UNAIDS PROGRAMME COORDINATING BOARD

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THIRTY-SECOND MEETING

Date: 25-27 June 2013

Venue: Executive Board Room, WHO, Geneva

Agenda item 1.4

Report by the Chair 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 the report of the Committee of Cosponsoring Organizations

Cost implications for decisions: none

ACRONYMS

ACRONYM	DEFINITION
AGDM	Age Gender and Diversity Mainstreaming
APNSW	Asia Pacific Network of Sex Workers
Apre-TLT	Adolescent Prevention and Treatment Literacy Toolkit
ART	Antiretroviral Treatment
ARVs	Antiretroviral Drugs
ASRH	Adolescent Sexual and Reproductive Health
CCO	Committee of Cosponsoring Organizationss
CCP	Comprehensive Condom Programming
CCPCJ	Commission on Crime Prevention and Criminal Justice
CEEAC	Communauté Économique des États de l'Afrique Centrale
CEMAC	Commission de la Communauté Économique et Monétaire de l'Afrique Centrale
CERT	Centre for Education Rights and Transformation
CND	Commission on Narcotic Drugs
CSE	comprehensive sexuality education
DOL	Division of Labour
DOTS	Directly Observed Treatment, Short-course
EAC	East African Community
ECOSOC	Economic and Social Council
EID	early infant diagnosis
EMIS	education management information systems
eMTCT	Elimination of Mother to Child Transmission
GALA	Gay and Lesbian Memory in Action
GBC	Global Business Coalition
GBV	Gender-based Violence
GNP+	Global Network of People Living with HIV
GPRM	Global Price Reporting Mechanism
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HICs	High Impact Countries
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTC	HIV Testing and Counselling
IATTs	interagency task teams
IAWG	Inter Agency Working Group
ICT	information and communication technology
IDP	internally displaced people
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
IPPF	International Planned Parenthood Federation
KAPs	Knowledge, Attitudes and Practices
LGBTI	lesbian, gay, bisexual, transgender and intersex
LGBTIQ	lesbian, gay, bisexual, transgender, intersex and questioning
MARPs	Most-at-Risk Populations
MDG	Millenium Development Goals
MMT	methadone maintenance treatment
MNCH	Maternal, New Born and Children Health
MSM	Men who Have Sex with Men
NewGen	New Generation
NSWP	Global Network of Sex Work Projects
OST	Opioid Substitution Therapy
OVC	Orphans and Vulnerable Children
PCB	UNAIDS' Programme Coordinating Board
PEP	Post-exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PIMA	Trade Mark of portable CD4 counters
PLHIV	People living with HIV
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother to Child Transmission
POC	point-of-care
PREP	pre-exposure prophylaxis
PRI	Penal Reform International
PRIDE	Promoting Rights Diversity and Equality
PSM	Procurement and Supply Management
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SADC	Southern African Development Community
SERAT	Sexuality Education Review and Analysis Tool
SGBV	sexual and gender-based violence
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations Children's Fund
UNITAID	International Drug Purchase Facility
UNODC	United Nations Office on Drugs and Crimes
UNSCR 1983	United Nations Security Council Resolution 1983
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	voluntary medical male circumcision
WFP	World Food Programme
WHO	World Health Organization
WRC	Women Refugee Commission
YKPs	young key populations
YPLHIV	young people living with HIV

INTRODUCTION

1. The full Committee of Cosponsoring Organizations (CCO) statement will be circulated upon delivery of the CCO statement by the 2013 CCO Chair, UNESCO Director-General Irina Bokova, at the 32nd meeting of the UNAIDS Programme Coordinating Board, 25-27 June 2013. It addresses the Cosponsors' vision for action leading-up to the target date for the 2015 Millennium Development Goals, and underscores their call for continued efforts to address the unfinished business of the MDGs in the post-2015 framework. In particular, the Cosponsors will emphasize the need for enhanced efforts to target country-level action, improve programming with key populations, and address the specific needs of adolescents and youth.

ANNEX - Agencies Progress Reports

United Nations High Commissioner for Refugees (UNHCR)

Total amount spent on AIDS in 2012 (US$)	
Global	$2,893,462
30+ High Impact Countries (HICs)	$5,548,028
Other regions	$8,079,899
Total	**$16,521,389**
Total UBRAF 2012	**$4,682,120**

Description of top 3 priorities and related key results

Priority 1: Equitable Access of Antiretroviral Treatment (ART) for Persons of Concern (Approximately 24% of total)

Background

In UNHCR programmes, the accelerating uptake of HIV testing and counselling services and treatment itself have been aided by technological and systems improvements including the implementation of provider-initiated HIV testing in some health care settings, reduction of medication costs and continued advocacy for the inclusion of refugees into National AIDS Programmes without discrimination and supports such programmes as required, in most cases through partners. UNHCR continues to put much emphasis on awareness and early detection of HIV. As fear and stigma are usually higher in refugee populations, UNHCR continues to work on development of messaging, which is culturally appropriate and well understood through use of adequate language and communication media.

In 2012, UNHCR continued advocacy and education campaigns against misconceptions (e.g. refugees have a higher HIV prevalence and result in increased HV incidence in the local population) through awareness and training sessions at all levels of host and refugee communities, as evidence shows a discriminatory and stigmatising environment affects health seeking behaviour negatively, adherence to treatment as well as voluntary HIV testing. Furthermore, to optimize treatment adherence and drug regimens, UNHCR studied adherence to ART and treatment outcomes among conflict-affected and forcibly displaced populations highlighting that even in humanitarian settings treatment strategies can be and therefore should be implemented[1]. To support point of care diagnosis and follow-up, UNHCR ensured HIV testing capacity at the health facility level and provided portable CD4 counters (PIMA) in selected countries in West and Central Africa. The benefit of this strategy largely extended to the general population, as national health programmes building

[1] http://www.conflictandhealth.com/content/6/1/9/abstract

on this experience decided to extend use of point of care material in the whole country (most recently in Cote d'Ivoire).

In addition, a regional initiative addressing access to sexual and reproductive health and protection services for sex-workers and children sexually exploited and abused in humanitarian settings continues to be implemented in East Africa since 2011. Interventions were based on processes involving partners from different sectors, ministries of health, community leaders and sex-workers. Assessments and programmes were developed and/or strengthened through targeted training and support with multi-functional teams in four countries (Ethiopia, Kenya, Uganda and Zambia), where HIV and sexual and reproductive health services for sex workers have been sustained and where communities have been sensitized and peer-led networks developed.

Finally, although information on HIV status is not requested during registration of refugees, information is provided on focal points and facilities to contact for information, HIV testing or treatment. Recent examples have shown that first and second level registration processes have allowed for identification of people living with HIV (PLHIV) among new arrivals (e.g. Niger and Burkina Faso). UNHCR then advocates for their inclusion into the national programme and orients them towards treatment services, with particular attention given to people already under medication in order to avoid treatment interruption.

Key results

- By the end of 2012, access to ART for refugees in UNHCR operations was sustained at 93% at a level similar to that of the surrounding population.
- 100% of sex-workers identified as HIV positive through the programmes in East and Southern Africa are now enrolled in the care and treatment programmes.

Priority 2: Social Protection Strategies and access to essential care and support (Approximately 21 % of total)

Background

As per UNHCR's Age Gender and Diversity Mainstreaming (AGDM) strategy, all members of the community are targeted for appropriate interventions according to their specific needs, strengths and vulnerabilities. Where social transfers, in cash or in-kind, are targeted as opposed to a general coverage, those suffering from chronic illnesses including People living with HIV are always included among the beneficiaries. In addition, the focus on seeking alternatives to camps, and the increasingly urban nature of displacement crises, requires new ways of reaching out to those in need of protection and assistance. Cash-based interventions (cash and vouchers) are an important tool in such settings and in 2012 UNHCR launched "*An Introduction to Cash-based Interventions in UNHCR Operations*"[2] to encourage the adoption of a pro-active approach to the use and scaling up of cash-based interventions.

The main aim of all UNHCR cash-based interventions is to increase protection by reducing

[2] http://www.unhcr.org/515a959e9.html

the risks faced by affected populations. Evidence shows by satisfying essential needs, resort to harmful coping mechanisms can be avoided. An immediate increase in a person's purchasing power also allows them to protect their assets and/or invest in the recovery of their livelihoods. The AGDM lens is also applied in cash-based programming and the document encourages a HIV-sensitive approach when setting up and implementing cash-based interventions. In addition, recent feasibility studies have already highlighted the need to consider the specific needs of People living with HIV. In Malaysia, financial assistance was provided for vulnerable PLHIV and households affected by HIV among persons of concern to UNHCR. In addition, the child protection program included individual support to unaccompanied and separated children. UNHCR regional office in Dakar in collaboration with implementing partners ensured the inclusiveness of livelihood programmes for HIV infected and affected populations of concern. Reviews were done for Mali, The Gambia, Senegal, Ghana and Togo and recommendations for adaptation in programming were made for 2013.

At regional level UNHCR continues to actively participate in the Social Protection working groups. The information generated has been used in UNHCR's Public Health and HIV Section to work on a concept paper on HIV-Sensitive Social Protection. Although the guidance has not been produced yet, it fed into the cash and voucher guidance mentioned above, the operational guidance for urban refugees[3], and the health insurance guidance[4].

Key results

- Launch of guidance "An Introduction of Cash-based Interventions in UNHCR Operations"[5].
- HIV sensitive guidance for urban refugees and health insurance guidance[6].

Priority 3: Prevention of Sexual Transmission (Approximately 22% of total)

Background

As the lead agency for protection, camp coordination and camp management and shelter clusters in the cluster approach, UNHCR placed emphasis and efforts to mainstream HIV/AIDS among these clusters. Moreover, UNHCR involves refugees and other persons of concern in all phases of programming, from assessment, implementation, to monitoring and evaluation. The inclusion of civil society and HIV positive support groups is promoted and supported from the onset of emergencies. This strategy is time saving and enables effective programming because PLHIV are reached much faster.

Emergencies in 2012 that have affected concentrated epidemic countries of Asia have demonstrated both a lack of HIV prioritization within the humanitarian response and the critical role played by HIV positive support groups in addressing Knowledge, Attitudes and

[3] http://www.unhcr.org/refworld/docid/4e27d8622.html
[4] http://www.unhcr.org/4f7d4cb1342.pdf
[5] http://www.unhcr.org/515a959e9.html
[6] http://www.unhcr.org/refworld/docid/4e27d8622.html

Practices (KAPs) needs from the onset of an emergency. In addition, the involvement of key populations ensured implementation of interventions for sex workers that they owned, particularly in Latin America, East and Horn for Africa and Southern Africa using peer-led and multi-sectoral team strategies. In Asia and Latin America access to services for men having sex with men were possible due to their leading role in mobilising, communicating and implementing the strategies.

In 2012, UNHCR organized a consultation with the International Association of Refugee Law Judges and the European Legal Network on Asylum and developed the Guidelines on International Protection No. 9: Claims to Refugee Status based on Sexual Orientation and/or Gender Identity[7]. These guidelines are a result of research that has shown that decisions on refugee claims made by lesbian, gay, bisexual, transgender and intersex (LGBTI) applicants are sometimes based on superficial understandings of their experiences, or on erroneous, culturally inappropriate or stereotypical assumptions. In several countries UNHCR with partners and in collaboration with local and national health authorities adapted and targeted HIV prevention programmes, such as in the recent Mali refugee crisis in Burkina Faso and Niger.

