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Report of 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. Thirty years since the emergence of AIDS, there are encouraging signs that the global AIDS response has altered the epidemic's course. HIV incidence is on the decline globally; more people than ever are receiving life-saving treatment and more responses are committed to human-rights and equity. In 22 of the most affected countries in Sub-Saharan Africa, the region hardest hit by AIDS, new HIV infections were reduced by 25% in 2010. Where only 15% of HIV-positive pregnant women in low- and middle-income countries received Antiretroviral drugs (ARVs) for the prevention of mother-to-child transmission (PMTCT) in 2005, 53% in of those in need received ARVs in 2009. Between 2004 and 2009, the number of people on treatment increased 13-fold. The number of children on antiretroviral therapy also rose, up from 75,000 children under 15 on treatment worldwide in 2005 to 365,400 in 2010.
2. This progress is uneven, however, and more remains to be done, especially to ensure that the most vulnerable and marginalized are not left behind. AIDS remains a leading cause of death in women of reproductive age globally and is a major cause of maternal mortality. In sub-Saharan Africa, women account for 60% of all people living with HIV. In Eastern Europe and Central Asia, the epidemic continues to rise, driven by multiple factors including injecting drug use and sexual transmission. Adults and children living with and affected by HIV too often suffer stigma and violations of their human rights, which can discourage them from seeking treatment or altering behaviour and also undermine the effectiveness of HIV-related interventions. And while the number of people on treatment has increased, only one third of people in need have access to essential medicines. In 2009, approximately 10 million eligible people went without HIV treatment. Access to treatment for children still lags behind access for adults. Treatment access is lower still among the marginalized.
3. In 2010, UNAIDS, responding to the evolving impact of the epidemic and the Second Independent Evaluation, redefined its mission and its course. The new "*UNAIDS Strategy 2012-2015: Getting to Zero*", developed through a consultative process and informed by the best evidence, focuses the Joint Programme's work in areas that will have the greatest impact on the epidemic's trajectory.
4. The Committee of Cosponsoring Organizations (CCO) commends the UNAIDS Programme Coordinating Board for approving this ambitious UNAIDS Strategy and remains committed to furthering its directions and goals. Indeed, the existing HIV strategies of several cosponsors are already consistent with UNAIDS Strategy. Some Cosponsors have revised their HIV strategies and policies to make specific links to the UNAIDS Strategy, including WFP, WHO, ILO and UNESCO.
5. The operationalization of the UNAIDS Strategy has driven key developments in 2010, including the adoption of a revised Division of Labour and the development of the Unified Budget and Results Accountability Framework (UBRAF), both of which aim to improve country-level delivery, strengthen joint working and increase accountability. The UBRAF would replace the Unified Budget and Workplan. Like its predecessor, it is intended to encourage action at the country level and to leverage additional investment in the AIDS response. Unlike the Unified Budget and Workplan, however, the UBRAF is structured to achieve the UNAIDS vision of *zero new HIV infections, zero AIDS-related deaths, and zero discrimination* by including clear links with the UNAIDS strategy.

6. This Report of the CCO also signals the UNAIDS family's commitment to greater cohesion, discipline and accountability. The report is the first of its kind—distributed in advance and available in translation. It includes agency-specific progress reports and shows how cosponsors have aligned their own work with the Strategic Directions and Goals of the UNAIDS Strategy, focusing on joint working and country-level results.
7. To deliver on the promise of the UNAIDS Strategy, cosponsors work jointly to achieve country level results, embodying the “One UN” concept. The vast majority of the Joint Programme's country level work is done by cosponsors, consistent with their mandates and guided by the updated Division of Labour. By coordinating our voices and work, the UN can provide evidence and best practice, work with government and non-government groups to achieve ambitious targets and do so with an emphasis on human rights, equity, international norms and gender equality.
8. With more than 7,000 people newly infected with HIV every day, an effective response to AIDS must address prevention gaps. To achieve the elimination of vertical transmission by 2015, UNICEF, WHO, UNFPA and the UNAIDS Secretariat and other partners are advancing an ambitious Elimination Framework for an end to mother-to-child transmission of HIV and new paediatric infections. A Global Task Team, including a diverse group of stakeholders, will report on progress at the High Level Meeting in New York, which will have taken place before this meeting of the Programme Coordinating Board. It is our hope that global endorsement of elimination of new paediatric infections will be one outcome of the General Assembly deliberations.
9. UNAIDS is also committed to ending all new infections among people who use drugs. UNODC is expanding and strengthening its work with national governments to address the low coverage of services among drug users. It is also working with countries to develop comprehensive models of appropriate service delivery for drug users in line with relevant national circumstances and the UNAIDS/UNODC/WHO “*Technical Guide for countries to set targets for Universal Access to HIV prevention, treatment and care for injecting drug users*”. This work included collaboration with UNHCR to implement a regional project for injecting drug users among refugees and returnees.
10. Addressing and reducing sexual transmission of HIV is key to revitalizing prevention, particularly among young people, men who have sex with men, and sex workers. This year, UNFPA and UNDP supported over 50 countries to enhance human rights protection and service access for sex workers and clients, men who have sex with men and transgender people. These efforts have increased coordination and harmonization among sex worker networks and organizations focused on HIV and STI prevention, sexual reproductive health (SRH) and the links between SRH, gender based violence and human rights.
11. To help countries empower young people to protect themselves from sexual transmission of HIV, UNESCO is working with cosponsor partners to deliver sexuality education in 17 priority countries. This work aims to improve condom access and usage, HIV testing, and HIV knowledge levels. This past April, the IATT on Education, convened by UNESCO, hosted an international symposium on the implementation of sexuality education.
12. Approximately 10 million people in need lacked access to HIV treatment in 2010 and only 40% of people living with HIV know their status. Work to catalyze the next phase of

HIV treatment, care and support is underway. WHO, with the UNAIDS Secretariat, launched Treatment 2.0 in 2010 and developed a five-year health sector strategy and work plan for the next biennium. WHO is now developing a Treatment 2.0 operational plan and advancing guidance on short-term priorities for drug optimization and simplified diagnostics. Making up the lag between adult and paediatric treatment is a high priority for UNICEF and WHO.

13. The Joint WHO/ILO policy guidelines on healthcare workers' access to HIV and tuberculosis prevention, care and treatment were finalized, endorsed by UNAIDS and launched in November 2010. WFP, which led the successful thematic session on food and nutrition at the last PCB, has a new policy that aims to ensure that people living with HIV and those being treated for tuberculosis receive nutrition assessment, education and counseling and, when necessary, appropriate food support.
14. UNICEF and the World Bank are assessing the effectiveness of the response for children affected by AIDS, looking to improve value for money and reach the many families providing essential care and support. UNICEF, with the IATT on Children and AIDS, is developing a guidance document entitled "*Taking Evidence to Impact*," which was launched at the 5th Global Partners Forum on Children Affected by HIV and AIDS in early June. The Forum was hosted jointly by UNICEF, the UNAIDS Secretariat, and PEPFAR (the President's Emergency Fund for AIDS Relief). The World Bank also provides major support to social protection programs at the request of countries and financed \$4.2 billion in new commitments in 2010.
15. Finally, cosponsors made significant contributions in 2010 to advancing human rights and gender equality for the AIDS response. In June, UNDP launched the Global Commission on HIV and the Law on behalf of the UNAIDS family. Following-up on its responsibilities within the "*UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV*", UNDP undertook leadership capacity development for women living with HIV in 23 countries across six regions.
16. Building on the development of the UNAIDS Guidance Note on HIV and Sex Work, UNFPA, and partners, including UNDP, UNODC and UNICEF developed an in-reach training programme, aimed at ensuring that Joint UN Teams can better respond to stigma and other HIV-related needs of key populations. Through its work on gender, UNFPA is also strengthening linkages between SRH and HIV and meeting the needs of women and girls. This includes supporting countries to prioritize women and girls in HIV prevention, treatment, care and support programmes.
17. Assuring HIV services in humanitarian crisis, conflict or emergency has been a priority during the past year, as there remain all too many such situations, challenging our ability to reach populations of humanitarian concern. UNHCR and WFP have led the response in this important area.
18. Building on its equity focus, UNICEF published "*Blame and Banishment*", a report on adolescent infection in Eastern Europe and Central Asia. The report reveals hidden epidemics among children and young people facing prejudice in a context of societal reluctance to acknowledge their rights, needs and aspirations. The UN family is working to encourage supportive laws and policies to advance young people's rights and access to services.

19. In July 2010, the UN General Assembly created UN Women, a new entity for gender equality and the empowerment of women. UN Women has expressed interest in becoming a UNAIDS Cosponsor. The CCO welcomes this interest and stands ready to move forward with procedures established for new co-sponsors. In the meantime, the joint programme continues to focus on women and girls and to promote women's rights and gender equality.
20. This year the Joint Programme has seized on two important opportunities to advance progress towards the 2015 goals. The High Level Meeting, held earlier this month, provided world leaders a chance to affirm their commitment to building on the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS to guide and monitor the HIV/AIDS response beyond 2010. At the HLM, UNAIDS re-emphasized both the exceptional nature of the AIDS fight and the need for increased integration and synergies to achieve broader health and development outcomes. These messages will also be promoted during the 6th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, which will take place in Rome in July 2011.
21. Moving forward, the UNAIDS family is committed to building on progress and to making gains in new areas. The CCO believes the new UBRAF will enable us to pursue the 2015 goals with the expertise, capacity, resources and high-level leadership that the UN system can provide. Together, we look forward to an even more coherent, efficient and coordinated response to AIDS in the coming years.

[Annex follows]

ANNEX: REPORTS BY INDIVIDUAL COSPONSOR

ILO

Total amount spent on AIDS in 2010:

- at country level	\$ 7,780,941
- at regional level	\$ 965,580
- at global level	\$ 4,220,865
- total spent	\$ 12,967,386

Total amount received from UBW in 2010: \$7,117,500

Description of top 3 priorities and related key results:

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 (approx. 30% of total spent)

Key Results:

Adoption of the Yaoundé Tripartite Declaration on the Social Protection Floor (SPF) at the 2nd African Decent Work Symposium on “Building a Social Protection Floor with the Global Jobs Pact”

- 47 countries from the African Region, with technical support from ILO, adopted the Yaoundé Tripartite Declaration on the Social Protection Floor (SPF) at the 2nd African Decent Work Symposium on “*Building a Social Protection Floor with the Global Jobs Pact*” convened in Cameroon, by the ILO. The ILO promoted and supported efforts to mainstream HIV into the SPF Declaration as part of job recovery initiatives in the Africa region. HIV is thus an integral part of the SPF initiative in the Africa region ensuring that the SPF initiative is HIV-sensitive.

Development of a global training course titled “HIV/AIDS and the world of work – a prevention and social protection perspective”

- A pioneering global training course titled “*HIV/AIDS and the world of work- a prevention and social protection perspective*” was organized by the ILO, the International Training Centre (ITC), Turin in 2010. 47 participants from 26 countries participated in this training course. 17 resource persons from the ILO, UNAIDS, WHO, GNP+, UNICEF, WFP, and the ITC facilitated the training sessions which provided state-of-the-art knowledge on Social Protection. This new course is aimed at building knowledge on HIV-sensitive social protection in countries affected by the HIV epidemic.

