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Report by the Committee of Cosponsoring Organizations

Additional documents for this item: *none*

Action required at this meeting - the Programme Coordinating Board is invited to: *take note of and give its comments on this report.*

Cost implications for decisions: *none*

INTRODUCTION

1. After two decades of expansion, the HIV epidemic has been pushed back: over 50 countries worldwide have achieved a reduction of total HIV infections by 25 percent or more. Reported coverage for ARV treatment has reached 47% in 2010 and treatments are far more affordable. In the last decade, the cost of anti-retroviral therapy (ART) has fallen from USD 30,000 per year to an average of USD 200 per year¹. In the last five years, HIV treatment has expanded 14-fold and over 5 million adults and children worldwide now receive life-saving ART, the fastest scale-up of life-saving treatment in history. New research findings² indicate that early antiretroviral treatment (ART) taken by the HIV-positive partner in a serodiscordant relationship provides a staggering 96 per cent protection against HIV acquisition by the HIV-negative partner. In the absence of a vaccine, we now know more than ever how to prevent new HIV infections from mother-to-child, amongst vulnerable populations and amongst adults in the general population. A new Investment Framework for the response indicates that millions of new infections and AIDS-related deaths could be averted through a set of strategic interventions, critical enablers and synergies. For the first time ever in the 30 year long history of the disease global leaders have begun to speak of the “beginning of the end of AIDS.”
2. However, despite the encouraging signs of success, over 2.7 million people become newly infected with HIV every year. For every three new people on treatment, five people become infected. At this pivotal moment in the AIDS history the strength and sustainability of leadership as well as commitment in the response are critical. Ironically however, at a time of optimism and hope, HIV funding is receding. The global economic crisis, other development priorities, and donor fatigue, have indeed left the world facing an imminent HIV and AIDS funding crisis. In 2011, overall development assistance fell by 3 percent, the first drop since 1997. AIDS financing from the Organization for Economic Co-operation and Development (OECD) countries fell for the first time in 2009 - forcing countries to start thinking about how to diversify their AIDS financing (by, for example, increasing the amount and sources of domestic financing and expanding their pool of external financing, including borrowing from developing banks) Funding cuts threaten to reverse some of the HIV prevention and treatment successes: some countries have been forced to restrict AIDS treatment enrollment to as far as possible ensure continuing support for those already on ART. HIV prevention budgets are increasingly tightened, heightening both the future AIDS treatment and prevention challenge.
3. After growing at about 20 percent annually for over a decade to reach \$8.7 billion in 2008, international HIV commitments leveled and disbursements fell by an estimated 10 percent in 2009³. While domestic financing is estimated at \$6.7 billion annually, this is only the case in middle and upper income countries. UNAIDS estimates at least \$17 billion from both international and domestic sources are required in 2012 to truly reach MDG-6 and reverse

¹ CHAI ART unit costing

² CAPRISA, I-PrEX trial, and the HIV Prevention Trials Network (HPTN) 052 trial

³ Source: Gorgens (2012), compiled from Schwartlander et al (2011), and UNAIDS & KFF (2011)

the epidemic. The transition from crisis management to a long term, sustainable response is key. Low income countries in sub-Saharan Africa are almost entirely reliant on external financing, however, prevention is slowly working and African countries are experiencing rapid economic and concomitant revenue growth. This transition will require both continued international assistance and increased domestic ownership and financing.

4. The Committee of Cosponsoring Organizations (CCO) has recognized the challenge ahead and continues to work concertedly to help countries accelerate the AIDS response in a way that safeguards the gains already made and builds on evidence-informed programmes to achieve sustainable progress. The CCO will extend greater support to countries to prioritize their AIDS responses in a context of budgetary constraints, by improving the efficiency and effectiveness of HIV program implementation and service delivery, in order to achieve the goals set out in the UNAIDS Getting to Zero Strategy and the 2011 Political Declaration on AIDS.
5. The CCO is also acutely aware of the importance of the current debate on the Post-2015 Development Agenda. Since their endorsement by the UN General Assembly, the MDGs have defined a common framework of priorities for the development community and helped draw much needed attention to the HIV and AIDS epidemic, which was then a global emergency. The past decade witnessed tremendous progress towards the realization of the MDGs. These gains must be protected in the Post 2015 Agenda. The current focus on Sustainable Development Goals and questioning of the relevance of three different Health MDGs in the global framework are worrisome. Health is an essential part of the development agenda and as such should be part of the future framework. Discussions are currently underway within and outside the UN system to redesign the Post-2015 Agenda. This process, led by UN DESA and UNDP, was formally launched earlier this year and will reach a key milestone with the special event on MDGs, at the 68th UNGA in September 2013.
6. All UNAIDS Cosponsors recognize the importance of maintaining focus over the next three years, on achievement of the MDGs, while simultaneously working with countries and development partners to build consensus around the Post-2015 Development Agenda. Cosponsors will work together to maintain positive momentum around the global HIV response and to ensure appropriate attention is given to HIV and AIDS in the Post-2015 Development Agenda.
7. With those challenges in mind, UNAIDS Cosponsors will continue to focus on the vision of “Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.” as well as the goals articulated in the 2011 Political Declaration on AIDS. This Report presents Cosponsors’ key priorities and results in 2011, and highlights our commitment to achieving country-level results with a greater level of accountability.
8. In addition, this report reflects the enhanced coherence of the UNAIDS family in implementing, through an efficient Division of Labor, targeted activities to meet the Joint

Programme's goals. This enhanced coordination embodies the UNAIDS family vision for "delivering as one".

9. To support and further strengthen the impact of the Joint Programme, UN Women, the entity for gender equality and the empowerment of women, created in July 2010 by the UN General Assembly, has submitted an official request to become a UNAIDS Cosponsor. The CCO has uniformly welcomed UN Women's request at its 2012 April meeting and recommended its acceptance as a Cosponsor by the PCB. Following the decision of the PCB, the CCO will work to integrate the new entity in the Joint Programme.
10. As a bigger UNAIDS family, we will keep on moving forward with renewed ambitions and dedication. Together, we will address, with even more efficiency, effectiveness, and coherence, the numerous challenges that still lie ahead as, together with our partners, we define the future of the AIDS response.

ANNEX

AGENCIES PROGRESS REPORTS

INTERNATIONAL LABOUR ORGANIZATION (ILO)

Total amount of spend on AIDS in 2011:

- at country level	\$11,265,165
- at regional level	\$2,187,455
- at global level	\$4,425,794
- total spend	\$17,878,414

Total amount received from UBW in 2011: \$4,004,904

Description of top 3 priorities and related key results:

Priority 1: Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half (Approximately 30% of total spend)

Background

The UNAIDS Strategy 2010 – 2015: *Getting too Zero* elevates Human Rights to the same level as Prevention and Treatment. Drawing inspiration from the UNAIDS Strategy, the ILO Programme on HIV/AIDS anchored its work around the theme: *Getting to Zero discrimination in the workplace*. The Recommendation on HIV and AIDS and the world of work (Recommendation No. 200) and the ILO Code of Practice provided the framework for the ILO's work on human rights.

Key results

- 42 countries and territories⁴ developed and implemented National tripartite HIV workplace policies based on technical and normative guidance from the ILO
- 32 countries⁵ developed and implemented National policies, Sectoral policies and legislation based on the principles of Recommendation No. 200

Country examples (High Impact Countries)

- In *South Africa*, Recommendation No. 200 was cited in a Johannesburg court case in which a HIV positive worker was awarded compensatory damages for unfair dismissal and discrimination on the grounds of his HIV status⁶.

⁴ Anguilla, Antigua and Barbuda, Armenia, Azerbaijan, Botswana, Brazil, Burundi, Burkina Faso, Cameroon, Chad, Chile, China, Congo, Costa Rica, Democratic Republic of Congo, Ethiopia, Ghana, Honduras, Kazakhstan, Kenya, Lesotho, Liberia, Malawi, Mali, Montserrat, Namibia, Nicaragua, Paraguay, Philippines, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Senegal, Sierra Leone, South Africa, Sri Lanka, Swaziland, Tajikistan, Tanzania, Thailand, Ukraine, Zambia, and Zimbabwe

⁵ Armenia, Azerbaijan, Botswana, Brazil, Burundi, Cambodia, Cameroon, Chile, China, Congo Brazzaville, Dominican Republic, Democratic Republic of Congo, Ghana, Kazakhstan, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Philippines, Saint Vincent and the Grenadines, Senegal, South Africa, Sri Lanka, Swaziland, Tajikistan, Thailand, Ukraine, Vietnam, Zambia, and Zimbabwe

⁶ http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_151844.pdf.

- In *Brazil*, Recommendation No. 200 was cited in 2 court cases where the ruling favored HIV positive workers who had been unfairly dismissed. The courts ordered that they be reinstated and compensated for lost wages and benefits.
- In *Ukraine*, the ILO provided technical and normative guidance during the development and enactment of a Law titled “*The Law of Ukraine on addressing the spread of illnesses caused by HIV, legal and social protection of people living with HIV*” which guarantees protection of the right to work for people living with HIV, members of their families and relatives and provides more active involvement of workplaces in prevention activities.

Priority 2: People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support (Approximately 27% of total spend)

Background

Social Protection is central to creating Decent Work and sustainable development. The ILO member States are in the process of adopting an autonomous Recommendation on the Social Protection Floor to broaden the coverage enjoyed by vulnerable workers.

Key results

- The ILO designed, developed and organized a new global state-of-the-art Social Protection training programme on the theme “HIV/AIDS and the world of work –a prevention and social protection perspective” in partnership with UNAIDS, WHO, the Global Network of People living with HIV (GNP+), UNICEF, WFP, HelpAge, FAO, UNICEF and the International Training Centre. The training programmes informed the implementation of social protection schemes at the national level.
- 33 countries⁷ implemented Social Protection schemes which included protecting the rights of PLHIV, health insurance coverage, social security, home-based care, cash transfers, micro finance and income generating activities with direct technical support from the ILO.

Country examples (High Impact Countries)

- Programmatic support to Cameroon to a Cooperatives project which has concurrently reinforced the knowledge levels of women infected or affected by HIV and increased the access to micro-credit facilities to grow their businesses and improve their livelihood;
- Normative guidance to China to organize workshops with the Ministry of Human Resource and Social Security (MOHRSS) policy makers, State Council AIDS Working Committee Office (SWACO) officials and CDC staff to discuss and address the revision of the current employment policy which excludes people living with HIV from working as civil servants;
- Tailored advocacy to India to Ministry of Labour and Employment (MOLE) to remove people living with HIV from the list of exclusions under the Rashtriya Swasthaya Blma Yojna (RSBY) – a health insurance scheme for unorganized workers;
- Evidence-informed advocacy based on the findings of the HIV-sensitive Social Protection research in Indonesia led to an announcement by the Ministry of Manpower and Transmigration that people living with HIV will no longer be excluded from the state health insurance scheme –Jamsostek.

⁷ Armenia, Benin, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, China, Congo Brazzaville, Democratic Republic of Congo, Ghana, Haiti, Honduras, Indonesia, Jamaica, Kenya, Malawi, Mali, Mozambique, Papua New Guinea, Philippines, Russian Federation, Senegal, South Africa, Sri Lanka, Swaziland, Tanzania, Thailand, Uganda, Ukraine, Vietnam, Zambia, and Zimbabwe

- Capacity building support to Mozambique for vocational training and the development of income generating initiatives and strengthened legislation for people living with and affected by HIV;

Priority 3: Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work (Approximately 25% of total spend)

Background

HIV Workplace programmes provide a valuable entry-point to reach large numbers of vulnerable workers in identified sectors with comprehensive HIV services and policies. The ILO approach to workplace programmes encompasses biomedical, behavioural and structural components aimed at addressing risk and vulnerability. The UNAIDS Know Your Epidemic – Know Your Response Approach is used to guide the identification of the target audience.

