GAPS AND NEEDS BY STRATEGIC GOAL / FUNCTION

A. 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	
Where are the gaps/needs	▪ 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. ▪ 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. ▪ Most young people, sex workers of all genders, 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. ▪ Particular settings and situations exacerbate HIV vulnerability including humanitarian settings, prison and other closed settings and in the context of migration and mobility. For example, uniformed services and armed groups are vulnerable to acquiring HIV through sexual transmission given that they are mostly young, away from home for long periods of time, have ready cash and have risk taking behaviours, especially in humanitarian contexts.

2. Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half	
Where are the gaps/needs	▪ Although preventable mother-to-child transmission of HIV in low- and middle-income countries remains unacceptably high with ~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 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, stigma and discrimination, poor quality of services and effective integration and linkages to HIV prevention interventions and family planning services, as well as barriers to access and utilization of services. Equity issues hinder access to services of IDUs, pregnant and nursing women in prison settings, marginalized populations, adolescents, etc. 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. The global, regional and national PMTCT effort is now transitioning from scale-up to elimination.

3. All new HIV infections prevented among people who use drugs	
Where are the gaps/needs	▪ Worldwide, nearly 3 million people who inject drugs are living with HIV, and another 13 million more are at risk of HIV infection. ▪ In addition, different amphetamine type stimulant drugs and crack cocaine, both in their injectable and non-injectable forms, and alcohol use (intoxication), have been associated with the sexual transmission of HIV. ▪ HIV service coverage is below 10% - globally, people who inject drugs have access to fewer than two clean needles per month; 8% have access to opioid substitution therapy; and only 4% of the HIV infected people who inject drugs have access to antiretroviral therapy. ▪ High levels of stigma around drug use and discrimination against people who use drugs, even by service providers, severely limit delivery and access to essential HIV services. ▪ People who use drugs are also vulnerable to other viral and bacterial infections including hepatitis, tuberculosis and sexually transmitted infections and to death from overdose. Hepatitis C infections among people who inject drugs in many countries have been reported to be more prevalent, sometimes as high as 90%. This is an important early indicator of unsafe drug injecting practices which can lead to potential HIV outbreaks in countries with currently low HIV prevalence among people who inject drugs. ▪ Many of those who use drugs are between the ages of 10 to 24 years. In some countries, the majority of people who inject drugs fall within this age group. ▪ Drug use is frequently linked to other vulnerability factors such as sex work and/or male-to-male sex. In many countries, especially young women and men, sell sex to pay for the drugs that they or their partners or their parents use. ▪ Female drug users and female partners of male drug users are especially vulnerable. This is due not only to the interface between unsafe drug use and unsafe sexual practices, but also to a notable lack of gender responsiveness in policies and services, resulting in a failure to address the specific needs of women and girls. ▪ HIV is a serious problem for populations living in prisons and other closed settings in many countries - resulting in higher HIV prevalence rates in

	prisons than those among outside communities. While many people who use drugs are imprisoned for their drug use, some non-drug users may be initiated into drug use when incarcerated, often adopting riskier injecting practices in the absence of effective HIV prevention efforts. In prisons, HIV can spread also by other HIV risk practices, such as unprotected sex (including male-to-male) and body piercing with unsterile equipment, and by vertical transmission. ▪ Although HIV epidemics have been well documented among people who inject drugs in prisons with low access to HIV services, comprehensive HIV services for drug users in prisons are available in less than 10 countries.

B. 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	
Where are the gaps/needs	▪ Over 5 million people were receiving antiretroviral therapy (ART) as of end 2009, 36% of those eligible by treatment criteria recommended in WHO 2010 ART guidelines. Only 28% of all children younger than 15 years who are eligible have access to treatment. ▪ Current guidelines recommend starting antiretroviral treatment earlier – with CD4 counts of ≤350 cells/mm3, which will reduce HIV mortality and morbidity, and enhance HIV and TB prevention, but also further stretch treatment resources. ▪ The cost of treating all those in need is becoming prohibitive, particularly for countries with high HIV prevalence and limited health infrastructure. Furthermore, current drug regimens used to treat adults and children, and tools for HIV diagnosis and treatment monitoring, remain too complex and expensive, hindering the decentralization and further expansion of treatment access. ▪ Access to HIV and non-HIV health services is constrained by under-resourced health systems, and many ART programmes are not well-integrated, with other health care and prevention services or with community systems and services. Structural and other barriers continue to result in inequitable access for many vulnerable and Most-At-Risk Populations (MARPs). People living with HIV and affected communities remain insufficiently engaged in HIV care and prevention. ▪ 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.

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 TB 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. Lack of information about TB among people living with HIV, activists and those from other populations is a key barrier to promoting TB prevention, treatment and advocacy and generating demand at the grass root level.

