United Nations E/2011/109

Economic and Social Council

Distr.: General
2 May 2011

Original: English

Substantive session of 2011
Geneva, 4-29 July 2011
Item 7 (g) of the provisional agenda*
Coordination, programme and other questions

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Note by the Secretary-General

The Secretary-General has the honour to transmit to the Economic and Social Council the report of the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), prepared pursuant to Council resolution 2009/6.

* E/2011/1.

11-32006 (E) 200511

Report of the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS)

Summary

The present report was prepared in response to Economic and Social Council resolution 2009/6, in which the Council requested the Secretary-General to transmit at its substantive session in 2011 a report prepared by the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), in collaboration with its co-sponsors and other relevant organizations and bodies of the United Nations system, on progress made in implementing a coordinated response of the United Nations system to the HIV/AIDS pandemic.

Historic gains have been achieved in the response to HIV. Globally, the number of adults newly infected with HIV has declined by nearly 20 per cent since 1999, AIDS deaths have fallen by 19 per cent in only five years, and the number of children newly infected with HIV was 24 per cent lower in 2009 than in 2004. The number of people receiving antiretroviral treatment continues to increase, rejuvenating households, communities and entire societies. Important research breakthroughs occurred in 2010, with clinical trials demonstrating the partial efficacy of a vaginal microbicide and pre-exposure antiretroviral prophylaxis, effectively expanding the toolkit of effective interventions to prevent new infections. Efforts have been made to increase the number of circumcised adult males, although faster progress is urgently needed to bring this highly effective intervention to scale to help reduce sexual transmission. Although stigma, discrimination and social marginalization continue to impede effective responses, some promising trends are evident, with the percentage of countries reporting the existence of laws and regulations protecting people living with HIV from discrimination increasing from 56 per cent in 2006 to 71 per cent in 2010.

These gains, while heartening, are fragile since the global financial and economic downturn has caused HIV financing to flatten. Although HIV incidence has declined globally, new infections are on the rise in several parts of the world, including in Eastern Europe, Central Asia, the Middle East, North Africa and some high-income countries.

Following the release of the final report of the second independent evaluation of UNAIDS in 2009, the Joint Programme undertook concerted steps to implement the recommendations of the evaluation, with particular focus on actions to enhance the coherence, coordination, efficiency and effectiveness of UNAIDS support to HIV responses. A new UNAIDS vision was formulated, envisaging zero new infections, zero AIDS-related deaths and zero discrimination. UNAIDS developed a new strategy for 2011-2015 reflecting this new vision, and providing for focused actions to accelerate progress under each pillar of the new UNAIDS vision. Work began on the development of a new UNAIDS unified budget, results and accountability framework, to become effective in January 2012.

Since its last report to the Council (E/2009/70), the Joint Programme has focused on achieving concrete results in 10 priority areas and across six cross-cutting strategies as set out in *Joint Action for Results: UNAIDS Outcome Framework 2009-2011*. These priority areas represent key themes where accelerated progress is needed

to achieve the global aim of universal access to HIV prevention, treatment, care and support. Business cases and unified advocacy strategies have been developed for priority areas, and workplans have been aligned to generate synergistic efforts by UNAIDS to expedite progress in each area.

The present report summarizes the Joint Programme's accomplishments over the past two years in implementing a coordinated response, with results reported for each priority area and cross-cutting strategy in the Outcome Framework. It also summarizes the Joint Programme's collective achievements, the contributions by individual co-sponsors and the UNAIDS secretariat and the challenges confronted.

In conclusion, the report offers a series of recommendations. The Economic and Social Council is invited to review the report and its recommendations.

I. Update on the epidemic

1. HIV remains one of the world's most pressing health and development challenges. In 2009, the latest year for which comprehensive epidemiological data are available, an estimated 33.3 million people were living with HIV — a 27 per cent increase over 1999. An estimated 2.6 million people were newly infected, including 370,000 children, and 1.8 million people died of HIV-related causes. The number of children orphaned by AIDS rose to 16.6 million in 2009, compared to 14.6 million in 2005.

2. Although these figures underline the continuing gravity of the epidemic, there is significant news to report. The number of new HIV infections in 2009 was nearly 20 per cent lower than in 1999, with HIV incidence declining at least 25 per cent over the last decade in at least 33 countries. With more than 6 million people receiving antiretroviral therapy as at December 2010, the rate of AIDS deaths is also falling, with the number of deaths in 2009 19 per cent lower than in 2004.

3. These gains, however, are fragile. Total funding for HIV programmes in low- and middle-income countries remained flat in 2009, with international financing declining in 2009 for the first time.

A. Regional variations

4. Sub-Saharan Africa remains most heavily affected by HIV, accounting for 68 per cent of all people living with HIV, 69 per cent of all new HIV infections and 72 per cent of AIDS deaths. The epidemic has sharply lowered life expectancy in many African countries, placed enormous burdens on health and social service systems and presented a historic challenge to the region.

5. The Caribbean is the region with the second highest HIV prevalence, and nearly 5 million people are living with HIV in Asian countries. Although HIV incidence has declined globally, the rate of new infections is increasing in Eastern Europe, Central Asia, the Middle East and North Africa, as well as in some high-income countries.