Adolescent Sexual and Reproductive Health (ASRH) is receiving increased attention in both development and humanitarian contexts though there was little documentation of progress to date in humanitarian settings or of programmes that effectively integrate Sexual and Reproductive Health (SRH) services for this population. To address this gap, UNHCR and UNFPA supported a yearlong exercise implemented by the Women Refugee Commission (WRC) and Save the Children to map existing ASRH programmes. The results of the analyses of 37 programmes are compiled in a document “Adolescent Sexual and Reproductive Health in Humanitarian Settings: Understanding and Documenting Good Practices, December 2012[8]. Aside from this in-depth analysis, UNHCR implements Age Gender and Diversity programming to ensure that all members of the community are targeted according to their specific needs, strengths and vulnerabilities. Among children, special attention is given to those at higher risk of engaging into unsafe sexual activity and those with protection risks. UNHCR specifically target them in trainings and peer-led programmes. Retaining girls in school and the inclusion of sexuality in education is also given a high priority in the 2012-2016 UNHCR education strategy[9].

UNHCR has been promoting voluntary medical male circumcision (VMMC) in many of its programmes and supporting national programmes to extend their implementation to refugee settings. Staff have been trained, theatres rehabilitated, material provided and promotion campaigns undertaken. By the end of 2012, Ethiopia, Kenya and Uganda had significantly scaled up their VMMC programmes and most refugee operations were effectively implementing such activities or had ensured that refugees could easily access the national programme.

[7] http://www.unhcr.org/refworld/docid/50348afc2.html
[8] http://his.unhcr.org/aae/wp-content/uploads/2012/11/Adolescent-Sexual-and-Reproductive-Health-in-Humanitarian-Settings-Understanding-and-Documenting-Good-Practices-December-2012.pdf
[9] http://www.unhcr.org/refworld/docid/4f4cd9812.html

Key results

- Guidelines on International Protection No. 9: Claims to Refugee Status based on Sexual Orientation and/or Gender Identity[10].
- Adolescent Sexual and Reproductive Health in Humanitarian Settings: Understanding and Documenting Good Practices, December 2012.

Other issues

Elimination of Mother to Child Transmission (eMTCT) in low and concentrated epidemics

In 2012, the percentage of women having access to eMTCT programmes for 23 operations with a health information system (HIS) in place increased even though only 35% of operations meet the 90% coverage standard, a 5% increase since 2008; large improvements were observed in countries such as Burundi (43% in 2008 to 98% in 2012) and Uganda (56% to 93%).

Sexual and Gender Based Violence

In refugee situations, UNHCR has the mandate to protect refugees and other persons of concern and provide them with assistance. As such, UNHCR ensures that refugees are protected against rape, that survivors are provided appropriate care and protection, and that HIV programmes are in place. In IDP (internally displaced people) situations, as the cluster lead for protection, and co-convener in the UNAIDS' Division of Labour (DoL) for HIV in humanitarian emergencies, UNHCR advocates that HIV and sexual and gender-based violence (SGBV) are mainstreamed across all clusters. In addition, with its protection monitoring strategy, UNHCR contributes to the identification, referral and support to SGBV victims. Support includes referral, legal and psychosocial support. Both SGBV and HIV multi-sectoral teams are formed in most settings, with members from management, protection, community services, and health sectors. Both groups are strongly feeding in each other's strategies as many members are in both groups. In almost all refugee contexts, SGBV plans systematically address SGBV/HIV linkage and include provision of PEP for rape survivors. A regional workshop in East-Africa on HIV and SGBV in emergencies had special sessions on United Nations Security Council Resolution 1983 (UNSCR 1983). UNHCR is working very closely with UNAIDS at regional level in East Africa on matters surrounding UNSCR 1983.

UNHCR has strengthened its efforts to ensure that justice is made more accessible (culturally, socially, and financially) to victims of SGBV at all stages of the displacement cycle. This is a crucial aspect of UNHCR's effective protection response to SGBV and also contributes to its prevention. UNHCR assumed a supportive role, assisting States to meet the international legal responsibilities and satisfy the requirements of the rule of law, and ensuring all persons of concern have access to existing justice mechanisms. An important

[10] http://www.unhcr.org/refworld/docid/50348afc2.html

tool designed to assist operations in preventing and responding to SGBV is UNHCR's "*Action against Sexual and Gender-Based Violence: An Updated Strategy"*[11] that was launched in 2011.

The strategy emphasizes the need for multi-sectoral approach to prevention and response, which includes HIV and AIDS and legal support activities to redress the culture of impunity surrounding SGBV. A number of regional instruments in Africa, the Americas and Europe contain detailed State obligations specifically relating to access to justice for SGBV survivors. UNHCR has been ensuring that staff members are fully aware of the legal commitments of the State where they are working as well as traditional justice systems. The organization has been engaging in activities to improve access to justice for SGBV survivors in three main categories: 1) legal support for survivors; 2) working with communities; and 3) supporting the authorities.

[11] http://www.unhcr.org/refworld/pdfid/4e01ffeb2.pdf

The United Nations Children's Fund (UNICEF)

Total amount spent on AIDS in 2012 (US$)	
Global	$3,164,829
30+ HICs	$47,118,191
Other regions	$43,668,718
Total[12]	**$93,951,738**
Total UBRAF 2012[13]	**$8,552,078**

Description of top 3 priorities and related key results:

Priority 1: 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 (Approximately 46% of total)

Background

The 'Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive' sets ambitious targets for 2015: reduce the number of children newly infected with HIV by 90 per cent and reduce maternal mortality among women living with HIV by 50 per cent. Despite progress, only 28 per cent of children 0–14 years receive life-saving medicines. More must be done to close the gap with adult treatment and retain pregnant women living with HIV in maternal and child health services.

Key results

To support Global Plan implementation UNICEF provided technical assistance and operational and normative guidance in 22 eMTCT (elimination of mother-to-child transmission) focus countries to develop and operationalize costed national eMTCT plans. In Zambia, Swaziland, Ethiopia, Kenya, Tanzania and Mozambique UNICEF co-led workshops with WHO on the development of Monitoring and Evaluation Frameworks for eMTCT plans. UNICEF also supported evaluations of national PMTCT programmes and conducted bottleneck analyses to inform development of national eMTCT action in Angola, Lesotho and Malawi.

UNICEF supported operational reviews of PMTCT (prevention of mother-to-child transmission) programmes in three countries in Eastern Europe and Central Asia. In Armenia and Kyrgyzstan these assessments resulted in revisions of national PMTCT strategies emphasizing the need for universal coverage with antenatal HIV testing and to re-focus prevention interventions on most at

[12] This amount does not include core UBRAF spent in 2012, which is indicated in the line below.
[13] Does not include commitments made in 2012 for salaries that extend to 2013. Those will be reflected as expenditures in 2013.

risk pregnant women, including women using drugs, women who have Injecting Drug Users (IDUs) partners, women selling sex, illegal migrants, homeless women and women in prisons.

With WHO, UNAIDS, and UNFPA, UNICEF supported 17[14] countries in West and Central Africa to accelerate the implementation of high impact integrated Maternal, New Born and Children Health (MNCH)/Reproductive Health(RH) /PMTCT programmes. UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) co-convene the Global Fund eMTCT working group, which leveraged over $130 million during 2011-2012. UNICEF also began implementation of a $2 million grant from the United States President's Emergency Plan for AIDS Relief (PEPFAR) in seven countries to improve the effectiveness of over $400 million in global grants focused on improving eMTCT outcomes and the efficiency and effectiveness of Global Fund grants.

UNICEF, with WHO, USAID and Save the Children led a multi-agency consultation on integrating paediatric HIV into community case management of newborns and young children. A $4.2 million partnership with the MAC AIDS Fund was signed in 2012 focusing on innovative solutions to scale up paediatric HIV treatment and care, and fostering South-South collaboration to enable exchange of experiences from four continents[15]. To shape markets, improve access to various types of testing and early infant diagnosis, and improve treatment initiation and monitoring at lower levels of the health care system, UNICEF began work to mobilize and scale up point-of-care diagnostic technologies at lower levels of care. This project, done in collaboration with the Chilton Health Access Initiative and supported by UNITAID, will be implemented in seven sub-Saharan African countries[16].

Priority 2: Support national capacity to increase the proportion of children orphaned or made vulnerable by HIV/AIDS receiving quality family, community and government support (Approximately 15% of total)

Background

The high burden of HIV related mortality continues to have a devastating impact on families, creating financial hardships, social exclusion and emotional distress for children. This means that there continues to be a need to provide protective services for children, in conjunction with child protection, child protection and education sectors, to reduce vulnerabilities which may, in turn, fuel new HIV infections.

Key results

In 2012 UNICEF embarked on partnership with the Economic Policy Research Institute in South Africa to analyze the extent to which cash transfer programmes are reaching the most vulnerable HIV affected households and the extent to which cash transfers are reducing risk behaviours in young people.

With technical assistance from UNICEF, countries such as Malawi, Kenya and Zimbabwe are

[14] Cote d'Ivoire, Cameroon, Chad, DRC, Ghana, Nigeria, Burundi, CAR, Congo, Gabon, Gambia, Mauritania, Guinea Bissau, Senegal, Sierra Leone, Togo and Niger
[15] Brazil, Commonwealth of Independent States, India and South Africa.
[16] Ethiopia, Kenya, Malawi, Mozambique, United Republic of Tanzania, Uganda and Zimbabwe.

building HIV outcome measures into social protection impact assessments. In the East Asia and Pacific region UNICEF mapped child and HIV sensitive social protection policies and programmes in nine[17] countries showing that most studied lacked social assistance provisions for vulnerable child populations, such as cash grants or food support. UNICEF supported innovative community-based and family-based interventions to further the eMTCT agenda.

With Hilton Foundation support, UNICEF promoted linkages between early childhood development and clinical services, using early childhood development as an entry point to identify HIV-exposed children and connect them with testing and treatment. In 2012, UNICEF also embarked on a new partnership with the International Children's Palliative Care Network to map needs and gaps in comprehensive HIV palliative care responses, including pain management, psychosocial support and economic support, in three sub-Saharan African countries[18]. A UNICEF led costing group was established in 2012 with PEPFAR, World Vision, UNAIDS, World Bank, and the Futures Institute to develop a costing methodology for protection, care and support of children affected by AIDS.

Priority 3: Support reduction of adolescent risk and vulnerability to HIV/AIDS by increasing access to and use of gender-sensitive prevention information, skills and services (Approximately 40% of total)

Background

An estimated 2.2 million adolescents aged 10 to 19 were living with HIV by the end of 2011. Although there has been a decrease in new infections in adolescents since 1990, it is not statistically significant. While global AIDS related deaths decreased by 26% between 2011 and the peak in 2004, AIDS related deaths in adolescents have increased by 50% in that time.

Key results

UNICEF worked with WHO and other partners to develop the United Nations guidelines on HIV testing and counseling of adolescents and global guidelines on providing services for adolescents living with HIV. Working through the Shuga Radio Initiative in six countries, UNICEF supported governments and partners to increase demand for testing and counseling as well as monitoring and reporting of HIV testing in adolescents and referral to key services. With the Futures Institute, UNICEF undertook a modeling and costing exercise for results for adolescents using the HIV investment framework, focusing on 23 high-burden countries with different epidemic typologies. Preliminary findings showed that this strategic shift in investment for adolescent HIV programming could reduce the number of new infections in adolescents by over 50 per cent by 2015 with sustained decline until 2030.

UNICEF commissioned work on HIV and adolescents in emergencies that resulted in recommendations on how to improve preparations for and responses to the needs of adolescents in humanitarian contexts. The UNICEF HIV, child protection and health sections worked with the Women's Refugee Commission to develop a training tool for community-based management of sexual violence in humanitarian settings to train community health workers on referring survivors of

[17] Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Vietnam
[18] Zimbabwe, South Africa, Kenya

sexual violence and providing direct care for them where referrals are not possible.