Key results

- 34 Countries⁸ (including 20 high impact countries) implemented HIV workplace programmes and policies with direct analytical and technical inputs from the ILO.
- 18 countries⁹ were provided with technical support to implement tailored workplace programmes aimed at reaching migrant and mobile workers in many sectors including along the major transport corridors in Southern Africa and Latin America.

Country examples (High Impact Countries)

- In Ghana, a total number of 13, 808 workers undertook voluntary counseling and testing (VCT) as part of the HIV behaviour change communication (BCC) workplace programme as an entry-point into prevention and treatment;
- In Zimbabwe, the ILO worked with national workplace stakeholders to ensure over 13,407 workers in the informal economy undertook voluntary counseling and testing (VCT).
- In Cambodia, the capacity building components of the workplace programme has strengthened the Provincial Department of Labour and Vocational Training (DoLVTs) capacity to implement Prakas #086 and the related guidelines endorsed by the Ministry of Labour and Vocational Training (MoLVT);
- In China, the workplace programme has improved the knowledge of rural migrant workers in the Guangdong province concerning their rights to decent working conditions, social protection and HIV prevention. An ILO Impact study shows that the percentage of workers who correctly identified three means of protection against HIV increased from 20.3% (baseline) to 86.6% (impact study);
- In Indonesia, the ILO's support to the implementation of HIV and AIDS programmes targeted at migrant workers has facilitated the development by the National AIDS Commission of an action plan for migrant workers and a strategy for high risk men
- An impact study conducted in 17 countries (including 12 high impact countries) where the ILO supported the implementation of HIV workplace programmes showed that: condom availability increased from 33.6% (baseline) to 77.9% (impact study); condom use with non regular partners increased by 14.4% percentage points (from baseline to impact

⁸ Botswana, Brazil, Burkina Faso, Cambodia, Cameroon, China, Cote d'Ivoire, Democratic Republic of Congo, Ghana, Guyana, Honduras, India, Indonesia, Kenya, Lao PDR, Liberia, Malawi, Mozambique, Nepal, Paraguay, Philippines, Rwanda, Senegal, Sierra Leone, South Africa, Sri Lanka, Swaziland, Tajikistan, Tanzania, Togo, Ukraine, Vietnam, Zambia, and Zimbabwe

⁹ Burkina Faso, Cambodia, China, Democratic Republic of Congo, Ghana, Guyana, India, Indonesia, Kenya, Lao PDR, Malawi, Mali, Mozambique, Nepal, Senegal, Sri Lanka, Swaziland, and Vietnam

study); the use of VCT services increased from 15.9% (baseline) to 46.1% (impact study); and positive attitudes towards PLHIV improved by 17.7% percentage points between the baseline and impact study.

Other issues:

1.0 A New Strategic Approach for the ILO

The ILO Programme on HIV/AIDS and the world of work has developed a new strategy to strengthen its focus and effectiveness in order to optimize its contribution to the global HIV response. The strategy responds to the needs expressed in the following documents: report on the independent evaluation of the ILO's programme on HIV/AIDS; the UNAIDS Strategy 2011 – 2015; the 2011 UN Political Declaration on HIV/AIDS; the ILO Strategic Policy Framework (2010 – 2015) and Programme and Budget (2012 – 2013).

Hinged on 7 building blocks, the new strategy should enhance the focus of the ILO around the UNAIDS High Impact Countries, strengthen the mainstreaming of HIV across the ILO and mainstreaming the world of work into the programmes of other agencies, scale up Social Protection schemes targeted at PLHIVs and vulnerable populations, forge strategic partnerships with identified partners as well as generate HIV-related workplace evidence to inform HIV and AIDS programmes worldwide. Gender has been recognized as a cross-cutting theme. A new slogan *getting to zero discrimination in the workplace* has been chosen to stimulate discussion, anchor the new approach as well as raise the profile of the new ILO response. The new strategy will be discussed by the ILO Governing Body.

2.0 Coordinating the global workplace and private sector response

In accordance with the revised division of labour (DoL) and the decision to strengthen the coordination of workplace and private sector efforts, the ILO convened a global inter agency task team to coordinate the efforts of the world of work and private sector response to strengthen delivery towards the achievement of the goals of the UNAIDS Strategy 2011- 2015 and the UN Political Declaration on HIV/AIDS. As a starting point, the IATT is undertaking a desk review of existing world of work and private sector HIV-related research with the view to identifying gaps in knowledge. A review has also been undertaken to assess the nature of the world of work component in National AIDS Strategies of the 31 High Impact Countries to inform the provision of tailored technical and normative guidance to countries during the current biennium.

3.0 The ILO Recommendation on the Social Protection Floor

Social protection mechanisms have been identified among the synergies with development sectors in the UNAIDS Investment Framework. The 101th session of the International Labour Conference (ILC) to be held in Geneva in May 2012 will discuss a new international labour standard on the Social Protection Floor which would provide flexible but meaningful guidance to member States in building Social Protection Floors (SPFs). The Recommendation on the SPF would contribute towards reducing risk and vulnerability of workers, individuals, households and communities to HIV and AIDS.

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

Total amount of spend on AIDS in 2011:

- at country level \$223,459,574¹⁰
- at regional level \$ 19,715,663 (core, supplemental and agency)
- at global level \$ 6,004,871 (core, supplemental and agency)
- total spend \$249,180,108

Total amount received from UBW in 2011: \$ 8,505,000

Description of top 3 priorities and related key results:

Priority 1: Coordinated UN action on human rights, governance and vulnerable populations (42.2% of spend¹¹)

Key results

- Core UBW resources were used to support 89 countries and 7 regions for the review, revision and implementation of legislation to promote HIV-related rights and increase access to justice services. In June 2010, UNDP launched the Global Commission on HIV and the Law on behalf of the UNAIDS family. The Commission engaged 700 government and civil society stakeholders from 140 countries in constructive dialogue on the creation of human rights based legal environments for effective HIV responses. Some early results include: submissions made to the Parliamentary Select Committee in Guyana contributed to the rejection of inappropriate legislation criminalizing HIV transmission and exposure. In Fiji a similar law criminalizing HIV transmission was repealed and discriminatory HIV-related travel restrictions lifted (www.hivlawcommission.org).
- Core UBW resources were used to support national authorities and stakeholders in 37 countries to strengthen governance and coordination of AIDS responses. For example, UNDP conducted a six country study in Belize, El Salvador, India, Indonesia, Malawi and Tanzania to document successes in national coordination of AIDS responses with a focus on national ownership, aid alignment, decentralization and civil society participation.
- Technical assistance and policy guidance on MSM, transgender people and sex work, as well as funding and fundraising support was provided to over 78 countries and 3 regions. For example, UNDP in collaboration with other UN agencies, supported the review, development and/or implementation of innovative municipal action plans to provide increased access to services for key populations in eighteen major cities around the world.

Priority 2: Linking action on gender equality, HIV and the MDGs overall (34.6% of core UBW spend¹²)

¹⁰ Estimated country level figure includes expenditure against stand-alone HIV projects only and Global Fund-related HIV expenditure (does not include mainstreamed HIV expenditure)

¹¹ Core UBW, supplemental and UNDP funds at global and regional level

¹² In addition to gender components of human rights spending

Key results

- Following up on UNDP's responsibilities within the 'UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV', **leadership capacity development for women living with HIV was undertaken in 29 countries across 6 regions**, resulting in increased partnerships between HIV positive women's organizations/networks and other key national stakeholders, as well as the set-up of micro-credit schemes and income-generating projects. These programmes were taken over by national authorities in several countries.
- Core UBW and other UNDP resources have been used to **support 29 countries to mainstream HIV into national and sector development plans and processes, PRSPs and MDG plans**, helping to create synergies between HIV responses and broader development efforts. UNDP's MDG Acceleration Framework (MAF) is a methodology that can assist countries to identify bottlenecks that impede implementation of MDG interventions and develop prioritized solutions as part of an MDG Action Plan. Support was provided to Papua New Guinea for MAF roll-out and development of costing tools for MDGs 4, 5 and 6, as well as support for a specific MDG 6 MAF for Belarus. Another example is the support UNDP provided, in collaboration with SADC, to selected ESA countries to incorporate HIV and gender into the Environmental Impact Assessments of capital projects. Six countries (Botswana, Lesotho, Malawi, South Africa, Uganda and Zambia) are now addressing short-term country specific gaps in EIA regulations, resulting in increased collaboration between NACs and Ministries of Health and Environment in these countries.
- In Asia and the Pacific, UNDP **supported eight priority countries** (India, China, Cambodia, Nepal, Vietnam, Thailand, Indonesia, and PNG) **in integrating HIV into national social protection strategy processes**, in collaboration with UNICEF, the UNAIDS Secretariat and ILO. This work benefited from socio-economic impact assessments by UNDP which provided the evidence-base for policy action and the cornerstone for impact mitigation steps, as well as a mapping of HIV-sensitive social protection programmes by UNICEF.

Priority 3: Capacity development of national partners for more effective implementation of multilateral funded HIV projects (23.2% of total global/regional UNDP funds)

Key results

- UNDP's partnership with the Global Fund to Fight AIDS, TB and Malaria has helped to develop country capacity to effectively implement large-scale health programmes. UNDP has served as a principal recipient in a total of 41 countries between 2003 and 2011. **In 14 of these countries, UNDP handed over its role to a national entity**, reflecting achievements in capacity development. It is in the process of doing so in another 9 countries for at least one grant.
- **Capacity development support to national entities has been expanded and scaled up to 12 UNDP PR countries**. Capacity development activities are systematically carried out as part of grant implementation, with specific, costed capacity development plans to ensure improved prioritization, sequencing and resource allocation and increased ownership. UNDP has developed a Capacity Development Toolkit for use by national entities and country offices in implementing national disease responses.
- Hand-in-hand with grant implementation and capacity development support, **UNDP also engages with the Global Fund on important substantive policy and programmatic issues in line with UNDP's mandate as co-sponsor of UNAIDS**. This includes promoting the inclusion of good governance principles and human rights and gender initiatives into GF grants, ensuring that financing reaches key populations, such as

women, men who have sex with men, and local networks of people living with HIV, helping to align the grants with national development plans and poverty reduction strategies, and contributing to the further enhancement of the country-level governance of GF programmes that respect principles of national ownership and aid effectiveness.

Other issues:

UNDP continues to play a crucial role in helping countries to halt and reverse the HIV epidemic as well as to address development dimensions of other health priorities. In doing so, UNDP also becomes more relevant and effective as an overall development actor.

UNDP is fully committed to increase its focus and therefore its impact at country level. The key to doing so is to leverage UNDP's mandate and core strengths to help countries improve their health results. UNDP's Executive Board re-affirmed action on HIV and health in the September 2011 Board meeting, calling on UNDP to update our corporate strategy on HIV and health to fully align and resonate with UNDP commitments in the UNAIDS Strategy "Getting to Zero" and with UNDP's partnership with the Global Fund.

UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO)

Total amount of spend on AIDS in 2011:

- at country level	\$26,262,106
- at regional level	\$5,648,679
- at global level	\$2,968,331
- total spend	\$34,879,116

Total amount received from UBW in 2011: \$4,208,274

Description of top 3 priorities and related key results:

Priority 1: Building country capacity for effective and sustainable education responses to HIV (approx. 40% of total spend)

While many countries have made progress in developing education sector HIV and AIDS policies and strategies, evidence suggests that their implementation is still limited. UNESCO supports countries to ensure that their education sector sub-systems and institutions play a critical role in HIV prevention, and to mitigate the impact of the HIV epidemic on learners and educators as well as the sector's ability to deliver on national education and development goals.