B. HIV and women

6. Globally, women represent a slight majority of people living with HIV. In sub-Saharan Africa, women account for 60 per cent or more of all people living with HIV. Risks are especially pronounced for young women and girls. In South Africa, young women ages 15 to 24 are three to four times more likely to be living with HIV than males the same age. These imbalances reflect not only the heightened physical vulnerability of girls and young women, but also a high prevalence of intergenerational partnerships, the lack of women-initiated prevention methods, the need for expanded access to educational opportunities for girls and women, which has proven to reduce their risk and vulnerability to HIV, and broader social and legal inequalities that impede the ability of young women to reduce their risk. In some countries, the prevalence of gender-based violence exceeds 50 per cent, with studies consistently linking women's experience of violence with a heightened risk of HIV infection. In such contexts, women and girls affected by humanitarian emergencies are at higher risk of being used as a weapon of war and of being sexually exploited

and consequently at risk of contracting HIV infection. This situation is further worsened by the impact of HIV and tuberculosis on household food and nutrition security and the depletion of household resources. This is particularly true for the most vulnerable, including pregnant and lactating women and children living with or affected by HIV.

C. Children, young people and HIV

7. Between 2004 and 2009, new paediatric infections declined by 24 per cent. Despite this progress, only 28 per cent of children under 15 in need of antiretroviral therapy received it in 2009. In addition, children affected by AIDS continue to face significant challenges. In 2010, 17.5 million children under 18 years of age had lost one or both parents to AIDS, representing 11 per cent of the global number of orphans. Ninety per cent of these children are in sub-Saharan Africa.

8. Nearly 23 per cent of people living with HIV worldwide are under the age of 24. In addition to the hundreds of thousands of newborns infected annually as a result of vertical transmission, many sexually active young people are vulnerable to HIV, with those between the ages of 15 and 24 accounting for 35 per cent of all new HIV infections in 2009. Although these figures underline young people's continuing vulnerability to HIV, important progress has been made in protecting them. As a result of steady progress in expanding programmes to prevent vertical transmission, the number of new infections among children fell by 24 per cent between 2004 and 2009. In 10 high-prevalence countries, HIV prevalence among young people has declined by at least 25 per cent since 2001. Although patterns vary within and among countries, available survey evidence indicates that more young people are delaying sexual debut and more of those who are sexually active are using condoms. Challenges remain, however, as only 34 per cent of young people worldwide exhibit accurate and comprehensive knowledge about HIV, well short of the 95 per cent target set forth in the 2001 Declaration of Commitment on HIV/AIDS.

D. Expanding knowledge base on HIV

9. Recent gains in the HIV response are driven in part by improved evidence regarding epidemiological trends, the emergence of new prevention and treatment tools, an expanding knowledge base on optimal uses of existing HIV strategies and improved sophistication in national strategic planning, programme implementation and monitoring and evaluation. In 2010, clinical trials provided evidence of the efficacy of a vaginal microbicide and of pre-exposure antiretroviral prophylaxis, and two studies in sub-Saharan Africa suggested that conditional cash transfers reduce young people's risk of HIV infection by alleviating economic and social vulnerability. Enhanced understanding of existing HIV interventions led to the revision in 2010 of international guidelines for antiretroviral therapy for HIV infection in adults and adolescents and antiretroviral drugs for treating pregnant women and preventing infection in infants, guiding countries in efforts to optimize the success of these critical tools. More than 15 countries have benefited from UNAIDS-supported studies on modes of transmission, which have provided critical strategic information to enable more accurate and timely focusing of scarce resources. In 2010, 182 countries reported data on progress in their HIV response; a summary of which is contained in the *UNAIDS Report on the Global AIDS Epidemic*

2010. For the first time, UNAIDS produced AIDS scorecards on key indicators of national progress, enabling countries to compare results.

II. Reporting back on UNAIDS key results

10. UNAIDS continues to be guided by internationally agreed development goals and accountability frameworks, including the time-bound targets set forth in the 2001 Declaration of Commitment on HIV/AIDS; the goal of achieving universal access to HIV prevention, treatment, care and support by 2010, as enshrined in the 2006 Political Declaration on HIV/AIDS; and the aim of achieving the Millennium Development Goals by 2015. Since its last report to the Economic and Social Council in 2009 (E/2009/70), UNAIDS has undergone important changes with the objective of improving the coherence, coordination, effectiveness and efficiency of the joint efforts of its 10 co-sponsors and the secretariat.

11. In December 2009, the results of the second independent evaluation of UNAIDS were reported to the UNAIDS Programme Coordinating Board, which resulted in 28 Board decision points touching upon all aspects of the Joint Programme's operations. UNAIDS expeditiously began a process to implement the evaluation recommendations.

12. In 2010, the Programme Coordinating Board endorsed a new vision for UNAIDS, which calls for focused efforts to achieve "zero new infections, zero AIDS-related deaths and zero discrimination" and a new comprehensive strategy for 2011-2015, which outlines policy and programmatic approaches to advance progress in each of the three pillars of the UNAIDS vision. In accordance with the recommendations of the second independent evaluation, UNAIDS adopted a new division of labour clarifying the roles and responsibilities of the co-sponsors and the secretariat in different thematic areas of work. The biennial UNAIDS unified budget and workplan, which for the last decade has united the efforts of the co-sponsors and the secretariat in a single two-year plan, will be succeeded by the UNAIDS unified budget, results and accountability framework in January 2012; this is a simpler format designed to improve the accountability, transparency and efficiency of the Joint Programme's efforts to catalyse an effective response to HIV at the country, regional and global levels.

13. In 2009, the Joint Programme launched the UNAIDS Outcome Framework 2009-2011, which called for focused, results-oriented action by UNAIDS in 10 priority areas and across six cross-cutting approaches. The 2010-2011 unified budget and workplan was aligned to accelerate results in priority areas, for which business plans setting forth specific goals, strategies and activities in different thematic areas were developed. The Outcome Framework has united the entire Joint Programme in a common effort to improve strategic coherence and generate concrete results in key areas that are pivotal to future success in the HIV response.