Generation of evidence on Social Protection through the private sector workplace

- The ILO and UNAIDS undertook an assessment titled “*The Private Workplace As A platform for Provision of Social Protection Against HIV/AIDS: Relevance, Promise and Constraints*” into the role of the private sector in the providing social protection schemes

to mitigate the impact of HIV and AIDS. The assessment identified a number of promising private sector social protection initiatives. The assessment, which is being widely disseminated, is part of the evidence gathering process in relation to social protection.

Support to 15 countries to implement tailored social protection schemes for people living with HIV and affected communities

- 15 high burden countries were supported by the ILO to implement a wide range of social protection schemes for people living with HIV and affected communities. The ILO support covered health insurance and social security for people living with HIV; income generation for people living with HIV and their families; micro-finance initiatives aimed at reducing the vulnerability of people living with HIV; and cash transfer programmes to mitigate the impact of HIV.

Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half (approx. 30% of total spent)

Key Results:

Adoption of first International Labour Standard on HIV and AIDS and the world of work

- An overwhelming number of ILO member States adopted the first International Labour Standard on HIV and AIDS and the world of work (Recommendation No. 200) in 2010 at the 99th Session of the International Labour Conference (ILC). UNAIDS and WHO participated in the ILC. The Recommendation aims at strengthening the contribution of the world of work to the UNAIDS Strategy 2011 – 2015, ILO Strategic Policy Framework (2010-2015) and the UN Millennium Development Goals (MDGs), particularly MDG 6.
- 9 countries have revised their policies and declarations to include references to the ILO Recommendation. An example is a recent court case in South Africa, where the Johannesburg Labour Court awarded the complainant compensatory damages for unfair dismissal and discrimination on the grounds of HIV status. In reaching its decision, the court made reference to the Code of Good Practice on the Key Aspects of HIV and AIDS in Employment. It also relied on the ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111) and the Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200).

Support to countries to review their legislation and policies on HIV and AIDS

- The ILO supported 20 countries to review and/or develop legislation or policies that address women and gender equality and 10 countries to train labour factory inspectors. In 9 countries, the ILO supported the training of Judges, Magistrates and Lawyers on HIV and AIDS and the law. The ILO partnered with GNP+ to train participants from PLHIV networks from 7 countries on: a) the role of organizations of people living with HIV in giving effect to the Recommendation on HIV and AIDS and b) advocacy at the workplace: the leadership of people living with HIV.

International Training course for Judges, Lawyers and Magistrates

- The ILO and the International Training Centre in Turin, organized an international training course on the theme “*Tackling discrimination at work: From theory to practice*” for 40 participants from all regions consisting of government and ministry officials, heads of heads of national equal employment opportunity agencies and gender equality agencies. The training provided state-of-the-art information and case studies on HIV-related discrimination in the workplace.

International Training course of “Tackling discrimination at work: from theory to practice”

- The ILO and the International Training Centre in Turin organized a training course on the theme “*International Labour Standards for Judges, Lawyers and Legal educators*”. 25 participants from all regions attended the course which provided insight into using International Labour Standards to address discrimination related issues at the national level including HIV-related discrimination.

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. (40% of total spent)

Key Results:

Support to scale up Regional ‘Know Your Status’ campaigns

- Countries in East Africa, with support from the ILO, Global Business Coalition (GBC), East African Business Coalition and GIZ, organized a Chief Executive Officer (CEO) HIV Testing Day. An audiovisual message from the ILO was broadcast simultaneously in the countries during the VCT event.

Support to countries to include world of work component in national AIDS strategy

- The ILO supported 31 countries to develop and/or review the world of work component of National AIDS Strategies and Plans. In 25 of these countries, ILO support included budgeted workplace components. 5 of these countries were supported to obtain resources for their National AIDS Strategies. A total of 51 countries have to date, reported to the ILO on the inclusion of a workplace component in their national AIDS strategies.

Support towards the implementation of world of work programmes targeted at vulnerable workers in key economic sectors

- In 23 countries, the ILO provided direct support for tailored programmes targeted at migrant and mobile workers. Re-fresher training programmes were organized for peer educators in 14 countries on combination prevention approaches to HIV. In a total of 20 countries, ILO support provided support to programmes targeted at different working populations including uniformed personnel and armed forces; sex workers and their clients; and young people.

Support for Joint initiatives to scale up HIV workplace programmes

- The ILO, GBC, UNAIDS, WHO and Global Fund organized a regional meeting in South Africa in 2010 to enhance partnerships; showcase different approaches used by

businesses to engage in TB-HIV responses; and learn about the ILO Recommendation and its implications for TB-HIV workplace programmes. The regional meeting also focused on reducing sexual transmission of HIV. ILO provided technical and financial support to private sector actors from Southern Africa in TB/HIV workplace programmes.

Global training programmes on Occupational Safety and Health (OSH) and HIV

- The ILO and the International Training Centre (ITC) in Turin conducted a training course on Occupational Safety and Health (OSH) for participants from 14 countries in the Africa and the Caribbean regions. The training focused on the Recommendation; the guidelines on Occupational Safety and Health Management Systems; and HIV and AIDS in the workplace.

Other issues:

The ILO Recommendation on HIV and AIDS and the world of work: The ILO fully supports and welcomes the new UNAIDS Strategy 2011 – 2015 and its focus on 3 interrelated strategic directions: revolutionizing prevention; catalyzing the next phase of treatment, care and support; and advancing human rights and gender inequality. The timely adoption of the first International Labour Standard on HIV and AIDS and the world of work (Recommendation 200) by the member States of the ILO provides the ILO with an increased opportunity to support the consolidation and scale up of world of work HIV and AIDS programmes and enhance the contribution to the 3 strategic directions of the UNAIDS Strategy 2011 – 2015.

Recommendation 200 is: advancing human rights and gender equality by calling on governments to review policies and laws to ensure they address all aspects of work and HIV-related stigma and discrimination for all categories of workers; contributing to the prevention revolution by promoting comprehensive HIV and AIDS programmes which address the different needs of women and men and provide access to all means of prevention within the workplace; and catalyzing the next phase of treatment by ensuring workers living with HIV and their dependents benefit from the full access to healthcare whether it is provided through public health facilities or private sector services. The ILO calls on all UN agencies, civil society organizations, private sector bodies and networks of people living with HIV to partner and enhance the implementation of Recommendation 200.

UNDP

Total amount spent on AIDS in 2010:

- at country level	\$ 276,540,426 ¹
- at regional level	\$ 16,906,760 ²
- at global level	\$ 5,184,025 ³
- total spent	\$ 298,631,211

Total amount received from UBW in 2010: \$ 8,505,000

Description of top 3 priorities and related key results:

Coordinated UN action on human rights, enabling legal environments and partnerships to address stigma and discrimination (40.6% of total spent⁴)

Key results:

- Core UBW resources were used to support 48 countries and 4 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's aim is to develop evidence-informed and human rights-based recommendations which will support countries to create and maintain enabling legal environments for effective HIV responses.
- UNDP, together with UNAIDS and the Global Fund, published an analysis of access to justice programming in Rd 6 and 7 HIV proposals and grants, which successfully influenced inclusion of a specific objective and operational plan on human rights and equity in the new Global Fund Strategy.
- Core UBW resources were used to address stigma, discrimination and social determinants of most-at-risk populations in national AIDS plans, sector strategies or plans through multi-stakeholder partnerships implemented in 30 countries.
- Technical assistance and policy guidance on MSM, transgender people and sex work, as well as funding and fundraising support was provided to over 37 countries.

Addressing women, girls, gender equality and HIV in national responses (29.7% of total spent⁵)

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 23 countries across 6 regions, resulting in increased partnerships between HIV positive women's organizations/networks and other key national stakeholders. In addition, the capacity of

¹ Estimated country level figure includes expenditure against stand-alone HIV projects only and Global Fund-related HIV expenditure (does not include mainstreamed HIV expenditure).

² Core, supplemental and agency.

³ Core, supplemental and agency.

⁴ Core UBW at global and regional level.

⁵ Core UBW at global and regional level, including gender components of human rights spending.

national networks of women living with HIV has been strengthened to more effectively engage in Universal Access processes/reporting and MDG reporting/advocacy in 14 countries.

- UNDP has led an inter-agency initiative called 'Universal Access for Women and Girls Now!', in 10 countries, to support countries to address gender equality in national HIV responses. An example of success includes the integration of a clear gender component and commitment to address gender-based violence in Zambia's new *National AIDS Strategic Framework (2011-2015)* and the creation of a new gender advisor post in the Zambia NAC to ensure on-going integration of gender into the national AIDS response.
- There are close links between UNDP's gender work and the Global Commission on HIV and the Law. One of the three main areas the Commission is investigating is 'laws which sustain or mitigate violence and discrimination lived by women'. The discussions and follow-up actions identified through the Commission's regional dialogues across six regions will further inform and strengthen UNDP's work in this important area.

Inclusive governance of national, decentralized and multi-sectoral responses (29.7% of total spent)

Key results:

- Core UBW resources were used to support national authorities and stakeholders in 26 countries to strengthen governance and coordination of AIDS responses, e.g. AIDS sector assessments were completed in DRC, Zambia and Lesotho to enable countries to better understand the institutional strengths and limitations/challenges to effective and efficient coordination of the AIDS response at national and sub national levels.
- Mainstreaming HIV into national and sector development plans and processes, PRSPs and MDG plans was supported in 21 countries and 2 regions. An evaluation of the mainstreaming programme resulted in a re-orientation with an emphasis on PRSPs in higher prevalence countries.
- UNDP supported socio-economic impact assessment studies and initiatives in 22 countries, including a four country study in Asia comparing impact of the economic crisis on HIV-affected households with comparable households not affected by HIV. The results and recommendations of these studies will feed into the future UNDP's social protection agenda.

Other issues:

UNDP strongly welcomes the UNAIDS Strategy 2011 – 2015 – “Getting to Zero” , and its emphasis on linking the HIV response to the broader MDG agenda, with particular attention to human rights and gender equality issues. UNDP is in a unique position to help reach the goals of the UNAIDS Strategy through its convening role within the UNAIDS Division of Labour and involvement in several key priority areas⁶ (highlights of selected achievements noted above), as well as its central role in coordinating the UN's efforts to monitor countries' rates of MDG achievement.

