GETTING ON TRACK IN AGENDA 2030

HIV IN VOLUNTARY NATIONAL REVIEWS OF SUSTAINABLE DEVELOPMENT IMPLEMENTATION

March 2018

MSM GF

FREE SPACE PROCESS

THE GLOBAL ADVOCACY PLATFORM TO FAST TRACK THE HIV AND HUMAN RIGHTS RESPONSES WITH GAY AND BISEXUAL MEN

Publication designed by Greg Tartaglione, Sr. Communications Officer at MSMGF

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EXECUTIVE SUMMARY

This report examines the inclusion of HIV-related data in Voluntary National Reviews (VNR) of Sustainable Development Goal (SDG) implementation. The 17 SDGs and accompanying 169 Targets in Agenda 2030 include a commitment to end the epidemic of AIDS by 2030 and an agreed upon indicator to monitor number of new HIV infections per 1,000 uninfected population by sex, age, and key population—gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people. 2017 marked the second year of SDG reporting in the VNRs, and the first time that Goal 3 on Health and the Target to end AIDS was reviewed. However, among the 43 VNR reports submitted by Member States in 2017, only 32 VNR reports include any mention of HIV. HIV is inconsistently and unevenly reported on across the VNR reports, and only nine VNR reports referred to HIV among key populations.

Based on interviews with eight activists that participated in national consultations in six different countries, this report finds that civil society was most successful in influencing the content of official VNR reports when acting in coalition and partnership across sectors. Furthermore, bringing national advocacy priorities substantiated with data in the form of shadow reports was useful to cultivate relationships with government officials and influence the content of official VNR reports. In some contexts, spotlight reports or other civil society accountability tools were used to supplement official VNR reports.

There remains unfinished business in the global HIV response, including persistent health disparities, stigma, and discrimination. HIV continues to severely impede the ability of countries to achieve development priorities beyond health, and continued visibility and integration of HIV within mainstream development goals has never been more important. The Agenda 2030 framework provides new opportunities to take HIV out of isolation and strengthen linkages between HIV and education, employment, and gender equality, among other priorities. The HLPF and VNRs are a useful entry point for civil society, UNAIDS, and governments to reinvigorate the global fight to end the epidemic, but this will require data, consultation with communities, and contextualizing HIV within the Agenda 2030 framework.

Realizing the SDGs and fulfilling the principle of "leaving no one behind" will require more effort to include HIV-related data and reporting on national HIV priorities and programming. The report concludes with recommendations to Member States, UN agencies, and civil society.

RECOMMENDATIONS FOR MEMBER STATES

Member States should:

1. Consult with a wide range of stakeholders to prepare their VNR reports, as recommended in paragraphs 78 and 79 of the 2030 Agenda. National consultation processes should be inclusive and transparent, and particularly seek inputs from HIV organizations, activists and advocates, including members of key populations.

2. In accordance with agreed-upon Indicator 3.3.1, include HIV incidence data disaggregated by sex, age, and key populations, including gay men and other men who have sex with men, sex workers, people who inject drugs, and transgender people. To the best extent possible, disaggregate incidence by sexual orientation, gender identity, and gender expression while respecting the confidentiality of individuals during the data collection and disaggregation process.

3. Include HIV treatment coverage data disaggregated by key population, sexual orientation, and gender identity.

4. Include and disaggregate data on stigma and discrimination as experienced by people living with and affected by HIV.

5. Include data on HIV mortality and co-infections disaggregated by sex, age, and key populations.

6. Coordinate with UNAIDS offices to include UNAIDS data in VNR reporting.

7. Build the capacity of civil society organizations and community representatives to actively participate in the national consultation process for VNR reporting.

8. Relying on the above data, clearly articulate the national strategy for addressing HIV in the context of Agenda 2030 and "leave no one behind," with a focus on groups that are disproportionately impacted by HIV.

RECOMMENDATIONS FOR UNAIDS

UNAIDS country offices should:

1. Coordinate with the relevant agencies and other ministries and stakeholders preparing VNR reports to encourage the inclusion of data about HIV, including key populations.
2. Advocate for HIV organizations, especially key population-led organizations, to participate in national consultations on VNR data gathering.
3. Support HIV civil society organizations to generate and collect the most up to date data to reflect the national reality of HIV in country.
4. Step up efforts together with other relevant stakeholders to provide training and capacity building for civil society and communities to participate in national consultations for VNR reporting.
5. Offer technical support to Health Ministries to collect data for Indicator 3.3.1 (HIV incidence data by key population).
6. Align efforts with key population guidelines and tools developed by other UN technical agencies, including the WHO.

UNAIDS Geneva and NYC offices should:

7. Support meaningful participation of HIV activists and community voices in side events and plenary sessions at the HLPF, as well as facilitate HIV activists and communities to offer input to the Outcome Documents of the HLPF.
8. Continue to integrate the work of UNAIDS into the realization of Agenda 2030, and particularly support the collection and inclusion of HIV related data in VNR reporting.
9. Coordinate to adequately prepare, inform, and educate mission staff in the lead up to, during, and following the HLPF.

RECOMMENDATIONS FOR HIV ADVOCATES AND ACTIVISTS

Organizations of every size and scope can influence Member States to include more information about HIV in VNR reporting.

National and Sub-National Civil Society Organizations should:

- Identify which organizations in your country are already addressing the SDGs, even if they are not your typical colleagues and allies. Start working within these existing networks to bring HIV organizations and issues to the table.

- Familiarize yourself with Agenda 2030, and in particular Goals that overlap with your current initiatives and work, including but not limited to Goal 3 (Health), Goal 4 (Education), Goal 5 (Gender Equality), Goal 10 (Ending Inequalities), Goal 16 (Peace, Justice, and Strong Institutions), and Goal 17 (Partnerships for the goals).

- Communicate with government ministries, HIV and AIDS bureaus, and other common partners in the government about the opportunities detailed in this report with regard to Agenda 2030 and HIV.

- Communicate with UNAIDS and its UN agency co-sponsors working on HIV about the necessity to participate actively in the SDGs and collect robust data on HIV.

If your country is participating in VNR reporting in 2018:

- Identify and contact the country focal point on UN DESA's website to understand where in the national consultation process your country is.

- Ascertain if a coalition or network organization in your country is already coordinating a civil society response to the VNR consultation process. If such an organization or network does not exist, create one with other organizations, not only health organizations but all organizations working on the SDGs.

- Find similarities and commonalities with other civil society organizations working on the SDGs, and advocate as a united front for inclusion of key issues in the VNR report.

- Contact government ministries, HIV and AIDS bureaus, PEPFAR, Global Fund, and UNAIDS to obtain the most recent data on HIV in your country, particularly incidence data disaggregated by age, gender, and key population.

- Advocate for the inclusion of HIV activists, advocates, and community representatives, especially members of key populations, in consultations to prepare the VNR report. Share best practices in national consultations outlined in this paper, such as collaborating with line ministries to draft content of the VNR report, allowing for civil society to write a section of the VNR report, or including an annex with civil society contributions.

- Identify who at your country's Permanent Mission to the UN in New York is responsible for the VNR report, and who is responsible for the negotiations of the Ministerial Declaration. Ensure that these individuals are provided with accurate, up-to-date information regarding HIV and that your national advocacy priorities are heard in the VNR report formulation and during the Ministerial Declaration negotiations.

If you are considering producing a parallel report to accompany the official VNR

A shadow report, spotlight report, or status report is a useful tool if the national consultation process for the official VNR report lacks transparency or fails to yield desired results. Parallel reports can include supplemental data and highlight the role of civil society in implementing Agenda 2030. A parallel report may be more successful when undertaken with a coalition working on a range of issues covered by the SDGs. Define your focus and use that to determine your questions and methods.

For shadow reporting, the Women's Major Group (a consortium of civil society organizations following the SDGs at the UN and described in more detail in section 4 of this report) suggests considering the policy framework under review in country, its implementation, data availability and use, and assessing outcomes and impact.

Regarding policy:
Consider including an analysis of the gaps in government programming and coverage, as well as funding commitments. Are key populations included? Additionally, it is important to highlight what is working well in your country; it creates goodwill with your government and can also serve as an example of best practices for others.

Regarding implementation:
What is the state of policy implementation? Are laws enforced? Which are the most successful examples of implementation? What are the most significant failures or weaknesses in implementation? What is scale and reach of the policies and programs? Where is funding insufficient or not reaching the programs it is supposed to reach? Who is left out? Also, importantly, are there social controls (community, religious, workplace) that limit access for key populations, women and girls, even if policies and programs are in place?

Regarding data:
What data is collected? What gaps in HIV data exist, especially for Indicator 3.3.1? Is the data disaggregated to include key populations? Is this information used to inform programming?

Regarding outcomes:
What outcomes do you see from SDG implementation? How are key populations and PLWHA affected? How are women and girls affected?

If your organization is considering attending a regional meeting

- Identify other civil society organizations that work on SDG implementation, and coordinate before the meeting on shared messaging and advocacy.

- Identify which government ministry will be attending the meeting.

- Organize a side event during the regional meeting, and seek sponsorship from a supportive Member State or UN Agency.

- Meet with supportive Member States during the regional meeting to tell them what you hope to see in the VNRs and SDG implementation going forward. Do not limit your advocacy to your own country, but coordinate beforehand with organizations in Member States you intend to engage. Respect national processes and sensitivities.

If your organization will attend the HLPF

- Identify which Major Group is most appropriate for your organization, and join its mailing list via the website (see section 4 of this report). Major Groups receive and distribute information about the HLPF, and are comprised of advocates working together. A great deal of information is shared online and participation is not limited to organizations that will attend the meetings.

- Organize a side event during the HLPF, and seek sponsorship from a supportive Member State or UN agency.

- Work within your Major Group to draft a statement or ask a question during the interactive panels and multi-stakeholder sessions.

- Advocate to your country's representative at the Permanent Mission to the UN in NYC for inclusive language in the Ministerial Declaration.

If your country is not reporting in 2018

- Cultivate relationships with diplomats at your country's Permanent Mission to the UN in New York, and provide input on the draft Ministerial Declaration.

- Provide input on the thematic review of the SDGs at the HLPF and Ministerial Declaration through Major Groups and international non-governmental organizations based in New York that specialize in UN headquarters negotiations.

- Encourage contacts in your government, especially the Ministry of Foreign Affairs, to participate in the VNR process in 2019, and start advocating for the inclusion of robust, disaggregated data about HIV in VNR reporting.

Global Civil Society Networks and International Non-Governmental Organizations should:

- Relay information and updates from the UN system to country-level partners, and assist smaller organizations navigate the UN system.

- Reach out to local and national organizations working in-country to support them in their efforts to network with other partners on the ground, and introduce them to personnel at relevant agencies and organizations, including at government ministries and in New York.

- Offer assistance to smaller organizations with paperwork and access to UN spaces, particularly if your organization has ECOSOC status.

- Share fundraising opportunities for activities to attend the HLPF.

- Share any and all information, materials and reports, about SDGs and the HLPF process with other organizations.

- Provide a good overview of previous HLPF meetings, and explain what to expect at the HLPF.

- Coordinate preparation for advocacy and the HLPF, including organizing prep calls.

- Provide training and education around HIV in the context of the SDGs, including through webinars and pre-HLPF institutes and conferences.

Other processes

- In March of each year, Member States submit data to UNAIDS through the Global AIDS Monitoring (GAM) in fulfillment of the 2016 Political Declaration on Ending AIDS. GAM represents the most comprehensive and systematic review of HIV in each country, including indicators for the 10 Global Commitments articulated in the 2016 Political Declaration. Guidance and indicators for reporting for GAM have been provided by UNAIDS, and the guidance emphasizes the role of civil society in data collection, including via submitting shadow reports.

The guidance states, "civil society organizations are well positioned to provide quantitative and qualitative information to augment the data collected by governments and to interpret the data collected. National AIDS councils, commissions, committees or their equivalents should seek input from the full spectrum of civil society, including NGOs, networks of people living with HIV, faith-based organizations, women, young people, trade unions and community-based organizations" (page 23).

- Find out if the UN Special Rapporteur (SR) on the Right to Health has scheduled a visit to your country, and what topics of research the SR is pursuing for reports to the Human Rights Council and UN General Assembly. Provide inputs to the SR to ensure that all reporting and recommendations include thorough analysis and data regarding HIV and that Member States are being encouraged to meet their HIV reporting obligations. Identify other Special Rapporteurs whose mandate overlaps with your advocacy priorities, and provide inputs on reports. Refer to factsheets prepared by ILGA-World that describe the ways SRs have previously included and reported on sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) topics.

- The Universal Periodic Review is a mechanism at the UN Human Rights Council to assesses nations' fulfillment of human rights obligations. NGOs can submit information for these reviews. Find out when your country's next review will happen, and use this as an opportunity to describe human rights violations faced by key populations. If possible, work in collaboration with other civil society organizations and coordinate efforts. Link the situation of key populations and HIV to human rights, and request that their issues be addressed and that information about key populations be included in VNR reporting under indicator 3.3.1.

1. INTRODUCTION

The SDGs, HLPF, and the VNR Process

1.1 Sustainable Development Goals and HIV

Agenda 2030 for Sustainable Development was endorsed by the United Nations (UN) General Assembly in September 2015. Building on the Millennium Development Goals (MDGs), the 17 Sustainable Development Goals (SDGs) and 169 accompanying targets take an intersectional approach to development that merges health, education, and other goals with the environmental and climate goals of the Rio Declaration on Environment and Development. The SDGs are also universally applied to all countries, meaning that monitoring will occur for all Member States. Finally, and importantly, the SDGs emphasize a new approach to development that aspires to "leave no one behind."

Goal 6 of the MDGs, Combat HIV/AIDS, Malaria, and Other Diseases, facilitated coordinated action on halting and reversing the spread of HIV. The SDGs integrated HIV into a broader health goal, SDG 3 (Ensure Healthy Lives and Promote Well-Being for All at All Ages), which covers a range of health and development challenges. SDG Target 3.3 states: "By 2030, end the epidemic of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases." The SDGs also go one step further than the MDGs by explicitly mentioning key populations, including gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender people,* in Indicator 3.3.1: "Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations." While still granting a degree of "country control" to define key populations, the inclusion of this terminology in agreed-upon indicators for the SDGs acknowledges the uneven impact of HIV among certain populations and reflects significant developments in the UNAIDS "Fast Track Strategy" for accelerating the HIV response among key populations.

* According to the 2015 UNAIDS Terminology Guidelines, key population groups "often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV." See more at http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf

The Fast Track Strategy aligns with SDG Target 3.3 and highlights access for key populations. Fast Track is based on two sets of targets for 2020 and 2030:

Table 1. Fast Track Targets from UNAIDS (2014)

By 2020	By 2030
90% of all people living with HIV will know their HIV status. 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. 90% of all people receiving antiretroviral therapy will have viral suppression. 500,000 new infections among adults Zero discrimination	95% of all people living with HIV will know their HIV status. 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. 95% of all people receiving antiretroviral therapy will have viral suppression. 200,000 new infections among adults Zero discrimination

If these ambitious treatment targets are realized by 2020, HIV transmission would be reduced by over 70 percent. However, key populations must be included to realize these efforts.

According to the UNAIDS 90-90-90 document, "Experiencing disproportionate risk and vulnerability, key populations warrant a prioritized, rights based response. However, due to the persistence of stigma, discrimination and social exclusion, members of key populations experience inequitable access to care and sub-optimal health outcomes. The 90-90-90 targets cannot be reached without overcoming the many factors that undermine effective responses for key populations."

UNAIDS. 2016. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic, page 11. http://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf

UNAIDS is clear that without reaching the most marginalized, including key populations, the epidemic will not end, and this highlights the critical aspect of leaving no one behind. To achieve 90-90-90, greater investment is needed, both for ART but also for programs to reach key populations and other marginalized groups.