In Asia Pacific, UNICEF, together with UNAIDS, UNESCO and UNFPA, supported the NewGEN Asia Leadership Short Course Training of Trainers, which was attended by more than 20 young people aged 15-26, from various youth networks and organizations. The regional training provided the young participants with skills and knowledge in advocacy, communication, strategic planning and leadership. Participants will roll out the leadership short course in their respective countries. UNICEF and Kazakhstan Union of PLHIV developed X-Road an interactive tool in Russian for use on web platforms and social networks. The tool uses contemporary language and action-filled videography to talk to young people about choices in drug use, HIV risk-taking and prevention. Outcomes of the story depend on the interactive choices made by the user. There were 2500 views in 2012.

Other issues

The beginning of the end of AIDS starts with children. Through smart and evidence-informed investments and a shared sense of global responsibility to protect and promote the rights of all children to survive and thrive, we can save millions of lives and achieve an AIDS-free generation.

Recently UNICEF started shifting its approach to programming, focusing on a more holistic and integrated approach that is conceptualized around the first and second decades of the child's life and focused on supporting strategic investment and programmatic as well as technical innovation. This agenda, which is reflected in the draft Medium Term Strategic Plan (2014-2017), includes work in the areas of: 1) PMTCT/paediatric ART; 2) protection of children affected by AIDS; and 3) adolescent prevention, treatment, care and support.

World Food Programme (WFP)

Total amount spent on AIDS in 2012 (US$)	
Global	$1,008,226
30+ HICs	$97,673,756
Other regions	$64,799,447
Total	**$163,481,430**
Total UBRAF 2012	**$3,936,440**
Description of top 3 priorities and related key results	

Priority 1: HIV and TB Treatment through Nutritional Support (Approximately 34% of total)

Background

In the UNAIDS Division of Labour, the World Health Organization (WHO) is the convening agency in the areas of ART (antiretroviral treatment) and Tuberculosis. WFP works with WHO and partners to ensure that food and nutrition support are adequately integrated into HIV treatment and TB programmes.

Improving the efficiency and effectiveness of treatment services is central to long-term success of the HIV response. The Treatment 2.0 Framework[19] aims to accelerate treatment scale-up and improve health outcomes by optimizing drug regimens, providing point-of-care and other simplified diagnostic and monitoring tools, reducing treatment costs, adapting service delivery models through decentralization and integration, and mobilizing communities to support the accessibility, uptake and success of treatment efforts. WFP works with governments and partners to ensure that treatment is accompanied by assessments of nutrition status, education and counselling on nutrition to maintain body weight and health and mitigate side-effects, and – where necessary – nutritious food to treat malnutrition. Furthermore, at times a household ration complements this support for a finite period of time, helping the household cope with the often high costs of care in the initial phase and making adherence to treatment and retention in care more likely.

To maximize synergies and partnerships, the UBRAF asks Cosponsors to prioritize their interventions and focus their investments in 38 high-priority countries, which together account for 70% of disease burden. WFP is currently supporting governments to implement HIV and TB programmes in 20 of these countries[20].

Key results

- In 2012, WFP reached a total of 2.8 million HIV or TB infected and affected beneficiaries through HIV/TB-specific and HIV/TB-sensitive programming in 33 countries[21]. Of these, 1.6 million beneficiaries were reached through HIV specific programmes (client and household members - ART, PMTCT, TB, and Orphans and Vulnerable Children - OVC), while 1.2 million were reached through HIV sensitive programmes including curative nutrition programmes for pregnant and lactating women (PLW) and OVC in school feeding.
- Emergency food assistance was provided to people living with HIV or TB in high-prevalence populations affected by emergencies in Afghanistan, the Democratic Republic of the Congo, Somalia and South Sudan; transition and post-crisis situations in Côte d'Ivoire and Haiti; refugee emergencies in Rwanda; natural

[19] UNAIDS/WHO. 2011. The Treatment 2.0 Framework for Action: Catalysing the Next Phase of Treatment, Care and Support. Geneva.
[20] Burundi, Cambodia, Central African Republic, Cote d'Ivoire, Djibouti, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, Kenya, Lesotho, Malawi, Mozambique, Rwanda, South Sudan, Swaziland, Tanzania, Zambia, Zimbabwe.
[21] Based on standard project document data from "2012 SPR Analysis: HIV and TB Programmes," April 2013, Nutrition and HIV/AIDS Unit, and standard project document data from the project beneficiary data-set 2002-2012 located at: http://wiki.wfp.org/operationalreporting/index.php/SPRdata#Project_beneficiary_data Please note, numbers are rounded.

disasters in Kenya and Malawi; and economic collapse in Zimbabwe.

- WFP ensured that food and nutrition support in conjunction with TB-DOTS (Directly Observed Treatment, Short-course) was included in the Round 10 Global Fund TB proposals of Djibouti, Lao People's Democratic Republic, Swaziland and Tajikistan. In 2012, technical support has been provided to Swaziland, Cote d'Ivoire and Benin, which resulted in the integration of food and nutrition support in Global Fund grants through reprogramming and phase 2 renewals.
- WFP functions as a Global Fund sub-recipient to implement food and nutrition activities in the health sector in countries including Djibouti, Cote d'Ivoire, Benin and Swaziland.
- In 2012, WFP implemented its nutrition rehabilitation approach and has assisted in aligning food assistance for TB patients with national food-by-prescription approaches
- WFP supports vulnerable people living with HIV who may be unable to obtain or adhere to ART and are prone to food insecurity and malnutrition and has conducted food and nutrition security vulnerability assessments of pre-ART clients to assist in the development of national food-by-prescription programmes.
- WFP has collaborated with private sector and academic partners to develop new and more suitable products for treating malnutrition and has facilitated operational research on the impact of food and nutritional support.

Priority 2: PMTCT Programmes (Approximately 24% of total)

Background

Gender inequality remains a key driver in the HIV epidemic. HIV is the leading cause of death of women of reproductive age. In the absence of HIV, maternal mortality would be 20% lower[22]. A focus on women and girls is a priority for WFP as women play a key role in guaranteeing food security for the household. Women are the primary caregiver and the ones producing, purchasing and preparing food for the household.

A recent review by WFP, which is due for publication in 2013, confirmed that food insecurity and hunger are frequently cited as barriers to access health services and can act as an economic barrier preventing women from seeking PMTCT services. Providing food along the PMTCT continuum enables women to access PMTCT services and receive those throughout the so-called PMTCT cascade, thus

[22] UNAIDS, "Ways to improve women's health in the HIV context", *24 July 2012*, http://www.unaids.org/en/resources/presscentre/featurestories/2012/july/20120724investmentgender/.

contributing to elimination of mother to child transmission and improving adherence and retention in care for them and their HIV exposed child[23].

As the joint UNAIDS, WFP, and WHO policy brief outlines, when a woman is HIV-positive, household food security is at risk. Furthermore, 90% of HIV-positive children contract the virus from their mother during pregnancy, delivery or breastfeeding, with inadequate nutritional status of the mother and inadequate care practices potentially increasing the risk of vertical HIV transmission. Through its PMTCT and its curative nutrition programmes for people living with HIV, WFP provides food and nutrition support to malnourished pregnant and lactating women and their children, thereby working with governments, UNICEF and WHO toward healthy mothers and healthy babies.

Key results

- In 2012, WFP reached nearly 96,000[24] women and their HIV-exposed infants with food and nutrition support as part of our PMTCT and curative nutrition programmes for people living with HIV in 27 of the high impact countries[25].
- Building on a renewed partnership with PEPFAR in Ethiopia ($56 million multi-year funding, reaching 89,000 beneficiaries in the first year), WFP interventions are tackling malnutrition among people living with HIV, while promoting proper ART and PMTCT uptake, addressing food insecurity and providing economic strengthening activities.
- In Ethiopia, 2,000 people living with HIV received food transfers in exchange for attending PMTCT services.
- PMTCT clients are increasingly being included in WFP's general nutrition programmes for pregnant and lactating women.
- In collaboration with UNICEF and WHO, WFP cooperates in PMTCT programmes as part of the UNAIDS Division of Labour.
- WFP has been an active member in a number of IATTs (interagency task teams) including those on PMTCT and Social Protection. WFP has collaborated with national actors to develop operational research and pilot initiatives for people living with HIV to demonstrate the effectiveness of integrating food and nutrition strategies with ART and PMTCT and increase treatment adherence, improve treatment outcomes and support nutritional health.
- PMTCT programmes have been integrated with mother-and-child health and nutrition services which simultaneously prevent HIV transmission and improve

[23] O'hIarlaithe, Micheal, Nils Grede, Saskia de Pee, Martin Bloem, "Economic and social factors are some of the most common barriers preventing women from accessing maternal and newborn child health (MNCH) and prevention of mother-to-child transmission (PMTCT) services - a literature review." To be published.
[24] Based on standard project document data from "2012 SPR Analysis: HIV and TB Programmes," April 2013, Nutrition and HIV/AIDS Unit, and standard project document data from the project beneficiary data-set 2002-2012 located at: http://wiki.wfp.org/operationalreporting/index.php/SPRdata#Project_beneficiary_data Please note, numbers are rounded.
[25] WFP operates MCHN programs in 59 countries, of which 27 are in HIC: Burundi, Cambodia, Cameroon, CAR, Cote D'Ivoire, DRC, Djibouti, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Niger, Rwanda, Sudan, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe.

health outcomes by ensuring that mothers and infants have access to growth monitoring, vaccinations, micronutrient supplementation, nutrition assessment, education, counselling and complementary foods.

Priority 3: PLHIV and Households affected by HIV are addressed in all national social protection strategies and have access to essential care and support (Approximately 42% of total)

Background

The 2011 Political Declaration on HIV/AIDS[26] pledges to use the momentum from the HIV response to strengthen health and community systems and to integrate HIV into health and development efforts, particularly into social protection programmes. In line with its policy and the UNAIDS Division of Labour, WFP works with UNICEF, the World Bank and ILO to enhance social protection for people living with HIV and people affected by HIV. The broad definition of social protection adopted by UNAIDS suggests that all WFP HIV-specific and HIV-sensitive beneficiaries could be counted under this category. Thus, all 2.8 million beneficiaries receiving WFP support could be classified under social protection[27].

HIV disrupts livelihoods as people living with HIV often temporarily lose the ability to work, which exacerbates food insecurity for them and their households. In addition, they are often excluded from informal safety nets due to stigma. The economic impact of HIV is significant for any household, diverting income to health care expenses, leaving less money for food and school fees. For women, it often carries a double burden of being both the caretaker of the family and part of the formal and informal labour force. Improved nutrition services will have a positive impact on people living with HIV and their households in general, and women in particular, because it enables them to stabilize their health, while continuing to serve as caregivers and provide for their families. Given the right opportunities, people living with HIV, and women in particular, can derive not only increased income, but also personal empowerment, improved quality of life and increased social acceptance from socio-economic support.

Key results

- WFP works with UNICEF and the World Bank to enhance social protection for people living with HIV and people affected by HIV through food transfers, cash, or vouchers and supports community based care by facilitating access to services and adherence to treatment.
- WFP HIV specific safety nets reached approximately 641.000 people living with HIV and orphans and vulnerable children and their households with food and

[26] United Nations. 65/277 *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS Progress.*
[27] Social Protection definitions can be further accessed at:
http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/JC1992_SocialProtection_en.pdf

nutrition support in 2012. WFP also 1.16 million orphans and vulnerable children reached through HIV-sensitive social protection programmes in High Impact Countries.

- WFP has provided nutritious food support to ART clients and complemented it with cash transfers which are given in lieu of the household food rations, thereby affording beneficiaries greater flexibility, stimulating the local markets, while simultaneously protecting nutritional programme objectives.
- WFP is exploring ways of integrating its Food-by-Prescription programme more effectively to livelihood activities to help people living with HIV overcome poverty and find sustainable sources of income.
- WFP works closely with UNICEF and other partners to provide social protection activities for children affected by HIV in countries including Benin, Central African Republic, Côte d'Ivoire, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Swaziland and the United Republic of Tanzania.
- In line with its Strategic Plan (2008-2013), WFP responds to requests from countries and communities for assistance in developing their capacities to implement social protection programmes including HIV-sensitive social safety nets and to ensure that people living with HIV are among the vulnerable groups targeted.