⁶ As the sole convener on 'punitive laws/human rights'; as co-convener with UNFPA on 'MSM/transgender/sex work' and 'women, girls and gender equality'; and as one of several main partners under others' leadership in six further areas

To support this effort, UNDP has designed a comprehensive set of strategies, tools, publications and services to support MDG-based national development strategies. A few are highlighted below:

- MDG Breakthrough Strategy
The MDG Breakthrough Strategy lays out UNDP's plan to help countries close the gap between where they are now and where they need to be to meet the MDGs and sustain progress achieved. It will help countries identify what is holding back MDG progress. It details proven interventions and lessons learned in order to address those constraints. It also guides our support to countries to build a foundation for sustaining the progress achieved, mitigate the risk of reversal and strengthen the partnerships that will be needed to achieve the MDGs by 2015.
- MDG Acceleration Framework (MAF) - www.undp.org/mdg/acceleration.shtml
The framework provides a systematic way for countries to develop their own action plan based on existing plans and processes to pursue their MDG priorities. It also helps governments to focus on disparities and inequalities, two of the major causes of uneven progress, by particularly responding to the needs of the vulnerable. In 2010, ten countries began to pilot the MDG Acceleration Framework (MAF) with support from UNDP and the broader UN system. For example, support was provided to Papua New Guinea for the roll-out of the MAF and costing tools for MDGs 4, 5 and 6. This support helped to ensure that HIV was not viewed solely as a health issue but one with social, cultural and economic drivers and implications, such as gender-based violence. The MAF and costing tools are expected to be used in annual budget preparations and allocations for more effective use of resources for HIV and health.
- UNDP also led development of an AIDS and MDGs publication which was launched during the 2010 MDG Summit. The publication provides a clear, evidence-informed framework for conceptualizing linkages between AIDS and MDGs, putting forward recommendations for accelerating progress through complementary, cross-MDG action and encouraging a more sustainable, development-oriented approach to the HIV epidemic. Contributions to the MDG Synthesis Report (http://content.undp.org/go/cms-service/download/asset?asset_id=2677427) and International Assessment (http://content.undp.org/go/cms-service/download/asset?asset_id=2620072) helped to strengthen HIV components of these flagship publications.
- Core UBW resources have been used to support 21 countries to include attention to HIV and pandemic disease within broader poverty reduction strategies, development plans, MDGs and domestic resource allocations, helping to create synergies between HIV responses and broader development efforts.

UNICEF

Total amount of spent on AIDS in 2010⁷:

- at country level	\$ 168,948,708
- at regional level	\$ 10,155,044
- at global level	\$ 8,070,735
- total spent	\$ 187,174,487 ⁸

Total amount received from UBW in 2010: \$18,689,162

Description of top 3 priorities and related key results:

Reduce the number of paediatric HIV infections; increase the proportion of HIV positive women receiving antiretroviral drugs (ARVs); increase the proportion of children receiving treatment for HIV/AIDS (approx. 30.5% of total spent)

Agreement on elimination of new paediatric HIV infections as a global goal further established UNICEF's commitment to scaling up prevention of mother-to-child HIV transmission (PMTCT) as a top organizational priority. As co-convenor under the UNAIDS Division of Labour to prevent mothers from dying and babies from becoming infected with HIV, UNICEF focused on strengthening national strategies, improving the availability and accessibility of effective PMTCT, and integration with other maternal, newborn and child health services. The elimination goal means that the measure of success will advance from an input – women given medicines – to an outcome – HIV-free child survival.

Key results:

Over the last 6 years there has been a substantial increase in the proportion of HIV-positive-pregnant women receiving ARVs for PMTCT from 10% in 2004 to 53% in 2009. In the same period the proportion of new paediatric infections has reduced by 24%. UNICEF country offices support national governments to implement ambitious strategies and targets, quality services and data to inform programming, with priority in the 22 high-burden countries that are home to approximately 87% of the world's 1.4 million pregnant women living with HIV. UNICEF also supports more available, lower-cost and more effective paediatric AIDS treatment. UNICEF country offices provide practical assistance to develop capacity in districts, clinics, health centres and within communities and civil society. For example, Kenya, Zambia, and Malawi, through innovations introduced by UNICEF, use mobile phone technology to share laboratory results with health centres. Clinics now use SMS messaging to remind mothers and community health workers of dates for return visits. UNICEF also has evaluated weaknesses in scale up of paediatric testing, introduced solutions to link HIV-infected children to services, and helped mainstream HIV testing and treatment into national responses. In addition, UNICEF's mandate for maternal and child survival, nutrition and water enables UNICEF to lead and help integrate PMTCT and paediatric care services with other essential activities in nearly all low-and middle- income countries. Implementation of proven strategies has raised standards for what can be done for newborns and infants.

⁷ Figures represent preliminary estimates as of March 2011.

⁸ These CCO Report expenditure figures are informed by nearly finalized UNICEF 2010 expenditures as of mid-March 2011. On the other hand, the total 2010 expenditure in the UNAIDS performance monitoring report 2010 (UNAIDS/PCB(28)/11.7 is based on the preliminary January-December 2010 expenditure figures as of February 2011.

Support national capacity to increase the proportion of children orphaned or made vulnerable by HIV/AIDS receiving quality family, community and government support
(approx. 24.2% of total spent)

UNICEF's equity focus has reinforced commitment to meeting the needs and rights of children affected by AIDS. In 2010, 17.5 million children under 18 years of age had lost one or both parents to AIDS. This is 11% of the global number of orphans due to all causes. Of these children, 90 per cent are in sub-Saharan Africa. Most countries have made significant progress towards parity in school attendance between orphans and non-orphans 10-14 years old. External support to households caring for orphans and vulnerable children (OVC), however, has remained inadequate. UNICEF addressed these issues through support for child sensitive social protection including identifying and addressing the barriers to access for social services, support for cash transfers for ultra-poor households, supporting block grants to schools to exempt vulnerable children from fees and levies and advocacy for the abolition of user-fees for primary health care and education.

Key results:

UNICEF concentrates on strengthening government and community-based social welfare and child protection systems that contribute, directly and indirectly, to basic service delivery for the most vulnerable children, including those who are AIDS affected. Financial protection, including cash transfers, has become a pillar of an effective social protection approach; initiatives to improve access to services, and policies and legislation that promote equity and reduce social exclusion are others. UNICEF supported the development of nationally owned social protection schemes in more than 20 countries. In East and Southern Africa UNICEF worked intensively through the Children and AIDS Regional Initiative (CARI) to scale up services for OVC and ensure sustainable national responses in 9 priority countries. The 2010 external review of the programme showed that CARI surpassed the original milestones set. UNICEF also supported the development of diagnostic and mapping tools to help countries assess the capacity of their child protection systems, determine what aspects need to be strengthened and at what cost. To promote evidence-based approaches to care for children, UNICEF supported the Better Care Network (BCN), an interagency network of religious groups, governments and individuals working on the issue of children without adequate family care, including OVC. UNICEF's social protection programming experience has contributed to the development of the UNAIDS social protection business case. UNICEF-commissioned work on the state of the evidence on HIV-Sensitive social protection was presented at the Vienna International AIDS Conference, a SADC meeting of African Parliamentarians and the World Bank Economic Reference Group.

Support reduction of adolescent risk and vulnerability to HIV/AIDS by increasing access to and use of gender-sensitive prevention information, skills and services
(approx. 29.2% of total spent)

Preventing new infections among young people is essential to halting and reversing the spread of HIV and AIDS. UNICEF emphasizes the analysis of the epidemic among adolescents, better guidance and country-level support for a continuum of approaches and sharper focus on children and young people 15-24 in the global AIDS response. The 2009 estimate of five million children and young people living with HIV represents a reduction of 12% from the 2001 estimate of 5.7 million. In sub-Saharan Africa, saw a decline of over 25 per cent in HIV prevalence among young people in 22 countries over that period, reflecting

delays in sexual debut, increased condom use and reductions in the numbers of sexual partnerships. Nonetheless, 41% of new infections happen in the 15-24 age group.

Key results:

In June 2010, UNICEF published a ground-breaking report, *Blame and Banishment*, on adolescent infection in Eastern Europe and Central Asia. The report reveals hidden epidemics among marginalized children and young people. UNICEF and partners are working to encourage supportive laws and policies that will advance children's rights and access to services. In 2010, UNICEF convened service providers and young people from 18 countries, primarily from eastern and southern Africa, in a global consultation on service provision for Adolescents Living with HIV (ALHIV). As a result, UNICEF and WHO are developing global guidance to better identify and meet the needs of ALHIV.

UNICEF is also leading innovations in media-based HIV education to reach young people at scale and influence conversations and attitudes (e.g. *Pasión por la Vida*, a regional initiative in Latin America challenging stigma, *Brothers for Life*, in Eastern and Southern Africa promoting male involvement and behavior change in men, and *Shuga*, a three-part TV drama produced by MTV with UNICEF and PEPFAR). A Johns Hopkins University evaluation of *Shuga* showed that it raised the HIV knowledge of young viewers increased their intention to test for HIV and improved their attitudes towards people living with HIV.

In 2010, UNICEF supported a comprehensive review of HIV prevention programming and policies in 20 priority countries that will inform technical support planning by the global Inter-Agency Task Team on Young People. In Kibera, Kenya, UNICEF helped young people map their own vulnerability using digital tools to collect data on places where they felt insecure and threatened, as well as safe spaces. In South Asia, UNICEF contributed to population size estimation of key populations, showing where need for prevention services is greatest.

Other Issues:

Priority 1 challenges: The elimination of vertical transmission and the rapid implementation of the new WHO guidelines depend on early identification of HIV positive pregnant mothers and making sure they attend existing maternal and newborn care, reproductive health and child survival services more frequently. Although the diagnosis of HIV in children under two years old is challenging, it has the potential to dramatically reduce mortality in infants. Health services in low- and middle-income countries need to improve their capacity to identify HIV-positive children, develop more suitable regimens for them and retain them once diagnosed.

Priority 2 challenges: Scaling up services for vulnerable children while retaining their quality is a major challenge. Care and support for OVC is part of a cycle of interventions linking care, support, primary prevention and access to treatment for HIV-positive young people. UNICEF will continue to support countries to develop national quality standards for OVC care and support. Many community-based organizations still struggle to access adequate resources for OVC and are unable to successfully bid for donor funds UNICEF and the World Bank are working jointly to improve the effectiveness and efficiency of global OVC expenditures.

Priority 3 challenges: Because no one prevention strategy works in all countries for all young people, bringing the right messages at the appropriate time to young audiences is a challenge. Prevention information and programming for young people should be delivered

through a continuum of age and context appropriate activities. It is essential to an informed response that young people participate in identifying and addressing their needs. Through integrated services that target the most vulnerable, removal of barriers to access, better data disaggregation and monitoring and evaluation of programmes, UNICEF assists countries be accountable to young people and focus on achieving measurable results in comprehensive knowledge of HIV, doubling condom use and doubling the number of young people knowing their HIV status.

UNESCO

Total amount of spent on AIDS in 2010:

- at country level	\$ 11,181,057
- at regional level	\$ 2,732,412
- at global level	\$ 3,626,805
- total spent	\$ 17,540,275

Total amount received from UBW in 2010: \$7,995,000

Description of top 3 priorities and related key results:

Building country capacity for effective and sustainable education responses to HIV (approx. 40% of total spent)

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. 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 has therefore prioritized building the capacity of the education sector to implement policies and strategies at all levels.

Key Result:

UNESCO has provided technical support and capacity-building for national partners to strengthen situation analysis, evidence-based planning, implementation, and monitoring and evaluation of the education sector response to HIV, with a particular focus on East and Southern Africa. This includes a joint programme with UNICEF and the Secretariat of the Southern Africa Development Community (SADC) in the region. This has resulted in better mainstreaming of HIV and AIDS in general education sector policies and strategies, which translates into improved HIV and sexuality education curricula, pre- and in-service teacher training, and support to teachers and learners affected by HIV and AIDS. The partnership has made essential linkages with ongoing initiatives in this area, such as the multi-stakeholder Care and Support for Teaching and Learning (CSTL) programme. Significant additional resources were also mobilized from the private sector for priority countries in the region.

Strengthening comprehensive HIV and sexuality education (approx. 30% of total spent)

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. UNESCO's approach also pays attention to non-health outcomes and human rights issues including stigma and discrimination, gender norms and equality and sexual diversity. In partnership with UNFPA and UNICEF, UNESCO is supporting delivery of sexuality education in the 17 priority countries of the UNAIDS Business Case on Young People. This partnership approach is carried through at regional and country level in co-ordinated advocacy and

technical support to achieve the bold results focused on improved condom access and usage, HIV testing and HIV knowledge levels.