Furthermore, the UNAIDS 2017 report ***Right to Health*** highlights the need to invest in HIV prevention, treatment, care and support, and that access to life-saving medications including ART is included in the right to health. Echoing Fast Track, the Right to Health report emphasizes that costs are not insurmountable if political will can be mustered.

Collecting data about key populations is inhibited by stigmatization, criminalization, and political unwillingness to acknowledge their existence. The lack of data further reinforces the invisibility of KPs. Human rights protections are key to achieving both the SDGs and ending the epidemic, particularly for leaving no one behind. At the same time, accountability within the health targets in Goal 3 are weak because the data collected often misses marginalized people most likely to be left behind.* The people likely to be left behind include the extreme poor, key populations, and other socially marginalized persons. When data used to make decisions about HIV programming are incomplete, the wrong programming decisions will be made. For this reason, HIV data about key populations is urgent.

In addition to Indicator 3.3.1 on HIV incidence, HIV and LGBTI rights activists advocated in *Agenda 2030 for LGBTI Health and Well-Being* for Member States participating in VNR reporting to additionally:

- Disaggregate HIV incidence by sexual orientation, gender identity and expression.
- Collect and disaggregate treatment coverage data by key population, sexual orientation, and gender identity and expression.
- Collect and disaggregate data on stigma and discrimination as experienced by people living with and affected by HIV, including: availability and accessibility of stigma-free health care services.

Only when all the above data is collected and accurately reflected in VNR reports will meaningful solutions to implementing the SDGs be possible. Civil society plays a crucial role in supplying these data to Member States, as well as sensitizing healthcare providers and statisticians to accurately report these data.

* For more resources about human rights and data in the SDGs, see the Human Rights section of References and Resources at the end of this report.

1.2. The High-Level Political Forum on Sustainable Development and the Ministerial Declaration

An important international mechanism for review of progress towards achieving the SDGs set out in Agenda 2030 is the annual High Level Political Forum (HLPF), convened under the auspices of the Economic and Social Council in New York. The HLPF is the central platform for follow-up and review of the SDGs, including both a thematic review of selected SDGs, side events, the adoption of a Ministerial Declaration to reaffirm Agenda 2030, and the Voluntary National Review (VNR) of SDG implementation by Member States, described in the next section.

HLPF Themes

Each year the HLPF discusses a set of SDGs and their interlinkages united by a theme. The thematic review of SDGs facilitates an in-depth review of progress made on all the Goals over the course of a four-year cycle; each annual group of SDGs united under the theme will represent the three dimensions of sustainable development (economic, social, and environmental).

In 2017, the HLPF theme was "Eradicating poverty and promoting prosperity in a changing world," and the following Goals were discussed and reviewed: Goal 1 (End poverty), Goal 2 (End hunger), Goal 3 (Health), Goal 5 (Gender equality), Goal 9 (Sustainable industrialization), and Goal 14 (Ocean conservation). Additionally, Goal 17 (Means of implementation and global partnership for sustainable development) is reviewed each year at the HLPF. Each Goal under review included an expert convening prior to the HLPF, as well as a panel at the HLPF to explore challenges and solutions to successful implementation.

The 2018 HLPF theme is "Transformation towards sustainable and resilient societies," and will include review of Goal 6 (Clean water and sanitation), Goal 7 (Affordable and clean energy), Goal 11 (Sustainable cities and communities), Goal 12 (Responsible consumption and production), and Goal 15 (Ecosystem management and life on land).

The 2019 HLPF theme is "Empowering people and ensuring inclusiveness and equality," and will include review of Goal 4 (Quality education), Goal 8 (Decent work and economic growth), Goal 10 (Reduced inequalities), Goal 13 (Climate action), and Goal 16 (Peace, justice, and strong institutions).

Regardless of the theme and the SDGs under review, nations opting-in to the VNR process are encouraged to report on progress for all 17 SDGs.

Side Events

Side events at the HLPF are an important opportunity to highlight HIV and human rights in the context of Agenda 2030. Space for official side events within the UN Headquarters is limited. Co-sponsorship for a side event with a Member State and/or UN agency will greatly increase the probability of the event being approved. Planning for a side event should begin several months prior to the HLPF, so that Member States and UN agencies can be mobilized and invited to attend.

At the 2017 HLPF, three side events focused on HIV in the SDGs:

- OutRight Action International, RFSL, and MSMGF with sponsorship from UNDP and the Permanent Mission of the Argentine Republic organized "The Importance of Data in Ensuring LGBTI Inclusion in Agenda 2030: The LGBTI Inclusion Index and Recommendations for Reporting on Health and Well-Being Indicators of SDG 3." At this event, RFSL introduced SOGIESC issues in the SDGs, UNDP described the LGBTI Inclusion Index, and MSMGF and OutRight presented a recently released paper about the type of data and indicators Member States should report on to monitor progress on LGBTI health needs.

- The International HIV/AIDS Alliance, Aidsfonds, UNAIDS and International Federation of the Red Cross organized an event sponsored by the Governments of the Netherlands, Denmark, and Luxembourg at the UNICEF office titled, "Community Actors Speak Out: the Role of Community Action in Delivering the SDGs." The event provided a platform for community representatives, in particular from youth-led organizations, from across the world to share their experiences working across the SDGs to leave no one behind and advocate for the rights of the most marginalized. The event provided key recommendations for governments to take forward for the effective implementation of the SDGs.

- The UNAIDS Programming Coordinating Board NGO Delegation organized "Leaving No One Behind in Decision-Making: Setting the example in the SDG Era." The session considered lessons from the AIDS response's principle of leaving no one behind and discussed how to consolidate partnerships that inspire and foster community empowerment and meaningful participation towards achieving the SDGs.

Ministerial Declaration

A Ministerial Declaration has been adopted at the previous two HLPFs. The purpose of the Ministerial Declaration is to reaffirm Member State commitment to Agenda 2030, and comment on the findings, progress and setbacks with regard to the thematic review. The 2016 Ministerial Declaration included people living with HIV/AIDS among people whose needs are reflected in the 2030 Agenda, stating: "We recall that those whose needs are reflected in the 2030 Agenda include all children, adolescents, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons, migrants and peoples living in areas affected by complex humanitarian emergencies, and peoples in areas affected by terrorism and conflict".

In the 2017 Ministerial Declaration, HIV is mentioned twice, first in paragraph 2 in reference to people living with HIV/AIDS as people whose needs must be met, similar to the 2016 Declaration. In paragraph 16 on health, the 2017 Ministerial Declaration states: "We must step up our efforts to promote immunization and combat communicable diseases such as HIV/AIDS and other sexually transmitted infections, tuberculosis, malaria, neglected tropical diseases and hepatitis, where achievements are gravely challenged, inter alia, by antimicrobial resistance."

In 2017, Jamaica and Austria were the co-conveners of the Ministerial Declaration negotiation process, which involved consultation with civil society and several rounds of revision. This process is likely to begin in the months preceding the July HLPF meeting. Civil society can influence the inclusion of content on HIV, human rights, and health in the Ministerial Declaration by advocating with government officials in capital at the Ministry of Foreign Affairs and with diplomats at the Permanent Mission to the UN in New York. It is important for the Ministry of Foreign Affairs to hear from local activists and community representatives in country and then relay your messages to diplomats at the UN. Regional meetings before the HLPF are another opportunity for advocacy with your government representatives, as described in section 1.4. Partnering with international non-governmental organizations and regional civil society networks can help amplify your messages and make new connections with diplomats and government representatives involved in negotiations.

1.3. Voluntary National Reviews

A key component of the HLPF are the Voluntary National Reviews (VNR) of SDG implementation. Member States volunteer to report on progress working toward the SDGs, including successes and difficulties. Member States submitting VNR reports present their findings in "interactive dialogues" with other Member States to share promising practices and exchange on what has worked in implementation. It is important to note that despite the focus on selected SDGs in each annual thematic review, Member States opting-in to VNR reporting are encouraged to report on all 17 SDGs. This process is meant to foster peer learning from other nations' successes and less successful efforts.

Governments prepare and submit VNR reports to the UN Department of Economic and Social Affairs Division for Sustainable Development (DESA-DSD). In February 2018, DESA-DSD released the 2018 *Handbook for the Preparation of Voluntary National Reviews,* and the section on Multi-stakeholder Participation (pages 13 and 14) emphasizes that civil society and national human rights organizations should be included in consultations. The Handbook builds off updated guidelines released in December 2017 that were based on inputs from civil society, including guiding principles and suggested structure and content. The 2018 Handbook and the December 2017 guidelines encourage Member States to include a section on "leaving no one behind," a key entry point to describe efforts to combat stigma and discrimination against people living with and affected by HIV. Additionally, the UN Development Group has also published guidance for SDG reporting, and a workshop is available for Member States that will report. As outlined in an informative Q&A and in accordance with paragraphs 78 and 79 of Agenda 2030, Member States are encouraged to consult with stakeholders to inform their reporting. All guidance for VNR reporting recommends civil society consultation in a transparent process.

In 2016, 22 nations presented VNR reports, and 43 nations presented VNR reports in 2017. The UN DESA released synthesis reports of the 2016 VNRs and the 2017 VNRs. HIV was included in just over half the VNR reports, and the 2017 Synthesis Report referred to efforts to combat communicable diseases, including HIV, including preventive interventions, surveillance, improved care, and protection against discrimination, and cited Kenya's HIV and AIDS Tribunal established in 2009, "which has contributed to reducing HIV-related stigma and discrimination through various awards, and presented an alternative avenue for redress for HIV-related human rights violations." * The full VNR reports from 2016 and 2017 are available online (linked above).

* 2017 Voluntary National Reviews Synthesis Report, https://sustainabledevelopment.un.org/content/documents/17109Synthesis_Report_VNRs_2017.pdf, page 10.

In 2018, 48 nations will present VNRs:

- Albania
- Andorra
- Armenia
- Australia
- Bahamas
- Bahrain
- Benin
- Bhutan
- Cabo Verde
- Canada
- Colombia
- Dominican Republic
- Ecuador
- Egypt
- Greece
- Guinea
- Hungary
- Iceland
- Ireland
- Jamaica
- Kiribati
- Lao People's Democratic Republic (PDR)
- Latvia
- Lebanon
- Lithuania
- Mali
- Malta
- Mexico
- Namibia
- Niger
- Paraguay
- Poland
- Qatar
- Republic of the Congo
- Romania
- Saudi Arabia
- Senegal
- Singapore
- Slovakia
- Spain
- Sri Lanka
- State of Palestine
- Sudan
- Switzerland
- Togo
- United Arab Emirates (UAE)
- Uruguay
- Viet Nam

At the time of this paper's publication, these countries may have already begun national consultation processes for the 2018 VNR report. Based on findings below from the 2017 VNR reports and consultations, HIV related data must be included with substantial input from community organizations to reflect the reality of implementation of SDG Target 3.3 and to realize the goal of leaving no one behind, including those living with and affected by HIV.

1.4. Regional Meetings

Regional meetings occur annually in preparation for the HLPF. The meetings are venues for peer learning via sharing best practices and development policy, and regional trends are identified. Regional meetings are a good venue for setting the tone to governments about civil society development priorities, and to foster more collaboration for regional advocacy. The dynamics of regional meetings may offer opportunities and discussions that would be more inhibited at global meetings.

2018 Regional meetings include:

- ECE, 1-2 March, Geneva (Europe)
- ESCAP, 28-30 March, Bangkok (Asia-Pacific)
- ECLAC, 18-20 April, Santiago (Latin America and the Caribbean)
- ESCWA, 24-26 April, location not set at time of writing (Arab world)
- ECA, not yet scheduled at time of writing (Africa)

Side events are also held during regional meetings, and present an opportunity to highlight regional and subregional manifestations of the HIV pandemic that would be overshadowed at the global meeting.

2. HIV IN THE 2017 VNR REPORTS

In 2017, 43 countries submitted Voluntary National Review (VNR) reports, 32 of which referred to HIV. Coverage of HIV is inconsistent and uneven across VNR reports, with most reports referring to HIV prevalence or incidence. Only nine VNR reports mentioned key populations, and even fewer refer to HIV-related stigma and discrimination. Table 2 delineates which topics and HIV-related data were included within the 32 VNR reports. This section presents an overview of the ways these Member States described HIV in the context of the SDGs in 2017 VNRs, and then outlines three other sources of HIV-related data that could be used to supplement gaps in VNR reports.

Note: *In this table, an X indicates one single reference to the topic of the column; inclusion of information about one topic does not necessarily imply overlap with other topics. A country without any X signifies that HIV was mentioned, but not with regard to the five topics in the Table. For the exact wording in the VNR reports, see Appendix A.*

Table 2. Summary of References to HIV in 2017 VNR Reports

VNR Report	Prevalence	Incidence	Key Populations	Stigma	Fast Track 90-90-90 Targets
Afghanistan		X	X		
Argentina	X				
Azerbaijan	X	X			
Bangladesh		X	X		
Belarus	X	X	X		
Belgium				X	
Belize	X		X		
Benin		X			X
Botswana					X
Brazil				X	
Chile		X	X		
Costa Rica			X	X	X
Cyprus		X			
El Salvador	X				
Ethiopia		X			
Guatemala		X	X		
Honduras					
India					X
Indonesia	X		X		
Kenya		X		X	
Malaysia		X			
Maldives					
Nepal					
Netherlands					
Nigeria		X			
Panama		X			
Peru		X			
Portugal					
Slovenia		X			
Sweden		X			X
Thailand	X				
Uruguay	X	X			
Zimbabwe	X		X		

2.1. HIV Prevalence, Incidence, and Key Populations in the 2017 VNR Reports

Incidence data is crucial to inform Health Ministries, donors, and civil society about new or recent HIV infections and the way an epidemic is concentrated and spreading. Many governments are reluctant to collect data about modes of transmission, sexual orientation, and gender identity and expression, and/or government agencies do not know a respectful way to collect these data. Prevalence data, while useful, is inadequate for designing effective and cost-efficient national HIV prevention, treatment, and support strategies, including investment approaches.

Of the 32 nations that referred to HIV in their VNR reports, 17 countries referred to incidence or new infections (Afghanistan, Azerbaijan, Bangladesh, Belarus, Benin, Chile, Cyprus, Ethiopia, Guatemala, Kenya, Malaysia, Nigeria, Panama, Peru, Slovenia, Sweden, and Uruguay), and nine countries referred to prevalence (Argentina, Azerbaijan, Belarus, Belize, El Salvador, Indonesia, Thailand, Uruguay, and Zimbabwe).

Due to "country control" in the definition of key populations, references to key populations may not have included the four groups that are known to disproportionately bear the burden of HIV and also experience punitive laws and stigma—namely, gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people. No nation reported specific information about all key populations, despite the inclusion of key populations in agreed-upon Indicator 3.3.1 ("number of new HIV infections per 1,000 uninfected population, by sex, age and key populations").

Key populations were only mentioned in nine reports (see exact wording in Appendix A):

- Afghanistan reported 7% prevalence among people who inject drugs (PWID), and that prevalence among female and male sex workers was 0 and 1% respectively.
- Bangladesh reported that the number of new HIV infections per 1,000 uninfected population, by sex, age and key populations remains low, but did not break out key populations.
- Belarus reported that they have a concentrated epidemic with 13.8 percent prevalence among PWID, 5.8 percent among women involved in the sex trade, and 4.8 percent among men who have sex with men.
- Belize reported that, "The 2011 Sexual Behaviour Survey reported 13.85% prevalence rate within the men having sex with men (MSM) population."
- Chile reported 14.5% prevalence among KPs but did not elaborate further.
- Costa Rica described using Global Fund money to support programs for MSM and transgender women.
- Guatemala referred to rising incidence and named KPs but did not break out data about KPs.
- Indonesia referred to the provision of ARVs for KPs but did not specify incidence or prevalence among these KPs.
- Zimbabwe described its HIV prevention programs targeting hotspots and key populations.

Five countries (Benin, Botswana, Costa Rica, India, and Sweden) referred to UNAIDS' Fast Track 90-90-90 targets to end the epidemic.

