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UNAIDS Strategy 2011-2015

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to:
give its comments on and endorse the UNAIDS Strategy 2011-2015

Cost implications for decisions: *none*

GETTING TO ZERO

2011-2015 Strategy

Joint United Nations Programme on HIV/AIDS (UNAIDS)

16 November 2010

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

Foreword

Dear Friends

Since the early days of the HIV epidemic, people, inspired with conviction and courage, have struggled against the odds and faced significant risks in pursuit of a more equitable world. Whether they are gay activists in New York, women's groups in African communities, sex workers in India, transgender people in Brazil, or people around the globe living with HIV, the HIV response has been led by those with purpose and vision. Their struggle has evolved into unprecedented national commitment and serves as a beacon of global solidarity.

At this pivotal moment in the global response, we must courageously face up to the challenges presented by a new context and embrace whole-heartedly the opportunities to break the trajectory of the epidemic. Guided by a new vision, this Strategy presents a transformative agenda for the global HIV response. It aims to serve in the development of our partners' strategies to ensure more focused, aligned and country-owned responses and to guide investments to deliver innovation and maximum returns for people most in need. Building on the principles and priorities of UNAIDS Outcome Framework, this Strategy will also serve as the platform to define United Nations' operational activities and resource allocation for HIV.

This Strategy has been developed through wide consultation, informed by the best evidence and driven by a moral imperative to achieve universal access to HIV prevention, care treatment and support and the Millennium Development Goals. UNAIDS is committed to leveraging existing and novel partnerships with people, communities, governments and country and global champions to support the implementation of this Strategy. In pursuit of social justice and human dignity, we must move decisively from slogan to action. Let us unite our efforts to ensure success.

Michel Sidibé
UNAIDS Executive Director

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Strategy – At a Glance

Global Commitments

- **Achieve universal access to HIV prevention, treatment, care and support by 2015**
- **Halt and reverse the spread of HIV and contribute to the achievement of the MDGs by 2015**

Strategic Directions	Vision and Goals
Revolutionise HIV prevention 7,400 people are newly infected with HIV every day. A revolution in prevention politics, policies and practices is critically needed. This can be achieved by fostering political incentives for commitment, catalysing transformative social movements regarding sexuality, drug use and HIV education for all, led by people living with HIV and affected communities, women and young people. It is also critical to target epidemic hotspots, particularly in mega-cities, and to ensure equitable access to quality, cost-effective HIV prevention programmes that include rapid adoption of scientific breakthroughs.	Vision: To get to **Zero New Infections** Goals for 2015: ▪ 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 ▪ Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half ▪ All new HIV infections prevented among people who inject drugs
Catalyse the next phase of treatment, care and support Two million people died from AIDS-related causes in 2009. Access to treatment for all who need it can come about through simpler, more affordable and effective drug regimens and delivery systems. Greater linkages between ART services and primary health, maternal and child health, TB and sexual and reproductive health services will further reduce costs and contribute to greater efficiencies. Enhanced capacity for rapid registration will increase access to medicines, as will countries' abilities to make use of TRIPS flexibilities. Nutritional support and social protection services must be strengthened for people living with and affected by HIV, including orphans and vulnerable children, through the use of social and cash transfers and the expansion of social insurance schemes.	Vision: To get to **Zero AIDS-related Deaths** Goals for 2015: ▪ Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment ▪ TB deaths among people living with HIV reduced by half ▪ 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
Advance human rights and gender equality for the HIV response Discrimination and other forms of human rights abuses continue to drive vulnerability to HIV, while legal and social barriers block an effective HIV response. Governments must be required to realise and protect human rights, including rights of women and girls; promote supportive legal environments and the removal of harmful laws; and reach the most underserved and vulnerable communities. Civil society must be mobilised to know and claim their human rights. The efforts of women and men to promote gender equality are fundamental to sexual and reproductive health and ending sexual and gender-based violence.	Vision: To get to **Zero Discrimination** Goals for 2015: ▪ Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality reduced by half ▪ HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions ▪ HIV-specific needs of women and girls are addressed in at least half of all national HIV responses ▪ Zero tolerance for gender-based violence

Core Themes

People
Inclusive responses reach the most vulnerable, communities mobilised, human rights protected

Countries
Nationally owned sustainable responses, financing diversified, systems strengthened

Synergies
Movements united, services integrated, efficiencies secured across MDGs

Executive Summary

Positioning the HIV response in the new global environment

1 The world has changed fundamentally since the historic commitments to the Millennium Development Goals and the 2001 Declaration of Commitment on HIV/AIDS were made. Prevailing political and economic orthodoxies have given way in the wake of the financial crisis. Emerging economic nations are challenging and setting global agendas. Autocracy and economic mismanagement have been replaced with significant and sustained growth and improved governance across much of Africa.

2 In this rapidly changing context, the global HIV response finds itself at a pivotal juncture, where the gains of the past are at risk and current approaches are reaching their limits. In 2008, an estimated 2.7 million people were infected with HIV, and 2 million people died. Only one-third of the 15 million people living with HIV in need of lifelong treatment are receiving it. New infections continue to outpace the number of people starting treatment, while the upward trend in resources flat-lined in 2009.

3 Despite widespread commitment to aid effectiveness principles for HIV, true national ownership and downward accountability are still far from assured. Southern interests, including those of civil society and people living with and affected by HIV, exercise too little influence in the architecture governing the global AIDS response.

4 The future costs that HIV imposes on people, families, communities and countries will be determined by the way national and global partners reposition the HIV response to leverage shifts in the macro context. Bold measures are called for, and the present trends provide much-needed momentum for change.

A global agenda to break the trajectory

5 It is paramount that new HIV infections are stopped. We need to achieve a transition that will see fewer people infected than are newly placed on treatment. Doing so will require decisive action guided by a groundbreaking vision: *zero new HIV infections, zero AIDS-related deaths, zero discrimination*.

6 While this vision may be aspirational, the journey towards its attainment is laid with concrete milestones: ten goals for 2015. In pursuit of this vision and these goals, UNAIDS will leverage its collective assets to set a strategic agenda for the global HIV response, as well as to maximise its resources to deliver results.

7 We believe that by taking the right decisions now, we can achieve universal access to HIV prevention, treatment, care and support and contribute to the achievement of the Millennium Development Goals.

Three Strategic Directions for a renewed global HIV response

8 Significantly reducing new HIV infections will require us to radically reshape the global response. Generating greater efficiencies is paramount to success and is possible if we approach service delivery differently. Success also depends on intensifying what we know works and focussing efforts where they are most needed. Analyzing the severity, scale, scope and impact of the epidemic will guide us in delivering maximum results.

9 We also must recognise that beyond its health impact, HIV acts as a lens that magnifies the ills of society and the weaknesses in our social systems. The HIV response gives us an opportunity to strengthen the social fabric, improve social justice and reinforce the systems

that deliver critical services for the most vulnerable members of our communities. We must achieve a balance between intensifying work in the hardest hit countries and identifying other settings, such as cities, where the impact of HIV is affecting specific communities—particularly men who have sex with men, sex workers and their clients and people who inject drugs.

10 Revolutionising HIV prevention politics, policies and practices will shift the debate from HIV prevalence to incidence, enabling us to identify transmission hotspots, empower people, particularly young people, to demand and own the response and incentivise political leaders to focus on populations and programmes that will make a difference in reducing new infections. Recent developments make both possible and necessary a revolution in the way HIV prevention is conducted and the impact of HIV prevention programmes. We must join our efforts to achieve these goals:

- 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;
- Vertical transmission of HIV eliminated and AIDS-related maternal deaths reduced by half;
- All new HIV infections prevented among people who use drugs.

11 UNAIDS will support the attainment of these goals, including by: (1) generating commitment to prevention throughout society by improving its political palatability; (2) ensuring that strategic information on epidemics, socio-economic drivers and responses serves to focus prevention efforts where they will deliver the greatest returns to investment; and (3) facilitating mass mobilisation for transformation of social norms to empower people to overcome stigma and discrimination and their risk of HIV including through comprehensive sexuality education and the engagement of networks of people living with HIV and other key populations.

12 Catalysing 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 regimens, will adopt innovative delivery models that both reduce unit costs and recognise and empower communities to demand and deliver better and more equitable treatment, care and support services that maximise linkages with other health and community services. We must join our efforts to achieve these goals:

- Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment;
- TB deaths among people living with HIV reduced by half;
- 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.

13 UNAIDS will support the attainment of these goals, including by: (1) catalysing the development of simpler, more affordable and effective treatment regimens and tools; (2) strengthening national and community systems to deliver decentralised and integrated services, for example to reduce factors that put people at risk of HIV-related TB and to promote the sexual and reproductive health and rights of people living with HIV; and (3) working with partners to scale up access to tailored care and support for people living with and affected by HIV, including through national social protection programmes.

14 Advancing human rights and gender equality for the HIV response means demanding an end to the criminalisation of consensual sex, drug use, sex work and HIV

transmission, and an end to sexual and gender-based violence. Criminalisation, stigma and discrimination drive people into the shadows and away from demanding and accessing the services they need. Gender equality and meeting the HIV-related needs of women and girls is essential to prevent new infections. We must join our efforts to achieve these goals:

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

15 UNAIDS will support the attainment of these goals, including by: (1) intensifying work with people living with HIV and at higher risk of HIV to know and claim their rights and with governments to realise and protect those rights including through the implementation of evidence-informed, actionable and human rights based recommendations of the *Global Commission on HIV and the Law*; (2) advancing county capacity to reduce stigma and discrimination and ensure equitable access to services including by working with civil society networks to affect policy change informed by the *People Living with HIV Stigma Index*; and (3) supporting countries and partners to fully implement the *UNAIDS Agenda for Accelerated for Women, Girls, Gender equality and HIV*.

Accountability through ownership: People, countries and synergies

16 Accountability through shared ownership is a guiding principle which must train our collective focus on three themes across all responses: people, the primacy of countries and the pursuit of synergies.

17 Effective HIV responses must be led and owned by people living with and affected by the epidemic to ensure a rights-based, sustainable response and to hold national and global partners to account. The remarkable gains to date are largely the result of their activism, mobilization and alliance-building with other stakeholders.

18 To sustain people-centred responses requires a shift in our mind-sets and approaches in relation to the primacy of country ownership. Thirty years into the epidemic, the key to success remains at country level. But the way in which countries are supported must be transformed to enable them to lead, manage and establish accountability systems for their responses.

19 Ensuring synergies between HIV-related and broader health and human development efforts represents a major opportunity for the response. By uniting movements—such as joining forces with the women's health movement to implement the UN Secretary-General's *Joint Action Plan to Improve the Health of Women and Children*—we can strengthen shared political commitment and action. Investing more strategically to achieve multiplier effects across Millennium Development Goals responds to people's needs and is one of the most promising approaches to making resources go further, promoting equity and securing better human development results. Major opportunities beckon in relation to TB/HIV integration and in leveraging services to eliminate vertical HIV transmission as a platform to deliver a continuum of care and a package of antenatal, child health and reproductive health services for both parents.

Partnership in a new world

20 Effective partnerships remain fundamental to successful and sustainable HIV responses. Partnerships give voice to those infected and affected, act as a catalytic force for change and provide accountability for political commitments. However, the changing environment, and its demands for new and innovative ways of working, signals the need for different kinds of partnerships—those that enable nationally owned responses, foster South-South cooperation and those that move beyond the traditional HIV and health sectors to broader development areas. These partnerships must include political alliances that link HIV movements with movements seeking justice through social change.

Strengthening the way UNAIDS delivers results

21 UNAIDS aims to lead and inspire the world in achieving universal access to HIV prevention, treatment, care and support. As an innovative collaboration, the strength of the Joint Programme is derived from the diverse expertise, experience and mandate of its ten Cosponsors and the added value of the UNAIDS Secretariat in delivering political leadership and advocacy, coordination and joint accountability.

22 This Strategy responds to the Second Independent Evaluation of UNAIDS, which emphasized the Joint Programme's successful leadership and mobilisation of broad-based political and social commitment at global and country level, while recommending that UNAIDS be more focused, strategic, flexible and responsive, efficient and accountable. This Strategy takes forward UNAIDS Outcome Framework 2009-2011 and is closely aligned with and will guide the HIV strategies of UNAIDS' Cosponsors. These strategies include those that are sector- or population-specific, such as HIV strategies on health and education and those relating to HIV and refugees, internally displaced persons, nutrition, children, women, young people and drugs and crime. Other Cosponsor strategies refer to multisectoral aspects of the HIV response, such as those that cover the governance of the response, development planning, social protection and financing.

23 In aspiring to zero duplication, zero incoherence and zero waste, UNAIDS will strengthen a number of mechanisms that cover the breadth of the Programme, from its governance through to the specifics of country delivery. Value-for-money in the delivery of effective and efficient business practices will be critical to ensure that scarce resources are targeted for results and transaction costs are kept to a minimum.

24 A fundamental shift will also be implemented in the Joint Programme's approach to partnership. This shift will be marked by increased selectivity, leveraging the Joint Programme's resources through involvement in new partnerships and networks, advocacy for a global solidarity compact, and the strengthening of mutual accountability mechanisms.

25 The specific contributions of UNAIDS to the achievement of each of the goals will be articulated in the operational plan of the Joint Programme, will drive the allocation of resources, and will represent the measure by which UNAIDS will be held accountable for the achievement of the medium-term goals. In developing the operational plan, key results and products along with targets and indicators to measure progress will be identified.

Overview of the document

26 The Strategy is presented in three parts that are preceded by a discussion of the changing context. Part 1 of the Strategy outlines a transformative agenda for the global

HIV response. This agenda emphasises reaping efficiencies and generating focus to ensure that resources are optimally deployed to significantly reduce new infections. Part 1 also introduces ten goals for 2015 which present milestones for the global response in its progress towards the long-term vision. These goals will also guide the work of the Joint Programme.

27 Part 2 sets out in greater detail the three Strategic Directions of the global agenda. Objectives are presented for each strategic direction that respond to a discussion of both the gaps and the opportunities in the response. Each of the three Strategic Directions concludes with an overview of the distinctive value-added of the Joint Programme in achieving the global goals, including illustrative examples of strategic partnerships and joint working.