14. In keeping with the Outcome Framework, the present report summarizes results in each of the 10 priority areas and the six cross-cutting strategies.

Priority areas

1. Reducing sexual transmission of HIV

15. With global incidence declining, there has been marked progress in efforts to prevent sexual transmission. Out of the 93 countries that reported data in 2010, 56 reported that less than 25 per cent of males had had more than one sex partner in the previous 12 months and 84 reported that less than 25 per cent of females had had more than one sex partner. In 2010, the secretariat and the World Health Organization (WHO) began working with countries to prepare for follow-up on and implementation of breakthrough research on microbicides and pre-exposure prophylaxis.

16. There is evidence that condom availability and regular condom use have increased in many countries. In 11 countries, at least 75 per cent of men and women reported in 2009 that they had used condoms during their last episode of higher-risk sex. In 2009, more than 50 million female condoms were distributed, including 36.2 million in sub-Saharan Africa, compared to 21.1 million in 2008. In 2010, the United Nations Population Fund (UNFPA) assisted 52 countries in the implementation of comprehensive procurement, supply management and distribution plans for condoms and other reproductive and sexual health commodities.

17. Although scale-up of adult male circumcision was slow in the immediate aftermath of the issuance by WHO and UNAIDS in 2007 of guidelines recommending the implementation of circumcision in 13 high-priority countries with high prevalence of HIV and low prevalence of male circumcision, recent gains have been reported, with an estimated 400,000 men circumcised in nine priority countries in 2010 alone. WHO and the secretariat have assisted all priority countries in undertaking situation analyses and developing implementation plans, with the secretariat also assisting in the conduct of costing analyses in three countries. WHO completed an early infant circumcision manual in 2010, issued guidance on the engagement of volunteers to support male circumcision scale-up, and advocated for male circumcision scale-up in multiple forums.

18. With untreated sexually transmitted infections increasing the risk of HIV transmission or acquisition by several orders of magnitude, UNAIDS assisted countries in implementing evidence-informed strategies for the prompt diagnosis, prevention and treatment of these infections. New normative guidance and technical assistance were produced, assisting at least 30 high-burden countries in achieving the 70 per cent target for diagnosis, treatment and counselling with respect to sexually transmitted infections at point of care. In many African countries, the incidence of these infections is on the decline.

19. UNAIDS convened a high-level commission on HIV prevention that issued a major call to action in 2010. The secretariat produced new guidance on planning, implementing and monitoring prevention programmes that combine behavioural, biomedical and structural interventions to achieve synergistic and long-lasting impacts. Under the leadership of the United Nations Educational, Scientific and Cultural Organization (UNESCO), the new voluntary *International Technical Guidance on Sexuality Education* was published in 2009, in partnership with UNAIDS, UNFPA, the United Nations Children's Fund (UNICEF) and WHO; follow-up support was provided to many countries in using the document to review

and strengthen their HIV prevention efforts in respect of young people. Following up a landmark global consultation convened in Tunisia in 2009, UNAIDS actively promoted the implementation of the "positive health, dignity and prevention strategy", which links focused primary prevention programmes by and for people living with HIV with intensified efforts to ensure universal access to antiretroviral treatment and meaningful human rights protection.

20. In addition, a new international labour standard on HIV and AIDS was adopted at the annual International Labour Conference on 17 June 2010. The HIV and AIDS Recommendation, 2010 (No. 200) calls for the development, adoption and effective implementation of national workplace policies on HIV and AIDS and the world of work, ensuring the full involvement of the actors in the world of work in achieving universal access to prevention, treatment, care and support measures for all to prevent sexual transmission.

2. Preventing mothers from dying and babies from becoming infected with HIV

21. From 2008 to 2009, the percentage of pregnant women living with HIV in low- and middle-income countries who received antiretroviral prophylaxis rose from 45 per cent to 53 per cent, surpassing 50 per cent for the first time. Despite these gains, in 2009, 370,000 children in low- and middle-income countries were newly infected with HIV during pregnancy, labour and delivery, and breastfeeding. HIV is also a leading cause of death among women of reproductive age globally. In 2010, world leaders committed to achieving the global elimination of mother-to-child transmission of HIV by 2015. In June 2010, United Nations agencies and key global partners committed to work towards the elimination of mother-to-child transmission by 2015.

22. UNAIDS delivered direct capacity-building support to 20 countries which collectively represent 85 per cent of the global burden of pregnant women living with HIV, to increase the success rates for prevention proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2010, UNICEF and UNFPA supported more than 40 countries in scaling up programmes to prevent vertical transmission. The World Food Programme (WFP) explored further integration of national programmes on the prevention of mother-to-child transmission into maternal neonatal child health services in eight countries. Furthermore, since such programmes and services are gradually integrated into an increasing number of countries, participation in them will not only help to prevent HIV transmission but will also contribute to broader maternal and infant health outcomes, allowing mothers and their infants to have access to vaccinations, micronutrient supplementation, nutrition assessment, education and counselling and complementary food when malnourished.

23. Drawing from accumulated evidence, WHO issued revised guidelines on the prevention of vertical transmission in 2010. These new guidelines, which are rapidly being implemented by countries in all regions, call for earlier initiation of antiretroviral therapy in pregnant women, routine assessment of HIV-positive pregnant women for their own health, close integration between antenatal settings and HIV treatment programmes, and the use of antiretroviral prophylaxis to prevent transmission during breastfeeding. In addition, the revised guidelines emphasize the need for countries to replace single-dose nevirapine or short-course zidovudine with more effective longer-duration combination regimens. In 2009, 30 per cent of

recipients of prevention services in antenatal settings received a suboptimal single-dose antiretroviral regimen, highlighting the importance of improving access to more effective combination regimens.