- Benin, Botswana, and Costa Rica referred to 90-90-90 as goals for their efforts.
- India's only reference to HIV was to "Achieve the global target of 90:90:90 for HIV/AIDS by 2020."
- Sweden referred to having already achieved 90-90-90.
- In addition to these five, Slovenia included, "The number of people infected with HIV is low (less than 1 per 1,000 people). The new National Strategy for Prevention and Control of HIV Infections 2017–2025 aims to make Slovenia a country with very few new HIV infections, which will be detected at an early stage and treated successfully."

2.2. Addressing the Data Gaps in VNR Reports

Despite the above-described low inclusion of HIV data in 2017 VNR reports, many pertinent data are available and already reported by Member States in other platforms.

The United Nations Political Declaration on Ending AIDS, adopted in 2016, focuses on accelerating the HIV response through 2020 and the broader 2030 Agenda in the form of 10 Global Commitments. The 2016 Political Declaration states:

> *76. Request the Secretary-General, with support from the Joint United Nations Programme on HIV/AIDS, to provide to the General Assembly, within its annual reviews, an annual report on progress achieved in realizing the commitments made in the present Declaration, and request continued support from the Joint Programme to assist countries in reporting annually on the AIDS response;*
>
> *77. Request the Secretary-General, with the support of the Joint United Nations Programme on HIV/AIDS, to contribute to the reviews of progress on the 2030 Agenda for Sustainable Development taking place at the high-level political forum on sustainable development so as to ensure that follow-up and review processes assess progress on the AIDS response;*

Paragraph 76 has been operationalized in the Global AIDS Monitoring (GAM), formally known as Global AIDS Progress Reports (GARPR). The GAM contains indicators for the 10 Global Commitments. Guidance and indicators for reporting for GAM have been provided by UNAIDS, and the guidance emphasizes the role of civil society in data collection.* Many indicators address KPs, ranging from incidence to ART coverage to specific indicators for each key population. GAM represents the most comprehensive and systematic review of HIV in each country. The reported data are utilized for national-level reviews, regional reviews, and global analysis.

* The guidance states, "Civil society organizations are well positioned to provide quantitative and qualitative information to augment the data collected by governments and to interpret the data collected. National AIDS councils, commissions, committees or their equivalents should seek input from the full spectrum of civil society, including NGOs, networks of people living with HIV, faith-based organizations, women, young people, trade unions and community-based organizations" (page 23).

Country data is submitted in late March each year, and Member States are encouraged to submit narrative summaries by commitment area. Countries may alternatively share any narrative analysis or reports they may produce for their own national processes. Data from GAM is made publicly available by UNAIDS through their data portal and may be useful for CS for shadow reports and advocating with government representatives.

In addition to the GAM and other data available at UNAIDS, two other sources may contain useful data to address data gaps on HIV:

1) The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the largest bilateral health initiative to address HIV/AIDS. Operating in over 50 countries, primarily in Africa, PEPFAR programs make data available online that may be beneficial to supplement and cross-check Member State reporting on HIV.

2) The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) is a multilateral partnership to raise and invest in programs in over 100 countries. Data on program implementation is reviewed by Country Coordinating Mechanisms. Civil society and community representatives based in countries where the Global Fund is investing could also seek data and information about the epidemic to supplement VNR reporting.

GAM remains the authoritative and systemic reporting mechanism for monitoring HIV globally. However, HIV data must be included in VNR reporting to highlight the interconnectedness of HIV to other development priorities. Data from GAM, PEPFAR, and the Global Fund can address gaps in official VNR reports prepared by Member States. Civil society representatives play a crucial role in advocating for inclusion of these data and other pertinent topics in fulfillment of VNR reporting guidelines, as described in the next section.

3. HIGHLIGHTS FROM CIVIL SOCIETY ADVOCACY IN 2017 VNR CONSULTATIONS

Throughout the history of the HIV response, community action has been essential in keeping governments accountable to address the uneven distribution of the epidemic across populations. For this reason, consultation with HIV organizations, and especially key population-led HIV organizations, is crucial to ensure comprehensive and accurate coverage of HIV in the framework of Agenda 2030 for sustainable development.

The VNR consultation process is different in each country. In 2017, several HIV and LGBTI activists participated in national consultation processes in Member States that completed VNR reporting. This section includes main findings from interviews with eight activists from six countries (Brazil, the Netherlands, Kenya, Nigeria, El Salvador, and Sweden) and distills promising practices and lessons learned for civil society organizations considering how to engage in future VNR consultation processes. The activists interviewed are not connected to one another and were selected based on connections with MSMGF. The intent of the interviews was to assess for best practices across country contexts. Each of these countries offer examples of what activists may encounter in advocacy and strategies to adapt for their own use.

Take Initiative to Form Coalitions and Partnerships

Generally speaking, activists described how critical it is to work with broad coalitions to influence VNR reporting. Given the wide breadth of topics in Agenda 2030, no single issue is guaranteed comprehensive coverage in VNR reporting. Multiple voices and a unified front among civil society organizations is an important strategy for activists and community members to consider. Indeed, the interconnected nature of the 17 SDGs offer multiple entry points and connections across traditional development sectors. Civil society leaders should capitalize on this opportunity and proactively build coalitions and partnerships with development implementers, sexual and reproductive health and rights organizations, human rights defenders, and other non-State actors.

Coordinating across these organizations may be time intensive, particularly in contexts where the government does not facilitate this process. Interviewed activists imparted the necessity to get involved early so that a variety of civil society voices could be consulted. This may require personal initiative, as the government coordinating agencies may or may not endeavor to make sure civil society voices are reflective of the true diversity of organizations in country.

Advocate for National Priorities Supported by Data

The Sustainable Development Goals and the principle of "leave no one behind" offer a wide-ranging platform for civil society to push for national advocacy priorities. Interviewees encouraged activists to link current work and initiatives to the SDGs, even if it is a not the framework traditionally used in national advocacy. Data is particularly useful during this process, and in particular, data that is outlined in the agreed upon indicators in the SDGs. These data may be available in government agencies, UN agencies, or through civil society generated and collected data.

In Brazil, Kenya, El Salvador, and the Netherlands, civil society activists compiled shadow reports (also called Status Report or Spotlight Report) to highlight civil society efforts in the implementation of Agenda 2030. These reports greatly influenced the content of the official VNR reports. In Kenya and Brazil, the civil society reports were released publicly to accompany the official report. In Nigeria, a civil society scorecard highlighted the gaps in state implementation of Agenda 2030, and advocated for increased participation and consideration of youth needs in development.

Cultivate Relationships with Government

Government response to civil society advocacy on VNR content may depend upon relationships with specific government departments and offices including the ministries responsible for developing the VNR report. In all contexts, interfacing with government agencies during the national consultation process offered an opportunity to cultivate relationships and influence the content of reports. The Dutch government permitted civil society to directly write content for the official report, whereas other governments were less transparent about which submissions or edits would be considered. Submitting data, narrative, and other content was useful to build relationships with government officials.

Additionally, the New York Mission to the United Nations was sometimes helpful, particularly for advocates who participated in the HLPF. UNAIDS, UNDP, and other UN agencies may also be helpful, particularly by sharing data on various development priorities.

3.1. Brazil: Close Collaboration with the Government and Production of a Spotlight Report

> *"Our civil society network has a good relationship with the Ministry of International Affairs and with the Brazilian mission to the UN in New York. The entire process, including releasing our shadow report, was respectful. When presenting the government VNR Report, the Brazilian Government mentioned the fact that CSOs produced their own Spotlight Report and, even with different views they were included in the national delegation – affirming it was an indicator of a democratic process." Alessandra Nilo, Director, Gestos – HIV, Communication and Gender*

Gestos – HIV, Communication and Gender , helped start and now lead the Brazilian Civil Society Working Group on the SDGs , which has over 40 members including networks and civil society organizations. Working group members come from many fields (social, economic and environmental), covering all the SDGs. Alessandra Nilo, Director of Gestos, explained, "After the approval of the SDGs in 2015, we pushed forward to form the National Commission on the SDGs. We instituted a process to create a civil society report including research on all the goals and targets." This network released a "Spotlight Report" in 2017. At the same time, Nilo was part of the Brazilian delegation to the HLPF, with ten other members of the civil society network. She shared input based on her experience for local, national and international organizations working on the SDGs.

While the civil society coalition was preparing its shadow report, they were in conversation with the government but were not involved in producing the government VNR report. Nilo explained, "We did not know that they would not include HIV in the VNR. When they released the report, it was done. But in our civil society report, the HIV chapter is interesting."

Nilo offered advice for CSOs considering producing shadow reports, including using the structure recommended in the guidance, and for a network rather than any single organization to produce the report. She attributes their success to focusing on the specific targets and their use of government data that they analyzed based on government information. She explained, "We included our perspective in our analysis of the data." They plan to follow up with future VNR reports. She said, "Our first spotlight report created a baseline, and later, during the processes of preparing new Spotlight Reports, we will see what has improved from the baseline and what has not."

Nilo emphasized that relationships with government were key, saying, "Our civil society network has a good relationship with the Ministry of International Affairs and with the Brazilian mission to the UN in New York." Nilo advised CSOs to look for all points of entry with the government, explaining that political changes may affect relationships, but good relationships with some agencies and with the Mission may endure and will benefit civil society in the VNR process. She emphasized that civil society coalitions are critical for advocacy, and that small organizations will have more influence as part of a national coalition, saying, "You will have more clout when approaching the government, and show the government that you are well informed about the process and ask the right questions." She added that it is important to highlight that civil society participation is a core area for SDG implementation, considering the scope of not leaving anyone behind. During past VNRs, whether civil society was involved in producing the report was considered an important indicator in itself. Nilo recommends emphasizing that UN Member States consider whether VNR reports include civil society input when approaching your own government.

The 11 people from Brazil's civil society coalition who were part of the government delegation to the HLPF were involved in many side events during the HLPF, and the Brazilian mission co-sponsored a number of these side events. Nilo emphasized the importance of the regional meetings before the HLPF, saying, "The regional meetings are important and strategic forums. You can discuss some things within the region and not with the entire globe. Regional meetings are prep for the global meeting. Regional meetings offer a moment for regional advocacy and conversations about specific issues you want to see addressed. There are side events at the regional meetings, too."

Nilo's advice for larger organizations, particularly for global networks, is to help build capacity and prepare for the global meeting. She reminded us that everyone needs to build capacity for the VNR process, saying, "International networks have the responsibility to share information with their networks about what is happening at the global level. And national level information sharing is the responsibility of national organizations. But organizations and networks of all sizes need more knowledge of the VNR process. Some have only recently started paying attention, and need to develop their own knowledge and share it, to shepherd smaller organizations. Global networks should have people in New York to do this, to share information, to update info, and to engage UN bodies."

3.2. Kenya: Organized Coalition Modified Official VNR Report and Produced an Annexed Status Report

"Understand if there is good will within your government and if you can truly achieve a consolidated form of reporting with them. If it's not comfortable [to collaborate with the government in this way], then go ahead and do an independent process. It's important to ensure our voice is included… don't just let it go. Give community and citizens voices, because these voices go missing from bureaucratic systems. We must ensure that no one is left behind. Whichever way, with or without government, our voices count." Florence Syevuo, National Coordinator, SDGs Kenya Forum

In Kenya, a unique coalition organization was created after the adoption of the Agenda 2030 for Sustainable Development to serve as a coordinating space for civil society engagement in Kenya's SDGs implementation, monitoring, and review. The SDGs Kenya Forum was born out of a desire to create "a new and different strategy" for citizen-led development, stated National Coordinator, Florence Syevuo. Syevuo continues, "Not much had been achieved under the MDGs, and CSOs in Kenya therefore felt that we needed to be more vocal and more strategically involved at the national, regional, and global levels. Since 2013, we have been active in communicating that the next development agenda should be people-oriented and people-centered." In this spirit, the Forum and its over 60 civil society organizational members on the coordinating committee engage with government to share concrete suggestions for implementation and strategies for involving the media, academia, and the private sector. The SDGs Kenya Forum is open to all types of civil society groups, and it is organized through thematic groups focusing on the 17 SDGs and relevant development issues in the Kenyan context. The Forum works with government ministries, state departments, and 47 county governments to ensure coherence across the Agenda 2030 for Sustainable Development and National Blueprint for Kenya's development, Vision 2030 – Medium Term Plan III.

After the Kenyan government committed to participate in the 2017 Voluntary National Review, the Forum members wanted to ensure that either the Forum's inputs would be incorporated into the national process or that a substantial shadow report would be formulated. "We negotiated," Syevuo recalled the initial deliberations with the SDGs Unit at the Ministry of Devolution and Planning. "We wanted to give our inputs in terms of what we've been able to achieve, what challenges we've faced, and some recommendations for CSOs SDGs implementation. We want to see this reflected in the national report." The Forum developed a parallel timetable to the Ministry's timetable for the VNR, to ensure that the Forum's consolidated feedback would be presented alongside the government process. This involved organizational members of the Forum taking the lead to bring civil society stakeholders together to compile data and draft content for specific Goals. This was a "rigorous exercise of convening members and coming up with very precise messages, outputs, and challenges," according to Syevuo. "It was a very good process of opening up the space for dialogue among citizens, civil society and then with the government."

Rahab Mwaniki, Campaign Manager at KANCO, a membership organization in Kenya that advocates for a robust HIV response inclusive of harm reduction and key populations, participated in the SDGs Kenya Forum reporting on SDG 3 with regard to health and HIV. Mwaniki insisted on a focus on challenges and progress pertaining to HIV-related stigma. Through the SDGs Kenya Forum, Mwaniki provided additional information and inputs to the official report, which included sections about maternal, neonatal and child health, and the HIV and AIDS Equity Tribunal. Mwaniki pointed out that data regarding HIV is available in various forums, for example the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the exercise for KANCO at the Forum was to mobilize communities and citizens, and to then consolidate and organize these data.

At the same time that the SDGs Kenya Forum was organizing itself, the government was similarly mobilizing its departments and agencies to collect their own information. The Forum was represented in all government VNR preparation meetings. Then in March 2017, a meeting was convened with the SDGs Kenya Forum and the Ministry of Devolution and Planning to give feedback and raise questions on the official VNR report. Around this time, the Forum decided to not only continue to offer feedback on the official report, but also to go ahead and produce a substantial CSO Status Report that would be included as an appendix to the official VNR report. The private sector would similarly produce a status report that would be included as an appendix to the official VNR report.

Syevuo reflects on this decision: "We were happy that [the government] kept their word. But of course, what we learned is to find mechanisms to ensure that next time our report is fully integrated into the main report. We need to ensure that the government sees non-state actors as equal partners with valuable contributions to development agendas. [The CSO strategy in 2017] wasn't perfect, but it was a good entry point and initiative for the Kenyan Government to see the possibility of collaborating with non-state actors in SDGs reporting."

Syevuo also stressed that this work cannot be accomplished by a single organization or a network. A wide variety of organizations must collaborate and pursue coordinated approaches, because a report "can only reflect the information submitted on the table." One of the challenges identified by Syevuo in this process was the different levels of understanding about the SDGs, especially reporting and translating the work that organizations are already accomplishing into the format and structure of Agenda 2030. This will require investment in capacity building at the grassroots, including knowledge dissemination about the Agenda 2030 framework. Of course, coordinating across so many different organizations with limited budget was a formidable challenge; according to Mwaniki: "We were rushed, and coordination was a problem. It required a lot of personal initiative." Early planning and coordination, ideally in tandem with agencies that contain data useful for reporting, is crucial.

Since the HLPF, the SDGs Kenya Forum has advocated to the government for annual domestic reporting on progress on the SDGs, whether or not the government has formally opted-in to the VNR process at the UN. The highly organized platform provided by SDGs Kenya Forum enabled civil society to actively participate in the VNR process, modifying both the official VNR report and producing a substantial CSO Status Report. These efforts created vital entry points for later engagement on development issues.