28 Part 3 presents the mechanisms through which the Joint Programme will strengthen the way it works to deliver results. Overviews of the renewed Division of Labour and the Unified Budget and Accountability Framework – the operational plan – are provided. Approaches for enhancing the role of UNAIDS field offices in the UN Resident Coordinator system and leveraging technical support to build country ownership and sustained capacity are also discussed. Further changes to the Joint Programme's approach to resource mobilisation, human resource deployment and working with people living with and affected by HIV are presented.

Introduction: Positioning the HIV response in the new global environment

I Promising but fragile progress

29 Over the past decade, political and financial commitment to address HIV has increased, while the HIV movement has consistently demonstrated its ability to transform resources into concrete results for people.

30 Countries committed to achieving universal access to HIV prevention, treatment, care and support for all in need by 2010. Significant progress has been made. Globally, new HIV infections declined by 17% between 2001 and 2008.[1] By the end of 2009, an estimated 5.25 million people in low- and middle-income countries were receiving life-prolonging antiretroviral therapy (ART), compared with 400,000 in 2003. Between 2004 and 2008, annual AIDS-related deaths decreased from 2.2 million to 2 million. Without treatment, 600,000 more people would have died in 2008.[2]

31 These remarkable gains are at risk. In 2008, an estimated 2.7 million people were infected with HIV.[3] Only one-third of the 15 million people living with HIV in need of lifelong HIV treatment are receiving it. New infections continue to outpace the number of people starting treatment.[4]

32 In 2008, four out of five low- and middle-income countries were not on track to meet their universal access targets.

The power of the HIV movement

In many places, the silence surrounding HIV has been shattered, driven by people living with HIV and the communities most affected by the epidemic: gay men in the Americas, Europe and Australia; activists in South Africa and Uganda; sex workers groups, like the Sonagachi collective and the Global Network of Sex Work Projects; and networks of drug users in Eastern Europe.

The international community has responded with unprecedented commitment and a massive mobilisation of resources—and transformed the HIV response.

The urgency of the pandemic demanded and resulted in exceptional global solidarity, as exemplified by the principle of the Greater Involvement of People Living with HIV (GIPA).

The HIV movement has pioneered results-based approaches; established ambitious targets; forged a novel consensus about the need to address social, political and economic determinants of HIV risk and vulnerability; and strengthened health and social welfare systems to respond to the needs of not only people affected by HIV, but other vulnerable populations as well.

II Diverse and evolving epidemics

33 If the global response is to accelerate progress towards universal access, we must constantly increase our knowledge about the dynamics of diverse and evolving HIV epidemics.

34 Epidemics vary from region to region, country to country and within countries. Countries are striving to better prioritise national HIV prevention responses by putting into practice the principle of "*Know your epidemic, know your response*,"[5] which is based on understanding and responding to the local specifics of an epidemic. It requires strong political commitment to evidence-informed responses and up-to-date strategic information on how and why people are contracting HIV—including the influence of social, political, economic and legal environments.

35 Heterosexual exposure is the primary mode of transmission in sub-Saharan Africa and accounts for 80% of new infections globally. Where epidemics have matured, new infections among people in steady, long-term partnerships are often high. Yet

programmes that focus on women, married couples or people in long-term relationships are rare, as are programmes that provide services for serodiscordant couples. Too often, the mutual responsibilities of both men and women in reducing risks of HIV transmission cannot be realised, in part because women are excluded from sexual decision-making, have not had access to comprehensive sexuality education and have unequal access to prevention methods. The advent of UN Women[6] provides an opportunity to put the HIV-related needs of women and girls, in Africa and elsewhere, more firmly on the agenda.

36 Epidemics among men who have sex with men,[7] people who use drugs[8] and sex workers[9] can be found around the world, but particularly in Asia and the Pacific, Latin America and the Caribbean and Eastern and Central Europe. These epidemics are fuelled by homophobia, stigma and discrimination and are exacerbated by punitive laws. The efforts of the *Global Commission on HIV and the Law* can galvanise action in order to make the law work for an effective and human rights-based response to HIV.

37 Around the world, millions of people living with HIV are living longer and more productive lives—a marked success that must be maintained and expanded. The HIV response must ensure sustainable and decentralised treatment, care and support in the context of epidemic shifts from rural to increasingly urban settings, including in the growing informal settlements of sub-Saharan Africa and other parts of the world.

III Facing and leveraging economic and political trends

38 Changes in the wider environment—most notably the global economic crisis—have serious implications for sustaining and strengthening the HIV response. The upward trend in resources flat-lined in 2009 and, in a number of countries, treatment programmes were unable to accept new clients and, in the worst cases, were cut back. Funding constraints could jeopardise what has been achieved and impede future efforts to achieve universal access.

39 Inefficiencies plague the HIV response at every level and can be traced to poor governance, corruption, weak institutional capacity and unsound or inappropriate policies and incentives. Poorly coordinated and transaction-heavy responses from national stakeholders, the UN family and the donor community impede progress, leading to duplicative, poorly managed and weak technical support for HIV and fragmented and inefficient health systems.

40 Income inequality within countries and the polarisation of population groups at opposite ends of the economic spectrum have become increasingly pronounced.[10] These trends also imply greater internal and cross-border movements of people and the associated potential for HIV risk and vulnerability. Developmental efforts, including the HIV response, must more rigorously target the poor and vulnerable within countries rather than poor countries *per se*.

41 The response must also contend with continued shifts in the development cooperation architecture. Even as the HIV response has begun to successfully re-position itself as integral to wider development and human rights efforts, funding flows for HIV remain fragmented, reflecting the continued proliferation of initiatives and implementers. Despite widespread recommitment to aid effectiveness principles, true national ownership is still far from assured, and Southern interests, including

those of civil society and people living with and affected by HIV, exercise too little influence in the global AIDS governance architecture.

42 Middle-income countries must assume greater responsibility for domestic funding of their responses, address internal inequities and engage in South-South partnerships grounded in principles of human rights and aid effectiveness. Emerging economies are wielding more clout in global negotiations on trade, development, human rights, intellectual property rights and other issues. This will have profound implications for many drivers of HIV and the response. The historic role of the BRICS countries (Brazil, Russia, India, China and South Africa) in relation to the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and essential medicines is a potential advantage for the HIV response.

IV AIDS and the MDGs: Working together for greater impact

43 The Millennium Development Goals (MDGs) are interlinked; progress on one goal supports progress in others. There are many opportunities to simultaneously advance the response to HIV as well as the achievement of other MDGs, lowering overall costs and increasing the impact of investments.

44 AIDS-related illnesses are a leading killer of women of reproductive age, and almost one in every five maternal deaths worldwide in 2008 was linked to HIV.[11] In six hyper-endemic countries, AIDS is responsible for over 40% of child mortality.[12] People with latent tuberculosis (TB) are increasingly becoming infected with HIV and developing active TB. Of the estimated 1.8 million people who died of TB in 2008, more than 25% were living with HIV.

45 HIV has dramatic consequences for entire communities. Most people who die from AIDS-related illnesses are young adults—among the most economically productive members of society. Across the world, an estimated 17.5 million children have lost at least one parent to HIV. Treatment, hospitalisation and loss of income, as well as providing care for family members living with HIV and for orphans, results in a high economic burden for households.[13]

V Seizing scientific breakthroughs

46 Science acts as a transformative force. Novel biomedical interventions and their application have the potential to vastly reshape HIV prevention approaches if informed by further research, local knowledge and human rights. The Bill and Melinda Gates Foundation have set and financed an innovative agenda to end new HIV infections.

47 Clinical trials have confirmed the prevention benefits of voluntary male circumcision.[14] Evidence also shows that antiretroviral drugs (ARVs) can substantially reduce the risk of vertical, sexual and blood-borne HIV transmission[15] while drug dependence treatment can significantly reduce the risk of HIV infection among people who use drugs.[16] Other novel interventions include microbicides, pre/post-HIV exposure prophylaxis, prevention of Herpes Simplex Virus-2 (HSV-2) infection, and the eventual discovery of a preventative HIV vaccine. One of even modest efficacy would have dramatic effects on the trajectory of the epidemic.

48 Innovation is dependent on convening consortia of universities, think tanks and implementers to find solutions to specific obstacles that hold back progress. More strategic partnerships with the private sector are needed to ensure that it continues

to serve as an engine of scientific innovation—in delivering new tools ranging from treatment advances to logistics and applications of new social media.

Key challenges for the global HIV response

In moving forward, the global HIV response is confronted by a number of challenges which call for the engagement of creative minds, including those from affected communities, to identify breakthrough solutions for the achievement of universal access:

- **HIV as a path-finder and investment opportunity**. The myth that the HIV response undermines progress on other global priorities must be confronted and replaced with a wider recognition that the response has been a path-finder. Getting to zero depends on a global response that sees power in solidarity and that rejects the trap of destructive competition for finite resources. As such, it is imperative that investments in the response through long-term and sustainable financing continue to be made and are scaled up.
- **Prioritisation, alignment and harmonisation**. The present economic and development climate makes it is absolutely essential that resources are put to optimal use. This demands far greater efforts to focus resources where they deliver the greatest returns through more disciplined approaches to priority setting and resource allocation. Progress continues to be held back through fragmented and externally inspired solutions to local epidemics. Development partners must improve their adherence to internationally agreed frameworks for alignment to country-determined priorities and harmonisation of procedures which are fundamental to country ownership, mutual accountability and improved use of resources.
- **Access to affordable medicines and commodities**. Gaps in HIV treatment access within and between countries are an affront to humanity that can and must be closed by ensuring access to affordable medicines and commodities for all. These gaps, driven by grievous social inequity, can only be filled through relentless political pressure and novel approaches to the development, pricing and delivery of treatments for HIV, TB, malaria and other health issues.
- **Systems strengthening**. Though it has been thirty years since communities began leading and demanding HIV responses, national programmes and global partners are just beginning to actively support, deepen and strengthen community engagement. We must insist on and institutionalise the principles and practices of community system strengthening in the global HIV response, and resist short-sighted notions that doing so is too costly, too complicated, or too indirect. On the contrary—the HIV response requires smarter and more sustained multi-sectoral support for the community systems that shape people's lives and complement human resources for health. A harmonised approach to strengthening HIV responses and community and health systems is essential.
- **Social injustice.** Stigma and discrimination, violence against women, homophobia and other HIV-related abuses of human rights remain widespread. These injustices discourage people from seeking the information and services that will protect them from HIV infection, from accessing HIV treatment and care and from adopting safe behaviours. Where HIV related stigma, discrimination and gender inequality persist, the global response will forever fall short of the transformations required to reach our shared vision.

PART 1 Strategic agenda for transformation

I Strategic Directions to end new infections

49 The world has changed fundamentally since the historic commitments to the Millennium Development Goals and the 2001 Declaration of Commitment on HIV/AIDS were made. Prevailing political and economic orthodoxies have given way in the wake of the financial crisis. Emerging economic nations are challenging and setting global agendas. And autocracy and economic mismanagement have been replaced with significant and sustained growth and improved governance across much of Africa.

50 The future costs that HIV imposes on people, families, communities and countries will be determined by the way national and global partners reposition the HIV response to leverage the shifts in the macro context. Choices will be shaped by scarce resources, shifting global priorities and the kinds of new alliances forged. Success or failure will be determined by the way 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.

51 It is in this context that the global HIV response finds itself at a pivotal juncture. A juncture in which the gains of the past are at risk and current approaches are reaching their limits.

52 It is paramount that new infections are stopped. We need to achieve an AIDS transition—where fewer people are infected than are newly placed on treatment. This calls for bold action that must be guided by a groundbreaking vision: *zero new HIV infections, zero discrimination, zero AIDS-related deaths.* While this vision may be aspirational, the journey towards its attainment is laid with concrete milestones: goals for 2015.

53 Zero babies born with HIV and zero transmission due to injecting drug use takes us towards zero new infections. Halving the number of people living with HIV who die from TB brings us closer to zero AIDS-related deaths. Eliminating punitive laws and practices around HIV transmission, sex work, drug use or homosexuality mark key steps to realising zero discrimination.

54 By achieving the AIDS transition, immense suffering can be prevented and countless lives saved, as well as tens of billions of dollars. Three Strategic Directions will guide us to break the trajectory of the epidemic and pursue our vision.

55 Revolutionising prevention will shift the debate from HIV prevalence to incidence, enabling us to identify transmission hotspots, empower young people to access quality sexuality education and incentivise political leaders to target resources to populations and programmes that will make a difference in reducing new infections.

56 Catalysing the next phase of treatment, care and support requires a radically simplified treatment platform that is good for people living with HIV and that will also cut new infections by scaling up treatment access. The next phase of treatment, based on new drug regimens, will adopt innovative delivery models that both reduce unit costs and recognise and empower communities to demand and deliver better treatment, care and support services that maximise linkages with other health and community services. This will be essential to improving equity, cutting costs and sustaining the response over the long term.

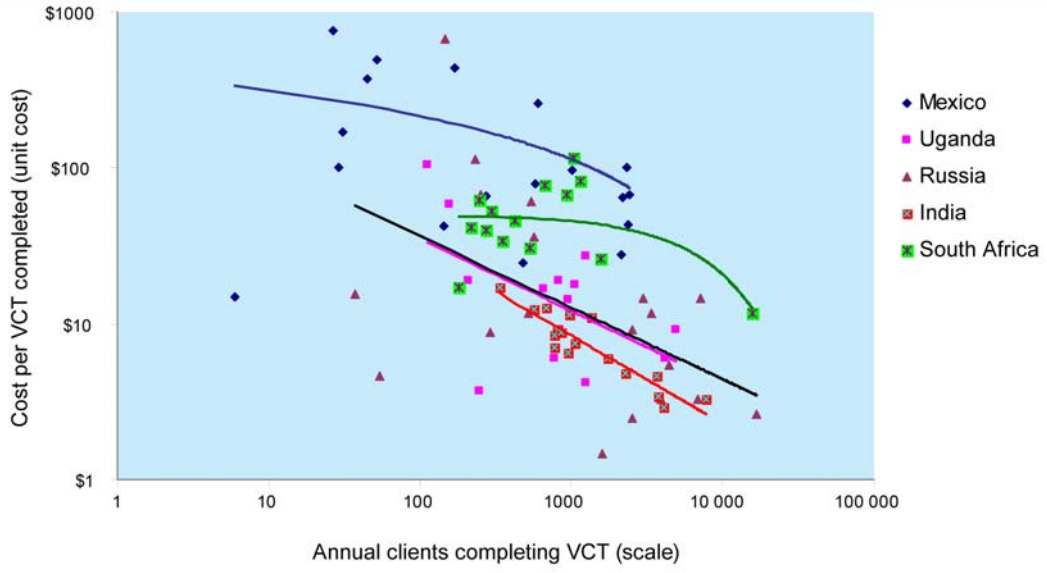
57 Advancing human rights and gender equality for the HIV response means demanding an end to the criminalisation of consensual sex, drug use, sex work and HIV transmission, and an end to sexual and gender-based violence. Criminalisation, stigma and discrimination drive people into the shadows and away from demanding and accessing the services they need. Gender equality and meeting the HIV-related needs of women and girls is essential to preventing new infections.