24. Although a majority of HIV-positive women are now receiving antiretroviral prophylaxis for vertical transmission, most are not routinely screened for their own health. In 2010, UNAIDS produced guidance on community-based maternal and newborn health care, and support was provided for the "continuum of care" initiative to promote integrated programming for HIV and maternal and newborn health care.

3. Ensuring that people living with HIV receive treatment

25. The number of people in low- and middle-income countries receiving antiretroviral treatment increased by roughly 25 per cent in 2010, a sign that the momentum towards greater treatment access is continuing. As at December 2009, eight low- and middle-income countries had already achieved 80 per cent treatment coverage. In 2010, UNAIDS provided technical support to more than 60 countries to scale up HIV treatment programmes, including the development and adaptation of national treatment guidelines, the implementation of strategies to monitor and address adverse events, and strategic approaches to improve clinical management. Also in 2010, WFP provided food and nutrition support in antiretroviral treatment programmes in 37 countries, invested extra efforts in staff and partner training in food-by-prescription principles, developed materials and supplied equipment to enhance the use of anthropometric measures in clinic-based nutrition assessment. The United Nations Development Programme (UNDP), WHO and the World Bank assisted at least 64 countries in strengthening drug procurement and supply management systems. The Office of the United Nations High Commissioner for Refugees (UNHCR) continues to advocate for the inclusion of forcibly displaced populations in national HIV programmes to access care and treatment.

26. In 2010, WHO issued revised guidelines on antiretroviral therapy that recommend earlier initiation of therapy, using a CD4 threshold of 350 cells/mm3 to guide treatment initiation in place of the earlier cut-off of 200 CD4 cells/mm3.[1] The new guidelines also urge countries to phase out regimens that include the antiretroviral drug d4T and to opt instead for alternative regimens with fewer side effects. Countries have taken rapid steps to adopt and implement the new guidelines, which increase by roughly 50 per cent the total number of people eligible for treatment.

27. Ensuring equitable treatment access for all people living with HIV remained an urgent focus of effort for UNAIDS over the past two years. With children having suboptimal treatment coverage in comparison to adults (28 per cent versus 37 per cent), the Joint Programme prioritized steps to increase the availability of early infant diagnosis, including a multi-country review and identification of best practices by UNICEF. Out of the 21 countries reporting data on antiretroviral treatment utilization by people who inject drugs, 14 reach fewer than 5 per cent of

[1] The CD4 cell is a key component of the human immune system, and its depletion is a classic sign of HIV-related immune suppression. The CD4 count measures the number of CD4 cells in a cubic millilitre of blood, providing important diagnostic information to guide clinical decision-making.

such persons, underlining the need for additional efforts to promote treatment equity.

28. Prices for first-line antiretroviral regimens in low-income countries declined modestly in 2009 after sharply falling earlier this decade, with evidence indicating that fewer countries are using flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights and other international intellectual property frameworks to obtain optimal prices. In 2010, UNDP supported 17 countries in building capacity for the adoption of enabling trade and health policies and legislation to ensure favourable pricing for HIV commodities. Through its AIDS medicines and diagnostic services WHO provided strategic information to country decision makers on sources and prices of HIV medicines.

29. The secretariat and WHO have spearheaded the Joint Programme's efforts to catalyse the next phase of treatment, care and support. An analytic and advocacy initiative called "Treatment 2.0" was launched at the XVIII International AIDS Conference in Vienna, at which UNAIDS played a prominent role. This initiative prioritizes the use of simpler, longer-lasting first-line regimens; the development of simple, affordable point-of-care diagnostics; cost reductions for all major elements of treatment delivery; the decentralization and simplification of service delivery systems; and the mobilization of communities to support treatment scale-up.

30. Prompt diagnosis of HIV and swift referral to care for people who test HIV-positive are critical to improving medical outcomes. In 2009, the median number of HIV tests performed per 1,000 persons rose by 22 per cent, with comparable increases in the number of health facilities delivering HIV testing services. In 2010, UNICEF supported four high-prevalence African countries in implementing community testing initiatives; UNFPA assisted 27 countries in integrating and linking voluntary counselling and testing in maternal health and other related services; and WHO reviewed experiences with provider-initiated testing and counselling approaches to identify optimal models for widespread implementation.

4. Preventing people living with HIV from dying of tuberculosis

31. Tuberculosis remains a leading cause of death among people living with HIV. In 2009, an estimated 380,000 people living with HIV died of tuberculosis. Although there are still considerable gaps in the effective management of HIV/tuberculosis co-infection, progress has been achieved. The percentage of tuberculosis patients tested for HIV increased from 4 per cent in 2003 to 26 per cent in 2009, and 55 countries tested at least 75 per cent of tuberculosis patients for HIV. Thirty-seven per cent of people living with HIV who tested HIV-positive in 2009 received antiretroviral therapy. Only 5 per cent of people living with HIV were screened for tuberculosis in 2009 and only 0.2 per cent of people living with HIV received isoniazid preventive therapy. In response to the prevalence of HIV and tuberculosis among health workers, in November 2010, WHO, ILO and UNAIDS officially launched joint policy guidelines to improve the access of health workers to HIV and tuberculosis prevention, treatment, care and support services.