3.3. Netherlands: Shadow Reporting to Inform Government Ministries and Draft Civil Society Section of the VNR

"Your national advocacy priorities should be linked to the SDGs.... Your analysis of the gaps and priorities should be used to push your national agenda. Keep pushing, pushing!" Rineke van Dam, Advocacy Officer, Rutgers

The Netherlands took an innovative approach to the official VNR report by allowing five groups of stakeholders to write sections of the report with minimal editing before publishing, in addition to the section written by the central government itself. The groups included: central government, local government, knowledge institutions, private sector, youth, and civil society. Civil society was also able to advocate with line ministries for inclusion of key data and topics in the section written by the central government. Additionally, during the interactive dialogue for the Netherlands' VNR, a youth advocate spoke next to an official delegate from the Ministry of Foreign Affairs.

This transparent approach offered a unique opportunity for civil society to ensure that their national priorities were included in the report. Rineke van Dam, Advocacy Officer at Rutgers, a nonprofit organization focused on sexual and reproductive health and rights and comprehensive sexuality education in the Netherlands and internationally, indicated that the Ministry of Foreign Affairs was very open to civil society participation, while line Ministries were less familiar with the SDGs and the VNR process. In order to assist in the formation of the VNR report, Rutgers prepared a shadow report as an advocacy material and distributed it to relevant line ministries at the beginning of the national consultation process. "This was helpful," van Dam commented, "Sometimes [line Ministries] just don't know where to start themselves. They are quite open to the things we share with them, and we work together on many programs."

In fact, Rutgers prepared the shadow report by Fall 2016, before the Netherlands government committed to offering different stakeholder groups separate sections of the official VNR report. The shadow report was adapted to the Universal Periodic Review (UPR) and the VNR civil society section, especially with regard to SDG 3 and SDG 5. Having this data and messaging on hand was very useful in advocacy with line Ministries, as well as during a December 2016 SDG conference convened by the Netherlands government with stakeholders to discuss the VNR and the state of SDG implementation in the Netherlands and abroad. At this meeting, Rutgers and WO=MEN Dutch Gender Network, led a session on gender equality in the Netherlands and international policy. This was a valuable opportunity to build relationships with SDG contact persons from the different line Ministries, which was essential to influence the content of their submissions to the VNR report.

This gets to the heart of the utility of the VNR process, according to van Dam: "In countries that are challenging and the government may not be open to [civil society] input, processes like the UPR are better. Effectiveness relies on your entry points with the government: supporting the government in writing the [VNR] report… in a soft, providing-content and supportive way is effective."

At the same time, van Dam stresses that the SDGs are nothing new: "What is included in the SDGs are existing commitments already agreed elsewhere. [Civil society's] national priorities should be linked to the SDGs…. Use the SDGs to push your national advocacy agenda." Civil society should view the SDGs as an additional opportunity to interface with government agencies and share data; indeed, van Dam insisted and persisted to meet with the National Statistical Agency to discuss the measurement of SDG indicators, including on sexual and reproductive health and rights data. Ultimately her persistence paid off, and a new space for dialogue was opened to discuss CSO input to measurement of SDG indicators.

The Netherlands government has committed to updating the VNR report each year, offering an opportunity for engagement among stakeholders on key development issues.

3.4. Sweden: Government Initiated Consultation with Civil Society

"Be part of the coordination / preparations from the very start to have a good overview of the process and what will happen, who is coordinating which part of the HLPF, etc. It is very difficult to just come to the space only for the country review sessions as virtually one is out of the process and in a way 'have missed the train'. It is also a very different monitoring / reporting mechanism from all other human rights mechanisms so it's worth to familiarize oneself with it prior to the HLPF." Micah Grzywnowicz, Riksförbundet för homosexuellas, bisexuellas, transpersoners och queeras rättigheter (RFSL)

Sweden's government consulted civil society organizations, as recommended in VNR guidelines and the 2030 Agenda. The two government ministries responsible for the implementation of the SDGs are the Ministry of Finance which is responsible for domestic implementation, and the Ministry for Foreign Affairs which is responsible for Sweden's engagement with SDGs internationally. These two agencies reached out to civil society organizations including Riksförbundet för homosexuellas, bisexuellas, transpersoners och queeras rättigheter (RFSL), known in English as the Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights. Micah Grzywnowicz (pronouns: they/them) explained that the board and a few of the staff members prepared a joint response to the questions asked about how RFSL contributes to the implementation of the SDGs. Grzywnowicz said, "The government organized a briefing with CSOs in January to inform us about the reporting process and the upcoming HLPF. Later on, RFSL was contacted to provide a written input on the implementation."

RFSL was not involved in drafting the government's VNR report, but the report that RFSL provided was positively received and one of their programmatic activities was included in the report as an example of best practices (LGBTQ Certification for businesses and similar entities). However, nothing more substantial made it to the report. Grzywnowicz was pleased with RFSL being included but also wished that more attention had been paid to ways to use the SDGs to promote rights, saying, "In general we were quite surprised and of course happy that RFSL's work was mentioned in the report as one of four best practices. Of course, we would have preferred more specific focus on the actual implementation of the SDGs and how it benefits LGBTQ people in Sweden. Mentioning that intersectional perspective is inclusive of SOGI is not enough as it does not always translate into concrete actions."

In addition to RFSL's contributions to the government consultation, Grzywnowicz participated in the HLPF. RFSL co-sponsored a side event and engaged with the Swedish government representatives at the HLPF. Grzywnowicz explained, "We engaged the Ambassador to the Agenda 2030 in our side event during HLPF, specifically asking to express Sweden's commitment to the implementation of the SDGs and its benefiting LGBTQ persons. It was a positive and engaged cooperation." Other opportunities to interact with their government representatives during the HLPF include the interactive dialogue on country VNR reports, and Swedish civil society was able to ask a question during this process. Civil society organizations worked together to formulate the question. Grzywnowicz said, "My colleagues from the delegation actively participated in the process and the chair of the Swedish CSO coalition read out the question. It was done in consultation with me so that the message during the interactive dialogue was inclusive of SOGI issues."

Even as these were good interactions, Grzywnowicz saw opportunities for more engagement during the HLPF. For example, they said, "I think the interactive dialogues in general were not very satisfying. There was very little time to engage and the time for answers was very limited which made the dialogue not very interactive. It didn't therefore allow to go into details or concrete implementation issues, or even sharing best practices. It was a pity that Sweden did not talk about best practices more as it would contribute to the peer-learning element of HLPF."

The opportunities to engage with governments during the HLPF are limited by the structure of the meetings. The HLPF does not offer space for CSOs to share their views and issues they face on national level. Grzywnowicz explained, "Interactive dialogue during the review is too controlled and too time limited for a meaningful engagement and any detail sharing." This is one reason to try to engage with the government before the HLPF, to use the opportunities that exist, and to create more opportunities to follow up with governments at home. The government organized a follow-up meeting with the CSOs and RFSL participated.

Grzywnowicz advised local and national organizations to get involved early, and to understand the process of the HLPF, adding, "It is very difficult to just come to the space only for the country review sessions as virtually one is out of the process and in a way 'have missed the train'. It is also a very different monitoring / reporting mechanism from all other human rights mechanisms so it's worth to familiarize oneself with it prior to the HLPF." Grzywnowicz also suggested that international and global organizations and networks should share information, materials and reports, provide a good overview of the previous sessions, and coordinate prep calls.

3.5. El Salvador: The Importance of Local and Global Networks

"They did not look for us, we looked for them. A key point is to try to get in touch with your country mission before the report is done. If you work with them, it would be extraordinary for them to tell a different story than you have told them for five months!" Andrea Ayala, Executive Director of Espacio de Mujeres Lesbianas por la Diversidad (ESMULES)

When El Salvador volunteered for the 2017 VNR process, human rights defenders in El Salvador acted together. El Salvador is a small Central American country, and so the human rights organizations were familiar with each other. The saw the importance of working with others, both in country and globally. Andrea Ayala, Executive Director of Espacio de Mujeres Lesbianas por la Diversidad (ESMULES), emphasized that this network of human rights defenders did the work to reach the people producing the VNR for El Salvador. Their networks included some UN agency workers in New York, and Ayala emphasized that the activists initiated the engagement with government and UN agencies. She said, "A year before the HLPF, UNFPA and UNDP began working on the issue. Our organization engaged with the agencies by reaching out by letters, reaching out to people in New York, to be put in touch with the right people in El Salvador." Their organic network of human rights defenders worked closely with government ministries and UN agencies in El Salvador and addressed a wide variety of issues across the SDGs, including HIV.

Ayala emphasized the importance of starting early, well before the report is complete. The human rights defenders offered suggestions and input to the government representatives preparing the report. Ayala said, "A key point is to try to get in touch with your country mission before the report is done. If you work with them, it would be extraordinary for them to tell a different story than you have told them for five months!" The human rights defenders did not have a role in drafting the report and so they were never sure what would be included. Because they were uncertain about what would be included in the official government report, they prepared a shadow report to ensure that their concerns were addressed. The government agencies they worked with were aware that they were preparing a civil society report.

The local human rights defenders compromised among themselves to ensure that the most important issues were addressed in the VNR. Knowing that they would not get everything they advocated for, they chose which issues to prioritize. Ayala explained, "One result of working in this coalition, which included LGBTI organizations and women's organizations as well as HIV organizations, was that we prioritized the issues most important to everyone, issues that need attention. In El Salvador, HIV is addressed very well by the government; we have universal ART for free; our AIDS clinics are open 24/7. For this reason, we did not push for more attention to HIV but instead pushed for LGBTI and abortion to be included in the VNR." They were successful, and these issues were included in the VNR, but HIV was not. However, they had advocated successfully for their priority issues to be included. While the network of human rights defenders in El Salvador had prepared a shadow report and used the shadow report in their advocacy, they did not release it because their most important issues were addressed in the report. The shadow report was a critical part of their government advocacy.

Ayala emphasized the need to reach out not only to UN agencies and the government, but also to reach out to larger organizations and networks that may be helpful with UN processes including the HLPF. People and organizations from small countries may especially benefit from affiliating with larger organizations and global networks. For example, international contacts and networks facilitated her participation at the HLPF in 2017. Ayala said, "To get into the UN system, be part of the networks and create a national network that works on the VNR and get in touch with a bigger network or organization that have the experience on working these kinds of issues. That is important for VNRs and it is especially important in small countries!"

3.6. Nigeria: Active Civil Society Participation and Creation of an Accountability Scorecard

In April 2017, the Nigerian Office of Senior Special Assistant to the President on SDGs (OSSAP-SDGs) organized a one-day National Consultation Workshop to enable stakeholders to contribute to the development of the official VNR report. A variety of national and sub-national civil society organizations were invited to attend this Workshop, including Education as a Vaccine (EVA), an Abuja-based nonprofit organization that focuses on the health, rights, and development of young people in Nigeria. EVA participated in the Workshop and a technical break-out section focused on SDG 3 on health, provided substantial inputs to the draft VNR report, and attended the National Validation Meeting of the draft VNR report.

Ekanem Itoro Effiong, Program Officer at EVA, participated in the submission of comments to the draft report, including detailed commentary on Goal 3, Goal 4, and Goal 5. The comments described the programmatic work of EVA, as well as provided additional data about HIV among youth in Nigeria. Ekanem recalls, "Unfortunately, substantial portions of our comments were not captured due to limited space available in the final report, as a lot of CSOs participated and made inputs. A lot of CSOs felt left out, so we urged the government to set up a mechanism where all inputs from CSOs working in the communities can be captured in the report."

Ekanem mentioned that the National Agency for the Control of AIDS (NACA) submitted inputs in the technical breakout section during VNR Consultation Workshop, including the 2015 HIV incidence rate. References ranging from anti-retroviral therapy and HIV testing as implemented by the State Agencies for the Control of AIDS, which abide by national guidelines set by NACA, appear in the official VNR report. However, these references do not include data disaggregated by sex or key population. For this reason, among others, the "report does not represent the exact reality on the ground," according to Ekanem.

In response, EVA took action to develop a scorecard on the implementation of the SDGs in 11 states in Nigeria. The scorecard compares and grades states on the implementation of the SDGs, and makes clear the gaps and required work for state governments, ranging from budget allocation for SDG implementation to the degree to which SDG programs will benefit adolescent and young people. The scorecards hold state governments accountable to committing to local rollout of Agenda 2030, and offer entry points for civil society to continue to follow-up on key issues within the SDGs in each locality.

Kosi Izundu, Advocacy Officer at EVA, attended the HLPF in New York, where she participated in the drafting of a question for Nigeria's interactive dialogue on the VNRs. Advocating through the Children and Youth Major Group, Izundu expressed that it was challenging to draft a single question to ask in the interactive dialogue: "Initially, the question was almost a page long… to address all issues, we had to streamline to find what topic [would] cut across our issues."

According to Izundu, one of the benefits of participating in the VNR drafting and strategizing at the HLPF with other Nigeria civil society advocates was to learn about what other sectors are working on. "The common issue is synergy—everyone works in siloes and doesn't come together as one. The VNR [process] was good to bring everyone together."

Initiatives like EVA's scorecard offer an opportunity for future collaboration and follow-up among civil society organizations. And despite the disconnect between the content of the official VNR report and what EVA advocates submitted, both Ekanem and Izundu agree it was a meaningful process. In order to make the government-coordinated process more transparent, accountability initiatives like the EVA scorecard should be considered by civil society advocates.

4. CONCLUSIONS & RECOMMENDATIONS:

Getting on Track for Active Engagement in the VNRs

As evidenced by this report, more HIV data are available than was included in the 2017 VNR reports. This indicates there are missed opportunities for UNAIDS, civil society, and Health Ministries to address HIV in the context of Agenda 2030. More coordination and support is required of UNAIDS in particular to ensure inclusion of HIV in the SDGs, and civil society must also engage in this unique opportunity to highlight challenges and successes in addressing HIV in the context of Agenda 2030.

In 2018, 48 nations will submit VNR reports and participate in the interactive dialogues at the HLPF. Activists and community representatives can influence their governments to include HIV-related data in the VNR reports, and shape the discourse around "leave no one behind" to include people living with and affected by HIV. This will require new partnerships and collaborations beyond typical alliances; in particular, engaging with mainstream development organizations and practitioners working on education, employment, gender equality, and other topics.

Each year, Member States participating in the VNR process will release "main messages" approximately a month before the HLPF, which is typically held in July in New York. The full VNR reports are then released in the days preceding the HLPF. Each country sets its own schedule for national consultation for the VNR, occasionally with the assistance of UN agencies. Civil society representatives interested in participating in the national consultations should contact their Ministry of Health and Ministry of Foreign Affairs, and their country and New York offices of UNAIDS and UNDP to find more information about which government agency or Ministry is leading on the VNR process.

4.1. In-Country Participation in National Consultations

Find out which organizations in your country are already working on the SDGs. Find out whether your country has a plan for the SDGs, and if it does, this is an opportunity to respond. If there is no plan of action in your country, find out if there is a process to develop a plan to implement the SDGs; this could present an opportunity to influence your nation's SDG plan. Most civil society stakeholders working on HIV are familiar with the Ministry of Health, but to influence what is reported in VNRs, it may be necessary to engage with other agencies, for example, with the Ministry of Foreign Affairs.

Countries where UNAIDS maintains an office may have more data about HIV and key populations, and civil society should work with UNAIDS to ensure these data are included in VNR reports. Other than Malta and Palestine, all countries that have opted-in to VNR reporting in 2018 have UNAIDS offices.*

* Each country page includes links to data and to contact information: http://www.unaids.org/en/regionscountries/countries

In 2017, civil society members from some countries produced shadow reports highlighting data and analysis omitted from the official government VNR report. For example, Brazil has a CSO network that worked closely with the government, but even though HIV organizations encouraged the inclusion of existing HIV data in the VNR report, this data was not included. Civil society partners then released their shadow report including HIV information and their interpretation of the data included.