Key results

- UNESCO has significantly strengthened its support to comprehensive education sector responses to HIV and AIDS at country level, increasing the technical support it provides to countries through the establishment of twenty-one regional and national positions, and through regional training and induction programmes for staff in Africa and Asia-Pacific. Practical Guidelines for Supporting EDUCAIDS Implementation were developed and are available for use by all UNAIDS Cosponsors working with the education sector. A more systematic approach to planning EDUCAIDS activities has been implemented in line with the UNAIDS Strategy (UNESCO also updated its strategy on HIV to be in full alignment with the UNAIDS Strategy), while the development of a global M&E framework to measure the education sector response to HIV and AIDS has better grounded planning in evidence and ensured greater accountability. Activities were conducted within the EDUCAIDS Framework in approximately 80 countries.
- As an example of action at country level, UNESCO has led the UN Education Sub-Group in Viet Nam to strengthen the education sector response to HIV and AIDS using EDUCAIDS. Achievements include formulation of a Strategic Plan on HIV by the Ministry of Education and Training; integration of sexuality education into the National Education Strategy, and of HIV prevention in the national school curriculum; and strengthened implementation of legislation on stigma and discrimination against those infected or affected by HIV.

Priority 2: Strengthening comprehensive HIV and sexuality education (approx. 30% of total spend)

UNESCO has taken a global leadership role in supporting countries to deliver well planned comprehensive HIV and sexuality education to empower young people to protect themselves from HIV and other sexually transmitted infections, to prevent unintended pregnancy, and to achieve better overall sexual and reproductive health.

Key results

- In 2011, UNESCO published the results of a landmark six-country cost and cost-effectiveness study of school-based sexuality education programmes. The study presents data on cost drivers and policy implications, particularly for ministries of education, giving an economic basis to the argument for school-based sexuality education, and found that sexuality education is cost-effective when delivered at scale and in conjunction with youth friendly SRH services for young people.
- Since the launch of the International Technical Guidance on Sexuality Education (ITGSE) in December 2009, at least 41 countries have taken strides towards the incorporation of comprehensive sexuality education in school curricula. In East and Southern Africa, UNESCO, UNFPA, UNICEF and the SADC Secretariat facilitated the review of curricula and training of curriculum developers from ten countries in the region on comprehensive sexuality education. In Kenya, intense support has opened the debate for strengthening the life skills curricula, and has been welcomed by young people and the associations of primary and secondary head teachers, who see the value of such education for learners in their care. In West Africa, analyses in Cape Verde, DRC, Guinea-Bissau and Senegal using a new sexuality education review tool have informed plans for advocacy and technical support. In Nigeria, in November 2011, UNESCO supported the Ministry of Education's first regional conference on HIV and AIDS and education, involving more than 1,500 education stakeholders. In China, UNESCO integrated sexuality education in pre-service teacher education in three pilot universities, reaching over 900 student teachers.

Priority 3: Advancing gender equality and protecting human rights (approx. 20% of total spend)

UNESCO promotes tolerance of cultural and sexual diversity, positive attitudes towards people living with HIV and the specific rights and needs of children and young people who are living with HIV, including through pioneering work to address the needs of positive learners. Recognizing that gender roles and relations have a significant influence on the course and impact of the epidemic, UNESCO has also placed a renewed focus on gender issues in its revised strategy for HIV and AIDS.

Key results

- UNESCO has contributed to improved HIV prevention and access to services for people living with HIV. In East and Southern Africa the involvement of teachers and learners living with HIV in school-based interventions helped address widespread discriminatory behaviours towards them, resulting in improved service uptake by HIV positive students and education personnel. In Angola, the innovative "Photo Voice" initiative reached 2,650 students and helped address widespread discriminatory behaviours towards HIV positive teachers and students.
- UNESCO has supported 68 countries to address HIV-related stigma and discrimination, particularly for marginalized and excluded populations, including through intensifying efforts to expand peer education to meet the HIV prevention needs of men who have sex with men (MSM) and transgender people. In Thailand 300 HIV prevention packages were produced for MSM and transgender people for use by peer educators and outreach workers in 30 provinces.
- In December 2011 UNESCO convened the United Nations' first-ever international consultation on homophobic bullying in educational institutions, producing striking evidence of the extent of the phenomenon and its consequences on access to quality

education and public health, as well as international best practice in terms of policies and interventions to prevent and address it.

Other issues:

UNESCO's stated overall objectives for the biennium were twofold: 1) to revitalize HIV prevention efforts as part of Universal Access, and 2) to scale-up and deepen country action. Major progress was achieved in both of these areas.

HIV prevention efforts were strengthened through the completion, wide dissemination and support for the use of a number of key resources by country partners, including UNESCO's *Short guide to the Essential Characteristics of Effective HIV Prevention*, the completion of the ground-breaking six-country cost and cost-effectiveness study for comprehensive sexuality education, significantly expanding the evidence base in this area, and the continued popularity of the *International Technical Guidance on Sexuality Education*, which is now referred to by countries as the global standard and benchmark for good quality and age-specific comprehensive sexuality education. In addition to hardcopy distribution of the Technical Guidance in all six UN working languages plus Portuguese, electronic dissemination has become increasingly utilized, with more than 30,000 downloads in English alone. Other resources completed during the biennium included guidance for supporting the needs of positive learners, and good policy and practice booklets on addressing gender inequality and improving HIV prevention education. In one example of UNESCO's approach and impact with UNAIDS UBW support in the biennium, other extrabudgetary funding was leveraged from two sources resulting in more than 20,000 teachers trained to teach about HIV prevention, reaching over 400,000 school children annually in Angola, Lesotho, Namibia and Swaziland.

UNESCO supported capacity building efforts with country partners to scale-up sexuality education programmes throughout Latin America and the Caribbean, Asia-Pacific, East and Southern Africa, and West and Central Africa, involving ministry counterparts, civil society organizations, bilateral organizations and UNAIDS cosponsors and Secretariat. Support for country action was intensified through the establishment at the start of the biennium of twenty new national programme officers dedicated to working on HIV education and prevention, backstopped and supported by UNESCO's Regional AIDS Advisors in Johannesburg, Santiago, Bangkok and Moscow, and with Regional AIDS Coordinators based in Dakar and Beirut. As a result of the investment in recruiting, training and supporting a new cadre of national staff, UNESCO is better placed than ever to provide high quality technical support and contribute to Joint Programme coordination mechanisms and action at country level. UNESCO has taken steps to expand and strengthen this investment in 2012-2013, with the creation of new posts in UNAIDS priority countries.

Innovative approaches have been successfully tested and implemented by UNESCO, for example an exhibit visited by over 1 million secondary school children at Bangkok's National Science Museum on sexuality and HIV/STI prevention, and the first UN-convened technical consultation on addressing homophobic bullying in educational institutions with participants from 25 countries, held in Rio de Janeiro, Brazil, in December 2011. The development, field testing and wide implementation of global indicators for HIV education and school health, developed by UNESCO and through the UNAIDS IATT on Education, are leading the way in harmonizing and improving coordination amongst development partners, reducing overlap and ensuring the most effective use of resources.

UNITED NATIONS POPULATION FUND (UNFPA)

Total amount of spend on AIDS in 2011:

- at country and regional level \$75,762,891.67
- at global level \$16,948,973.64
- total spent \$92,711,865.31

Total amount received from UBW in 2011: (i) \$7,341,250.81 - funds received under the Letter of Agreement 2010-2011 UNAIDS UBW (ii) \$586,000 - funds received under the Letter of Agreement towards UNFPA allotment from unprogrammed UBW Interagency funds for Technical Support; (iii) \$330,289 - funds received under First Amendment to the Letter of Agreement 2010-2011 UNAIDS UBW towards UNFPA's share of unobligated/unencumbered cosponsors funds as at 31 December 2009. **Total funds received under UBW Core UQA46 in 2011: \$8,257,539.81.**

Description of top 3 priorities and related key results:

Priority 1: Reduce sexual transmission of HIV. 34.84% of total spent (Broad Activity 2, 6, 10 and 13 - \$32,301,981.23/92,711,865.31)

Key results

- UNFPA supported **68 countries to develop a comprehensive procurement, supply management and distribution plan for condoms and other essential commodities.** Effective use of and training in LMIS (Logistics Management Information Systems – e.g. Country Commodity Manager (CCM) and CHANNEL systems) for advanced logistic management and monitoring of RH commodities resulted in more comprehensive logistics management systems in 37 countries.
- **Eighty six countries are implementing the UNFPA “10 Step Strategic Approach to Comprehensive Condom Programming (CCP)”.** Ten countries finalized or reviewed National Condom Policies and Strategies and eight countries began implementation of the condom demand generation framework targeting young people. Advocacy efforts, such as the CONDOMIZE!-Campaign at international and regional conferences, addressed critical challenges related to the lack of availability of condoms and the stigmatization of their use. The expansion of the “www.allaboutcondoms.org” web site, introducing two components: the “condomize” online social networking campaign with a Facebook, Twitter, and YouTube presence and a condom education programme with interactive learning video games and educational materials in the six UN languages and sign language utilized the internet’s potential to reach millions with innovative approaches to create demand.
- **Seventy nine countries** were supported by UNFPA to develop and/or implement programmes on **HIV prevention services for female, male and transgender sex workers.** UNFPA provided catalytic support to increase sex worker participation across Namibia to harmonise donor support and better focus national priorities on sex work; support for a mobile HIV and sexual and reproductive health (SRH) service for sex workers in the border town of Maputsoe, Lesotho; and, activities to promote economic empowerment of sex workers in Gabon. Data generation, mapping, assessments and population size estimations were undertaken in 26 countries leading to better informed national strategies, plans and programmes. In Rwanda, for instance, the National AIDS Control Commission developed a minimum package for sex workers. HIV Prevention

Report Cards for Key Populations to guide country level responses were completed for 10 countries.

- **Forty five UNFPA country offices programmed with uniformed services in HIV, SRH and gender based violence (GBV)** working with peacekeeping missions, supporting Disarmament, Demobilization and Reintegration (DDR) programmes and procuring and distributing condoms for HIV prevention as part of the MISP.

Priority 2: Empowering young people to protect themselves from HIV. 10.87% of total spent (Broad Activity 11 - \$10,077,091.50/92,711,865.31)

Key results

- In **70 countries** national implementing partners were supported in the design, implementation and evaluation of **comprehensive sexuality education programs**. In Eastern Europe and Central Asia, UNFPA support resulted in a charter on comprehensive education and national level prioritized action on SRH and education for youth. Capacity was built for 70 Curriculum Development Specialists from the Ministries of Education from Ten SADC Countries; Lesotho, Swaziland, South Africa, Uganda and Zambia have already incorporated lessons learned into their curriculum reviews and a training of trainers (ToT) toolkit has been developed.
- **Eighty seven countries were supported to strengthen youth friendly SRH/HIV services** within and outside the health sector including for information, counseling and testing, and promotion and negotiation of male and female condom use through programme reviews, training of health care providers and national institutions, and establishment or strengthening youth friendly centers and youth outreach including peer educators. For young PLHIV, national capacity building in Eastern and Southern Africa, in partnership with UNICEF and WHO, targeted provision of high quality treatment services that also addressed issues of adherence, disclosure and reduction of stigma at home, in the school, and community.
- UNFPA provided financial and technical support for capacity building of the HIV Young Leaders Fund which is enabling a new leadership among **young people most affected by HIV**. The Fund has provided 23 grants to community projects in 19 countries and is encouraging youth-led initiatives in advocacy, peer-based services and community mobilization. Young people determine where the grants go and also provide technical support.
- UNFPA supported three (3) national situation assessments (Ghana, Zambia, Kyrgyzstan) and subsequent development of 4 national action plans (Namibia, Malawi, Ghana and Kyrgyzstan) resulting in the incorporation of the **three bold results (Increasing comprehensive knowledge among young people, doubling condom use and doubling HIV Counseling and testing)** in the Malawi National AIDS Workplan 2010-11 and Ghana's National Strategic Plan 2011-2015- and the Operational Plan 2011-2013; and Mozambique adopted young people as a priority area.

