HIV PROGRAMME: **ACHIEVING OUR GOALS**

APRIL 2014

OPERATIONAL PLAN 2014–2015

World Health Organization

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OPERATIONAL PLAN 2014–2015

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ABBREVIATIONS

AFRO	WHO Regional Office for Africa
AIDS	acquired immunodeficiency syndrome
AMRO	WHO Regional Office for the Americas
ANC	antenatal care
API	active pharmaceutical ingredient
ART	antiretroviral therapy
ARV	antiretroviral
Option B	A recommended approach offering ART to all HIV-positive pregnant and breastfeeding women, and then continuing lifelong ART for those "eligible" for treatment (i.e. CD4 ≤500)
Option B+	A recommended approach offering lifelong ART to all HIV-positive pregnant women regardless of their clinical stage or CD4 count
CD4	T–lymphocyte cell bearing CD4 receptor
CDC	United States Centers for Disease Control and Prevention
d4T	Stavudine
EIA	enzyme immunoassays
EMRO	WHO Regional Office for the Eastern Mediterranean
EURO	WHO Regional Office for Europe
GHSS	Global Health Sector Strategy on HIV/AIDS
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HIVDR	HIV drug resistance
ILO	International Labour Office
IPT	isoniazid preventive therapy
M&E	monitoring and evaluation
MCH	maternal and child health
MDG	Millennium Development Goal
MSM	men who have sex with men
NCD	noncommunicable disease
NTD	neglected tropical disease
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
RDT	rapid diagnostic tests
SEARO	WHO Regional Office for South-East Asia
STAC-HIV	Strategic and Technical Advisory Committee for HIV/AIDS
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VMMC	voluntary medical male circumcision
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

PART 1: TOWARDS 2015

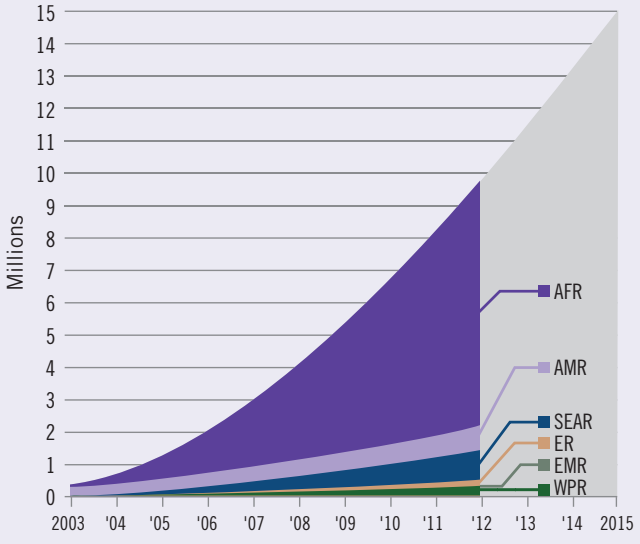
Gerhard Joren/ADB

1.1 ACHIEVING GLOBAL GOALS

The 2014–2015 biennium is critical in the fight against HIV: It is the culmination of a major global effort to achieve the health-related Millennium Development Goals (MDGs) and other global HIV goals and targets by 2015.[1] Significant opportunities exist to build on progress to date and bring the world closer to its ultimate goal of ending the HIV pandemic.

The past decade produced some remarkable achievements. By the end of 2012, nearly 10 million people were receiving antiretroviral therapy (ART) in low- and middle-income countries.[2] Universal access for all people in most urgent need of ART has been achieved in many countries, and the global target of ART for 15 million people by 2015 is within reach (Figure 1).

Figure 1. HIV treatment scale up from 2003 to 2012, by WHO region



AFR: African Region, AMR: Region of the Americas, SEAR: South-East Asia Region, ER: European Region, EMR: Eastern Mediterranean Region, WPR: Western Pacific Region

Source: Global update on HIV treatment 2013: results, impact and opportunities: WHO report in partnership with UNICEF and UNAIDS (2013)

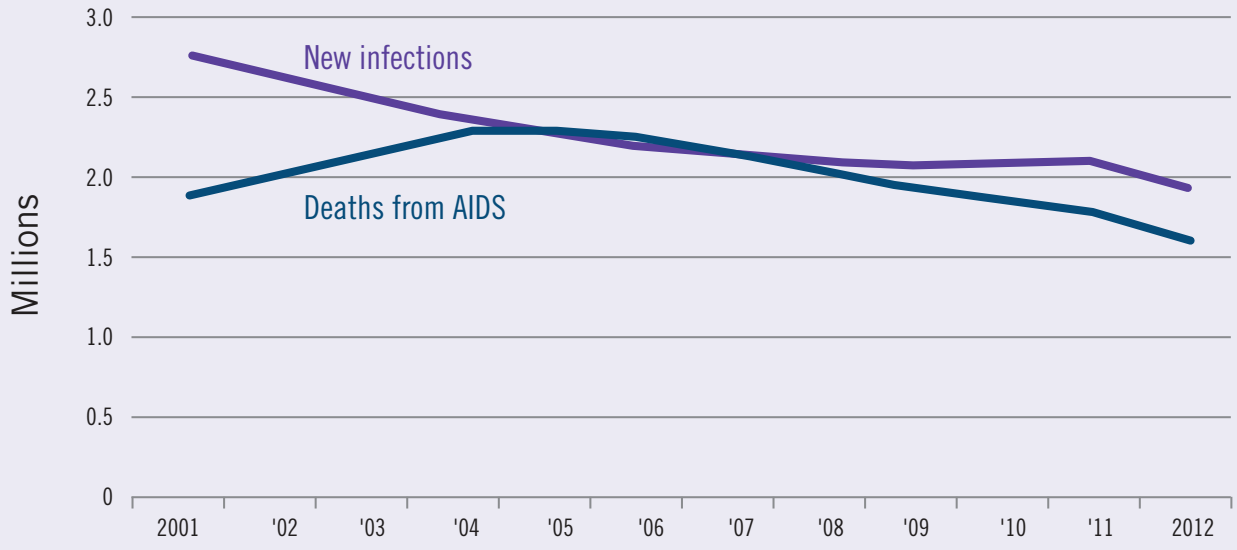
1 These include the *Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS* (2011); the *Global health sector strategy on HIV/AIDS 2010–2015; Getting to Zero: UNAIDS Strategy 2011–2015;* and the *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

2 Global update on HIV treatment 2013: Results, impact and opportunities. Geneva: World Health Organization, United Nations Children's Fund, Joint United Nations Programme on HIV/AIDS; 2013.

The tide is turning against HIV. After years of increasing incidence of HIV infection and related deaths, the pandemic appears to have peaked. AIDS-related deaths have fallen by 25% in the past decade, and new HIV infections by more than 20% since 2006 (Figure 2).[3] These gains have been made possible by sustained global and national political commitment and substantial investments, effective community mobilization, innovations in science, technology and implementation, as well as robust multisectoral approaches. Major opportunities have arisen in the past two years to strengthen the response to HIV, including additional evidence of the prevention benefits of antiretroviral drugs (ARVs), along with concerted international efforts to eliminate mother-to-child transmission of HIV.

Nevertheless, as the 2015 deadline approaches, significant challenges remain to be fully addressed. The majority of people living with HIV in low- and middle-income countries are unaware of their HIV status, and many who present for testing and treatment do so too late. ART coverage is inadequate in several regions, and critical gaps in coverage persist, notably among pregnant women, children and key populations. Globally, more than two million people are newly infected with HIV every year.[3] In sub-Saharan Africa and south Asia, the number of new infections occurring between partners in HIV serodiscordant couples is increasing and – where injection drug use is a major route of HIV transmission – drug users remain a significant 'bridging' population for sexual transmission. Key populations continue to experience high HIV prevalence rates in both concentrated and generalized epidemic settings, and face significant barriers to accessing prevention and treatment services, including human rights abuses, stigma and discrimination. The current plan is focused on addressing these persistent challenges.

Figure 2. New HIV infections and AIDS deaths from 2001 to 2012



Source: WHO/UNAIDS 2013.

3 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013.

1.2 ABOUT THIS PLAN

WHO contribution to global goals and targets

This plan describes how WHO will contribute to achieving major international HIV-related goals and targets in the 2014–2015 biennium in accordance with the needs formulated by WHO Member States (Box 1). WHO work is particularly relevant to achieving the following 2015 global targets and commitments:[4]

- Reaching 15 million people with life-saving ART.
- Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths.
- Reducing tuberculosis deaths in people living with HIV by 50%.
- Reducing sexual transmission of HIV by 50%.
- Reducing transmission of HIV among people who inject drugs by 50%.
- Eliminating parallel systems for HIV-related services, in order to strengthen integration of the AIDS response in global health and development efforts.

4 These targets and commitments are drawn from the 2011 *Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS*. They are consistent with the targets for MDG 6, as well as those set out in the *Global health sector strategy on HIV/AIDS 2011–2015; Getting to Zero: UNAIDS strategy 2010–2015;* the UNAIDS *Unified budget, results and accountability framework*; the *Global plan to Stop TB 2011–2015;* and the *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.*

5 *HIV/AIDS strategy for the African Region* (updated 2012); *Pan American Health Organization regional HIV/STI plan for the health sector 2006–2015; South-East Asia regional health sector strategy on HIV, 2011–2015; European action plan for HIV/AIDS 2012–2015; Eastern Mediterranean regional strategy for health sector response to HIV 2011–2015.*

Box 1. WHO leads the health sector response to HIV

The World Health Organization (WHO) leads and coordinates the global health sector response to the HIV pandemic, focusing on the highest impact interventions that can be delivered through health and related community-based services. This work is distributed across many departments at WHO headquarters, led by the HIV Programme, and carried out in all WHO regional and country offices. WHO's HIV-related work is guided by the *Global health sector strategy on HIV/AIDS 2011–2015,* as endorsed by the sixty-fourth World Health Assembly, and is reflected in the WHO *Global programme of work* and biennial programme budgets. Complementary regional HIV plans guide implementation in WHO regional offices.[5]

As a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), WHO contributes to the coordinated United Nations (UN) response to the HIV pandemic. WHO is the convening agency for ART and HIV/tuberculosis (TB) coinfection. WHO also convenes, together with the United Nations Children's Fund (UNICEF), UN collaboration to eliminate mother-to-child transmission of HIV, while also contributing to the broad agenda of UNAIDS. The work of the Joint Programme is guided by the *UNAIDS Strategy 2011–2015* and the *Unified budget, results and accountability framework 2012–15.*

WHO works with a wide range of partners, including ministries of health and national AIDS programmes, donor governments and their agencies, the Global Fund to Fight AIDS, Tuberculosis and Malaria, research institutions, health care providers, private foundations, nongovernmental organizations and civil society groups, including people living with HIV and other affected communities.

1.3 ABOUT THE WHO HIV PROGRAMME

Results-based planning

The current plan reflects the results-based approach to strategic and operational planning that is followed by WHO as a whole. The application of a clear results chain based on standard terminology (Figure 3) is a key element of recent WHO reform and is integrated into the WHO *Programme budget*.

The WHO *Global health sector strategy for HIV/AIDS* (GHSS) sets the strategic goals and desired impact to which the HIV Programme contributes. The *Programme budget* and this *Operational plan* define the HIV Programme activities and specific products for the next two years. These activities are implemented across WHO to achieve *results in countries* consistent with the goals of the GHSS, including a reduction in new HIV infections and reduced HIV- and TB-related mortality.

An organization-wide response

The WHO HIV Programme is delivered across all three levels of the organization – headquarters, regional offices and country offices – based on a clear division of labour (Figure 4). At all three levels, actions are intended to deliver results in countries in terms of optimal human and financial capacity, technical proficiency, effective programming, efficient health service delivery and impact on HIV and related health conditions.

