeded the global target of 70 per cent of tuberculosis case detection rate set for 2015. In addition, 500 million condoms have been distributed and 22 million people have received HIV testing and counselling.[1]

34. UNDP-managed Global Fund grants contributed significantly to Zambia achieving a 25 per cent reduction in the incidence of HIV and 50 per cent fewer AIDS-related deaths. By mid-2014, 600,987 people living with HIV in Zambia were accessing life-saving antiretroviral therapy. Similarly, in Zimbabwe, supported by UNDP-managed Global Fund grants, AIDS-related deaths have decreased from 160,000 in 2001 to 39,000 in 2012; Zimbabwe has seen one of the sharpest declines in HIV prevalence in Southern Africa, from 27 per cent in 1997 to under 14 per cent in 2012.

35. As of January 2015, over 61 per cent of UNDP grants are rated A1 or A2 by the Global Fund, compared with 37 per cent of grants implemented by other partners, despite the fact that UNDP is operating in some of the most challenging environments. Thanks to capacity-development of national partners, six grants were handed over in four countries in 2015. Beyond the programme implementation, the past year has seen a further deepening in UNDP engagement with the Global Fund on human rights, key populations, gender, health systems capacity-development and sustainable financing. In 2014, as a part of the Global Fund's development continuum working group, UNDP led the discussion on delivering health programmes in challenging operating environments.

36. UNFPA signed a memorandum of understanding with the Global Fund on strengthening SRHR and HIV integration, focusing on 13 countries (Bangladesh, Chad, Côte d'Ivoire, Ethiopia, Eritrea, Indonesia, Mozambique, Nigeria, South Africa, the United Republic of Tanzania, Togo, Uganda and Zambia) to realize equitable access to integrated SRH services that are anchored in human rights and are gender responsive. Together with UNICEF, focused technical assistance is already being provided to countries on procurement and supply chain management to increase provision of life-saving SRH and HIV commodities. Monitoring data indicates that the memorandum of understanding has led to a doubling of UNFPA engagement in the Global Fund at country level.

37. As a growing number of countries are transitioning out of Global Fund eligibility, UNDP and UNFPA are co-convening with other partners the Equitable Access Initiative, which aims to ensure sustained financing for effective and evidence-based HIV programmes. Modelling suggests that 87 per cent of people living with HIV will reside in middle-income countries in less than 10 years' time. Over the next year, the Equitable Access Initiative is expected to propose a nuanced health and development classification that goes beyond traditional economic markers.

[1] Cumulative since beginning of implementation of grants, as of end-2013.

♦ **Ebola**

38. The Ebola outbreak in West Africa pushed the United Nations system to find new ways to respond quickly and effectively. UNDP and UNFPA built on their experiences in responding to HIV to make significant contributions. UNDP supported essential cash-payment programmes, which ensured an estimated 38,000 Ebola response workers in West Africa were paid on time. UNDP also supported essential community outreach, such as engaging motorbike taxi riders for intensive awareness-raising on Ebola, reaching between 150,000 and 200,000 people over a two-month period in Freetown, Sierra Leone. The Ebola outbreak had a direct impact on Global Fund programmes in Guinea, Liberia and Sierra Leone, jeopardizing the continuity of essential HIV services and retention of people on treatment. UNDP sought to secure access to interventions for antiretroviral HIV-prevention, including prevention of mother-to-child transmission, by helping country coordinating mechanisms to reprogramme existing Global Fund grants to ensure continuity of essential services.

39. UNFPA mobilized over 8,000 Ebola contact tracers, who monitored more than 90,000 contacts, to prevent further transmission. In Sierra Leone, UNFPA supported 450,000 women of reproductive age with reproductive health kits; in Guinea, it provided 10,000 pregnant and Ebola-cured women with hygiene and solidarity kits; and in Liberia, the Fund supported the furnishing of 370 health facilities nationwide (55 per cent) with supplies and equipment for infection prevention and control, as well as reproductive health, including kits for Ebola patients and survivors of gender-based violence (GBV).

♦ **Intellectual property and HIV**

40. In view of the importance of assuring sustained access to affordable HIV drugs and commodities, UNDP supported several low- and middle-income countries to improve treatment access outcomes by providing technical support to incorporate trade-related aspects of intellectual property rights (TRIPS) flexibilities relating to public health into national laws and policies in 2014. Countries benefiting from specific capacity strengthening on the incorporation and use of TRIPS flexibilities included Cambodia, Ghana, Indonesia, Kyrgyzstan, Lesotho, Myanmar, Republic of Moldova, Swaziland, Tajikistan and Zambia.