32. Since its 2009 report, UNAIDS has intensified efforts to increase access to essential services for people living with HIV/tuberculosis co-infection. WFP and the United Nations Office on Drugs and Crime supported more than 60 countries in scaling up HIV/tuberculosis programming. WHO collaborated with ILO on the finalization of policy guidelines for HIV/tuberculosis prevention, care and

treatment; ILO assisted 12 countries in 2010 in implementing HIV/tuberculosis workplace programmes; and WHO issued guidelines on isoniazid preventive therapy, infection control for tuberculosis, and intensified tuberculosis case-finding (the "Three 'I's").

5. Protecting drug users from becoming infected with HIV

33. Efforts to prevent drug users from becoming infected remain inadequate. According to data from 29 countries, in 2009, HIV prevention programmes reached 31.6 per cent of people who inject drugs. Neither needle and syringe programmes nor opioid agonist therapy were available in most countries reporting data in 2010, and fewer than 10 countries provide comprehensive HIV prevention services in prisons.

34. With the aim of building greater support for robust evidence-based programming for people who inject drugs and to improve service access, in 2010, the United Nations Office on Drugs and Crime assisted over 50 countries in strengthening related programming and policy efforts. With support from the Joint Programme, several countries in Asia took steps to permit the introduction of evidence-informed components of harm reduction programming for people who inject drugs. Evidence-based tools, guidelines and best practices for people who inject drugs, live in prison settings or are vulnerable to human trafficking were produced, and countries were assisted in the establishment of service targets for these groups. Work began on the development of policy guidance for the diagnosis and treatment of viral hepatitis among people who inject drugs.

6. Empowering men who have sex with men, sex workers, people who use drugs and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy

35. Support for programming for key populations remains insufficient. In 2010, programmes for key populations accounted for 22 per cent of HIV spending in low-level epidemics, 9 per cent in concentrated epidemics and 2 per cent in generalized epidemics. These percentages represent an increase over 2008 for low-level and generalized epidemics of 19.4 per cent and 0.6 per cent, respectively, but a reduction of 9.8 per cent was reported by countries with concentrated epidemics. The low priority for focused programming for key populations in low-level and concentrated epidemics is especially troubling, as epidemics in these settings are primarily characterized by transmission within these groups. The very low figure reported in generalized epidemics is also disturbing, since recent modes-of-transmission studies have determined that key populations account for between one quarter and one third of new infections in some countries in which HIV is generalized.

36. With the aim of reversing the continuous under-prioritization of responses for key populations, UNAIDS has intensified its work to build strong support for evidence-informed, rights-based policies and programmes for those most at risk. Major regional and global consultations on HIV among men who have sex with men convened by UNDP, WHO and the secretariat have called attention to the worldwide epidemic in this population. UNFPA and other partners facilitated the first-ever regional consultation on HIV and sex work in Asia and the Pacific, bringing together Governments and female, male and transgender sex workers to develop

common policy and programmatic approaches. Similarly, UNFPA and partners organized a groundbreaking consultation in the Caribbean.

37. In 2010, UNDP and UNFPA delivered technical support to 67 countries in enhancing human rights protection and service access for these key populations and implementing policy guidance to address their vulnerabilities. UNESCO published peer education outreach guidance on working with men who have sex with men in the Asia-Pacific region. Technical support was delivered to 67 countries in 2010 to improve results for key populations. The United Nations Office on Drugs and Crime, WHO, UNAIDS, the Global Fund and the Asian Network of People who Use Drugs supported the finalization of a regional strategy for harm reduction in Asia and the Pacific for the period 2010-2015. The strategy was jointly developed by all key stakeholders under the auspices of the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. WHO and the secretariat also provided technical support to countries to estimate the size of key populations, a critical step in the development of focused, results-oriented strategies to address their HIV-related needs.

7. Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS

38. Stigma, discrimination and social marginalization continue to impede effective HIV responses. In 2011, 48 countries, territories and entities imposed some form of restriction on the entry, stay and residence of people living with HIV; a large number of countries criminalize HIV transmission or exposure, including more than 20 countries in sub-Saharan Africa that have implemented such measures in recent years; 116 countries criminalize some aspect of sex work; 79 countries and territories worldwide criminalize same-sex sexual relations; and 32 countries have laws that provide for the death penalty for certain drug-related offences.

39. However, there are some promising trends in this priority area. The number of countries reporting the existence of laws and regulations protecting people living with HIV from discrimination increased from 87 in 2008 to 124 in 2010, with the percentage of countries having such laws increasing from 56 per cent in 2006 to 71 per cent in 2010. In 2010, China, Namibia, Ukraine and the United States of America repealed their respective HIV-based travel restrictions, and two other countries (Ecuador and India) issued clarifications that such restrictions are no longer in place. More countries are now recognizing the existence of punitive laws that block effective responses, with the number of countries reporting such laws rising from roughly 41 per cent in 2006 to 67 per cent in 2010. The percentage of countries reporting the existence of anti-stigma efforts increased from 39 per cent in 2006 to 90 per cent in 2010, although only a minority of countries have budgets in place for anti-stigma activities.

40. On behalf of the UNAIDS family, UNDP launched the Global Commission on HIV and the Law, in 2010, bringing together world-renowned leaders from all walks of life and regions to address the need for legal reform to create an enabling environment for strong HIV responses. UNAIDS supported the review, revision and implementation of legislation to promote HIV-related rights and increase access to justice services in more than 60 countries and successfully advocated for legal and policy reforms. In more than 40 countries, UNAIDS provided financial support, training or other capacity-building exercises, assisted in the development of

sensitization initiatives, and provided normative guidance to promote efforts to reduce stigma and discrimination.