II An agenda for transformation: Efficiency and focus

58 Dramatically reducing new HIV infections will require us to radically reshape the response. Success depends on intensifying what we know works and focusing efforts where they are most needed. Analysing the severity, scale, scope and impact of the epidemic can guide us to those settings where we can deliver maximum results.

59 Generating greater efficiencies is possible if country programmes approach delivery differently. Evidence suggests, for example, that the cost of delivering voluntary counselling and testing (VCT) services varies enormously across countries (Table 1.1). Selecting and scaling up efficient approaches that meet local needs improves uptake and reduces unit costs.[17] Studies of other services, including sex worker programmes, risk reduction among people who use drugs and for the interruption of vertical transmission, also show that efficiency can be increased dramatically.

1.1 Focusing on: higher efficiency in large scale VCT programmes



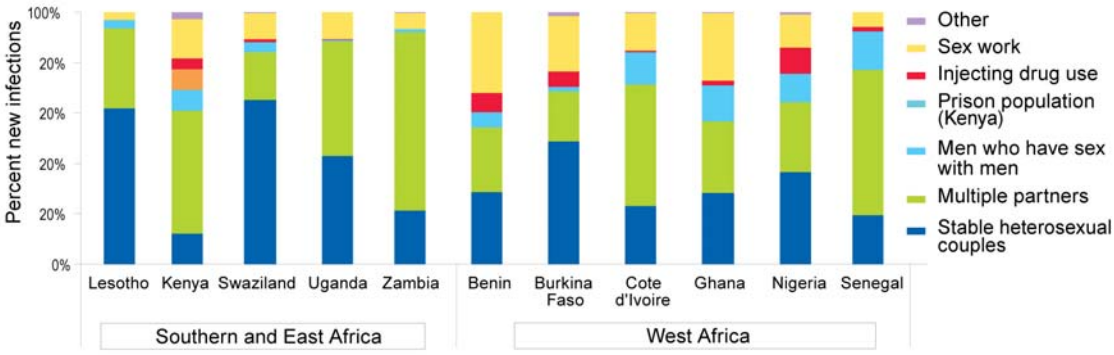
Source: Marseille et al. 2007

60 We can generate further efficiencies by seeking all opportunities to integrate the HIV response with other health and development efforts. Integrating services to end vertical HIV transmission[18] with sexual and reproductive health services provides one of many opportunities to do more with less—while serving people better.

61 Task shifting to community health workers also shows great promise for reducing costs while maintaining results. Community conversations can democratise problem-solving and result in more locally appropriate, better owned and more sustainable solutions that assure maximum value-for-money.

62 Using the most current epidemiologic data on modes of transmission, the latest information on social context and a fuller understanding of the strengths and weaknesses of the existing response, it is possible for countries to focus and intensify efforts where they will produce the greatest impact (Table 1.2). [19] Improved national HIV strategic planning based on such analyses can increase efficiency and effectiveness of the response by ensuring efforts are directed to meet the country's real and current needs in order to stop new infections.

1.2 Focusing on: modes of transmission in sub-Saharan Africa



Source: UNAIDS 2010

63 In most of sub-Saharan Africa, HIV remains a dominant health threat, while in other parts of the world it represents a minor part of the overall national health agenda. Yet many countries with low HIV prevalence have raging epidemics concentrated among men who have sex with men, transgender people, sex workers and their clients and/or people who use drugs. For example, Table 1.3 presents 15 countries that have a large population of people who inject drugs (over 100,000) coupled with a high prevalence of HIV among this population (over 10%).[20] Similar groupings of countries can be constructed for other populations across epidemics including men who have sex with men and sex workers and their clients.

1.3 Focusing on: countries with a high burden of HIV among people who inject drugs*

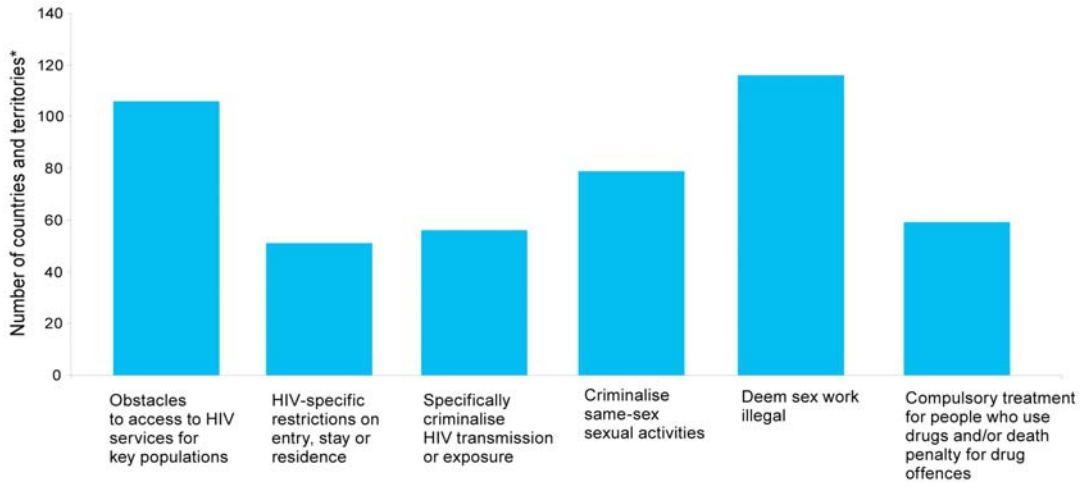
Azerbaijan	Indonesia	Malaysia	Thailand
Brazil	Iran	Pakistan	Ukraine
China	Kazakhstan	Russian Federation	Vietnam
India	Kenya	South Africa	

* Low- and Middle-Income Countries where estimated number of people who inject drugs is >100,000 and estimated HIV prevalence among people who inject drugs is > 10%.
Source: Mathers et al. 2008

64 As a global community, we must recognise that beyond its health impact, HIV acts as a lens that magnifies the ills of society and the weaknesses in our social systems. The United Nations has a duty to promote human rights and to stand with the vulnerable, to open political space where their voices can be heard and to advocate and build capacity to empower those most affected to exercise leadership and fully access HIV prevention, treatment, care and support services.

65 The HIV response gives us an opportunity to strengthen the social fabric, combat inequalities that undermine human rights and economic stability, improve social justice and reinforce the systems that deliver critical services for the most vulnerable members of our communities. In focusing our efforts, we must account for and address punitive legal environments that block effective HIV responses and marginalise communities. The scope of this challenge is presented in Table 1.4.[21]

1.4 Focusing on: punitive laws and HIV



Selected punitive laws that block universal access to HIV prevention, treatment, care and support

* Number of countries and territories with selected types of punitive laws. Data compiled on 209 countries, not all counties reported on each type of law.
Source: GNP+ et al. 2010

66 International partners often emphasise a cost-benefit approach that focuses their resources on the global disease burden. One approach to focusing on disease burden suggests that intensified efforts in the illustrative grouping of countries in Table 1.5 could change the trajectory of the global HIV epidemic. Bringing greater efficiency and focus to national responses and global support in these 20 countries could tackle: 74% of new HIV infections globally; over 80% of the gap between need and actual coverage of adult ART; nearly 80% of the gap between need and coverage of services to prevent vertical transmission, and; nearly all HIV-related TB, while gaining momentum in building the legal environments and social norms that promote inclusiveness and human rights (Table 1.5).[22] With any approach to focusing resources through country selectivity, criteria for inclusion must be flexible, transparent and applied in a dynamic manner.

67 The HIV epidemic has also reached catastrophic proportions in some smaller countries such as Botswana, Lesotho, Namibia, Swaziland and 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 prioritised for support.

68 An additional approach to effectively directing resources is through a focus on those countries with the greatest gaps in service delivery coverage. For example, by intensifying efforts in just 25 countries, we could reach approximately 91% of the global number of women in need of ARVs that prevent vertical transmission.

69 Focus must also be placed on the very specific epidemics spreading in various mega-cities around the world as well as in the context of humanitarian emergencies. Likewise,

the global response should not neglect those countries that may have the opportunity to maintain currently low HIV prevalence at modest cost but lack the means to respond.

1.5 Focusing on: achieving greater impact

Brazil
Cambodia
Cameroon
China
Democratic Republic of the Congo
Ethiopia
India
Kenya
Malawi
Mozambique
Myanmar
Nigeria
Russian Federation
South Africa
Thailand
Uganda
Ukraine
United Republic of Tanzania
Zambia
Zimbabwe

Intensified, joint action in these countries*

Would address

- Over 70% of new global HIV infections
- Over 80% of the global gap in ART for eligible adults
- Over 75% of the global gap in prevention of vertical transmission
- Over 95% of the global burden of HIV/TB
- Major injecting drug use-driven HIV epidemics (over half of the countries also listed in table 1.3)
- Punitive laws, including laws that restrict travel for people living with HIV, (14 of these countries have three or more such laws, see table 1.4)

Would boost aid effectiveness

- Enhance implementation of over $US 5.1 billion active Global Fund HIV grants
- Leverage PEPFAR funding (2007-2009 was over $US 7.4 billion)

Would engage

- All five BRICS countries (Brazil, Russian Federation, India, China, South Africa)

* Countries which meet 3 of the 5 criteria, according to independent data sources: > 1% of global new HIV infections; >1% of the global gap in adult ART (350 CD4); >1% of global burden of HIV- related TB; Estimated number of people who inject drugs is > 100,000 and estimated HIV prevalence among people who inject drugs is > 10%.; Presence of laws that impede universal access for marginalised groups including sex workers, men who have sex with men and transgender people, people who inject drugs

Source: UNAIDS, 2010

III Accountability through ownership: People, countries and synergies

70 Accountability through shared ownership is a guiding principle which will train our focus on people, the primacy of countries and the pursuit of synergies.

71 Effective HIV responses must be owned by people living with and affected by the epidemic to ensure a rights-based, sustainable response and to hold national and global partners to account. The remarkable gains to date are largely the result of their activism, mobilisation and alliance-building with other stakeholders.

72 In punitive legal and social environments, HIV responses must create space to involve the criminalised, marginalised and disempowered. They have the expertise, experience, and a major stake in informing the best response. We must democratise problem solving, open channels to local knowledge and strengthen sustainable community systems and action so as to enable people to own their solutions. More equitable power relationships at country level must be sought to ensure that the voices of the people most affected are heard, are valued and drive the response. Inclusiveness is the only route to ensuring the downward accountability that delivers results for people.

73 To sustain people-centred responses requires a shift in our mind-sets and approaches in relation to the primacy of country ownership. Thirty years into the epidemic, the key to success remains at country level. However, the way in which countries are supported must be transformed to enable them to lead, manage and establish accountability systems for their responses. Creating space for national debate and dialogue on the governance of the response, including its financing, can improve public accountability and foster more widespread ownership.

74 Country ownership can be reinforced by refocusing our approach to technical support on building and strengthening lasting local institutional capacity. Experts from within countries, as well as those living with and affected by HIV, represent the key to nationally owned and sustainable technical support. The market for technical support must be improved; increased transparency will foster ownership through accountability.

75 Stronger and more diversified funding sources must be pursued to make the delivery of results possible. Yet financing must be linked to robust financial sustainability transition plans, and external funding must be harmonised and aligned to support domestic financing mechanisms.

76 We must better incentivise political leaders to take bold decisions in addressing the epidemics of their countries and dismantle incentives that perpetuate short-term “fixes.” These incentives must be shaped by people-centred approaches, guided by evidence and the pursuit of human rights and reinforced through enhanced systems of accountability.

77 Generating synergies between HIV-related and broader health and human development efforts represents a major opportunity for the response. A successful HIV response is essential to achieving the MDGs in many countries. At the same time, progress towards other MDGs is critical for the HIV response.

78 By uniting movements we can generate renewed political commitment and action for the response. Joining forces with the women’s health movement to implement the

UN Secretary-General's *Joint Action Plan to Improve the Health of Women and Children* presents a vehicle for synergistic action. The HIV movement can also team up with the women's movement to end violence against women and girls as well as to align efforts to tackle cervical cancer with those to eliminate vertical transmission. Recent evidence shows that bringing an equity focus on hardest-to-reach children is the most practical and cost-effective way of meeting the health MDGs.[23]

79 Synergies enable the delivery of holistic services that respond to people's needs. The time has come to dismantle the silos and use HIV as an entry point to more integrated delivery systems from the community upwards. We can deliver quick wins by integrating HIV and TB services, and integrating both with primary health care. Elimination of vertical transmission provides a platform to deliver a continuum of care and a package of antenatal, maternal, child health and reproductive health services. This would ensure that pregnant women are not only offered HIV screening, but that they and their partners are also offered services to prevent HIV and other sexually transmitted infections, unwanted pregnancies and sexual violence.

80 Investing more strategically to capture synergies and achieve multiplier effects across the MDGs is one of the most promising approaches to making resources go further, promoting equity and securing better human development results.

IV New partnership paradigm

81 Effective partnerships are fundamental to a successful and sustainable HIV response. The building of bridges between stakeholders and movements calls for a transformation in the way the HIV response approaches partnerships. Partnerships give voice to those infected and affected, act as a catalytic force for change and provide accountability for political commitments. However, the changing environment, and its demands for new and innovative ways of working, signals the need for different kinds of partnerships—those that enable nationally owned responses, foster South-South cooperation and those that move beyond the traditional HIV and health sectors to broader development areas. These partnerships must include political alliances that link HIV movements with movements seeking justice through social change.