Key result:

UNESCO has supported countries to implement and scale-up comprehensive HIV and sexuality education through advocacy to build commitment among decision-makers, and technical guidance and capacity-building for education managers, planners, curriculum specialists and teacher educators to develop, implement and deliver effective HIV and sexuality education programmes. Preliminary results include:

- Kenya Ministry of Education supported to strengthen sexuality education through the existing life skills curriculum;
- Technical review committees established in South Africa and Namibia with comprehensive curriculum audits scheduled for 2011;
- Situation analyses and curriculum scans complete in 8 countries in Latin America and the Caribbean, and planned for 10 countries in East and Southern Africa;
- Teacher training institutions strengthened in Botswana, Lesotho, Malawi, Zambia, Zimbabwe and China;
- Healthy sexuality and HIV prevention promoted to adolescents in Thailand through year-long National Science Museum exhibition (2,000-5,000 visitors per day since August 2010).

Advancing gender equality and protecting human rights (approx. 20% of total spent)

Effective responses to HIV and AIDS must promote gender equality and human rights and tackle stigma and discrimination, both through education and more widely. 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, making it a strategic priority for this biennium and beyond.

Key result:

UNESCO has supported countries to intensify and scale up education outreach and support to respond to the needs of key populations, including through the following actions:

- Responding to the needs of HIV positive learners and teachers, including through establishing community support groups for children and young people affected by HIV and AIDS, strengthening education sector workplace approaches and positive teachers networks in southern Africa and, at the global level, developing guidance to strengthen the education sector response to the needs of young people living with HIV;
- Targeted peer outreach education for men who have sex with men (MSM) in Asia-Pacific, including support for regional and national MSM networks to provide information and counseling services and raise awareness of stigma and discrimination among the general population;

- Expanding access to HIV prevention and tackling discrimination with marginalized groups in Central Asia, with a particular focus on promoting the rights of women migrants.
-

Other issues:

UNESCO is committed to ensuring that all work in these priority areas is forward-looking, aligned with the UNAIDS Strategy and national priorities, and based on the latest evidence, whether through generating new data to expand the evidence base, or supporting countries to analyze and use the data generated, including through monitoring and evaluation of programmes. This biennium, UNESCO's most ground-breaking research has focused on sexuality education. The Organization has commissioned an innovative study into the cost and cost-effectiveness of sexuality education in six countries (Estonia, India, Indonesia, Kenya, the Netherlands, and Nigeria). The study fills a critical gap in the evidence base for sexuality education, and demonstrates that, when planned and implemented carefully, comprehensive sexuality education rolled out through schools is a cost-effective way of mitigating poor health outcomes for young people. UNESCO is also supporting the UNAIDS IATT on Education to conduct a global progress survey on the education sector's engagement in national responses to HIV and AIDS. In the area of supporting countries to use data for a more effective response to the epidemic, UNESCO is building on the work of the IATT on Education to lead on the development of a global monitoring and evaluation framework for education sector responses to HIV. Selected core indicators were identified in 2010 and will be field tested in 2011 in various regions including East and Southern Africa, the Caribbean and Asia.

Strong partnerships, including with ministries of education, UNAIDS cosponsors, and civil society organizations and networks are also critical to the effectiveness of UNESCO's actions. In addition to joint work through the IATT on Education, convened by UNESCO, other IATTs, the UNAIDS Interagency Working Group on women, girls, gender equality and HIV and regional and country teams, UNESCO has strengthened partnerships with cosponsors on a number of priority issues, whether sexuality education in Latin America, or actions to support men who have sex with men in Asia-Pacific. UNESCO and UNICEF's regional partnership to reinvigorate the education sector response in East and Southern Africa has also helped to boost collaboration at national level.

Finally, to ensure that UNESCO delivers on its priorities, this biennium the Organization has invested significant resources to recruit, train and support high-calibre national staff. Twenty new National Professional Officers (NPOs) have been established, including ten in East and Southern Africa. Half are funded by the UBW; half through extrabudgetary funds leveraged by UBW. Placement of the NPOs reflects strategic priorities, particularly delivering on the bold results of the business case on empowering young people to protect themselves from HIV, country needs and epidemic priorities, and countries where UNESCO lacked a regular presence. This increased investment in national staff has significantly increased UNESCO's capacity to identify and respond to country needs, strengthen the role of education in the HIV response, and address the gender and human rights issues that hinder effective responses to HIV and AIDS.

UNFPA

Total amount spent on AIDS in 2010:

- at country level	\$ 64,638,555
- at regional level	\$ 11,457,876
- at global level	\$ 20,344,336
- total spent	\$ 96,440,767

Total amount received from UBW in 2010: \$13,633,750

Description of top 3 priorities and related key results:

Reduce sexual transmission of HIV (33.2% of total spent)

Key results:

UNFPA supported **52 countries to develop a comprehensive procurement, supply management and distribution plan for condoms and other essential commodities.** Results include:

- Strengthened capacity of personnel from private and public laboratories in LAC on the standards and specifications of quality control of reproductive health commodities; and improved South-South collaboration through the establishment of two electronic networks of lab technicians to share protocols and training materials in Latin America and Caribbean regions.
- Strengthen the capacity of staff in 13 countries in the Asia and Pacific Region and 17 countries in the LAC region on the provision of essential HIV prevention services.

UNFPA provided **technical support to implement the “10-step Strategic Approach” to scale up comprehensive condom programming (CCP) in 74 countries.** Results include:

- Increased development of National Condom Strategies and costed Operational Plans in 38 countries; and development of Condom Demand Generation strategies in 3 countries.
- Largest supplier of male condoms to low-income countries – amounting to 680 million; and the second largest supplier of female condoms – 14 million supplied in 2009 as compared to 14.9 million by USAID.
- Strengthened the capacity of staff in 15 African countries to integrate CCP and reproductive health commodity security resulting in the development of national integrated plans in Benin, Burkina Faso and Cote d’Ivoire. Increased availability of tools including a standard Condom Demand Generation Framework to customize effective male/female condom demand.

Technical assistance provided to national governments to **expand male circumcision services in 13 countries** resulting in 21% increase in uptake of MC in Malawi and a comprehensive roll out of MC in Zimbabwe.

UNFPA supported 45 countries to enhance human rights protection and service access for **sex workers and clients, men who have sex with men and transgender people**; 33 countries to implement policy guidance and other information that address the vulnerabilities

and most-at-risk populations; and 45 countries to develop and/or implement programmes to scale up provision of HIV prevention treatment, care and support services to people engaging in sex work and sex between men. Results included:

- Increased coordination and harmonization among sex workers, sex work networks and organizations on work related to HIV/STI prevention and SRH and linkages between SRH, gender based violence, human rights, and HIV.
- New partnerships established with governments, sex workers and the UN in 8 priority countries to facilitate work in Asia Pacific region.
- Improved coverage and quality of SRH and HIV services provided to male and female sex workers by hospital and provincial health offices in Thailand; and increased implementation of HIV prevention services to sex workers in 41 provinces.

UNFPA supported **74 countries to integrate and implement HIV and AIDS policies and programmes for populations affected by humanitarian crisis**. Results include:

- Strengthened integration of HIV prevention into national contingency plans (Comoros) and integration of gender-based violence prevention in emergency protocols (Mozambique); strengthened capacity of 60 service providers and 120 peer educators on the Minimum Initial Service Package for improved implementation of MISP (Uganda), and of 42 female ex-combatants to deliver SRH and HIV services to internally displaced persons and repatriates (Burundi); provided HIV prevention services including STI treatment to over 2,000 militaries, polices and dependents (DRC); and, provided RH/HIV services to UNHCR-managed camps in 25 countries.

UNFPA supported **29 countries to integrate HIV into Poverty Reduction Strategy Papers, national development plans and sectoral plans** including:

- Integration of condom promotion, empowering young people, reproductive health, gender issues and sex work as priority areas in National Strategic Plan on STI/HIV/AIDS (Mongolia) and in National Population Plan, National Gender Policy, National Health Strategy, and National Youth Policy (Nepal).
- Increased advocacy on integrated policies resulted in comprehensive population and development, SRH and HIV integration in Poverty Reduction and Development Strategies in 8 African countries.

Empowering young people to protect themselves from HIV (26% of total spent)

Key results:

UNFPA supported 60 countries to develop and implement programmes for most at-risk young people. Results include:

- Development of national action plans (Namibia, Malawi) which incorporated the 3 bold results in the UNAIDS Outcome Framework and Business Case on *Empowering Young People to Protect Themselves from HIV*; and Mozambique adopted young people as a priority area.
- Increased guidance provided to 10 countries in Asia on implementing UNFPA's *Framework for Action on Adolescents and Youth* in the areas of supportive policy

making, sexuality education, sexual and reproductive health services, including HIV, and youth participation resulting in the development of Country Action Plans.

Improved the human resource capacity of the Ministry of Education by providing 6 Youth Aides to deliver SRH and Health and Family Life Education in the formal public school system (Jamaica).

- Strengthened the financial and technical capacity of the HIV Youth Leadership Fund to support 23 grantees in 18 countries and one global program to implement projects and to develop monitoring and evaluation, advocacy and project management skills.
- Strengthened the technical capacity of 72 policy makers and programmers on programming for most-at-risk young people in the Asia Pacific region.
- Increased advocacy for young people's issues among the international technical community and intergovernmental processes including international conferences such as the World Youth Conference and the International AIDS Conference.

Strengthening linkages between SRH & HIV; and meeting HIV needs of women and girls (22% of total spent)

Key results:

UNFPA supported 42 countries to design, implement or evaluate prevention, treatment, care, and support programmes specifically intended to **empower women and girls**; and 26 countries to develop and/or implement HIV-related policies that specifically address **gender based violence and other actions promoting gender equality**. Results include:

- Strengthened the capacity of 7 countries to: review and launch national strategies and guidelines on gender-based violence and gender; implement National Plan on GBV prevention; and to advocate with the Council of Churches for awareness of religious councilors of SRH, HIV and gender based violence.
- Provided technical and financial support to establish and equip one-stop-centers for survivors of gender-based violence – the Zimbabwe center served 500 clients and Lesotho center received over 10 clients per day for counseling services.
- Strengthened the capacity of 15 countries to: assess the linkages between gender-based violence and HIV in National Strategic Plans; build effective partnerships at national level in order to integrate a comprehensive response to violence against women and girls into national AIDS strategies and plans; and engage men and boys to promote and address gender equality.

UNFPA provided technical and financial support, built the evidence base and disseminated guidance and tools to **strengthen sexual and reproductive health and HIV linkages**. Results include:

- Development of the Operational Plan on Adolescent's Sexual and Reproductive Health where HIV and other relevant cross cutting issues are addressed, including SRH-HIV linkages (Bangladesh).
- Improved operations at the legislative, governance, operations and service-delivery levels from integration of the HIV programme into the National Family Planning Board (Jamaica); more systematic referral mechanism for VCT and maternal health services from integration of referral systems into HIV prevention training (PNG); and improved couple counseling and HIV testing through integrating couple antenatal care and couple

HIV testing and counselling into the service protocol and training course for health care providers in the maternal and child health programme (Thailand).