41. An initiative led by the New Partnership for Africa's Development to ensure the safety, efficacy and availability of medicines in Africa was bolstered through UNDP policy advice to the African Union's African Medicines Regulatory Harmonisation initiative. Other initiatives in Africa to strengthen the policy impacting affordable access to health technologies were also advanced with UNDP support, including in the Economic Community of West African States region on building pharmaceutical manufacturing capacity, and on pooled procurement in the Southern African Development Community. With the launch of a guidebook on using a competition law, a relatively underutilized but effective tool to promote access to health technologies, UNDP provided a broader set of policy measures for low- and middle-income countries to expand treatment access.

♦ **Adolescents and youth**

42. Adolescents and youth bear a significant burden of the HIV epidemic. Efforts to end the epidemic must concentrate on their health and human rights. The PCB requested UNAIDS to support countries to review age and gender barriers to HIV services. This is being operationalized through the 'All In!' campaign – a multi-partner collaboration that aims to end AIDS among adolescents. While all countries are encouraged to join in this global effort, All In! will initially focus on 25 countries encompassing all regions of the world, for intensified support. The initiative was formally launched in February 2015 in Nairobi, and gap analyses have already been undertaken in Jamaica, Swaziland and Zimbabwe. As its contribution to the campaign, UNDP is leading the analysis of laws related to age and gender barriers to HIV services for adolescents. UNFPA co-chairs work streams on country programme support, advocacy and communication, building on the Fund's leadership in youth engagement, empowerment of adolescent girls and access to SRH information and services.

43. UNDP and UNFPA will continue to strengthen and accelerate HIV programmes while finding synergies with other health programmes. This includes integrating HIV into broader health planning, identifying approaches for sustainable financing of comprehensive HIV responses and promoting greater efficiencies in programmes, particularly through integration and decentralization of services. To support countries to reap the benefits of the demographic dividend, UNFPA is advocating for investment in the education and health of adolescents and youth, in particular adolescent girls.

Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

44. Effective education can help prevent new HIV infections and reduce HIV stigma by providing people with information about HIV and how it is passed on – and in doing so, empower people to live healthy and fulfilling lives. In 2014, UNFPA provided technical support to an additional 24 countries to develop comprehensive sexuality education curricula that are aligned with international standards, raising the total to 63. . UNFPA developed operational guidance for comprehensive sexuality education, which will guide future work for young people both in and out of school.

45. In Central Africa, UNFPA, in partnership with United Nations Educational, Scientific and Cultural Organization (UNESCO), revised DVD-based training modules and trained over 1,000 teachers; 420 trainers/supervisors were trained on similar information and communications technology-based modules in Cameroon, Chad, Congo and Gabon. UNESCO and UNFPA supported teacher training in Armenia, Kazakhstan, Kyrgyzstan and Ukraine on SRH and HIV, and an information and communications technology-based training course developed for teacher preparation on health education reached 26,000 educators in the region.

46. UNFPA broke new ground in innovative approaches to engaging adolescent in SRH and HIV. In Cambodia, for example, one million young people were reached through the Love9 social media campaign. UNFPA supported creative peer education approaches to SRH and HIV education in the Arab States region. Theatre-based peer education reached 32,000 young persons in Lebanon, 12,000 in Egypt and 18,000 in the rest of the region; in addition, the Y-PEER 'Let's Talk' campaign reached 1,490,000 young people.

47. UNFPA and UNESCO signed a memorandum of understanding, which will further strengthen their collaboration on comprehensive sexuality education and SRH for adolescents and youth. This will be driven forward through the implementation of UNFPA operational guidance and supporting the implementation of regional commitments.

Achieve gender equality and empower all women and girls

48. Globally, men and women make up an equal share of the people living with HIV. However, in sub-Saharan Africa, women account for 58 per cent of people living with the virus. For social and physiological reasons, adolescent girls and young women are particularly vulnerable; with HIV infection rates more than double those of males in the same age group. HIV is the leading cause of death among women of reproductive age, and it contributes significantly to maternal mortality due to progression of the disease itself and through higher rates of sepsis, anaemia and other pregnancy-related conditions.