WHO headquarters focuses on global leadership, normative guidance, policy development, coordination across regions, regional capacity-building and global level strategic information. Policy development and normative guidance involve convening or working with experts and partners to develop guidelines, technical briefs, policy statements and global standards for HIV prevention, treatment and care. The global coordination role ensures that work undertaken across all levels is consistent with the organization's strategies, priorities and budget. Headquarters also plays the leading role in compiling data and other strategic information for global reporting. The HIV Programme collaborates closely with other programme areas, including TB, viral hepatitis, drug dependence, maternal, newborn, child and adolescent health, reproductive health, essential medicines, and health information systems.

WHO regional offices play the leading role in coordinating technical assistance to the country offices and in regional strategy development, partnerships, coordination and advocacy. Regional offices also monitor the response at the regional/country levels, coordinate regional initiatives and facilitate collaboration with low- and middle-income countries in other regions. HIV teams are located in all six regional offices.

Figure 3. The WHO results chain

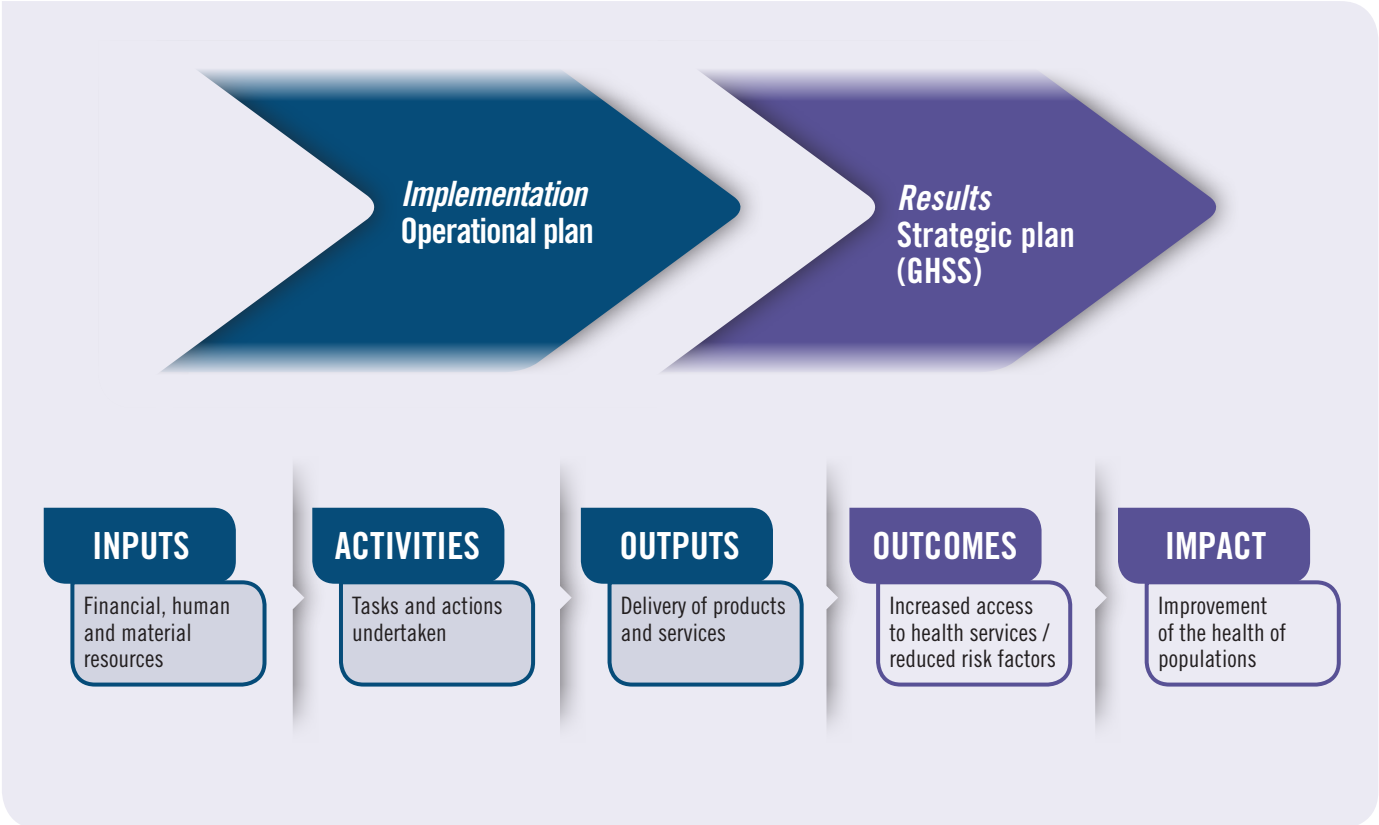
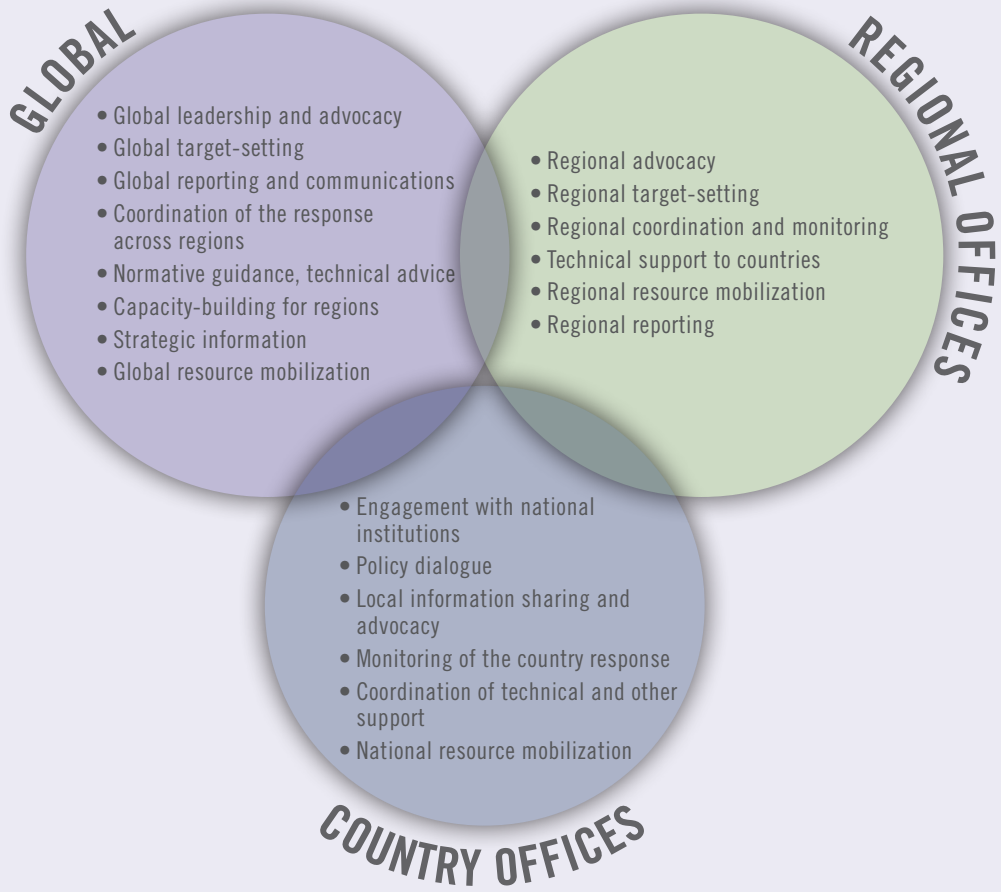


Figure 4. HIV Programme division of labour across WHO



WHO country offices engage directly with the ministry of health and other stakeholders to influence and support the implementation of WHO guidance and policies. There are HIV staff members in over 80 country offices, including staff working in related health areas. To ensure that limited resources are allocated for the most impact, country support in this biennium will be concentrated in 59 focus countries (Annex 1). This includes the 38 'high-impact countries' identified by UNAIDS, the 22 EMTCT Global Plan countries, and other countries identified by WHO regional offices as having strategic importance. Additional countries will be supported depending on needs and available resources.

Supporting countries

Each level of WHO performs specific functions designed ultimately to support action and contribute to results in countries (Figure 5). At the global level, WHO collates information, engages in policy and scientific dialogue, and builds global partnerships. The results are used to develop

Figure 5. Achieving results in countries

evidence-based and policy-relevant normative guidance and tools. These are then adapted at the regional level and used to engage in regional policy discussions and to build regional technical capacity. Finally, WHO country offices help guide national policy dialogue and facilitate the provision of technical support for policy development, programme design and service delivery that ultimately translate into meaningful results at the country level.

Working with partners

WHO implements its HIV Programme in collaboration with Member States and a broad range of multilateral, bilateral and other agencies, as well as civil society networks and organizations (Figure 6).

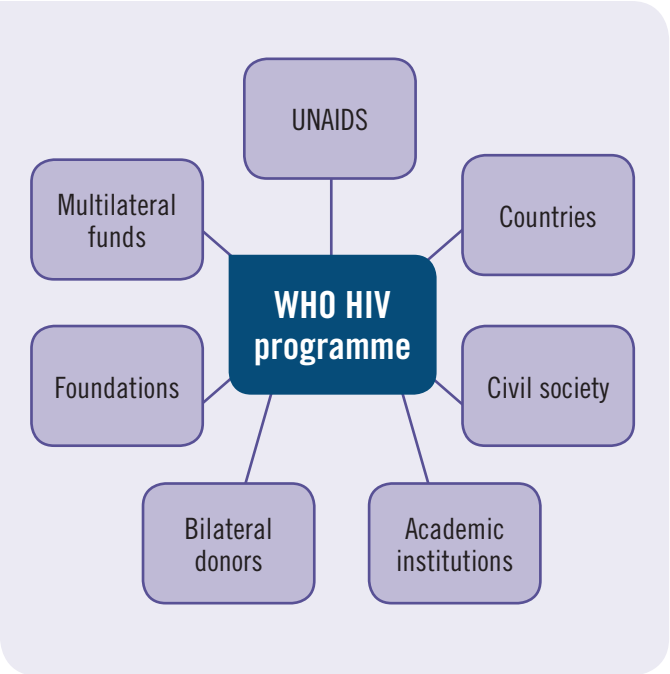
WHO collaborates very closely with the UNAIDS Secretariat and cosponsors on a wide range of technical issues at global, regional and country levels. Through participation in the UNAIDS governance process, WHO influences UNAIDS policy and benefits from technical and policy input from the UNAIDS Secretariat and Programme Coordinating Board. Strong collaboration exists between WHO and several UNAIDS cosponsors on specific technical areas. For example, WHO and UNICEF co-convene activities on the elimination of mother-to-child transmission of HIV. WHO works closely with the United Nations Office on Drugs and Crime (UNODC) on injecting drug use; with the United Nations Development Programme (UNDP) on key populations and human rights; with the International Labour Office (ILO) on workplace issues; and with the UNAIDS Secretariat on treatment and strategic information.

The United States Government, through the President's Emergency Plan for AIDS Relief (PEPFAR), is also a strong partner in the work of the WHO HIV Programme. Financial and technical support from PEPFAR has been channelled through the United States Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID) for many years, and this support will continue in 2014–2015. Regular technical consultations with these agencies take place at the global level and in countries.

Several other bilateral partners provide important technical input to the HIV Programme. Collaboration with the Government of Canada has been particularly strong, as has technical collaboration with the German Agency for International Cooperation (GIZ), and with France through secondments of technical staff.

Significant financial and technical input is also being provided by the Bill & Melinda Gates Foundation, including for general programme management, ARV market

Figure 6. Key WHO partnerships in HIV



surveillance, optimization of drugs and diagnostics, HIV drug resistance and toxicity monitoring, implementation of pre-exposure prophylaxis (PrEP) demonstration projects, and voluntary medical male circumcision (VMMC).