Priority 3: Strengthening linkages between SRH & HIV; and meeting HIV needs of women and girls. 33.45% of total spent (Broad Activity 5 and 12 - \$31,014,646.58/92,711,865.31)

Key results

- UNFPA supported 60 countries to design, implement or evaluate prevention, treatment, care, and support programmes specifically intended to **empower women and girls**; and

- 46 countries to develop and/or implement HIV-related policies that specifically address **gender based violence** and other actions **promoting gender equality**.
- Benin, Lesotho, Namibia, Swaziland and Tanzania developed national action plans on women, girls, gender equality and HIV.
 - Mozambique, Swaziland, Zimbabwe, Burundi, Seychelles, Uganda, Madagascar, DRC, and Zambia launched or reviewed national strategies or guidelines on GBV and gender (in relation to HIV).
 - Research on HIV, SRH, GBV to inform future planning was conducted and reports disseminated to stakeholders in Ethiopia, Zambia, Mozambique and Uganda (Female Condoms Study).
- The IAWG on Gender Equality and HIV in partnership with [MenEngage Alliance](#), [Sonke Gender Justice](#) and [ATHENA Network](#) convened a consultation with 17 countries for Integrating Programming to Address **Gender-Based Violence** and **Engage Men and Boys** to Challenge Gender Inequality in National AIDS Strategies and Plans. Participants were drawn from Ministries of Health and/or Women/Gender, and National AIDS Councils (NACs), civil society and the national UN offices. As a result, the consultations were able to achieve 1) consensus and understanding regarding the mutually reinforcing cycle of gender-based-violence and HIV, and the potential role of engaging men and boys for gender equality to interrupt and halt this cycle and strengthen the national AIDS response; 2) analysis of existing country plans, and 3) country level action plans to support the integration attention to gender-based violence, and the engagement of men and boys for gender equality, in National Strategic Plans on HIV and AIDS and other relevant national policies and plans. Plans are in place to follow up in countries to identify areas for support and monitor progress.
 - Enhanced understanding **linking SRH and HIV** policies, systems, and service delivery led to strengthened national capacity to scale up linked SRH and HIV programmes. 20 countries assessed SRH/HIV linkages utilizing the Rapid Assessment Tool for SRH and HIV Linkages, shaping related national plans. 16 country summaries have been prepared and made available (www.srhivlinkages.org) highlighting the process, findings, lessons learned, recommendations, and way forward. To assess progress in linking SRH and HIV, 17 country impact assessments have been undertaken with the first phase of countries to implement the rapid assessment; and support continues to seven EU-funded African countries to strengthen linkages/integration.
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Other issues:

Elimination of New HIV infections Among Children and Keeping Their Mothers Alive

The [Global Plan Towards the Elimination of New HIV infections Among Children and Keeping Their Mothers Alive](#) and the *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015* guide UNFPA's scale up towards eMTCT through the SRH/Maternal Neonatal Health Care platform. Thirty eight countries have received direct support to-date including through regional consultation in Eastern Europe and Central Asia on upscaling user-friendly FP services for PLHIV and key populations to reduce unintended pregnancies in these groups. Collective results of partners include 65 per cent of health facilities in Madagascar offering PMTCT and newborn care services; scale-up of PMTCT in 80 per cent of all health facilities in Malawi; and increased uptake of Voluntary Counseling and Testing and Prevention of Mother to Child Transmission services in Burundi.

Empowering men who have sex with men, sex workers and transgender people to protect themselves from HIV infection, achieve full health, and realize their human rights

The UNAIDS Advisory Group on HIV and Sex Work, co-chaired by UNFPA, launched guidance to inform national responses on reducing the demand for unprotected paid sex, economic empowerment, rights, and differentiating sex work and trafficking. In-Reach Training addressing stigma, discrimination and HIV risk and vulnerability of key populations reached 37 UN Country Teams.

UNFPA also led the establishment of the Caribbean HIV and Sex Work Technical Working Group whose key purpose is to enhance and accelerate mobilization around the response to HIV and Sex Work in the Caribbean region, improving coordination and coherence, networking, and technical exchange. Also in the Caribbean, the Georgetown Declaration on HIV and Sex Work was developed, accepted and disseminated for Advocacy as an outcome of the Sex Work Regional Technical Working Group.

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)

Total amount of spend on AIDS in 2011:

- at country level: \$ 16,271,920
- at regional level : \$ 1,243,197
- at global level: \$ 1,212,448
- total spend: \$18,727,565

Total amount received from UBW in 2011: \$ 4,604,145

Description of top 3 priorities and related key results:

Priority 1: Support implementation of integrated and comprehensive HIV and AIDS response programmes for people of concern to UNHCR, and their surrounding host communities, and ensure that resources are available for these programmes (41 % of total spend)

Key results

- 47% of countries with >10,000 refugees and 38% with IDPs included in national Strategic Plans;
- Approximately 87 percent of refugees have access to treatment programme that were established for surrounding populations/host communities.

Examples of interventions

- As co-conveners of the DoL “Addressing HIV in Humanitarian Emergencies”, UNHCR and WFP conducted several consultations and workshops, including a two-day expanded DOL meeting with co-sponsor partners, humanitarian agencies and HIV NGOs usually working in stable settings, in UNHCR Geneva. Areas of collaboration and coordination were discussed and an Inter-Agency Task Team (IATT) was established. Similar working groups are being established in the Americas and in the East and Horn of Africa. In 2010, UNHCR contributed to the revision of the IASC guidelines for addressing HIV in humanitarian settings and supported training in collaboration with UNAIDS and other agencies in South Sudan, Ethiopia, Uganda, Kenya, CAR, DRC, LAC countries. In 2011, this training was extended to Nepal and Sri Lanka.
- On-going support in Kakuma-Kenya and Malaysia. This support makes a difference as refugees have access to VCT services, ART and care.
- UNHCR’s HIV programmes are implemented in a predictable manner which with experience has shown to be efficient: At the onset of new emergencies, e.g. in Cote d’Ivoire, Horn of Africa, a minimum package is delivered in the response to reduce HIV transmission: Access to HIV priority activities (condoms and continuity of ART). Then the HIV comprehensive programme is integrated into the national AIDS programme as the situation stabilizes. Community-based and community-led interventions targeting populations at high risk of HIV infection have been initiated but need further development to address stigma and discrimination.
- UNHCR’s initiative in East Africa supported the establishment of HIV/AIDS clinical services for sex workers at higher risk of HIV. Assessments and programmes were developed and/or strengthened, in particular training and support of multifunctional teams in Ethiopia, Kenya, and Uganda where HIV, Sexual and Reproductive Health (SRH) services for sex workers have significantly improved, community sensitized and peer-led networks developed.

- During 2011 new emergencies, UNHCR participated to inter-agency work or lead need assessments to support the integration of HIV into the humanitarian response (e.g. Cote d'Ivoire, Togo, Liberia, Horn of Africa, as well as the review of the IDPs situation in Sri Lanka). In Cote d' Ivoire, UNHCR supported the establishment of the HIV coordination working group in Grand Gedeh-Liberia where the agency and its Implementing Partners have conducted a detailed mapping of HIV/AIDS services.
- In 2011, UNHCR participated in the review of the national policy framework and implementation guide for tuberculosis and HIV in Yemen, where the updated antiretroviral therapy (ART) guidelines were distributed, and shared with UNHCR partners.
- Art performance (drama, street theater, music show), IEC material and radio broadcasts were recognized important tools for community based sensitization in East region of Chad, Nepal, Ethiopia and South Sudan to target populations affected by humanitarian crisis, including key populations at higher risk.
- UNHCR is fully involved in the cluster approach and is the focal point for HIV as a cross-cutting issue. As such UNHCR reviews projects proposals, assessments Terms of References and provide guidance beyond the health cluster, mainly to the protection, the shelter and the camp coordination and camp management clusters.
- The close partnership with UNFPA has further expanded in the field of reproductive health and HIV, and included in addition to support of reproductive health commodities for refugee operations, joint programming for clinical response to survivors of sexual and gender based violence, including post exposure prophylaxis, as well as adolescent HIV and sexual and reproductive health, and focus on populations at higher Risk of HIV infection among refugees and other persons of concern.
- UNHCR is a founder and active member of the Inter-Agency Working Group on Reproductive Health in Crisis which promotes access to quality reproductive health care for refugees and others affected by humanitarian emergencies and linkages between reproductive health and HIV. As such UNHCR provided technical and financial support to the working group, support the facilitation of the annual IAWG workshop, lead the HIV sub-working group and participate in many others such as the GVB working group.
- UNHCR also works in high prevalence countries with MOHs to improve quality of HIV counseling, testing, care and treatment.

Priority 2: UNHCR provided support to the implementation and scaling up of HIV and AIDS interventions for women and girls in conflict, post-conflict and displacement settings, including promotion, support and coordination of sexual and gender violence response activities to reduce their vulnerabilities and risk behaviors to HIV (25 % of total spend)

Key results

- 85 countries supported programmes of HIV prevention, care, treatment and/or support specifically intended to women and girls, including linkages with reproductive health services and GBV programmes.
- Most countries have seen an improvement in access to PEP by rape survivors. In Chad, the percentage on rape survivors who receive PEP within 72 hours increased from 38 % in 2010 to reach 94 % in 2011. Similarly in Ethiopia, this indicator increased from 73% to reach 90% in 2011.

Examples of interventions

- Support to GBV prevention and response in Haiti, in the Americas, and new Humanitarian Emergencies. Reproductive health and HIV inter linkages are strengthened (STIs, family planning, GBV) in most UNHCR operations.
- UNHCR participated to a joint mission with UNFPA, UNIFEM, UNODC, UNAIDS, WHO/PAHO and the government in the Amazon region to assess SGBV and HIV/AIDS in areas of women asylum seekers from Colombia, and supported a workshop on RH, HIV and human rights for sex workers in Ecuador and Columbia.
- UNHCR Cote d'Ivoire supported a gender based violence training for program managers in IDP sites, and participated to the campaign "to know our rights" targeting young girls internally displaced and at risk of HIV infection.
- In South Sudan, UNHCR supported capacity building on SGBV prevention and response, involving implementing partners, health authorities, local NGOs and the Police. UNHCR supported PMTCT training for service providers of implementing partner (ARRA) in Ethiopia.
- These activities led to a timely access to PEP for rape survivors, maximum use of resources and access to a comprehensive RH/HIV programme. Coordination mechanisms on GBV are challenging and the establishment of a coordination platform between all stakeholders is important to clarify roles and responsibilities (development of standard operating procedures). Women and girls are better served when RH/HIV services are integrated and of good quality.

Priority 3: Coordination, advocacy and support for integration and implementation of specific programmes, including Reproductive Health and life skills, for young people of concern to UNHCR, through strengthened strategic partnerships with key stakeholders (13% of total spend).

Key results

- Support to HIV programme was provided in 55 countries and IEC materials was developed and printed in 100% of UNHCR operations.
- HIV prevention package was provided in 100% of return operations, e.g. South Sudan and Democratic Republic of Congo.
- Condoms were provided in 75 countries with support from UNFPA and national programmes.

