UNAIDS 2012-2015 UNIFIED BUDGET AND ACCOUNTABILITY FRAMEWORK

ACHIEVING THE “GETTING TO ZERO” VISION
BY COMBINING THE EFFORTS OF
THE JOINT PROGRAMME TO IMPLEMENT
UNAIDS 2011-2015 STRATEGY

Outline for stakeholder comments and consultation
PURPOSE OF THIS DOCUMENT

This document is an initial draft of the outline of the 2012-2015 UNAIDS Unified Budget and Accountability Framework (UBAF) which serves as an instrument to translate the strategic goals of the UNAIDS 2011-2015 Strategy into action.

The document is a means to gather inputs from a broad range of stakeholders through a consultative process. Comments received on this initial outline will be taken into account and reflected in the further development of the 2012-2015 UBAF.

The deadline for written comments on this outline is close of business on 16 March 2011.

The UBAF development process is aimed at being as consultative as possible and involves a broad array of stakeholders. It is characterized by a collaborative approach involving not only UNAIDS Secretariat and all Cosponsors, but also Governments, civil society, funding organizations, foundations and regional development banks as well as other international organizations.

A multi-stakeholder consultation will take place on 10 March 2011 to seek input from this wide range of stakeholders in the further development of the UBAF, in particular the Business Plan. The consultation will be chaired by Madame Mariame Sy of Senegal, chair of the Programme Coordinating Board (PCB) Subcommittee on the formulation of the UBAF. Other members of the Subcommittee are also expected to attend the consultation, and a meeting of the Subcommittee is scheduled for 11 March 2011 to consider the outcomes of the consultation. This will allow the consultation to feed into discussions of the PCB Subcommittee as well as the Committee of Cosponsoring Organizations (CCO) at the end of March.

The document will also be posted on the UNAIDS website and input sought directly from all interested parties.

The next steps in further developing the UBAF will focus on:

■ Reflecting the contributions of each Cosponsor and the Secretariat that will be an integral part of and incorporated in the Accountability Framework

■ Establishing indicators and targets against each strategic goal / cross-cutting strategic area to measure achievements and progress

■ Incorporating regional / country priorities in the Unified Budget and Accountability Framework
1. EXECUTIVE SUMMARY

The UNAIDS Unified Budget and Accountability Framework (UBAF) is the successor to the Unified Budget and Workplan (UBW), the Joint Programme’s instrument that aims at maximizing the coherence, coordination and impact of the UN’s response to AIDS by combining the effort of 10 UN Cosponsors and a Secretariat. The UBAF is being envisaged as a simple yet comprehensive mechanism for planning, managing, monitoring and reporting on the activities of the Joint Programme.

The UNAIDS 2011-2015 Strategy adopted by the PCB in December 2010 aims at achieving UNAIDS “getting-to-zero” vision. This includes:

- Zero new HIV infections
- Zero AIDS-related deaths
- Zero discrimination

The UBAF outlines how the Joint Programme will contribute to the achievement of this Strategy in terms of (a) operational actions, (b) required resources and (c) monitoring of progress and results. It incorporates:

- A Business Plan that provides a framework to capture the contribution of the Joint Programme to operationalize UNAIDS 2011-2015 Strategy.
- An Accountability Framework that will measure the achievements of the Joint Programme and provide a clear link between investments and results.
- A Budget to fund the core contributions of the Cosponsors and Secretariat in 2012-2015 to operationalize the goals of UNAIDS Strategy.

These elements of the UBAF are guided by UNAIDS 2011-2015 Strategy, the ten strategic Goals in the Strategy and cross-cutting strategic areas represented by (i) leadership and advocacy, (ii) coordination, coherence and partnerships, and (iii) mutual accountability.
2. BACKGROUND

A. UNAIDS ACHIEVEMENTS AND CHALLENGES

The world was slow to react to the HIV epidemic 30 years ago, with devastating results and 30 million lives that have been lost due to AIDS. Nonetheless, during the past decade, political and financial commitment to address HIV has increased and the global response to AIDS has demonstrated its ability to transform resources into concrete results for people.

New HIV infections have fallen by nearly 20% in the last 10 years. AIDS-related deaths have fallen by nearly 20% in the last 5 years. At least 56 countries have stabilized or significantly slowed down the rate of new HIV infections. This includes nearly all countries in sub-Saharan Africa. On human rights, more countries than ever before are reporting on efforts to address stigma and discrimination within their national AIDS responses.

We are seeing a return on investments in HIV prevention efforts—efforts that have broken the trajectory of the epidemic. People are starting to adopt safer behaviours. Young people in particular are leading a prevention revolution. They are doing this by delaying the first time they have sex, having fewer partners and increasing condom use. Between 2000 and 2008, the rate of new HIV infections among young people declined by more than 25%. These results were seen in 15 of the most affected countries in sub-Saharan Africa. Fewer babies are being born with HIV and HIV infection rates among children have dropped by 24% in five years. Elimination of mother-to-child transmission is possible by 2015.

We can now say that for every one person accessing treatment two people will become infected. Clearly, treatment needs are still outpacing prevention efforts, but we are closing the gap. Millions of people are also living longer, as access to HIV treatment services are scaled up. However, these remarkable gains are at risk, and despite these gains, in 2009, an estimated 2.6 million people were newly infected with HIV.

Many areas still require significant effort and focus. For example, around 49 countries and territories include HIV as a basis for denying visas or residence permits. Also several countries have still not implemented legal protection on discrimination against people living with HIV.

1 UNAIDS, 2012-1015 Strategy, Getting to zero
Drug use and related HIV infection are also still under-addressed. For example the figure below presents 15 countries that have a large number of people who inject drugs (more than 100,000) coupled with a high prevalence of HIV among this population (exceeding 20%).

Similar needs are observed among men who have sex with men, sex workers and their clients, and transgender people in many countries.

The future costs that HIV imposes on people, families, communities and countries will be determined by how the HIV response will be repositioned to respond to the shifts in the overall context of the response. Choices will be shaped by scarce resources, shifting global priorities and the types of new alliances forged. Success or failure will be determined by how prevention programmes are focused, how the next phase of treatment is delivered, and the strength of our collective commitment to human rights and gender equality. In this context, the global HIV response finds itself at a critical juncture in which the gains of the past are at risk and current approaches are reaching their limits.

**B. UNAIDS UNIQUE VALUE-ADD**

UNAIDS is not a single entity but a Joint Programme which relies on the combined, coordinated and targeted efforts of 10 Cosponsors and a Secretariat to respond to the epidemic. It was established to draw on the experience and strengths of the cosponsoring organizations in developing coherent strategies and policies, providing assistance to build country and community capacity, and mobilizing political and social support for action to prevent and respond to AIDS, while involving a wide range of sectors and institutions at national level.

---

2 Economic and Social Council (ECOSOC) Resolution 1994/24, issued 26th July 1994, Annex
At country-level, UNAIDS works through Joint Teams and Joint Programmes of Support as part of efforts to foster coordination and multi-sectoral collaboration for the UN to ‘Deliver as One’. Through its near universal country presence and extensive partnerships, UNAIDS has a unique role to play in efforts to achieve the vision of zero new HIV infections, zero AIDS-related deaths and zero discrimination by:

- Generating, analyzing and promoting the use of strategic information to guide evidence-based policies and resources allocation;
- Working with countries and donors to ensure that resources for the AIDS response are invested in the most effective and efficient way, and;
- Advocating for human and gender rights and to drive the AIDS response at global, regional and country level.

Since UNAIDS was established in 1996, the annual budget of the programme has grown four-fold (from US$60 million to US$242 million) while global resources for AIDS have seen a fifty-fold increase (from US$300 million to approximately $16 billion last year). Compared to the overall funding for AIDS, UNAIDS budget is modest, in particular considering the resources leveraged for the response to AIDS through UNAIDS advocacy, strategic information and initiatives supported by UNAIDS. This is particularly true when it comes to the catalytic role of UNAIDS core resources have played in mobilizing international and domestic resources for AIDS at the country level. This catalytic role in leveraging HIV/AIDS funding goes beyond UNAIDS Cosponsors, including major funding organizations like the Global Fund to Fight AIDS, TB and Malaria and bilateral programmes such as PEPFAR, and other partners.