Other issues

WFP as the convener in the thematic area on Food and Nutrition and HIV, organized a two-day meeting on food and nutrition in the HIV response prior to the International AIDS Conference in Washington in July 2012 which led to the establishment of the Inter Agency Task Team (IATT) on food and nutrition. Members include UN agencies, academia and civil society working together to improve partner - stakeholder collaboration and moving forward the policy agenda for Food and Nutrition, within the HIV response. The first round table meeting of the new IATT on HIV, food and nutrition was held in Washington DC, USA and attended by more than 30 stakeholders. Since then, quarterly follow-up calls have been hosted and three sub working groups have been set up: resource mobilization and advocacy, research, programmes.

United Nations Development Programme (UNDP)

Total amount spent on AIDS in 2012 (US$)	
Global	$3,142,405
30+ High Impact Countries	$121,237,850
Other regions	$95,097,455
Total	**$219,477,710**
Total UBRAF 2012	**$7,737,529**

Description of top 3 priorities and related key results:

Priority 1: Improving HIV and health outcomes through attention to governance, human rights and vulnerable groups (Approximately 23.8% of total)

Background

UNDP works with partners to address the interactions between human rights, enabling legal environments and good governance as critical enablers for effective HIV, health and development responses

Key results

- UNDP, as Secretariat of the Global Commission on HIV and the Law, undertook evidence based research to inform the findings and recommendations of the Commission's final report. This included publication of 18 working papers[28] that provided in-depth analysis for the key issues[29] addressed in the Commission's ground-breaking report.
- UNDP has supported action in 73 countries to follow-up to the Commission's recommendations and advance human rights and enabling legal environments for effective HIV responses, including in 31 UNAIDS High Impact Countries. Multi-stakeholder national dialogues were supported in 20 countries, in addition to legal environment assessments and legal reviews in 51 countries. This support has resulted in on-going constructive multi-stakeholder dialogues between governments and civil society, national coalitions advocating for relevant law and regulation reform and parliaments in an increasing number of countries actively promoting proposals for reform. For example in Kenya, through UNDP's leadership and convening role, the government of Kenya and various constituencies for the first time convened to discuss key human rights and legal issues that affect HIV (First National Symposium on HIV, Law and Human Rights) as well as dialogue on criminalized groups such as injecting drug users, men who have sex with men and sex workers. The government of Kenya is

[28] http://www.hivlawcommission.org/index.php/working-papers
[29] Stigma & discrimination, criminalization of HIV transmission, drug use, MSM, transgender people, sex workers, prisoners. migrants, children & youth, women, Intellectual Property and access to medicines

also the first East African Community (EAC) country to have assented to the new EAC HIV Bill which will become law in all EAC countries.

- UNDP, together with civil society partners and the Global Fund, developed an operational plan for the human rights objective of the Global Fund Strategy.
- UNDP's role in addressing inequalities experienced by key populations has largely been through the lens of HIV and governance, working with both government representatives and civil society organisations at global, regional, national and local levels to bring the human rights concerns of key populations in relation to HIV to the fore. Through the Urban Health and Justice Initiative for key populations, UNDP has worked with local and national level government entities in over 20 countries to improve service delivery and access to justice for key populations within urban contexts. For example, in Nigeria, the plan for the two central municipalities in the Lagos metropolitan area, Ikeja and Shonolu, was endorsed by mayors and developed in collaboration with men who have sex with men and sex workers. The plan focuses on: (1) empowering local leadership and communities; (2) scaling up treatment, care and support services for key populations; and (3) strengthening access to justice and rights-based programming for key populations.
- In Asia-Pacific, UNDP is the regional technical assistance provider to two multi-country Global Fund programmes[30] for MSM. UNDP supported the development and design of the proposals as well as technical support for grant implementation. Both multi-country programmes are community-led and aim to respond to the needs of MSM. UNDP has also used its technical assistance role to leverage resources and increase partnerships to address discriminatory laws, human rights and stigma and discrimination. For instance through strengthening the capacity of National Human Rights Institutions in six countries to address human rights violations related to HIV, sexual orientation and gender identity.

Priority 2: Improving HIV and health outcomes through mainstreaming, gender and the MDGs (Approximately 15.3 % of total)

Background

UNDP's approach to HIV is embedded within a broader development strategy that recognizes the importance of working across sectors to address HIV, gender, social protection, poverty reduction, health and the MDGs in an integrated manner.

Key results

- UNDP supported 43 countries in mainstreaming gender equality into national HIV policies, plans and strategies;
- UNDP and UNFPA, together with the Inter Agency Working Group (IAWG) on women and girls, organised a consultation on Integrating Strategies to Address Gender-based

[30] South Asia programme covering Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka; and Southeast Asia programme covering Indonesia, Malaysia, the Philippines and Timor Leste

Violence and Engage Men and Boys to Advance Gender Equality through National HIV Plans and Strategies. Angola, Malawi, Mozambique, Tanzania, South Africa, and Zimbabwe reviewed their national HIV and Gender policies, strategies and plans and developed country action plans to strengthen attention to gender equality, GBV, and engaging men and boys in their national planning processes and forthcoming national HIV strategies and plans

- UNDP has strengthened policy engagement with the Global Fund to promote integration of gender in its policies, strategies and programmes. 85% of Country Offices where UNDP is a Principal Recipient assess Global Fund project outcomes as contributing to achieving gender equality results.
- In India, UNDP supported the creation, expansion and reform of multiple HIV-sensitive social protection programmes in several states, reaching more than 400,000 people by the end of 2012
- Assisting countries in their efforts to achieve the MDGs remains a top priority for UNDP, including through implementation of the MDG Acceleration Framework in 45 countries, with national partners and UN Country Teams. Examples include the development of a MDG Acceleration Action Plan for HIV and TB in Moldova and an HIV-specific plan for Ukraine. The plans will assist both countries in ensuring their HIV responses are more effective, targeted, cost-effective and sustainable.

Priority 3: Improving HIV and health outcomes through Global Fund implementation support and capacity development (Approximately 60.9 % of total)

Background

As a partner of the Global Fund, since 2003 UNDP has supported more than 40 countries to implement large-scale HIV, tuberculosis and malaria programmes, focusing on countries facing capacity or governance challenges. When serving as interim Principal Recipient, one of UNDP's most important roles is to support long-term sustainability of national programmes and to support capacity development of one or more national entities to enable them to assume the management of grants. As a result of these efforts, UNDP has exited from the role of Principal Recipient in 23 countries since 2003, including 9 countries in 2011 and 2012.

Key results

- In 2012, UNDP continued to strengthen a systematic approach to enhance capacity of national entities to manage grants and ensure smooth and timely transitions, using measurable milestones. Contributions to capacity development have been reinforced through the development of a 'Capacity Development Toolkit to Strengthen National Entities to Implement National Responses for HIV, Tuberculosis and Malaria'. The Toolkit was produced based on best practices from comprehensive capacity development efforts undertaken in Zambia and Zimbabwe, providing a vision and systematic approach to strengthen national partners' systems for programme management and implementation. UNDP country teams – in countries as diverse as Belize, Haiti, Mali, Montenegro**,**

Tajikistan and Uzbekistan – are utilizing the Toolkit to enhance capacity development for national partners.

- In 2012, UNDP managed Global Fund HIV grants as interim Principal Recipient in 26 countries[31]: At the end of 2012, one million people were receiving life-saving antiretroviral treatment through UNDP-managed Global Fund programmes[32]. In addition, between 2003 and 2012, UNDP-managed programmes contributed to reaching 12 million people with HIV counselling and testing[33], 230,000 women benefitting from services to prevent mother to child transmission of HIV, 1.6 million people receiving treatment for STIs, 120,000 people receiving treatment for TB/HIV and distribution of 520 million condoms.

Other issues

UNDP is playing an important role as a co-chair of the UN Task Team on Post-2015, and in coordinating wide-ranging national, thematic, and global consultations on the post-2015 development agenda, in collaboration with partners. To help realise the Secretary-General's vision that discussions should be open and inclusive in line with the UN's principles, 87 national dialogues and numerous regional dialogues on post-2015 have taken place, in addition to 11 global thematic consultations on issues selected by the UNDG[34]. An ambitious social media platform has enabled an unprecedented global conversation enabling people around the world and concerned stakeholders discuss the future development agenda.

UNDP is also part of the technical team supporting the Open Working Group of the General Assembly, mandated by Rio+20, which will submit a proposal for sustainable development goals. UNDP is advocating for preparation of the post-2015 agenda to be enhanced by accelerating achievement of the current MDGs, bringing the development and environment tracks together, and by focusing on the need for clear, measurable, and easily communicated goals and targets which advance sustainable development.

[31] Angola, Belarus, Belize, Bolivia, Bosnia and Herzegovina, Democratic Republic of Congo, Cuba, El Salvador, Haiti, Iran, Kyrgyzstan, Maldives, Mali, Montenegro, Nepal, Sao Tome and Principe, Sudan, South Sudan, Syrian Arab Republic, Tajikistan, Togo, Uzbekistan, West Bank and Gaza Strip, Yemen, Zambia, Zimbabwe

[32] Relates to people currently on ARV treatment. Figures are not cumulated since the beginning of the programs

[33] Relates to the number of HIV testing provided. Over time, the same individual might receive more than one HIV testing

[34] Inequalities, health, education, growth and employment, environmental sustainability, governance, conflict and fragility, population dynamics, hunger, food and nutrition security, water and energy.

United Nations Population Fund (UNFPA)

Total amount spent on AIDS in 2012 (US$)	
Global	$18,566,497
30+ High Impact Countries	$40,452,782
Other regions	$25,837,522
Total	**$84,856,801**
Total UBRAF 2012	**$9,066,607.15**

Description of top 3 priorities and related key results:

Priority 1: Reduce sexual transmission of HIV (Approximately 48% of total)

Key results

- The 2012 report on the Global Programme to Enhance Reproductive Health Commodity Security (RHCS) highlights that in 2011 UNFPA expended $32 million to provide commodities including condoms and $44 million for funding capacity development including logistics management and human resources to support country programme implementation35. Improved reproductive health (RH) commodity stock control and quality management, including for condoms, was achieved via regional training on use of "Access RH" software attended by RH commodity managers from Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Reported stock-outs have been reduced to 2%. An electronic network among practitioners in RHCS and Comprehensive Condom Programming (CCP) from Cambodia, Indonesia, Lao PDR, Myanmar, Philippines and Timor-Leste was formed for South-South collaboration in forecasting, procurement and distribution.
- Eighty six countries are scaling up the UNFPA “10 Step Strategic Approach to Comprehensive Condom Programming36”. Four countries (Guatemala, Jamaica, Kenya and Paraguay) developed new condom strategies; and Burundi developed a national male and female condom policy. Through capacity building workshops, 18 LAC (Latin American and Caribbean) countries and 12 ESA (East and Southern Africa) countries drafted 2013 action plans to scale up CCP in 2013.

[35] UNFPA 2012. The Global Programme to Enhance Reproductive Health Commodity Security. Annual Report 2011.

[36] Benin, Botswana, Burkina Faso, Burundi, Cape Verde, Cameroon, Central African Republic, Cote D’Ivoire, Republic of the Congo, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe; Cambodia, China, India, Indonesia, Kiribati, Lao PDR, Mongolia, Myanmar, Pakistan, Papua New Guinea, Thailand, Timor-Leste, Viet Nam; Anguilla, Antigua & Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, Bonaire, British Virgin Islands (Tortola), Cayman Islands, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Eustatius, St. Kitts/Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos Islands; Argentina, Bolivia, Colombia, Costa Rica, Ecuador, Peru; Morocco, Sudan; Albania, Armenia, Georgia, Moldova, Turkey, Ukraine

The CONDOMIZE! Campaign, advocating for increased condom access and demand with a strong focus on community development and participation, had high visibility at the 2012 IAC opening ceremony through its video[37] and the UNAIDS Executive Director highlighting condoms and the Campaign in his opening speech. This resulted in major media coverage, re-energizing community organizations to boost their condom promotion programmes and requests to roll out the Campaign at country level[38].