Examples of interventions

- UNHCR addresses HIV integration into adolescent sexual and reproductive health programmes. Opportunities for operational research were identified. Partnership with UNFPA on condom programming continued over 2011.
- In Venezuela, UNHCR signed joint project agreement with UNFPA and UNAIDS to strengthening the community response on HIV prevention and sexual and reproductive health with youth among local population and displaced persons at the border region with Colombia. The objective is to establish key alliances with local health programs, schools and youth organizations.
- In Chad, community health workers in camps developed a network in the east and south camps and were trained on peer education and theater techniques. Similarly UNHCR supported a training of peer educators among urban refugees in Goma-DRC to develop their communication skills on HIV/AIDS.
- UNHCR is working with its partners at country level as well as the MOHs to address the special health and protection needs of adolescent sex-workers, involved in survival sex

- and sexual exploitation and Men Having Sex with Men. Assessments and programmes were developed and/or strengthened in Ethiopia, Kenya and Uganda.
- In Nepal, UNHCR continued its training programme for peer educators of youth-friendly centers accessible to refugees.
 - These activities led to the integration of RH/HIV services, including access for young people: 1) Concerted condom programming (availability and distribution in refugees operations), 2) Support to RH services in camp settings, and establishment of HIV peer-led networks.
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Other issues:

UNHCR continued advocating for the inclusion of refugees, stateless people and asylum seekers into HIV national plan (e.g. Panama and Botswana). Advocacy also took place for the integration of HIV as cross-cutting issue in all clusters, and not only health cluster, particularly at the onset of new emergencies. More can be done to include HIV response targeting displaced populations in country contingency plans and involve and empower country-based stakeholders (in particular organizations caring for PLWHIV) to support HIV programmes during humanitarian crisis.

UNHCR generated HIV evidence-based information through routine data collection (Health Information System in place in 40 operations), assessments and surveys that allow adjustment of on-going interventions and feed into programme planning 2012-2013. In 2011, UNHCR conducted two studies in Kenya and Malaysia looking at HAART adherence among refugees and host community, highlighting strengths and weaknesses in counseling and patient follow-up.

The accomplishments in past few years made a difference and efforts need to be sustained. UNHCR's network of HIV professional at all level (from HQ to the deep field), the establishment of multi-functional teams and the culture of evidence-based decision ensure the gold standard in the field. Not only coverage but also quality is increasing.

With the number of refugees under treatment increasing drastically, new challenges face UNHCR for the present and the future, in particular treatment adherence. Most refugees are included in the national treatment programme; some are even enrolled into a health insurance scheme, (e.g. Iran, Ghana, Benin, Gambia, and DRC). In new emergencies, continuation of ART for those displaced and access to PEP for rape survivors is a great success in term of individual and public health. After long negotiations solutions were found in Botswana to give access to PMTCT for refugees, some separate VCT services are phased out after the integration of refugees in national VCT programmes and condoms programming is well established in collaboration with UNFPA.

THE UNITED NATIONS CHILDREN'S FUND (UNICEF)

Total amount (all funding sources) spent on AIDS in 2011:

- at country level	\$ 130,778,403
- at regional level	\$ 12,786,565
- at global level	\$ 7,813,533
- total spent	\$ 151,378,500

Total amount received from UBW in 2011: \$ 9,429,403

Description of top 3 priorities and related key results:

Introduction

To date UNICEF's investments in an AIDS free generation have positively affected the trajectory of the pandemic and contributed to mitigating the impact AIDS has on children and their families. The Unite for Children, Unite against AIDS campaign influenced the discourse to prevent children from "falling through the cracks" by working with partners, including UNAIDS and Co-sponsors, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), the United States President's Emergency Plan for AIDS Relief (PEPFAR), the International Drug Purchase Facility (UNITAID), as well as people living with HIV and AIDS and others. Central to UNICEF's HIV mandate has been the drive to achieve the goals of the Political Declaration on HIV and AIDS (2011), Millennium Development Goals– as well as realizing the goals of the UNAIDS "Getting to Zero" Strategy.

UNICEF in its work on HIV/AIDS focuses on the following 3 Key Results Areas:

Priority 1: Reduce the number of pediatric HIV infections; increase the proportion of HIV positive women receiving antiretroviral drugs (ARVs); increase the proportion of children receiving treatment for HIV/AIDS (37% of total spent)

Context

In 2010, 48 per cent of HIV-positive pregnant women in low- and middle-income countries received antiretroviral drugs for PMTCT, compared to only 14 per cent in 2005. As access to prevention of mother-to-child transmission (PMTCT) services increased, the annual number of children acquiring HIV infection steeply decreased in the past few years. An estimated 390,000 children were newly infected with HIV in 2010, 30 per cent fewer than the peak of 560,000 children newly infected annually in 2002 and 2003. In 2011 the elimination of mother-to-child transmission (eMTCT) remained a UNICEF top organizational priority. In line with the UNAIDS 'Division of Labor' UNICEF provided leadership in the implementation of the United Nations Secretary-General's "Global Strategy for Women and Children's Health" and the "Global Plan towards the elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive".

Key results

Following the June 2011 UNICEF/WHO led-Inter Agency Task Team (IATT) mission to Vietnam, the government introduced a policy shift on infant feeding and HIV. The government changed the PMTCT ARV policy to option B which includes maternal triple ARV throughout the entire breastfeeding period, and is now considering recommending exclusive breastfeeding for infants born to HIV-positive mothers. UNICEF worked with the newly established UNAIDS and US

Government-led Global Steering Group (GSG) to support the implementation of the Global Plan. As co-convenor of the Interagency Task Team on the Prevention and Treatment of HIV in Pregnant Women, Mothers and their Children (IATT), UNICEF continued coordinating technical assistance to develop, cost and implement national eMTCT plans in the 22 PMTCT priority countries. To effectively carry out this function UNICEF has established a secretariat with 6 staff located both at headquarters and within regional offices. At the end of 2011, ten countries had costed national plans in place and are now moving forward with implementation. In support of the eMTCT agenda, UNICEF worked with priority countries to develop and refine a dashboard for tracking progress and adopted a leadership strategy to support countries in advancing programmatic and technological innovation to achieve elimination. This includes simplification of protocols, use of point of care diagnostics, integration with the maternal newborn child health platform where appropriate; engagement of community systems in service delivery; co-packaging of PMTCT medicines and safe pregnancy commodities and use of SMS technology to accelerate transmission of results and support adherence. More specifically, UNICEF worked with the Government of Lesotho to pilot and assess the government-led Minimum PMTCT Package initiative, an innovative co-packaging approach to PMTCT/Maternal Newborn Child Health related commodities. In Zambia, UNICEF, supported the operationalization of the use of mobile phone technologies to strengthen health services for mothers and infants in rural health clinics. Project MWANA improved broader maternal, newborn and child health continuum of care, including HIV/PMTCT with specific attention to infant-feeding. To date, more than 3,000 infant HIV test results have been relayed using Short Message Service rapid technology, with a reduced turnaround time of about 50 per cent. Together with UNITAID, UNICEF supported the early identification of infants infected with HIV by providing commodities for the dry blood spots and DNA PCR technology in 17 countries.

Priority 2: Support national capacity to increase the proportion of children orphaned or made vulnerable by HIV/AIDS receiving quality family, community and government support (19% of total spent)

Context

Social protection, care and support can contribute to more equitable development outcomes by reducing poverty and social exclusion of households and children affected by AIDS. Most countries in sub-Saharan Africa have made significant progress towards parity in school attendance for orphans and non-orphans 10-14 years old. In 27 out of 31 countries in sub-Saharan Africa that report data, school attendance among children who have lost both parents, including parents who have died of AIDS, has increased. AIDS and child-sensitive social protection efforts led and supported by UNICEF have been catalysts for broader initiatives that have affected health and development outcomes. Kenya, Malawi, Namibia, South Africa and Zambia, motivated in part by the severity of the AIDS epidemic, have several large national cash-transfer programmes that benefit AIDS-affected individuals and households without explicitly targeting them. There has been a demonstrable impact on nutrition, education and health-seeking behaviours for children affected by AIDS

Key results

In June 2011, UNICEF and the IATT on Children Affected by AIDS launched the “Taking Evidence to Impact: Making a difference for vulnerable children in a world with HIV/AIDS”¹³ during the Fifth Global Partners Forum on Children affected by HIV and AIDS. Fifteen global agencies, as well as the US government endorsed the new guidance including its

¹³ http://www.unicef.gr/pdfs/UNICEF_Taking_Evidence_to_Impact.pdf

recommendations on programmatic approaches for responding to CABA. In line with “Evidence to Impact”, UNICEF launched a Challenge Fund in Namibia, Mozambique, Sierra Leone and Uganda to catalyze responses to children affected by AIDS. As a result, Mozambique started innovating community case management models that identify the most vulnerable children and refer them to a range of health, education and social welfare services. In East and Southern Africa, UNICEF provided TA to 13 countries to support evidence informed strategic national plans for the protection, care and support of vulnerable children initiated through mapping of the child protection systems. UNICEF successfully advocated with Government partners in Moldova, Serbia and Ukraine to change the way health and social welfare systems are structured in order to provide more comprehensive services. UNICEF has been working closely with USG/PEPFAR to support social welfare systems strengthening and has been able to leverage funding for this work in a number of countries including Uganda, Swaziland and Malawi. UNICEF supported Thailand in its GFATM Round 10 submission resulting in an allocation of US\$ 42 million for enhancing the systems, capacity and monitoring for protection, care and support for children infected and impacted by HIV/AIDS.

Priority 3: Support reduction of adolescent risk and vulnerability to HIV/AIDS by increasing access to and use of gender-sensitive prevention information, skills and services (38% of total spent)

Context

Between 2001 and 2009, the prevalence of HIV among adolescents and young people (aged 15 – 24 years) fell by 12% globally and UNAIDS reported that by the end of 2010, 12 countries with high HIV prevalence had achieved a statistically significant decline in HIV prevalence among adolescent and young pregnant mothers. Despite these encouraging trends young people still account for 41% of new infections. To reach the global goal of a 50% reduction in new HIV infections, a focus on adolescents and young people is critical. Following the October 2011 Global Technical Consultation on HIV prevention UNICEF reaffirmed its commitment to lead strengthened advocacy and programme efforts for results in adolescents. With equity at the heart of UNICEF’s response, the organization’s prevention efforts focused on building the case for more effective and efficient prevention programming, strengthening partnerships for engagement and mobilization of adolescents and young people, strengthening partnerships for programme delivery and monitoring and strengthening data to improve programming efficiency.

Key results

In 2011 UNICEF in collaboration with UNAIDS, UNESCO, UNFPA, ILO, WHO and the World Bank released a global advocacy report on HIV and young people, “Opportunity in Crisis: Preventing HIV from Early Adolescence to Early Adulthood”¹⁴. The report is unique in that it presents for the first time country specific estimates of the number of adolescents living with HIV (male and female) and the number of new HIV infections in young people aged 15 – 24 years. Significant efforts have been placed on improving data access in 2011. UNICEF supported the East Asia and the Pacific (EAP) Data Hub in analyzing data for 1,400 indicators and disseminated that information to 2,772 contacts within the region UNICEF has also stepped up its efforts globally to support operational research on adolescent vulnerability to HIV in Bangladesh, Bhutan, Bosnia, Burkina Faso, DRC, Moldova, Nepal, Serbia and Ukraine. In 2011 adolescents living with HIV (ALHIV) became more front and center. The newly established Global Technical Advisory Group (TAG) drew on expertise from UN agencies, bilaterals and research institutions resulting in the launch of an ALHIV training initiative with eight countries.

¹⁴ http://www.unicef.org/lac/Opportunity_in_Crisis-Report_EN_052711.pdf

Regional dialogs in West and Central Africa and Latin American were held for young people living with HIV, and the outputs of these meetings concretely contributed to national HIV care and support guidelines. In 2011, UNICEF worked with PEPFAR and MTV in Kenya and Nigeria to develop and launch Shuga II, a follow-up multimedia TV drama series to be launched in 2012. In response to the evaluation findings from 2010, UNICEF entered into an agreement with MTV to develop a radio drama series to be broadcast in seven countries in Eastern and Southern Africa and West and Central Africa as a complement to the TV initiative. The radio show will focus on themes prioritized by the seven countries including promotion of HIV testing and counseling (HTC) by young people and through the effort, UNICEF will lead the development of mobile-SMS service promotion and monitoring to strengthen data on the use of HTC and linked services by young people.