49. UNDP and UNFPA, together with UN-Women, are co-convenors within UNAIDS on work on gender equality and women and girls' rights. Achievements in 2014 centred on supporting enabling legal and policy environments, empowering women's groups and addressing GBV.

- **Supporting enabling legal and policy environments**

50. UNDP and UNFPA developed tools to support the integration of gender equality and human rights throughout the planning cycle of HIV prevention and treatment efforts; these include the UNAIDS gender assessment tool; the UNDP road map on mainstreaming gender into national HIV strategies and plans; the UNDP Checklist for Integrating Gender into the New Funding Model of

the Global Fund; and the SRH and HIV Linkages Compendium: Indicators and Related Assessment Tools, produced by the Inter-agency Working Group on SRH and HIV/AIDS Linkages.

51. UNDP strengthened the inclusion of HIV in national gender plans, policies and laws in over 41 countries. Examples include the development and implementation of a monitoring plan on HIV and gender in Malawi; incorporating linkages to gender, GBV and sexual reproductive rights in Namibia; integrating HIV in the five-year national strategic plan on gender equality and the empowerment of women in Cambodia; integrating HIV into the draft sexual-offense bills of Somalia and Jamaica in Asia-Pacific; integrating HIV services into antenatal facilities in Papua New Guinea.

52. In Viet Nam, UNDP, together with the UNAIDS Secretariat, UNICEF and UN-Women, supported consultations on the revision of laws on family and marriage, social insurance and civil status to better reflect gender equality and to remove discriminatory provisions against vulnerable groups, such as children, women, the lesbian, gay, bisexual and transgender (LGBT) people, people living with HIV and key populations. These consultations helped Viet Nam to broaden eligibility for compulsory social insurance. Similarly, in Mozambique, UNDP and the Joint UN Team on AIDS supported the Government and civil society, leading to the passage of a law that decriminalizes HIV transmission and the revision of the civil code and other relevant legislation to ensure greater protection for women. Advocacy with and training for 50 parliamentarians on enabling legal environments, human rights and gender equality by UNAIDS Secretariat, UN-Women, UNFPA and UNDP contributed to the adoption of a protective law on HIV and AIDS for people living with HIV in Côte d'Ivoire.

53. UNDP assisted national partners' environmental and social impact assessment (ESIA), increasing funding from capital projects for gender-responsive HIV programming in at least eight countries. For example, Lesotho improved analysis of HIV and gender in ESIA reports; Mozambique included HIV and gender integration in ESIAs in the new HIV national solidarity programme; Botswana has developed a customized ESIA guideline and established a multisectoral national ESIA monitoring team; South Africa has included a study on the Medupi power station and its overall impact on HIV and gender relations in surrounding communities, and among construction workers.

54. UNDP developed technical guidance to assist countries to integrate gender into national strategic plans and Global Fund processes, resulting in greater attention to the gender dimensions of HIV in Global Fund concept notes and programming in at least eight countries, and guidance for country coordinating mechanisms (Pakistan), national dialogues (Zambia) and concept notes (Kyrgyzstan).

Empowering women's groups

55. UNFPA continued to support activist networks and organisations engaged in policy dialogues to improve the SRH and HIV dimensions of the lives of women and girls. Financial and technical support was provided to sex work networks, and to the Global Network of People living with HIV and the International Community of Women Living with HIV/AIDS to shape policy; the related joint survey on the quality of family planning services for women living with HIV in Cameroon, Nigeria and Zambia was instrumental for influencing rights-based elimination of mother-to-child transmission and family planning programming.

56. UNDP supported engagement of gender and women's movements with networks of HIV affected women and girls. The Karama initiative addresses the needs of women living with HIV through 17 civil society organizations, reaching over 1,300 beneficiaries in seven Middle Eastern and North African countries and nearly 300 micro-projects. It was highlighted as a 'regional development solution' during the first Global South-South Development Expo. UNDP also supported South-South learning and engagement of women living with HIV and sex worker rights networks, for example, between the Eurasian Women's Network on AIDS and the Sex Workers' Rights Advocacy Network.

Addressing gender-based violence

57. UNDP and UNFPA have consistently promoted recognition of GBV as a cause and consequence of HIV, reflected throughout their work on SRHR and HIV linkages. UNFPA South Africa supported a study on violence against women, which is the first ever national effort to gather and analyse data on the scale, determinants, consequences, and responses to GBV in South Africa; this will help shape the country's national solidarity programme on GBV.