- Assessment of implementation of the Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages in 25 countries provided results and good practice for linkages; and identified actions to improve health, human rights, and gender equality related to SRH and HIV.
 - Strengthened capacity of national staff in 18 African countries to better understand SRH and HIV linkages which resulted in reprogramming of Global Fund round 9 proposals around PMTCT and proposals for Round 10 developed to accommodate integrated linkages on SRH and HIV/AIDS.
-

Other issues:

Preventing mothers from dying and babies from getting infected with HIV: UNFPA provided technical support to 61 countries for programmatic scale-up of PMTCT and service integration, including through regional train-the-trainer workshops in 5 African countries, as well as focused capacity-building exercises in numerous other countries, such as Turkmenistan and Nepal. Support was provided for development and implementation of national strategies for prevention of mother-to-child transmission in countries such as Bangladesh, Cambodia and Nigeria. Further guidance is being designed to contribute to scale-up of the comprehensive PMTCT services and provide practical guidance on how to strengthen policy and programming to implement the first two prongs of primary prevention of HIV among girls and women, and prevention of unintended pregnancies among women living with HIV. With regard to the way forward, UNFPA will incorporate all four prongs of comprehensive PMTCT into national reproductive health and HIV health and development strategies and plans; establish national coordination mechanisms between sexual and reproductive health and HIV to strengthen implementation of all four prongs; develop costed plans for scaling up comprehensive PMTCT; and link PMTCT health facility-based programmes with community-level programmes addressing the broader issues such as gender dynamics, education, stigma and discrimination, and economic empowerment.

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: UNFPA led the efforts to develop the UNAIDS Guidance Note on HIV and Sex Work. To support this work UNFPA, UNDP, UNICEF, UNODC, and the UNAIDS secretariat have developed an In Reach Training programme. The goal of the training is to ensure that Joint United Nations Teams are prepared to better respond to the HIV-related needs of sex workers, injecting drug users and men who have sex with men within the context of the United Nations policies and programmes on HIV. There have also been great strides in addressing HIV risk and vulnerability in the context of sex work in 2010 including establishment of the UNAIDS Advisory Group on HIV and Sex Work, which brings together the UNAIDS Cosponsors and secretariat, regional sex work networks, civil society and academia to further guide country- and regional-level responses.

UNHCR

Total amount spent on AIDS in 2010:

- at country level	\$ 11,332,705 ⁹
- at regional level	\$ 1,125,000 ¹⁰
- at global level	\$ 1,380,000 ¹¹
- total spent	\$ 13,837,705

Total amount received from UBW in 2010: \$ 4,250,000

Description of top 3 priorities and related key results:

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 (42 % of total spent)

Key results:

38% of countries with >10,000 refugees and 33% with IDPs included in national HIV Strategic Plans.

Examples of interventions:

- In Mozambique, UNHCR received HIV funding under One UN Joint Program and funds helped the agency adopt a broader approach towards urban refugees, inclusive of HIV prevention programs,
- In South Sudan, UNHCR donated kits of medical equipment and supplies to selected Primary Health Care Centres and Units constructed by UNHCR in support of return and reintegration projects in health sector.
- In Nepal, UNHCR supported local NGOs and CBOs to produce street drama performance to raise awareness on the inter linkages between reproductive health and HIV & AIDS, targeting most at risk persons inside and outside the refugee camps.
- UNHCR supported a PMTCT training in Chad in order to improve the quality of services and to strengthen the inter linkages between HIV and Sexual and Reproductive Health. Significant progress is achieved in PMTCT and VCT in the camp health facilities.
- Community outreach activities were carried out using mobile teams and door-to-door visits to sensitize on HIV/AIDS, VCT services and PMTCT services for both urban and rural refugees and host communities in Gambia and Ghana.
- In Brazil, UNHCR developed the SOPs (standard operating procedures) to improve access by persons of concern to UNHCR to HIV/AIDS prevention, care and treatment with the support of the UN Joint Team.
- In Lebanon, UNHCR's advocacy work led to an agreement with the National AIDS Programme to include the refugees under the HIV/AIDS action plan targeting the Most At Risk Populations for them to access services through the national system.

⁹ \$ 3,009,391 (resources outside UBW framework) + \$ 2,495,000 (Core UBW) + \$ 3,550,000 (supplemental) + \$ 2,278,314 (UNHCR regular global/regional resources).

¹⁰ Core UBW.

¹¹ \$ 630,000 (Core UBW) + \$ 750,000 (Supplemental).

- A Joint UNODC and UNHCR regional project for injecting drug users among refugees and returnees was implemented. Two drop-in and outreach centers were established by local NGOs in Afghanistan and another by DOST Welfare Foundation, UNHCR's implementing partner, in Khyber Pukhtoon Khaw province of Pakistan.
- In Dadaab- Kenya, there is marked stigma associated with HIV and it is important to expand existing strategies to include training of religious leaders in HIV and Human rights. Training on HIV and Most AT Risk Population was conducted for UNHCR staff with focus on issues of MSM and Sex workers facing discrimination when accessing health services. Benefits have been noted from Income Generating Activities with most sex workers reporting reduction in sex partners, improvement is in discrimination against children of sex workers at school. But the problem is still present in the community at large. Peer-led approaches and networking need to be more proactive.

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. (26 % of total spent)

Key results:

- About 85 countries were supported to design, implement or evaluate prevention, care, treatment and/or support programmes/interventions specifically intended to empower women and girls.
- HIV and SGBV prevention programmes, including integration of reproductive health services were implemented in 85 countries.
- Assessments and trainings on at risk groups including sex in 5 countries.

Examples of interventions:

- UNHCR Brazil supported the development of a booklet on women's rights, HIV/AIDS and SGBV prevention and response in the Amazon region with a focus on border areas. The booklet was developed within the framework of the Amazon Aids Women initiative of the UN Joint Team on HIV/AIDS.
- In South Sudan and Congo Brazzaville, UNHCR worked on fighting SGBV and supported capacity building on prevention and response, involving different stakeholders such as implementing partners, health authorities, local NGOs and the Police.
- In Kenya, a rapid need assessment was conducted in Kakuma to assess the interventions targeting sex workers and their clients. It was found that unprotected sex is common and condom negotiation is a big issue. About 90% of sex workers were not using contraceptives. As family planning services in the camp are very weak, HIV positive clients are not routinely offered contraception. More women than men are taking up HIV counseling and testing services at the ANC clinic in Dadaab. More than 50% of couple counseling is taking place in Dagahaley camp. Progress has been made in the interventions targeting sex workers in all three camps and one initial intervention targeting men who have sex with men has been initiated.
- In Bangui-Central African Republic, women support group and their network of community workers had an important contribution to the promotion of established PMTCT services supported by UNHCR.

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. (12.5 % of total spent)

Key results:

- Advocacy against mandatory testing conducted in Europe, MENA, Americas and other regions.
- Target of IEC material in 100% of UNHCR operations is achieved

Examples of interventions:

- In Lebanon, UNHCR advocated with the National AIDS Program to include refugees in the Strategic and Operational Youth Action Plan on HIV/AIDS for the years 2010- 2012, which will deliver youth friendly reproductive health services including HIV/AIDS. UNHCR collaborated with UNFPA on awareness raising events under the Y-PEER programme, targeting high schools where Iraqi refugees are enrolled.
- In Mozambique, UNHCR supported the networking of youth peer educators for HIV/AIDS prevention and sexual and reproductive health issues. Training empowered the peers to plan and design their project, as well to monitor its implementation, and evaluate the achievements. In addition, UNHCR's partner implemented awareness raising interventions on youth reproductive health and HIV in the host and refugee communities targeting them at health centers and schools. These HIV campaigns had a visible impact on students who were able to describe how HIV is transmitted and prevented, how to care for people living with HIV and most important they had reduced significantly their discriminatory comments in comparison to previous year.
- In Ethiopia, the Community Conversation (CC) strategy has shown incredible results such as widespread acceptance of condom use among youth Somalis in refugee camps (Eastern region). It has also enabled the community to have adequate knowledge and better attitudes towards HIV/AIDS. There has been a marked reduction in the levels of stigma and discrimination towards PLWHIV.

Other issues:

- Provision of technical support to scale up HIV programmes for adolescents and children among displaced populations, including the separated, the unaccompanied and orphans, to reduce their vulnerabilities to HIV and to provide necessary support and work towards a durable solution (9% of total spent). The programme was implemented in 80 countries.
- Coordination and collaboration with key stakeholders, and support to programmes addressing HIV related stigma and discrimination among persons of concern to UNHCR to ensure that their human rights are protected (5% of total spent). All UNHCR operations supported a conducive environment to reduce HIV related stigma and discrimination. Capacity building on stigma reduction was implemented in 3 regions.
- Support to integration of HIV in health information system, and conducting standardized assessments, surveillance (biological and behavioural), monitoring, evaluation, and programmatic research in conflict-affected and displacement settings (4% of total spent). Analysis of data/information in 50% of target countries with UNHCR HIV/AIDS programmes. Behaviour Surveillance Survey were conducted in 45 countries (Kenya,

Tanzania, Rwanda, and Uganda; Refugee ART adherence studies were conducted in Kenya and Uganda; HIV data in non-camp health information system were integrated in Democratic Republic of Congo and Pakistan. More progress is expected in 2011.

- Advocacy and support for review, change and elimination of legal and policy barriers impeding equitable access to comprehensive HIV and AIDS services and commodities for displaced populations (1.5.% of total spent). UNHCR conducts regular advocacy work to ensure that refugees and other persons of concern have access to HIV prevention, care, support and treatment services.

UNODC

Total amount spend on AIDS in 2010:

- at country level	\$ 27,846,514
- at regional level	\$ 6,674,200
- at global level	\$ 3,580,687
- total spent	\$ 38,101,401

Total amount received from UBW in 2010: \$5,902,982

Description of top 3 priorities and related key results:

Provide technical assistance to countries for resource mobilization, establishment of multisectoral working groups, assessment of programmatic needs and capacity-building towards the development, implementation and monitoring and evaluation of evidence-informed comprehensive HIV prevention, treatment and care services for injecting drug users, in prison settings, and for people vulnerable to human trafficking (62% of total spent)

Key results:

Technical assistance provided by UNODC in more than 67 countries facilitated programmatic scaling-up in 2010, for example: in the Russian Federation, UNODC HIV programmes for injecting drug users reached 5,400 new clients; in Nepal, UNODC supported the implementation of the largest harm reduction programme in the country providing services to over 12,000 drug users; in Myanmar, UNODC support helped to increase the coverage of methadone maintenance therapy from 512 in 2008 to 972 in September 2010; in the Baltic states, UNODC supported a ten-fold increase in the number of methadone maintenance therapy provision sites (from 1 to 10) in Latvia and to increase the number of injecting drug users receiving methadone by 50% in Vilnius, Lithuania; in Estonia, Latvia, Lithuania, UNODC projects contributed to the downward trend in newly diagnosed HIV infections. Launching opioid substitution therapy was supported in Afghanistan, Morocco, Lebanon, and Pakistan.