- UNFPA supported 80 countries to develop and/or implement programmes on HIV prevention services for female, male and transgender sex workers. In-reach training addressing stigma, discrimination and HIV risk and vulnerability of key populations continues to have impact with increase in the number of UNFPA Country Offices programming strategically in this area (800% increase over 6 years). On-going financial and technical support for capacity strengthening of the Global Network of Sex Work Projects (NSWP) and its regional and country level networks and organisations resulted in meaningful participation of sex workers in the development of policies, guidance, tools and programmes and participation in international fora. UNFPA's financial and technical assistance to the alternate International AIDS Conference Kolkata Hub for Sex Workers, including for sex worker participation and to facilitate NSWP serving as Hub organizer, helped enable the Sex Worker Hub become the largest gathering of sex workers across the world to discuss and share programming advice on HIV and sex work.

Priority 2: Empowering young people to protect themselves from HIV (Approximately 21% of total)

Key results

- The Fund supported 95 countries to design and implement comprehensive age-appropriate sexuality education including capacities for providing technical assistance on design, implementation and evaluation of comprehensive sexuality education. The Fund supported curricula reviews for 10 ESA countries and built the capacity of 200 curriculum developers and civil society partners. As a result, Swaziland, Lesotho, Zambia, Tanzania and Uganda revised their curricula.
- UNFPA and partners supported the empowerment of 200 young people from 54 countries to effectively advocate for their issues through a knowledge- and skills-building pre-conference to the 2012 International AIDS Conference. The youth developed a Declaration laying the foundation for how youth organizations, networks and activists will collaborate, mobilize and make their voices heard over the next years to reach the 2015 goals of the Political Declaration on AIDS.
- A mini-survey was conducted in the 17 priority countries to understand country programmes targeting young people's access to condoms. Malawi and Swaziland

[37] http://www.youtube.com/watch?v=2RUyBq93qxs&feature=youtu.be
[38] http://www.thecondomizecampaign.org/events_aids_readmore/

were supported to develop 2013 action plans and strategies for demand creation for condoms for young people. The drafts will be finalized in 2013 following additional behavioural and social-cultural research to better understand attitudes, beliefs, condom knowledge and practices that put young people at risk of unintended pregnancy and HIV. Capacity of about 100 Government officials, NGO service providers and peer educators from Malawi and Swaziland was strengthened through skills-building workshops on condoms for young people.

Priority 3: Strengthening linkages between SRH & HIV; and meeting HIV needs of women and girls (Approximately 30% of total)

Key results

- Thirty-nine countries (18 in 2012) completed sexual and reproductive health (SRH) and HIV linkage assessments, country summaries have been prepared and made available39 highlighting the process, findings, lessons learned, recommendations and way forward. To assess progress, 17 impact assessments have been undertaken with the first round of countries which implemented the rapid assessment. UNFPA continued to support 7 African countries benefitting from European Union funding to strengthen linkages and integration.
- UNFPA and partners supported 36 countries to integrate gender-based violence (GBV) and engage men and boys in national AIDS strategies and plans. Financial and technical support to a consultation addressing GBV and engagement of men and boys for gender equality resulted in country plans for Integrating Strategies to Address GBV and Engage Men and Boys to Advance Gender Equality through National HIV Plans and Strategies. The consultation was organised by the UN Inter Agency Working Group in partnership with the ATHENA Network, MenEngage Alliance, and Sonke Gender Justice and built on the global consultations convened in 2010 and 2011. The consultations successfully addressed the intersections of gender equality and HIV, including: championing women's rights in the context of HIV, addressing the HIV needs of women and girls, enhancing efforts to integrate a focus on gender based violence as a cause and consequence of HIV into HIV responses, and actively engaging men and boys in achieving gender equality to challenge constructions of masculinities that exacerbate the spread and impact of HIV. UNFPA supported 6 countries (Angola, Malawi, Mozambique, Tanzania, South Africa, and Zimbabwe) to review their national HIV and Gender policies, strategies and plans, and assess their strengths and weaknesses for addressing gender based violence and engaging men and boys. The resulting country action plans will strengthen cross-cutting attention to gender equality, gender based violence, and engaging men and boys in their national planning processes and forthcoming national HIV strategies and plans.
- UNFPA supported Promundo on gender transformative programming in Europe

[39] www.srhhivlinkages.org

and Central Asia on increasing male involvement in reproductive health and a training toolkit on Men and Boys engagement for Women's empowerment in the Middle East and North Africa region. UNFPA co-funded and co-organised a global consultation on sex worker-led initiatives to address gender based violence against sex workers where agreement was reached to commence the process of identifying a new standard in evidence that successfully captures evidence-based practice in addition to more traditional forms of evidence too dependent on medical and quantitative data.

Other issues (Approximately 1% of total)

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

The Global Plan Towards the Elimination of New HIV infections Among Children and Keeping Their Mothers Alive and the *Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015* guides UNFPA's scale up towards eMTCT through the Sexual and Reproductive Health/Maternal Neonatal Health Care platform. UNFPA, in partnership with WHO, led the Inter Agency Task Team eMTCT Integration Working Group and through the provision of technical assistance: produced a case study and film on how Rwanda is delivering eMTCT through the SRH platform and community; piloted in Zambia the consolidation of SRH and HIV assessments to maximise impact and coordination; promoted, disseminated and conducted capacity building and workplanning with government, UN system and civil society partners to implement the *Preventing HIV and Unintended Pregnancies Strategic Framework* in the context of the *Global Plan,* developed a related job aid and issued a 2nd edition of the framework with the latest guidance on couples' counselling and testing, sero-discordance, treatment as prevention, options B/B+[40], hormonal contraception and HIV, and terminology.

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, in collaboration with the World Bank and Johns Hopkins Bloomberg School of Public Health supported the undertaking of a study, *The Global HIV Epidemics among Sex Workers,* adding to the existing knowledge and evidence-base of HIV and sex work. Study findings include community empowerment approach to HIV prevention, treatment, and care is cost-effective, with significant projected impact on HIV incidence among sex workers and transmission beyond the sex worker community; and reiterated the central importance of adopting a rights-affirming, empowerment-based approach to scale up comprehensive HIV services, and addressing stigma, discrimination, and violence against sex workers. UNFPA, WHO, the UNAIDS Secretariat and the Global Network of Sex Work Projects launched the guideline: *Prevention and Treatment of HIV and other Sexually Transmitted*

[40] http://www.unicef.org/aids/files/hiv_Key_considerations_options_B.pdf

Infections for Sex Workers in Low-and Middle-Income Countries, Recommendations for a public health approach[41]. The Guideline provides technical recommendations on effective interventions for the prevention and treatment of HIV and other sexually transmitted infections among sex workers. The *HIV and Sex Work Collection: Innovative Responses in Asia and the Pacific*[42] (UNFPA, UNAIDS and APNSW) document 11 programmes from 7 countries providing an analysis of lessons from experience in the region, was also launched.

Humanitarian Setting and Fragile Contexts

UNFPA continued the development of an initiative to increase humanitarian actors' capacity to develop and manage multi-sectoral gender based violence prevention and response programmes that includes an e-learning course and user manual (both available in multiple languages); a regionally-adaptable in-person training curriculum; and a web-based community of practice. To date, over 400 actors have completed the course and rated it highly. A companion guide that complements the e-learning course with additional case studies, best practices, and activities was launched in April 2012. In February 2012, UNFPA and the International Medical Corps pilot-tested the in-person training curriculum at a well-evaluated course in Nairobi. The training curriculum is now available for use in English, French and Arabic.

[41] http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf

[42] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/20121212_HIV_SW.pdf

United Nations Office on Drugs and Crimes (UNODC)

Total amount spent on AIDS in 2012 (US$):	
Global	$1,663,800
30+ High Impact Countries	$8,289,000
Other regions	$8,322,300
Total	$**18,275,100**
Total UBRAF 2012	**$5,750,000**

Description of top 3 priorities and related key results:

Priority 1: To facilitate the review and adaptation of national legislation and policies concerning narcotic drugs, criminal justice, prison management and HIV (Approximately 20% of total)

Background

Taking into account all relevant General Assembly, ECOSOC (Economic and Social Council), Commission on Narcotic Drugs (CND), UNAIDS Programme Coordinating Board and Commission on Crime Prevention and Criminal Justice (CCPCJ) resolutions, UNODC facilitates policy and strategy development and advocacy related to HIV and people who use drugs, and HIV in prisons and other closed settings, and provides strategic inputs to the review and revision of national HIV/AIDS policies and strategies to support key interventions in HIV prevention, treatment, care and support for these population groups.

Key results

- At its fifty-fifth session (Vienna, 12-16 March 2012), the Commission on Narcotic Drugs (CND) adopted a Resolution 55/5 "*Promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies*"[43], noting with great concern the alarming rise in the incidence of HIV/AIDS and other blood-borne diseases among injecting drug users, and reaffirming its commitment to work towards the goal of universal access to comprehensive prevention programmes and treatment, care and related support services. In the Resolution, the CND urged Member States to consider incorporating female-oriented programmes in their drug policies and strategies, and encouraged Member

[43] http://www.unodc.org/documents/commissions/CND-Res-2011to2019/CND-Res-2012/Resolution_55_5.pdf

States to integrate essential female-specific services in the overall design, implementation, monitoring and evaluation of policies and programmes, where needed, including voluntary HIV counselling and testing, and treatment, support and recovery from trauma related to drug use as a result of sexual or other forms of violence. The CND called upon Member States to pay due attention to the specific needs of women while applying the relevant target goals as set forth in the Political Declaration on HIV and AIDS adopted by the General Assembly in its resolution 65/277 of 10 June 2011 and incorporating those goals in their relevant national strategies.

- At its twenty-first session (Vienna, 23-27 April 2012), the Commission on Crime Prevention and Criminal Justice (CCPCJ), adopted a Draft resolution I "*Standard Minimum Rules for the Treatment of Prisoners"* [44]. At the Open-ended Intergovernmental Expert Group Meeting on the *Standard Minimum Rules for the Treatment of Prisoners* (Buenos Aires, 11-13 December 2012), facilitated by UNODC, it was agreed, among other things, under the area (b): Medical and Health Services (Rules 22-26, Rule 52, Rule 62, Rule 71/2) *"To add reference, in Rules 22, to the principle of equivalence of health care; to clarify that health care services in prison settings are to be provided free of charge without discrimination; to refer to the need of having in place evidence-based HIV, tuberculosis and other disease prevention, treatment, care and support services as well as to drug dependence treatment programmes in prison settings which are complementary to and compatible with those in the community; to add that health policy in prisons shall be integrated or at least compatible with, national health policy*[45]*"*.
- At its twenty-first session (Vienna, 23-27 April 2012), the Commission on Crime Prevention and Criminal Justice (CCPCJ), adopted a resolution "*United Nations Principles and guidelines on Access to Legal Aid in Criminal Justice systems*"[46]. The resolution adopted the UN principles and guideline. In addition to addressing the needs of prisoners, the Principle 10 and the Guideline 11 make specific references to drug users and to PLHIV among others. This resolution was adopted in December 2012 by the General Assembly (A/RES/67/187).