58. In South Africa and Botswana, UNFPA strengthened male involvement to support gender equality and GBV prevention using the 'One Man Can' toolkit and modalities. UNFPA Botswana supported a nationally-aired 12-episode radio series and eight call-in radio programmes on SRH, HIV/GBV prevention, condoms, and gender equality. It trained 20 media personnel, resulting in increased coverage of adolescent SRH issues; reached 1,372 marginalized young people and 4059 community members through cultural dialogues, focus-group discussions, youth engagement sessions and other outreach addressing GBV, HIV, gender and cultural and social norms.

59. In 2014, UNDP supported GBV programming in over 30 countries, including specific focus on access to justice in approximately 20 countries. In Papua New Guinea, UNDP support resulted in a GBV strategy, with HIV as a key focus area, addressing the links between violence and HIV transmission; and increased programming for GBV and HIV service provision. UNDP launched a regional initiative with Caribbean Vulnerable Communities, ICW Latina and others to address discrimination against women and girls living with HIV in health-care settings; supported education for nurses and police in Guyana on HIV and GBV in order to reduce discrimination and provide universal access to HIV services; assisted Cambodia to implement its new national action plan on violence against women, with special focus on violence faced by women and girls living with HIV and AIDS, including female sex workers.

60. UNDP supported South-South learning for the Eurasian Women's Network on AIDS with UNFPA, UNAIDS and UN-Women. Capacity-building activities were provided for representatives from national-level associations of women living with HIV from 11 countries (Armenia, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, Ukraine and Uzbekistan) with training to gather evidence on GBV/HIV linkages.

61. UNFPA Zambia supported the Government to incorporate GBV in the revised National HIV and AIDS Strategic Framework 2014-2016, and the national gender policy addressing gender-related causes and impacts of HIV among women and girls, and to continue to roll out the Anti-Gender Based Violence Act of 2011, reaching an estimated 1,000 survivors of GBV with SRH and HIV health services.

62. UNDP and WHO organized a multi-country regional consultation in East and Southern Africa on linkages between the harmful use of alcohol, GBV and HIV that needed policy reform. Participating countries identified priorities and key activities for follow-up. In the Democratic Republic of the Congo, participants in a multisectoral consultation officially adopted a road map on actions to address HIV, GBV and alcoholism, and pledged to raise funds and take action.

63. Looking forward, many challenges remain in addressing the HIV-related needs and the rights of women and girls. These include deeply rooted harmful norms, inadequate resource allocation and a lack of sex-and-age disaggregated data. The UNAIDS agenda for women and girls, which guided the work of the joint programme for the last five years, expired at the end of 2014. It is being reviewed; findings will inform future activities on HIV, gender and the rights of women and girls.

Reduce inequality within and among countries

64. The intersection of AIDS and inequalities provides further opportunities to take the AIDS response out of isolation. AIDS is a disease of inequality, and it disproportionately affects socially marginalized communities. The AIDS movement has demonstrated the importance of putting people and those most affected at the centre of the response, addressing inequalities among social

groups, including criminalized populations and those who have lower rates of access to health care, housing and HIV prevention, as well as higher rates of poverty.

65. Key populations – a term that principally refers to sex workers; men who have sex with men; people who use drugs; and transgender people – are disproportionately affected by the HIV epidemic. Currently, programmes to reach key populations account for just 4 per cent of HIV expenditure. UNAIDS recommended that this expenditure increase to 14 per cent.

66. UNDP and UNFPA worked with WHO and other partners on normative guidance, including consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. In light of rising HIV infections in adolescents and young people, the joint programme drafted technical briefs on HIV and young key populations. Following the success of the sex workers implementation tool, implementation tools for the other key populations were initiated by UNDP, UNFPA and their partners, all to be released in 2015/2016. UNDP worked with the International Labour Organization on a manual on the rights of LGBT workers. UNFPA strengthened key population normative guidance, including co-editing *The Lancet* series on HIV and sex work, which summarized current strategic information and best practices, an Asia-Pacific curriculum for tailoring global tools to country contexts, and a North Africa policy concerning sex work and migration. In addition, UNDP, UNFPA and the Global Network of Sex Work Projects jointly chair the UNAIDS Steering Committee on HIV and Sex Work, which provides strategic guidance on policy, programmatic and data requirements on sex work.