UNODC organized workshops and supported technical consultations on monitoring and evaluation in Afghanistan, Morocco, Viet Nam, Ukraine and Kyrgyzstan, and organized a special workshop at the AIDS 2010 conference in Vienna for setting targets for Universal Access to HIV prevention, treatment and care for injecting drug users. UNODC continued to support the Reference Group on HIV and Injecting Drug Use, which produced the first ever global estimates on coverage of HIV services among injecting drug users, published in the journal Lancet in 2010. The estimates are available at: http://www.unodc.org/documents/hiv-aids/publications/2010_UN_IDU_Ref_Group_Statement.pdf.

UNODC supported the AIDS 2010 Conference in Vienna as an international partner, organized a number of conference sessions, Global Village activities, and a 6-day training for its over 80 staff members, who are implementing UNODC's HIV/AIDS activities covering more than 90 countries.

In collaboration with relevant partners, advocate and provide technical support to countries to address the occupational health of law enforcement personnel with regards to HIV, and to build their capacity to facilitate the provision of evidence-informed, human rights-based comprehensive and gender responsive HIV services for injecting drug users, in prison settings and for people vulnerable to human trafficking (11% of total spent)

Key results:

UNODC support to over 32 countries to address the occupational health of law enforcement personnel with regards to HIV, and to build their capacity included training, development and dissemination of guidelines and tools in several countries, including in Eastern Europe, Central Asia, South Asia, South-East Asia, North Africa and the Middle East and Southern Africa.

For example, UNODC developed the police training curriculum with the National AIDS Control Programme and supported training on harm reduction for police forces in Afghanistan, and designed and tested a model training on HIV in prisons for health penitentiary staff in Panama. UNODC conducted training and advocacy on harm reduction for over 1,600 police officers in Myanmar, and facilitated training of over 120 prison staff and supported establishing supportive environment in prison settings in 12 provinces in Indonesia.

In Central Asia, UNODC developed a manual for the police and low threshold services related to health protection measures for drug users and people vulnerable to human trafficking, and updated occupational standards for prison staff in Kyrgyzstan that include provisions related to health protection. In the Russian Federation, UNODC developed a manual on Drug Referral Schemes containing recommendations for law enforcement officers with regard to injecting drug use, and delivered over 40 workshops for law enforcement officers on HIV/AIDS with regional partners. In Namibia, UNODC supported HIV counseling and testing, as well as ART adherence counseling to both prisoners and prison staff in 11 out of the 13 prison clinics of the country. UNODC supported to ensure that pharmacological treatment of opioid dependence for drug users continues in police custody in Estonia and Lithuania.

Advocate and provide technical support to countries to develop human rights-based, gender-responsive and equitable AIDS policies and programmes for prison settings, injecting drug users, and people vulnerable to human trafficking in line with human rights treaties and other related international standards (8% of total spent)

Key results:

UNODC assistance to over 49 countries to develop human rights based, gender-responsive and equitable AIDS policies and programmes included advocacy among countries in East Asia and Pacific region to shift away from detaining people who use drugs in compulsory centres for drug users (CCDUs), and support to expand evidence-informed and voluntary drug dependence treatment services in the community. In September 2010, UNODC and the UNAIDS Regional Support Team convened an 'Informal Consultation on Compulsory Centres for Drug Users', which was attended by over 50 participants representing civil society organisations and networks, donor partners, UN agencies and technical experts. The consultation advanced the international debate and social mobilization on the HIV risks

and human rights issues regarding the compulsory centres for drug users. In Cambodia, in collaboration with key stakeholders, UNODC led drafting of the UN Common View Point on the rights-based approach to drug dependence, drug use and the compulsory centres for drug users, and advocated for expansion of needle and syringe programmes.

UNODC also produced a discussion paper “From coercion to cohesion: Treating drug dependence through health care, not punishment”, suggesting to move from compulsory treatment to community -based treatment and alternatives to imprisonment for drug users and drug dependent persons.

UNODC advocated for increased HIV services for female drug users and female prisoners, and expanded provision of gender-sensitive HIV services in community sites and prisons, for example in Afghanistan, Bangladesh, Northeast India, Iran and Nepal. In the Russian Federation, UNODC implemented gender-sensitive referral (case-management) schemes and training on provision of harm reduction services for female drug users and HIV-positive injecting drug users released from prisons. UNODC also supported the production and global dissemination of reports on women who inject drugs to illustrate female injecting drug users’ risks, experiences and needs.

Other issues:

While globally, from 2001 to 2009, the rate of new HIV infections stabilized or decreased by more than 25% in at least 56 countries, including 34 countries in sub-Saharan Africa, new infections among drug users continued to rise, particularly in Eastern Europe and in Central Asia. However, data indicate also that new infections among drug users are absolutely preventable, if a comprehensive package of harm reduction and drug dependence treatment programmes are implemented. While there are a number of countries where there were virtually no new infection among injecting drug users in the past years, overall the implementation of a comprehensive response is hindered by policies and practices perpetuating stigma and discrimination.

Drug users continue to be subject of severe discrimination and stigmatization in many countries for two main reasons: Drug use is often viewed as anti-social behaviour resulting from lack of will power, bad character and moral insufficiencies, all of which could be stopped through reprimand and severe punishment. Consequently, drug users are often incarcerated, forced into drug detention centres, subject to cruel treatment, and their rights to health and services violated. They also do not seek services, as doing so might have drastic and severe social and legal consequences for them.

The second reason for discrimination and stigmatization is the risk of HIV infection. For many years drug use has been seen as a self-inflicted disease, and being HIV-positive was seen in the same way. In fact, in the early days of the HIV epidemics, drug users together with homosexual men were seen responsible of spreading the disease. Too often, services have not been provided at all or at a sub-standard level, because it was the public view that “they deserve to be HIV infected and to die of AIDS”.

Data indicate also a trend of emerging HIV epidemics in countries, where the epidemic was traditionally heterosexually driven. These are, for example, Kenya, Mauritius, Mozambique, Cote d’Ivoire, Nigeria and Cape Verde. New epidemics are also observed in conflict and post-conflict countries, such as Afghanistan and Iraq.

Another factor for the increase of the number of new HIV infections is non-injecting drug use and the increasing use of amphetamine-type stimulants and crack cocaine. Here data suggest a close relation between sexual risk and drug use particularly in the Caribbean, Latin America and some countries of South-East Asia.

Highly stigmatised and discriminated, the needs and rights to health of the 30 million people who every year go through the prisons system are neglected. Governmental, non-governmental and international organisations do not provide the required attention, nor funding, to the population in detention. Gender and age based violence, poor prison conditions, poor management and overcrowding aggravate this situation. Policies and services are inadequate and most of the time isolated from the public health and community services. As a consequence HIV and TB morbidity and mortality rates are much higher than in the community and HIV/TB are the primary causes of deaths in many prison systems. All modes of transmission occurring in the community occur also in prisons: sexual transmission, blood-to-blood transmission as well as mother-to-child transmission. A standardized, internationally endorsed package for HIV prevention and treatment in closed settings, combined with targeted advocacy are an urgent necessity.

Through a comprehensive package of harm reduction and drug dependence treatment programmes, prisons specific and general criminal justice reform interventions, new HIV infections and co-infections with tuberculosis and hepatitis C could be prevented in the community, in prison and other closed settings.

WFP

Total amount spent on AIDS in 2010:

- at country level	\$ 136,118,068
- at regional level	\$ 10,790,598
- at global level	\$ 3,220,000
- total spent	\$ 150,128,666

Total amount received from UBW in 2010: USD \$5,265,906

Description of top 3 priorities and related key results:

In 2010 WFP reached 3.0 million beneficiaries in its HIV and AIDS programmes, including children, in 47 countries benefited from nutritional rehabilitation, safety nets or a combination of these either through in health facilities or by mitigating the burden on affected households. Many PLHIV may also benefit from other WFP programmes that do not target them: examples include school feeding and food-for-assets programmes.

WFP's HIV and AIDS policy was approved by the WFP Executive Board and endorsed by UNAIDS in late 2010. The policy guides WFP's work in line with the UNAIDS five year Strategy. It further aims to ensure that people living with HIV (PLHIV) as well as people who are being treated for tuberculosis (TB) receive nutrition assessment, education and counseling (NAEC) and, when they are malnourished and/or food insecure, appropriate food support.

In preparing its new HIV and AIDS Policy, WFP worked with universities to review the evidence related to nutrition and HIV, nutrition and TB, and food insecurity and HIV. Three background papers summarizing the state of the evidence have been published in the Food and Nutrition Bulletin Supplement: Nutrition and Food Insecurity in Relation to HIV and AIDS and Tuberculosis. At the regional level, WFP published a study; "*Food Insecurity and Nutritional Barriers to Antiretroviral Therapy: Lessons from Latin America and the Caribbean*".

In responding to HIV and AIDS, WFP will continue to build on evidence-based, efficient and effective programmes that augment and complement those of its many partners. WFP plans to continue the successful integration of nutritional support in the universal access context, by translating policy into informed actions.

Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment (38% of total spent)

Key results:

In 2010, WFP reached almost 2.0 million beneficiaries through care and treatment programmes. WFP Kenya, Lesotho, Malawi, Mozambique, Rwanda and Swaziland invested extra efforts in staff and partner training on Food-by-Prescription (FBP) principles, developed materials and supplied equipment to enhance the use of anthropometric measures in clinic based nutrition assessment. WFP works with governments and partners to ensure that treatment is accompanied by assessment of nutritional status, education and counseling on meeting nutrient requirements for maintaining body weight and good health

and mitigating treatment side effects, and where necessary provide nutritious foods to treat malnutrition.

WFP is increasingly implementing programmes in partnership with Ministries of Health to ensure that WFP activities are designed as enablers of broader government led programmes rather than as standalone activities. The current development of a FBP programme in Swaziland with the National Nutrition Council, which is part of the Ministry of Health, is an example of this approach. Another example is the Mozambique piloting of a voucher-based system to make a basic food basket available to malnourished people on ART: the pilot is being developed at the request of the Ministry of Health, which allocated World Bank funds through WFP for this purpose.

WFP's participation in research partnerships in Zambia (with the Centre for Infectious Disease Research Zambia, CIDRZ) has helped explore the impact of nutritional supplements and household food assistance on treatment success as well as on social stability and livelihood protection and promotion in client's households. Findings have helped inform Zambia's Round 10 Global Fund proposal.

The inclusion of HIV nutrition support in the joint UN Programme on Nutrition in Lesotho developed by UN agencies (UNICEF, WHO, FAO and WFP) in partnership with the government in 2010 also calls for the introduction of nutritional screening measures, complemented by household assistance. Commonalities in nutrition rehabilitation principles between maternal and child health programmes and HIV and TB related services increasingly call for convergence in strategy, protocol and services delivery mechanisms

TB deaths among people living with HIV reduced by half (28% of total spent)

Key results:

Overall in 2010, WFP provided nutritional TB treatment support to 28 countries representing 30 % of all food based support in care and treatment. The food was provided to as individual and/or household rations, reaching nearly a million beneficiaries. In most countries in East, Central, and Southern Africa, discussions and programme review activities in context of Food-by-Prescription have also reached out to TB programmes, seeking increased convergence and alignment of approaches.

In sub-Saharan Africa, the triple burden of HIV, TB and malnutrition reinforces the need for nutrition and food support. It is well recognized that a symptomatic TB client in a country with a high HIV burden is likely to have many of the same nutritional support needs as an HIV and AIDS client. A co-infected individual is likely to face even greater nutritional challenges. For example, in Zambia, the HIV and AIDS prevalence among people between the ages of 15 – 49 is 13.5% and up to 70% of those are co-infected with TB.