Other issues:

With the advent of new evidence and powerful new prevention and treatment tools, global leaders have begun to speak of the “beginning of the end of AIDS.” While we must do more and better with less, this in no way means we should scale down the HIV response. More needs to be done in addressing the AIDS response’s inequities that span age, gender, geography and economic status. In the highest burden countries in sub-Saharan Africa, HIV knowledge disparities are reported by wealth quintile, residence and gender. Intimate partner violence remains a serious problem in sub-Saharan Africa. In low-level or concentrated epidemics, infection is spread primarily by people who engage in behavior contrary to accepted culture and may even be illegal. Disparities in access to prevention also reflect disparities in access to HIV testing. The majority of households caring for orphans and other vulnerable children still do not receive adequate economic support, creating deprivation which can fuel new infections. There is still a great deal to do to keep families alive particularly in fragile states and where health and other systems are weak. A main driver of inequities in the HIV response is stigma and discrimination.

In addressing the programmatic challenges we cannot underestimate the need for political leadership in times of economic austerity and waning public interest for a 30 year old epidemic. Today, while resources for HIV are dwindling, new science and years of implementation experience provide children with the opportunity to grow up as part of an AIDS free generation. Wise investments – based on science and local knowledge of the epidemic – are central to the future AIDS response. UNICEF believes it can make a difference with sustained financial support and political leadership around integration, innovation and equity to support the scale-up of high impact intervention and facilitate activities and investments that will have a positive effect on HIV outcomes.

UNITED NATIONS OFFICE ON DRUGS AND CRIME (UNODC)

Total amount of spend on AIDS in 2011:

- at country level	\$26,271,155
- at regional level	\$3,149,650
- at global level	\$2,322,732
- total spend	\$31,743,537

Total amount received from UBW in 2011: \$5,961,904

Description of top 3 priorities and related key results:

Priority 1: Technical assistance and capacity building for scaling up services for drug users (x% of total spend, not feasible)

Key results

In over 100 countries worldwide, UNODC, in line with its mandates, has been assisting in developing evidence-informed and costed policies and programmes, implementing large-scale and wide-ranging interventions to prevent HIV infection, and in providing care and support to people living with HIV and AIDS related to drug use, prison settings, and human trafficking. UNODC has supported countries to assess situation and needs and to enhance human resources and the systems of government and civil society required for evidence-informed, comprehensive HIV responses. Its activities have been geared towards strengthening national capacity to address the stigma and discrimination attached to HIV and AIDS and drug use and imprisonment, scaling up delivery of HIV prevention, treatment, care and support, including monitoring and evaluation of those services, and increasing their coverage and sustainability. UNODC has advocated and provided training and technical support for the development of human rights-based, gender-responsive and equitable AIDS policies and programmes, including assistance in the development of national strategic plans on HIV/AIDS for 2011-2015.

Priority 2: Female drug use and HIV (x% of total spend, not feasible)

Key results

UNODC has advocated increased HIV policies and programmes and removal of barriers to access comprehensive services for women who use drugs and female prisoners. Training and other support for expanding provision of gender-sensitive HIV services in communities and prisons have been provided through projects in several countries, for example, in Afghanistan, Bangladesh, India, Iran, Nepal, Pakistan, the Russian Federation and Ukraine. The key country-level achievements include: determined characteristics, magnitude and service needs of female injecting and non-injecting drug users; mapped service coverage of comprehensive HIV prevention, treatment, care and support; identified service delivery gaps; improved knowledge and skills of service providers of non-governmental organizations, governmental health care clinics, drug dependence treatment facilities in the community and health care clinics in female prison settings; financially and technically strengthened provision of low-threshold services for female injecting and non-injecting drug users; developed and sustained direct service provision of comprehensive, gender-sensitive HIV services; developed enabling environment providing conditions that support gender sensitive comprehensive approaches to HIV prevention, treatment and care services.

Priority 3: Legislative and policy analyses and reviews on drug use and HIV (x% of total spend, not feasible)

Key results

Legislative and policy analyses and reviews supported by UNODC have contributed to implementing legal reforms related to services for drug users, improving policies and legal environment for HIV prevention services and increasing access to HIV prevention services for people in prison and in other closed settings. To support expanding evidence-informed and voluntary community-based drug dependence treatment services, civil society organizations and networks, donor partners, other United Nations bodies and technical experts have been involved in an advanced discussion and strategic social mobilization related to the full spectrum of effective interventions and implementation of HIV risk prevention and treatment, within the context of protecting human rights, for example, in Asia and the Pacific region.

Other issues:

In several countries, UNODC has played a key role in scaling up interventions related to the full spectrum of drug dependence treatment services, to include prevention, pharmacological interventions such as opioid-agonist treatment therapy, social assistance for marginalized populations, rehabilitation and reintegration. Those efforts have contributed, for example, in Myanmar, to increasing by nearly 200 per cent the use of opioid substitution therapy from 2008 to 2010; in Latvia, to achieving a 10-fold increase in the number of pharmacological interventions; in Vilnius, to increase by over 50 per cent the number of injecting drug users accessing pharmacological interventions; and in Nepal, to reaching over a third (over 12,000) of the estimated population of people who inject drugs with HIV prevention services in the country. Examples of the impact of such multisectoral efforts include decreased HIV prevalence among people who inject drugs in Myanmar and downward trends observed in numbers of newly diagnosed HIV infections related to injecting drug use in Estonia, Latvia, Lithuania and Nepal. Still, levels of coverage of interventions should be raised and multiple delivery models should be utilized, including outreach, low-threshold drop-in centres and peer education, and barriers to access those services should be identified and removed as a matter of priority, including in prisons and other closed settings. It is important to ensure that existing HIV prevention and treatment services do not exclude drug users and that access to services is supported by community-based interventions and outreach services.

Special attention is required to meet the needs of drug users who are particularly vulnerable to stigmatization and discrimination, who face significant barriers to accessing services and who experience additional marginalization or vulnerability, such as women, young people and ethnic minorities who use drugs. There is also a need to develop models of how to increase the empowerment of people who use drugs so as to contribute to more appropriate, effective and responsive policies and programmes. Risks for HIV infection and comprehensive responses with regard to the use of cocaine, “crack” cocaine and amphetamine-type stimulants require more attention. As part of a comprehensive response to HIV among people who inject drugs, it is necessary to address also other common health conditions, including tuberculosis, hepatitis C, sexually transmitted infections and mental health problems.

Essential interventions remain unavailable in many prisons and detention centres around the world. Medical services offering treatment for tuberculosis, viral hepatitis and sexually transmitted infections are also often unavailable in closed settings. Absence, denial or interruption of needed medical services as a result of incarceration can have serious, negative implications for treatment outcomes and risk. The health and law enforcement sectors should work in partnership to ensure that access to and utilization of a comprehensive approach to HIV prevention, treatment and care services in prisons and other closed settings, are optimized.

Scaling up support to strengthen national capacity to monitor emerging trends in HIV among people who use drugs, including regional and subregional collaboration in HIV surveillance, is urgently needed, for example in sub-Saharan Africa. To this end, workshops and technical consultations on monitoring and evaluation have been organized for example in Afghanistan, Kenya, Kyrgyzstan, Morocco, Myanmar, Ukraine and Viet Nam. Production of the first ever global, regional and country estimates on coverage of HIV services among people who inject drugs in 2010 was supported by UNODC.

THE WORLD BANK

Total amount spent on AIDS in 2011:

- at country level \$ 1,799,160,000
- at regional level \$ 6,044,822
- at global level \$ 11,226,098
- total spent \$ 1,816,430,920

Total amount received from UBW in 2011: \$ 7,561,720

Description of top 3 priorities and related key results:

The World Bank provided by the end of 2011, \$5 billion in financing for AIDS, including 15 years continuous support as the only remaining external financier of Brazil and India's AIDS programs, and a new \$400 million AIDS credit to Nigeria. A total of \$1.8 billion of these funds were for projects under implementation during the 2010/11 UBW cycle. World Bank AIDS projects predominantly finance prevention activities (with other major global players such as the PEPFAR and the Global Fund predominantly supporting treatment). The impetus for a focus on prevention is two-fold: firstly, without 'turning off the tap' of new infections, HIV will remain a persistent development challenge in the foreseeable future; secondly, successful prevention requires an understanding of the causes of new infections and the relationship between HIV prevention programs and the reported decline in new annual infections (20% reduction in new HIV infections in the last 10 years). Confirming causality has been challenging and a weak evidence base for HIV prevention remains. To improve the scale-up of effective HIV prevention programs, prevention evaluations of impact to actually measure the number of infections averted, are therefore critical. In support of and in addition to lending operations, the World Bank finances analytic work to assist countries to better understand HIV epidemic characteristics and plan for effective HIV prevention responses. During 2010 and 2011, the World Bank initiated impact evaluations and efficiency-effectiveness studies in over 15 countries, including South Africa, Nigeria, Kenya, Zimbabwe, Zambia, Uganda, Ukraine, India and China. **The India impact evaluation concluded that the national AIDS program underpinned by the World Bank had averted 3 million HIV infections.**

Priority 1: Countries are supported to implement evidence-based, prioritized, and effective HIV prevention programs (50% of total spent)

Key result expected in 2015

In 50% of the 22 countries where the World Bank has focused its efforts for sexual transmission technical support, HIV prevalence amongst the youth 15 to 24 has decreased by at least 25%

Key results achieved in 2011

The World Bank worked with countries to generate evidence on "what works in prevention" in various epidemic contexts to ensure that effective and efficient prevention strategies and programs are designed and funded.

For example, the Bank kept a strong focus in 2011 on HIV prevention evaluations:

Innovative research and technical guidance help increase countries' understanding of how services are best provided, and what works to reduce HIV transmission. In 2011, the Bank had ongoing or -just completed during the year- HIV prevention evaluations in more than 32

countries. In Lesotho for example, the Bank is conducting an evaluation -in partnership with UNAIDS and WHO- on the community contribution to changing HIV/AIDS beliefs and behaviors. In Tanzania, the Bank is conducting two HIV Prevention evaluations on the impact of financial incentives (Conditional Cash Transfer-CCT) on HIV and STI prevention and the impact of CCTs on staying STI negative and on new HIV infections amongst young girls.

Priority 2: Countries are supported to improve strategic planning for better allocation and program efficiency and effectiveness and sustainability (20% of total spent)

Key result expected in 2015

In the focus countries, HIV strategic plans were developed under country leadership, and have been costed. At least 50% of resources have been secured for the implementation of these plans.

Key results achieved in 2011

The Bank in partnership with the UNAIDS Cosponsors and the UNAIDS Secretariat provides a core package of services for strategic planning that includes rapid peer reviews of draft strategies and operational plans; quality assurance and coaching throughout the strategic planning process; and tools and guidelines to assist countries in developing efficient and effective national AIDS strategies. In 2011, the Bank has provided operational support to several countries to enhance implementation of their national HIV/AIDS responses including through participation in mid-term reviews of national HIV/AIDS Programs.