67. UNDP and UNFPA, working with the World Bank, WHO, the Global Fund, MEASURE Evaluation, the United States President's Emergency Plan for AIDS Relief and other key partners, are supporting 38 countries to conduct size estimations and programmatic mapping of key populations for better tailored national and city-level responses. Four countries (Democratic Republic of the Congo, Dominican Republic, Madagascar and Mauritius) have already completed this research.

68. 'Being LGBT in Asia' is a ground-breaking joint initiative by UNDP and the United States Agency for International Development, bringing together grass-roots LGBT organizations, community leaders and national institutions to understand the challenges faced by LGBT people in Asia. Working in eight countries – Cambodia, China, Indonesia, Mongolia, Nepal, Philippines, Thailand and Viet Nam, the effort examines LGBT-lived experiences from human rights and development perspectives. The initiative has established an evidence base on LGBT rights and social issues in the region by convening eight inclusive national dialogues and a regional dialogue. A second phase has started with additional support from Swedish International Development Authority.

69. UNDP and UNFPA supported an innovative study to address violence against sex workers with the Asia Pacific Network of Sex Workers/Centre for Advocacy on Stigma and Marginalisation and the UNAIDS regional support team. Sex workers were centrally involved in conducting research as peer interviewers, supported by qualitative researchers in the four country studies in Indonesia, Myanmar, Nepal and Sri Lanka. Among the findings were that all respondents experience some form of violence, including rape, gang rape, arbitrary detention, beatings, humiliation and public shaming. Often, the perpetrators were members of the police forces. This data is already guiding policy and legislative advocacy and technical support in 2015 and beyond.

70. UNFPA and UNDP assisted review of regulatory frameworks affecting key populations in several countries: occupational health and safety standards for sex workers were improved in China and Colombia; sex work ordinance in Viet Nam was amended to include harm-reduction programming and human rights protection; legal support was provided to people living with HIV and key populations in Georgia; Thailand removed parental consent requirements for adolescent HIV testing and counselling; a series of legal/policy reviews occurred across Eastern and Southern Africa on adolescent SRH and GBV including for LGBT youth within schools.

71. The continued use of a 'health lens' approach allows for pragmatic public health responses, including engagement of both health providers and key population networks. However, inadequate attention has been given to improving the legal status, human rights, and other enabling environment issues that block their access to services. UNDP and UNFPA will continue to support and link both community-led and government responses to facilitate continued impact.

Make cities and human settlements inclusive, safe, resilient and sustainable

72. As the world becomes increasingly urbanized, so too is the HIV epidemic. Population growth and urbanization are projected to add 2.5 billion people to the world's urban population by 2050. It is estimated that in sub-Saharan Africa, HIV prevalence in urban areas is now double that of rural areas. Focusing on municipal levels allows HIV responses to have a more granular and targeted approach. Building on the UNDP/UNFPA-led Urban Health and Justice initiative, UNAIDS launched on World AIDS Day 2014 the Fast-Track Cities initiative.

73. In 2014, the Urban Health and Justice initiative operated in over 42 cities strengthening local governance and planning with direct engagement of key populations groups of men who have sex with men, sex workers, transgender people and people who use drugs, to improve the responsiveness of local HIV strategies to the needs of these communities. In Mozambique, services for key populations in cities were integrated in the new national strategic plan on AIDS. In Asia-Pacific, WHO and UNDP are rolling out a training package to address stigma and discrimination in health-care settings with government health departments and community-based organizations in 12 countries.

Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

74. Stigma and discrimination against key populations remain one of the major barriers to effective HIV responses worldwide. Punitive laws remain in place against people living with HIV, sex workers, transgender people, men who have sex with men and people who inject drugs in many countries. Lack of domestic resources, limited quantitative data and insufficient focus on key population programming perpetuates this discrimination and limits the effectiveness of responses. The 35th PCB reflected on a report on actions taken by the joint programme to reduce HIV-related stigma and discrimination in all forms.

75. In 2014, UNDP supported Governments and civil society in advancing the recommendations of the Global Commission on HIV and the Law in 84 countries. UNDP developed guidance documents on how to conduct legal environment assessments (LEA) and national dialogues to support countries in advancing the findings and recommendations of the Global Commission on HIV and the Law. The documents have been used to support countries in pursuing law reform in several countries. The LEA tool is now a part of Global Fund's guidance on developing HIV concept notes; the guidance will also be adapted for tuberculosis and malaria.