82 The global HIV movement's partnership agenda must place renewed emphasis on ensuring the full involvement of people living with and affected by HIV, support young people to exercise increasing leadership, catalyse governments to use strategic information to develop evidence-informed and rights-based responses that generate the highest returns on investments, engage the private sector to promote innovation and leverage contributions from other sectors for the HIV response.

83 The HIV response demands a new global compact of solidarity and shared responsibility. A renewed advocacy effort must be launched to encourage the continued commitment of the global North to support development efforts in the global South, with a focus on long-term predictable financing, particularly through multilateral mechanisms. In return, working through mechanisms such as the G20, emerging economies will need to be encouraged to shoulder an increasing share of domestic HIV financing as well as contributing funding to international efforts.

84 Within this compact, we must ensure that the global community continues to provide least-developed countries with technical and financial support that builds and strengthens national institutions to mount evidence-informed and rights-based responses that will drastically reduce new infections. This global compact can serve

as a trailblazer in the pursuit of solidarity, equity and human dignity beyond the AIDS response.

V Vision and goals for the HIV response and the contribution of the Joint Programme

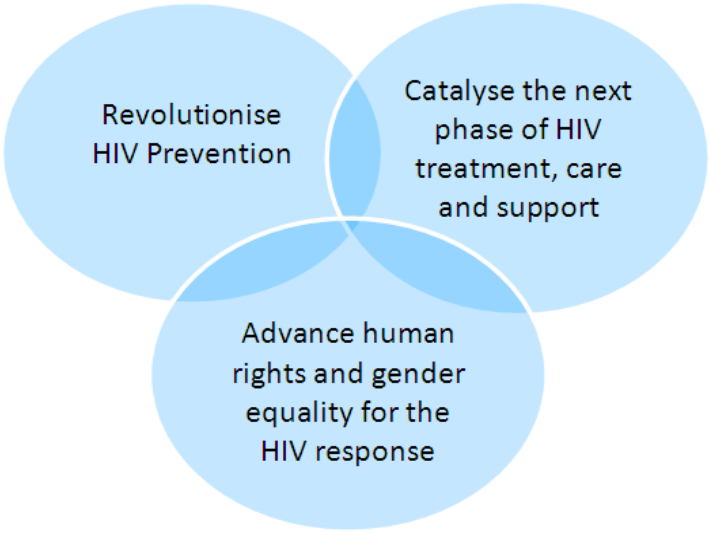
85 This strategy presents UNAIDS' vision for the long-term future of HIV with a corresponding medium-term agenda for the global response. The medium-term agenda is presented as a series of ambitious yet feasible goals for the global response over the next five years. These goals emerged from UNAIDS' Outcome Framework, which has been guiding and focusing UNAIDS work since 2009 by identifying critical gaps in the HIV response; describing the social, political and structural constraints that limit results; and highlighting opportunities where countries and global partners could make a significant difference.

86 These goals will also serve to orient the work and engagement of the Joint Programme in the global HIV response over the next five years. The specific contributions of UNAIDS to the achievement of each of the goals will be articulated in the Joint Programme's operational plan and budget, driving the allocation of the resources of the Joint Programme, and will represent the measure by which UNAIDS will be held accountable for the achievement of the medium-term goals. In developing the operational plan, key results, indicators and base lines for the goals of this Strategy will be identified.

Through this Strategy, UNAIDS will galvanise global commitment to the following actions in support of the outcomes of the 2010 MDG Summit[24]I (in *Keeping the promise: united to achieve the Millennium Development Goals*)**:**

- Redouble efforts to achieve universal access to HIV prevention, treatment, care and support
- Significantly intensify efforts to reduce new infections within more equitable, efficient, evidence-informed and rights-based national responses
- Address HIV from a developmental perspective which requires the strengthening of national networks of sound and workable institutions and systems to mount multisectoral responses
- Build new strategic partnerships to strengthen and leverage the linkages between HIV and other health- and development-related initiatives in support of the *AIDS plus MDGs* agenda
- Plan for long-term sustainability and accountability through nationally-owned HIV responses

PART 2 Leadership Agenda: Three Strategic Directions



Strategic Direction 1: Revolutionise HIV prevention

Goals for 2015

- 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.
- Vertical transmission of HIV eliminated and AIDS-related maternal deaths reduced by half
- All new HIV infections prevented among people who use drugs

Objectives

- To generate political commitment to address how and why people are getting infected
- To mobilise communities to effectively demand transformative social and legal change
- To direct resources to epidemic hotspots through the right interventions

I Background

87 The past ten years have brought some remarkable successes in HIV prevention.[25] Incidence rates fell more than 25% in 33 countries, including 22 countries in sub-Saharan Africa that carry the highest burden. While the studies may not be definitive, such results suggest that HIV prevention can work—when communities are mobilised to change social norms around sexual and drug use behaviours, when young people are empowered to act on information and access services, when men and women have access to and choose to use condoms and when countries invest in effective and comprehensive evidence-informed programmes around sex work and drug use.

88 However, over the past decade, the number of people newly infected with HIV has increased by more than 25% in seven countries. And despite reductions, in 2008 1.9 million more people became infected with HIV in sub-Saharan Africa alone. To halt all HIV epidemics will require nothing short of revolutionising the prevention of HIV transmission.

II Gaps in prevention

89 Combination prevention[26] approaches based on sound evidence of effectiveness and efficacy—"*Know your epidemic, know your response"* —have not been widely applied. As a result, national prevention efforts are often inadequate and poorly focused.

90 Heterosexual exposure is the primary mode of transmission in sub-Saharan Africa. As epidemics have matured, the number of new infections among people in so-called "low risk" partnerships is often high. Yet programmes that focus on adults, married couples or people in long-term relationships, and provide prevention services for serodiscordant couples, are rare.

91 Most young people still have inadequate access to quality health services, including sexual and reproductive health and rights programmes, HIV testing and condom provision. Effective school-based sexuality education is still not available in most countries.[27] In many societies, attitudes and laws stifle public discussion of sexuality—for example, in relation to condom use, abortion, and sexual diversity. Yet whether the HIV epidemic is generalised or concentrated, most-affected populations include young people. Because their youth compounds other vulnerabilities, young women and men have additional for information, services, and social support.

92 Although easily preventable at low-cost, vertical transmission of HIV in low- and middle-income countries remains unacceptably high. An estimated 53% of pregnant women living with HIV received antiretroviral drugs to reduce the risk of transmitting HIV to their infants in 2009.[28] In the same year, 379,000 babies acquired HIV.[29] Progress is too slow, and programmes often offer far from an adequate standard of care—for example, the continued use of single dose nevirapine instead of recommended combination therapy.

93 The ability of young women to protect themselves from HIV is frequently compromised by a combination of biological, social, cultural, legal and economic factors. As a result, adolescent women in sub-Saharan Africa are between two and four–and-a-half times more likely to be infected with HIV than men of the same age.[30]

94 Food insecurity can make people more susceptible to HIV, as it may lead to behaviours with negative impacts in order to obtain food, such as selling assets, migrating in search of work, taking children out of school or engaging in commercial sex. While many people engage in behaviours that increase the risk of HIV transmission regardless of food security status, food insecurity can increase the likelihood of such risky behaviour.[31]

95 Prevention programming also remains unacceptably low for people at higher risk of infection, such as people who inject drugs, men who have sex with men, transgender people[32] and female, male and transgender sex workers and their clients. Further, although use of non-injecting drugs, such as stimulants, has been linked to increased risky behaviours and HIV infection,[33] few programmes address this association. Many countries with concentrated HIV epidemics still fail to scale up necessary, evidence-informed interventions, such as harm reduction,[34] peer-led prevention outreach and male and female condom programming.

III What is needed to revolutionise prevention?

96 A significant renewal is required in HIV prevention. Reductions in new HIV infections have not been sufficient to contain the epidemic, and in many cases HIV prevention responses have not focused on where they will have maximum impact.

97 The prevention landscape has altered over the past decade, with significantly more promise in combining biomedical prevention programmes with behaviour change. The body of data available concerning the nature and determinants of HIV risk in particular settings has increased markedly. New programme options are being added to the range of prevention activities, which can increase impact by orders of magnitude. For example, testing and counselling couples together has far more significant impact on sexual practice than individual testing programmes, and focussing efforts on discordant couples can open up a range of new options to directly impact on a significant fraction of HIV exposure risk. These developments make both possible and necessary a revolution in the way HIV prevention is conducted and the impact of HIV prevention programmes.

Revolutionising the way we think about prevention

Individual	**>>>**	**Network**
Leaflet	**>>>**	**Social media**
Victim	**>>>**	**Actor**
Institution	**>>>**	**Movement**
"We know what works"	**>>>**	**"You know what works"**
Prevalence	**>>>**	**Incidence**
Treatment vs. prevention	**>>>**	**Treatment and prevention**
AIDS is exceptional	**>>>**	**AIDS leads the way**

98 Countries need better information about the determinants, dynamics and impact of their epidemic to develop cost-effective responses targeted at those in need, including people at higher risk and vulnerable to HIV.

99 Evidence is mounting that comprehensive sexuality education empowers young people to make informed decisions regarding their sexual health and behaviours, while also playing a part in combating damaging beliefs and misconceptions about HIV and sexual health. Family-centred approaches recognise that social norms are set at the family and community level, and that parents, other kin and community leaders can have a defining impact on the aspirations and choices of young people. Efforts to make health services "youth friendly" by breaking down barriers to use are providing access to sexual and reproductive health services and commodities. Enabling young people to act as change agents, and focusing social and political movements around specific initiatives, will energise the revolution from the bottom up and the top down.

100 Services delivered in health care settings are important, but are unlikely on their own to overcome the structural barriers that block effective responses to HIV. Mobilised communities demanding significant social and legal changes are key to removing barriers to access, uptake and sustained use of quality prevention services.

101 People living with HIV have always been powerful advocates for HIV prevention, but relatively few programmes have directly engaged them in prevention initiatives. Yet effective prevention depends on such engagement as well as involving those groups at higher risk in programme design and delivery. Innovative approaches that involve people living with HIV, such as "Positive Health, Dignity and Prevention",[35] are urgently needed. Political and programmatic commitment to involving affected communities must be ensured.

102 When social support and other programmes for people with disabilities are delivered in an HIV-sensitive manner, they contribute to overcoming the historic neglect of HIV

prevention and support for people with disabilities.[36] The significantly under-reported rates of HIV infection and related disease and death among people with disabilities also need to be tackled directly through AIDS programming efforts.

103 There must be no more denial of the harmful social, sexual and gender norms that drive vulnerability: the social exclusion of particular groups; refusal to admit the existence of men who have sex with men; marginalisation of people who use drugs; and gender inequality, violence and other forms of abuse directed towards women. Leaders must be enlisted to support a prevention revolution by giving them greater recognition for their efforts when they do the right thing in responding to HIV, even if it does not serve short-term populist goals.

104 The best HIV responses have been transformative in their impact. Such transformative prevention efforts can be seen in South Africa, where mass mobilisations have been implemented using the whole apparatus of democracy to bring together HIV services, knowledge of status and health-changing behaviour; in Kenya's scale-up of voluntary male circumcision in the context of HIV education and behaviour change; and the significant scale-up in access to harm reduction in Malaysia, despite remaining challenges.

105 A global transformation will put HIV prevention efforts at the forefront of the most effective development practice by supporting a renewal of HIV prevention in synergy with expanding treatment access, focus and rigour in programme implementation and country ownership that enables HIV responses to set the pace in the creation of resilient, equitable and inclusive societies.

IV UNAIDS focus and added-value

Impact areas for transformation

106 To generate political commitment to address how and why people are getting infected, we will create positive incentives for leaders to do the right things in responding to HIV by better recognising these critical efforts. We will ensure mapping of vulnerability and risk—as well as programmatic gaps in the response—and political, legal and cultural blockages and opportunities, which will influence leaders and empower civil society to undertake more effective advocacy.

107 To mobilise communities to effectively demand transformative social and legal change, movements will be fostered that create shared social commitment to health, overcome stigma and discrimination and support people in changing their behaviours. It is critical that we empower and facilitate young people as change agents in activating their communities to redress harmful social norms governing sexuality, gender roles and other behaviours. The potential of peer-led approaches involving men who have sex with men, people who use drugs and sex workers, as well as people living with HIV through the "Positive Health, Dignity and Prevention" approach**,** should be maximised.

108 To direct resources to epidemic hotspots through the right interventions, countries will be challenged to develop national AIDS strategies which place emphasis on prioritised prevention programmes and include bold prevention targets based on *know your epidemic, know your response*. Countries will be supported to ensure that strategies account for an understanding of both the economic and social returns on investments and define optimal levels of programme scale-up. More focused programmes will be encouraged which saturate HIV hotspots—the geographic locations and social networks

where HIV is most persistent or rapidly increasing—to deliver concerted action in the context of proven combination prevention approaches. Implementation and scale-up of innovative and promising new interventions such as microbicides and other female-initiated prevention methods, male circumcision and vaccines (when available) will be critical to reshaping the response.

109 *Strategic partnerships to deliver results*

- Partner with networks of people living with HIV and other key populations[37], in the context of peer-led, rights-based initiatives, to increase voluntary HIV testing and counselling, treatment adherence and HIV and human rights literacy and protection.
- Build synergies by working with sexual and reproductive health communities and leveraging the maternal, newborn and child health initiative of the H4+ (WHO, UNICEF, UNFPA, World Bank, UNAIDS). Employ efforts to eliminate vertical HIV transmission as an entry point to increase maternal survival through the provision of ART to pregnant women; to promote linkages to antenatal care, including antenatal syphilis screening and treatment; and to provide full access to contraception through sexual and reproductive health services, including for adolescents.
- Work with funding entities, such as the Global Fund to Fight AIDS, TB and Malaria (Global Fund) and PEPFAR, to promote adherence to normative guidance, harmonised reporting and scale-up of priority areas, including the prevention of vertical and heterosexual transmission; transmission among men who have sex with men, people who inject drugs and in the context of sex work; and TB among people living with HIV.
- Engage with networks of young people to disseminate prevention messages and support education programmes that allow young people to understand and exercise their rights to information and to services.
- Engage with academic and professional societies in the North and the South to build capacity at country level and support the generation of operational research and data collection on the structural and social drivers of the epidemics.
- Engage in lesson-learning partnerships that have the potential to facilitate major breakthroughs. For example, engage with the leadership of mega-cities and the Healthy Cities Initiative to drastically cut new infections in growing conurbations, or engage with entities such the Millennium Villages Project to understand how to scale up HIV prevention, treatment, care and support in the context of integrated rural development.