During the 2010-2011 reporting period:

- **45 countries have received support:** Afghanistan (NSP), Argentina, Belize (peer review), Bhutan (peer review) Benin (epi, NSP), Brazil, Costa Rica, Cote d'Ivoire, Dominican Republic, Egypt, El Salvador, FYR Macedonia, Georgia (NSP, OP, Peer Review), Ghana, Guatemala, Haiti, Jamaica, Jordan (SA, NSP, OP), Lao PDR, Lesotho, Liberia (NSP, M&E), Mauritius, Morocco (Gap Analysis – informed the successful GFATM proposal), Myanmar, Nepal, Nicaragua, Niger, OECS (Caribbean States), Pakistan (NSP), Panama, Paraguay, Peru, Saint Lucia, Sierra Leone (NSP), Sudan (NSP, Resource estimations), Syrian Arab Republic (NSP, Costed OP), Tanzania, Trinidad & Tobago, Tunisia (Harm Reduction strategy), Ukraine (OP), Uruguay, Venezuela, Yemen (OP), Zambia, (NSP, OP) Zimbabwe (Peer review)
- **17 Peer Reviews have been conducted and five are being planned:** Benin, Belize, Bhutan, Burkina-Faso, Georgia, Ivory Coast, Jamaica, Mauritania, Namibia, Laos, Lesotho, Myanmar, OECS (Caribbean States), Nigeria, Sudan, Zambia, Zimbabwe, Bosnia - Herzegovina

Priority 3: Countries in sub-Saharan Africa supported to develop and implement efficient and effective HIV-sensitive social protection programs (20% of total spent)

Key result expected by 2015

At least 50% of social protection programmes in high burden countries have social safety nets that are protective of persons made vulnerable by HIV/AIDS.

Key results achieved in 2011

The World Bank provides major support to social protection programs at the request of countries, in FY11 alone, the sector committed over \$4 billion in lending. The World Bank recently completed an assessment of safety nets, poverty and HIV/AIDS in Botswana, Namibia and Swaziland, three middle income countries in southern Africa with some of the highest

HIV/AIDS rates in the world. All three have formal and informal safety nets that are being overwhelmed by high HIV/AIDS prevalence. The World Bank defines social safety nets (SSN) as non-contributory transfer programs that are targeted at the poor and vulnerable with the intention of insulating them from economic shocks. SSN are intended to work alongside other government programs such as health, education, and social insurance to promote economic growth and lower risk. Until recently in many African countries formal social protection programs have been weak or non-existent. Prior to the spread of HIV, Botswana and Namibia both had relatively developed formal safety nets while Swaziland had few formal mechanisms to help cushion the poor from the effects of poverty. The rise in HIV prevalence increased adult mortality rates, decreased economic productivity, and created more orphans and vulnerable children. As more and more adults were infected and their conditions worsened, they were unable to provide for themselves or their families. Their rising health care costs placed an even greater strain on household budget. In many countries this led to ad hoc programs targeting those most affected by the epidemic, but often with weak sustainability as they were funded through HIV/AIDS programs and not linked to any on-going social protection programs. The Bank is collaborating at country level with other cosponsors on Social Safety Nets. For example, the Bank and UNICEF are collaborating in more than 18 countries in Sub-Saharan Africa (including Angola, Niger, Sierra Leone, Uganda etc ..) on Social Protection Programs, like in Niger, where the World Bank and UNICEF have worked very closely for the past three years for the development of a SP strategy and a SSN with a strong focus on Health.

Other issues:

Ongoing World Bank analytic work

In support of its financing operations, the Bank has funded hundreds of analytical studies to better understand the epidemiology and social drivers of the disease as well as cost-effective ways for countries to finance, design, and deliver prevention, treatment and care services. The Bank is currently carrying out four main types of analysis to improve the efficiency and effectiveness of HIV responses: (1) Allocative Efficiency Analyses, (2) Program Efficiency Analyses, (3) Effectiveness Studies and (4) Financing and Sustainability Studies.

(1) The Bank supports countries to strengthen allocative efficiency through epidemic, policy and response syntheses and expenditure tracking surveys and analyses. The Bank has prepared a handbook on how to undertake Allocative Efficiency analyses (developed in 2008), and will be updating the handbook in 2012. (2) The Bank has also developed global guidelines on how to undertake Program Efficiency Studies and a framework to support countries to strengthen technical efficiency. Using these guidelines, the Bank is supporting countries to deliver HIV services at low cost, without compromising quality. Those guidelines form the basis for the current work in Kenya, Zambia and Ukraine. (3) The Bank is developing a handbook on *evaluating the population-level effects of large-scale, real-life HIV prevention efforts*. The Bank is leading efforts to strengthen the middle ground between observational studies and randomized trials, emphasizing two key pre-requisites for rigorous evidence: a plausible counterfactual; and credible HIV incidence end-points or surrogates so as to estimate infections averted because of prevention programs implemented. (4) The Bank is assisting several countries to project their future AIDS costs and understand how these costs may be managed and financed (South Africa, in partnership with PEPFAR, Jamaica in partnership with UCO and Caribbean RST, Lesotho (planned), Ghana, Vietnam, and Malaysia). The Bank is also assisting countries to motivate greater domestic spending through return-on-investment studies that demonstrate the longer-term savings obtained by well-targeted investments.

WORLD FOOD PROGRAMME (WFP)

Total amount of spend on AIDS in 2011 :

Core:	\$4,200,000
Supplemental:	\$12,000,000
- at country level	\$102,222,678
- at regional/global level	\$1,987,768
- total spend	\$120,410,446

Total amount received from UBW in 2011: \$ 3,567,209

Description of top 3 priorities and related key results:

Priority 1 (40% of total spend, where possible): Universal access to ART therapy for PLHIV who are eligible for treatment

Key results

- As part of the *Treatment 2.0 framework* WFP works with governments and partners to ensure that treatment is accompanied by assessments of nutrition status, education and counselling on nutrition to maintain body weight and health and mitigate side-effects, and – where necessary – nutritious food to treat malnutrition.
- WFP also supports vulnerable PLHIV who may be unable to obtain or adhere to ART and who are prone to food insecurity and malnutrition. A food and nutrition security vulnerability assessment of pre-ART clients – conducted in Namibia to inform the development of a national food-by-prescription programme and consideration of complementary social assistance – found that 16 percent were malnourished although food security challenges appeared limited. A similar rapid assessment in Djibouti found malnutrition among 38 percent of ART and TB directly observed treatment, shortcourse (DOTS) clients.
- As well as implementing and assessing the impact of food and nutrition support, WFP is directly involved in programmes that facilitate operational research, which improves knowledge and expertise regarding the role of food and nutrition support.
- WFP works with the private sector and academic partners to develop new and more suitable products for treating malnutrition – low body mass index – among adult PLHIV on ART or TB treatment. These partnerships conduct qualitative research to improve understanding of which products, textures and flavours are preferred by most adults in the early stage of treatment, in both Asia and Africa. From this, one or two products with appropriate nutrient composition for treating malnutrition among adults will be developed.
- WFP and RAND Health Corporation collaborated with national actors on operational research and pilot initiatives for PLHIV in Bolivia and Honduras. These aim to demonstrate the effectiveness of integrating food and nutrition strategies with ART and PMTCT, to increase treatment adherence, improve treatment outcomes and support nutritional health.

Priority 2 (35% of total spend, where possible): TB deaths among PLHIV reduced by half

Key results

- Tuberculosis is a chronic and debilitating disease, requiring at least six months of treatment, and much longer for multi- or extensively drug-resistant TB. It is often

- accompanied by weight loss, so the food and nutrition services provided to PLHIV are similarly beneficial in supporting the treatment and recovery of TB patients.
- Food and nutrition support in conjunction with TB-DOTS was included in the Round 10 Global Fund TB proposals of Djibouti, Lao People's Democratic Republic, Swaziland and Tajikistan; the Djibouti and Swaziland proposals were endorsed. WFP provided technical support for developing the proposals, and governments in all four countries have requested WFP to assist with the design and implementation of integrated food and nutrition activities.
 - Another important aspect of WFP's HIV and AIDS policy and the UNAIDS strategy is addressing TB where HIV and TB epidemics converge. Providing food and nutrition services to both PLHIV on ART and TB patients can help integrate the two programmes. Services are being integrated in , Ghana, Guinea, Malawi and Sierra Leone, where food assistance for TB patients is being aligned with the national food-by-prescription approach already being applied at most ART sites; in 2012, a nutrition rehabilitation approach will replace the current household treatment support package.

Priority 3 (25% of total spend, where possible): PLHIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

Key results

- The 2011 Political Declaration on HIV/AIDS pledges to use momentum from the HIV response to strengthen health and community systems, and to integrate HIV into health and development efforts, particularly programmes for enhancing economic and social protection. In line with its policy and the UNAIDS Division of Labour, WFP works with UNICEF and the World Bank to enhance social protection for PLHIV and people affected by HIV.
- Transfers of food, cash or vouchers, combined with community-based care, facilitate access to services and adherence to treatment. Social protection has a clear role in improving HIV responses, so collaboration between HIV and social protection experts must be intensified, to design appropriate strategies for specific settings.
- WFP is exploring ways of integrating the provision of food and nutrition services into health sector-based care-and-treatment programmes through cash or voucher schemes operating at the community level. In this approach, the health sector determines the eligibility for food support of PLHIV and, possibly, their household members; support is provided as cash or a voucher that can be redeemed for specific foods at a store or outlet in the community. This limits the burden on the health care system and brings services closer to clients.
- Building on a renewed partnership with PEPFAR in Ethiopia, WFP worked with the Government to prepare and roll out a voucher-based support scheme that facilitates urban PLHIV's access to basic foods during the early phase of ART, to maintain a healthy and socially stable life while engaging in livelihood recovery.
- WFP also works with UNICEF and other partners on social protection activities for children affected by HIV, in Benin, the Central African Republic, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Swaziland and the United Republic of Tanzania. In Swaziland, food assistance to children attending early childhood care and development services through neighbourhood care points is increasingly managed jointly by WFP and World Vision International, overseen and financed by the national AIDS authority. In Mozambique, WFP complements the national social protection framework by

building on community-based social welfare to provide support to children affected by HIV.

- Social protection in general has expanded in recent years, and safety nets are used increasingly to achieve nutrition and health outcomes. In line with its Strategic Plan (2008–2013), WFP responds to requests from countries and communities for assistance in developing their capacities to implement social protection programmes, including HIV-sensitive social safety nets that ensure that PLHIV are among the vulnerable groups targeted.

In addition to treatment, TB and social protection WFP also plays a role in eMTCT.

- WFP, the United Nations Children’s Fund (UNICEF) and WHO cooperate in PMTCT programmes as part of the UNAIDS Division of Labour. In 2011, 48 percent of HIV-positive pregnant women in low- and middle-income countries received anti-retroviral prophylaxis. WFP supports programmes in 17 of the 22 Global Plan priority countries; in five – Botswana, Lesotho, Namibia, South Africa and Swaziland – coverage exceeded 80 percent in 2011.
- PMTCT programmes are best integrated with mother-and-child health and nutrition services. This simultaneously prevents HIV transmission and improves health outcomes by ensuring that mothers and infants have access to growth monitoring, vaccinations, micronutrient supplementation, nutrition assessment, education and counselling, and complementary foods. The provision of more comprehensive services could facilitate eligible women’s uptake of and adherence to PMTCT programmes; food provides an important motivation for attending and following up on appointments.
- In Mozambique, Rwanda and Zambia, WFP supports a consultation process with government counterparts and implementing partners to review national PMTCT and mother-and-child health strategies, including operational considerations. In Congo, Ethiopia, Lesotho, Malawi, Mozambique, Rwanda, Swaziland, the United Republic of Tanzania and Zambia, WFP is involved in implementing PMTCT services.
- In coming years, WFP will continue to expand its cooperation with UNICEF, particularly on PMTCT issues: children affected by AIDS, paediatric AIDS and infant feeding. To contribute more to PMTCT, WFP has joined the Inter- Agency Task Team (IATT) on PMTCT.