Multilateral funding agencies such as the GAVI Alliance and UNITAID are also important partners. WHO enjoys a strong working relationship with the Global Fund to Fight AIDS, Tuberculosis and Malaria, and provides technical input for its grant development and implementation. In 2012–2013, WHO was involved in several country programme reviews supported by the Global Fund, and in the development of regional Global Fund investment strategies. Collaboration will be further strengthened in 2014–2015 through an agreement for WHO to provide technical support to countries applying for Global Fund grants under the new funding model.

Many partners and experts are involved in WHO advisory groups and consultations on specific technical issues. Notably, the work of the WHO HIV Programme is informed by the Strategic and Technical Advisory Committee for HIV/AIDS (STAC-HIV), an external advisory body that provides regular recommendations to WHO on a broad range of policy and technical issues. WHO also works closely with its many collaborating centres and regional knowledge hubs.

The organization highly values input from civil society and continues to develop strong ties with civil society groups, including through a Civil Society Reference Group.

PART 2: OPERATIONAL OBJECTIVES FOR 2014–2015

Sven Torfinn / Panos Pictures

To accelerate progress towards 2015 global goals and targets, the health sector needs to concentrate on a limited number of key objectives. As eligibility for ARVs expands in response to new WHO guidance, the drugs need to be used strategically to maximize their benefits for both treatment and prevention. In parallel, a concerted effort is needed to strengthen the continuum of HIV prevention, testing, treatment and care. Further innovation is needed to increase demand for HIV testing and treatment, maximize long-term patient retention and treatment adherence, integrate the provision of ARVs across health systems, and more effectively address the relationship between HIV and NCDs.

To promote long-term sustainability of the response to HIV, further effort is also needed to develop simpler, better drugs and diagnostic tools, and to make them available at affordable prices. Better data and analyses are critical – especially at country level – to guide decision-making, prioritization, programme planning and implementation of HIV programmes and related health services. Major efforts are also needed to reduce barriers to HIV prevention, diagnosis, treatment and care for key populations.

This plan incorporates a number of new emphases for the HIV Programme. In particular, there will be a stronger focus on non-HIV outcomes, such as: viral hepatitis in the context of HIV infection; validating the dual elimination of mother-to-child HIV transmission and congenital syphilis; and tackling of HIV and noncommunicable diseases (NCDs) through the strengthening of chronic and primary care.

The current plan is structured around the following six operational objectives for the 2014–2015 biennium:

- Strategic use of ARVs for HIV treatment and prevention;
- Eliminating HIV in children and expanding access to paediatric treatment;
- An improved health sector response to HIV among key populations;
- Further innovation in HIV prevention, diagnosis, treatment and care;
- Strategic information for effective scale up;
- Stronger links between HIV and related health outcomes.

These operational objectives have been formulated based on an assessment of key predicted gaps, challenges and opportunities in the HIV response over the next two years. They also reflect changes that are essential to achieving global and national targets and commitments by the end of 2015. Part 2 of this plan discusses these operational objectives in detail, providing a brief rationale for each one and how WHO activities and deliverables will contribute to their achievement. Examples are provided to illustrate the work that WHO regional offices are undertaking in relation to each operational objective.

A number of cross-cutting issues underpin the achievement of the six operational objectives, including critical enablers such as human rights, legal environments, gender-transformative approaches and efforts to reduce violence against women and girls. Attention is needed, both within the HIV Programme and among its many partners, to address these issues.

OPERATIONAL OBJECTIVE 1: STRATEGIC USE OF ARVS FOR HIV TREATMENT AND PREVENTION

Expanding access to ARVs and ensuring that they are used strategically for both treatment and HIV prevention are essential to reduce further HIV-related mortality and new infections in countries, and to achieve many of the major global and national targets for HIV. Providing countries with guidance and assistance on the strategic use of ARVs is therefore the 'flagship' objective of the HIV Programme in 2014–2015. Work to achieve this objective will build on lessons learned from the successful scale up of ART in recent years, as well as progress made in scaling up activities to prevent mother-to-child transmission. The aim is also to capitalize on emerging evidence of the benefits of ARV drugs for HIV prevention. Activities in this area are closely linked to the other five operational objectives in this plan.

Implementing the 2013 consolidated ARV guidelines

In 2013, WHO published *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. These guidelines combine new and existing guidance for ARV use in targeted age groups and populations – adults, pregnant and breastfeeding women, adolescents, children and key populations – for both treatment and prevention (Box 2). WHO estimates that more than 28 million people living with HIV globally will become eligible for ARV drugs under the new guidelines, compared with 17 million under the previous (2010) guidelines.[6] While expanded eligibility for ART and a wider range of options for using ARV drugs provide new opportunities to save lives, they also pose challenges to policy-makers and implementers in many countries. In 2014–2015, the HIV Programme will therefore place strong emphasis on translating the new guidelines into policies and protocols through technical support and capacity-building. At the country level, this work will contribute to increased access

Box 2. Key recommendations from the WHO ARV guidelines

The 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* incorporate new science and practice since the previous update in 2010. This comprises the development of simpler, safer, once-daily, combination single-pill ART regimens suitable for use in most age groups and populations; the emergence of point-of-care diagnostics; new service delivery approaches that allow HIV testing and treatment monitoring to be diversified and decentralized; the trend towards earlier initiation of treatment for both adults and children, and simplified programming for prevention of mother-to-child transmission (PMTCT) of HIV, as well as recognition of the broader prevention benefits of ARVs.

New clinical recommendations promote expanded eligibility criteria for ART with a CD4 threshold for treatment initiation of 500 cells/mm^3 or less for adults, adolescents and children. Priority should be given to individuals with severe or advanced HIV infection and those with a CD4 count of 350 cells/mm^3 or less. ART is recommended to be initiated regardless of the CD4 count for certain populations, including those with active TB disease who are living with HIV, people with HIV and hepatitis B virus (HBV) infection who have severe chronic liver disease, HIV-positive partners in serodiscordant couples, pregnant and breastfeeding women and children younger than five years of age. Harmonization of ART regimens for adults and older children is recommended with a new, preferred first-line ART regimen.* The need to phase out d4T in first-line ART regimens for adults and adolescents is reinforced. Viral load testing is now recommended as the preferred approach to monitoring ART success and detecting treatment failure, complementing clinical and immunological monitoring of people receiving ART.

The guidelines emphasize that ARV drugs should be used within a broad continuum of HIV care. New guidance is provided on community-based HIV testing and counselling, HIV testing for adolescents and using post-exposure prophylaxis after sexual assault. Updated operational and programmatic recommendations are presented on how to strengthen key aspects of the continuum of HIV care and improve linkages between HIV-related health services.

Summaries of existing WHO guidance are provided for HIV testing and counselling, HIV prevention, general care for people living with HIV, the management of common coinfections and other comorbidities, and monitoring and managing drug toxicity.

* tenofovir (TDF) + TDF/ lamivudine (or TDF/emtricitabine) + efavirenz as a fixed dose combination.

6 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Summary of new recommendations. Geneva: World Health Organization; 2013.

to ARVs, improved clinical outcomes for people living with HIV, reductions in HIV incidence and stronger linkages between HIV-related services across health systems.

Main activities and products

- Regional and country capacity-building and support to adopt and implement the 2013 consolidated guidelines (Box 3).
- Evaluation of country adoption and implementation of the guidelines.
- Relevant technical updates, as required.

WHO/Viktor Suvorov

Policy development on the strategic use of ARVs and a review of the ARV guidelines

In the coming two years, WHO will develop a longer-term vision and strategy for ARV use as part of the post-2015 health and development agenda. This will be done through consultations, policy initiatives, discussion papers, assessments and analyses of emerging evidence and practice. WHO will also continue to contribute to the implementation research agenda, focused on reducing gaps in the HIV treatment cascade and the continuum of care, strengthening the optimal use of ARVs to prevent sexual transmission of HIV, and integrating ARVs across the health system. These efforts will all inform six-monthly updates and development of the next revision of the WHO ARV guidelines, currently anticipated for publication in 2015.

Main activities and products

- Consultations and policy document on the strategic use of ARVs as a roadmap for the next ARV guidelines.
- Collaboration with partners to develop a clinical and implementation science research agenda to answer gaps in knowledge related to ARV use, the treatment cascade, programmatic priorities and innovation.
- Systematic reviews, feasibility studies, consultations and guideline meetings for the 2015 revision.
- Publication of six-monthly updates to the 2013 ARV guidelines.

Box 3. Putting global guidance into practice: Strategic use of ARVs in Africa and the Eastern Mediterranean

In 2014–2015, assisting countries to implement the *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* will be a priority for all WHO regional offices, including the Regional Office for Africa (AFRO) and the Regional Office for the Mediterranean (EMRO). The African and Eastern Mediterranean regions have, respectively, the highest and lowest coverage of ART globally.

Assistance provided by AFRO will include supporting the establishment of national multidisciplinary working groups and hosting adaptation workshops to assess the performance of national HIV and TB programmes, and to determine resource and capacity needs for introducing new ARV regimens and technologies recommended in the consolidated guidelines. AFRO will also support countries to scale up an appropriate mix of approaches for HIV testing, including voluntary testing, provider-initiated testing, mobile outreach and special testing events and campaigns. Support will be provided to monitor the quality of service delivery and strengthen service linkages to improve retention along the continuum of care. The Regional Office is also engaging with countries to support a strategic investment approach to HIV that ensures optimal use of national resources and assists external resource mobilization efforts through the Global Fund, PEPFAR and other multilateral and bilateral agencies.

The low coverage of ART in the region served by EMRO is primarily due to low access to and utilization of HIV testing services, as well as sub-optimal linkages between health services and poor retention in HIV care. In 2013, EMRO launched a regional *Initiative to end the HIV treatment crisis,* and with UNAIDS published a joint advocacy document recommending innovation in service delivery approaches for HIV testing, care and treatment. This includes a move away from HIV testing through public health facilities to community-based testing and outreach to key populations. Important elements of this approach are provision of same-day HIV test results; integration of provider-initiated testing in TB and antenatal care (ANC) clinics, rather than referral to stand-alone HIV testing and counselling sites; point-of-care CD4 testing; and decentralization of ART to community-based health services and private providers. In 2014–2015, EMRO is supporting countries to conduct analyses of lost opportunities along the continuum of HIV testing, treatment and care in order to engage and retain people living with HIV. Based on the findings of such analyses, EMRO will collaborate with UNAIDS on the development of treatment acceleration plans in focus countries to drive national strategic planning and resource mobilization efforts for ART scale up, including the development of concept notes to be submitted to the Global Fund.

- Publication of an updated (2015) version of the ARV guidelines and associated operational and programmatic guidance.
- Research, analysis and consultations to set post-2015 treatment targets.

Prequalification of HIV medicines and diagnostics

Every year, hundreds of millions of US dollars are spent purchasing HIV diagnostics and medicines through international financing and/or procurement mechanisms. The quality standardization and control of such products is an important consideration in terms of their development, manufacturing, evaluation, supply, safe and effective use, as well as monitoring.

By prequalifying in vitro diagnostics and HIV/AIDS medicines, WHO verifies that they continue to meet international standards of quality, safety and efficacy.[7] By 31 December 2013, WHO had prequalified 23 HIV diagnostics (rapid diagnostic tests (RDTs), enzyme immunoassays (EIAs), and virological and CD4 technologies) and one adult male circumcision device, 234 medicinal products for treating HIV-related conditions, and 12 active pharmaceutical ingredients for use in manufacturing related pharmaceutical products. It also prequalified 29 medicine quality-control laboratories (covering all WHO regions). In parallel with its prequalification efforts, and with a view to the future, the WHO Team provides technical assistance and training opportunities, to expand capacity to produce and regulate quality-assured diagnostics and medicines, including their monitoring and testing.