Leveraging the full potential of the Joint Programme: Illustrative examples of joint working to support revolutionising prevention

110 UNAIDS will expand support to countries to implement the learning objectives contained in the groundbreaking *International Technical Guidance on Sexuality Education*, published by UNICEF, UNFPA, UNESCO, WHO and UNAIDS Secretariat. The voluntary Guidance provides age-specific benchmarks that can be used to ensure that young people receive the good-quality education they need in order to make responsible choices about their sexual and social relationships in a world affected by HIV.

111 Together with the UNAIDS Secretariat, other Cosponsors and national partners, the World Bank conducts analytic work on HIV transmission dynamics, which provides countries with insights on the diversity of their epidemic, to improve the planning and costing of prevention policies for maximum efficiency and effectiveness. UNDP advances these efforts by supporting countries to understand the socio-economic drivers of HIV and to respond with appropriate structural interventions, within broader MDG and development plans and actions. UNFPA and the World Bank will conduct a major new synthesis analysis of the global epidemics of HIV in sex workers. This will review epidemiological evidence, intervention efficacy and costs, and will model the costs and impact of addressing the needs of these populations at scale in various epidemic contexts.

Strategic Direction 2: Catalyse the next phase of treatment, care and support

Goals for 2015

- Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment
- TB deaths among people living with HIV reduced by half
- 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

Objectives

- To ensure people living with HIV are able to access effective treatment when they need it
- To strengthen national and community systems to deliver treatment, care and support
- To significantly scale up access to care, support and social protection by people living with and affected by HIV

I Background

112 In 2010, an estimated 10 million people living with HIV are in need of treatment but do not have access to it.[38] Millions of people who could live healthy and productive lives will die unless the treatment gap is closed. Even after treatment is available to everyone who needs it, people living with and affected by HIV will continue to require care and support services.

II Gaps in treatment, care and support

113 Fewer than 40% of people living with HIV are aware of their status.[39] Stigma and discrimination act as major barriers to HIV testing and counselling. Serious, even life-threatening exposure to violence, stigma, loss of family, employment and property can and often do result when people are revealed as living with HIV.

114 The overall costs of providing HIV treatment will increase as countries scale up treatment, adopt recommendations on earlier initiation of ART, provide safer but more expensive regimens and respond to the growing need for second- and third-line treatment.[40] Furthermore, the non-drug costs of delivering ART remain high, accounting for up to 60% of the overall costs of treatment.[41]

115 Between 2000 and 2010, robust competition among generic medicines producers was primarily responsible for price drops. Yet restrictions on generic competition create major barriers to the development and manufacture of products well-adapted for use in resource-poor settings, including fixed-dose combinations and paediatric formulations.

116 While paediatric HIV has been virtually eliminated in industrialised countries, children still account for close to one in six new infections occurring in sub-Saharan Africa. Global commitment to paediatric treatment remains inadequate with just 28% of all

children under 15 years of age who are in need having access to treatment in low- and middle-income countries.[42]

117 Increasing numbers of people on ART mean growing needs for lifelong support to fight opportunistic infections and provide palliative and home-based care. The treatment, care and support needs of young people aged 15-24 are underestimated and unmet in most countries. Social norms that prohibit drug use and pre-marital sex often lead service providers to overlook or actively discourage HIV help-seeking by young people.

118 Treatment service delivery in the past has largely depended on specialist doctors, thus limiting access to treatment in countries with insufficient trained medical staff and for people who live far from specialised facilities. Although there is task shifting to other cadres in some settings, regulatory, professional, financial and attitudinal impediments remain.

119 The “demand side” of treatment—that is what makes patients enrol for treatment and adhere to treatment—has not received enough attention. Poor quality services, stigma, discrimination and homophobia hinder treatment uptake and adherence. Costs of accessing services, including visit fees and transport costs, can also be an important barrier, especially among food-insecure people. Furthermore, the global economic crisis is having a substantial negative effect on HIV programmes and patients ability to seek and adhere to treatment.[43] Low treatment adherence may result in HIV drug resistance, leading to the need for expensive second-line and third-line regimens.

120 Integration of treatment programmes with food and nutritional support remains inadequate. Weight loss or malnutrition may affect the effectiveness of ART. The risk of death among malnourished patients that start ART is two to six times higher compared with non-malnourished patients, independent of CD4 count.[44]. Similarly, while evidence demonstrates that treatment of drug dependence increases ART adherence, integration of ART with treatment of drug dependence and rehabilitation programs is still rare.

121 TB is the leading cause of death among people living with HIV. In 2007, cases of HIV/TB co-infection accounted for more than 26% of all TB deaths and 23% of all deaths among people living with HIV.[45] The majority of these deaths (83%) occurred in sub-Saharan Africa, where the mortality rate from HIV-related TB is more than 20 times higher than elsewhere in the world. For those who survive TB, the disease can take an enormous toll physically and financially. Furthermore, the rapid growth of multidrug-resistant TB poses an even greater threat to people living with HIV due to alarmingly high mortality rates.

III Delivering treatment, care and support

122 Treatment 2.0 is a new approach to simplifying the way HIV treatment is currently provided and to scale up access to life-saving medicines. Using a combination of efforts, it could reduce treatment costs, make treatment regimens simpler and smarter, reduce the burden on health systems and improve the quality of life for people living with HIV and their families. Modelling suggests that, compared with current treatment approaches, Treatment 2.0 could avert an additional 10 million deaths by 2025.

123 By maximising the dramatic impact of treatment on preventing new infections, Treatment 2.0 could reduce the number of people newly infected with HIV by up to 1 million annually if countries provide antiretroviral therapy to everyone who needs it, following the revised WHO treatment guidelines. ART has been shown to reduce HIV

transmission by 92% among discordant couples and has a significant positive impact on rates of TB and maternal and child deaths.

124 More countries should be encouraged to initiate public sector production of generics through new and strengthened South-South cooperation and public-private partnerships. The bulk purchasing of HIV medicines by the Global Fund, UNITAID, PEPFAR and others and work on forecasting led by the Clinton Health Access Initiative and WHO, should continue to support treatment scale up.

125 New methods of service delivery, including integration of HIV treatment with maternal and child health services, sexual and reproductive health services, nutritional support, along with community-based and workplace delivery of ART should be prioritised to scale up access and bring treatment closer to where people live. More analysis is needed in different epidemic contexts of barriers to access and how to overcome them through a combination of health, social protection and community systems strengthening.

Treatment 2.0: Achieving the full benefits of treatment requires progress across five areas.

Optimise drug regimens: UNAIDS calls for the development of new pharmaceutical compounds that will lead to a "smarter, better pill" that will be less toxic, longer-acting and easier to use. Combined with dose optimisation and improved sequencing of first and second line regimens this will simplify treatment protocols and improve efficacy. Optimising HIV treatment will also result in other health benefits, including much lower rates of TB and malaria among people living with HIV.

Provide access to point-of-care diagnostics: Monitoring treatment requires complex equipment and specialised laboratory technicians. Simplifying diagnostic tools in order to provide viral load and CD4 cell counts at the point of care could help to reduce the burden on health systems. Such a simplified treatment platform could defray costs and increase people's access to treatment.

Reduce costs: Despite drastic reductions in drug pricing over the past decade, the costs of antiretroviral therapy programmes continue to rise. While drugs must continue to be made more affordable—including first- and second-line regimens—potential gains are highest in reducing the non-drug-related costs of providing treatment, such as diagnostics, hospitalisation, monitoring treatment, and out-of-pocket expenses. These costs are currently twice the cost of the drugs themselves.

Adapt delivery systems: Simpler diagnostics and treatment regimens will also allow for further decentralising and integrating of service delivery systems, thereby reducing redundancy and complexity, and facilitating a more effective continuum of treatment, care and support. Task-shifting and strengthening procurement and supply systems will be important elements of this change.

Mobilise communities: Treatment access and adherence can be improved by involving the community in managing treatment programmes and by promoting scale-up of voluntary testing and confidentiality and reducing stigma and discrimination in health care settings and communities. Strengthening the demand and uptake for testing and treatment will both improve treatment coverage and help to reduce costs for extensive outreach. Greater involvement of community-based organisations in treatment maintenance, adherence support and monitoring will reduce the burden on health systems.

126 Sharing of best practices in controlling TB, HIV, malaria, hepatitis B and C, congenital syphilis and other diseases, as well as the integration of prevention and treatment services for these diseases, is critical to improve coverage, quality and cost-effectiveness of services.

127 Economic strengthening of poor HIV-affected households, providing comprehensive social care, overcoming stigma and discrimination and ensuring affordable HIV-related services are important components of a multisectoral approach to HIV. HIV care and support demands a comprehensive set of services, including psychosocial, physical, socio-economic, nutritional and legal care and support. These under-prioritised services are crucial to the well-being and survival of people living with HIV and their caregivers as well as orphans and vulnerable children. Care and support services are needed from the point of diagnosis throughout the course of HIV-related illness, regardless of ability to access ART.

128 The bulk of care and support is provided by families—specifically women—and communities, including community-based and faith-based organisations. Greater efforts are required to ensure male involvement in care and support. Care for vulnerable children affected by AIDS is often provided by grandparents; however, older people's contributions, and their own needs for care and support, must be adequately recognised and supported through cash transfers and other forms of social protection.

129 The acceleration of HIV-specific and HIV-sensitive social protection programming can help to scale up comprehensive and predictable protection, care and support for vulnerable families and children affected by HIV, the majority of which currently receive little or no external support.[46]

130 For universal access to be a reality, international and domestic funding must be scaled up and available. HIV funds must be used more efficiently. Closing the "inefficiency gap" and making better use of existing funding is fundamental to producing better overall results in HIV treatment and care.

IV UNAIDS focus and added value

Impact areas for transformation

131 To ensure people living with HIV are able to access effective treatment when they need it, UNAIDS will catalyse a coordinated global effort to achieve the goal of simpler, more affordable, more effective drugs and point-of-care diagnostic and patient monitoring tools. Major cost-savings are to be gained by reducing non-drug-related costs of providing treatment—currently the major part of treatment costs.

132 To strengthen national and community systems to deliver treatment, care and support, community system capacity needs major expansion in order to deliver decentralised, integrated services. Successful models of partnership between health service providers and community-level providers will need to be scaled up. Country capacity to advance treatment access requires scaled-up systems which provide for faster registration of quality HIV-related medicines. Ensuring access to affordable medicines will also require concerted action to support national governments to make use of TRIPS flexibilities, advocating for the exclusion of legal provisions that could negatively affect access to essential medicines.

133 To significantly scale up access to care and support by people living with and affected by HIV, relevant services need to be tailored to individual, household and community needs, and HIV-sensitive social transfers must be embedded into national social protection systems. We will generate national and international consensus on HIV-sensitive social protection policy in order to accelerate the establishment of effective and transformative programmes.

134 *Strategic partnerships to deliver results*

- Collaborate with public-private partnerships, such as Stop TB, to improve early detection and treatment of HIV, improved chronic disease management and the integration of prevention and treatment of co-infections.
- Partner with the pharmaceutical industry to implement tiered pricing for ARVs and other HIV commodities in low- and middle-income countries to increase access to affordable medicines and speed up access to the next generation of treatment.
- Broker relationships with companies, business associations and employers' federations to promote HIV programmes in the workplace, and in the communities where they operate, to increase access of workers and their families to HIV prevention, treatment, care and support services.
- Work with families, communities and faith-based organisations and strengthen community and social welfare systems so as to ensure continuous access to treatment and supplies for vulnerable and socially excluded populations—as well as recognise and support caregivers.
- Work with networks of people who use drugs and service providers to ensure continuity in harm reduction and treatment of drug dependence, prevention of sexual transmission, and care and support services to drug users.
- Engage coalitions of health providers and professional and paraprofessional societies across disciplines (clinical, nursing, public health, etc.) to expand outreach and anchor prevention and treatment, care and support among a variety of health fields.

Leveraging the full potential of the Joint Programme: illustrative examples of joint working to support catalysing the next phase of treatment, care and support

135 WHO, with WFP, UNODC, ILO, the UNAIDS Secretariat and other Cosponsors, work towards the reduction of many factors that put individuals at risk of HIV-related TB—such as poor housing and work conditions, drug use and malnutrition. Together with other partners, WHO will work towards universal access to timely, comprehensive and integrated HIV and TB services. Universal access to integrated HIV and TB prevention, treatment and care services will prevent new TB and HIV infections, will reduce the number of HIV/TB cases and deaths and will have a positive impact on most other UNAIDS priorities.

136 The *Advancing the Sexual and Reproductive Health and Human Rights of People living with HIV* guidance package is the outcome of a two-year process led by the Global Network of People living with HIV (GNP+), the International Community of Women with HIV/AIDS and Young Positives in collaboration with EngenderHealth, International Planned Parenthood Federation, UNFPA, WHO and the UNAIDS Secretariat. This package presents the essential steps to support the sexual and reproductive health and rights (SRHR) of people living with HIV. SRHR is fundamental to the wellbeing of people living with HIV, enabling longer, healthier, more satisfying and productive lives while playing a critical role in the prevention of new HIV infections. The Joint Programme will work with networks of people living with HIV and key populations to document the realities of individual lived experiences by examining the context in which SRHR are enabled or denied.