76. National dialogues on HIV and the law were held in 19 countries in Asia and the Pacific region. In Pakistan, the dialogue led to the passing of the Sindh Provincial AIDS Law, the first AIDS law in South Asia. The Governments of Bangladesh, India, Nepal and Pakistan recognized transgender/*hijra* as a third gender. UNDP supported a regional HIV legal network providing people with HIV and key populations in Eastern Europe and Central Asia (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation and Ukraine) with access to quality free legal aid. From January to September 2014, more than 1,200 requests for HIV-related legal assistance were processed. In Africa, UNDP support resulted in HIV-related law review and reform in Lesotho, Namibia, Swaziland and United Republic of Tanzania; the East African Community developed and validated an analysis of how HIV laws of partner States align with the new HIV bill of the East African Community; and the Economic Community of West African States Secretariat drafted a minimum HIV law package for adoption by member States.

With support from UNDP, Chad amended current laws to include protections for people living with HIV; Mozambique approved a new HIV law free of provisions criminalizing HIV transmission; and Nigeria passed an anti-stigma bill. In the Arab States, UNDP supported the Government of Djibouti to commit to ratifying the Arab Convention on HIV Prevention and Protection of the Rights of People Living with HIV.

77. UNDP supported the establishment of the Africa Regional Judges' Forum on HIV, Human Rights and the Law. The first forum comprised of judges from Botswana, Kenya, Malawi, Namibia, South Africa, Swaziland, the United Republic of Tanzania and Zimbabwe. Discussions at the forum focused on challenging current laws, and criminalizing provisions posed in preventing access to HIV, health and other social services for women and girls, people living with HIV and key populations. The forum agreed to form a core group of judicial experts, who will capacitate themselves to become an expert group for judicial excellence in the context of HIV, human rights and the law in the region.

78. UNDP supported six countries in Latin America to revise HIV laws (Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Uruguay). Two laws have been presented to parliaments in Costa Rica and Uruguay, and one law has been approved in Honduras. UNDP supported the review of gender identity laws in Costa Rica, El Salvador, Guatemala and Nicaragua. Support was provided to the Dominican Republic to remove punitive articles from draft HIV legislation and to support the drafting of anti-discrimination legislation.

79. Laws and policies need to be continuously monitored since positive changes can be easily be reversed. By succinctly laying out the public health and human rights evidence and advancing the rationale for legal reform, the report of the Global Commission brings further impetus and focus to these efforts, and facilitates sharing good practices between countries. It is therefore important to continue to support countries in advancing the Commission's follow-up in collaboration with stakeholders including interested governments, United Nations partners and civil society.

IV. Conclusion

80. The SDG implementation agenda offers a unique opportunity to adopt a more people-oriented approach to global health that leaves single-sector approaches behind, and addresses the structural drivers of the HIV epidemic. In the context of HIV, this means scaling up critical AIDS and SDG strategies that deliver shared gains, ensuring policy environment support sustaining these benefits, and expanding the AIDS and SDG partnerships to mobilize a broad range of health and development actors. Without a more joined-up way of working, the international community will not be able to ensure healthy lives and well-being for all.

81. Two agenda-setting processes in 2016 will have a major impact on the future of the global response to AIDS: the United Nations General Assembly Special Session on drug policy and the High-level Meeting on AIDS. UNDP and UNFPA will support Member States to use the Special Session as an opportunity to rethink international approaches to drug use to be more inclusive of human rights and public health. UNDP and UNFPA will support the High-level Meeting on AIDS to reinvigorate political commitment to ending AIDS as part of the SDG agenda, which will be informed by the UNAIDS strategy 2016-2021.

82. Redoubling efforts to reduce inequity, confront stigma and discrimination, and ensure the human rights of all people, will be critical to ending the AIDS epidemic. Looking forward, there is a strong global consensus on the proposed target of ending the AIDS epidemic by 2030. By fully implementing the fast-track approach of the UNAIDS strategy, UNDP and UNFPA, together with other co-sponsors and the UNAIDS Secretariat, could avert nearly 28 million new HIV infections and 21 million AIDS-related deaths by 2030.