During 2014 and 2015, WHO will assess a range of diagnostics and medicines for HIV treatment and prevention, principally HIV RDTs, CD4 and viral load technologies, early infant diagnosis and adolescent male circumcision devices, and medicines included in the *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. In doing so, it will continue to reduce timelines for prequalification and national regulatory approval, contribute to harmonization of regulatory requirements, and provide regulatory scientific advice to manufacturers working to reformulate existing medicines, or develop new diagnostics and medicines. It will also operate expert review panels to carry out risk-based assessment of products not yet prequalified, or assessed by a stringent regulatory authority, to determine their eligibility for time-limited procurement. Each of these activities will help to stimulate competition for quality, priority products, and importantly, speed up access to those products.

Main activities and products

- Assessment of diagnostics and medicines included in the *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.*
- Operate expert review panels to carry out risk-based assessment of products not yet prequalified.

OPERATIONAL OBJECTIVE 2: ELIMINATION OF HIV IN CHILDREN AND EXPANDED ACCESS TO PAEDIATRIC TREATMENT

Scaling up ARVs for all pregnant and breastfeeding women living with HIV

Recent progress in expanding coverage of ARV prophylaxis and treatment for pregnant women living with HIV has offered hope that the goal of virtually eliminating mother-to-child HIV transmission in low- and middle-income countries can be achieved. Since its launch in 2011, the *Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* has helped to catalyse efforts in this area, especially in the plan's 22 priority countries (see Annex 2) that together account for 90% of all pregnant women living with HIV and new infections in children worldwide.

WHO / Michael Jensen

7 Assessment of diagnostic for prequalification incorporates assessment of appropriateness for use in resource-limited settings.

Globally, over 900 000 pregnant women in low- and middle-income countries received either ART or the recommended prophylaxis in 2012, a third more than the number who received it in 2009.[8] As a result, fewer children are acquiring HIV: in the 21 African priority countries of the Global Plan, overall mother-to-child transmission rates declined from an estimated 26% in 2009 to 17% in 2012, and more than 800 000 HIV infections in children were prevented over these four years. Despite this progress, the percentage of treatment-eligible pregnant women living with HIV who received ART for their own health in 2011 in low- and middle-income countries was only 30%, considerably lower than the estimated coverage of 54% among *all* adults eligible for ART.

To close this gap and simplify ARV programming, several countries have begun to offer lifelong, triple-drug ART to all pregnant and breastfeeding women – regardless of CD4 count – for their own health, to prevent vertical HIV transmission and to reduce the risk of HIV transmission to sexual partners. In the 2013 consolidated ARV guidelines, WHO formally recommends that all pregnant and breastfeeding women living with HIV should initiate ART regardless of CD4 count, at least for the duration of mother-to-child transmission risk. At the same time, based on programmatic and operational advantages, WHO recommends that countries consider continuing lifelong ART for pregnant and breastfeeding women ("Option B+"). A major focus of the HIV Programme in 2014–2015 will be to support countries – especially those that are prioritized in the global plan – to implement these and related recommendations. This work will bring the world closer to eliminating vertical HIV transmission and achieving the goal of an AIDS-free generation, while also expanding access to ART and improving clinical outcomes for women living with HIV.

Main activities and products

- Regional and country capacity-building and support to adopt and implement 2013 guidelines with regard to ARVs for pregnant and breastfeeding women (i.e. Options B/B+).
- Evaluation of country adoption and implementation of ARVs for pregnant and breastfeeding women.
- Report on PMTCT impact evaluations in Africa.
- Technical updates, as required.

Scaling up infant diagnosis and paediatric ART

Global ART coverage for children has consistently been around half of that for adults. In the 22 global plan priority countries, ART coverage for children below 15 years of age increased from 29% (566 000 children) in 2011 to 34% (630 000 children) in 2012, but the pace of scale up continues to lag: coverage for children rose 11% in 12 months in these countries, compared with 21% for adults.[9] This is because paediatric ART involves unique challenges, including difficulty identifying children in need of treatment, limited availability, complexity, and poor palatability of drug formulations for infants, and the need to use virological testing to determine HIV infection in children aged under 18 months. New 'sprinkle' formulations of the WHO-recommended first-line ART regimen for infants are likely to become available in 2014, which may improve palatability and adherence.

WHO recognizes that a huge effort is needed to reach the global goal of providing ART to all eligible children by 2015. Accordingly, it will strongly support countries in their efforts to expand access to infant HIV diagnosis and paediatric ART, principally for the adoption and implementation of recommendations in the 2013 consolidated ARV guidelines. WHO will also support evaluation of progress in implementing these guidelines with a view to preparing necessary technical updates and revising the maternal and child health (MCH) and paediatric components of the guidelines in 2015.

Main activities and products

- Regional and country capacity-building and support to adopt and implement 2013 consolidated guidelines with regard to infant HIV testing and paediatric ART.
- Evaluation of country adoption and implementation of paediatric components of the 2013 ARV guidelines.
- Technical update/operational guide on infant HIV testing.
- Systematic reviews, feasibility studies, consultations and guideline meetings for the 2015 revision of the MCH and paediatric components of the WHO ARV guidelines.
- Updated 2015 guidance on paediatric and adolescent care and treatment, including ARVs and formulations for these groups, and related operational and service delivery guidance.

Scaling up HIV testing, counselling and care for adolescents

More than 2 million adolescents (10–19 years of age) are living with HIV,[10] and many do not receive the care and support they need to stay in good health and prevent HIV transmission. Millions more are at risk of HIV infection. ART coverage for adolescents is not known. Inadequate attention to their needs has led to a 50% increase in globally reported AIDS-related deaths between 2005 and 2012, compared to a 30% decline in the general

8 2013 Progress report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Geneva: Joint United Nations Programme on HIV/AIDS, United States President's Emergency Plan for AIDS Relief, United Nations Children's Fund, World Health Organization; 2013.

9 2013 Progress report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Geneva: Joint United Nations Programme on HIV/AIDS, United States President's Emergency Plan for AIDS Relief, United Nations Children's Fund, World Health Organization; 2013.

10 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013.

population.[11] Efforts are needed to increase HIV testing and counselling among adolescents, and to improve service delivery approaches for treatment and care. In 2013, WHO and partners published the first guidelines on HIV testing, counselling and care for adolescents living with HIV and those at risk.[12] Disseminating these guidelines and providing support to countries for their implementation will be a high priority in 2014–2015.

Main activities and products

- Regional and country capacity-building and support to adopt and implement 2013 guidelines on HIV testing, counselling and care for adolescents.
- Relevant technical updates, as required.

Global leadership, coordination and partnership

Under the UNAIDS division of labour, WHO and UNICEF are jointly responsible for PMTCT and paediatric treatment. UNICEF will be a key partner in this area of work, together with other members of the Global Steering Group and the Interagency Task Team that support implementation of the global plan. WHO will continue its work with UNICEF to coordinate and co-chair these groups, as well as regional task forces.

Box 4. Eliminating mother-to-child HIV transmission in South-East Asia

For the WHO South-East Asia Regional Office, the challenges of expanding access to PMTCT and paediatric ART include increasing uptake earlier in the continuum of care, achieving high retention in care for both HIV-positive pregnant women and HIV-positive children on ART, and achieving maximal viral load suppression. The recommended switch to a simplified, fixed-dose triple ARV combination for all HIV-positive pregnant and breastfeeding women will involve working with countries to develop options for financing, the expansion of task shifting, improved community engagement, and increasing the role of MCH services in providing ART. Countries in the Region have also requested technical support to develop operational guidelines and validation tools for the elimination of mother-to-child HIV transmission and congenital syphilis, as well as support to scale up community-based HIV testing.

OPERATIONAL OBJECTIVE 3: AN IMPROVED HEALTH SECTOR RESPONSE TO HIV AMONG KEY POPULATIONS

Addressing HIV among key populations is increasingly accepted as critical to ensure a greater impact on HIV incidence and mortality in both generalized and concentrated epidemics. Key populations are disproportionately affected by HIV and at a higher risk of infection due to social vulnerability as well as risk-associated behaviours. These populations include sex workers, men who have sex with men (MSM), transgender people, people who inject drugs, and prisoners. The criminalization of same-sex behaviour, drug use and sex work, together with stigma and discrimination, significantly limits the access of key population groups to health and social services, including for HIV. For example, although global data on ART coverage among key populations are limited, a 2010 report including 19 low- and middle-income countries in Europe and central Asia indicated that only 21% of eligible people living with HIV who inject drugs actually received ART.[13]

In many countries, HIV programming for key populations is inadequate or under-resourced, including in generalized epidemic settings. The development and implementation of targeted prevention, treatment, care and support

WHO

programming are therefore critical. Programmes that address key populations also need to address their diverse nature, their meaningful involvement in the HIV response, and to consider structural and social factors that increase vulnerability to disease and poor health.

WHO is in a unique position to help countries improve their health sector response to HIV among key populations.

11 Towards an AIDS-free generation – Children and AIDS, Sixth Stocktaking Report, 2013. New York, NY: United Nations Children's Fund; 2013.

12 HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV. Geneva: Global Network of People living with HIV, United Nations Educational, Scientific and Cultural Organization, United Nations Populations Fund, United Nations Children's Fund, World Health Organization; 2013.

13 Global update on HIV treatment 2013 – Results, impact and opportunities. Geneva: World Health Organization, United Nations Children's Fund, Joint United Nations Programme on HIV/AIDS; 2013.

This includes developing and implementing community-based approaches to HIV testing, prevention, treatment and care, linking these approaches effectively with health facility-based services and eliminating the barriers that key populations face in accessing these services.

Implementing existing WHO guidance on HIV among key populations

Working with many partners, WHO has developed a wide range of policy briefs, technical guidance and good practice documentation to help countries address the often complex issues of HIV prevention, diagnosis, care and treatment for specific populations. In the 2012–2013 biennium, relevant WHO publications included guidance on the prevention and treatment of HIV and other sexually transmitted infections (STI) for sex workers; guidance on HIV prevention, treatment and care in prisons and other closed settings; a technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, and guidance on prevention of viral hepatitis B and C among people who inject drugs. In 2014–2015, the HIV Programme will provide support to countries to adopt and implement these guidelines.

Main activities and products

- Regional and country capacity-building and support to implement recent WHO guidance on HIV among key populations.
- Promotion and support for scale up of partner notification interventions and couples testing and counselling, including links with family planning, Option B+ and treatment as prevention.

Consolidated guidance on HIV among key populations

Overall, WHO guidance on HIV among key populations has been population-specific. A major technical focus of the HIV Programme in 2014–2015 will be to consolidate all WHO existing guidance relating to five key populations: men who have sex with men, transgender people, people who inject drugs, sex workers, and people in prisons and other closed settings. The main goal of this consolidation project is to provide all relevant guidance on these populations in one document, in order to simplify decision-making and programming at regional and country levels. The consolidated guidelines will also include areas that had previously not been addressed, such as overdose management, and guidance for each key population will be updated, where appropriate, during the consolidation process.

Box 5. The global challenge of HIV among key populations

It has long been assumed that key populations represent a modest share of the HIV pandemic, and that the prevalence of HIV among them is largely confined to countries with low-level, concentrated epidemics. However, these key populations represent most of the affected people outside sub-Saharan Africa, and an increasingly recognized share of new infections in urban settings within sub-Saharan Africa.

- In low- and middle-income countries, men who have sex with men are 19 times more likely to have HIV than the general population, and female sex workers are 14 times more likely to have HIV than other women.[14]
- A recent review of evidence from 15 countries found that around 20% of transgender people are living with HIV. Transgender women are 50 times more likely to have HIV than the general population.[14]
- Key populations and their sex partners account for as much as 80% of new infections in Morocco, 65% in Peru, 50% in Nigeria, 47% in the Dominican Republic, 33% in Kenya, and 28% in Mozambique.[15]
- MSM account for more than one third of new infections in the People's Republic of China, and projections indicate that MSM could make up half or more of all new infections in Asia by 2020.[15]
- Nearly 40% of new HIV infections in Eastern Europe and Central Asia in 2011 were among people who inject drugs.[16]

The need to consider other highly vulnerable and affected populations that are context-specific, such as mobile populations and migrants, will also be emphasized. Building on the new guidelines on adolescent testing, treatment and care developed by WHO in 2013, the specific needs of adolescents (aged 10 to 19 years) – neglected to date in many national HIV responses – will receive particular attention.