4.2. Attending the HLPF

The participation of non-State actors from major groups and other stakeholders is outlined in General Assembly Resolution 67/290 regarding the format and organizational aspects of the HLPF. The registration of representatives from non-governmental organizations must be completed using the CSO Net online events registration system. More information about registering for the HLPF and other UN meetings is circulated by UN-DESA and the Major Groups, described below.

NGOs with ECOSOC status can register individuals to attend the HLPF. Organizations that are in consultative status with ECOSOC can request up to 9 temporary grounds passes at a time, in addition to 7 annual grounds passes. These passes need to be requested through the Integrated Civil Society Organizations System (iCSO). More information on how to request grounds passes can be found on the website.

If your organization does not have ECOSOC status and you would like to attend the HLPF, consider working with an ECOSOC-registered organization. If your organization participates in global networks addressing HIV and works on the SDGs and VNR processes, these networks may be able to facilitate access to the HLPF. Some CSO representatives have been included as part of their national delegations, so reach out to your Ministry of Foreign Affairs and your country's New York mission to the UN to understand opportunities for attending the HLPF.

4.3. Major Groups at the United Nations

Engagement on the SDGs at the United Nations Headquarters is primarily through the Major Groups and other Stakeholders (MGoS). Major Groups are intended to represent every sector of society and non-governmental organizations (NGOs) are encouraged to join, as described below.

Major Groups receive information from UN agencies organizing the HLPF and other meetings and share with their members. Major Groups may also be given the opportunity to speak during stakeholder consultations and other meetings. For example, in order to make an intervention from the floor during an HLPF panel, Major Group representatives (rather than a single organization) submit a request to intervene. In such situations, the statement will need to be approved by other members of the Major Group and reflect multiple issues, not only HIV.

There are ten Major Groups active at the UN in New York:

- Business and Industry
- Children and Youth
- Farmers
- Indigenous Peoples
- Local Authorities
- Non-governmental Organizations
- Persons with Disabilities
- Scientific and Technological Community
- Women (WMG)
- Workers and Trade Unions

To join a Major Group, consider which of these categories best fits your organization. If no other, consider joining the NGO Major Group. The contact information for the "organizing partners" of each Major Group is available on the UN DESA-DSD website. Write to the organizing partner of the Major Group your organization would like to join, and explain that you represent an organization that is interested in working on the 2030 Agenda.

HIV activists and advocates have achieved great representation within some of the Major Groups, particularly Children and Youth and Women. It is in your interest to join a Major Group, build solidarity with other organizations, and shape the discourse around HIV within the Major Group.

4.4. Side events and interactive sessions during the HLPF

Interactive sessions at the HLPF include panels addressing health and development. When topics include health, human rights, stigma, discrimination, and leaving no one behind, there may be opportunities to ask questions or to intervene from the floor at the end of a session. It is important to be in the room early in order to take advantage of these opportunities because UN personnel typically ask who would like to speak if time permits, and a list is kept with speakers' names in the order they will be asked to speak. Generally, only one or two minutes is given to civil society interventions, with slightly more to government representatives. Member States are given priority to speak.

In addition to interactive sessions, side events are held, some of which address HIV. The deadline for applications to host side events within the UN will be circulated by UN DESA. For example, side events can be a way to bring attention to HIV and related issues including tuberculosis and Hepatitis C co-infection.

The deadline to propose side events during the HLPF will likely be in May. Sponsorship by Member States and/or UN agencies is helpful to encourage government representatives to attend, and is usually necessary to be allocated space within UN headquarters. Nearby venues outside headquarters typically charge for the use of their space.

4.5. Other Processes

Global AIDS Monitoring (GAM)

In March of each year, Member States submit data to UNAIDS through the GAM and in fulfillment to the 10 Global Commitments to end AIDS as articulated in the 2016 Political Declaration. GAM represents the most comprehensive and systematic review of HIV in each country. Guidance and indicators for reporting for GAM have been provided by UNAIDS, and the guidance emphasizes the role of civil society in data collection. UNAIDS will accept shadow reports from civil society to complement State reporting in the GAM at aidsreporting@unaids.org.

Universal Periodic Review

All UN Member States participate in the Universal Periodic Review (UPR), a process by which States are reviewed every four and a half years regarding the human rights situation in their country. Conducted under the auspices of the UN Human Rights Council, the UPR accepts shadow reports from civil society. UPR shadow reporting is another avenue for HIV and VNR advocacy when your nation is reviewed.

Special Rapporteur on the Right to Health and other Special Procedure Mandate Holders

Submit inputs to the Special Rapporteur on the Right to Health, particularly if a visit is scheduled to your country. The SR's report "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" reiterated the role of health in attaining the SDGs and highlighted community empowerment of marginalized groups, such as key populations, as critical to ending the epidemic. Other Special Procedure mandate holders are also interested in submissions and inputs from civil society regarding the connections between human rights and HIV.

For more specific recommendations about how to get involved in the VNRs, please refer to the Executive Summary on pages 4-13 of this report.

5. APPENDIX A

Excerpts from 2017 VNR Reports

PREVALENCE
KEY POPULATIONS
INCIDENCE
STIGMA
FAST TRACK

In this appendix, the presence of one of the icons above indicates at least one single reference to the according topic in a country's 2017 VNR Report. Inclusion of information about one topic does not necessarily imply overlap with other topics.

Afghanistan

According to the WHO, the number of HIV positive or prevalence is low in Afghanistan. Most of the infected population are who inject drugs, which it is prevalence is 7%, however, 94% report using sterilized injecting kits. The prevalence of women sex workers is 0 and among guy is only 1%. The antiretroviral therapy is providing only for 200 women to prevent the transmission of the HIV from infected mother to child which 1%. Routine test of collected blood is done on 52% and the expected antiretroviral therapy coverage is for 3% (World Health Organization, 2016). (p46)

Argentina

Argentina's indicators include HIV prevalence 3.3.1.
Número de diagnósticos de VIH por 100.000 habitantes (Tasa de VIH por 100.000 habitantes) and HIV-related deaths Tasa de mortalidad por Sida por 100.000 habitantes. Report says: asa de mortalidad por Sida por 100.000 habitantes y Casos nuevos notificados de Tuberculosis cada 100.000 habitantes Ambos indicadores están vinculados a la meta 3.3 "Para 2030, poner fin a las epide- mias del SIDA, la Tuberculosis, la Malaria y las enfermedades tropicales desatendidas y combatir la hepatitis, las enfermedades transmitidas por el agua y otras enfermeda- des transmisibles". La evolución de la mortalidad por SIDA en la Argentina presenta tres períodos dife- renciados. El primero, desde comienzos de los años 80s, está caracterizado por una tendencia ascendente de la mortalidad, consecuente con el descubrimiento de la en- fermedad y el desarrollo de las primeras herramientas diagnósticas y terapéuticas. El segundo, comienza a mediados de los años 90s, acompañándose de un mayor gra- do de conocimiento de la enfermedad y la introducción de una estrategia terapéuti- ca que implicó el uso de varios fármacos combinados, impactando en una tendencia descendente de las defunciones por SIDA. La tercera etapa corresponde a la última década y es coincidente con una estabilización de las defunciones por SIDA. En efec- to, la tasa bruta de mortalidad por SIDA se mantiene en valores similares desde el año 2000 y por debajo de la Meta establecida para el año 2015 (3,5 por 100.000), en el marco de los ODM, desde el año 2009 (3,4 por 100.000 en 2009 y 2013).(p71)

Expenditures are included page 104 and 105 on stopping sexual transmission of AIDS.

Azerbaijan

By the end of 2015, the total number of HIV / AIDS infected people registered in Azerbaijan made 5,629 people, whereas among citizens made 5,439 people, the share of the population living with HIV is 0.06%(p12)....
Appropriate measures have been carried out in the country in the field of detection and prevention of HIV and treatment of HIV-infected people, and the Law "On combating disease caused by human immunodeficiency virus" and the Action Programs "On immunoprophylaxis of infectious diseases for 2011-2015" and "On combating HIV/AIDS for 2016-2020" have been adopted. Currently, there is a network of medical facilities equipped with modern equipment and combating HIV infection in the country, including the Republican AIDS Control Center and antiretroviral therapy centers in the cities and regions(p22) ....
Azerbaijan is among the countries with a low rate of HIV infection. In total, at the end of 2015, the number of people registered as infected with HIV/AIDS in the country was 5,629. Table 6.13 shows the number of people newly infected with HIV per 1000 healthy people in the period 2010- 2015. As can be seen from the table, this indicator has seen a rise from 0.05 to 0.07. An upward trend has been observed in both men and women. In 2015, the figure for men increased by 66.7% compared to 2010 or from 0.06 to 0.1, and for women it increased by 2.5 times or from 0.02 to 0.05. (p46-48)

Bangladesh

HIV prevalence is still very low, but there is a high risk of infection(p19) ...
3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 0.004 (2016); <0.01 (2015) (UNAIDS, 2016)(p54)

Belarus

Заболеваемость ВИЧ-инфекцией в Республике Беларусь в 2016 году составила 25,2 случая на 100 тысяч населения и удерживается в концентрированной стадии, т.е. распространенность ВИЧ-инфекции преобладает в наиболее уязвимых к ВИЧ группах населения: среди инъекционных наркопотребителей (13,8%), женщин, вовлеченных в секс-бизнес (5,8%), и мужчин, практикующих секс с мужчинами (4,8%). (Refers UN agencies including UNAIDS and Global Fund, prevalence for 25.2 per 100k, and concentrated epidemic, among PWID 13.8%, women involved in sex trde 5.8%, and men who have se with men 4.8% WHO certificate for the elimination of mother-to-child transmission of HIV) (p20-21)

Belgium

Measures against HIV and aids, Hepatitis C or TB are furthermore coordinated within specific plans. The one on HIV (2014-2019) contains 58 actions to curb the number of new HIV infections, to further improve access to HIV-specialized prevention, detection, care and quality assistance services and programs, and to bring down all forms of stigma and discrimination, especially when they are based on serological or health status (3.3)(p15)

Belize

HIV/AIDS prevalence shows trends of stabilization, access to antiretroviral drugs in- creased, and mother-to-child HIV transmission rates reduced . ...The knowledge on HIV/AIDs transmission among the 15-24 age group was low. ... 2016 statistics suggests that communicable diseases were directly linked to 20% of deaths in Belize, with a third of those deaths being among HIV/AIDS patients(p25)....
Advanced HIV infection is one of the leading causes of death among the rate of infection is high among females 20-24 years and females 60-64 years in 2015. By the end of 2016, the HIV prevalence rate was at 1.5%. The 2016 figure reflects a 0.1% increase from the previously recorded 1.4% recorded in the previous 3 consecutive years (2013-2015) . For 2016 there was a greater volume of HIV testing done among persons 15 to 39 years. Though there is an increase of HIV testing in both sexes, there is a continued short fall in established target of increasing HIV testing in the male pop- ulation. Patterns have shown greater HIV testing in the female population, at a ratio of 0.5 to 0.6 M:1F. There is an also a similar pattern showing higher rates of men dying from AIDS related com- plications among the affected. The 2011 Sexual Behaviour Survey reported 13.85% prevalence rate within the men having sex with men (MSM)population . Intervention in the mother to child trans- mission program and other preventative programs led to improvement in reducing HIV prevalence.(p27)

Benin

Les cibles prioritaires relatives à l'ODD 3, à savoir : les cibles 3.1, 3.2, 3.3 et 3.7 sont des cibles OMD en retard pour lesquelles le pays doit poursuivre ses efforts en ce qui concerne la réduction de la mortalité maternelle, des décès évitables de nouveau-nés et des maladies comme le paludisme, la tuberculose et le SIDA. Ainsi, en ce qui concerne le VIH par exemple (cible 3.3.), le Bénin a validé en février 2017 son Plan de Rattrapage d'Urgence 2017-2018 et sa Feuille de Route pour l'atteinte des cibles ambitieuses de traitement 90-90-90 d'ici à 2020. Ces deux documents budgétisés ambitionnent d'augmenter la proportion de personnes sous traitement antirétroviral respectivement de 35% d'ici fin 2018 et de 46% d'ici fin 2020 et offrent ainsi le cadre de mise en œuvre de la cible 3.3. (p12)
Statistical data: 3.3.1a: Nombre de nouvelles infections à VIH pour 1 000 personnes séronégatives (à désagréger par sexe et par âge et par groupe de population) (2015, AIDS Info) 70 in 1000. 3.3.1b Taux de transmission du VIH de la mère à l'enfant: (2014) 7.62% ESDG. 3.3.1c Taux de couverture en ARV des PVVIH: (2015) 48.7% PNLS/ Estimation Spectrum. (p60)
Official Presentation at Interactive Dialogue: "The current level of the indicators are very bad for Benin except with nutrition, HIV and Malaria prevalence where Benin has better figures."

Botswana

Figure 4 .5 shows that as in the case of maternal mortality, there was an initial improvement in both infant mortality and under five mortality during the period 1991 to 1996 and some major reversal was experienced during the period around 2006, which is associated with HIV. The trend has, however, drastically decreased to 27 and 17 per 1000 live births for under 5 and infant mortality, respectively. The rapid decline in infant and childhood mortality between 2001 and 2011 is not surprising. Overtheperiod2001-2011improvedsocioeconomicstatus (education, employment etc.) ofthe population led to increased access to and utilization of health services. Government programs more especially Prevention of Mother to Child Transmission PMTCT, national Anti-Retrovlral Therapy (ART) program and nutrition programs contributed to the declines in infant and childhood mortality... Prevention of Mother to Child Transmission (PMTCT commenced in 2002 with full integration to the then existing MCH service. Through this programme mothers were put on ARTto reduce the possibility oftransmirt ing HIVfrom motherto child (p23)....

4.3.5 TARGET 3.3: ENDING THE EPIDEMICS OF AIDS ANDTUBERCULOSIS

Botswana has the second highest level of HIV (human immunodeficiency virus) prevalence in the world. The 2015 estimated data for adult HIV prevalence among the population aged 15-49 years is around 22%, with 350 000 people are living with HIVand an estimated 9,900 people newly infected in 2015only.(p24)

Because ofthe HIVepidemic, key health indicators, such as life expectancy, have deteriorated catastrophically. However, through determination and In partnership with development partners, the Government instituted robust programmes that contained and reversed the epidemic (Botswana Leads the Way, 2016) and have started rebounding life expectancy rates in recent years owing to increased access to life-saving antiretroviral treatment. HIV prevalence among adults (15-49 years) has remained relatively stable overthe last 10 years, with a significant gender disparity of higher female prevalence than male prevalence (Rgure 4.6). ... Botswana endorsed the 2016 Political Declaration on ending HIVj AIDSby2030,which has a renewed focuson integrating the HIV response into the broader development agenda.

The Government of Botswana adopted the Fast track targets from the 2016 Political Declaration and committed to put in place robust measures to further accelerate the HIV response and to address country level barriers that impede access to prevention and treatment services.

One of the fast-track targets is the 90-90-90 targets (90% of people living with HIV to know their HIV status, 90% of those diagnosed living on antiretroviral treatment (ART) and 90% of people in treatment with fully suppressed viral load) by 2020. The results in 2016 of this fast -track target showed that Botswana had reached 72% toward the first 9 0 (people came forward for HIV testing and tested and know their HIV status), out of those people tested, 74% are on ART (towards second 90) and fromthe 74% ontreatment, 94% are viral suppressed (towards the th ird 90). It also shows that there are still gaps in working towards the target of first 90 and second 90. Furthermore, Botswana has committed to reduce new HIV infections by 75% in particular among adolescent girls and young women and their male sexual partners. Evidence indicates that the HIV prevalence among adolescent girls and young women (AGYW) aged 15-19 is double that oftheir male counterpart (3.6/6.2) and for aged 20-24 years old HIV prevalence of young women is 3 times that of their male counterparts (5/14.6). This emphasizes the need for a much more targeted approach for addressing adolescent girls and young women (AGYW) and their male sexual partners.