Strategic Direction 3: Advance human rights and gender equality for the HIV response

Goals for 2015

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

Objectives

- To support countries to protect human rights in the context of HIV through law, law enforcement and access to justice
- To advance country capacity for equitable service provision and reaching the people most in need
- To ensure the needs and rights of women and girls in the context of HIV are addressed in national HIV strategies

I Background

137 Social division and exclusion drive the HIV epidemic. These forces deprive individuals and communities of opportunities and incentives to protect themselves and to create healthy and secure futures for themselves and their children. Paramount among these divisions are gender inequality, the stigmatisation of people living with and affected by HIV and criminal laws that block public health and health promotion. Failure to realise and protect rights, harmful gender norms and gender-based violence obstruct the social transformations that are needed to achieve reductions in HIV infections and related sickness and deaths.

138 Many of the great victories in the HIV response have been human rights victories, achieved through advocacy, activism and litigation. At this juncture, a new generation of activists is needed to understand and defend human rights in the context of HIV – led by young people, women and men, from affected communities and supported by a new generation of government leaders committed to protecting human rights for people living with and at higher risk of HIV.

II Gaps in achieving human rights and gender equality

139 Laws that create barriers to HIV prevention and treatment for different groups of people remain widespread and, in some countries, are on the rise. In 2008, one in three countries did not have laws prohibiting discrimination against people living with HIV. Nearly two-thirds of countries reported policies or laws that impede access to HIV services by certain populations, including minors.[47] Problematic laws include those that restrict women's equal access to education, employment, property, credit or divorce; laws that criminalise sex workers, men who have sex with men and people who use drugs; and laws that inappropriately criminalise HIV transmission. Men who have sex with men, transgender people and sex workers are often the victims of hate crimes and

gender-based violence; and in many countries, law enforcement officers perpetrate violence, rape, harassment and arbitrary arrest of sex workers, people who use drugs and sexual minorities.

140 In sub-Saharan Africa, 60% of people living with HIV are women and girls.[48] But most funding dedicated to women provides ART to prevent vertical transmission. It is essential to combine HIV-related funding with other resources to address the full range of women's vulnerabilities, for example, programmes for discordant couples, young women and female sex workers and to change harmful gender norms and economic disempowerment.

141 Discriminatory laws, policies, practices and persistent stigma continue to undermine efforts to advance HIV programming for marginalised groups, including sex workers, men who have sex with men, transgender people and people who use drugs as well as incarcerated people and others in enclosed settings and people affected by humanitarian emergencies. At any given point, 9.8 million people are in prison worldwide, facing high rates of sexual violence, drug use and TB. An estimated 200 million people are affected by humanitarian emergencies annually, of whom 2 million are people living with HIV. These groups face multiple interacting vulnerabilities and service needs, and their human rights must be protected.

III Demanding action for human rights and gender equality

142 Human rights require that HIV programmes and resources address those most affected. Putting human rights, equity and gender equality at the centre of the HIV response requires a major shift in coverage, content and resourcing of HIV programming. Generic HIV programmes that fail to address gender, sexuality, inequality, criminality, mobility and drug use must be transformed.

143 A true focus on women's rights in the context of HIV demands that all women and girls vulnerable to HIV benefit from a wide range of prevention, treatment, care and support programmes that are tailored to the particular realities of their lives. Integration of HIV and sexual and reproductive health and rights programmes marks one such critical step.

144 Recent research and experience in programme implementation emphasises the importance of actively engaging men in addressing negative male behaviours and changing harmful gender norms such as early marriage, male domination of decision-making, intergenerational sex and widow inheritance.[49] Scaling up effective gender-sensitive and gender-transformative interventions that target men is needed just as much as efforts to ensure women have roles in decision-making from the household level to the parliament.

145 All forms of gender-based violence and discrimination—against women and girls, men who have sex with men, transgender people and sex workers—should be recognised as human rights violations. Programmes to eliminate such violence and discrimination, as well as provide redress for them, should be put in place.

146 Leaders must demonstrate political courage by removing punitive laws that block effective responses to HIV and replacing them with protective policies and laws including those in defence of non-discrimination and equality before the law, regardless of health status, gender, sexual orientation, drug use and sex work. The positive impact of supportive legal and policy environments can be seen across the response and around the world. A number of countries have repealed HIV-related restrictions on entry, stay and residence in the country. These restrictions are often a proxy indicator of high levels of discrimination against people living with HIV.

147 Support to governments to realise and protect rights must be accompanied by efforts to enable civil society to claim those rights. Significant expansion of programmes that empower civil society to know and demand their rights is needed. These include programmes to reduce HIV stigma and discrimination, to provide legal aid and legal literacy, to reform laws, to train police and health care workers on non-discrimination, and to support the equality of women in public and private spheres. Such programmes are already often part of national responses, but they remain isolated projects. For a new generation of HIV activists and for "Positive Health, Dignity and Prevention", these programmes should be an integral part of every response and taken to appropriate scale.

IV UNAIDS focus and added value

Impact areas for transformation

148 To support countries to protect human rights in the context of HIV through law, law enforcement and access to justice, we will intensify our work with people living with and at higher risk of HIV to know and claim their rights and with governments to realise and protect those rights. This requires the generation of more complete, timely and transparent information on country-level rights and legal frameworks and their impact on HIV; support for expansion of programmes on legal literacy, legal assistance, and law reform; and support to leadership and programmes in government, parliament and the judiciary to strengthen systems of justice in the context of HIV.

149 To advance country capacity to reduce stigma and discrimination and to realise equitable service provision for those most affected by HIV, countries must be supported to eliminate stigma and discrimination in HIV-related programming. To do so, data collection with people at higher risk of infection particularly on programme coverage and barriers to access, will be enhanced. We will also ensure the greater participation of people living with HIV, women and key populations in decision-making forums and intensify support to people living with HIV to lead efforts to reduce stigma and mobilise as forces for change, self-protection and empowerment. Discriminatory policies and practices that limit access to HIV services by vulnerable groups including people affected by humanitarian emergencies will be addressed.

150 To ensure that the needs and rights of women and girls are addressed in national HIV programmes, a much broader range of programmes are needed that address the HIV-related needs of girls and women across the span of their lives. These must include programmes to reduce harmful gender norms, to provide legal support for property and inheritance rights and to enhance economic and social empowerment, including for caregivers. We will support countries to prohibit gender-based violence and discrimination, including through the active involvement of men and boys. We will do more to mobilise women leaders to inform the development and implementation of HIV strategies and to integrate these into the women's movement, including through the implementation of the principles and recommendations of UNAIDS' *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV*.

151 *Strategic partnerships to deliver results*

- Support regional and country networks of men who have sex with men, transgender, sex workers, people who inject drugs, including those which focus on young people living with HIV, to gather evidence and organise themselves to influence regional economic and political agendas.

- Work with civil society networks to conduct research, such as on the *People Living with HIV Stigma Index*, and disseminate research findings and messages to affect policy and funding changes.
- Partner with women's rights advocates to create demand for voluntary testing and counselling and to enable women and girls to learn and demand their rights to HIV prevention and treatment as well as protection from coercion and violence. Build bridges with micro-finance and nutrition initiatives for maximum effect.
- Strengthen faith-based organisations to expand their pivotal role in the community; to integrate HIV prevention, care and support; and to steadily address stigma and discrimination.

Leveraging the full potential of the Joint Programme: illustrative examples of joint working to support advancing human rights and gender equality

152 The *Global Commission on HIV and the Law* will assist in developing actionable, evidence-informed and human rights-based recommendations for effective HIV responses that promote and protect the human rights of people living with and most vulnerable to HIV. To this end, the Commission focuses on some of the most challenging legal and human rights issues in the context of HIV. Regional dialogues, which are critical for bringing local perspective as well as creating national ownership for follow-on, are being rolled out through inter-agency action with UNDP, WHO, UNICEF and UNFPA and the UNAIDS Secretariat. In tandem with the *Global Commission on HIV and the Law*, these Cosponsors, with UNHCR and UNODC will develop a punitive law index to track progress on the removal of punitive laws.

153 UNAIDS will support countries to implement the *Action Framework on Women, Girls, Gender Equality and HIV.* The Framework is a collaborative effort among the UNAIDS Secretariat, UNDP, ILO, UNICEF, UNFPA, WHO, UNESCO, World Bank and UNIFEM/UN Women. The Framework was developed in response to the pressing need to address gender inequality and human rights violations that affect women and girls in particular. It outlines specific actions to mitigate the particular effect of the HIV epidemic on women and girls and to translate political commitment into scaled-up action.

Summary Table of UNAIDS Focus and Added Value in Three Strategic Directions

VISION	ZERO NEW HIV INFECTIONS			ZERO AIDS-RELATED DEATHS			ZERO DISCRIMINATION		
STRATEGIC DIRECTIONS	**Revolutionise HIV Prevention**			**Catalyse the next phase of treatment, care and support**			**Advance human rights and gender equality for the HIV response**		
OBJECTIVES	To generate political commitment to how and why people are getting infected	To mobilise communities to demand transformative change	To direct resources to epidemic hotspots	To ensure people living with HIV can access treatment	To strengthen national and community systems to deliver services	To scale up access to care, support and social protection services	To support countries to protect human rights in the context of HIV	To advance country capacity for equitable service provision	To ensure needs of women and girls are addressed in national programmes
IMPACT AREAS	Leaders positively incentivised to make the right decisions	Young people empowered to redress harmful social norms	Strategies emphasise prioritised prevention programmes	Better drugs and point-of-care tools developed	Community system capacity to deliver integrated services expanded	Care and support services adapted to diverse needs	Key populations empowered to claim their rights	People living with HIV mobilised as forces of change	Programmes that support women and girls across the full range of their lives implemented
	Political and legal blockages mapped and addressed	Positive Health, Dignity and Prevention approaches scaled up	Innovative and effective prevention approaches introduced and scaled up	Major non-drug-related cost savings identified and gained	Country capacity for registration of medicines and use of TRIPS scaled up	HIV-sensitive social transfers embedded into national programmes	Complete information on legal frameworks disseminated	Data collection with people at higher risk strengthened and put to use	Programmes to counter gender-based violence implemented

CORE THEMES

Inclusive, country owned sustainable responses
- Build and strengthen lasting local institutional capacity
- Mobilise national leaders to allocate funding, including domestic, to those at highest risk of infection with the most cost-effective interventions

People at the centre of the response
- Promote the leadership and capacity of peer-led organisations and networks of people living with, affected by and at higher risk of HIV in the design, implementation and evaluation of HIV responses at the global and national level

Synergies between the HIV response and broader MDG and human development efforts
- Generate collaboration between various networks and movements promoting health and development causes
- Leverage resources for the implementation of appropriate, equitable and cost-effective approaches to programme and service integration

PART 3 How UNAIDS will deliver on its goals

I Optimising the comparative advantage of the Joint Programme

154 UNAIDS aims to lead and inspire the world in achieving universal access to HIV prevention, treatment, care and support. As an innovative collaboration, the strength of the Joint Programme is derived from the diverse expertise, experience and mandate of its ten Cosponsors and the added value of the UNAIDS Secretariat in political leadership and advocacy, coordination and fostering joint accountability.

155 This Strategy is closely aligned with and will guide the HIV strategies of UNAIDS' Cosponsors. These strategies include those that are sector- or population-specific, such as HIV strategies on health and education and those relating to HIV and refugees, internally displaced persons, nutrition, children, women, young people, and drugs and crime. Others Cosponsor strategies refer to the multisectoral aspects of the HIV response, such as those that cover the governance of the response, development planning, social protection and financing.

UNAIDS added value, vis-à-vis other actors in the development landscape, in achieving the vision of *zero new HIV infections, zero discrimination, zero AIDS-related deaths* is articulated in its Mission Statement. Its core and unique strengths are leveraged in this Strategy. In particular:

- As a UN entity, UNAIDS exercises leadership in the global AIDS response by promulgating and promoting norms and standards, convening UN agencies, donors, governments, people living with HIV and affected communities, civil society organisations and the private sector in selective high-yielding partnerships, and by mobilising resources for an equitable global response.
- As a joint programme, UNAIDS optimises the UN response by modelling UN reform and 'delivering as one' through its unique coordination function that ensures policy coherence as well as operational coordination—as exemplified by the implementation of the UNAIDS Outcome Framework by UN Joint Country Teams on AIDS.
- As a programme of 10 Cosponsoring UN agencies, UNAIDS delivers value in supporting multi-sectoral responses, addressing social drivers and impacts of the epidemic and leveraging and influencing factors that impact on the epidemic—often in indirect ways through, for example, education policy, food security, social protection, employment, etc.
- Based on its long-standing partnership approach with countries, UNAIDS is particularly well placed to serve as a valuable partner as the AIDS response moves to longer-term approaches with country ownership at its heart—including by supporting the involvement of people living with and affected by HIV as well as other vulnerable groups and their representatives in the development, implementation and evaluation of HIV responses.
- With its presence in nearly every low- and middle-income country, UNAIDS generates and promotes the use of strategic information and evidence-informed policy to guide investments in targeted and quality responses and advocates for mutual accountability to ensure their implementation.
- With its human rights mandate, UNAIDS advocates for the human dignity, equality, rights, security and empowerment of all people.

II Putting the Strategy into operation

156 Putting the Strategy into operation will require changing the way we do business. We must aim for nothing less than zero duplication, zero incoherence and zero waste. In getting to zero we need to strengthen a number of mechanisms that cover the breadth of the Programme from its governance through to the specifics of country delivery. Value-for-money in the delivery of effective and efficient business practices will be

critical to ensure that scarce resources are targeted for results as transaction costs are kept to a minimum. Stakeholder ownership of a Unified Budget and Accountability Framework (UBAF) – the operational plan of the Joint Programme – will also be key to ensuring that activities are prioritised around the Strategic Directions, goals and key results, and that the delivery of such results are implemented in the broader context of a harmonised and accountable UN.