Other issues:

Approved in November 2010, the WFP HIV and AIDS policy is in line with the Joint United Nations Programme on HIV/AIDS (UNAIDS) five-year strategy Getting to Zero for 2011–2015, the UNAIDS Division of Labour, and the WFP Strategic Plan (2008–2013). In fact, WFP was one of the first cosponsors to ensure its policy and strategies are fully aligned with UNAIDS. In 2011, WFP assisted 2.3 million PLHIV and people affected by HIV – including children – in 38 countries, with nutrition rehabilitation, safety nets or both. WFP has also focused its efforts in the UNAIDS Priority Countries, and this will increase in the next biennium. WFP is shifting from mitigation of HIV to enabling access to treatment and positive outcomes through nutrition support. Almost two years into implementing its policy, and in response to the UNAIDS strategy, WFP is realigning its focus using a two-pronged approach: collaborating with country stakeholders, country coordinating mechanisms and national disease programmes to ensure that food and nutrition support is included in all national HIV and AIDS and tuberculosis strategies and programmes; and developing and implementing food and nutrition assistance programmes that test models and support government programmes.

Strengthening UNAIDS' Three Ones: one framework, one plan, one budget, and monitoring and evaluation

WFP continues to provide technical guidance and operational expertise in integrating HIV and food and nutrition into national AIDS strategies, Poverty Reduction Strategy Papers, national development plans, national budgets, Medium-Term Expenditure Frameworks and sectoral plans. To enhance the effectiveness of national AIDS responses, and in-line with the Three Ones strategy, WFP provides technical assistance for developing proposals for the Global Fund and PEPFAR that address food and nutrition needs of PLHIV and TB patients. To improve and standardize outcome and impact indicators for food and nutrition interventions in HIV and TB, WFP, WHO, Food and Nutrition Technical Assistance 2 (FANTA-2)¹⁵ and PEPFAR worked on a set of global indicators for elements such as nutrition care and HIV, PMTCT and food security and HIV. These indicators were reviewed by the Indicator Review Panel convened by the UNAIDS Monitoring and Evaluations Reference Group, for finalization in early 2012 and roll-out later in the year. In 2011, WFP developed an HIV and TB programme M&E guide, to assist countries in adopting corporately approved HIV and TB indicators that are part of WFP's overall strategic results framework. In West Africa, 11¹⁶ countries were trained on the new policy and M&E framework. Roll-out will continue across all regions in 2012.

DoL : Addressing HIV in Humanitarian Settings

In March 2011, in line with the new Division of Labour, the UNAIDS Secretariat transferred the responsibility for addressing HIV and AIDS in humanitarian emergencies to the two Cosponsors leading this thematic area: the Office of the United Nations High Commissioner for Refugees (UNHCR) and WFP.

World Health Organization (WHO)

Total amount of spend on AIDS in 2011

- at country level	\$53,503,331
- at regional level	\$25,602,832
- at global level	\$37,822,593
- total spend	\$116,928,756

Total amount received from UBW in 2011: \$13,182,650

Description of top 3 priorities and related key results:

Priority 1: Ensuring that people living with HIV receive HIV treatment (40% of total spent)

During 2011, WHO continued to develop and update normative guidance related to HIV treatment, laboratory support and overall clinical management, as well as provide ongoing support to countries as they implement this guidance.

Key results

- Normative treatment guidance published in 2010 (including on antiretroviral therapy in adults, children, the prevention of mother-to-child transmission of HIV, infant feeding and HIV/TB) continued to receive attention from Member States, technical partners and the international community during 2011. A web-based interactive adaptation guide was published online in 2011 to support countries in their implementation efforts. WHO, through its HIV-dedicated staff in more than 80 countries, provided direct technical support for the adaptation of the new guidelines through, for example, regional workshops and individual missions. WHO directly supported HIV treatment and care guidelines roll-out in 40 countries through regional workshops in four regions.
- In the second half of 2011, WHO initiated a global dialogue on the “Strategic Use of Antiretrovirals”. Bringing together a broad range of governments, researchers, service providers, civil society and development partners, the first meeting focused on the identification of clinical issues that influence decisions on how to use the full potential of antiretroviral drugs (ARVs) for treatment and prevention in a rational way. A second dialogue in early 2012 will focus on operational and programmatic issues of the strategic use of ARVs. Together, they will inform a comprehensive update of ARV guidance in 2013 - bringing together critical pieces of clinical, operational and programmatic guidance in consolidated guidelines - that is more relevant and easier to use by: those who are driving scale up at country level; programme planners; and policy makers. The dialogue also identified critical issues for which WHO will fast track new guidance for release in early 2012, including on: PMTCT options; HIV testing and counseling for couples; and ARV for prevention and treatment in sero-discordant couples; and, more broadly, antiretroviral treatment as prevention.
- Building on the momentum of the launch of the Treatment 2.0 initiative, a key publication in 2011 was the *Treatment 2.0 framework for action: catalysing the next phase of treatment, care and support*. This document outlines how UNAIDS and WHO will work with partner organizations to accelerate global efforts to scale up treatment towards

- sustained universal access, optimizing both HIV specific and broader health outcomes, including maximizing the HIV and TB preventive benefits of antiretroviral therapy (ART).
- Particular emphasis was given in 2011 to increasing access to treatment and prevention services for key populations. An update of guidance for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users was initiated, as well as the development of guidance for men who have sex with men (MSM) and sex workers. With regard to pre-exposure prophylaxis of HIV (PrEP), WHO received planning permission from the WHO Guidelines Review Committee for the development of Rapid Advice on the use of PrEP for MSM and sero-discordant couples. PrEP Country consultations were facilitated in Thailand, Zambia, Zimbabwe, Peru and Ecuador. Regional consultations were convened in southern Africa (Johannesburg), Latin America (Brasilia), east Africa (Nairobi) and Asia (Bangkok).
 - The WHO's essential medicines list was updated to include 20 antiretroviral drugs including fixed dose combinations. WHO has so far prequalified a total of 202 HIV related drugs, 178 of which are ARV drugs. WHO also revised its Early Warning Indicators to prevent HIV Drug Resistance in August 2011 - and will release the new indicator set in 2012.
 - On the ground, the Eastern Mediterranean and African regions provide examples of how WHO is implementing its treatment guidance and support. WHO provided intensive technical support to strengthen the HIV care and treatment components of National HIV/AIDS Control programs in Sudan, South Sudan, Yemen and Afghanistan. Technical support entailed support to decision making on ART scale-up strategies; health worker training on service organization and delivery, patient monitoring, HIV testing and counselling and clinical mentoring; as well as training on procurement and supplies management. In Africa, support to expand ART in line with the 2010 WHO guidelines resulted in thirty five countries adapting these guidelines.
 - Details on all WHO publications can be found at <http://www.who.int/hiv/pub/en/>

Priority 2: Preventing mothers from dying and babies from becoming infected with HIV (PMTCT) (15% of total spent)

Within the Joint Programme WHO co-convenes the work related to PMTCT with UNICEF and co-leads the expanded Interagency Task Team (IATT) for PMTCT, which includes several co-sponsors and additional implementing partners and donors.

Key results

- In 2011, WHO's work in support of PMTCT included key activities at the global, regional and country levels in such areas as: normative guidelines; development of the elimination framework; and direct technical support to countries.
- Country and regional PMTCT adaptation workshops took place in the following regions: Africa, the Eastern Mediterranean, The Western Pacific and South East Asia. Nearly all high burden countries have now adopted the new WHO PMTCT guidelines. A comprehensive, integrated HIV ARV adaptation/implementation guide, including PMTCT ARV guidelines and HIV and infant feeding, was completed and launched in 2011.

- In the area of global PMTCT monitoring and evaluation, WHO continued to work closely with UNICEF and the UNAIDS Secretariat on global reporting, e.g., for the Universal Access Report.
- WHO launched a *Pediatric advocacy toolkit: For improved pediatric HIV diagnosis, care and treatment in high HIV prevalence countries and regions*. The toolkit was developed by members of the Interagency Task Team pediatric working group to support efforts in advocating for increased commitment to, and resources for, pediatric HIV diagnosis, care and treatment in high HIV prevalence countries and regions. The use of this toolkit is aimed at generating a commitment among Ministries of Health and relevant policymakers and partners to prioritize pediatric HIV treatment and for these policymakers to take measureable actions to increase access to and quality of pediatric HIV treatment coverage
- New evidence stemming from the WHO-led *Kesho Bora Study - Preventing mother-to-child transmission of HIV during breastfeeding*, and published in *Lancet Infectious Diseases*, showed safety and efficacy of combination antiretroviral drugs during pregnancy, delivery and breastfeeding and supports the 2010 revised WHO guidelines. The Kesho Bora study found that giving HIV positive mothers a combination of 3 antiretroviral drugs during pregnancy, delivery and breastfeeding cuts HIV infections in infants by 43% by the age of 1 year and reduces transmissions during breastfeeding by 54% compared with the previously recommended ARV drug regimen stopped at delivery.
- In 2011, WHO also published results of a technical consultation: *Towards the elimination of mother-to-child transmission of HIV*, which was held in collaboration with UNICEF, UNFPA and UNAIDS. The consultation discussed the overall goal of MTCT elimination, developed technical guidance, and outlined a draft framework for goals and monitoring (including indicators, baselines, target-setting, monitoring and reporting), and for an operational framework and action plan to support the elimination of MTCT at the global, regional and country levels.

Priority 3: Preventing people living with HIV from dying of tuberculosis (15% of total spent)

Key results

- WHO continued to collect TB/HIV implementation data from all countries through harmonised efforts between TB and HIV control programmes and coordination with UNAIDS. WHO TB/HIV data was harmonized with those of the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis and Malaria. The TB/HIV sections of the Global TB control and the Universal Access HIV reports were also harmonised with consistent messaging and data for the first time.
- WHO HQ provided technical support and capacity building in HIV/TB Three I's for HIV/TB in three regions: Africa, the Americas and Europe. WHO also conducted six regional meetings on the Three I's for HIV/TB in these regions. Two national stakeholders meetings were organized in Mali and Kenya to promote the integration of TB/HIV

- services and the decentralization of ART in TB clinics. Technical support to countries in Africa also included advice on expanding ART in line with the 2010 WHO guidelines.
- The update of the Policy on Collaborative TB/HIV Activities was finalised in accordance with the requirements of the WHO Guidelines Review Committee (GRC), involving the conduct of systematic reviews, establishment of a guidelines updating group and a wider peer review process. The document was submitted and approved by GRC in December 2011, and was released in March 2012 with a massive media coverage. It was estimated that almost a million lives were saved by the implementation of the TB/HIV interventions globally between 2004-2010.

Other issues:

The Global Health Sector Strategy on HIV 2011-2015 (GHSS) was endorsed by WHO member States, and disseminated in 2011. The strategy was developed through a broad consultative process, involving over 90 Member States and inputs from 2,000 individuals and organizations. The Strategy outlines priority treatment interventions for countries to implement and how WHO will support countries to implement the health sector response to HIV - this is aligned with the UNAIDS Strategy and will guide the work of WHO over the period of 2011-2015. A detailed operational plan, to guide implementation of the GHSS, will be published in early 2012. The *Global Health Sector Strategy on HIV 2011-2015* will continue to serve as a blueprint for increasing country relevance of all levels of WHO's programme of work on HIV. The first-ever WHO-wide programme of work on HIV 2012/13 will serve as a basis to ensure strong internal cohesion among all HIV activities of the organisation - and maximise organisational efficiency.

2011 WHO, together with the UNAIDS Secretariat and UNICEF, published the *Progress report 2011: Global HIV/AIDS response*: a global report on health sector progress towards Universal Access. The report also included the bi-annual epidemic update.

At the same time as demands from countries for WHO guidance and support further increased during 2011, financial resources as a whole for WHO decreased. WHO responded to this challenge with a far reaching strategic review and reorganization of its HIV programme, leading to a leaner organizational structure with clearly defined priorities shaping the organization-wide programme on HIV. For example, WHO headquarters shifted its resources away from direct country support to the development of global normative tools and guidance, while Regional and country Offices privileged the development of technical support networks and country support for guidelines adaptation and policy development. As a result, WHO is well positioned to respond to the demands of Member States and development partners.