In addition, the country recognized that fast tracking the AIDS response requires working closelywith communities in orderto scale up services through community service delivery, addressing underlying social and cutturalfactorscontributing to HIVepidemicand to reduce stigma and discrimination. (p24) ... This is because it is poverty that heightens women's experiences of GBV and Increasesthelrvulnerabilityto HIV. ... Women's economic dependence on their partners contributes to their vulnerability to HIV infection and GBV. (p25) ... Botsw1111a has made progress towards halting the spread of HIV. The Elimination of Mother to Child Transmission programme was very instrumental in halting the AIDS pandemicthrough the reduction otthe HIVtransmission both for mother and the child. In addition, Botswana has made significant progress towards eliminating mother to child transmission.

Despitethese gains gaps do existfor pediatric treatment andthisneedto beaddressed.(p33)

Brazil

In the area of health, civil society involves local health councils to foster integrative and complementary health practices, especially can- cer prevention projects, to provide support and assistance to people with HIV/ AIDSanddrugaddiction,andtocontainnewcommunicablediseas- es (Zika and Chikungunya)(p35). ...
Currently, over 70% of the population depends almost exclusively on the public health service to receive medical care. This structure has contributed to the achieve- ment of the target of reducing child mortality and combating HIV/ AIDS, malaria and other diseases under the MDGs. The United Health System provides access to health goods and ser- vices at all levels of care: provides approximately 95% of basic health- care; funds almost 70% of hospitalizations in the country; is the pri- mary responsible for urgent and emergency care; is in charge of almost all public health services (e.g. vaccination); provides coverage for high-complexity, high-cost treatments, such as antiretroviral therapy for HIV and transplants, among others. ... In the Brazilian population, some groups and regions still present high incidence of infectious diseases. Thus, Brazilian public health works to ght such diseases, especially through: i) the National Tuberculo- sis Control Program; ii) the National Malaria Prevention and Control Program and the National Surveillance Policy; and iii) the actions for Prevention and Control of HIV, AIDS and other Sexually Transmit- ted Infections and Viral Hepatitis. These initiatives provide standardized diagnoses and treatments through the public health network and some localities are innovat- ing by introducing active outreach of cases for the treatment of peo- ple with tuberculosis and malaria. In the ght against HIV/AIDS, the Uni ed Health System (SUS) works with prevention through edu- cation and awareness-raising campaigns and massive distribution of condoms, in addition to offering comprehensive medical care, empha- sizing on guaranteed access to antiretroviral therapy (ART).(p57-58)

Chile

Respecto de la Tasa de notificación de VIH, nuevas infecciones, la información preliminar para el 2015 indica que alcanzó 8,7 por cada 100.00 habitantes27, con diferencias por sexo (14,9 en hombres y 2,6 en mujeres) y grupos de edad, registrándose tasas más altas en la población de 20 a 29 años (25,8); de 30 a 39 años (14,7) y de 40 a 49 años (8,4).Nota 27: Si bien la metadata internacional solicita el "Número de nuevas infecciones por el VIH por cada 1.000 habitantes no infectados, desglosado por sexo, edad y sectores clave de la población", se reporta el número de notificaciones de casos de VIH por cada 100.000 habitantes. Actualmente se trabaja en la homologación a la metodología internacional (p28) ... Para abordar la epidemia del SIDA, se realizan acciones en aspectos normativos, formativos o capacitación, de prevención y sensibilización. En aspectos normativos: Guía Clínica AUGE Síndrome de la Inmunodeficiencia adquirir el Virus de Inmunodeficiencia Humana VIH/SIDA; Protocolo de Atención a Mujeres Viviendo con VIH. Asimismo, el 2016 se publica y entra en vigencia el Reglamento del Examen para la Detección del VIH en personas privadas de libertad38; se modifica la Ley 20.987 sobre Procedimiento para el Examen del VIH respecto de menores de edad; actualmente se encuentra en elaboración una Norma de Diagnóstico de la Infección por VIH. Entre las estrategias utilizadas, destacan los trabajos territoriales en poblaciones claves: servicios de consejería de pares y examen de VIH; capacitaciones en el ámbito comunicacional; uso correcto del condón y promoción del examen de VIH.
En el ámbito de la coordinación, destaca la Mesa de Participación Nacional en VIH/SIDA y Derechos Humanos y la Mesa Nacional con Pueblos Indígenas en VIH/SIDA y Derechos Humanos.
Convenios colaborativos para el desarrollo de planes de trabajo en Promoción y Prevención del VIH/SIDA e ITS y No discriminación. Programa Nacional de acceso a condones, que considera la distribución para iniciativas preventivas y como complemento a tratamientos clínicos de personas que viven con VIH y/o cursan con una ITS. ...
El Programa Nacional de Inmunizaciones incluye: Vacunación con BCG (contra tuberculosis) a los recién nacidos en todas las maternidades; vacunación contra la Hepatitis B, con tres dosis más un refuerzo durante el primer año de vida; vacunación a profesionales y técnicos, personal de salud que otorgue atención directa a pacientes; vacunación con 4 dosis a personas con diagnóstico de insuficiencia renal crónica (IRC) que ingresan a diálisis, infección por virus hepatitis Cy hemofilia; vacunación con 3 dosis a personas con VIH y trabajadores/as sexuales con indicación médica y exámenes de Ag superficie de hepatitis B y anticore total negativo, sin vacunación previa. (p32-33)
... en el área de poner fin a las epidemias y enfermedades transmisibles, se han implementado acciones, en aspectos normativos, formativos, de prevención y sensibilización, entre los que cabe destacar: Protocolo de Atención a Mujeres Viviendo con VIH; Reglamento del Examen para la Detección del VIH en personas privadas de libertad; modificación de la Ley 20.987 sobre Procedimiento para el Examen del VIH respecto de menores de edad; y actualmente se encuentra en elaboración una Norma de Diagnóstico de la Infección por VIH.(p71) ...

Chile *(cont.)*

... Data: Indicator 3.3.1. 3.3.1 Número de nuevas infecciones por el VIH por cada 1.000 habitantes no infectados, desglosado por sexo, edad y sectores clave de la población: 8.7. Número de nuevas infecciones por el VIH por cada 1.000 habitantes no infectados, desglosado por sexo, edad y sectores clave de la población (Hombres) (por cada 1.000 infectados): 14.9. Número de nuevas infecciones por el VIH por cada 1.000 habitantes no infectados, desglosado por sexo, edad y sectores clave de la población (Mujeres) (por cada 1.000 infectadas) 2.6. Observación: Cifra reportada considera notificaciones de VIH por cada 100.000 habitantes. Fuente: Formulario de Notificación VIH/SIDA - Departamento de Epidemiología, Ministerio de Salud.(p87)

Costa Rica

5.4.3. Iniciativas para la prevención de casos del VIH En el año 2016, el país implementó el Plan Estratégico Nacional del VIH (2016-2021) el cual responde al marco intersectorial entre instituciones públicas, privadas y OSC para coordinar el trabajo de todos los asociados, con la conducción del 'Consejo Nacional de Atención Integral al VIH y Sida' (CONASIDA).

Este Plan, está orientado a colocar al VIH como amenaza para la salud pública para el año 2030, a la eliminación del estigma y discriminación relacionada a la enfermedad, y al aseguramiento del compromiso que el país adquirió a: que el 90% de las personas que viven con VIH conozcan su estado serológico; que el 90% de las personas que sí lo conocen reciban un tratamiento adecuado y de calidad; y que el 90% de las personas que ya reciben este tratamiento puedan suprimir la carga viral63.

Además, se cuenta con un proyecto país llamado 'Costa Rica, Modelo Sostenible de Prevención Combinada y Atención a la Población de Hombres que tienen Sexo con Hombres (HsH) y Trans Fémina' el cual fue aprobado por el Fondo Mundial de lucha contra el SIDA, la Tuberculosis y la Malaria para el periodo (2015-2018). El objetivo principal de este proyectoes contener la epidemia VIH en estas poblaciones, al asegurar el acceso universal a la prevención, tratamiento, atención y cuidado del VIH; mejorar el entorno legal, social y político para el ejercicio pleno de los derechos humanos de estas poblaciones y proveer al país con información estratégica en VIH necesaria, para las poblaciones clave, para una mejor y adecuada toma de decisiones a nivel político e institucional (nota 64).(p62-65)

Cyprus

National strategy, reduce incidence, various target groups ... Target 3.3 a Strategic Plan on Control HIV/AIDS epidemic is in place and a National Committee implemented the various actions under the Ministry of Health, in which different government and non-governmental organizations were represented. A National Strategy to control tuberculosis was developed and approved by the Council of Ministers in 2016. A National Committee nominated by the Minister of Health is responsible for its implementation. The target is to reach a steady downward trend in the spread of HIV, hence the following activities are being carried out: prevention activities for various target groups; HIV testing and counselling; prevention of HIV and AIDS, as well as treatment, care, monitoring and assessment; developing the related human and organisational resources.(p19)

El Salvador

Por otro lado, el país ha realizado esfuerzos importantes para identi car y mejorar su capacidad de respuesta para atención del virus de inmunode ciencia humana (VIH). En términos absolutos, la tendencia de noticación de casos nuevos de VIH/ sida aumentó de manera progresiva en los primeros 17 años hasta el 2001. Posteriormente, el comportamiento se estabilizó, alcanzando en 2016 los 1154 casos anuales. (p49-50)

Ethiopia

Prevention and control of communicable diseases: Prevention and control of communicable diseases is among the types of health services which received increased attention. HIV/AIDS, Malaria and Tuberclausis are the main communicable disseases. The government has shown concerted effort to prevent and control these communicable diseases by coordinating and leading all forces of development all over the country. Results achieved were remarkable. Activies involved included health sector capacity building, awareness creation, pooling of resources, setting institutional and coordination mechanisms, incorporating afffairs of HIV/AIDS in various sectors plans and programs and monitoring and evaluation of the programs. HIV/AIDS: Number of patients newly contracting HIV reduced considerably. Only 0.03% contracted HIV newly in the FY 2015/16. To eliminate HIV incidence, the government arranged for upto 10 million people to get tested for HIV and for the positive ones among these to receive ART. ... Patients that received and completed treatment in FY 2015/16 reached 92 percent. These commendable performances are attributed to the implementation of 'Community TB Detection Program', to the implementation of Synchronized TB-HIV/AIDS Prevention and Control and the Expansion of Services for the Supply of Anterotrovial drugs free of charge.(p27) ...
Data: HIV/AIDS incidence rate (%) Baseline (2014/2015): .03%. Performance (2015/2016): .03%. Planned target (2019/2020): .01%.(p48)

Guatemala

Indicador 3.3.1. Número de nuevas infecciones por el VIH por cada 1,000 habitantes no infectados, desagregado por sexo, edad y sectores clave de la población.(p105)
Estado de situación
El contagio y la transmisión del VIH se han convertido en un problema estructural de la salud pública. Esto se evidencia en que el indicador definido para el seguimiento de esta enfermedad conserva un patrón histórico que afecta a los mismos grupos de población que poseen el mayor riesgo y contexto de vulnerabilidad.
Para el año 2015 (línea de base), la epidemia de VIH/sida reportada por el MSPAS afectó mayormente al grupo etario adolescente y adulto joven, con predominio de las edades comprendidas entre los 19 y los 34 años de edad (54.9%), con mayor prevalencia entre personas del sexo masculino (68%). La infección predominó mediante vía de transmisión sexual (95.1%) y de madre a hijo (2.1%). En relación con el nivel de escolaridad, la mayoría se concentra entre personas con nivel primaria (27.4%); le siguen quienes tienen estudios de diversificado (17.0%); analfabetas (11.8 %); personas con nivel universitario (11.1%); y con estudios básicos (10.0%). También se cuenta un porcentaje de casos sin dato reportado (22.7%). La epidemia tiene mayor incidencia en mestizos (78.2%), y en cuanto a estado conyugal se cuentan más casos entre solteros (60.4%); les siguen quienes están en unión libre (19.1%) y casados (17.5%). Con respecto al lugar de residencia, el predominio se da en los residentes de los departamentos de Guatemala (42.0%), Escuintla (11.4%), Izabal (6.0%), San Marcos (5.19%), Retalhuleu (3.9%), Petén (3.2%) y Alta Verapaz (3.1%). De los datos anteriores se podría establecer que la aproximación al perfil de una persona con más riesgo de contraer el virus del VIH o que vive con VIH, para el año 2015, fue: adulto joven, masculino, mestizo, soltero, con nivel de escolaridad bajo o analfabeta, que practica sus relaciones sexo genitales con diversas parejas sin métodos anticonceptivos de barrera y que reside primordialmente en los departamentos de Guatemala, Escuintla, Izabal, San Marcos, Retalhuleu, Petén y Alta Verapaz.
A la situación anterior se suman los casos atendidos por medio del seguro social. Según el Instituto Guatemalteco de Seguridad Social (IGSS), en la infección por VIH predomina un índice de masculinidad del 3.1, en edades de 31 a 45 años (48%), 46 a 60 años (21%), 18 a 30 años (20%), mayores de 60 años (11%) y menores de 18 años (0.4%).
Tabla 3.5 Incidencia de nuevas infecciones de VIH (2010-2015) 3.3.1 Número de nuevas infecciones por VIH por cada 100,000 derechohabientes de la población con seguro del sistema de salud pública. 2010: 35.1; 2011: 39.9; 2012: 43.9; 2013: 46.3; 2014: 48.9; 2015: 50.8. (p121-122)

Guatemala *(cont.)*

... El MSPAS ejecuta acciones vinculadas con el ODS 3 en seis programas presupuestarios: (12) fomento de la salud y medicina preventiva; (13) recuperación de la salud; (15) prevención de la mortalidad materna y neonatal; (16) prevención y control de infecciones de transmisión sexual (ITS) y VIH/sida; (17) prevención y control de la tuberculosis; (18) prevención y control de enfermedades vectoriales y zoonóticas. El presupuesto asignado y ejecutado que se relaciona con cada acción priorizada se planifica y emplea según cada programa presupuestario. Tabla 3.15 Gasto en salud en acciones estratégicas (2016-2017) Meta 3.3 Secto VIH y otros, Programa 16,17,18: Personas atendidas para la prevención de ITS y VIH 2016 Asignado:53.01; Ejecutado: 46.03; Personas: 563,089. 2017 Asignado: 65.94; Ejecutado: 1.7; Personas:227,454
Personas atendidas con diagnóstico de ITS y/o VIH: 2016: Asignado:28.83; Ejecutado: 24.52; Personas: 93,101. 2017: Asignado: 24.83; Ejecutado: 4.64; Personas: 20,481. ... Su quehacer incorpora el enfoque de intersectorialidad de derechos en los procesos institucionales, identificando la gestión de agendas para responder a las demandas que presentan las mujeres viviendo con VIH, los grupos LGTBTI, las mujeres trabajadoras sexuales, mujeres de la tercera edad, mujeres migrantes y mujeres discapacitadas, con lo cual se contribuye a la reducción de brechas de desigualdad. ... La Fundación Fernando Iturbide, por su parte, cuenta con programas de educación sexual y reproductiva, importancia del cuidado de la salud, formas de transmisión de ITS y VIH/sida, empoderamiento y equidad de género para el cuidado de la salud y para vivir en una cultura de salud.
...Onusida, en su línea estratégica estipulada en el Undaf actual, se vincula con el indicador de desarrollo social que busca que las poblaciones priorizadas aumenten su acceso a servicios integrales de salud de calidad, con pertinencia cultural y equidad, en los que se promuevan acciones enfocadas en los grupos de mayor riesgo para que puedan acceder a servicios de prevención de ITS y VIH. Entre sus acciones, elaboró en 2016 el estudio Caso de inversión para Guatemala76 y socializó el documento final con el MSPAS, el Minfin y la Comisión de Finanzas del Congreso de la República. En el documento se presentan y analizan los diversos posibles escenarios, mostrando el impacto de una asignación efectiva de recursos sobre los costos futuros de la respuesta nacional, y el consiguiente impacto en las infecciones y muertes evitadas. En este mismo esfuerzo, el PMA, con el propósito de fortalecer la respuesta integral frente al VIH, busca generar evidencia relacionada con el estado nutricional de las personas viviendo con VIH. Actualmente, se encuentra en proceso la realización de la investigación denominada «Seguridad alimentaria nutricional de las personas con VIH que asisten a las unidades de atención integral en Guatemala». ...
Este mismo fondo realiza acciones dirigidas a fortalecer las capacidades de cuatro organizaciones de la sociedad civil para la incidencia, diálogo político y auditoría social, a nivel nacional y territorial, en los ámbitos de acceso a servicios de salud sexual y reproductiva, planificación familiar, atención integral de las personas trans, VIH y derechos humanos, defensa, promoción y protección de tales derechos, y posicionamiento de los derechos sexuales y reproductivos de las poblaciones en más alto riesgo.
Desde la cooperación bilateral, el Gobierno del Reino Unido, a través del Departamento de Desarrollo Internacional (DFID, por sus siglas en inglés), aun cuando no tiene presencia en el país y no cuenta con un instrumento de cooperación con el Gobierno guatemalteco, apoya al país por medio de proyectos de cooperación multilateral con impacto directo, entre los que destaca el apoyo para el combate a la tuberculosis, VIH/sida y malaria, implementado por el Fondo Global. Además, el Reino Unido contribuye con fondos específicos para el combate de estas enfermedades y apoya la gestión de UNFPA en Guatemala.(p136-138)