The consolidated guidance will promote a programme-wide perspective, helping countries to plan, develop and monitor programmes relevant to the particular epidemiological context of each key population more efficiently and comprehensively. Issues that are common across key populations will also be more effectively addressed. The guidelines will strongly promote the need to concurrently address strategic information, targeted interventions, accessible service modalities, and critical enablers such as legal and policy environments, equity and human rights.

14 Global update on HIV treatment 2013 – Results, impact and opportunities. Geneva: World Health Organization, United Nations Children's Fund, Joint United Nations Programme on HIV/AIDS; 2013.

15 Tackling HIV among key populations: Essential to achieving an AIDS-free generation – Issue Brief (August 2013). New York, NY: American Foundation for AIDS Research; 2013.

16 HIV/AIDS data and statistics. Copenhagen: WHO Regional Office for Europe; 2013 (**http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/data-and-statistics**, accessed 28 February 2014).

An important element of this work will be directly engaging with networks and key populations to strengthen partnerships between public sector and community-based service providers for the delivery of HIV interventions.

Main activities and products

- Consolidated guidelines on comprehensive HIV testing, prevention, treatment and support for key populations and adolescents.
- Regional and country capacity-building and support to adopt and implement the consolidated guidelines.
- Contribute to developing implementation tools for MSM and transgender populations.
- Key population technical briefs.
- Target-setting guide for MSM, transgender people and sex workers.
- Evidence brief on interventions to address violence against sex workers.

Box 6. Addressing HIV among key populations in the Western Pacific

In the Western Pacific Region, HIV epidemics are concentrated among men who have sex with men, sex workers and their clients, transgender people and injecting drug users. In 2014–2015, the WHO Regional Office for the Western Pacific is focusing on three priorities to address HIV among these groups: strategic information, testing and treatment, as well as HIV and STI prevention. Innovative service delivery models to extend the reach of HIV services and enhance retention of key populations in care are also being implemented in several countries. As stigma among health care providers is a major barrier for access to HIV and STI prevention and care, implementation of training modules on basic HIV knowledge and stigma reduction published by UNDP and WHO is also a priority.

OPERATIONAL OBJECTIVE 4: FURTHER INNOVATION IN HIV PREVENTION, TREATMENT AND CARE

More strategic use of ARVs for treatment and prevention, and increased access to HIV-related health services for pregnant women, children and key populations, will require further innovations in the HIV response. These include the development of new drugs and diagnostics, new approaches to delivering HIV services, increased access to new and underutilized interventions, and research to guide the effective implementation of HIV and related services along the continuum of care.

In the 2012–2013 biennium, the HIV Programme promoted innovation in these areas under the rubric 'Treatment 2.0'. In 2014–2015, these efforts will continue with the objective of promoting further innovations in the HIV response. This will include specific activities to increase uptake of new or underutilized biomedical HIV prevention interventions, such as oral PrEP and VMMC. WHO will also engage more closely with selected elements of the HIV treatment and prevention research agenda.

Scale up and innovation in drugs and diagnostics

The recommendation in the consolidated ARV guidelines of a single, once-daily, triple-drug regimen suitable for use in most age groups and populations presents an important opportunity to expand ART access in the next few years. However, significant challenges remain to ensure the availability of optimal ARV drugs in many low- and middle-income countries. These challenges include the lack of tolerable and convenient paediatric formulations, understanding and managing ARV toxicities and contraindications, and the relative complexity and expense of second- and third-line ART. WHO will therefore continue work to address these challenges. Emerging issues that will also require engagement by WHO include exploring opportunities for ARV dosage reduction, the potential use of prodrugs, expanding access to integrase inhibitors, determining the optimal package of treatment, care and support for specific populations – including late presenters – and the longer-term impact of ARV use, including its link to comorbidities.

The 2013 ARV guidelines recommend the use of viral load testing as the preferred approach to monitoring the success of ART and diagnosing treatment failure, in addition to clinical and CD4 monitoring. Point-of-care CD4 testing technology is now available, and point-of-care viral load technology is emerging. WHO will work in this biennium to help countries determine and implement the appropriate combination of diagnostic approaches and

technologies, including with regard to quality assurance for new diagnostics through the WHO prequalification process, and to promote the affordability of new and emerging technologies.

Main activities and products

- Collaboration with partners to develop mid- and long-term ARV drug optimization approaches for adults, adolescents and children, including a clinical and operational research agenda for optimized ARVs.
- Technical guidance and regional and country capacity-building and support on preferred diagnostic technologies and standards, point-of-care technologies, and prioritization of products for WHO prequalification.

Scale up and innovation in biomedical prevention and HIV testing

Several innovations in biomedical prevention have emerged in recent years. Until recently, uptake of VMMC for HIV prevention has been relatively low, but more countries are now committing to expanding this approach (Figure 7). In 2012–2013, WHO produced a framework for the clinical evaluation of devices for male circumcision, and a new guideline on the use of the collar clamp and elastic collar compression devices for VMMC. In this biennium, WHO will focus on the dissemination and implementation of these tools to support expanded access to this important intervention.

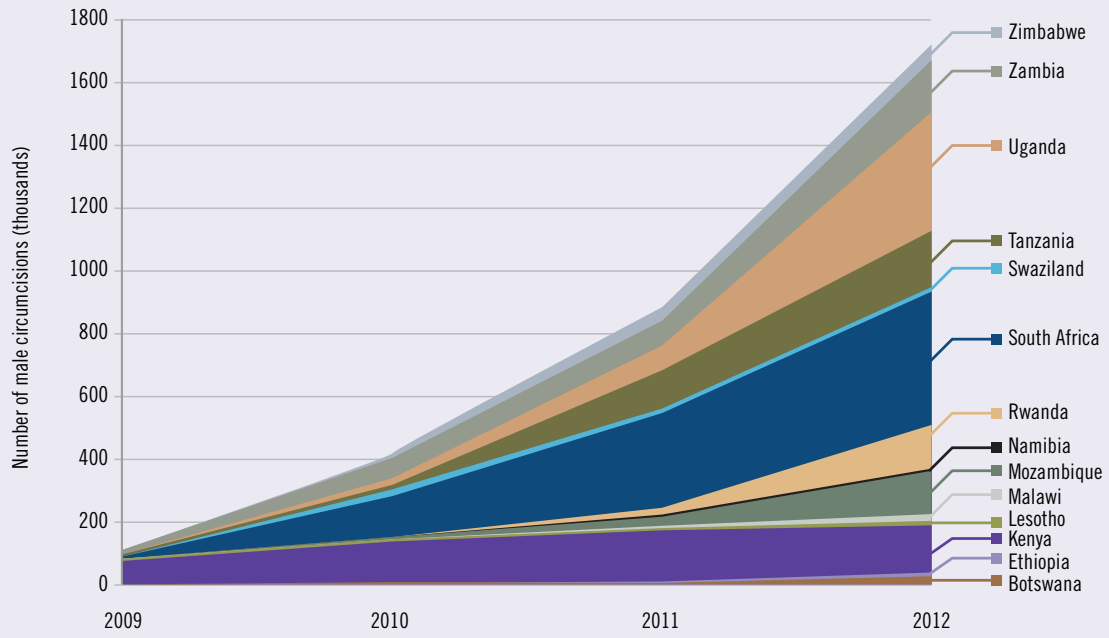
In 2012–2013, WHO published guidance on oral PrEP for serodiscordant couples, as well as men and transgender women who have sex with men, recommending that this intervention be rolled out as demonstration projects in a limited number of countries. These projects will be implemented in 2014–2015, with appropriate technical guidance and support from WHO.

WHO has provided extensive technical and operational guidance on HIV testing and counselling – including provider-initiated testing and counselling in clinical settings – which is critical to ensuring timely access to treatment, care and support. In 2014–2015, emphasis will be placed on developing and promoting community-based testing modalities, such as a 'test for triage'. This approach links people diagnosed using a HIV RDTs in community settings – such as mobile and outreach testing – to a care setting for confirmation of their status and clinical assessment. A new technical brief will be developed to address the emerging issue of self-testing for HIV using RDTs, with emphasis on the need for appropriate links to prevention, care and support services.

Main activities and products

- Development and promotion of community-based HIV testing models.
- Technical brief on self-testing.
- Technical assistance for product selection including validation of HIV testing algorithms, and expanded quality management systems for testing services.

Figure 7. Annual number of voluntary medical male circumcisions in selected countries



Source: WHO and Ministries of Health 2013.

- Prequalification of HIV-related diagnostics, including new dual HIV/*Treponema pallidum* (syphilis) RDTs.
- Guidance on safe male circumcision, including surveillance and monitoring.
- Support for at least four countries to conduct demonstration projects to introduce oral PrEP as part of combined prevention efforts, including indicators for PrEP monitoring and evaluation.

Innovation in service delivery

ARV drugs and related services need to be delivered as effectively, equitably and efficiently as possible by optimizing available human and financial resources, ensuring appropriate links between care settings and services, supporting adherence to lifelong treatment and maximizing retention of patients across the continuum of care. To help achieve these results, the 2013 consolidated ARV guidelines propose a range of innovations, especially for primary and chronic care. These include specific measures to integrate the provision of ARVs within maternal and child health, TB, hepatitis and drug dependence services. The guidelines also propose options for further decentralizing ART, such as maintaining patients on ART at the community level between regular clinical visits, i.e. outside health facilities, in settings such as outreach sites, health posts, home-based services or community-based organizations. WHO support to implement these innovative approaches in 2014–2015 will include elaboration of technical guidance on community-based service delivery models, with a view to updating operational guidance in the 2015 ARV guidelines.

Main activities and products

- Regional and country capacity-building and support to adopt operational recommendations on integrated service delivery of 2013 consolidated ARV guidelines.
- Policy development on service delivery options and integration of HIV within primary health care, including a 'white paper' examining the post-2015 agenda for the health sector response to HIV, within the context of universal health coverage.
- Updated service delivery guidance for the 2015 revision of ARV guidelines, including increased attention to community-based models of care.

Further innovation through research

To support continued innovation, WHO will contribute to the development of a clinical and implementation research agenda, exploring links between HIV 'cure' research and research on HIV treatment and biomedical prevention. As clinical trials of topical PrEP vaginal gel and the continuous release vaginal ring are due to report findings in this biennium, WHO will work with partners to develop an appropriate implementation research agenda and normative guidance for these interventions. WHO will also continue its work on vaccine innovation through the joint WHO/UNAIDS HIV Vaccine Initiative.

Main activities and products

- Collaboration with partners on development of relevant clinical and implementation research agendas, including implementation of ARVs for prevention.
- Technical guidance on emerging biomedical interventions, as required.
- Guidance and capacity-building on regulatory and ethical issues in biomedical prevention research.
- Support for research to address scientific and technical bottlenecks in HIV vaccine development.
- Review of clinical trial plans to ensure efficacy data adequately document the public health impact of an HIV vaccine.
- Analysis of global genetic variability of HIV to guide the design of vaccine candidates.