As part of the efforts of UNAIDS, its Secretariat performs a critical role in providing leadership in the response to AIDS and advocating, brokering, convening and catalyzing action to address financial, social, political, legal and structural barriers that limit the effectiveness of the response, promoting coherence, enabling delivery at the local level, and monitoring progress.
C. THE CHANGING ENVIRONMENT AND THE IMPLICATIONS FOR THE AIDS RESPONSE

Three main external factors require an adaptive response from the UN Joint Programme on AIDS (UNAIDS), namely (a) the nature and the changes of the epidemic, (b) economic constraints, and (c) the shifting donor landscape.

A changing epidemic – In numerous countries, for example in South Asia and sub-Saharan Africa, new epidemiological patterns have emerged, with older adults in stable, long-term relationships representing a growing proportion of people newly infected. For example, in Lesotho, an estimated 62% of incident infections in 2008 were among adults in long-term relationships.

New infections are increasing again in Eastern Europe and Central Asia, with an estimated 87,000 infections in 2008, more than three times higher than the estimated 26,000 in 2001. With increasing transmission among the sexual partners of drug users, many countries in the region are experiencing a transition from an epidemic that is heavily concentrated among drug users to one that is increasingly characterized by significant sexual transmission.

Asia’s epidemic has been concentrated in specific populations, namely injecting drug users, sex workers and their clients, and men who have sex with men. However, the epidemic is steadily expanding into lower-risk populations. In China, for example, where the epidemic was previously driven by transmission during injecting drug use, heterosexual transmission has become the predominant mode of HIV transmission.

In the USA, the proportion of new infections among men who have sex with men has been rising since the early 1990s and by 2006 constituted the largest fraction of new HIV infections, a pattern that has also been seen in a number of other western countries.

Economic constraints – The global AIDS response has been remarkably successful in mobilizing funding – yet the positive growth rate is unlikely to continue given the global macroeconomic conditions. To achieve universal access to prevention, treatment, care and support, total annual investments in the response must reach US$ 25.1 billion, roughly 40%

---


4 AIDS Outlook 2010. UNAIDS.
more than total investments in 2008. The enduring global economic difficulties are likely to imperil both the gains achieved thus far, as well as efforts to close coverage gaps. According to the World Bank, 40% of low- and middle-income countries are highly exposed to the global economic crisis, limiting their resources allocated towards the AIDS response.

**Shifting donor landscape** – Compounding the economic crisis are a shifting donor landscape and perceived changing priorities. Several donor countries have adjusted their aid modalities by removing “earmarks” for AIDS in their budgets in order to give policymakers more flexibility to shift resources to other priorities. In order to ensure sustainable financing, there is a need to increase domestic investments rather than being dependent on international assistance.

There also appears to be a financing and policy shift among donors towards favoring countries with a high burden of disease and lower income status. There is a risk that this could have profound effects on most-at-risk-populations (MARP s) that comprise concentrated epidemics in certain countries, if sufficient domestic resources to reach these groups cannot be assured.

**D. LESSONS LEARNT**

Over many years, UNAIDS has focused on joint planning, coordinated resource mobilisation and collective reporting, and many lessons can be learnt from the experience of UNAIDS. While there are clearly transaction costs of bringing together 10 UN entities, these have been outweighed by reduced fragmentation, improved coherence and increased effectiveness.

A budget focused on results accompanied by a performance monitoring framework, regular dialogue with key stakeholders and high quality reporting have been important in developing and maintaining the confidence of UNAIDS donors and other partners. A peer review mechanism has been an integral part of the Unified Budget and Workplan (UBW) and has ensured the identification of gaps, elimination of duplication and enhanced accountability.

---

5 AIDS Outlook 2010. UNAIDS.
With resource mobilisation the responsibility of the Executive Director of UNAIDS, multiple and competing fundraising efforts have been avoided, which has been appreciated by donor governments. The autonomy given to the UNAIDS Executive Director to decide on the allocation of resources – against specific outcomes and outputs approved by the PCB – and performance-based release of funds have provided important flexibility for the Joint Programme to respond to emerging needs.

In 2010, the UNAIDS Board agreed a series of recommendations based on the outcomes of an independent evaluation of the Joint Programme’s activities and structure. Implementation of the outcomes will be completed in 2011 and will deliver on the evaluation’s goals of ensuring that UNAIDS is focused, strategic in its approach, flexible, efficient and responsive, and with improved accountability and governance. The evaluation led directly to the development of the “UNAIDS Strategy 2011-2015: Getting to Zero” and the ongoing development of the UBAF (described in this document) to reinforce existing review mechanisms, reporting and accountability based on the 2011-2015 UNAIDS Strategy.

3. UNAIDS VISION AND 2011-2015 STRATEGY

A. VISION

As recommended by the independent evaluation, UNAIDS has developed a new vision and mission statement for the Joint Programme to ensure focus and strategic orientation. The new vision positions UNAIDS in the response, recognizing the changing nature of the epidemic and environment to achieve the ultimate vision of **zero new HIV infections, zero AIDS-related deaths** and **zero discrimination**.

The new vision and mission statement were approved at the 26th PCB meeting in June 2010 and highlight the contribution of the Joint Programme in the response and the role UNAIDS needs to play going forward (see box below).

---

**UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support.**

**Uniting** the efforts of United Nations System, civil society, national governments, the private sector, global institutions and people living with and most affected by HIV;

**Speaking out** in solidarity with the people most affected by HIV in defense of human dignity, human rights and gender equality;

**Mobilizing** political, technical, scientific and financial resources and holding ourselves and others accountable for results;

**Empowering** agents of change with strategic information and evidence to influence and ensure that resources are targeted where they deliver the greatest impact; and

**Supporting** inclusive country leadership for sustainable responses that are integral to and integrated with national health and development efforts.
B. UNAIDS 2011-2015 STRATEGY

UNAIDS 2011-2015 Strategy emerged from several months of intensive multi-stakeholder consultation and negotiation through which key strategic issues for the next five years of the global response were identified. These include:

- Redoubling political commitment to sustain and accelerate gains and an ambitious set of targets
- Ensuring diversified, predictable and sustainable financing in the context of flat-lining of resources
- Enabling country ownership and mechanisms of mutual accountability for resources and results
- Promoting the meaningful participation of people living with HIV, affected and vulnerable populations
- Maximizing efficiencies by reducing unit costs, implementing and scaling up innovative delivery systems, and integrating HIV and primary health care services
- Recalibrating the technical support market for enhanced transparency and strengthening of lasting national institutions

The Strategy presents UNAIDS vision for the transformative agenda needed for the global HIV response. Major components of the transformative agenda include:

---

**Increasing focus, efficiency and mutual accountability.** Focus on results and efficiency to dramatically and drastically reduce new infections. This new medium-term agenda emphasizes increased focus and reaping efficiencies to ensure that resources are deployed optimally to achieve zero duplication, zero incoherence and zero waste.

Accountability can be enhanced through three core themes: a) people inclusive responses reaching out to the most vulnerable, mobilizing communities and protecting rights; b) country owned sustainable responses, with diversified financing and strengthened systems; c) synergies maximized with movements united, services integrated and efficiencies achieved across the Millennium Development Goals (MDGs).

**Partnerships.** Looking for new kinds of partnerships which will reach out to the broader development and human rights areas, increase south-south collaboration, ensure country ownership and engage emerging economies. A new paradigm is needed which creates a movement towards social justice, where all people deserve access to health, including the most vulnerable ones, often PLHIV.

New partnerships are about leveraging resources through alliances and networks, the full involvement of people infected and affected by HIV, stronger connections with young people, women’s movements, parliamentarians, media, etc. This includes more strategic partnerships with the private sector, universities, think-tanks and implementers, to ensure that these continue to serve as an engine of innovation—in delivering new tools ranging from treatment advances to logistics and applications of new social media, and in finding solutions to specific obstacles that hold back progress.
The AIDS response is essential to achieving the Millennium Development Goals (MDGs), and conversely the MDGs have a role in achieving universal access to HIV prevention, treatment, care and support. By situating the AIDS response within the broader development agenda and integrating AIDS with other health, development and human rights efforts, the world can accelerate progress across the array of MDGs, optimize efficiency in the use of resources and save and improve more lives.

To be effective and sustainable, the AIDS response – working strategically with other development partners – must continue to ramp up its push for positive social change and become more holistic in approaching these drivers and their companion health, development and rights challenges that affect and are affected by the epidemic - such as maternal and child health, gender violence and inequality, and universal education.