Priority 2: To develop evidence base which supports public health approaches for HIV prevention, treatment and care services for people who use drugs, and those living in prisons and other closed settings. (Approximately 15 % of total)

Background

With regard to injecting drug use, UNODC undertakes activities to develop the evidence base in all key countries and regions based on the decisions made by the

[44] http://www.un.org/Docs/journal/asp/ws.asp?m=E/CN.15/2012/L.4/Rev.2
[45] http://www.unodc.org/documents/justice-and-prison-reform/EGM-Uploads/final_report_2nd_IEGM.pdf
[46] http://www.un.org/Docs/journal/asp/ws.asp?m=E/CN.15/2012/L.14/Rev.1

Commission on Narcotic Drugs, the Programme Coordinating Board of UNAIDS and the Economic and Social Council in 2009 regarding a comprehensive package of HIV-related services for injecting drug users, which includes the following nine interventions:

1. Needle and syringe programmes
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB).

UNODC also supports countries in mounting an effective response to HIV and AIDS in prisons and other closed settings, taking into consideration principles of international law, including international rules, guidelines, declarations and covenants governing prison health, international standards of medical ethics, and international labour standards.

Key results:

- In 2012, UNODC has initiated the UNODC/ILO/UNDP/WHO/UNAIDS Policy Brief on *"HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*[47]*"*, aiming at supporting decision makers in ministries of justice, authorities responsible for closed settings and ministries of health, as well as authorities responsible for workplace safety and occupational health, in planning and implementing a response to HIV in prisons and other closed settings. The document outlines the comprehensive package consisting of 15 interventions that are essential for effective HIV prevention and treatment in prisons and other closed settings.

- In accordance with the Programme Coordinating Board decision from June 2009 calling upon Member States, civil society organizations and UNAIDS to increase attention to certain groups of non-injecting drug users, especially those who use crack cocaine and amphetamine type stimulants, and their link to increased risk of contracting HIV through high-risk sexual practices, UNODC organized a "*Global*

[47] http://www.unodc.org/documents/hiv-aids/HIV_prisons_advance_copy_july_2012_leaflet_UNODC_ILO_UNDP_Ebook.pdf

Technical Meeting on Stimulant Drug Use and HIV" attended by leading researchers, technical experts from countries affected by stimulant use and HIV, and representatives of Civil Society and the UN (Sao Paulo, Brazil, January 25-27 2012). The recommendations suggested a targeted approach to address unique needs of certain sub-groups of stimulant users as they intersect HIV prevention, treatment, and care. A global guidance document *"Technical Guide to HIV Prevention, Treatment and Care for Stimulant Users (Discussion Paper)"* is being finalized based on the recommendations and further consultations with the meeting participants.

- UNODC has convened and chaired an "Informal meeting of the Reference Group to the United Nations *on injecting drug use and HIV*" during the AIDS 2012 Conference (Washington DC, 24 July 2012). An Interim Steering Committee of the Reference Group identified potential topics for future thematic papers, such as the need to update epidemiological and service coverage data with regard to injecting drug use and HIV; injecting drug use among other key populations such as Sex Workers; drug use in custodial settings; and the need for a comprehensive literature review on non-IDU and HIV. UNODC has compiled data from available country, regional and global data sources with regard to the prevalence of injecting drug use, and the prevalence of HIV, HCV, HBV, and active TB among people who inject drugs.

Priority 3: To support countries in increasing the coverage, quality, impact and sustainability of HIV prevention, treatment, care and support services for people who use drugs, and HIV prevention, treatment, care and for people living in prisons and other closed settings. (Approximately 65% of total)

Background

UNODC is responding to HIV and AIDS with regard to drug use, in particular injecting drug use, and HIV in prisons and other closed settings worldwide, reaching over 100 countries, for the purpose of scaling up the delivery of HIV prevention, treatment, care and support services, including their monitoring and evaluation, and for increasing their coverage, quality, impact and sustainability. Its work is designed to strengthen the national capacities to implement large-scale and wide-ranging interventions to prevent HIV infection, to provide treatment, care and support to people living with HIV and AIDS, to improve global, regional and national level understanding of the epidemic, and to strengthen the national capacities to address stigma and discrimination related to HIV and AIDS.

Key results

- In 2012, UNODC has made notable progress in advancing global dialogue and advocacy about gender-responsive HIV programmes and improving equitable access to HIV/AIDS prevention, treatment and care services for female drug

users and female prisoners, illustrated by outcomes achieved in several countries, for example in Ukraine, Afghanistan, Pakistan and Nepal. The capacity of service providers to deliver gender-specific services has been significantly enhanced, and the work has informed development of targeted interventions within specific geographical settings. UNODC has also contributed to the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV by global advocacy, promotion and provision of technical assistance in the delivery of gender responsive services, including PMTCT, to female drug users and women living in prisons and other closed settings.

- UNODC participated in a Penal Reform International (PRI) round table on health aspects of the "*United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*" (Bangkok rules), adopted by the GA in December 2011. UNODC contributed to the development of PRI's Guidance Document and Index of Compliance document ensuring an adequate coverage of HIV prevention, treatment, care and support in women's prisons.
- UNODC organised a session on "Drug use and HIV" at the "*6ème conference francophone du VIH/sida*" (Geneva, March 2012), fostered current partnerships in the delivery of the comprehensive package for HIV in prisons and identified areas for strengthening evidence-based responses to HIV and drug use, and HIV in prisons, such as the development of methadone maintenance treatment (MMT) in several African countries. At the AIDS 2012 Conference UNODC organised a Satellite event on HIV in prisons, contributed to a Bridging session on "*Justice System and provision of services*"; supported the Global village networking zone on HIV in prisons; supported the organisation of a workshop "*Working together for the implementation of prevention, medical care and harm reduction in prisons: a practical experience!*", and present two posters, respectively on assessment of HIV and tuberculosis in prisons in Swaziland.

International Labour Organization (ILO)

Total amount spent on AIDS in 2012 (US$): :	
Global	$4,587,545
30+ High Impact Countries	$7,101,082
Other regions	$2,992,953
Total	**$14,681,580**
Total UBRAF 2012	**$4,592,479**

Description of top 3 priorities and related key results:

Priority 1: Revolutionize HIV prevention (Approximately 20% of total)

Key results

- In Thailand, the ILO developed and piloted an approach to access young men who have sex with men (MSM) by partnering with the entertainment industry. Technical support was provided to capacitate two NGOs to work with 20 gay saunas in Bangkok, to establish HIV policies and programmes and improve access to HIV services for employees and customers. Results: improved access to condoms, lubricants, HIV information and referrals for young men who have sex with men; improved capacity of NGOs and entertainment sector enterprises to implement HIV workplace programmes;.a regional training tool has been developed to facilitate the scale up of similar programmes in the entertainment sector.
- In Southern Africa, the ILO is supporting the implementation of a regional HIV and AIDS programme titled the Economic Empowerment and HIV Vulnerability Reduction Programme, in 6 high impact countries which include: Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe. The programme, which focusses on women (including sex workers), is implemented along the busy transport corridor in Southern Africa. It combines HIV prevention initiatives with economic empowerment initiatives and provides access to HIV services for mobile and migrant workers, sex workers and traders along the hotspots of the corridor. Results: Through development of business skills and access to credit, the project beneficiaries built a stronger resilience to HIV.
- The ILO launched a research project to address lesbian, gay, bisexual and transgender (LGBT) rights in the workplace. The PRIDE Project: Promoting Rights Diversity and Equality (PRIDE), being implemented in South Africa, Thailand, Hungary and Argentina has identified multiple layers of discrimination facing LGBT persons in the workplace. . Follow-up: The project is documenting successful approaches to dealing with challenges faced by LGBTs in the workplace that will inform the ILO's strategy to ensure that LGBT issues are mainstreamed across all HIV workplace programmes.

- The ILO, UNODC and UNDP jointly launched a joint comprehensive package of 15 interventions to address HIV in prisons settings. Results: the joint policy brief is informing the implementation of HIV prevention programmes targeted at IDUs and MSM in closed settings.
- The ILO worked with the Global Network of people living with HIV and provided technical and financial support for the development of an evidence brief on HIV stigma and discrimination at work, based on the findings of the PLHIV (people living with HIV) Stigma Index. Results: The findings contributed in part to the ILO's decision to launch a communications campaign titled "Getting to Zero at Work" in December 2012.which aims at enhancing the role of the workplace in reducing stigma and discrimination.

Priority 2: Catalyse the next phase of treatment, care and support (Approximately 35% of total)

Key results

- The ILO capacitated national world of work actors in the area of generating demand for Voluntary Counselling and Testing (VCT) as an entry point into treatment and a strategy to close the treatment gap. In 5 high impact countries: China, India, Kenya, Mozambique and Tanzania, the ILO conducted tailored training for 303 government employees, 218 representatives from Employers 'organizations and 124 representatives from Workers' organizations. Results: the training resulted in VCT advocacy campaigns in specific enterprises which led to 3069 workers undertaking VCT within the premise of their workplace. 989 workers were referred to public health facilities for follow up
- In Sierra Leone, the ILO in collaboration with Sierra Rutil Mining Company and the national AIDS Secretariat conducted an evaluation to further understand the factors which contributed to the higher than national average uptake of VCT, eMTCT and ART treatment adherence (90 – 100%). Results: the evaluation revealed that high uptake of VCT and treatment adherence was due to: strict confidentiality of HIV status; assurance of continued employment; company's goodwill; friendly approachable and trusted clinic staff; and easy access to the health facilities.
- The ILO applied the "Step by Step Approach to integrating TB into existing HIV workplace programmes" and the "WHO/ILO/UNAIDS Guidance on TB and TB/HIV prevention, diagnosis, treatment and care in the workplace" to support the implementation of TB/HIV workplace programmes in 16 countries. Results: the trained peer educators supported the implementation of TB/HIV workplace programmes and policies in 270 workplaces in the formal economy, directly reaching 176.108 employees and 9.707 workers in the informal economy.
- In 2012, the ILO adopted a Recommendation on Social Protection. This instrument provides strong policy and programme guidance to countries to establish or maintain basic floors in their national social protection systems. Results: Assessments of the HIV sensitivity of social protection schemes in Sri Lanka, China and Indonesia stimulated good outcomes. For example, in Indonesia, the exclusion of people living with HIV within

the national health insurance scheme for formal sector workers was removed. In China, a decree was issued in December 2012 prohibiting the rejection of people living with HIV from medical treatment.

- In the Asia Pacific region, the ILO developed a simple costing tool for determining the costs of integrating HIV prevention, care, treatment and support into national healthcare schemes. Results: this tool was used in Indonesia to successfully advocate for inclusion of HIV program costs into the national social protection floor initiative.
- The ILO, UNAIDS, GBC (Global Business Coalition) Health, GNP+ (Global Network of People Living with HIV) and WHO built the capacity of 40 national social protection and HIV specialists from 19 countries in HIV and AIDS Prevention and Social Protection. Results: the training programmes have facilitated the establishment of a cadre of National Social Protection experts responsible for the countries' implementation of HIV-Sensitive Social Protection schemes

Priority 3: Advance human rights and gender equality (Approximately 45% of total)

Key results

- The ILO supported the drafting, review and/or finalization of National HIV and AIDS Workplace Policies.in 32 countries. (Antigua and Barbuda, Armenia, Azerbaijan, Belize, Botswana, Burkina Faso, Cameroon, Chad, China, Costa Rica, Cote d'Ivoire, Ghana, Honduras, India, Indonesia, Japan, Jordan, Kazakhstan, Lesotho, Malawi, Mali, Namibia, Philippines, Russia Federation, South Africa, Sri Lanka, Swaziland, Tajikistan, Trinidad and Tobago, Ukraine, Tanzania and Zambia.)
- In the Middle East and North Africa, the ILO supported the implementation of two studies on "Review of laws and practices and priority setting on HIV and AIDS". **Results**: Discrepancies between the employment legislation and the ILO Recommendation N° 200 were identified in the areas of Testing, Social Protection and Occupational Safety and Health and addressed.
- In Latin America, the ILO provided tailored support to promote and implement key human right principles contained in Recommendation N° 200 through labour inspectorates. **Results**: In Nicaragua, Honduras, Chile and Brazil, the ILO carried out a labour inspectors' training programme including the development of monitoring tools to identify and report on HIV related discrimination in the workplace.
- In the Asia Pacific region, the ILO piloted two approaches to increase access to legal services for PLHIV and key populations. **Results**: In Cambodia, a standalone legal service established for sex workers reached over 400 sex workers with legal services to address police and client related violations. In China, a hotline was established to provide combined legal services to PLHIV and key affected populations.
- In Southern Africa the ILO supported the review of the SADC (Southern African Development Community) Code on HIV and Employment and strengthened its

alignment to Recommendation N° 200. The SADC Code covers 15 countries in the epicentre of the HIV epidemic.