Key achievements have been made in the recognition of the role of nutrition support in conjunction with TB-DOTS in Swaziland and Djibouti, where food and nutrition support were included in the Round 10 GFATM TB proposals, both of which were endorsed. Following WFP's critical technical support to the proposal development, governments of both countries have also requested that WFP play an important role in the design and implementation of integrated food and nutrition activities. In Georgia, WFP provided technical assistance to the Georgian National AIDS Programme, the National TB Programme and key stakeholders to develop a *national strategy on nutrition support for PLHIV/TB in Georgia*.

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 (34% of total spent)

Key results:

A milestone in the HIV response is the use of cash or voucher transfers for HIV programming. Vouchers where appropriate, are used to provide specific food and ease logistics requirements, distances and stigma. In Zambia and Zimbabwe voucher based food assistance programmes were elaborated following the early 2009 Zambia pilot scheme. Household food assistance as well as other benefits (in Zambia a bar of soap is provided through the same voucher, financed by UNICEF) is provided to care and treatment clients (ART, TB, PMTCT) who are malnourished and/or food insecure to protect household care and productive capacity during client recovery while enhancing the wellbeing of the client. The voucher schemes serve as models for national learning and possible future replication within national social protection strategies.

WFP has helped governments to build systems such as the Productive Safety Net Programme in Ethiopia. Such safety nets are designed to address food insecurity rather than HIV, but they are important in preventing the spread of HIV and addressing the needs of PLHIV, for example by helping them to overcome barriers to access and adherence to essential care and support, including ART. Such safety nets protect people's livelihoods and prevent them from engaging in coping behaviours that could expose them to HIV. When treatment has helped PLHIV and TB patients to recover medically and nutritionally, they can be referred to safety nets linked to national social protection schemes. Where such safety nets do not exist, WFP will advocate for their creation and work with governments to ensure that they include PLHIV.

WFP provided technical and programme support to Benin, Central African Republic (CAR), Cote d'Ivoire Ethiopia, Kenya, Lesotho, Malawi, Swaziland, and Tanzania to implement social protection activities for children. An innovative approach in CAR allowed for children to remain with foster families but under the supervision of a specialized instructor that provides food and other needed support to the foster families. This approach guarantees that the children remain in a family environment while they benefit from care and other services provided by the relief organization. In addition, this approach can prevent cases of child abuse encountered in some foster families.

Other Issues:

Integration of food and nutrition in essential services: During this period of financial constraint, good investments are more important than ever. Integrated HIV, food and nutrition interventions can enable and catalyze the achievement of both vertical and broader horizontal health objectives. Integrated HIV, food and nutrition interventions should also be understood as ways to increase the return on investment for existing HIV treatment, care and support programmes. Food and nutrition interventions can reduce mortality and morbidity, while improving quality of life of affected individuals, households and communities, and when combined with treatment, they can improve uptake and adherence and overall treatment success.

An integrated HIV and AIDS response requires leveraging the strengths of both the health sector and individual communities. While only the health sector can ensure nutritional status is always seen in conjunction with the course of treatment, it is far too overburdened to fully support affected households. Research needs to be conducted on how best to link treatment programmes based in the health sector with community-based care and support activities in order to guarantee a continuum of comprehensive care to patients and their households through an adequate referral system between health facility and communities.

Prevention of mother-to-child transmission of HIV (PMTCT): WFP explored possibilities for integration of nutrition support to PMTCT with MCHN for alignment with national intervention strategies in Mozambique, Rwanda and Zambia. This involves consultation with Government counterparts, review of national PMTCT and MCH strategies and operational considerations with implementing partners at all levels.

Monitoring & Evaluation: There is a greater need to strengthen and standardize outcome and impact indicators for food and nutrition interventions in HIV and TB. WFP, together with WHO, FANTA and PEPFAR, is working on a set of globally recognised harmonized food and nutrition indicators. These include indicators on nutrition care and HIV, PMTCT and food security and HIV. Once these are agreed, WFP can finalize its Monitoring and Evaluation Toolkit and roll it out to its HIV operations in support of its new policy.

WHO

Total amount spent on AIDS¹²

- at country level	\$ 52,578,443
- at regional level	\$ 24,476,913
- at global level	\$ 45,314,141
- total spent	\$ 122,369,497

Total amount received from UBW in 2010: \$ 20,735,000

Description of top 3 priorities and related key results:

Ensuring that people living with HIV receive HIV treatment of adults and children (41% of total spent)

During 2010 intensive work was undertaken in developing and updating norms and standards related to HIV treatment, laboratory support and overall clinical management.

Key results:

Treatment guidelines for adults and adolescents, for children and for PMTCT were published and launched at the Vienna International AIDS Conference. WHO provided direct technical support for the adaptation of the new guidelines to 30 countries through regional workshops and to 10 countries through individual missions. These guidelines have been, or are being, adapted and implemented in all regions. A web-based interactive adaptation guide was completed in the first quarter of 2011 and will be published online early in the second quarter to support countries in their implementation efforts.

The Joint WHO/ILO policy guidelines on health care workers' access to HIV and TB prevention, care and treatment were finalized, endorsed by UNAIDS, and launched in November 2010.

WHO provided technical support to more than 30 countries on implementation and interpretation of the surveys of transmitted and acquired HIVDR and conducted capacity building workshops for 13 countries. WHO continued to provide support for HIVDR transmission surveys with results available from 25 countries as of the end of 2010. In 2010 guidance was developed and training was provided on HIVDR early warning indicators monitoring and 26 countries implemented such monitoring. The software of WHO HIVDR database was installed in 10 countries. The WHO global HIVDR Laboratory Network was strengthened through training for 11 countries with 80 trainees participating from a number of other institutions, and expansion of accreditation of laboratories and assay procedures. Joint work was started to ensure sustainability of the HIV drug resistance programmes, including the inclusion of drug resistance monitoring and prevention plans into national programmes, Global Fund funding proposals and PEPFAR Country Operational Plan.

In the area of pharmacovigilance, normative guidelines and reference standards were developed for the monitoring of ARV drugs including priority case definitions of ARV adverse events, standardized toxicity rating scales and clinical management. A practical handbook

¹² As of 31.12.2010.

of pharmacovigilance of ARV drugs was published. Technical support was provided to six focus countries (Cote d'Ivoire, Tanzania, Zambia, Vietnam, Ukraine and Brazil) to establish pharmacovigilance programmes. Staffs were recruited as pharmacovigilance focal points in the respective WHO country offices.

WHO developed analyses for simplifying cohort monitoring in order for countries to better monitor impact of ART interventions. It has also fully documented status of retention in ART programmes at country level, based on country reported data for the annual health sector report for HIV/AIDS response in the health sector.

In June 2010 WHO and UNAIDS jointly launched the Treatment 2.0 initiative. This collaborative initiative aims at catalysing the next phase of treatment, care and support in five priority work areas and frames WHO's work in HIV diagnosis, treatment, care and support under WHO's global health sector strategy on HIV, 2011-2015. Thematic priorities for this work are: testing and counseling, ART for adults and children, retention in care, ARVs and ART in prevention, drug and diagnostics optimization, service delivery, pharmacovigilance and drug resistance, co-morbidities including TB and viral hepatitis, and nutrition. Priority activities currently under way include development of a Treatment 2.0 operational plan with the UNAIDS Secretariat and key global partners and advancing short-term priorities for drug optimization and simplified diagnostics. WHO convenes the interagency working groups for treatment and TB/HIV, which aim to advance joint planning and implementation of activities across UNAIDS Cosponsors.

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

Considerable normative and advocacy work was undertaken to accelerate implementation of collaborative TB/HIV activities, including work related to the *Three I's for HIV/TB*.

Key results:

New guidelines for intensified tuberculosis case-finding (ICF) and isoniazid preventive therapy (IPT) for people living with HIV in resource-constrained settings were released on World AIDS Day. They are the results of a process of comprehensive review of the available scientific evidence and a global consultation process. The guideline re-conceptualize the 1998 WHO/UNAIDS Policy on TB prevention and provide guidance to national HIV and tuberculosis programmes and those providing HIV services on how to accelerate the nationwide implementation of IPT and ICF. They include evidence-based recommendations for adults, children and infants living with HIV, address implementation issues and identify key research gaps in order to scale up TB prevention, diagnosis and treatment as a core component of the HIV response. An advocacy toolkit on the *Three I's for HIV/TB* was developed for Southern Africa and implementation workshops have been held with national TB and HIV programmes, civil society representatives and funding agencies.

Other normative work includes the update of the WHO Interim Policy on collaborative TB/HIV activities. Systematic literature reviews on HIV testing for TB patients and presumptive TB cases, co-trimoxazole preventive therapy for TB patients living with HIV, the use of ART for TB prevention, and review of the evidence to identify best models of integration of TB and HIV services were conducted during 2010 as part of the update of the TB/HIV policy. A priority TB/HIV research agenda was also defined and published in 2010 and concomitant advocacy work was done to introduce the identified priority research questions to researchers and research funding agencies. Activities to scale up the delivery

of ART using decentralized TB services were initiated and situation analyses were conducted in five Sub-Saharan African countries. WHO provided technical support for conducting situation analyses in five African countries namely Mali, Cameroon, The Democratic Republic of Congo, Ethiopia and Kenya to assess the implementation of collaborative TB/HIV activities in TB clinics and provided recommendations on the delivery of ART through TB services. Technical support and normative guidance will be provided to countries to scaling up ART and HIV prevention using decentralized TB facilities and services depending on the local context of the countries.

The integration of TB and HIV services, in prisons and targeted programmes for people who use drugs, was promoted at several meetings and workshops in the WHO European and African Regions. The mandatory hospitalization of TB patients and excessive verticalization of the two programmes in Eastern Europe and Central Asia were identified as critical barriers for scaling up collaborative TB and concerted advocacy and consultation with national governments was initiated.

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 for PMTCT, which includes UN agencies and 18 additional implementing partners and donors. WHO co-leads the IATT working groups on: M&E, pediatrics, infant feeding and elimination scale-up and supports UNFPA on the working group on primary prevention and family planning.

Key results:

In 2010, WHO's work in support of PMTCT included key activities at global, regional and country levels in the following areas: normative guidelines; integration of PMTCT with maternal, neonatal and child health and the MDGs; support for the Global Fund; development of the elimination framework; technical support on monitoring and evaluation; and strong support for its global convening role for PMTCT.

In conjunction with revisions of other key HIV normative guidelines, WHO revised the guidelines on PMTCT ARVs and HIV and infant feeding in 2010. These were initially released in short form as "rapid advice," which allowed countries to begin working quickly on country adaptations and revisions. The full guidelines were published in July and launched at the Vienna AIDS conference. In particular, the PMTCT and infant feeding guidelines represent a major change towards more effective regimens and safe infant feeding in the context of HIV and breastfeeding, and provide the normative basis for the possibility of elimination of new paediatric infections.

WHO provided direct technical support on PMTCT related programs to at least 15 countries in addition to ongoing support provided by WHO regional offices and dedicated staff in WHO offices in the 25 high burden countries. Adaptation workshops were organized in countries and regions including India, Africa (several workshops), Eastern Mediterranean, Western Pacific and South East Asian. During the past year, nearly all high burden countries have moved quickly to adopt the new guidelines.