Accountability through shared ownership is a guiding principle that must guide UNAIDS collective focus on three core themes across all responses: people, the primacy of countries and the pursuit of synergies.

UNAIDS Strategy for 2011-2015 was adopted by the PCB at its December 2010 meeting. It includes three strategic directions and ten corresponding strategic goals to support the “getting-to-zero” vision. The achievement of those ten strategic goals is further underpinned by three cross-cutting strategic areas – see figure below:
## A. Strategic direction 1: Revolutionize HIV prevention

1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work
2. Vertical transmission of HIV eliminated, and AIDS related maternal mortality reduced by half
3. All new HIV infections prevented among people who use drugs

## B. Strategic direction 2: Catalyze the next phase of treatment, care and support

1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment
2. TB deaths among people living with HIV reduced by half
3. People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

## C. Strategic direction 3: Advance human rights and gender equality

1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half
2. HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions
3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses
4. Zero tolerance for gender-based violence

### D. Cross-cutting strategic areas

1. Leadership and Advocacy: to mobilize commitment and influence the setting of a rights-based and gender-sensitive HIV political agenda for the 10 strategic goals
2. Coordination, coherence and partnerships: to ensure delivery on the 10 strategic goals
3. Mutual accountability: to enhance programme efficiency and effectiveness and optimally deliver on the Joint Programme mission, vision and strategy with measurable results

Given the changing nature of the epidemic and the need for greater focus, UNAIDS will not only have to concentrate its efforts programmatically, but also consider how to provide support to countries in a way which has the greatest impact on the epidemic.6

By providing enhanced support to 20 priority countries – shown in the figure below – UNAIDS will be able to:

- Tackle 74% of new HIV infections globally
- Address over 80% of the gap between need and actual coverage of ART
- Cover over 75% of the global gap in prevention of vertical transmission and 95% of the global burden of HIV-associated TB

---

6 UNAIDS 2011-2015 Strategy
The HIV epidemic has also reached catastrophic proportions in some smaller countries such as Botswana, Lesotho, Namibia and Swaziland and some countries in the Caribbean. Due to their small population size, such countries contribute little to the global burden of disease, but investing in strengthened HIV responses is critical to their very survival, and they too must be given priority for support.

By focusing on a set of priority countries, UNAIDS can achieve the greatest impact, and this must be a guiding principle to respond to the call of the PCB that the UBAF be formulated based on epidemic priorities. At the same time, the Joint Programme will need to provide support to all other AIDS-affected countries. As the UBAF is developed further it will for each goal in the Strategy specify the kind of support that will be provided to different countries.

4. **THE UBAF - A FUNDAMENTAL CHANGE**

As described above, the UBAF comprises three main elements:

- A Business Plan
- An Accountability Framework
- A Budget

As an instrument to operationalize the UNAIDS 2011-2015 Strategy, the UBAF will need to demonstrate clear linkages to the UNAIDS 2011-2015 Strategy and the accountability of the Joint Programme vis-à-vis the goals in the Strategy. The UBAF will need to be based on country and epidemiological priorities with the budget and resources aligned to strategic goals as well as regional and country priorities.
As an approach, the UBAF is a fundamentally different from the past and will:

- Be guided by UNAIDS Vision, Mission and Strategy and be clearly aligned with the three strategic directions and the corresponding ten strategic goals
- Allocate resources based on epidemic priorities, the performance of the Cosponsors, and the funds that Cosponsors themselves raise (not entitlements or pro-rata increases)
- Be country focused, incorporate regional and country priorities, and leverage UN system (and other organizations) capacities at country level
- Have special focus on a set of priority countries with the greatest impact on the epidemic
- Be a results framework (building on 2009-2011 outcome framework and business cases), rather than a workplan
- Present the expected results and contributions of the Cosponsors and the Secretariat and have clear performance criteria which serve as a basis for resource allocations
- Have a four-year planning cycle with biennial budget cycles and a one-year revolving planning cycle that incorporates broad stakeholder reviews of performance
- Capture global as well as all HIV-targeted country level resources and show UNAIDS role as catalytic force for the AIDS response

The proposed structure of the 2012-2015 UBAF is shown in the figure below:
5. BUSINESS PLAN

The following Business Plan has been developed to ensure a clear link to strategic directions and corresponding strategic goals / cross-cutting strategic areas, specifically; key programmatic elements which directly support objectives, which in turn contribute to the strategic goal / cross-cutting strategic area.

For each strategic goal / cross-cutting strategic area, the Business Plan also outlines the rationale for addressing the goal (“where are the gaps / needs”) and will focus on regions and countries based on epidemiologic priorities to ensure maximum impact.

The following pages and tables present a first draft of the elements of the Business Plan
A. STRATEGIC DIRECTION 1: REVOLUTIONIZE HIV PREVENTION

To achieve universal access to HIV prevention, treatment, care and support, prevention spending ought to constitute approximately 45% of the global resource needs for the HIV response based on UNAIDS’ estimates. In reality, funding for HIV prevention has become the smallest part of the HIV budgets of many countries. In 2007, countries spent on average only 21% of HIV-related resources on prevention efforts.

This is a complex and challenging issue which requires the Joint Programme to urgently work together to further intensify prevention efforts. UNAIDS must invigorate a Combination Prevention Revolution to achieve our bold vision of zero new infections.

The Joint Programme will contribute to the following three strategic goals:

1) Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work
2) Vertical transmission of HIV eliminated, and AIDS related maternal mortality reduced by half
3) All new HIV infections prevented among people who use drugs

Summary of the Objectives and Key Programmatic Elements of the Joint Programme
- To be further detailed

REVOLUTIONIZE HIV PREVENTION – Region and country focus
- Regional priorities and inputs from regions have been incorporated in developing the following tables. During further development of the Business Plan, regional and country priorities will be captured more specifically.
A. Strategic direction 1: Revolutionize HIV prevention – Vision: To get to Zero New Infections

1. Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>What the Joint Programme aims to achieve - objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sexual transmission remains the main route of HIV transmission (80%) of the estimated 2.6 million people newly infected with HIV in 2009. Heterosexual exposure is the primary mode of transmission in sub-Saharan Africa where more women than men are living with HIV, and young women are as much as eight times more likely than men to be HIV positive.</td>
<td>• Know your epidemic. Know your response is at the centre of funded national strategic and operational plans in all countries.</td>
</tr>
<tr>
<td>• Globally, 40% of HIV infections and more than half of all other sexually transmitted infections occur among young people aged 15 to 24 and, men who have sex with men, sex workers, and transgender people have higher rates of HIV infection than the general population. Despite this, less than 3% of global prevention funding in spent on these populations.</td>
<td>• Evidence-informed combination prevention programmes are incorporated into national strategic and operational plans and are funded and implemented in at least 25 priority countries.</td>
</tr>
<tr>
<td>• Most young people, sex workers, men who have sex with men and transgender people still have no access to sexual and reproductive health programmes that provide the information, skills, services and commodities or the social support they need to prevent HIV. Many laws and policies go as far as to exclude these populations from accessing sexual health and HIV-related services. Programmes targeting prevention, addressing stigma, discrimination, violence and criminalization need to be scaled up (or started where non-existent) towards a social transformation to increase access to prevention.</td>
<td>• 25 priority countries are supported to implement evidence-based, prioritized, effective and efficient combination HIV prevention programs.</td>
</tr>
<tr>
<td>• Particular settings and situations exacerbate HIV vulnerability including humanitarian settings, where are the gaps/needs in 50 countries.</td>
<td>• In all countries, reduced demand for unprotected sex including unprotected paid sex.</td>
</tr>
<tr>
<td>• Where are the gaps/needs in 50 countries.</td>
<td>• Countries capacitated to intensify demand and access to existing prevention technologies and to rapidly introduce and scale up new prevention technologies as they become available.</td>
</tr>
<tr>
<td>• How the Joint Programme will achieve it – key programmatic elements</td>
<td>• Establishment of essential HIV/SRH services, legal support and strong community action by and for sex workers, men who have sex with men and transgender populations in at least 50% of municipalities in 50 countries.</td>
</tr>
<tr>
<td>Over the 2012-2015 period, UNAIDS will:</td>
<td>• Strengthened positive social norms and removal of harmful social norms towards an enabling environment to significantly expand access to and demand for comprehensive HIV and SRH services in at least 25 countries.</td>
</tr>
<tr>
<td>• Increase access to and generate demand for male and female condoms, including within humanitarian response situations in all countries.</td>
<td>• Improved knowledge, demand and use of HIV testing services and condoms by young people at high risk of infection in at least 17 countries.</td>
</tr>
<tr>
<td>• Build evidence base and other strategic information on combined effective and efficient prevention methods for generalized and concentrated epidemics.</td>
<td>• Support the development of HIV prevention policies and scale up of prevention and care services for vulnerable workers (including mobile and migrant workers), displaced populations, and young people in key economic sectors in 25 high burden countries.</td>
</tr>
<tr>
<td>• Strengthen HIV surveillance systems to enable effective analysis and use of HIV incidence including age and population-disaggregated data in at least 20 countries.</td>
<td>• Support key service providers in at least 17 countries to implement, monitor and evaluate HIV prevention programs targeting young people in school and community settings including comprehensive sexuality education, HIV testing and risk reduction counseling, and condom programmes.</td>
</tr>
<tr>
<td>• Support evidence-based advocacy for the removal of legal, social, economic and cultural barriers to accessing SRH education and prevention services for men who have sex with men and sex workers in 50% of municipalities in 50 countries</td>
<td>• Strengthen capacity of young people, youth-led organizations and partners to serve as complementary service providers and engage in scaling-up existing evidence-informed prevention approaches and driving the development of HIV prevention interventions in all countries.</td>
</tr>
<tr>
<td>• Empower organizations of sex workers, men who have sex with men, transgender people and most at risk adolescents and young people to be included as partners in expanding access to and delivery of comprehensive HIV/SRH programmes.</td>
<td>• Advocate for and support research efforts on new and emerging HIV prevention technologies and approaches [including microbicides, pre-exposure prophylaxis, HIV vaccines] and support their inclusion in the scale up of combination prevention if they continue to show effectiveness in trials.</td>
</tr>
<tr>
<td>• Support key service providers in at least 17 countries to implement, monitor and evaluate HIV prevention programs targeting young people in school and community settings including comprehensive sexuality education, HIV testing and risk reduction counseling, and condom programmes.</td>
<td>• Support scale-up of medical male circumcision programmes (covering biomedical and behavioural aspects) in 13 high-burden countries.</td>
</tr>
<tr>
<td>• Strengthen capacity of young people, youth-led organizations and partners to serve as complementary service providers and engage in scaling-up existing evidence-informed prevention approaches and driving the development of HIV prevention interventions in all countries.</td>
<td>• Support in national prevention programmes of early diagnosis and prevention support for people living with HIV including HIV-positive adolescents.</td>
</tr>
<tr>
<td>• Advocate for and support research efforts on new and emerging HIV prevention technologies and approaches [including microbicides, pre-exposure prophylaxis, HIV vaccines] and support their inclusion in the scale up of combination prevention if they continue to show effectiveness in trials.</td>
<td>• Support the development of HIV prevention policies and scale up of prevention and care services for vulnerable workers (including mobile and migrant workers), displaced populations, and young people in key economic sectors in 25 high burden countries.</td>
</tr>
<tr>
<td>• Support scale-up of medical male circumcision programmes (covering biomedical and behavioural aspects) in 13 high-burden countries.</td>
<td>• Support implementation of HIV prevention policies and programmes for uniformed services, people living in prisons and other closed settings in XX countries.</td>
</tr>
</tbody>
</table>
## A. Strategic direction 1: Revolutionize HIV prevention – Vision: To get to Zero New Infections

### 2. Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half

### Where are the gaps/needs

- Preventable mother-to-child transmission of HIV in low- and middle-income countries remains unacceptably high with approximately 370,000 children newly infected in 2009. Globally, only 24% of pregnant women received an HIV test and only 53% of pregnant women living with HIV received antiretroviral drugs to reduce the risk of transmitting HIV to their infants in 2009, with nearly half still receiving less efficacious regimens.

- Comprehensive PMTCT programming requires implementation of 4 key programme elements: 1) preventing HIV in women of reproductive age; 2) preventing unintended pregnancies in women living with HIV; 3) reducing HIV transmission from women living with HIV to their infants, and 4) providing appropriate early treatment and care for women living with HIV, their children and families.

- National efforts are often hampered by low geographic and facility coverage, poor quality of services, and barriers to access and utilization of services. HIV contributes 9% to maternal mortality in sub-Saharan Africa.

- Key gaps include full implementation of routine HIV testing (PITC), involvement of male partners, scale-up of more efficacious regimens (both ARVs and ART) based on the 2010 WHO guidelines, safer infant feeding with ARV prophylaxis during breastfeeding, effective strategies to reduce new infections in women (and especially adolescent girls), access to family planning, integration with maternal newborn child health and reproductive health, and effective linkages with HIV care and treatment. In prisons settings, pregnant and nursing women’s access to PMTCT is especially low.

### What the Joint Programme aims to achieve - objectives

- National MTCT elimination plan implemented in the 22 priority countries in sub-Saharan Africa and Asia accounting for about 90% of the pregnant women living with HIV and also home to over 80% of the children under 15 needing antiretroviral therapy so that transmission rate is <5% by 2015.

- Support all countries in developing and implementing national MTCT elimination plans to reduce overall vertical transmission by 90% from 2009 baseline.

- Overall improvements in maternal and child health and survival.

### How the Joint Programme will achieve it – key programmatic elements

Over the 2012-2015 period, UNAIDS will:

- Publicize and implement the global MTCT elimination strategic and monitoring framework.

- Regularly update policy, operational and clinical guidance for PMTCT.

- Keep the momentum on elimination of MTCT through high level leadership, advocacy and resource mobilisation.

- Promote comprehensive HIV prevention and treatment services for pregnant women and their children, support bidirectional integration of HIV with maternal, newborn and child health and sexual and reproductive health services in all countries with a focus on the 22 high burden countries. Special attention will be paid to treatment for mothers’ own health, addressing loss to follow up and quality of PMTCT services, drug-using HIV positive pregnant women, safer infant feeding - including increasing adoption of exclusive breastfeeding - male partner involvement, and the integration of nutrition and food support within PMTCT programmes to increase adherence, treatment success and HIV–free survival.

- Focus on supporting primary prevention of HIV in women of childbearing age, particularly pregnant women and prevention of unintended pregnancies in women living with HIV as part of rights-based sexual and reproductive health as well as scaling up ARV prophylaxis and treatment for mothers and children.

- Strengthen capacities in the 22 high burden countries to improve follow-up, including referrals, treatment and reproductive health services for HIV positive pregnant women, their infants and adolescents.

- Focus on nationwide integration of PMTCT in maternal neonatal child health, improve uptake and attendance of PMTCT, sexual and reproductive health and MCH services and address maternal and child malnutrition in the context of PMTCT in all countries.
A. Strategic direction 1: Revolutionize HIV prevention – Vision: To get to Zero New Infections

3. All new HIV infections prevented among people who use drugs

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>What the Joint Programme aims to achieve - objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opioid substitution therapy (OST) is available in 70 countries and needle and syringe programmes (NSP) in 82 countries. Globally, people who inject drugs have access to fewer than two clean needles per month. Nearly 3 million people who inject drugs are living with HIV, and 13 million more are at risk of HIV infection. Excluding sub-Saharan Africa, this adds up to 30% of all new HIV infections in the world.</td>
<td>• Harm reduction services and drug dependence treatment programmes scaled up including in prisons and other closed settings in XX priority countries, consistent with UN guidance.</td>
</tr>
<tr>
<td>• Certain types of non-injecting drugs, such as amphetamine-type stimulants and crack cocaine, have been associated with the sexual transmission of HIV in different regions. But coverage with evidence based HIV interventions, even for people who inject drugs, is below 10%.</td>
<td>• Reduction in the incarceration of drug users</td>
</tr>
<tr>
<td>• HIV epidemics have been well documented among injecting drug users in prisons with very low access to harm reduction services. Comprehensive HIV services for drug users in prisons are available in less than 10 countries.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the Joint Programme will achieve it – key programmatic elements</th>
<th>Over the 2012-2015 period, UNAIDS will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support the adoption of evidence-informed and human rights focused HIV and drug use policies and strategies in XX countries (XX countries by 2013).</td>
<td></td>
</tr>
<tr>
<td>• Support XX countries to scale up comprehensive package of HIV prevention, treatment and care interventions including drug dependence treatment programmes, including in prisons and other closed settings (XX countries by 2013).</td>
<td></td>
</tr>
<tr>
<td>• Support the generation and use of strategic information on prevalence, social/behavioural risk determinants and service coverage and quality among drug users and among people living in prisons and other closed settings in XX countries (XX countries by 2013).</td>
<td></td>
</tr>
<tr>
<td>• Support voluntary access by drug users to alternative measures to detention and incarceration in XX countries (XX countries by 2013).</td>
<td></td>
</tr>
</tbody>
</table>
B. STRATEGIC DIRECTION 2: CATALYZE THE NEXT PHASE OF TREATMENT, CARE AND SUPPORT

Catalyzing the next generation of treatment, care and support will deliver a radically simplified treatment platform that is good for people living with HIV and will also cut new infections by scaling up treatment access. The next phase of treatment, based on new drug regimes, will adopt innovative delivery models that both reduce unit costs and recognize and empower communities to demand and deliver better and more equitable treatment, care and support services that maximize links with other health and community services.