Box 7. Scaling up voluntary male medical circumcision in Africa

While the pace of scaling up access to VMMC services is increasing in almost all the 14 priority countries served by the WHO Regional Office for Africa, significant challenges remain. These include inadequate domestic and international investment in this intervention, a lack of trained staff, and poor procurement, leading to stock-outs of male circumcision kits and other supplies. Low demand for VMMC among 25–49 year old men is frequently due to sociocultural factors, especially in countries where circumcision has not traditionally been practised. AFRO is working to support countries to increase awareness about the public and individual health benefits of VMMC, enhance demand through innovative advocacy and communication approaches, make operational linkages with adolescent sexual and reproductive health activities, increase available funding, review regulations to allow health providers other than medical doctors to perform circumcision, and adopt safe, non-surgical devices. AFRO is also promoting the integration of early infant male circumcision into maternal, neonatal and child health programmes.

OPERATIONAL OBJECTIVE 5: STRATEGIC INFORMATION FOR EFFECTIVE SCALE UP

Kieran Dodds / Tearfund / Panos Pictures

Comprehensive and reliable strategic information is critical to guide the HIV response at all levels, and to inform the design, costing, delivery and evaluation of effective HIV programmes in countries. As national HIV programmes have matured, strategic information requirements have become more complex. Today, these involve basic epidemiological and surveillance trend data and how the measures used are affected by high ART coverage; key population size estimation and epidemic modelling; data related to monitoring and evaluation (M&E) of programme performance and impact based on appropriate indicators; understanding sources of new infections and developing tools for incidence estimations at population level; information on cost effectiveness and cost efficiency; information on pricing and procurement of HIV-related commodities; and monitoring of drug resistance and toxicities.

During the 2014–2015 biennium, WHO contributions in all these areas will be essential to achieving all other objectives in this plan and to monitoring progress towards the 2015 goals. WHO will work towards ensuring that strategic information becomes more relevant for informing the HIV health sector response.

Annual reporting and monitoring of progress

At the global level, WHO plays a leading role in reporting on the global response to HIV and implementation of the *Global Health Sector Strategy on HIV/AIDS*, notably through annual progress reports on scale up of health sector interventions, including ART, VMMC, PMTCT, TB/HIV services, and HIV testing and counselling. These reports will continue to be published, with in-depth analyses of key themes, gaps and challenges to help policy-makers identify critical issues for their own countries. WHO will also contribute to, or support the development of relevant regional and national progress reports.

Global reporting and access to data will be facilitated by maintaining key global databases, such as the Global Health Observatory, the Global HIV Case Reporting Database and the WHO HIV Country Intelligence Database, a key internal resource maintained and shared jointly by headquarters, regional and country offices. WHO also contributes to major global reports on HIV, such as those produced by UNAIDS and UNICEF.

Main activities and products

- Monitoring and reporting on implementation of the GHSS 2011–2015 and development of the GHSS 2016–2020.
- Publication of WHO progress reports and contributions to other global reports (UNAIDS global report, United Nations MDG reports, UNICEF Stocktaking Reports) and regional reports.

- Comanagement of the Global AIDS Response Progress Reporting (GARPR) process.
- Updating of relevant HIV databases (including Global Health Observatory, Global HIV Case Reporting Database).
- Maintenance of WHO HIV Country Intelligence Database, including tracking implementation of 2013 ARV guidelines.
- Development of regional systems for monitoring global indicators and implementation of regional strategies

Consolidated strategic information guidelines

In recent years, WHO and its partners have published a wide range of guidelines, tools and indicators for the generation of strategic information for the health sector response to HIV. A major priority for this biennium will be to update, consolidate and simplify all existing M&E guidance on strategic information for the health sector response to HIV, including understanding needs, tracking inputs, measuring treatment and prevention services, and documenting impact. The guidelines will also outline core processes and mechanisms to generate, communicate and use strategic information on the health sector response and strengthen overall information systems, with a strong focus on linking strategic information more effectively to programme planning and evaluation. The consolidated guidelines will help countries to align and streamline HIV and related M&E activities and indicators across the health sector.

Main activities and products

- Development of consolidated guidelines on strategic information for the HIV health sector response.
- Regional and country capacity-building and implementation support for consolidated guidance on strategic information for the HIV health sector response.
- Updating of HIV surveillance package (HIV incidence measurement, Integrated Biological and Behavioural Surveillance (IBBS) update, ANC/PMTCT surveillance transition guidance).

Technical support for national strategy development

A more systematic approach to linking strategic information to HIV programmes will also form the basis for work in this biennium to support national processes at country level, such as epidemiological analysis, strategy development, programme reviews, and programmatic and financial gap analysis. This includes the roll out of the *Guide to conducting programme reviews for the health sector response to HIV/AIDS*, developed by WHO in 2013. National programme reviews are increasingly important to assess the results and impact of programmes in relation to the priorities defined in national strategic and operational plans. In this biennium, WHO will focus particularly on assisting countries to undertake these reviews within the context of the country programme cycle, including for those countries that do so in the context of implementing the new funding model of the Global Fund.

'Knowing your epidemic' is also critical to planning and implementing HIV programming at the country level. However, significant gaps in data persist in many countries, notably with regard to the size of affected key populations in both concentrated and generalized epidemic settings. Assistance provided by WHO for national planning processes will therefore include tools and support to develop more accurate estimates of sub-populations affected by HIV.

Main activities and products

- Regional and country capacity-building for national programme reviews, including support for Global Fund processes.
- Support for countries to generate sub-population estimates and to implement metrics systems for reporting.
- Support for countries to identify technical assistance needs and mobilize resources to strengthen their health information systems.
- Field-testing and implementation of a tool on gender-sensitive monitoring and evaluation of HIV programming.

Box 8. Developing national HIV estimates in Eastern Europe

The HIV epidemic in the WHO European Region is concentrated in socially marginalized populations: people who inject drugs and their sexual partners, men who have sex with men, sex workers, prisoners and migrants. In some eastern European countries, including the Russian Federation, data for an accurate description of epidemiological trends and key population sizes are often insufficient to produce useful national HIV estimates using the Spectrum/Estimation and Projection Package (EPP) models recommended by WHO/UNAIDS. These models use data sources such as HIV prevalence studies in key populations, combined with population size estimates and ART and PMTCT programme data. Some eastern European countries struggle to use these models because their national systems have limited sentinel surveillance in key populations, resources and institutional capacity. The WHO Regional Office for Europe is providing support to help countries overcome these challenges.

HIV drug resistance and toxicity monitoring

In 2012, WHO published the first global report on HIV drug resistance (HIVDR). A second report will be published in 2014–2015. WHO will also continue its work through the HIV ResNet to strengthen HIVDR surveillance and monitoring systems at the country level, which are essential to ensuring the most effective, rational and sustainable use of ARVs.

The 2013 WHO ARV guidelines will result in increased and prolonged exposure to ART for people living with HIV. Although WHO has determined that the risk of harm from recommended ARV regimens is small, most toxicity studies tend to have limited sample size and to have been conducted in industrialized countries. The guidelines also highlight evidence gaps and concerns about potential drug toxicities. Accordingly, WHO recommends that countries implement toxicity surveillance within HIV programmes to assess the frequency and clinical relevance of specific types of toxicities associated with the short- and long-term use of ARVs, increase confidence in their use, identify populations with risk factors and plan preventive strategies. Building upon the WHO guidelines and technical briefs, notably with regard to surveillance of ARV toxicity in pregnant and breastfeeding women, the HIV Programme will develop further normative guidance and assist countries to implement toxicity surveillance at sentinel sites in 2014–2015.

Main activities and products

- Global reporting, data management and analysis of HIVDR.
- Strengthening management and expansion of WHO Global HIVDR Genotyping and Laboratory Network (HIV ResNet).
- Regional and national capacity-building for integration and implementation of HIVDR prevention and surveillance activities in national routine surveillance and M&E programmes.
- Normative guidance on ARV toxicity surveillance as part of M&E in HIV programmes, with capacity-building and support for toxicity surveillance for pregnant and breastfeeding women for PMTCT Option B+ and children at sentinel sites.

ARV market reporting and analysis

WHO will continue its work with partners to collect and disseminate data on the global ARV marketplace, through the Global Price Reporting Mechanism and other databases, and to undertake demand forecasting and related surveys. Data collected through these mechanisms provide important information to countries on the cost of ARVs, their ingredients, as well as diagnostics. In 2014–2015, more attention will be given to publishing and disseminating analyses of these data, in order to inform global procurement efforts and to guide national and international procurement decision-making. WHO will also continue to work with countries and partners to prevent drug stock-outs and participate in international efforts to ensure supply security for ARV programmes and prevent drug theft.

Main activities and products

- ARV marketplace surveillance (Global Price Reporting Mechanism, Drug Regulatory Database, Active Pharmaceutical Ingredients (API) Database, Opioid database).
- Annual surveys and reports on the use of ARVs and HIV-related diagnostics.
- Annual update of a procurement guide for HIV laboratory commodities.
- Dissemination of *Manual for procurement of diagnostics and related laboratory items and equipment.*
- Annual update of country HIV commodity procurement profiles.
- Production of ARV global demand forecasts (adults, children and PMTCT).
- Capacity-building and coordination with partners to prevent stock-outs and increase supply security for ARVs and related commodities.

Box 9. Monitoring HIV drug resistance in the Americas

The WHO Regional Office for the Americas/Pan American Health Organization (AMRO/PAHO) has focused recent technical cooperation on HIV drug resistance on the consolidation of early warning indicators into national M&E plans and information systems. Monitoring pre-treatment resistance and surveillance of acquired resistance, including viral load suppression, have been identified as regional priorities. An HIVDR Technical Cooperation Network coordinated by AMRO/PAHO, established to support HIVDR surveillance implementation, includes experts from national programmes, reference laboratories, universities, network-accredited laboratories and WHO collaborating centres. In 2014–2015, AMRO/PAHO will extend HIVDR surveillance training to the Caribbean, and support the implementation of harmonized pre-treatment and acquired resistance surveillance in at least 10 countries. The Regional Office will help to coordinate technical and financial support for this work among HIVDR network partners. Capacity-building for HIV genotyping at national level and use of programmatic data (genotyping results for acquired resistance and viral load suppression) will also be supported to help ensure the long-term sustainability of HIVDR surveillance in the region.

Validation of dual elimination of HIV and congenital syphilis

In 2014–2015, the process of assessing and validating whether a county has successfully eliminated mother-to-child HIV transmission will be further consolidated. This activity will continue to be closely linked to the validation process for the elimination of congenital syphilis, as they share a number of common characteristics such as similar control interventions. Countries may choose to validate only one disease (EMTCT of HIV, EMTCT of syphilis) or both.

Main activity and product

- Provide the secretariat of the global process for validating the elimination of mother-to-child transmission of HIV and congenital syphilis, with regional and country capacity-building and implementation support.

Box 10. Dual elimination of mother-to-child HIV transmission and congenital syphilis in the Americas

In 2014–2015, the WHO Regional Office for the Americas/ Pan American Health Organization (AMRO/PAHO) will continue its work to implement the *Strategy and plan of action for the elimination of mother-to-child transmission of HIV and congenital syphilis* adopted by the Regional Committee in 2010. AMRO/PAHO has developed and disseminated various tools to support its implementation, including an M&E framework, a regional reporting system, a field guide and a methodology to validate achievement of the elimination targets, based on headquarters guidance. An evaluation undertaken in 2013 showed significant progress in its implementation, with five countries achieving targets for reducing vertical transmission of HIV and fourteen for congenital syphilis.

OPERATIONAL OBJECTIVE 6: STRONGER LINKS BETWEEN HIV AND RELATED HEALTH OUTCOMES

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HIV is closely linked to a wide range of other health conditions, including communicable diseases such as TB, viral hepatitis and STIs. People living with HIV are also at increased risk of developing a range of NCDs such as hypertension, cardiovascular disease, some types of cancer and – as a result of living longer due to effective ART – diseases associated with ageing. Other health conditions that affect people with HIV are mental health disorders, tobacco, alcohol and drug dependence, and a range of neglected tropical diseases (NTDs). Addressing these coinfections, comorbidities and other health challenges is essential to improving overall health outcomes for people living with HIV. WHO work under this objective will help countries to manage the clinical and health systems challenges of this wide range of conditions, and to take advantage of opportunities to strengthen non-HIV outcomes through the HIV response.