India

Specific targets under the national health policy 2017: achieve the global target of 90-90-90 for HIV/AIDS by 2020 (p14)

Indonesia

The prevalence of TB, leprocy, filariasis and malaria is significantly declining, but prevalence of HIV/AIDS is still high. (Pg. ix)

The HIV prevalence is controled below 0.5% and ARV treatment has increased. The trend of HIV/AIDS cases has increased yet it is still below 0.50%. The prevalence of HIV reaches 0.37% in 2016. Meanwhile, the AIDS case rate is at 28.45/100,000 population in 2016, varies from the lowest in West Sulawesi Province (0.09/100,000 population) and the highest in Papua Province (416.91/100,000 population). However, AIDS cases have already reached the household level where the AIDS cases at present infant. Therefore, the government commits to control the HIV prevalence below 0.50% among others through the sustainable comprehensive services at the districts/municipalities to provide HIV/AIDS service to the community, as well as the Prevention Mother to Child Transmission (PMTCT) program. The AIDS case fatality rate (CFR) decreased from 13.55% (2005) to 1.11% (2016). The number of people living with HIV and AIDS who received the Antiretroviral (ARV) treatment has increased from 2,381 (2005) to 77,748 (2016). (p. 34-35)

Kenya

Ensuring healthy lives and wellbeing for all at all ages is one of the goals that form part of the unfinished business of the MDGs. Although significant progress has been made, indicators such as maternal mortality rate, under-five mortality rate and neonatal mortality rate and the HIV incidence rate have not been on track. A wide range of initiatives are strengthening service delivery and improving health outcomes such as enhanced investments in human resource for health, , the equipment leasing strategy, HIV related stigma reduction initiative and expanded treatment coverage. ...

To address the maternal and child health, a number of innovative interventions are being implemented. One such intervention is Beyond Zero campaign an initiative of H.E. First Lady, Mrs. Margaret Kenyatta which aims to end preventable deaths among women and children and give new impetus to fight against HIV through policy prioritization, resource allocation and improved service delivery. The campaign seeks to leverage on the convening power of the First Lady for strengthening existing health and community systems, mobilizing the contributions of private and public sectors and development partners, catalyzing innovation and accelerating action by stakeholders and political leaders for the full implementation of Kenya's HIV, maternal and child health commitments.(p2) ... The national HIV response has been a leading example in establishing an inclusive response, fostering multi-sectoral partnerships and pursuing innovative approaches. (p3)

... For social development and to meet the basic needs of its people Kenya is investing in its people by undertaking transformation in 6 key social sectors: Education and Training; Health including HIV and AIDS; (p5) ... Currently, the number of new HIV infections per 1,000 uninfected is 146.According to the HIV estimates report(2016) HIV preference rate realized a significant drop from 6.7% in 2003 to 5.9% in 2015. However, the prevalence rate among women at 6.3% remains higher than their male counterparts at 5.5% in 2015. The number of new infections annually fell by 19% overll and by 66% with regards to transmission from mother to child from 12,000 to 4,6000 between 2013 and 2016. The proportion of pregnant women, adults and children who tested positive and were put on ARVs increased to 66% of those living with HIV and an estimated 580,000 deaths were averted by 2016 by scaling up ART.

The HIV and AIDS equity Tribunal was established in 2009, under section 25 of the HIV prevention and Control Act of 2006. IT is the only HIV specific statutory body in the world and it is granted powers of a subordinate court and has the broad mandate to "ear and determine complaints arising out any breach of the provisions of HAPCA, excluding criminal jurisdiction and may perform any other such functions as may be conferred upon if by HAPCA or any other written law being in force. The tribunal has contributed to reducing HIV related stigma and discrimination through various awards, and has presented an alternative avenue for redress for HIV related human rights violations and has improved justice adjudication over 2000 cases. As the only judicial mechanism in the world specifically dedicated to the epidemic, HIV and AIDS Tribunal of Kenya can serve as a possible model for replication in other countries.

Kenya *(cont.)*

The Beyond Zero Campaign initiative by H.E. First Lady, Mrs. Margaret Kenyatta aims to end preventable deaths among women and children and give new impetus to fight against HIV through policy prioritization, resource allocation and improved service delivery. The campaign seeks to leverage on the convening power of the First Lady for strengthening existing health and community systems, mobilizing the contributions of private and public sectors and development partners, catalyzing innovation and accelerating action by stakeholders and political leaders and promote leadership and accountability at family, community and national levels for the full implementation ofKenya's HIV, maternal and child health commitments. The achievements of the campaign include delivery of mobile clinics to all 47 county referral hospitals in the country. By bringing health delivery closer to Kenya's citizens, the mobile clinics have been able to treat mothers and children who would otherwise have been obliged to walk miles to seek treatment. This has contributed to a 66% drop in HIV infections from mother to child between 2013 and 2016. ... Kenya HIV and Health situation room: As part of the big data collaboration, this platform has revolutionalized data management programme tracking and evaluation by bringing together data from four(4) different agencies of Government in five(5) sub-system to provide easy to interpret graphical representation of the HIV situation on health facility and community services uptake, commodity supply that is allowing national and county managers to track performance real-time. It is now being expanded to other reproductive maternal health indicators.(p23-26)

Malaysia

Key Development Achievements: reversed the spread of HIV/AIDS (p. iv) ...
Communicable diseases are also under control, with sustained efforts resulting in drastic declines in malaria incidence and new HIV infections, as well as stabilisation of HIV-related deaths. (p. 19)...
50% decline in new HIV cases from 22 (2000) to 10.9 per 100,000 uninfected population (2015) (p.20) ...
Key success factors: Partnership with NGOs to serve specialised needs (e.g., HIV/AIDS, elderly, persons with disabilities) (p. 21)

Maldives

Maldives has seen substantial progress in eradicating extreme poverty and hunger, achieving universal primary education, reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases. (p4) ...
The Maldives is further committed to tackle HIV/AIDS, TB and other communicable diseases whilst grappling to control frequent outbreaks of vector borne diseases such as dengue and chikungunya.(p9)

Nepal

Other targets include the virtual elimination of the prevalence of HIV.... (p2)

Netherlands

Through awareness-raising programmes at schools, prevention of teenage pregnancies and the provision of HIV screening and medication, special attention is given to the position of young people.(p20) ... [Curaçao:] In addition, approximately 35% of HIV/AIDS cases are undocumented. This challenge is not unique to Curaçao.(p22)

Nigeria

...the incidence of Human Immuno- deficiency Virus (HIV) infections, Tuberculosis and Malaria was reduced. (p. 28)...
New HIV infections per 1,000 uninfected population: Baseline (2015): 264; Derived 2020 Benchmark: 176. 2030 Target: 0. (p. 29) ...
An estimated new infection rate of 264 for every 1,000 uninfected persons for HIV and Acquired Immune Deficiency Syndrome (AIDS) will be reduced significantly through the provision of anti-retroviral medication to people living with the disease. The prevention of mother to child transmission is also accorded priority. (p. 30) ...
Programmes that are designed towards reduction in the scourge of HIV and AIDS, Tuberculosis (TB) and Malaria are common among stakeholders in the health sector. Most states have established State Agency for the Control of AIDS (SACA) to institutionally coordinate public health measures deployed in the last decade expanding prevention, through advocacy for increased spending. The aim is to reduce the prevalence rate of HIV and AIDS, malaria and tuberculosis. Other services include clinical consultation, counselling and testing for HIV, antiretroviral therapy and ambulance services. (p. 31)...
New Life Community Care Initiative (NELCCI) campaigns for implementation of SDGs in rural communities within the South-East Region of Nigeria. As part of its SDGs implementation campaign, NELCCI collaborates with the State Agency for the Control of AIDS to run HIV status test in rural communities. Findings from NELCCI's test reports serve as one of the main information source for the Agency to plan for supplies of Anti- Retroviral (ARV) drugs and other referral services. (p. 32)...
The girl-child is exposed to VVF and HIV and AIDS through early marriage, which impedes her growth and development. (p. 37)

Panama

En el marco de disminuir las brechas en la mortalidad de los niños (as) menores de cinco años, mejorar la salud materna y combatir el VIH/SIDA, el Paludismo (Malaria) y otras enfermedades, señaladas en la evaluación de los Objetivos de Desarrollo del Milenio (ODM), y dar cumplimiento a los ODS, el Ministerio de Salud inicia el proceso de definición de objetivos estratégicos, metas e indicadores para abordar los nudos críticos identificados y la elaboración del Plan 2030, que implica el desarrollo de procesos en el tiempo y espacio, de la mano de la sustentabilidad, la eficiencia, eficacia y la equidad de los servicios.(p46) ... Tasa estimada de incidencia del VIH en menores de 15 años por 1.000 personas no infectadas (Unidades) 20005: 0.03; 2006: 0.03; 2007: 0.04; 2008: 0.02; 2009: 0.02; 2010: 0.02; 2011: 0.01; 2012: 0.01; 2013:0.01; 2014: 0.01; 2015: 0.01. Tasa estimada de incidencia del VIH (Total) por 1.000 personas no infectadas (Unidades): 20005: 0.27; 2006: 0.27; 2007: 0.27; 2008: 0.27; 2009: 0.27; 2010: 0.27; 2011: 0.26; 2012: 0.26; 2013:0.26; 2014: 0.26; 2015: 0.26. (p47)...
CUADRO 14. ACCIONES RELEVANTES PARA PROMOVER LA SALUD Y EL BIENESTAR ... Promover el abordaje integral de las enfermedades crónicas, Salud mental, violencia y accidentes viales, control del tabaco, enfermedades infecciosas prevalentes (malaria, VIH/sida, Tuberculosis) y zoonóticas, derechos de la salud sexual y reproductiva. ...(p52)

Peru

En todos los talleres de consulta se recopilaron visiones de desarrollo al año 2030, que fueron publicadas en un informe de setiembre de 2013 titulado "¿Qué futuro queremos para el Perú?", con los resultados de las consultas realizadas. Estas consultas priorizaron las voces de aquellas personas tradicionalmente excluidas de los procesos de toma de decisión, incluyendo a mujeres afro-descendientes e indígenas amazónicas y alto-andinas, niñas y niños, personas con discapacidad, líderes locales y representantes de organizaciones de base, personas viviendo con VIH/SIDA, jóvenes de ambos sexos, trabajadoras del hogar, entre muchas y muchos más.(p12)

Portugal

In particular, the National Health Plandetermines the development of priority health programmes in 11 areas, including viral hepatitis, HIV/AIDS infection and Tuberculosis.(p23)

Slovenia

The number of people infected with HIV is low (less than 1 per 1,000 people). The new National Strategy for Prevention and Control of HIV Infections 2017–2025 aims to make Slovenia a country with very few new HIV infections, which will be detected at an early stage and treated successfully. The strategy also addresses prevention of spreading of other sexually transmitted diseases.(p23)

Sweden

In 2015, 450 cases of HIV infection were reported in Sweden. Over the last five years, the level has been an average of 455 new cases annually. Of these, about 80 per cent are foreign-born persons, of whom a large proportion had the infection before their arrival in Sweden. Today, approximately 74 persons per 100 000 inhabitants (approximately 0.07 per cent) have HIV, which is among the lowest rates in Europe. Just over 7 000 people are living with diagnosed HIV infection. Since 2005, Sweden has had a national strategy on HIV/AIDS and other infectious diseases. Sweden is the first country in the world to have achieved one of the UN targets for HIV, the UNAIDS 90-90-90 target.(p21)

Thailand

New cases of pandemic diseases are also on the decline. Statistical appendix: UNAIDS estimated in the year 2014 that the population rates, per 100,000 people, of new HIV infections ranged from just 0.06 – 0.16 people. In 2016, the World Health Organization (WHO) recognized Thailand as the first country in Asia and the second country in the world to eliminate the mother-to- child transmission of HIV and syphilis.(p13) ... 79.89 percent of registered HIV-infected and AIDs patients have access to antiviral drugs.(p15)

Uruguay

Objectivos sanitarios nacionales: 2.3 2.3. Reducción de la morbimortalidad por vih/sida. 3.3 3.3. Eliminación de la transmisión vertical de sí lis y vih.(p91) ... 2.1. MARCO NORMATIVO NACIONAL Y COMPROMISOS INTERNACIONALES Consenso de Montevideo hacia la Conferencia 2014 de El Cairo+20 (2013), que incluyó el acuerdo de "garantizar el acceso efectivo a una amplia gama de métodos anticonceptivos modernos, basados en evidencia cientí ca con pertinencia cultural, incluyendo la anticoncepción oral de emergencia" (Medida prioritaria 44); e "implementar programas de salud sexual y salud reproductiva integrales, oportunos y de calidad para adolescentes y jóvenes, que incluyan servicios de salud sexual y salud reproductiva amigables, con perspectiva de género, derechos humanos, intergeneracional e intercultural (...) para que tengan una vida sexual responsable, placentera y saludable, eviten los embarazos tempranos y los no deseados, la transmisión del vih (...)" (Medida prioritaria 12) (13)(p95-96). ... Meta 3.3 sida, tuberculosis, malaria y otras enfermedades transmisibles: 3.3.1. Número de nuevas infecciones por vih por cada 1.000 habitantes no infectados, desglosado por sexo, edad y sectores clave de la población. 27,3/100.000 hab. (2015, devisa-msp) M: 36,2/100.000 hab. F: 17,8/100.000 hab. La estimación para el año 2015 de la prevalencia de vih, utilizando el sistema de modelaje Spectrum, recomendado por onusida, fue de 0,5% en población de 15 a 49 años. Se estima que existen 12.000 personas con vih en el país, de las cuales 10.000 conocen su estado serológico (38). En 2015, la tasa de nuevas infecciones alcanzó un valor de 27,3 por 100.000 habitantes, en una tendencia descendente y con predominio en varones (Grá co 4). Grá co 4. Evolución de la tasa de noti cación (por 100.000 hab.) de nuevas infecciones de vih. Uruguay 2011-2015 Tasa globale: 2011: 34.58; 2012: 34.90; 2013: 30.84; 2014: 28.58; 2015: 27.36; Masculino: 2011: 44.71; 2012: 45.36; 2013: 41.43; 2014: 38.56; 2015: 36.25; Feminino: 2011: 24.42; 2012: 25.02; 2013: 20.82; 2014: 19.17; 2015: 17.88; Fuente: msp. devisa – Área Programática its - vih/sida. La tasa de nuevas infecciones es más alta en el grupo de 25 a 44 años, seguida por el grupo de 45 a 64 años. Este comportamiento se ha mantenido en varones desde 2011 (Gráfico 5) y aparece en el sexo femenino a partir de 2014. En 2015, entre las personas privadas de libertad (ppl) la prevalencia de vih alcanzaba el 1,3%; predominando en mujeres (39)