The Joint Programme will contribute to the following three strategic goals:

1) Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment
2) TB deaths among people living with HIV reduced by half
3) People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

Summary of Objectives and Key Programmatic Elements of the Joint Programme

- To be further detailed

CATALYZE THE NEXT PHASE OF TREATMENT, CARE AND SUPPORT – Region and country focus

- Regional priorities and inputs from regions have been incorporated in developing the following tables. During further development of the Business Plan, regional and country priorities will be captured more specifically.
### B. Strategic direction 2: Catalyze the next phase of treatment, care and support – Vision: To get to Zero AIDS-related Deaths

#### 1. Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>What the Joint Programme aims to achieve - objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Over 5 million people were receiving antiretroviral therapy (ART) as of end 2009, 36% of those eligible by WHO 2010 guidelines. Only 28% of all children younger than 15 years who are eligible have access to treatment. Ten million people in need of ART do not have access.</td>
<td>▪ Contribute to the global goal of universal access to ART for all people living with HIV who are eligible by 2015 with particular focus in 20 priority countries (covering 80% of the global gap in ART for eligible adults).</td>
</tr>
<tr>
<td>▪ Structural and other barriers continue to result in inequitable access for many vulnerable and Most-At-Risk Populations (MARPs). Current guidelines recommend treating people earlier – with CD4 counts of ≤350. Earlier treatment also enhances HIV and TB prevention.</td>
<td>▪ Through the Treatment 2.0 initiative, the Joint Programme will support action globally and in countries to achieve the five priorities of Treatment 2.0: optimize drug regimens, advance point-of-care and other simplified platforms for diagnosis and monitoring, reduce costs, adapt service delivery systems and mobilize communities.</td>
</tr>
<tr>
<td>▪ The cost of treatment is, however, becoming prohibitive. Drug regimens used to treat adults and children remain too complex and expensive. HIV diagnosis and treatment monitoring remain too complex and expensive. Access to HIV and non-HIV health services is constrained by under-resourced health systems, and many ART programmes are not well-integrated with prevention services, with other health services or with community systems and services.</td>
<td>▪ In addition, the Joint Programme will contribute to enhancing equity access for children, women and men, MARPS, populations affected by humanitarian situations and other vulnerable populations, and strengthen linkages with food and nutritional support.</td>
</tr>
<tr>
<td>▪ The risk of death among malnourished people who start ART is 2-6 times higher than among non-malnourished people, independent of CD4 count. People living with HIV and affected communities remain insufficiently engaged.</td>
<td></td>
</tr>
<tr>
<td>▪ There is a need to expand related services that improve treatment outcomes, including those aimed at promoting and protecting human rights, food and nutritional support, family, workplace and humanitarian settings support services.</td>
<td></td>
</tr>
</tbody>
</table>

#### How the Joint Programme will achieve it – key programmatic elements

Over the 2012-2015 period, UNAIDS will:

- Provide overall leadership and advocacy to mobilize resources for treatment and for partners to achieve the goals of Treatment 2.0 at the global, regional and country levels
- Drive the development of new HIV interventions and support implementation of comprehensive HIV packages, including nutrition and/or food support, for key populations (XX countries by 2013)
- Identify evidence gaps and advocate for research across the thematic areas noted above
- Expand and revise global normative guidance for treatment in the areas of drug regimen optimization, simplified monitoring and service delivery, to include new clinical guidelines, guidance to increase retention in care, overcome barriers to integration of treatment with TB, Hep C, and other OIs and co-morbidities, and operational tools to enhance equity and linkages to nutritional and other areas of support
- Ensure that cost-reduction and financial sustainability plans for drugs and diagnostics, including attention to TRIPS flexibilities, pooled procurement and local production, are fully implemented (XX countries by 2013)
- Produce strategic information to track progress on achieving the five priorities of treatment 2.0 and guide countries in their efforts to scale up ART.
- Provide technical assistance to all countries, with intensified support to 20 priority high prevalence and strategic countries with low ART coverage.
### B. Strategic direction 2: Catalyze the next phase of treatment, care and support – Vision: To get to Zero AIDS-related Deaths

#### 2. TB deaths among people living with HIV reduced by half

**Where are the gaps/needs**

- Tuberculosis is the leading cause of death among HIV infected people. In 2009, cases of HIV and TB co-infection accounted for more than 23% of all TB deaths and 22% of all deaths among people living with HIV (0.4 million deaths in 2009). 83% of HIV-related deaths occur in sub-Saharan Africa (mortality is 20 times higher than elsewhere in the world). Only 140,000 TB patients living with HIV received ART in 2009.

- The 2004 WHO "Interim" Policy on collaborative TB/HIV activities focuses on decreasing the joint burden of tuberculosis and HIV for adults and children. Prevention of TB among people living with HIV requires prevention interventions for both HIV infection and TB including earlier anti-retroviral therapy and the Three I's for HIV/TB: isoniazid preventive therapy (IPT) for adults and children, intensified case finding (ICF) and infection control for TB (IC).

- A strong TB program is important for those diagnosed with TB. Malnutrition in co-infected individuals jeopardizes the effectiveness of treatment.

- The implementation of the Three I's for HIV/TB and earlier ART has been very slow. By the end of 2009 only 86,000 of the 33.4 million people living with HIV had received IPT and only 1.7 million people estimated to be living with HIV were screened for TB; ART treatment coverage for people living with HIV is below 40%.

- Barriers to the implementation of the Three I's for HIV/TB and earlier ART include: a lack of political leadership and weak advocacy, misconceptions about IPT, weak drug supply chain, lack of health care worker knowledge of IPT, missing monitoring and evaluation systems for collaborative TB/HIV activities.

**What the Joint Programme aims to achieve - objectives**

- The Joint Programme aims to achieve a 50% reduction in TB deaths among adults and children living with HIV by 2015.

- The focus will be on achieving universal access to comprehensive/integrated HIV and TB prevention, diagnosis and treatment services.

- TB prevention interventions for adults and children include the Three Is for HIV/TB as well as earlier initiation of antiretroviral treatment.

- The Joint Programme will also work towards reducing vulnerability and factors that put individuals at risk of HIV-related TB, such as poor housing, poor working conditions, drug use and poor nutrition. Integration of nutritional and food support with treatment programmes and other HIV services will be promoted.

**How the Joint Programme will achieve it – key programmatic elements**

Over the 2012-2015 period, UNAIDS will:

- Expand normative guidance and tools including issuing 2011 HIV/TB collaborative activities policy, country adaptation guides, new HIV/TB monitoring and evaluation tools

- Provide technical assistance on HIV-associated TB recommendations to all countries, with intensified support to 21 countries that contribute 85% of the global burden of TB cases among people living with HIV.