Comorbidities and noncommunicable diseases

In 2014–2015, efforts will be undertaken across the HIV Programme to link clinical and operational HIV guidance more closely to existing WHO recommendations for coinfections and comorbidities. These efforts will focus on normative work on the management of NCDs and HIV and the role of nutrition, integrated service delivery models and operational guidance. Relevant strategic information will be produced, such as new estimates of the burden of HIV and NCDs. Technical updates on adult and paediatric opportunistic infections, and HIV and mental health, will also be developed.

Main activities and products

- Technical updates on the management of adult, adolescent and paediatric opportunistic infections.
- Normative guidance on management of NCDs and HIV, and long-term complications of ART among adults, adolescents and children.
- Integrated service delivery models and operational guidance for HIV and NCDs.
- Estimates of the burden of HIV and NCDs and ageing through systematic reviews.
- Technical and programmatic updates on HIV and mental health.
- Completion of normative work on management of nutrition in HIV-infected adults and adolescents.
- Guidelines on sexual and reproductive health for women living with HIV.
- Guidance to mitigate violence against women in the context of HIV.

HIV in the context of chronic and primary care

Compared with the acute care model common in many countries, planned chronic and primary care models provide more opportunities for prevention, early identification, timely intervention and community-based support. Chronic care requires integrating and linking related services to ensure comprehensive and consistent patient management over time, including providing these services in single settings, systems to share information and effective referrals across settings and providers. At the global policy level, a key focus of WHO work in 2014–2015 will therefore involve assessing opportunities to provide HIV-related services and services for other chronic conditions as part of primary health care, within the context of universal health coverage.

Main product

- White paper on contribution of HIV response to non-HIV outcomes in the context of universal health coverage and chronic and primary care.

HIV and tuberculosis

TB is a leading, preventable cause of death among people living with HIV and will remain a high priority for the WHO HIV Programme in 2014–2015. The 2013 WHO consolidated ARV guidelines recommend that ART is initiated in all individuals with HIV and active TB disease, that in settings with a high burden of HIV and TB, ART is initiated in TB treatment settings, and that TB treatment is provided in HIV care settings where a TB diagnosis has also been made. In 2012, WHO updated its policy and guidelines on collaborative HIV/TB activities, strongly reaffirming the need for HIV and TB control programmes and their partners to work together to provide access to integrated services. Such integrated services should preferably be available at the same time and location for prevention, diagnosis, treatment and care of both conditions. The Global Fund has proposed that countries with a high burden of both diseases be required to submit integrated HIV/TB proposals. Together with the WHO Global TB Programme, the HIV Programme will develop technical guidance and support countries to ensure more effective collaboration and integrated programming for HIV/TB, including joint HIV and TB programme reviews and improved TB case-finding among people living with HIV.

Main activities and products

- Technical assistance to countries for increased TB/HIV collaboration, including updates of data on intensified TB case-finding in children and adolescents, smear-negative TB guidelines, isoniazid preventive therapy (IPT) guidelines for people living with HIV, TB infection control guidelines and impact measurement of TB infection control activities.
- Review of the TB/HIV cascade of care, including the role of the Xpert MTB-Rif (*Mycobacterium tuberculosis* rifampicin) diagnostic test in improved TB case-finding.
- Technical support for regions and countries to conduct programme reviews and develop joint TB/HIV Global Fund concept notes.
- Operational guidance to improve the quality of TB/HIV services and to scale up activities in countries with low and concentrated HIV epidemics.
- Coordination, advocacy and support for global TB/HIV partnerships.

Box 11. Fighting the dual epidemics of HIV and TB in Africa

The WHO African Region has a high burden of HIV/TB, and many countries in the region are far from attaining targets to test all HIV patients for TB. Coverage rates of isoniazid preventive therapy among eligible people living with HIV are particularly low. The WHO Regional Office for Africa has provided support to ensure more effective collaboration and integrated programming for HIV/TB among countries, including the improvement of TB case-finding and joint programme reviews. In 2014–2015, AFRO will further assist countries to integrate HIV interventions and services, including ART, into related health programmes such as TB, maternal, child and infant health care, adolescent and reproductive health, and STI control. The Regional Office will also support countries to scale up new technologies such as Xpert MTB/RIF and point-of-care CD4 testing, and will support countries to submit joint HIV/TB proposals to the Global Fund.

HIV and viral hepatitis

The HIV Programme will increase its focus on viral hepatitis and HIV coinfection in 2014–2015. HIV coinfection profoundly affects almost every aspect of the natural history of HBV infection, and liver disease has emerged as a leading cause of death in people coinfected with HIV and HBV. At the same time, the first-line ART regimen recommended by WHO has a significant impact on HBV, and WHO now recommends initiating ART in all people coinfected with HIV and HBV with evidence of severe chronic liver disease, regardless of CD4 count. Coinfection with HIV and hepatitis C (HCV), which is particularly common among injecting drug users, accelerates HCV-related progression of liver fibrosis and leads to a higher rate of end-stage liver disease and mortality. Recognizing these important links, WHO will work to strengthen collaboration between HIV and hepatitis programmes at headquarters and between headquarters and regions. New normative work in this area will include the generation of estimates of HIV and viral hepatitis coinfection, and new clinical guidance on the management of HIV and HBV/HCV coinfection, including screening, treatment, care and key issues related to drug interactions, notably in the case of ARVs and HCV drugs. Hepatitis will also be addressed in the consolidated guidance for key populations.

Main activities and products

- Convening of partners to develop a clinical and operational research agenda for HIV/hepatitis coinfection and integrated service delivery.
- Guidance on management of HIV/HBV and HIV/HCV coinfection, including screening and testing.
- Prequalification of diagnostics for HCV and HBV.
- New estimates of HIV/HBV and HIV/HCV burden.
- Regional strategic plans for viral hepatitis prevention and treatment.

Box 12. Realizing the WHO commitment to viral hepatitis

Viral hepatitis is a largely neglected epidemic. In the WHO European Region, for example, an estimated 13 million people live with chronic hepatitis B infection, and an estimated 15 million people are infected with hepatitis C, most of whom are unaware that they are infected. Because the disease is often left untreated, chronic hepatitis is a major cause of liver cirrhosis and primary liver cancer. HBV and HCV are responsible for about 36 000 and 85 000 deaths per year in the Region, respectively.[17] With increasing availability of effective treatment for HIV, chronic and untreated viral hepatitis is becoming a more predominant cause of death than HIV among people living with HIV/hepatitis coinfection.

In 2010, the World Health Assembly recognized the health burden caused by viral hepatitis and adopted a resolution that called for WHO to develop a comprehensive approach to prevent and control these diseases. Since then, HCV treatment guidelines have been developed to complement earlier guidance on preventing the transmission of bloodborne viruses. The new guidelines provide a framework for governments and health care providers to institute screening, care and treatment for those infected with HCV in resource-limited settings, including people who inject drugs. In 2014–2015, several WHO regional offices, including those for the European, Eastern Mediterranean and Western Pacific regions, are supporting activities related to viral hepatitis advocacy, partnership and communication, including the roll-out of hepatitis treatment guidance and the development of regional action plans in support of the World Health Assembly resolution.

Blood supplies and safety

The risk of HIV and hepatitis transmission through unsafe transfusions will persist in many low- and middle-income countries without adequate investment in blood screening services, injection and surgical safety and other occupational health measures. Longstanding WHO work in the area of blood safety will therefore continue in this biennium.

17 Hope VD, Eramova I, Capurro D & Donoghoe MC (2013). Prevalence and estimation of hepatitis B and C infections in the WHO European Region: a review of data focusing on the countries outside the European Union and the European Free Trade Association. Epidemiology and Infection doi:10.1017/S0950268813000940.

Main activities and products

- A global status report on blood safety and self-sufficiency published in 2015.
- Operational research on burden of disease due to transfusion-transmissible infections.
- Models and tools for estimating blood and blood product needs.
- Technical guidelines, tools and support for implementation of national haemovigilance systems, external quality assessment of testing for transfusion-transmissible infections in blood transfusion services, blood management and good clinical transfusion practice.
- Guidance on strategic information systems for blood transfusion services.
- Implementation support for blood donor selection and donor counselling, based on WHO guidelines.

Box 13. The continuing challenge of blood supply and safety

The median blood donation rate in high-income countries is around 39 donations/1000 population, compared to around 13/1000 in middle-income countries and just 4/1000 in low-income countries. Seventy countries remained dependent on family/replacement and paid blood donors for more than half of their blood supplies in 2011. HIV prevalence in blood donations was 0.1% and 0.6% in low- and middle-income countries respectively, compared to 0.003% in high-income countries.[18]

In the 46 countries in the African Region, only 45% of blood requirements are being met. Shortages of voluntary non-remunerated donors, low donation rates, irregular supply and stock-outs of test kits for transfusion-transmissible infections are common challenges. Improved logistics and supply management systems are needed to minimize these gaps. WHO is providing advice, technical support and tools to countries to strengthen blood transfusion services, improve the quality and coverage of blood screening, design and implement innovative strategies for recruitment and retention of voluntary non-remunerated donors, and establish systems for blood donor counselling.

18 Blood safety and availability (Fact sheet N° 279). Geneva: World Health Organization; 2013.

PART 3: MONITORING PROGRESS

While the HIV Programme will contribute to the achievement of global targets, progress in 2014–2015 cannot be wholly attributed to WHO. Higher-level global targets for outcomes and impact are dependent on the actions of a large number of actors such as national governments, multilateral organizations and civil society. Many indicators have been included in planning for the achievement of the MDGs, United Nations commitments, and in the UNAIDS *Unified budget, results and accountability framework*. Similarly, WHO has included in its *Programme budget* a number of indicators for 2014–2015. These are primarily output and outcome level indicators, and beyond the scope of this plan.

A different set of process indicators will be required to measure the operational implementation of the HIV Programme in 2014–2015. Such indicators must measure the results of the activities carried out rather than the higher-level outputs and outcomes that are measured elsewhere. Normally these results are distinct products (e.g. guidance documents) or services (e.g. technical support to countries) produced or delivered by the HIV Programme.

A monitoring framework for this plan appears in Annex 2. It contains a set of 10 process indicators with targets to be achieved by the end of 2015. These indicators are linked to actions that the WHO HIV Programme will take in support of reaching strategic level targets and commitments.

Qualitative and quantitative data on the indicators will be collected over the course of the biennium and used to report on progress early in 2016.

WHO/Gary Hampton

PART 4: RESOURCE REQUIREMENTS

4.1 OPERATIONAL BUDGET

The 2014–2015 budget for the WHO HIV Programme is US$ 131.5 million.[19] The distribution of this budget reflects the relative importance of the six operational objectives (Table 1 and Figure 8). The flagship objective (Strategic use of ARVs) will receive the largest share of the budget.

'Strategic information for effective scale up' also receives a large proportion of the budget due to the central role of the HIV Programme in providing strategic information and the wide range of data collected and disseminated. Significant allocations will also be made to the other four operational objective areas.

The distribution of the budget at global, regional and country levels is shown in Table 2 and Figure 9. This distribution is consistent with recent efforts in WHO to shift resources to countries and regions. Less than one third of the total HIV Programme budget is allocated at the headquarters level.