Uruguay *(cont.)*

En 2015, la tasa de transmisión vertical (tv) de vih fue de 1,8% (2/112); 1,25% (1/80) en el subsector público y 3,1% (1/32) en el privado. Esto indica que se alcanzó la meta de eliminación (< 2%) a nivel nacional en el subsector público, no así en el privado (por su bajo número de mujeres embarazadas con vih).
La cobertura de la terapia antirretroviral (tarv) al momento de la gestación en mujeres con vih conocido previo al embarazo es de 63%, una cifra mayor a la estimada en la población global (50% en 2015). Las mujeres embarazadas con vih, conocido previo al embarazo, con atención en el subsector privado, tuvieron una cober- tura de tarv signi cativamente mayor (100%) respecto a las del subsector público (47%). El inicio de tarv en el embarazo (o su mantenimiento en aquellas que ya lo recibían al momento de la concepción), alcanzó un 89% en el snis (meta oms 95%), menor en el sector público (87,2%) respecto al privado (93,8%) (40). (p108)... El vih muestra una tendencia a la baja en la tasa de noti caciones nuevas en todos los grupos etarios y ha descendido la mortalidad por esta causa. La transmisión vertical del vih está muy próxima a los niveles de eliminación con un 1,8%. ... Notas: MinisteriodeSaludPública.DíaMundialdelvih/sida.Año2016.DepartamentodeVigilanciaen Salud – Área Programática its - vih/sida. digesa. En: http://www.msp.gub.uy/sites/default/ les/ archivos_adjuntos/DIA_VIH_2016%20_1_.pdf (p115)
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Meta 5. ... A su vez, se han desarrollado distintas intervenciones públicas vinculadas a la temática (como ya se mencionó en el capítulo del ods 3, la meta 3.7) con el n de dar vigencia a esta normativa como, por ejemplo: el acceso a mac modernos a través del Sistema Nacional Integrado de Salud, la interrupción voluntaria del embarazo, acciones vinculadas con la humanización del parto, la reproducción asistida, el combate a las Infecciones de Transmisión Sexual (its) – vih, el acceso a servicios de salud sexual y salud reproductiva en todos los prestadores de salud, entre otras. Cuadro 2. Programas, comisiones y planes para garantizar srr: Plan de impacto para erradicar la Sí lis congénita y vih (2010) (p153) Nota: 34 El msp elaboró seis guías clínicas que regulan la implementación de los servicios de ssr: "Guía para implementar servicios para la atención de la salud sexual y reproductiva de las instituciones prestadoras de salud" (2010), "Guía clínica de diagnóstico, monitorización y tratamiento de sí lis en la mujer embarazada y sí lis congénita" (2012), "Guía técnica para la interrupción voluntaria del embarazo ive" (2012), "Guías en Salud Sexual y Reproductiva. Capítulo: Abordaje de la Salud Sexual y Reproductiva en personas con discapacidad" (octubre, 2012), "Guías Nacionales para el Abordaje de la Confección Tuberculosis y Virus de Inmunode ciencia Humana" (octubre, 2012), "Guía clínica para la eliminación de la sí lis congénita y transmisión vertical de vih" (2013).(p 340) ... Indicador 3.3.1: Número de nuevas infecciones por el vih por cada 1.000 habitantes no infectados, desglosado por sexo, edad y sectores clave de la población Nivel de disponibilidad del dato en Uruguay: 2 Nivel de disponibilidad del dato a nivel mundial: 2 (p339) Indicador 3.3.1 – suplementario: Número de casos con rmados de vih según sexo Total: 2011: 1055; 2012: 1196; 2013: 1062; 2014: 986; 2015: 945; Masculino: 2011: 705; 2012: 751; 2013: 689; 2014: 644; 2015: 617; Femenino: 2011: 445; 2012: 443; 2013: 370; 2014: 342; 2015: 325; Muertes SIDA: 2011: 199; 2012: 186; 2013: 174; 2014: 175; 2015: 170; Fuente: Ministerio de Salud Pública (p 341)
Fórmula de cálculo: Número de casos con rmados vih. Indicador 3.3.1 – complementario: Nuevas infecciones vih según tramo de edad: Total: 2011: 1055; 2012: 1196; 2013:1062; 2014: 986; 2015: 945; 1-14: 2011: 12; 2012: 14; 2013: 10; 2014: 5; 2015: 5; 15-24: 2011: 147; 2012: 139; 2013: 139; 2014: 140; 2015: 122; 25-34: 2011: 300; 2012: 263; 2013: 290; 2014: 262; 2015: 245; 35-44: 2011: 226; 2012: 192; 2013: 274; 2014: 226; 2015: 248; 45-54: 2011: 102; 2012: 131; 2013: 202; 2014: 198; 2015: 167; 55 y +: 2011: 74; 2012: 76; 2013: 108; 2014: 107; 2015: 118; Sin dato: 2011: 194; 2012: 361; 2013: 39; 2014: 48; 2015: 42; Fuente: Ministerio de Salud Pública

Uruguay *(cont.)*

Fórmula de cálculo: Número de casos con rmados vih.
Indicador 3.3.1 – complementario: Vía de transmisión vih: Total: 2011: 1055; 2012: 1196; 2013: 1062; 2014: 986; 2015: 945; Sexuale: 2011: 666; 2012: 784; 2013: 792; 2014: 496; 2015: 753; Sanguinea: 2011: 37; 2012: 50; 2013: 53; 2014: 40; 2015: 46; Vertical: 2011:99; 2012: 9; 2013: 3; 2014: 5; 2015: 4; Sin dato: 2011: 343; 2012: 353; 2013: 254; 2014: 445; 2015: 142; Fuente: Ministerio de Salud Pública
Fórmula de cálculo: Número de casos con rmados vih.
Indicador 3.3.1 – complementario: Transmisión vertical vih: Niños infectados 2011: 9; 2012: 9; 2013: 2; 2014: 5; 2015: 2; Expuestos: 2011: sd; 2012: 142; 2013: 124; 2014: 4; 2015: 2; Tasa de transmisión vertical: 2011: sd; 2012: 6; 2013: 2; 2014: 4; 2015: 2; Fuente: Ministerio de Salud Pública
Fórmula de cálculo: Número de casos con rmados vih. Indicador 3.3.1 – complementario: Nuevas infecciones vih según departamento Total: 2011: 1055; 2012: 1196; 2013: 1062; 2014: 986; 2015: 945; Montevideo: 2011: 641; 2012: 736; 2013: 631; 2014: 605; 2015: 565; Artigas: 2011: 19; 2012: 14; 2013: 21; 2014: 19; 2015: 20; Canelones: 2011: 111; 2012: 129; 2013: 87; 2014: 83; 2015: 88; Cerro Largo: 2011: 10; 2012: 10; 2013: 16; 2014: 12; 2015: 17; Colonia: 2011: 12; 2012: 14; 2013: 18; 2014: 13; 2015: 20; Durazno: 2011: 8; 2012: 5; 2013: 4; 2014: 8; 2015: 5; Flores: 2011: 1; 2012: 4; 2013: 5; 2014: 3; 2015: 6; Florida: 2011:4 ; 2012: 7; 2013: 11; 2014: 5; 2015: 9; Lavalleja: 2011: 5; 2012: 9; 2013: 4; 2014: 6; 2015: 10; Maldonado: 2011: 70; 2012: 57; 2013: 63; 2014: 66; 2015: 44; Paysandu: 2011: 22; 2012: 19; 2013: 21; 2014: 23; 2015: 24; Rio Negro: 2011: 3; 2012: 7; 2013: 17; 2014: 5; 2015: 8; Rivera: 2011: 38; 2012: 24; 2013: 43; 2014: 24; 2015: 27; Rocha: 2011: 19; 2012: 14; 2013: 17; 2014: 16; 2015: 16; Salto: 2011: 34; 2012: 33; 2013: 22; 2014: 31; 2015: 38; San Jose: 2011: 22; 2012: 21; 2013: 31; 2014: 24; 2015: 20; Soriano: 2011:14 ; 2012: 20; 2013:19 ; 2014: 24; 2015: 14; Tacuarembo: 2011: 15; 2012: 10; 2013: 13; 2014: 9; 2015: 9; Treinta y Tres: 2011: 7; 2012: 6; 2013: 9; 2014: 10; 2015: 5; Sin Dato: 2011: 0; 2012: 57; 2013: 10; 2014: 0; 2015: 0; uente: Ministerio de Salud Pública
Fórmula de cálculo: Número de casos con rmados vih. Indicador 3.3.1 – complementario: Incidencia vih (cada 1.000 habitantes no infectados) según sexo y tramo de edad. Total: 2011: 0.36; 2012: 0.35; 2013: 0.34; 2014: 0.33; 2015: 0.31; 2016: 0.30; menores de 15: 2011: 0.0; 2012: 0.0; 2013: 0.0; 2014: 0.0; 2015: 0.0; 2016: 0.0; 15 y mas: 2011: 0.21; 2012: 0.20; 2013: 0.19; 2014: 0.18; 2015: 0.17; 2016: 0.17; Total:2011: 0.36; 2012: 0.35; 2013: 0.34; 2014: 0.33; 2015: 0.31; 2016: 0.30; Femenino: 2011:0.07; 2012: 0.07; 2013: 0.06; 2014: 0.06; 2015: 0.06; 2016: 0.07; Masculino: 2011: 0.26; 2012: 0.25; 2013: 0.24; 2014: 0.23; 2015: 0.22; 2016: 0,53. Fuente: Ministerio de Salud Pública
Fórmula de cálculo: Número de casos con rmados sobre población total por mil habitantes. Indicador 3.3.1 – complementario: Tasa de mortalidad por hiv/sida por cada 100.000 habitantes. 2010: 5.60; 2011: sd; 2012: 5.40; 2013: 5.00; 2014: 5.10; 2015: 4.90.

Zimbabwe

A robust HIV/AIDS response strategy. Zimbabwe has also pioneered innovative approaches including mobilising of domestic resources through the AIDS levy to ensure sustainability. This is being supplemented by donor support to the health sector through the Health Development Fund and the Global Fund which secured. Of concern is the unavailability of current comprehensive data on the burden of non- communicable diseases (NCDs) and their risk factors due to failure by the country to conduct the recommended WHO NCD STEPWISE survey and this has impacted negatively on any meaningful NCD programming. Notwithstanding, Zimbabwe has made significant progress in the health front including:
· Drop in HIV prevalence to 14 per cent in 2016 (Female at 16.6 per cent; Male at 11.2 per cent) from 18 per cent in 2005/06(p7). ...
A strong partnership between government and development partners has been established through the Zimbabwe UN Development Assistance Framework (ZUNDAF). The onset of the implementation of the SDGs coincided with the first year of implementing the new ZUNDAF (2016 – 2020). The ZUNDAF (2016-2020) is supporting national development efforts in six result areas that are fully aligned to the Sustainable Development Goals (SDGs) namely: Social Services and Protection; Poverty Reduction and Value Addition; Food and Nutrition; Gender Equality; HIV and AIDS; and Public Administration and Governance. ZUNDAF presents a good opportunity to mainstream and align the SDGs with the national priorities.(p16) ...

Zimbabwe*(cont.)*

The 2016-2020 Zimbabwe United Nations Development Assistance Framework (ZUNDAF) is aimed at promoting inclusive growth and sustainable development by supporting national development priorities as informed by the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET) as well as advancing the achievement of the SDGs. ZUNDAF results which are linked to ZIMASSET and the SDGs are guided by six national priority areas, namely: 1. Food and Nutrition Security 2. Gender Equality 3. HIV and AIDS 4. Poverty Reduction and Value Addition 5. Public Administration and Governance 6. Social Services and Protection.(p17) ...

A robust HIV/AIDS response strategy. Zimbabwe has also pioneered innovative approaches including mobilising of domestic resources through the AIDS levy to ensure sustainability. This is being augmented by donor support to the health sector through the Health Development Fund and the Global Fund which secured over $400 million for HIV related interventions. The Ministry of Health has adopted the national consolidated HIV guidelines in line with the 2015 World Health Organisation guidelines. This has resulted in the development of an HIV Prevention Revitalisation Roadmap to guide implementation of high impact HIV prevention interventions, particularly targeting hotspots and key populations. ... The Revised Gender Policy (2017) has a thematic area on Gender and Health. The policy recognise that gender inequality is responsible for most of the health issues. It further acknowledged that poor access to health services (particularly cancer management services), HIV and AIDS drugs, safe water and sanitation impacts negatively more on women than men and provide strategies to improve gender sensitivity in health service delivery. Status and Trends: Despite challenging economic conditions and dwindling allocations of the national budget to health (see Table 3), Zimbabwe has made significant progress in the health front including: HIV prevalence has declined from 18 per cent in 2005-06 to 13.8 per cent in 2015 percent among women and men age 15-49. It is still higher among women at 16.7 per cent as compared to men (10.5 per cent). HIV prevalence among young people aged 15-24 is also higher among young women (6.7 percent) compared to 2.9 percent. Owing to a combination of robust HIV prevention programmes that included social marketing, massive community mobilisation and awareness campaigns combined with HIV-counselling and testing, condom promotion and distribution, prevention of mother to child transmission and others, Zimbabwe has become a global example in HIV prevention.

· The scale up of treatment services played a major part in lowering both the HIV prevalence and incidence. The Global Fund disbursed US$125 million during 2016. As at September 2016, close to a million people were provided with ART and nearly two million people were HIV tested, counselled and received their results (women accounting for 63 per cent of the coverage in each).(p24-25)

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ABOUT

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About MSMGF

The Global Forum on MSM & HIV (MSMGF) was founded in 2006 at the Toronto International AIDS Conference by an international group of activists concerned about the disproportionate HIV disease burden being shouldered by men who have sex with men worldwide. Today, we are an expanding network of advocates and experts in sexual health, human rights, research, and policy, working to ensure an effective response to HIV among gay men and other men who have sex with men. MSMGF watchdogs public health policies and funding trends; strengthens local advocacy capacity through our programs initiatives; and supports more than 120 community-based organizations across 62 countries who are at the frontlines of the HIV response.

@msmgf • msmgf.org • contact@msmgf.org
1111 Broadway, 3rd Floor, Oakland, CA 94607 U.S.A.
P: +1.510.849.6311

About The Platform

The Platform works towards achieving UNAIDS 2020 and 2030 targets by advising UN agencies, the Global Fund, U.S. PEPFAR, bilateral donors, and international funders of the global HIV response. Convened by MSMGF and UNAIDS, the Platform, in partnership with grassroots advocates and their networks represented by the Consortium of MSM and Transgender Networks, takes an active role in elevating the sexual health and human rights concerns of gay, bisexual and other men who have sex with men in the context of the global HIV response.

Free Space Process

The Free Space Process (FSP) partnership brings together 11 international civil society, key population networks, and network organizations in an effort to proactively coordinate and collaborate on joint advocacy. FSP provides a "free space" for partners to discuss and work on common strategic policy and aims to maximize dynamic, experienced, and well connected advocacy for greater effect and combined policy impact.

icssupport.org/what-we-do/free-space-process/

* PSF comprises the Partnership to Inspire, Transform and Connect the HIV response (PITCH), Stop AIDS Alliance, and Free Space Process.

FREE
SPACE
PROCESS

THE GLOBAL ADVOCACY
PLATFORM
TO FAST TRACK THE HIV AND
HUMAN RIGHTS RESPONSES
WITH GAY AND BISEXUAL MEN