Early in 2010, WHO released its PMTCT Strategic Vision, 2010-2015, outlining a comprehensive and integrated approach to support scale-up of PMTCT in high burden

countries and in all regions, and link PMTCT and MDG 6 with support for MDG 4 and 5. This document provides a framework for collaboration and coordination across WHO's work related to HIV, maternal, neonatal and child health, and sexual and reproductive health in order to support efforts to eliminate new paediatric HIV infections.

WHO provided support to the Global Fund during a year in which the Global Fund declared PMTCT to be a key priority area, with special emphasis for reprogramming and new funding in Round 10. WHO actively supported and co-convened a Global Fund meeting in Nairobi in June 2010, bringing together 20 high burden countries to focus on developing country plans for Global Fund applications and country scale-up plans. WHO updated technical guidance for the Global Fund on PMTCT and infant feeding, and including MNCH and SRH, and provided country, regional and HQ in-depth reviews of proposals.

In 2010, several high level meetings affirmed the goal of elimination of vertical transmission. To support this new agenda, WHO convened a large interagency and partner technical consultation in November 2010, to define the technical issues, goals and targets for elimination, and provide a guidance framework for a way forward. WHO and partners are now actively working on an Elimination Framework, including an Action Framework, a Strategic Guide for Elimination, and an M&E Framework for Elimination. WHO also actively supported regional initiatives for elimination, including ongoing leadership in PAHO and support for new elimination frameworks in Asia and the Pacific and in the African region.

WHO continued its leadership role on global PMTCT monitoring and evaluation, working closely with UNICEF and the UNAIDS Secretariat on global reporting (e.g. the Universal Access Report), which includes key documentation of progress on PMTCT. WHO also convened and developed a generic protocol for PMTCT "impact evaluation", which is now being implemented in several countries, co-convened a technical consultation to revise the UNAIDS Spectrum model to be consistent with new evidence and the new 2010 guidelines, finalized new M&E guidance for PMTCT and is participating in costing analyses and estimates for PMTCT and elimination.

During the past year, WHO finalized tools and training packages for PMTCT implementation and integration, including the IMAI/IMCI/IMPAC and integrated patient monitoring system package. Most high MTCT burden countries have attended an inter-country training of trainers.

Other issues:

In 2010 WHO developed the *Global Health Sector Strategy for HIV: 2011-2015* through a broad consultative process involving over 90 Member States and inputs from 2,000 individuals and organizations. The Strategy will guide the health sector response to HIV and outlines recommended country action and WHO contributions in support of country action in four strategic areas: optimizing HIV prevention, diagnosis, treatment and care outcomes, leveraging broader health outcomes through HIV responses, building strong and sustainable health systems, and reducing vulnerability and structural barriers to accessing services. The goals and targets of the Strategy are aligned with the UNAIDS Strategy and will guide the work of WHO from 2011 to 2015.

WHO published the annual *Towards Universal Access* report, which presents progress on HIV intervention coverage and reports on how HIV investments are strengthening key

components of health systems, such as disease surveillance. The report was launched prior to the October GFATM replenishment meeting and has contributed significantly vehicle to drive paradigm shift towards prioritization and efficiency increases in the HIV response.

WHO contributed significantly to the UNAIDS Global Report 2010, and the UNICEF AIDS and Children Stocktaking Report. It also released *HIV/AIDS Programme Highlights 2008-09* to inform donors and other partners of major achievements of the WHO HIV programme in the last biennium and published *Priority Interventions 2010: HIV/AIDS prevention, treatment and care in the health sector* which defines the essential interventions the health sector should deliver, and provides key references and links to web-based resources.

World Bank

Total amount spent on AIDS in 2010:

- at country level	\$ 1,799,160,000
- at regional level	\$ 9,453,570
- at global level	\$ 6,694,270 ¹³
- total spent	\$ 1,815,307,840

Total amount received from UBW in 2010: \$ 10,979,241

Description of top 3 priorities and related key results:

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 result achieved in 2010:

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. Some examples from 2010 include:

MENA regional synthesis: as part of analytical and advisory services to regional governments and development partners, the World Bank, in partnership with UNAIDS and WHO, led a groundbreaking HIV epidemic, policy and response synthesis report that has led to program shifts. “*Characterizing the HIV/AIDS Epidemic in MENA*” shows how focusing investments on prevention efforts for priority populations at increased risk of HIV infection can yield long-term health and social benefits. Thanks to the synthesis, the governments of Sudan, Syria, Jordan, Egypt, and Morocco have increased their resource allocation to most at-risk populations.

South Africa Synthesis: The main aim of this synthesis project is to inform the new NSP on how to improve HIV prevention and align prevention focus with the current HIV transmission patterns. South Africa is facing a major and mounting challenge as it strives to respond to the epidemic. New infections outstrip AIDS-related deaths and every year, there are an additional ~100,000 South Africans living with HIV. Even under the most optimistic scenarios, about 5 million more South Africans will become HIV infected over the next two decades, roughly the number who are currently living with the virus. In order to cut the number of new infections, there needs to be a massive focus on HIV prevention which works. In the absence of a “game-changing” new technology in the near future, such as a vaccine, existing epidemiologically relevant interventions need to be better targeted, promoted and quality assured, and implemented at sufficient scale and with the right messaging. In the national KYE/KYR synthesis report, the Government expects bold, evidence-informed and actionable recommendations and our best technical advice on what it would take to “decimate new infections in the next five years” (SANAC CEO). The recommendations will form the basis of the HIV prevention component of the new national

¹³ Managed at global level but 90% spent on activities in country.

HIV NSP whose development has commenced and will be finalized in the next six months. The participants of this retreat came from key contributing organizations in this synthesis process (SANAC, UNAIDS, NDoH, HSRC, DPSA, USAID-HPI, SACEMA).

HIV impact evaluations: Innovative research and technical guidance, real-time program monitoring and rapid impact evaluation to increase understanding of how services are being provided, and what works to reduce HIV transmission and under what circumstances, remained a key part of the Bank's support to countries. For example, in India, the Bank is using evidence to analyze the quality and effectiveness of HIV prevention programs. Preliminary findings indicate that new HIV infections have dropped by 60% largely due to interventions targeting sex workers. Outputs from this activity will provide direct assistance to India, with the primary intent of influencing the country's programs and policies.

Analytic work on HIV among MSM: In partnership with UNAIDS, UNDP, and WHO, the World Bank completed a major analytical study on one of the most-at risk populations responsible for a significant number of HIV infections around the world. Titled, "*The Global HIV Epidemics among Men Who Have Sex with Men (MSM): Epidemiology, Prevention, Access to Care and Human Rights*," the study evaluates global costs of inaction in addressing HIV among MSM, critically reviews epidemiological evidence of HIV transmission, rigorously reviews the evidence of efficacy and intervention costs, and models the costs and impact of addressing the needs of this population in various epidemic contexts. The study found that coverage rates for essential services within health systems for MSM in LMIC remain low, with only between 1 in 5 and 1 in 10 MSM having any access to targeted HIV prevention services. The study has found that addressing the MSM epidemic significantly affects a country's epidemic—even in generalized epidemic scenarios such as those in Sub-Saharan Africa.

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 result achieved in 2010:

During the reporting period, there were 40 country requests from East and Southern Africa, West and Central Africa, Latin America and the Caribbean, Asia and Pacific, MENA, and Europe. Of these, 26 were new country requests. The World Bank provided strategic intelligence and planning support that enabled countries to develop prioritized and costed national AIDS strategies, and to improve their allocation efficiency, resulting in effective national responses focused on epidemic dynamics. For example, Ghana, Benin, Sierra Leone, Zambia, Ukraine, Georgia, Saint Lucia, Trinidad and Tobago, Nepal and Laos, were able to prioritize and focus resources on epidemic dynamics, resulting into focused national priorities for an effective and efficient national response.

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 result achieved in 2010:

The recent global food, fuel and financial crises have underscored the importance of effective safety nets to protect the most vulnerable individuals and to make sure that the hard won gains of economic growth are translated into equitable development. The World Bank provides major support to social protection programs at the request of countries, financing \$4.2 billion in new commitments in FY10 alone. During the last five years (FY05-09), the World Bank has approved 123 social safety nets projects in 60 countries, and allocations toward social safety nets alone have totaled \$3.13 billion in FY09 and \$2.58 billion in FY10—including to 20 countries that are new to the safety nets portfolio. Dialogue with client countries has indicated that there is clearly scope for leveraging the massive scale of these investments to reemphasize the need to take into account HIV-related developmental outcomes. The World Bank experience in low- and middle-income countries Latin American is a striking example of the power of social safety nets to improve the lives of the poor and can provide important insights to guide efforts in other regions, particularly in countries worst affected by the HIV/AIDS epidemics in Southern and Eastern-Africa.

Moving forward, the World Bank will coordinate and evaluate key aspects of the Social Protection response that affect HIV outcomes, including social transfers (cash, food, in-kind) embedded in national social protection programs, the provision of nutrition, essential to guarantee that antiretroviral therapy is effective, and the safety net support needed to ensure that caregivers are able to take in and maintain infected and affected children. Priority countries will include Burkina Faso, Cambodia, Côte d'Ivoire, Ghana, Kenya and Rwanda.

In addition, during the reporting period, the on-going **evaluation of the community response to HIV and AIDS**, which the World Bank is implementing in six countries (Burkina-Faso, Kenya, Lesotho, Nigeria, South Africa and Zimbabwe), in partnership with DFID, the UK NGO AIDS Consortium, and other partners, reached midpoint. The aim is to evaluate the extent to which a strong community response helps increase the strength of the national AIDS response. Findings of the evaluation will help establish whether communities with a stronger community response to the HIV and AIDS epidemic show differences in health, HIV, behavioural and social indicators and greater access to and utilization of HIV and AIDS services. These finding will also provide information on the potential for developing effective partnerships between government ministries and civil society organizations.

Other issues:

With 10,000 employees working in more than 100 country offices worldwide, the World Bank is the largest development agency with a critical role in improving development effectiveness, improving the perilous health and social safety nets of the world's poorest, and guarding millions against poverty.

The World Bank remains an engaged partner in HIV: The World Bank has been and remains a committed global leader in HIV: in AIDS financing and through technical support to improve the efficiency, effectiveness and sustainability of HIV responses. Globally and

corporately, the World Bank is committed to supporting governments in the areas HIV prevention, HIV strategic planning and HIV-sensitive social protection. In its current financial role, the World Bank currently lends USD1.8 billion for AIDS. In its advisory role, the Bank assists countries as diverse as Brazil, South Africa, Nigeria, Kenya, India and China to buy the best outcomes for their AIDS dollars.

As HIV funding decreases, the World Bank's role in HIV financing may increase in future: As grant money decreases, countries may turn increasingly to the Bank for financing - and the Bank stands ready to provide financing through a wide-range of mechanisms depending on client context and need, including specific AIDS credits, AIDS elements of health projects and results-based financing instruments.

The World Bank's role as a knowledge bank for effective HIV prevention efforts will become increasingly important: The Bank is supporting numerous prevention evaluations to strengthen global HIV prevention science.

In line with the UNAIDS Strategy approved by the PCB in 2010, improving the efficiency and effectiveness of strategic planning and prevention, and making Social Protection programs more HIV-sensitive are corporate, sector, and program priorities at the core of the World Bank's mission.

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