- In 16 countries the ILO built the capacity of 270 judges, lawyers, magistrates and parliamentarians in HIV and Labour Law.
- The ILO provided training for national world of work stakeholders in 12 countries on gender mainstreaming into HIV workplace programmes.
- The ILO strategy was to mainstream gender based violence and sexual harassment training across different streams of its work. **Results**: Gender based violence was mainstreamed into wellness campaigns, trade Unions and business networks initiatives.

Other issues:

For the rest of the 2012 – 13 the ILO will focus its resources on:
Generation of Strategic Information

- Generate global estimates on female and male workers living with HIV/AIDS
- Generate strategic information demonstrating how HIV workplace programmes contribute towards addressing the needs of key populations, including LGBTIs
- Generate strategic information on what works in HIV and AIDS workplace programmes and social protection coverage for people living with HIV

Tailored Support To Implement HIV Workplace Programmes

- Mass Mobilization of world of work actors to undertake voluntary counselling and testing (VCT).
- Greater focus on reducing the levels of stigma and discrimination within the workplace, working closely with networks of people living with HIV and the systematic use of the Stigma Index.
- Accelerate the systematic scale up of the basic programmes of the Investment Framework through HIV workplace programmes.

United Nations Educational, Scientific and Cultural Organization (UNESCO)

Total amount spent on AIDS in 2012(US$)::	
Global	$2,185,153
30+ High Impact Countries	$5,059,624
Other regions	$5,056,375
Total	**$12,301,153**

Total UBRAF 2012 $6,200,000

Description of top 3 priorities and related key results:

Priority 1: Supporting countries to scale-up good quality comprehensive sexuality education (Approximately 64% of total)

Background

Over 60% of UNESCO's activities, through both core and non-core funding, contribute to UBRAF goal A1 through a focus on accelerating efforts to advocate for and provide technical guidance and support for the development and implementation of scaled-up HIV and sexuality education. Activities include contributing to and disseminating evidence on effectiveness and impact of HIV and sexuality education curricula; providing technical support to curriculum developers and teacher trainers; and global and country level advocacy in support of comprehensive sexuality education (CSE) including through the involvement of youth-serving and youth-led organisations and in close cooperation with ministries of education and health. UNESCO's work to scale-up CSE builds upon its specific mandate and expertise in the domain of education, as well as on longstanding relationships with ministries of education. Close coordination with UNFPA, UNICEF, WHO and other UN agencies and other development partners ensures that each organization contributes its unique strengths and avoids duplication in CSE programmes and initiatives.

Key results

- Worldwide, UNESCO has provided technical support to ministries of education in 75 countries to scale-up comprehensive sexuality education, and over a million learners will have benefitted from educators trained in 2012 through UNESCO-supported capacity-development initiatives for good quality HIV and comprehensive sexuality education. A process has been launched to mobilize political commitment to make good quality HIV and sexuality education, SRH (sexual and reproductive health) and youth-friendly services available to young people in 21 East and Southern African countries. A state-of-the-art regional diagnostic report has been drafted, and a high-level group was established comprising experts from the region to advocate for and lead the process, supported by a Technical Coordinating Group including UNICEF, UNFPA, WHO and UNAIDS and civil society organizations. UBRAF funding was used to leverage over USD 7.2 million for this initiative.
- UNESCO seeks to provide support for curriculum review and analysis, to scan curriculum and identify opportunities for strengthening HIV and sexuality education. To support these efforts, the Sexuality Education Review and Analysis Tool (SERAT) was developed by UNESCO in West and Central Africa and has already been used in more than 16 countries. Curriculum scans have been completed in 10 East and Southern African countries. Tanzania, Lesotho and Zambia also benefitted from a new peer review mechanism to support curriculum review processes, and in CEMAC[48] and

[48] Commission de la Communauté Économique et Monétaire de l'Afrique Centrale

CEEAC[49] countries UNESCO-supported information and communication technology (ICT)-based teacher training materials have been targeted to primary and secondary school teachers.

- Training and support was provided for EMIS staff to use and analyse HIV-sensitive indicators in national education M&E systems in Zambia, South Africa, Namibia, Tanzania, Jamaica and Viet Nam. UN partners and the Southern Africa Development Community secretariat collaborated on the completion of a Global M&E Framework for Comprehensive Education Responses to HIV and AIDS.
- Data analysis from the Global Progress Survey on Education Sector Engagement in National AIDS Responses produced 39 country situational reports and trend analyses comparing 2004 and 2011 data from 30 countries. The Inter Agency Task Team on Education has designed advocacy/communication tools using the Global Progress Survey.
- UNESCO undertook research on global trends in the use of ICT in education and health to inform a new project on new media and HIV knowledge among young people, and detailed country research studies were completed in Jamaica, China and Zimbabwe.

Priority 2: Promoting gender equality and addressing gender-based violence and harmful gender norms in school contexts (Approximately 20% of total)

Background

As part of broader strategy for the scale-up of CSE linked to SRH services, and as part of its contribution to the UNAIDS *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV,* UNESCO has focused significant efforts on UBRAF goals C3 and C4, with a specific focus on gender equality and gender-based violence in school settings. Working with countries and other UN and development partners, UNESCO has applied its expertise in education to expand access for girls and young women to CSE and increase the uptake of SRH services. UNESCO also spearheaded a landmark initiative to address homophobic bullying and harmful gender norms in educational institutions, including through efforts to improve the evidence base on the nature and scope of homophobic bullying in regions where there is no or little data.

Key results

- In 2012 UNESCO published its seventh booklet in the UNESCO "Good Policy and Practice in HIV and Health Education" series, which focuses on Gender Equality, HIV and Education[50]. The discussion papers and related case studies cover issues such as integrating gender and HIV into the national curriculum; gender based approaches to curriculum development; increasing girls' access to education; and synergies between education, gender equality, HIV and sexual and reproductive health.

[49] Communauté Économique des États de l'Afrique Centrale

[50] http://unesdoc.unesco.org/images/0021/002187/218793e.pdf

- UNESCO convened the United Nations' first-ever international consultation to address homophobic bullying in educational institutions, which brought together experts from UN agencies, NGOs, ministries of education and academia from over 25 countries. In follow-up to this landmark consultation, UNESCO published its eighth booklet in the "Good Policy and Practice in HIV and Health Education" series titled "Education Sector Responses to Homophobic Bullying[51]". These global initiatives have been accompanied by a series of country-level activities. For example, a workshop on homophobic bullying was held in Beijing in November 2012, and UNESCO is working with the UNDP to support a multi-country study on the prevalence of homophobic bullying in Peru, Chile and Guatemala. In South Africa, the Gay and Lesbian Memory in Action (GALA) and Centre for Education Rights and Transformation (CERT) received support from UNESCO to convene the first colloquium on LGBTIQ (lesbian, gay, bisexual, transgender, intersex and questioning) issues in education in South Africa, leading to the production of a report, recommendations, and the establishment of a network of LGBTIQ youth-in-education experts. Building on its extensive experience in teacher training in formal and non-formal education, UNESCO collaborated with national Ministries in Myanmar and Cambodia on a programme called "Creating Connections: empowering women to talk about sexual and reproductive health." Within the context of the programme, a sub-national Training of Trainers course was organized in Cambodia for 22 provincial trainers and in Myanmar for 32 trainers from 19 education colleges. UNESCO also supported a local NGO in Myanmar, Akayar Women, to conduct this training for different women's groups.
- The Sexuality Education Review and Analysis Tool (SERAT) was designed to assess gender responsiveness and collect gender sensitive data at several levels (curriculum content, teacher training, national policies and strategies, and epidemiological data). A similar tool has been developed jointly with International Planned Parenthood Federation (IPPF) to be used by civil-society partners to ensure that the needs of women and girls in relation to HIV are addressed and monitored in their community and schools.
- UNESCO seeks to engage men and boys for gender equality, and has launched an innovative pilot programme in the Democratic Republic of the Congo (DRC) to work with universities and engage male students as ambassadors for the prevention of sexual and gender-based violence (SGBV). The programme involved the production and validation of new teaching modules on gender equality and violence prevention which are now being taught in universities in the North and South Kivu Regions.
- UNESCO contributed to the development of a regional discussion paper, coordinated by the UNDP's Asia-Pacific Regional Centre, which looked at evidence on the intersections between HIV and gender-based violence in the region. The paper contributes to the workplan of the Inter Agency Task Team on Women, Girls, Gender Equality and HIV, and is scheduled to be published in early-2013.

[51] http://unesdoc.unesco.org/images/0021/002164/216493e.pdf

Priority 3: Empowering PLHIV and key populations and eliminating stigma and discrimination in school settings (Approximately 16% of total)

Background

Many adolescents and young people living with HIV, who use drugs, adolescent MSM and transgender people and sexually exploited adolescents are denied access to good quality education, including comprehensive sexuality education. When in school they are often ignored or stigmatized, bullied and victims of violence, and it is widely recognized that stigma and discrimination are major obstacles to accessing voluntary counselling and testing, prevention and treatment services. To address this, UNESCO's work under UBRAF goals A3, B1, B3 and C1 has focused on increasing the knowledge levels of education staff, adolescents and young people, and other community members about HIV, human rights, and developing supportive attitudes towards those infected and affected by HIV.

Key results

- In collaboration with GNP+, a guidance document was published in 2012 titled "Positive Learning: Meeting the needs of young people living with HIV (YPLHIV) in the education sector[52]". It outlines roles and responsibilities for the education sector in supporting YPLHIV, and also serves as a tool for networks of young people living with HIV (YPLHIV) to advocate for more appropriate, conducive and supportive education systems. UNESCO has also coordinated a range of country-level initiatives in East and Southern Africa, including the creation of "Young Positives-Friendly" educational spaces, in cooperation with SAfAIDS; the promotion of "positive speaking" interventions in schools to address issues of stigma and discrimination; the development of a Photo Book featuring photos and testimonies from young people and teachers living with HIV in Southern Africa; and the development of an Adolescent Prevention and Treatment Literacy Toolkit (APre-TLT) to be rolled out in schools.
- UNESCO continues to support countries to apply the UNESCO/ILO HIV&AIDS Workplace Policy. UNESCO supported seven countries in the development of HIV workplace programs in East and Southern Africa, and is collaborating with ILO and UNDP to support West and Central African countries to adapt the workplace policy in consultation with Ministries of Education from thirteen countries, teacher unions, and people living with HIV networks. A policy document has been drafted, and a regional workshop was held in 2012 in Accra, Ghana. In Eastern Europe and Central Asia, the ministries of education of Russia, Ukraine, Kyrgyzstan, Tajikistan and Belarus endorsed the development of national policies on HIV for the Education sector. Technical assistance was provided to the five member-states by UNESCO to develop relevant national policies based on the UNESCO/ILO 2011 Regional Recommendations.
- The Asia Pacific Inter-Agency Task Team (IATT) on young key populations (YKPs) was founded in 2009 with UNESCO support and chaired by UNESCO in 2012. UNESCO initiated the development of a UN Global Guidance on adolescent key populations, for which a concept note was developed. The short course "Understanding the Focus on

[52] http://unesdoc.unesco.org/images/0021/002164/216485E.pdf

Young Key Affected Populations in Concentrated and Low Risk HIV Epidemics" developed by a consortium from the University of Melbourne with support from UNICEF, UNFPA and UNESCO, was revised and a training session was hosted at UNESCO Bangkok, Thailand in August 2012. With the IATT, UNESCO also spearheaded the New Generation (NewGen) Asia initiative, which aims to develop the capacity of the next generation of young leaders from key populations, and trained over 100 young leaders in 2012 alone. In Cambodia, UNESCO worked with the National AIDS Authority and the UN Joint Team on AIDS to develop an institutional core competency framework for PLHIV and MARPs (Most-at-Risk Populations) Community Networks, in collaboration with Bandah Chatomuk (BC), a network of MSM and transgender persons in Cambodia.