8. Meeting the HIV needs of women and girls and stopping sexual and gender-based violence

41. The number of countries reporting policies in place to ensure equal access among women and men to prevention, treatment and support services increased from 111 in 2008 to 144 in 2010. Globally, HIV treatment coverage in 2009 was higher for women than for men. Eighty percent of national HIV strategies specifically address the needs of women and girls, although only 46 per cent budget for such activities.

42. As at December 2010, more than 60 countries had initiated implementation of the new UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV. More than 400 civil society organizations, including women's groups, engaged in this global effort.

43. In 2010, UNAIDS provided focused advocacy and technical support in more than 40 countries to promote gender equality in the context of HIV. A framework for integrating gender in national monitoring and evaluation systems was generated, and guidance was provided on the creation of gender indicators for national responses. The Global Coalition on Women and AIDS remained active, agreeing on funding criteria for new projects and undertaking focused work to strengthen networks of women living with HIV. UNAIDS issued guidance on the prevention of intimate partner and gender-based violence, drawing on emerging evidence of effective interventions. UNFPA documented good practices on engaging men and boys in the promotion of gender equity, specifically with respect to sexual and reproductive health and HIV prevention, treatment, care and support, and widely disseminated findings to programme planners, health providers, peer educators and advocates.

9. Empowering young people to protect themselves from HIV

44. Young people are leading a prevention revolution, with HIV prevalence declining among young people in the most heavily affected countries. In 2010, UNAIDS provided technical support for HIV policies and programmes affecting young people in more than 60 countries.

45. UNESCO supported education ministries and other partners in numerous countries to strengthen HIV programming for young people, including through comprehensive HIV and sexuality education and the UNAIDS Global Initiative on Education and HIV and AIDS (EDUCAIDS), with activities now reported in more than 80 countries. UNHCR provided youth-oriented programme support to young people in humanitarian settings in 55 countries. Taking into account the diversity of young people, UNFPA focused particular efforts on strengthening HIV prevention efforts for most-at-risk young people, including those engaged in sex work, men who have sex with men, and young people who use drugs. UNICEF supported a national consultation for sex providers and young people living with HIV in Uganda, and programme capacity was expanded for 2,300 programme managers and service providers in youth-friendly health centres in Eastern Europe and Central Asia.

10. Enhancing social protection for people affected by HIV

46. UNAIDS intensified efforts to strengthen social protection initiatives for people living with HIV. Studies consistently find that HIV infection increases financial pressures on affected households and deepens poverty. Poverty, and food insecurity in particular, constitute significant barriers to treatment uptake and adherence. HIV is also associated with considerable caregiving responsibilities that are not adequately compensated, with a six-country study in sub-Saharan Africa finding that volunteer caregivers performed an average of 69 hours of free work each month. ILO assessed social security and national health insurance schemes for ways to extend coverage for populations vulnerable to HIV and persons affected by HIV, in order to prevent deepening poverty.

47. With UNAIDS support, at least 20 countries either implemented cash transfer programmes or were studying their implementation to mitigate the epidemic's impact on children orphaned or made vulnerable by HIV. WFP implemented such cash or voucher programmes in a total of 14 countries. With the leadership of ILO, at least 32 countries received UNAIDS support in 2010 to strengthen workplace HIV prevention, treatment, care and support assistance. HIV has been integrated into all UNHCR humanitarian operations worldwide and, in 2010, at least 74 countries received HIV-related assistance.

Cross-cutting strategies

1. Bringing AIDS planning and action into national development policy and broader accountability frameworks

48. During the past two years, UNAIDS led efforts to link the HIV response to other social movements and to broader health and development efforts. The UNAIDS initiative "AIDS plus MDGs" seeks to leverage progress in the HIV response to accelerate advances towards achieving all the Goals and conversely to capitalize on development gains to strengthen the impact and sustainability of HIV programmes. This initiative was highlighted in the report of the Secretary-General on progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS (A/64/735), which focused on the integral linkages between HIV programmes and broader development efforts. At the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals in September 2010, UNAIDS organized a high-profile session with the Governments of China, Ethiopia, Nigeria and South Africa, to further galvanize the attention of world leaders to the initiative. The close linkages between the HIV response and other Goals were also recognized in the outcome document of the meeting (resolution 65/1), calling for a synergetic approach and integrated service delivery.

49. UNAIDS worked with the H4+ agencies (UNICEF, WHO, UNFPA, the World Bank and UNAIDS) to support the Secretary-General's Global Strategy for Women's and Children's Health, the first blueprint of its kind to help intensify and better coordinate existing efforts, build new commitments and establish an accountability framework for delivering results across the health-related Goals. The Global Strategy is a momentous opportunity through which women's and children's health can obtain the highest level of visibility and support. It was developed and endorsed by a wide range of actors, including Governments, international

organizations, philanthropic institutions, civil society, the business community, health workers, professional associations and academic and research institutions, and welcomed by all 192 Member States.

50. In 2010, UNAIDS supported more than 50 countries in integrating HIV into poverty reduction strategy papers and other mainstream development planning instruments. Assistance was provided to 57 countries to integrate HIV into decent work country programmes.

2. Optimizing United Nations support for applications to and programme implementation of the Global Fund to Fight AIDS, Tuberculosis and Malaria

51. The Global Fund and UNAIDS took steps to further strengthen their partnership, with UNAIDS providing robust support for efforts by the Global Fund to mobilize resources for implementing future funding rounds. In 2010, UNAIDS supported 68 country and regional applicants to develop proposals for Round 10 of the Global Fund. Fifteen countries were selected to receive additional and prioritized support based on their disease burden, income level and success with previous Global Fund applications. Sixty-nine per cent of these countries were successful compared to the overall success rate of 41 per cent. UNAIDS support to Round 10 contributed to the mobilization of $732 million in HIV-related funding.