- Produce strategic information to track implementation and impact progress and guide countries in their efforts

- Provide global leadership and advocacy to mobilize resources and partners to focus on integrated approaches to addressing HIV/TB

- Strengthen the integration of food and nutrition support into treatment programs for vulnerable TB patients in all countries (XX countries by 2013)
### B. Strategic direction 2: Catalyze the next phase of treatment, care and support – Vision: To get to Zero AIDS-related Deaths

#### 3. PLHIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

| Where are the gaps/needs | People infected and affected by HIV still face significant barriers accessing HIV treatment, care and support. HIV sensitive social protection, including social transfers, as part of national social protection systems, can significantly scale up access to services among people living with and affected by HIV.
| | Coverage of comprehensive social protection remains low, particularly in low income countries and for populations of humanitarian concern. An estimated 75-80% of the global population does not have access to social protection measures to allow them to deal with life’s risks. On average 11% HIV affected households caring for children get any form of external support. Integration of treatment programmes with food and
| | Nutritional support remains inadequate. Weight loss or malnutrition may impact the effectiveness of antiretroviral therapy.
| | Financial barriers to treatment also threaten treatment access and adherence. Caregivers, who are predominantly female, continue to face a high financial and emotional burden. Many national strategies lack comprehensive care and support programmes, including access to palliative care.

| What the Joint Programme aims to achieve - objectives | At least 20 countries have in place national HIV sensitive social protection policies and programmes, which are incorporated within national AIDS and development plans and budgets.
| | Improved food security and nutrition for vulnerable people living with and/or affected by HIV in these 20 countries.
| | Parity between orphan and non-orphan access to primary and secondary school education in high prevalence countries.
| | Facilitate access to HIV services for populations of humanitarian concern.

| How the Joint Programme will achieve it – key programmatic elements | Over the 2012-2015 period, UNAIDS will:
| | Support the development of national HIV strategies in at least 15 countries which include comprehensive approaches to care and support, including palliative care and support for care givers.
| | Strengthen and make HIV-sensitive social welfare and child protection systems in 20 countries.
| | Scale up social transfers (cash/food/vouchers) and sustainable livelihoods programmes for the poorest HIV-affected households in 15 countries.
| | Increase access and adherence to treatment through stigma reduction, food and nutrition and equitable health financing.
| | Promote equitable and sustainable financing mechanisms for HIV-affected individuals and households.
| | Strengthen and disseminate global evidence on HIV sensitive social protection.
| | Social protection schemes covering workers made HIV-sensitive.
| | Prioritize HIV care and support in global response to humanitarian emergencies.
C. STRATEGIC DIRECTION 3: ADVANCE HUMAN RIGHTS AND GENDER EQUALITY FOR THE HIV RESPONSE

Advancing human rights and gender equality for the HIV response means ending the HIV-related stigma, discrimination, gender inequality and violence against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services. It means putting laws, policies and programmes in place to create legal environments that protect people from infection and support access to justice. At the core of these efforts is protecting human rights in the context of HIV – including the rights of people living with HIV, women, young people, men who have sex with men, people who use drugs and sex workers and their clients.

The Joint Programme will contribute to the following four strategic goals:

1) Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half
2) HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions
3) HIV-specific needs of women and girls are addressed in at least half of all national HIV responses
4) Zero tolerance for gender-based violence

Summary of Objectives and Key Programmatic Elements of the Joint Programme

- To be further detailed

ADVANCE HUMAN RIGHTS AND GENDER EQUALITY FOR THE HIV RESPONSE – Region and country focus

- Regional priorities and inputs from regions have been incorporated in developing the following tables. During further development of the Business Plan, regional and country priorities will be captured more specifically.
C. Strategic direction 3: Advance human rights and gender equality for the HIV response – Vision: To get to Zero Discrimination

1. Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half

| Where are the gaps/needs | • Protective legal environments are essential to the achievement of universal access to HIV prevention, treatment, care and support, while punitive laws and practices undermine the HIV response. Two-thirds of countries now have some form of legal protection against discrimination for people living with HIV. Unfortunately, roughly one-quarter of countries have inappropriately framed laws that broadly criminalize HIV transmission or exposure, creating legal disincentives to HIV testing and disclosure while doing little or nothing to reduce new infections.  
  
• Protection against discrimination based on HIV status remains an urgent priority in all countries, as does legal protection for women and legal access to HIV services and commodities for young people. Despite widespread and sometimes virulent homophobia, the number of countries decriminalizing homosexual behavior is slowly increasing. Nevertheless, over one-third of countries still criminalize same-sex activities between consenting adults, and there is a strong association between such illegality and poor service coverage and uptake.  
  
• Legal barriers to universal access for sex workers and drug users are particularly severe. Legal access to comprehensive harm reduction services and products is demonstrably associated with a dramatic reduction in HIV infections linked to injection drug use, but globally, less than 10% of injecting drug users have access to harm reduction services. At least 32 countries have death penalty of drug users and 27 countries have compulsory drug detention centres. Similarly, few countries have legal environments that facilitate organization and self-protection amongst sex workers. |

| What the Joint Programme aims to achieve - objectives | • Inappropriate criminalization of HIV transmission and legal barriers to HIV service utilization reversed in at least 20 countries.  
  
• Stigma and discrimination reduced and access to justice increased for people living with HIV and other key populations in all countries. |

| How the Joint Programme will achieve it – key programmatic elements | Over the 2012-2015 period, UNAIDS will:  
  
• Support the empowerment of key populations and people living with HIV to claim their rights and to act as forces of change in all countries and in relevant global forums and processes.  
  
• Further develop and update the evidence base, including documentation of relevant laws and practices that facilitate or impede effective responses to HIV, and facilitation of good practice through South-South learning and exchange.  
  
• Support learning and dialogue amongst parliamentarians, human rights bodies, the judiciary, the legal profession, public health leaders and key populations in at least 50 countries with counter-productive laws or legal environments, with a view to initiate and support movements for law reform, drawing as appropriate on the ILO international labour standard on HIV and AIDS and the world of work.  
  
• Strengthen local capacity to reduce stigma and discrimination and to expand access to legal services and legal literacy for key populations. |
### C. Strategic direction 3: Advance human rights and gender equality for the HIV response –
#### Vision: To get to Zero Discrimination

### 2. HIV-related restrictions on entry, stay and residence eliminated in half of all national HIV responses

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>What the Joint Programme aims to achieve - objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Some 48 countries continue to deny entry, stay and residence based on HIV positive status. This is discriminatory and achieves no valid public health goal. These restrictions are often a proxy indicator of high levels of discrimination against people living with HIV and can undermine commitment to effective, evidence-based HIV prevention approaches.</td>
<td>▪ The lifting of all restrictions on entry, stay and residence that are based on HIV positive status only or that apply blanket restrictions against HIV positive people.</td>
</tr>
<tr>
<td>▪ Change is possible. Recently, five countries – China, India, Ukraine, the United States of America and Uruguay – have lifted such restrictions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the Joint Programme will achieve it – key programmatic elements</th>
<th>Over the 2012-2015 period, UNAIDS will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Continue to monitor and share information about restrictions on entry, stay and residence affecting people living with HIV, including HIV-related restrictions that apply in particular to refugees, asylum seekers, foreign students and foreign academics.</td>
<td>▪ Continue to monitor and share information about restrictions on entry, stay and residence affecting people living with HIV, including HIV-related restrictions that apply in particular to refugees, asylum seekers, foreign students and foreign academics.</td>
</tr>
<tr>
<td>▪ Continue education and dialogue with key stakeholders and influencers in countries with such restrictions, to build national coalitions for relevant law and regulation reform.</td>
<td>▪ Continue education and dialogue with key stakeholders and influencers in countries with such restrictions, to build national coalitions for relevant law and regulation reform.</td>
</tr>
<tr>
<td>▪ Support dialogue between Gulf States and countries that send significant numbers of migrants to the Gulf States to both remove relevant travel restrictions and to improve HIV-related services for migrants.</td>
<td>▪ Support dialogue between Gulf States and countries that send significant numbers of migrants to the Gulf States to both remove relevant travel restrictions and to improve HIV-related services for migrants.</td>
</tr>
</tbody>
</table>
### C. Strategic direction 3: Advance human rights and gender equality for the HIV response – Vision: To get to Zero Discrimination