Implementation Mechanisms	Areas of Focus for UNAIDS
Measuring progress and improving accountability	- Actively engage UNAIDS Programme Coordinating Board in the development of the UBAF - Strengthen links between the UBAF and Cosponsor corporate results frameworks - Focus the UBAF on epidemic priorities and achievement of results at country level - Allocate funds based on clear principles and criteria for performance to deliver key products and enhance accountability for results
Division of Labour	- Convene Cosponsors around Strategy goals based on their comparative advantage in countries - Secretariat to assume overall leadership on political advocacy, strategic information and accountability to Board for results
Partnership	- Exercise selectivity in partnership building to leverage and optimise resources, assess new and existing partnerships on the basis of shared objectives and value-added, and hold partnerships to account through strengthened mutual accountability mechanisms
UN Reform in action	- Participate effectively in the Resident Coordinator system and further pioneer our role in “delivering as one” by enhancing efficient and accountable joint work.
Building country ownership and sustainable capacity	- Build lasting national capacity, systems and institutions with an increasing emphasis on South-South and regional technical support - Step up the quality, efficiency and impact of technical support
Knowledge translation	- Influence research spending towards better strategic information, return-on-investment analysis, programmatic gap analysis and mapping of risks, vulnerability and blockages - Assume role as global knowledge hub for operational research to provide guidance on directing resources to models and interventions that return greatest value for money
Resource mobilisation	- Diversify funding sources for the global HIV response through enhanced domestic role, micro-philanthropy, high-net worth individuals, and innovative financing mechanisms - Link Joint Programme fundraising to key products that deliver on Strategy goals
Organisational strengthening	- Enhance staff competency in political analysis, human rights and gender and knowledge translation - Use lessons learned about staffing deployment and patterns that are yielding information to collectively assist in addressing gaps and concerns at the country level - Model principles of inclusion, dignity and human rights by recognising same-sex partnerships, supporting the work of UN Cares and UN+

Measuring progress and improving accountability

157 The Unified Budget and Accountability Framework (UBAF) will be developed to operationalise the Strategy, mobilise the necessary resources for its implementation and measure progress and results. The UBAF is a governance instrument to enhance planning, management, monitoring and reporting on activities and resources of the Joint Programme. The UBAF will present the expected results of the Joint Programme's work on HIV and clearly show the measurable contributions of the different Cosponsors and the Secretariat.

Relationship between the Strategy and Unified Budget and Accountability Framework

158 Resources will be allocated against results and products and reflected in Cosponsor and Secretariat individual work plans. At country level the work of the Joint UN Teams on AIDS and Joint Programmes of Support will be critical. UN efforts will be based on each country's epidemic, programmatic and capacity gaps as well as the specific niche and added value of the Cosponsors in any particular country.

159 The measurement of results and reporting by the Cosponsors and Secretariat will be strengthened through linking the UBAF to Cosponsors' Corporate Results Frameworks and by working with Joint UN Teams on AIDS to develop simpler and more streamlined country-level reporting. In particular, this will entail alignment of results across global, regional and country levels against the goals of the Strategy; more effective and harmonised use of existing indicators; and involving all stakeholders in the planning, implementation and review of achievements, as well as holding stakeholders to account for their contributions and progress against agreed goals through joint reviews involving national and international partners. Achievements against the Strategy will be further monitored using global AIDS and MDG indicators.[50]

160 The UNAIDS family is accountable to deliver on its goals and priorities through the revised Division of Labour. Existing inter-agency structures and accountability frameworks for reporting, monitoring and evaluating the Joint Programme will form the bedrock for the Division of Labour.

Strengthening joint working within the Joint Programme: The division of labour among Cosponsors and the Secretariat

161 Guided by a set of core principles, the Division of Labour consolidates how the UNAIDS family collectively implements the Strategy by accentuating the comparative advantages of the Joint Programme as a whole—Cosponsors and Secretariat—and its constituent parts. By leveraging respective organisational mandates and resources, enhancing joint working and partnerships, major efficiencies are gained and transaction costs for countries are reduced.

162 To strengthen oversight and accountability the Division of Labour identifies either one or two convening organisations from among Cosponsors for each of a number of thematic areas that have been identified to support the achievement of the Strategy's goals (See

Annex 1). Convenors will ensure that programme needs are identified and addressed through collective work with designated partners.

163 The UNAIDS Secretariat shall exercise responsibility for ensuring the overall functioning and accountability of the Division of Labour, with focus on: (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; and (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.

164 At country level, UNAIDS emphasises the importance of developing and implementing an effective joint programme that responds to national needs and leadership. The regional and global Division of Labour is intended to support country leadership and needs. The Division of Labour at country level should be applied as a flexible framework to assign roles and responsibilities within the UN system, taking into account country priorities as well as the presence and relative strength of individual Cosponsors and the Secretariat on the ground.

Partnership

165 In leveraging a new partnership movement and advocating for, and brokering, a new compact of global solidarity to deliver a transformative HIV response, the Joint Programme must adopt a new approach to partnership. The approach will require selectivity that leverages and optimises resources, assesses new and existing partnerships on the basis of shared objectives and value-added and holds partnerships to account through strengthened mutual accountability mechanisms. Selectivity in partnership—and network building—will be implemented on the basis of the following criteria: the partnership's niche in filling an essential gap; results-orientation; the extent to which UNAIDS can add value based on comparative advantages; and the partnership's ability to deliver on the Strategic Directions of the Strategy.

166 Through partnership approaches, the following key results will be achieved:

- Country partners in the global South will drive and implement human rights-based approaches to HIV prevention, treatment, care and support and prioritise effective interventions, with the engagement of parliamentarians, opinion-shapers such as faith-based organisations, youth networks and women's rights networks;
- Civil society, with particular emphasis on networks of people living with and affected by HIV, will join governments, donors and other stakeholders as partners in the leadership, advocacy, resource mobilisation, implementation, monitoring and evaluation of national HIV responses;
- International donors together with funding partners such as the Global Fund and PEPFAR, will provide robust, predictable funding for national responses, including community systems strengthening, health systems strengthening and effective utilisation of dual-track financing mechanisms, all centred around national ownership;
- Collaboration with the pharmaceutical and diagnostic industries will increase access to more effective and affordable antiretroviral medicines and diagnostics, with attention to technology transfer, quality assurance in drug production and procurement, with particular effort to catalysing research in the global South.

- By providing normative leadership, the Joint Programme will strengthen the commitment of national responses to reach the MDGs by 2015.

UN Reform

167 From its beginnings, UNAIDS has been seen as an example of how the UN might be reformed—an experiment in inter-agency coordination. UNAIDS will remain at the forefront of UN reform by providing leadership, policy influence and advocacy on AIDS and the MDGs. The changing development architecture and landscape underscores the imperative for UN system-wide coherence and the need for UNAIDS to maintain a pioneering role in "delivering as one," taking measures to improve efficiency and accountability to enhance HIV responses.

168 A more effective positioning of UNAIDS field offices within the Resident Coordinator system will enhance coordination and accountability of the UN response to HIV in countries. The Directors of the UNAIDS Regional Support Teams will continue to be members of the Regional UN Development Group Teams, which provide oversight, leadership, strategic guidance, coherent technical support and performance management to Resident Coordinators and UN Country Teams (UNCTs) for the achievement of country-level results–with government leadership.

Building country ownership and sustainable capacity

169 A proliferation of providers of support present new opportunities as well as the need for re-examination of both the technical support market and the goals it is meant to serve. Emphasis will be increasingly placed on strengthening UNAIDS' role in capacity development and on building lasting national and regional capacities, systems and institutions. UNAIDS stresses the importance of using experts from within the regions and countries as well as from within the key affected populations to provide technical support. More pronounced support for South-South cooperation on technical support and increased involvement of emerging economies will be sought.

170 UNAIDS will increase the impact and sustainability of HIV country responses by influencing the provision of quality technical support. This goal will be achieved by:

- Improving country partner capacity and systems to identify, plan, coordinate and lead technical support as well as monitoring the quality and outcomes of technical support.
- Increasing the information available and the transparency of both the demand for, and supply of, technical support—in so doing, improving effectiveness, efficiency, impact and accountability in the technical support system.
- Developing and strengthening synergies and accountability between technical support mechanisms and providers—including providers from emerging and Southern countries.

Enhancing knowledge translation and the generation and use of strategic information

171 The need for scientific and strategic inputs to policy formulation and programming at all levels with a priority focus on countries can be met by the Joint Programme in its following roles:

- Generating and facilitating state-of-the-art, timely, high-quality scientific information and strategic knowledge on the HIV epidemic.

- Building capacity at country level for the definition, compilation, analysis and dissemination of consistent, credible, high-quality scientific information and strategic knowledge, particularly in generating disaggregated data as well as returns on investment across different interventions.
- Understanding diverse stakeholders' information needs and brokering use of appropriate channels (from community theatre to new social media) to translate relevant scientific advances into information for action.
- Identifying barriers to effective programme performance and advocating and supporting the creation of knowledge that can be applied across all settings and contexts; expanding the knowledge base on effective and efficient scale-up of delivery of programmes and making informed choices.
- Addressing the implementation gap by supporting and building capacity to identify the political barriers and gaps in programmatic capacity.

Mobilising financial resources for the HIV response and the Joint Programme

172 Meeting country-defined targets for universal access through 2015 will require significantly enhanced investments in the HIV response. At the global and regional levels, more compelling, evidence-informed narratives of the benefits and efficiencies of investing in the HIV response are needed—including the concrete results that they deliver on HIV and across the MDGs.

173 At the national level, efforts will be intensified to develop the evidence base for returns on HIV investments with emphasis on the prevention dividend. Support will be provided both to governments to develop and fully fund medium-term sustainability plans and to civil society to create the political incentives necessary to increase domestic funding and reduce reliance on external donors (particularly in emerging and middle-income economies).

174 The shifting environment presents considerable opportunities for the Joint Programme; it must diversify its funding sources and leverage more resources for the results identified in this Strategy, both for its own operations and for the broader response. Diversification will include outreach to emerging economies, the European Union, international financial institutions and foundations and philanthropists. The Joint Programme will further develop its partnership with pooled funding mechanisms, such as the Global Fund and UNITAID, to increase their implementation impact in return for direct funding.

175 Strategy goals lend themselves to the development of specific joint fundraising efforts by the Secretariat and one or more Cosponsors. These will be developed and exploited in collaboration with innovative financing mechanisms as well as partnerships with micro-philanthropy ventures, engaging youth and leveraging new social media. Cosponsors will re-double their efforts to raise and allot resources to HIV and related activities in addition to those raised directly by the Secretariat for the Joint Programme.

Organisational strengthening for a more effective Joint Programme

176 To ensure a rational and cost-effective deployment of human resources, the Secretariat and Cosponsors have analysed the capacity requirements at country and regional levels and will collectively define the key requirements for Joint Programme staffing. Investments will be made in the competencies among Joint Programme staff to ensure appropriate and sufficient capacity in all technical areas of the Joint Programme, human rights, partnership building, political advocacy and the translation of knowledge into better national policies and strategies.

177 With country delivery as the basis for staffing, the Secretariat has initiated measures to enhance the use of resources: Managerial efficiencies will be improved and flexibility in the provision of the most cost-effective administration services will be ensured. New corporate strategies and policies have been developed in the areas of finance, human resources, administration, and information management and technology.

178 UNAIDS will continue to exercise its commitment to working with people living with and affected by HIV—putting people first. The Joint Programme will maintain support for UN+, the UN system-wide advocacy group of staff living with HIV, and for UN Cares, which aims to unify HIV workplace programmes across the UN system. The UNAIDS family will also support and “deliver as one,” a comprehensive range of HIV services to all UN personnel and their families.

179 These initiatives will help to ensure that UNAIDS’ guiding principles and policies are put into practice within the Joint Programme. Thereby, UNAIDS will lead by example in advocating and contributing to a world with zero new HIV infections, zero discrimination, zero AIDS-related deaths.

Annex 1. Division of Labour Matrix

Role of the UNAIDS Secretariat: Overall Coordination, Coherence and Accountability of the Division of Labour

The UNAIDS Secretariat shall have overall responsibility for ensuring the functioning and accountability across all areas in the Division of Labour on matters of:

- ***Leadership & Advocacy*:** To influence the setting of a rights-based and gender-sensitive HIV political agenda for the three Strategic Directions outlined in the UNAIDS Strategy, in order to reposition the Joint Programme within a changing (aid and development) environment, based on the analysis of strategic information, including data on the current drivers of the HIV epidemic. The three Strategic Directions are:
    - revolutionising HIV prevention;
    - catalysing the next phase of treatment, care and support; and
    - advancing human rights and gender equality for the HIV response.
- ***Coordination, Coherence & Partnerships*:** Across all of the areas outlined in the Division of Labour (DoL) Matrix, to ensure delivery on the three Strategic Directions.
- ***Mutual accountability*:** To support mutual accountability of the Secretariat & Cosponsors to enhance programme efficiency and effectiveness and to optimally deliver on the shared Joint Programme Mission, Vision and Strategy, with measurable results.

More specifically the Secretariat shall:

- Lead in advocacy and facilitate generation of strategic information for an evidence-informed, rights-based and gender-sensitive global HIV political agenda in line with collectively agreed agenda
- Assure overarching coherence, coordination and support for effective and flexible partnerships across all areas outlined in the Division of Labour, including with people living with HIV, in close collaboration with Cosponsors
- Capitalise on inter-agency mechanisms to ensure appropriate coordination and cohesion across the three Strategic Directions in order to:
    - identify concrete deliverables and targets, taking into consideration the goals of UNAIDS Strategy and results identified in the Unified Budget and Accountability Framework (UBAF)
    - define how all Division of Labour areas will contribute to the three Strategic Directions and the achievement of the Strategy goals
    - facilitate coordination and collaboration across all areas of the Division of Labour in order to maximise potential synergies
    - enhance the role that human rights and gender equality must play to improve the outcomes on prevention and treatment, care and support
    - promote synergies between those efforts that focus on prevention, treatment, care and support, as part of the AIDS response, and those efforts that are being mainstreamed into broader areas of development; and
    - ensure mutual accountability mechanisms, including optimum use of the UBAF for the entire Joint Programme to the Executive Director and the Programme Coordinating Board
- Collect and synthesise key data on the epidemic, in line with newly emerging trends, patterns and typologies, including from a human rights and gender perspective, to monitor and evaluate progress towards universal access and achievement of the MDGs
- Lead the development, coordination and implementation of a mutual accountability framework (in line with above) for the entire Joint Programme (encourage utilisation of CEWG, MERG)
- Create space for and support Cosponsors to act as One UN, maximising their joint comparative advantages at the country level vis-à-vis development partners, in support of national efforts to achieve universal access and MDGs
- Facilitate in brokering and strengthening synergies, complementarities and accountability between technical support mechanisms and providers for appropriate national HIV responses
- Lead in the resource mobilisation for the core Budget and collaborate, where appropriate, with Cosponsors for mobilising supplemental and any other funds.