Table 1. Distribution of HIV Programme budget 2014–2015, by operational objective

Operational objective	Budget (US$)
1. Strategic use of ARVs	57 860 000
2. Eliminating HIV in children and expanding access to paediatric ART	15 780 000
3. An improved health sector response to HIV among key populations	14 465 000
4. Further innovation in HIV prevention, treatment and care	10 520 000
5. Strategic information for effective scale up	21 040 000
6. Stronger links between HIV and related health outcomes	11 835 000
Total	**131 500 000**

Table 2. Distribution of HIV Programme budget 2014–2015, by organizational level

Level	Budget (US$)
Global	41 900 000
Regional	31 300 000
Country	58 300 000
Total	**131 500 000**

Figure 8. HIV Programme budget 2014–2015, by operational objective

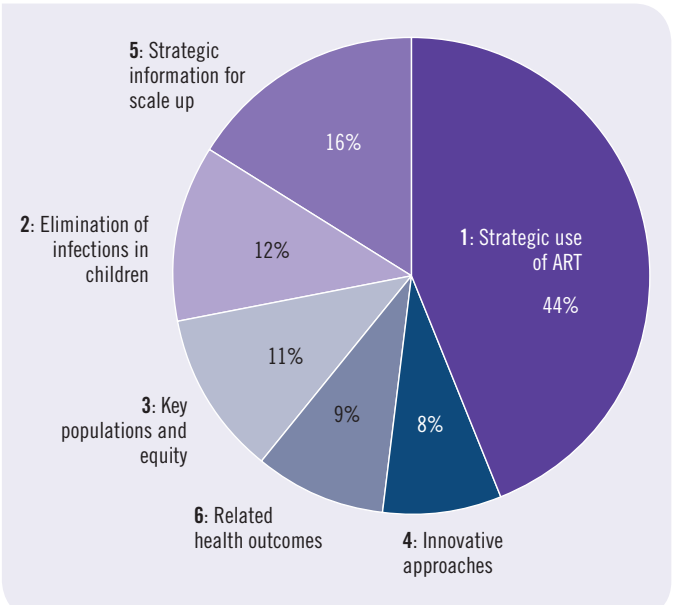
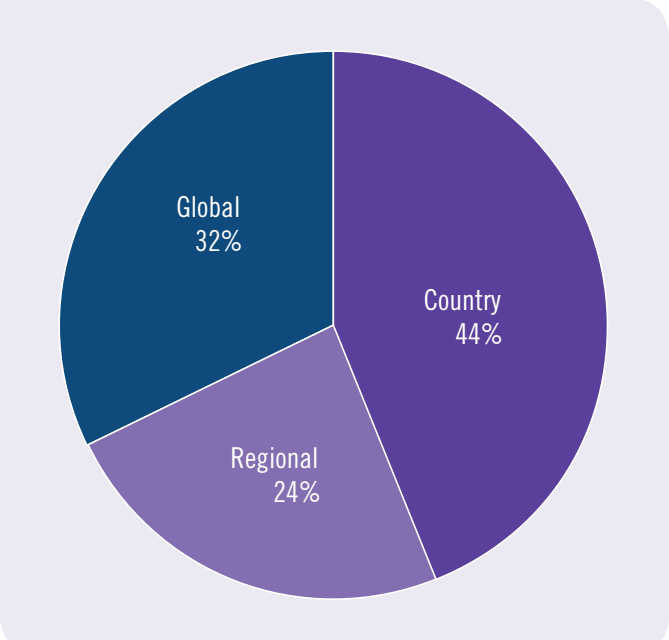


Figure 9. Budget by organizational level



19 This is the budget ceiling established for the HIV Programme in the WHO *Programme budget 2014–2015*. It does not include direct or indirect contributions to the AIDS response made through other programme areas, nor does it reflect possible increases in the budget ceiling.

The regional and country budgets are distributed according to the burden of disease, the number of focus countries in each region, and competing regional priorities (Table 3 and Figure 10). The African Region receives the largest proportion of the regional HIV budget (51%) due to its high disease burden, the relatively large number of focus countries and its limited capacity to respond to the HIV epidemic.

4.2 HUMAN RESOURCES

It is estimated that over 180 professional staff will be required to fully implement the HIV Programme plan in 2014–2015 (Table 4). The distribution of staff reflects the WHO commitment to provide support at the implementation level, with around 82% of staff located at regional and country levels.

Table 3. Distribution of HIV Programme budget 2014–2015, by region

WHO region	Budget (US$)
African Region	45 900 000
Region of the Americas	4 000 000
South-East Asia Region	14 200 000
Eastern Mediterranean Region	9 600 000
European Region	5 800 000
Western Pacific Region	10 100 000
Total	**89 600 000**

Figure 10. Distribution of HIV Programme budget 2014–2015, by region

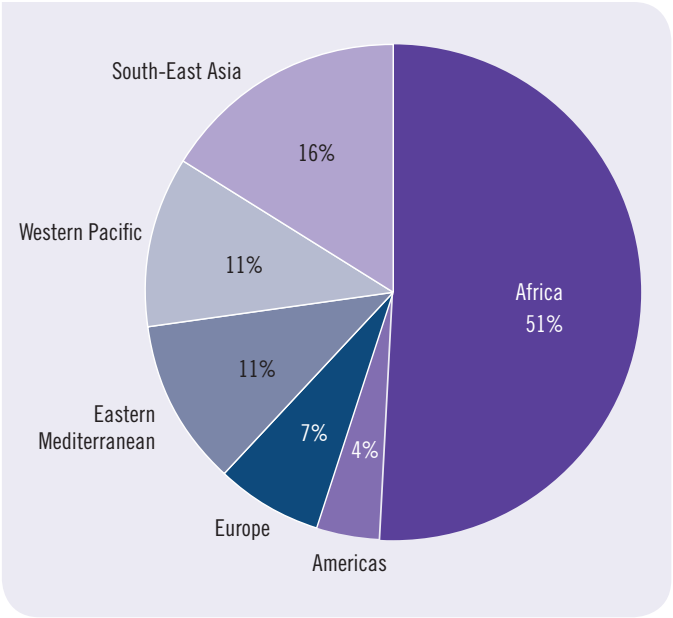


Table 4. Projected human resource requirements

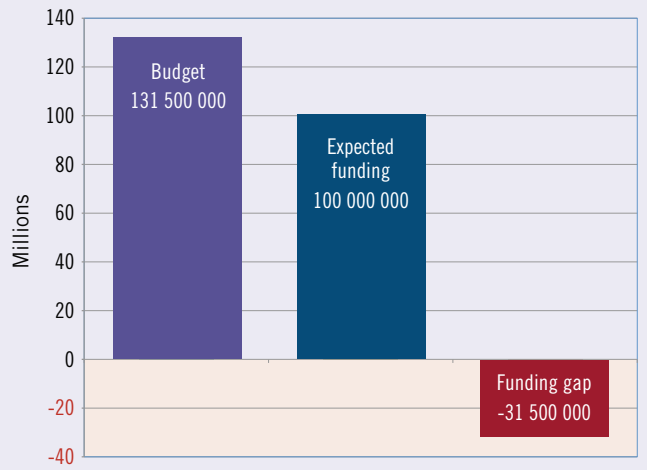
Organizational level	International staff	National staff	Total
Headquarters	34	0	34
African Region	23	38	61
Americas Region	27	0	27
South-East Asia Region	9	10	19
Eastern Mediterranean Region	6	9	15
European Region	4	11	15
Western Pacific Region	8	7	15
Total	**111**	**75**	**186**

4.3 ANTICIPATED FUNDING

In 2012–2013, the HIV Programme raised an estimated US$ 100 million.[20] The programme is heavily dependent on the generosity of five major donors: the United States of America, UNAIDS, the Bill & Melinda Gates Foundation, the Government of Canada, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Figure 11). Other important contributions have been received from the Children's Investment Fund Foundation (CIFF), the OPEC Fund for International Development (OFID), the University of South Carolina, the ZeShan Foundation, Australia, France, Germany (GIZ) and Japan. Contributions have also been received in earlier biennia from the Drosos Foundation and the governments of Austria, Brazil, Italy, Luxembourg, Spain and the United Kingdom.

20 Net of programme support costs.

Figure 11. Estimated unmet needs for WHO HIV Programme 2014–2015 (US$)



4.4 UNMET RESOURCE NEEDS

The HIV Programme currently expects to be short of the funding required to implement the 2014–2015 plan by slightly more than US$ 30 million (Figure 11). The African Region will be particularly affected, since this is where WHO efforts in the strategic use of ARVs need to be particularly focused.

Much of the funding received by the HIV Programme is earmarked for specific activities, which limits reallocation of resources to where they are most needed. Additional funding is especially required for the following areas:

- Strategic use of ARVs in Africa.
- Innovation in the development of drugs and diagnostics, service delivery and research.
- Development and implementation of consolidated guidelines on strategic information and key populations.
- HIV and hepatitis coinfection.
- Development of the 2016–2020 Global health sector strategy and national health sector plans.

ANNEX 1. FOCUS COUNTRIES

Country	Region*
Angola†	AFR
Bolivia	AMR
Botswana†	AFR
Brazil	AMR
Burundi†	AFR
Cambodia	WPR
Cameroon†	AFR
Central African Republic	AFR
Chad†	AFR
China	WPR
Cote d'Ivoire†	AFR
Democratic Republic of the Congo†	AFR
Djibouti	EMR
Dominican Republic	AMR
Ecuador	AMR
El Salvador	AMR
Ethiopia†	AFR
Ghana†	AFR
Guatemala	AMR
Haiti	AMR
Honduras	AMR
India†	SEAR
Indonesia	SEAR
Iran	EMR
Jamaica	AMR
Kazakhstan	EUR
Kenya†	AFR
Kyrgyzstan	EUR
Lesotho†	AFR
Libya	EMR
Malawi†	AFR
Morocco	EMR

Country	Region*
Mozambique†	AFR
Myanmar	SEAR
Namibia†	AFR
Nepal	SEAR
Nigeria†	AFR
Pakistan	EMR
Papua New Guinea	WPR
Paraguay	AMR
Philippines	WPR
Russia	EUR
Rwanda	AFR
Somalia	EMR
South Africa†	AFR
South Sudan	AFR
Sudan	EMR
Swaziland†	AFR
Tajikistan	EUR
United Republic of Tanzania†	AFR
Thailand	SEAR
Turkmenistan	EUR
Uganda†	AFR
Ukraine	EUR
Uzbekistan	EUR
Viet Nam	WPR
Yemen	EMR
Zambia†	AFR
Zimbabwe†	AFR

* (AFR: WHO African Region; AMR: WHO Region of the Americas; SEAR: WHO South-East Asia Region; EMR: WHO Eastern Mediterranean Region; EUR: WHO European Region; WPR: WHO Western Pacific Region).

† EMTCT Global Plan countries

ANNEX 2. MONITORING FRAMEWORK (2014–2015)

No.	Indicator	Target
1	Number of consolidated technical guidance documents produced or updated in 2014–2015	3
2	Number of focus countries supported by WHO in 2014–2015 to implement updated recommendations on treatment initiation in non-pregnant adults, consistent with 2013 consolidated ARV guidelines	59
3	Number of new HIV drugs and diagnostic products prequalified by WHO in 2014–2015	37[21]
4	Number of focus countries supported by WHO in 2014–2015 to complete the transition to Option B/B+ for pregnant women living with HIV, consistent with 2013 consolidated ARV guidelines	50
5	Number of focus countries receiving WHO technical support in 2014–2015 to adapt/implement the new consolidated guidance on key populations	12
6	Number of focus countries supported by WHO in 2014–2015 to implement/expand access to VMMC	13
7	Number of global/regional progress reports on health sector response to HIV produced by WHO in 2014–2015	7
8	Number of focus countries supported by WHO in 2014–2015 to introduce/complete validation of dual elimination of mother-to-child transmission of HIV and congenital syphilis	10
9	Number of focus countries supported by WHO in 2014–2015 to submit joint TB/HIV concept notes to the Global Fund	15
10	Number of WHO technical or strategic meetings conducted in 2014–2015 with the active participation of civil society	25

21 This will include 25 HIV medicines and 12 diagnostics products.

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