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, including PLHIV and core populations, do 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. ▪ Care givers, 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.

C. ADVANCE HUMAN RIGHTS AND GENDER EQUALITY FOR THE HIV RESPONSE

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 - including laws, law enforcement and access to justice, 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. Many countries fail to enforce protective laws and in many cases, enforcement practices contribute to human rights violations which fuel the spread of 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 wide-spread 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 male, female and transgender 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. Sex work is criminalized in many countries with a range of countries having forced rehabilitation programmes for sex workers and it is estimated that only one in three sex workers have access to HIV prevention services and support.

2. HIV-related restrictions on entry, stay and residence eliminated in half of all national HIV responses	
Where are the gaps/needs	▪ 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. ▪ Change is possible. Recently, five countries – China, India, Ukraine, the United States of America and Uruguay – have lifted such restrictions.

3. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses	
Where are the gaps/needs	▪ Thirty years into the HIV epidemic, women and girls face many interacting social, 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 education and health, legal and social 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 has particular impacts on women and girls in all epidemic settings – generalized, concentrated and low level. ▪ HIV contributes to 20% of maternal deaths. MDGs 3, 4, 5 and 6 are interconnected, requiring linkages between sexual and reproductive health and HIV, from a gender equality perspective. ▪ Women in marginalized groups, such as women who use drugs, sex workers, prisoners, street youth, or those who are in humanitarian settings are particularly vulnerable. In some regions, 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. ▪ Women living with HIV face stigma and discrimination on the basis of their gender as well as their HIV status. As a result, they experience particular violations of their human rights. ▪ Most of the care for people living with HIV takes place in the home, and women and girls account for two thirds to ninety per cent of all caregivers.[1] The unequal division of household and care-giving responsibilities greatly reduces girls' and women's capacity to exercise their rights and their access to opportunities. ▪ 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 and rights, including sexual and reproductive health and socio-economic determinants of HIV and gender inequality. This requires a multi-sectoral approach across the span of their lives and responsive to special circumstances such as displacement.

4. Zero tolerance for gender-based violence	
Where are the gaps/needs	▪ Studies have shown that experiencing gender-based violence[2] increases the risk of HIV infection. Discrimination, inequality, violence or the fear of violence hinders women and girls from negotiating safer sex or refusing unwanted sex. These same factors may also prevent women accessing HIV prevention, treatment and care services. In conflict and post-conflict

1 Secretary-General's Task Force, 2004; Southern Africa Partnership Programme 2005: Impact of Home Based Care on Women & Girls in Southern Africa, p6.

2"Gender-based violence is physical, mental or social violence and abuse (including sexual violence) that includes acts (attempted or threatened) carried out with or without force and without the consent of the victim. ***The violence is directed against a person because of her or his gender (because she is a woman or because he is a man) or gender role in a society or culture***. Forms of gender violence include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early or forced marriage, discrimination, the denial of food, education or freedom, domestic violence, female genital mutilation and incest" UNHCR. How to Guide: Sexual and Gender-based Violence Programme in Liberia. January 2001. Available at: www.rhrc.org/resources/h2g008.pdf

	situations, these trends are amplified. 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 against women and girls. Lesbians, gay men, bisexuals and transgender people (LGBT), as well as female, male and transgender sex workers, are typically more affected by GBV than surrounding populations. ▪ Overall, GBV is widespread. Depending on the country, between 15% and 71% of women aged 15 to49 years report experiences of physical or sexual violence by a husband or intimate partner. Intimate partner violence and the lack of power to request condom use increases women's risk of contracting HIV. It may also limit women's access to HIV prevention and services. Rape and sexual violence is widespread in many settings, and is of particular concern in conflict situations and humanitarian emergencies. At the same time, few countries have protocols for comprehensive post-rape care, including emergency contraception and post-exposure prophylaxis. ▪ Young people have particular needs; about 20% of girls and 10% of boys experience sexual abuse globally, and early sexual debut and early marriage in general is associated with a higher risk of contracting HIV and experiencing GBV. ▪ Worldwide, many countries lack accurate and official data on all forms of GBV in both conflict and non-conflict settings. This lack of understanding has an impact at all levels – from national policy making to the practices and protocols of law enforcement, social service and health service personnel, including capacity-building on gender equality, GBV and HIV prevention and impact mitigation. ▪ 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.

D. LEADERSHIP, COORDINATION AND MUTUAL ACCOUNTABILITY

1. Leadership and Advocacy	
Where are the gaps/needs	▪ 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.

2. Coordination, coherence and partnerships	
Where are the gaps/needs	▪ 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. ▪ Strategic plans are not aligned with the epidemiological situation, are often not operationalized, are not linked with existing budgets and are often too complex.

3. Mutual accountability	
Where are the gaps/needs	▪ 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.