#### 3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>What the Joint Programme aims to achieve - objectives</th>
<th>How the Joint Programme will achieve it – key programmatic elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thirty years into the HIV epidemic, women and girls face many interacting socio-cultural, economic and legal challenges, including human rights violations and discrimination, which put their health and rights at risk. These issues not only limit the autonomy and ability of women and girls to protect themselves from HIV, but also hinder access to services and ultimately the ability of women and girls to exercise their human rights. Globally half of all people living with HIV are women and girls, 60% in sub-Saharan Africa. HIV contributes to 20% of maternal deaths.</td>
<td>Implementation of evidence-informed HIV prevention, treatment, care and support policies, programmes, and services for women and girls across the full range of their lives including:</td>
<td>Over the 2012-2015 period, UNAIDS will:</td>
</tr>
<tr>
<td>• Women in marginalized groups, such as women who use drugs, are prisoners, or in humanitarian settings are particularly vulnerable. Young women between 15-24 years of age are two to eight times more likely to have contracted HIV than men of the same age group.</td>
<td>• better evidence and increased understanding of the specific needs of women and girls with tailored national AIDS responses</td>
<td>• Support at least 50 countries to undertake a broad consultative process to identify the key issues faced by women and girls in the context of HIV, and agree on relevant strategic actions, guided by the UNAIDS Agenda for Women and Girls.</td>
</tr>
<tr>
<td>• It is essential to increase the focus on women in national HIV responses and combine HIV-related funding with other resources to address the full range of women’s and girls’ needs, including sexual and reproductive health through a multisectoral approach across the span of their lives and according to special circumstances such as displacement.</td>
<td>• scaled-up action and resources</td>
<td>• Support at least 25 countries to incorporate strategic actions for women and girls into their national AIDS strategic plans, with appropriate budgets for implementation, monitoring, and evaluation.</td>
</tr>
<tr>
<td></td>
<td>• an enabling environment that promotes and protects the human rights of women and girls and their empowerment</td>
<td>• Support all countries to better link gender, sexual and reproductive health, and HIV at the policy, systems, and services delivery levels including access to comprehensive, good quality, sexual and reproductive health, harm reduction and drug dependence treatment programmes, education, information and services for women and girls, in all settings, including during humanitarian situations (50 countries by 2013).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support interventions to address gender equality, by engaging men and boys in programmes that challenge traditional norms of masculinity and unequal gender relations. (25 countries by 2013).</td>
</tr>
</tbody>
</table>
C. Strategic direction 3: Advance human rights and gender equality for the HIV response – Vision: To get to Zero Discrimination

4. Zero tolerance for gender-based violence

| Where are the gaps/needs |  
|-------------------------|---|
| • Cross-sectional research from Africa and India has consistently found that women who have experienced gender-based violence (GBV) are more likely to be infected with HIV. Similarly, disclosure of HIV status may catalyze GBV, and fear of GBV may delay a woman’s decision to disclose her HIV status and/or to access health services. |
| • Girls are at increased risk for infection due to social and cultural norms that dictate how women, especially young women, and men negotiate sexual behavior. These same gender norms often condone GBV. |
| • Overall, GBV is widespread. Depending on the country, between 15% and 71% of women aged 15 to 49 years report experiences of physical or sexual violence by a husband or intimate partner. Rape and sexual violence is widespread in many settings, and is of particular concern in conflict situations and humanitarian emergencies. Lesbians, gay men, bisexuals and transgender people (LGBT), as well as sex workers, are typically more affected by GBV than surrounding populations. |
| • Young people have particular needs; about 20% of girls and 10% of boys experience sexual abuse globally, and early sexual debut in general is associated with a higher risk of contracting HIV and experiencing GBV. |
| • Increasing evidence of the linkages between GBV and HIV demands more strategic attention to GBV in HIV programming and more attention to HIV in GBV programming. However, action against GBV in and of itself is still not clearly prioritized in many countries and there is often a lack of clarity on the relative roles and contributions of law enforcement, gender equality ministries or services, and health services. Addressing the intersection of GBV and HIV can be even more challenging. |

| What the Joint Programme aims to achieve - objectives |  
|-------------------------|---|
| • All countries have improved their understanding of the scale and scope of GBV and its links to HIV, with commensurate policy responses. |
| • GBV associated with HIV is measurably reduced in the countries where GBV is significantly associated with HIV incidence or HIV disclosure. |

| How the Joint Programme will achieve it – key programmatic elements |  
|-------------------------|---|
| Over the 2012-2015 period UNAIDS will: |
| • Consolidate, analyze and promote the use of evidence related to the prevalence of violence against women and violence against LGBT and sex workers; the association of GBV and HIV; and proven, effective policy and programmatic responses. |
| • Widen the scope of action and the range of actors linking GBV and HIV, working closely with UNWomen, the UNiTE campaign, efforts to address GBV among LGBTIs, and organizations engaging men and boys as partners for gender equality. |
| • Support 10 crisis/post-crisis countries significantly affected by HIV to scale up, promote, support and coordinate integration of GBV and HIV into conflict prevention, resolution and recovery efforts, including with refugees and internally-displaced people. |
| • Support hyperendemic countries to integrate or strongly link strategies, plans, policies, services, resource allocation programming addressing the combination of HIV prevention, treatment, care and support, gender equality and gender-based violence. |
| • Ensure that all countries reviewing or developing national HIV strategies or GBV strategies have access to evidence on GBV/HIV linkages and support to integrate appropriate policies and programmes, including on how to engage men and boys as partners for gender equality. |
D. CROSS-CUTTING STRATEGIC AREAS

Underpinning the work of the Joint Programme are cross-cutting strategic areas which primarily fall under the responsibility of UNAIDS Secretariat. These include:

1) Leadership and political advocacy based on analysis of strategic information, as well as its generation where there is a gap
2) Coordination, coherence and partnerships across all priority areas
3) Mutual accountability of the Secretariat and Cosponsors, including the compilation and synthesis of data on the epidemic and response that reflect the impact of the Joint Programme

Summary of Objectives and Key Programmatic Elements of the Joint Programme
- To be further detailed

CROSS-CUTTING STRATEGIC AREAS – Region and country focus
- During further development of the Business Plan, regional and country priorities will be captured.
### D. Cross-cutting strategic areas

#### 1. Leadership and Advocacy

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>What the Joint Programme aims to achieve - objectives</th>
</tr>
</thead>
</table>
| Leadership, political and resource commitments have been shown to be prerequisites for a successful multi-sectoral AIDS response. Such leadership needs to be enhanced and maintained, and requires investments in rights-based, evidence-informed and gender responsive programmes that target current drivers of the HIV epidemic and link HIV to the broader health and development agenda. | Positive and measurable movement on controversial issues.  
Excellence in national responses that are based on evidence, gender equality, human rights and equity.  
Renewed and expanded political commitment to such responses in terms of national ownership across a broader range of key stakeholders.  
AIDS integrated into global health, human rights, gender, and development agendas. |

#### How the Joint Programme will achieve it – key programmatic elements

Over the 2012-2015 period, UNAIDS will:

- Promote transformative leadership and commitment for a sustainable AIDS response including at national, local and community levels and among key populations.
- Promote links between HIV responses and the broader MDG agenda as well as cross-cutting strategies that deliver in a cost-effective manner on multiple MDGs at the same time.
- Ensure that national responses in 20 key countries respond fully to "Know Your Epidemic" analysis, addressing those most vulnerable to HIV with adequate and tailored prevention, treatment, care and support programmes.
- Significantly expand programmes/resources/strategies to work with PLHIV in terms of positive health, dignity and prevention.
- Convene and strengthen civil society, including PLHIV, communities and FBOs.
- Undertake advocacy to secure the highest levels of commitment, effective partnerships and investment of national resources to advance gender equality and rights-based AIDS responses in an efficient and sustainable manner.
- Generate strategic information and intelligence on countries and regions to inform high level decision making and prioritization of the AIDS response at all levels.
- Engage inter-governmental and inter-agency fora, multilateral institutions and funding mechanisms in the implementation of UNAIDS Strategy.
- Mobilise resources for UNAIDS catalytic role in the AIDS response.
D. Cross-cutting strategic areas