52. UNAIDS also worked to strengthen processes to plan and implement Global Fund grants. In 2010, UNDP acted as a Global Fund principal recipient in a total of 29 countries that faced unusually difficult circumstances, with programme delivery reaching $400 million. Support was provided to 15 countries to strengthen country coordinating mechanisms for the Global Fund, with 1,363 days of technical support provided in such areas as country coordinating mechanism dashboard implementation, conflict-of-interest policies and orientation for new country coordinating mechanism members. The AIDS Strategy and Action Plan service, housed at the World Bank, continues to provide technical advice and guidance to strengthen national strategies, which provide the broad directions and targets on which successful Global Fund proposals are based. In 2010, the World Bank sponsored a week-long capacity-building programme to accelerate the translation of national strategies into expedited programme implementation in Eastern and Southern Africa. Also in 2010, at least 32 countries received intensive UNAIDS technical support for the implementation of programmes approved for funding by the Global Fund.

3. Improving country-by-country strategic information generation, analysis and use, including through the mobilization of novel sources

53. The evidence base for country-level action on HIV continues to expand. In 2010, 182 countries reported data on standardized HIV indicators to UNAIDS, with many receiving focused assistance from the secretariat and other United Nations partners. Forty-three out of 46 countries in sub-Saharan Africa reported 2010 coverage data to WHO. In 2010, countries undertook universal access reviews to assess progress against national targets, identify challenges and bottlenecks, and agree on strategies for moving forward. Normative documents regarding second-generation HIV surveillance, mortality and paediatric HIV surveillance, ethical conduct of HIV surveillance and the use of HIV incidence assays.

54. Modes-of-transmission studies in more than 20 countries assisted policymakers in aligning national programmes with documented needs. These studies compare programmatic and funding priorities with the geographic and population distribution of incident infections, enabling countries to identify and address gaps and mismatches between actual needs and available resources. In 2010, UNAIDS assisted countries in using the Spectrum model, which generates country-specific estimates for HIV prevalence and incidence, AIDS deaths and service needs for HIV.

55. Out of 134 countries submitting reports to UNAIDS on the standardized questionnaire for the National Composite Policy Index in 2010, 118 reported having an HIV monitoring and evaluation framework. The secretariat produced guidelines to support country-owned and country-led monitoring and evaluation assessments.

4. Assessing and realigning the management of technical assistance programmes

56. UNAIDS remains an important source of technical support and guidance to countries. In 2010, technical support facilities in five regions provided 14,700 days of technical assistance in 67 countries. United Nations partners completed an additional five national technical support plans in 2010, adding to the 11 that were in place as at December 2009.

57. A new division of labour for the provision of technical support, an important outcome of the second independent evaluation of UNAIDS, aims to clarify the roles and responsibilities of individual co-sponsors and the secretariat partners with respect to the provision of United Nations technical support. The revised division of labour also employs greater flexibility and encourages the adaptation of the agreed global apportionment of roles and responsibilities at the country and regional levels, depending on United Nations system capacity and actual needs. This approach relies on UNAIDS co-sponsors to work in particular technical areas and on the secretariat to play a coordinating and catalytic role.

5. Developing shared messages for sustained political commitment, leadership development and advocacy

58. The second independent evaluation confirmed the effectiveness, impact and visibility of UNAIDS advocacy. During the past two years, the Joint Programme continued and strengthened its advocacy for sustained political commitment and leadership in the AIDS response. The new UNAIDS vision was embraced by various partners and stakeholders and provided a framework for stronger advocacy efforts. The UNAIDS strategy for 2011-2015 emphasizes shared messages on key actions and strategies needed to achieve the agreed vision.

59. UNAIDS had a vigorous and high-profile presence at major global and regional meetings, including the Community of Portuguese-Speaking Countries, the International Organization of la Francophonie and the African Union. The momentum generated among African leaders led the African Union to adopt bold decisions on maternal, infant and child health and on the elimination of mother-to-child transmission of HIV. In addition, the African Union decided to extend the 2006 Abuja call for accelerated action towards universal access to HIV/AIDS, tuberculosis and malaria services in Africa to 2015, to coincide with the Millennium Development Goal target date. With UNAIDS support, HIV was prominently featured in the agendas of the Global Fund Board, the International Drug Purchase

Facility (UNITAID) and the Stop TB Partnership, as well as WFP and other UNAIDS co-sponsors. In 2010, the secretariat produced, coordinated or facilitated 15 key reports, 63 press releases and 100 issue briefs.

60. At the 2009 Parliament of the World's Religions, the Joint Programme launched a new strategic framework for partnership with faith-based organizations in its response to HIV. The goal of the framework is to encourage stronger partnerships between UNAIDS and faith-based organizations in order to achieve the goals of universal access. The framework is intended to provide a structure for the development of ongoing workplans and partnerships in response to AIDS by the UNAIDS Secretariat, co-sponsors and faith-based organizations. In partnership with the Ecumenical Advocacy Alliance, Cordaid and the International Network of Religious Leaders Living with and Affected by HIV, UNAIDS hosted a summit of high-level religious leaders on the response to HIV in the Netherlands in March 2010. The meeting explored opportunities for religious leaders to promote universal access to HIV prevention, treatment, care and support in their communities and speak out against stigma and discrimination affecting people living with HIV. It brought together some 40 Bahá'í, Buddhist, Christian, Hindu, Jewish, Muslim and Sikh leaders, the AIDS Ambassadors of the Netherlands and Sweden, leaders and representatives of networks of people living with HIV and other organizations active in the response to HIV.