Division of Labour Area	Convener(s)	Agency Partners			
Reduce sexual transmission of HIV	WB UNFPA	UNDP UNICEF WFP	WHO UNFPA	WB UNESCO	ILO UNHCR
Prevent mothers from dying and babies from becoming infected with HIV	WHO UNICEF	UNICEF WFP	UNFPA WHO		
Ensure that people living with HIV receive treatment	WHO	UNDP UNICEF	UNHCR WHO	UNHCR ILO	WFP
Prevent people living with HIV from dying of TB	WHO	UNICEF WFP	WHO ILO	UNODC	
Protect drugs users from becoming infected with HIV and ensure access to comprehensive HIV services for people in prisons and other closed settings	UNODC	UNDP UNICEF WB	WHO UNODC UNFPA	UNESCO	
Empower men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy	UNDP UNFPA	UNDP WB UNESCO	UNFPA WHO		
Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS	UNDP	UNDP UNESCO	UNFPA WHO	UNODC ILO	UNHCR
Meet the HIV needs of women and girls and stop sexual and gender-based violence	UNDP UNFPA	UNDP UNICEF WFP	UNFPA WHO UNODC	UNESCO UNHCR ILO	
Empower young people to protect themselves from HIV	UNICEF UNFPA	UNICEF UNESCO	WFP UNFPA	UNHCR ILO	WHO
Enhance social protection for people affected by HIV	UNICEF WB	ILO UNDP UNICEF	WFP WHO UNHCR	WB	
Address HIV in humanitarian emergencies	UNHCR WFP	UNDP UNICEF	WHO UNODC	UNFPA UNHCR	WFP
Integrate food and nutrition within the HIV response	WFP	UNICEF WFP	WHO UNHCR		
Scale up HIV workplace policies and programmes and mobilise the private sector	ILO	UNESCO	WHO	ILO	
Ensure good quality education for a more effective HIV response	UNESCO	UNESCO UNFPA	WHO ILO	UNICEF	
Support to strategic, prioritised and costed multisectoral national AIDS Plans	WB	ILO UNHCR WHO	UNDP WB UNODC	WFP UNICEF	UNFPA UNESCO

List of acronyms

ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
BRICS	Brazil, Russia, India, China and South Africa
CEWG	Cosponsor Evaluation Working Group
DoL	Division of Labour
GNP+	Global Network of People living with HIV
GIPA	Greater Involvement of People living with HIV
ILO	International Labour Organization
MDGs	Millennium Development Goals
MERG	Monitoring and Evaluation Reference Group
PEPFAR	US President's Emergency Plan for HIV/AIDS Relief
PHDP	Positive Health, Dignity and Prevention
RC	United Nations Resident Coordinator
RST	Regional Support Team
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
TRIPS	Trade Related Aspects of Intellectual Property Rights
UBAF	Unified Budget and Accountability Framework
UBW	Unified Budget and Workplan
UCC	UNAIDS Country Coordinator
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	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
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

References

[1] UNAIDS, *AIDS Epidemic Update*, (UNAIDS, 2009)

[2] United Nations Summit, *High-level Plenary Meeting of the General Assembly*, (New York, 20-22 September 2010) http://www.un.org/millenniumgoals/pdf/MDG_FS_6_EN.pdf

[3] UNAIDS, *AIDS Epidemic Update*, (UNAIDS, 2009)

[4] UNAIDS, *Outlook Report,* (UNAIDS, 2010)

[5] To *know your epidemic* requires that countries identify the key drivers of the epidemic focusing on the relationship between the epidemiology of HIV infection and the behaviours and social conditions that impede their ability to access and use HIV information and services. Knowing your epidemic is the basis for *knowing your response,* which provides countries with an opportunity to critically assess who is and who should be participating in HIV prevention. UNAIDS, *Practical Guidelines for Intensifying HIV Prevention*, (UNAIDS, 2007)

[6] In July 2010, the United Nations General Assembly created UN Women, the United Nations Entity for Gender Equality and the Empowerment of Women. For more information see http://www.unwomen.org/

[7] Men who have sex with men are defined as males who have sex with other males, regardless of whether or not they have sex with women or have a personal/ social identity associated with that behaviour, such as being 'gay' or 'bisexual'. UNAIDS, *Universal Access for MSM and Transgender People: Action Framework,* (UNAIDS, 2009)

[8] People who use drugs include injecting drug users, a population of particular concern in relation to HIV given use of contaminated injecting material as a route of transmission of HIV, as well as other drug users who frequently have an elevated risk of HIV as a result of increased risky sexual behaviour and sex work associated with drug use.

[9] Sex workers are defined as female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating. UNAIDS, *Sex work and HIV/AIDS,* (UNAIDS Technical Update, June 2002)

[10] International Labour Office, *World of Work Report 2008: Income inequalities in the age of financial globalization, International Institute for Labour Studies*, (ILO, Geneva, 2008)

[11] Murray, C., et al., *Maternal Mortality for 181 countries, 1980 – 2008: a systematic analysis of progress towards Millennium Development Goal 5,* (The Lancet, 375(9726): 1609-1623; April 2010)

[12] UNICEF, *State of the world's children special edition: Celebrating 20 years of the convention on the rights of the child*, (UNICEF, New York, 2009)

[13] UNICEF, *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS* (UNICEF, New York, 2006); UNAIDS, *Children and AIDS Fourth Stocktaking Report,* (UNAIDS, Geneva, 2009); UNICEF, http://www.childinfo.org/hiv_aids_children_affected.html accessed October 2010

[14] Doyle, s., et al, *The Impact of Male Circumcision on HIV Transmission*, (The Journal of Urology, Vol. 183(1); Jan. 2010); Newell, M-L., & Barnighausen, T., *Male circumcision to cut HIV risk in general population,* (The Lancet, 369(9562); 2007)

[15] See for example, Castilla J, et al, *Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV*, (Journal Acquired Immune Deficiency Syndrome, 1;40(1): 96-101; September 2005)

[16] Institute of Medicine, *Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence,* (National Academies Press, Washington DC, 2007)

[17] Marseille, E., et al, *HIV prevention costs and program scale: data from the Prevent AIDS: Network for Cost-Effectiveness Analysis (PANCEA) project in five low and middle-income countries*, (BMC Health Services Research, 7(108): 6; 2007)

[18] Vertical transmission is HIV transmission from mother to child during pregnancy, childbearing or during breastfeeding. Without any intervention, the risk of transmission from a mother to her child can be as high as 45%, depending on the duration of breastfeeding. More than 90% of children living with HIV are likely to have been infected through vertical transmission.

[19] **West Africa:** UNAIDS; New HIV infections by mode of transmission in West Africa. A multi-country analysis, (UNAIDS, Draft Report, 2010); **Southern & East Africa:** UNAIDS Country Reports, available at http://www.unaidsrstesa.org/hiv-prevention-modes-of-transmission.

[20] Adapted from Mathers B. M,, et al., *Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review*, (The Lancet, 372(9651):1733-45; 2008)

[21] GNP+, International Harm Reduction Association, ilga, IPPF, UNAIDS, *Making the Law Work for the HIV Response* (July, 2010) http://data.unaids.org/pub/BaseDocument/2010/20100728_hr_poster_en.pdf

[22] UNAIDS own data, 2010. For more information visit www.unaids.org

[23] UNICEF, *Narrowing the Gaps to Meet the Goals*, (UNICEF, September 2009); UNICEF, *Progress for Children Achieving the MDGs with Equity*, (UNICEF, Number 9; September 2010)

[24] United Nations General Assembly, *Keeping the promise: united to achieve the Millennium Development Goals*, (A/65/L.1, 17 Sept 2010). http://www.un.org/en/mdg/summit2010/

[25] Piot, P., et al, *Coming to terms with complexity: a call to action for HIV prevention*, (The Lancet, 6736(08); 2008)

[26] Combination prevention has the following features: it is tailored to national and local needs and contexts, includes a combination of biomedical, behavioural and structural elements—to reduce both the immediate risks and the underlying vulnerabilities; is developed with the full engagement of affected communities, promoting human rights and gender equality; operates

synergistically, consistently over time, on multiple levels—individual, family and society; invests in decentralized and community responses and enhances coordination and management; and is flexible and based on continuous learning—it can adapt to changing epidemic patterns and can rapidly adjust and deploy new tools and innovations.

[27] See UNESCO, UNAIDS, UNFPA, UNICEF, WHO, *International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators*, (2009); UNAIDS Inter-Agency Task Team (IATT) on Education, *A Strategic Approach: HIV & AIDS and Education*, (2009)

[28] WHO, UNAIDS, UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector* (WHO, 2010) http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf

[29] WHO, UNAIDS, UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector* (WHO, 2010) http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf

[30] USAID, *HIV Prevention Knowledge Base: Emerging Areas,* (September 2009) http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_Knowledge_Base_%20Intergenerational_and_Transactional.pdf

[31] Weiser S., et al, *Food Insufficiency is Associated with High Risk Sexual Behaviour among Women in Botswana and Swaziland*, (PLoS Med, 4:1576-1577; 2007); Miller C., et al, *A Qualitative Analysis of the Impact of Food Insecurity on High-Risk Sexual Practices in Uganda, (*AIDS Behav, 2010) http://www.ncbi.nlm.nih.gov/pubmed/20405316; Oldewage-Theron W, et al, *Poverty, Household Food Insecurity and Nutrition: Coping Strategies in an Informal Settlement in the Vaal Triangle, South Africa*, (Public Health 120:795–804; 2006)

[32] Broadly speaking, the term 'transgender' comprises individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term "transgender people" describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another. WHO, *Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region,* (WHO, 2010)

[33] Strathdee, S., Stockman, J., *Epidemiology of HIV Among Injecting and Non-injecting Drug users: Current Trends and Implications for Interventions,* (Current HIV/AIDS Reports, 7(2): 99-106; April 2010)

[34] WHO, UNODC, UNAIDS, *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, (2009), provides targets for all of the nine essential elements of comprehensive responses for HIV prevention among people who inject drugs.

[35] Positive Health, Dignity and Prevention objectives:

- Increasing access to, and understanding of, evidence-informed, human rights-based public health policies and programmes that support individuals living with HIV to make choices that address their needs and allow them to live healthy lives.
- Scaling-up and supporting existing HIV testing, care, support, treatment, and prevention programmes that are community-owned and led.
- Scaling-up and supporting literacy programmes in health, treatment and prevention and ensuring that human rights and legal literacy is promoted and implemented.
- Ensuring that undiagnosed and diagnosed people living with HIV, along with their partners and communities, are included in HIV prevention programmes that highlight shared responsibility, regardless of known or perceived HIV status and have options rather than restrictions in order to be empowered to protect themselves and their partner(s).
- Scaling-up and supporting social capital programmes that focus on community-driven, sustainable responses to HIV by investing in community development, networking, capacity- building and resources for PLHIV organisations and networks. (*Positive Health Dignity and Prevention Framework*. Draft)

[36] N. Groce, *HIV/AIDS and Individuals with Disability* (Health and Human Rights, 2005)

[37] Key populations, or key populations at higher risk, are groups who are more likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful HIV response. In all countries key populations include people living with HIV. In most settings men who have sex with men, transgender people, people who inject drugs, and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations who are key to their epidemic and response based on the epidemiological and social context.

[38] WHO, UNAIDS, UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector* (WHO, 2010) http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf

[39] UNAIDS, *Outlook Report,* (UNAIDS, 2010); UNAIDS, *Report on the Global AIDS Epidemic*, (UNAIDS, 2008)

[40] The first combination of drugs taken by a patient is usually called the first line regimen and when this no longer works to block HIV, another regimen made up of new medicines is needed. This is usually not needed for many years, and is called the second line regimen. If this also eventually fails, a third line or salvage cocktail of medicines is usually recommended (WHO, 2009). For more details on treatment see *Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a public health approach*, (WHO, 2006 revision) http://www.who.int/hiv/pub/guidelines/artadultguidelines.pdf

[41] *Treatment 2.0*, (UNAIDS, 2010)

http://data.unaids.org/pub/Outlook/2010/20100713_outlook_treatment2_0_en.pdf

[42] WHO, UNAIDS, UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector* (WHO, 2010) http://whqlibdoc.who.int/publications/2010/9789241500395_eng.pdf

[43] UNAIDS, *Impact of the Global Financial and Economic Crisis on the AIDS Response* (UNAIDS, 2009)

[44] Thiers, B. H., *Mortality of HIV-1-infected patients in the first year of anti-retroviral therapy: comparison between low-income and high-income countries,* (The Lancet 367:817-824; 2006)

[45] *Global TB Control,* Epidemiology Strategy Financing, (WHO, 2009)

http://www.who.int/tb/publications/global_report/2009/pdf/full_report.pdf

[46] UNICEF, UNAIDS, IDS, *Enhancing Social Protection for HIV Prevention, Treatment, Care & Support*, (Accessed October 2010. Extracted from Temin, M., *HIV-Sensitive Social Protection: What Does the Evidence Say?,* UNICEF, forthcoming 2010*)*; UNAIDS, *Expanded Business Case: Enhancing Social Protection*, (May 2010)

[47] UNAIDS, (UNAIDS, 2010) http://www.unaids.org/en/Priorities/03_06_Punitive_laws_stigma.asp

[48] UNAIDS, *Report on the Global AIDS Epidemic,* (UNAIDS, 2008); Garcia-Calleja. J, M., Gouws, E., Ghys, P. D., *National population based HIV prevalence surveys in sub-Saharan Africa: results and implications for HIV and AIDS estimates,* (Sexually Transmitted Infections, 82 (3):iii 64–iii 70; 2006)

[49] USAID, *Engaging Men for Gender Equality and Improved Reproductive Health,* (Population Reference Bureau, 2009); Barker, G., et al, *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions*, (WHO, 2007) http://www.who.int/gender/documents/Engaging_men_boys.pdf

[50] There are more than 60 indicators to measure progress towards the Millennium Development Goals. Information on these can be found at http://unstats.un.org/unsd/mdg/Default.aspx.

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