2. Coordination, coherence and partnerships

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The changing environment demands greater coherence, coordination and innovative partnerships to enable nationally owned and people centered approaches address challenges within an increasingly complex and competitive environment.</td>
</tr>
<tr>
<td>• Strategic plans are not aligned with the epidemiological situation, are often not operationalized, are not linked with existing budgets and are often too complex.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What the Joint Programme aims to achieve - objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A new paradigm for technical, political and financial partnerships and programmes that accelerate social change.</td>
</tr>
<tr>
<td>• AIDS responses are country-owned, human rights-based, appropriate, coordinated and sustainable.</td>
</tr>
<tr>
<td>• Implementation of evidence-informed, prioritized, costed national strategic and operational plans which are aligned to other sectoral plans and development processes to achieve Universal Access targets.</td>
</tr>
<tr>
<td>• AIDS strategic planning improves allocative and program efficiency and effectiveness and program sustainability.</td>
</tr>
<tr>
<td>• Technical and policy support are demand driven and cost effective.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How the Joint Programme will achieve it – key programmatic elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the 2012-2015 period, UNAIDS will:</td>
</tr>
<tr>
<td>• Collaborate with People Living with HIV, key populations and young people to engage in and influence the design and decision-making of national and sub-national HIV policies and plans through community generated data and approaches (XX countries by 2013)</td>
</tr>
<tr>
<td>• Strengthen national capacity, systems and institutions, including HIV and health information systems with an increasing emphasis on south to south and regional cooperation, to address a new phase of prevention, treatment and care programmes (XX countries by 2013)</td>
</tr>
<tr>
<td>• Develop strategic alliances and partnerships to enhance access to safe and affordable quality diagnostics and treatment for potential efficiency gains (XX countries by 2013)</td>
</tr>
<tr>
<td>• Engage further the private sector in all countries to facilitate and strengthen the national AIDS response (XX countries by 2013)</td>
</tr>
<tr>
<td>• Maximize efficiency and sustainability of HIV programmes through alignment with and integration into broader health and development strategies</td>
</tr>
<tr>
<td>• Support the development and implementation of national strategic planning and programme tools (including third generation of National Strategic Plans, Modes of Transmission, National AIDS Spending Assessments, sectoral operational plans, mid-term reviews) (XX countries by 2013)</td>
</tr>
<tr>
<td>• Develop and implement, with effective financing by partners, Joint Operational Plans (XX countries by 2013)</td>
</tr>
</tbody>
</table>
## D. Cross-cutting strategic areas

### 3. Mutual accountability

<table>
<thead>
<tr>
<th>Where are the gaps/needs</th>
<th>The Secretariat and Cosponsors need to enhance programme efficiency and effectiveness to deliver on a shared Joint Programme Vision, Mission and Strategy, with measurable results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the Joint Programme aims to achieve - objectives</td>
<td>UNAIDS delivers value for money, clearly managing high impact operations that link human and financial resources to results and demonstrate improved efficiency, effectiveness and outreach.</td>
</tr>
<tr>
<td>How the Joint Programme will achieve it – key programmatic elements</td>
<td>Over the 2012-2015 period, UNAIDS will:</td>
</tr>
<tr>
<td></td>
<td>- Develop mutual accountability frameworks and systems for delivery of UNAIDS Vision, Mission and Strategy, with measurable results at global, regional and country levels</td>
</tr>
<tr>
<td></td>
<td>- Develop a Programme-wide culture of joint action and accountability with results based management, policies focusing on cost effectiveness and technologically innovative solutions for monitoring, learning and reporting</td>
</tr>
<tr>
<td></td>
<td>- Conduct systematic reviews, and where applicable implement reforms, of country level Joint Programmes of Support on AIDS</td>
</tr>
<tr>
<td></td>
<td>- Build and further strengthen systems and tools to collect, manage and disseminate evidence on the epidemic and on the response to inform decision making at community, country, regional and global levels</td>
</tr>
<tr>
<td></td>
<td>- Advocate for stronger community involvement in service delivery and renewed country ownership</td>
</tr>
</tbody>
</table>
6. PRINCIPLES AND APPROACH TO ACCOUNTABILITY AND INDICATORS

As previously described, the UBAF will be linked directly to the goals in the UNAIDS 2011-2015 Strategy and be a higher-level results framework (as opposed to a workplan as in previous biennia). For the first time, UNAIDS will have a four-year planning cycle, from 2012-2015 (instead of two years) which aims at demonstrating clear links between resources invested and results.

Performance monitoring of the UBAF will be guided by the principles outlined in the UN Evaluation Group norms and standards, principles established by the Development Assistance Committee of the Organization for Economic Co-Operation and Development (OECD/DAC), and other evaluation policies and guidelines adopted in the UN system.

In accordance with a decision of UNAIDS Board, Secretariat and Cosponsor performance will be defined around commitments made on development of UN capacity and results at country level. Progress against the goals in the UNAIDS 2011-2015 Strategy and contributions of UNAIDS will therefore primarily be measured at the country level and include more stakeholder involvement than in the past.

A provisional set of 40-50 indicators, has been identified for the UBAF, and these will form a basis for setting targets across the four year period of the UBAF. Following consultation in the Cosponsor Evaluation Working Group, the indicators have been drawn from Cosponsor corporate results frameworks to ensure balance across the ten strategic goals of the UNAIDS 2011-2015 Strategy and the Division of Labour Areas.

The largest group of indicators will be drawn from the revised indicators endorsed by the HIV and AIDS Monitoring and Evaluation Group in February 2011, building on the updated set of indicators of the 2001 UN General Assembly Declaration of Commitment on HIV/AIDS. These indicators will link to other UN initiatives and global AIDS and MDG indicators, and be complementary to indicators developed by other key partners such as the Global Fund and PEPFAR.

To minimize duplication and maximize coherence, Cosponsors will principally report individual achievements through their own organizational indicators and reports, a key element of their own accountability. The UBAF will link to these indicators and reports but will focus on demonstrating what the Joint Programme has achieved through combining individual Cosponsor and Secretariat efforts while emphasizing mutual accountability.
7. **PRINCIPLES AND APPROACH TO BUDGET AND RESOURCES ALLOCATION**

The UBAF is proposed to include four budget areas with the first three mirroring the Strategic Directions in UNAIDS Strategy:

A. Strategic Direction 1: Revolutionize HIV prevention;
B. Strategic Direction 2: Catalyze the next phase of treatment, care and support;
C. Strategic Direction 3: Advance human rights and gender equality for the HIV response;
D. Cross-cutting strategic areas.

The budget will:

- Have two two-year cycles (2012-2013 and 2014-2015) which will be reviewed annually.
- Present two main types of funding, ‘core UBAF’ and ‘other HIV and AIDS funds’\(^7\). The ‘Other HIV and AIDS funds’ will encompass all UNAIDS-related spending at country, regional and global levels, including funding at country level that has previously fallen outside of the UBW;
- Be divided into two main components, ‘Cosponsor’ and ‘Secretariat’\(^8\);
- Present funding for global level activities separated from funding for regional and country level activities which will be combined together;
- Be aligned as far as possible to ongoing planning and budget processes of the Cosponsors;
- Ensure comparability with previous budget allocations to facilitate comparison.

Rather than entitlement and pro-rata increases, allocation of funds will be based on epidemic priorities, the performance of the Cosponsors, and the funds that individual Cosponsors raise at global and regional levels. To address epidemic priorities, funds will be allocated through by strategic directions and goals and by geographical region.

\(^7\) There will be a detailed breakdown of ‘own’ funds in an annex providing additional details of Cosponsors’ assessed contributions or regular budgets and supplemental funds.

\(^8\) The ‘Interagency’ component in previous UBWs will be integrated in Secretariat and Cosponsor components.
APPENDIX 1: ABBREVIATIONS

- ART – Anti-Retroviral Treatment
- BRICS – Brazil, Russia, India, China and South Africa
- GNP+ – Global Network of People living with HIV
- GIPA – Greater Involvement of People living with HIV
- ILO – International Labour Organization
- MARPs – Most At Risk Populations
- MDGs – Millennium Development Goals
- MSM – Men having Sex with Men
- NGO – Non-Government Organisation
- PCB – UNAIDS Programme Coordinating Board
- PLHIV – People Living with HIV
- PMTCT – Prevention of Mother To Child Transmission
- SIE – Second Independent Evaluation
- TB – Tuberculosis
- TRIPS – Trade Related Aspects of Intellectual Property Rights
- UBAF – Unified Budget and Accountability Framework
- UBW – Unified Budget and Workplan
- UNAIDS – United Nations Joint Programme on HIV/AIDS
- UNDP – United Nations Development Programme
- UNESCO – United Nations Educational, Scientific and Cultural Organization
- UNFPA – United Nations Population Fund
- UNHCR – Office of the United Nations High Commissioner for Refugees
- UNICEF – United Nations Children’s Fund
- UNIFEM – United Nations Development Fund for Women
- UNODC – United Nations Office on Drugs and Crime
- WB – World Bank
- WFP – World Food Programme
- WHO – World Health Organization
APPENDIX 2: GLOSSARY – to be discussed at the MS Meeting

- Key populations – to be developed
- Vulnerable groups – to be developed
- People living with and/or affected by HIV – to be developed
- Harm reduction – to be developed
- Comprehensive education programmes – to be developed
- Combination prevention – to be developed
- Multisectoral response – to be developed
- Risk populations – to be developed
- (...)