61. UNESCO engaged with ministers of education in South-East Asia, Southern Africa, Eastern Europe and Central Asia. Ministers of Finance from the Southern African Development Community were engaged by the World Bank to build support for increased fiscal space for HIV-related domestic financing. With ILO support, an additional 14 countries adopted tripartite declarations on HIV and the world of work.

62. The Joint Programme worked to position the UNAIDS Programme Coordinating Board as a central policymaking body in the HIV response. In 2010, thematic sessions were held on linkages between HIV and sexual and reproductive health and on the role of food and nutrition.

6. Broadening and strengthening engagement with communities, civil society and networks of people living with HIV at all levels of the response

63. The UNAIDS strategy for 2011-2015 prioritizes robust, strategic partnerships that focus on enabling nationally owned responses, foster South-South cooperation and move beyond traditional health sectors to broader development areas, in keeping with the very essence of UNAIDS, which itself is a pioneering partnership of 10 United Nations co-sponsors and the secretariat. In 2010, 96 per cent of countries reported that their national HIV strategy explicitly addressed the involvement of people living with HIV, up from 75 per cent in 2006. In 2010, UNAIDS strengthened its support for global and regional networks of people living with HIV, and UNDP supported local and national groups of people living with HIV in 48 countries.

64. UN Cares is an inter-agency programme designed to reduce the negative impact of HIV on the United Nations workplace by educating staff and families about HIV and provide support for staff living with HIV. In 2010, UN Cares received a special commendation at the UN 21 Awards, which were established as part of the reform effort in 1996 to recognize staff members' innovation, efficiency

and excellence in the delivery of the Organization's programmes and services. Commendations are given for excellence and/or outstanding inter-agency coordination.

65. UNAIDS continued its work in Chief Executive Board-related bodies, helping to raise its profile and share its experience in shaping United Nations reforms, in such areas as the harmonization of business practices.

66. Following up on the overarching partnership framework provided by the 2011-2015 strategy, UNAIDS began consultations to develop focused strategies on working in partnership with key constituencies, including civil society. The secretariat mobilized resources to enable civil society representatives to attend the 2010 International AIDS Conference in Vienna. A communications facility continues to provide strengthened support to non-governmental delegates to the UNAIDS Programme Coordinating Board.

67. UNAIDS also supported the roll out of the People Living with AIDS Stigma Index at the country level in more than 30 countries. Technical support facilities provided 3,481 days of technical support to civil society organizations in 2010. In collaboration with the regional technical support hubs of the International HIV/AIDS Alliance[2] and the Civil Society Action Team,[3] a community systems strengthening framework was developed to strengthen community-based activities aimed at improving health, with particular focus on the implementation of Global Fund grants.

68. In preparation for the high-level meeting on AIDS to be held in June 2011, the President of the General Assembly convened, with secretariat support, a civil society task force to ensure strong involvement. The task force undertook extensive outreach to global, regional and national networks to facilitate a strong civil society presence at the meeting. In April 2011, more than 400 attendees participated in an all-day civil society hearing at the General Assembly, addressing such issues as enhancing community-level access to HIV funding and services, a new generation of national partnerships, and linking HIV with other global movements. The hearing resulted in findings and recommendations to be considered by Member States as they negotiate an outcome document for the high-level meeting.

III. Recommendations and proposed actions for the Economic and Social Council

The Economic and Social Council may wish to consider the following actions:

(a) **Commend the support provided by the Joint Programme to progress achieved towards universal access to HIV prevention, treatment, care and support, including its assistance to countries in reporting on the progress to the General Assembly, resulting in a record 182 country reports and the most comprehensive overview to date of the response at the country level;**

[2] See www.aidsalliance.org/Pagedetails.aspx?id=265.

[3] See www.csactionteam.org.

(b) **Acknowledge the steady expansion of evidence regarding epidemiological trends and effective strategies for prevention, treatment, care and support, and urge continued investments in research efforts to build the knowledge base on HIV and accelerated actions to bring evidence-informed strategies to scale;**

(c) **Acknowledge the close links between HIV and other global health and development goals, underlining the need to integrate HIV in other global movements and development initiatives at the level of strategic planning, service delivery and monitoring and evaluation;**

(d) **Acknowledge the significant gains made in bringing critical HIV interventions to scale as well as the continued relevance and urgency of the goal of universal access to HIV prevention, treatment, care and support in reversing the epidemic, and the need to address stigma, discrimination, gender inequality and other legal or social factors that undermine universal access;**

(e) **Acknowledge the critical importance of key populations in all aspects of national HIV responses, global advocacy efforts and the work of the United Nations system on HIV, and encourage increased support to civil society capacity for programme implementation and advocacy;**

(f) **Welcome the new UNAIDS vision of zero new infections, zero AIDS-related deaths and zero discrimination referred to in the UNAIDS Strategy for 2011-2015, and encourage intensified advocacy and alignment of such key functions as advocacy, normative guidance, strategic information and technical support, to accelerate progress under each of these strategic pillars;**

(g) **Express concerns regarding the recent flattening of global financial support for HIV and encourage all stakeholders, including international donors, affected countries, countries with emerging economies, private corporations and high net worth individuals, to commit to ensuring a well-financed, optimally efficient, sustainable response to HIV;**

(h) **Note the implementation by UNAIDS of the recommendations from the second independent evaluation of the Joint Programme and encourage continued efforts by UNAIDS to enhance the coherence, coordination, efficiency and effectiveness of the Joint Programme's contributions to the response.**