- Work has also been ongoing to raise awareness on HIV prevention and combat stigma and discrimination. In Russia and the Ukraine, a UNESCO partnership with Psychologies magazine has resulted in the publication of 27 articles on HIV and health, with the goal of empowering parents to talk to children about values, responsibility, relationships, and healthy sexuality and healthy life. For example, the December 2012 issue told the story of a 29-year-old woman living with HIV who is raising a daughter born free from the virus. The article reached over 600,000 readers. In Guatemala, UNESCO contributed to the organization of a photo exhibition called "a Celebration of Life," which was shown in four different locations and is accompanied by educational activities aimed increasing knowledge on prevention and healthy lifestyle choices, as well as reducing stigma, discrimination and violence against HIV positive people. Over 10,000 people are estimated to have seen the exhibit.

World Health Organization (WHO)

Total amount spent on AIDS in 2012 (US$)::	
Global	$ 45,163,103
30+ HICs	$ 29,203,083
Regions and Other Countries	$ 43,226,403
Total	**$ 117,592,589**
Total UBRAF 2012	**$ 17,500,000**

Description of top 3 priorities and related key results:

Priority 1: Universal Access to Antiretroviral Therapy - ART (Approximately 33% of total)

Background

In 2012, WHO continued to work toward achieving universal access to ART through the development of normative guidance on HIV treatment, laboratory support and clinical management, as well as by providing support to countries to implement this guidance.

Key results

- In 2012 global guidance was adapted and implemented to achieve the five pillars of Treatment 2.0, including support for strategic information that measures effectiveness and impact, with particular focus on countries with high prevalence and low ART coverage. For service delivery, a consultation on retention in HIV care was undertaken and a consultation report released and widely circulated. A framework implementation checklist was also developed to assist in measuring effectiveness and impact.
- A number of systematic evidence reviews on integration of ART, drug optimization, models of service delivery (including provision of ART by nurses), and POC (Point-of-Care) technology were commissioned and finalized in support of the 2013 Consolidated ART guidelines process.
- WHO released a number of guidance documents to support drug regimen optimization. Key among these were two consultation reports on the strategic use of antiretrovirals for the treatment and prevention of HIV/AIDS, and a “Think Tank” meeting report that lays out a vision for the optimization of antiretroviral therapy for the short to medium-term, and promotes the key principles of regimen optimization (including robustness, minimal toxicity, fixed-dose combinations, and alignment across populations). Three technical updates on

critical treatment optimization issues have been issued that have advanced the treatment simplification agenda, both globally and in several high HIV burden countries.

- WHO released several guidance documents in the area of HIV diagnostics, including guidance on couples HIV testing and counselling, a strategic policy framework on service delivery approaches to HIV testing and counselling, and a handbook on planning, implementing and monitoring home-based HIV testing and counselling. WHO also prequalified a point-of-care CD4 technology and began evaluation of other products, both for CD4 and viral load. WHO likewise convened an expert meeting on short, medium and long term product development priorities in HIV-related diagnostics.
- The Global Price Reporting Mechanism (GPRM) database platform was improved in 2012. In addition to quality control and duplicate removal, its interface now shows time-trend in the median prices of ARVs (antiretrovirals) and volumes transactions by time, and has a fully functional download facility to access primary data. A real time update of the prices of different ARV formulations is available in the public domain via the GPRM interface. WHO also conducted surveys of access to ARVs and other commodities, convened annual consultations on demand forecasting, and developed PSM (Procurement and Supply Management) tools and supported countries on PSM problem-solving.
- Continued efforts were made to provide guidance to countries to collect data on treatment access for key populations in order to improve equitable access. This included development of a package of adolescent STI and reproductive health care which included HPV (Human Papilloma Virus); development of updated guidelines for cervical cancer screening and treatment; and production of updated guidance on laboratory diagnosis of STIs. In the European region, data on retention on ART is being specifically disaggregated for IDUs to ensure data is available.

Priority 2: Elimination of Vertical Transmission (Approximately 16% of total)

Background

In 2012 WHO worked closely with UNICEF and others toward the virtual elimination of vertical transmission, in both generalized and concentrated epidemic settings, through development of a global plan and monitoring framework, supporting the integration of PMTCT (prevention of mother-to-child tranmission) into antenatal and postnatal care and sexual and reproductive health programmes, strengthening maternal and child health services, and supporting the implementation of PMTCT and paediatric treatment programmes.

Key results:

- The Global Monitoring Framework and Strategy for the "Global plan to eliminate new HIV infections among children and keeping their mothers alive" was published and validated in 2012. WHO led the development of this framework, in partnership with UNICEF and the Inter-Agency Task Team PMTCT working group, to ensure joint vision and harmonization with international M&E recommendations in the areas of HIV, maternal, and child health.
- As co-chair of the Interagency Task Team (IATT), WHO continues to work with partners to ensure that the Global Plan milestones and targets are monitored; country eMTCT plans are reviewed in line with the global monitoring strategy; and PMTCT effectiveness and impact are properly assessed.
- WHO has supported on-going efforts to support scale up of early infant diagnosis (EID) testing and expansion of programs to treat children. In addition, the Paediatric ARV Working Group convened by WHO regularly reviews new drug data and formulations to advice on the best strategies for treating children in low-resource settings.
- Updated estimates of HIV transmission probabilities associated with different antiretroviral interventions for prevention of mother-to-child transmission were developed following a systematic review of available published evidence.
- WHO convened a major technical meeting and produced key guidance documents for integrating eMTCT and congenital syphilis, and supported 8 countries for piloting the process and criteria. In addition, WHO outlined a draft protocol to field test the new dual rapid diagnostic tests for HIV and syphilis to support enhanced integrated HIV and syphilis screening.
- An update of the "Reproductive Choices and Family Planning for Persons Living with HIV[53]" toolkit was finalized and printed. This tool is for use in HIV service delivery points to counsel clients on reproductive health and family planning methods.
- In 2012, WHO and UNICEF finalized and disseminated a framework for priority actions for HIV and infant feeding. HIV and infant feeding recommendations were integrated into regional training courses for infant and young child feeding and early newborn care.
- As part of the 2013 Consolidated ARV Guidelines process, systematic reviews were done to evaluate the feasibility of integrating ART into antenatal settings, optimal treatment regimens for children; timing of initiation of treatment in children; strategies for decentralized care; task shifting, improved adherence, and treatment initiation for pregnant women.

[53] http://www.who.int/reproductivehealth/publications/family_planning/9241595132/en/

Priority 3: Reduced Sexual Transmission (Approximately 16% of total)

Background

In 2012 WHO collaborated closely with other UNAIDS cosponsors to reduce sexual transmission of HIV, notably through building capacity for HIV prevention, design and implementation of combination prevention programmes for key populations, and supporting the development and uptake of new prevention technologies including vaccine research.

Key results

- WHO, together with UNICEF, UNFPA and UNESCO, has developed a network of technical and community-based partners to provide recommendations to policy makers and national programme managers on prioritizing, planning and providing HIV testing, counselling, care and treatment services for adolescents in resource-limited countries. This guidance is informed by a robust human rights perspective, systematic reviews, community consultations, surveys of adolescents and health workers, indirect evidence, extensive field experience and international expert opinion.
- In collaboration with its UN partners and civil society WHO has developed guidance for prevention, treatment and care of HIV and Other STIs for sex workers. In addition to providing normative guidance, these documents are used by key population groups as advocacy tools to advocate for UA to HIV prevention, treatment and care.
- WHO has played a major role in coordinating global, regional and country activities on voluntary medical male circumcision (VMMC). This has included development of normative guidance and a framework for clinical evaluation of male circumcision devices; reviews of study data, assessments of VMMC M&E systems; risk analyses; and pre-qualification of male circumcision devices. WHO has also convened regional VMMC progress meetings; developed a VMMC clearinghouse and undertaken other activities to promote VMMC.
- WHO convened a capacity strengthening workshop on pre-exposure prophylaxis (PrEP) and has developed guidance on PrEP for sero-discordant couples, men and transgender women who have sex with men at high risk of HIV.
- WHO has continued to host the joint WHO/UNAIDS vaccine initiative which advises and guides the HIV vaccine development activities of the global research community. This includes (a) scientific consensus-building, (b) guidance on vaccine evaluation, (c) assessment of the evidence base for policy recommendations on vaccine introduction and use, and (d) guidance to national regulatory agencies on approaches and methodologies related to the assessment, licensure and surveillance of vaccines.
- WHO was involved in reviewing and assessing the effectiveness and relevance of various ‘combination prevention’ approaches for a variety of populations

including key populations, adolescents and sero-discordant couples. WHO also began to develop combination prevention implementation research trials.

Other issues

In addition to the above key priority areas, WHO leads the UNAIDS effort in addressing HIV/TB co-infection. WHO has also been active in numerous other areas such as service delivery integration; addressing opportunistic infections including hepatitis; HIV prevention, treatment and care for key populations; gender-sensitive approaches to HIV prevention, treatment and care; gender-based violence and HIV; human rights, and ethics of HIV; financing HIV programmes; and collecting and analysing strategic information on the epidemic.

The World Bank

Total amount spent on AIDS in 2012 (US$):	
30+ HICs	$1,498,974,117
Total	**$2,501,104,505**
Total UBRAF 2012	**$6,828,339**

Description of top 3 priorities and related key results:

The World Bank as an institution has set two clear goals for itself: end extreme poverty and promote shared prosperity by fostering income growth of the bottom 40 percent of the population in every country. These goals ensure we address the priorities of equity and inclusion more systematically in all of our strategic decision-making; they cannot be achieved without a strong focus on growth in human development such as health. Everyone, including the poorest 40% and those vulnerable, should be able to access the quality health and social services they need. The priorities of our HIV/AIDS program reflect those goals as we focus on helping countries design, finance and implement the most efficient HIV service delivery systems and social protection programs, with all vulnerable population in mind.

Priority 1: Implementation Efficiency and Support, Effectiveness, and Sustainability, focusing on HIV prevention (Approximately 40% of total)

Background

Efficient implementation is essential for ensuring that HIV funds are used to maximum impact. Program managers and those making funding allocations will typically want to look at inefficiency to make decisions on how to deliver HIV services at lowest cost. Tools such as Program Efficiency analyses have therefore been developed by the World Bank and partners to assist countries in understanding how to deliver the most HIV services for the least cost and in the most integrated ways, without compromising agreed quality standards. Inefficiency is not ubiquitous—some service delivery models are more efficient than others. For these reasons, the methods these studies use to diagnose implementation inefficiencies, blend themes from different efficiency measurement methodologies, review successes in different sectors, and take into account specific service delivery contexts.

Efficiency studies are undertaken to review programs with known effectiveness. An associated body of work has therefore been developed to support innovative research and evaluation strategies through which governments can determine the population-level effectiveness of programs that have been implemented to scale to drive evidence-based decision making. The next wave of impact evaluation thinking

under this program for instance, will focus on: multi-method impact evaluations, particularly embracing quasi-experimental designs and evaluation of combination and integrated services provided to populations, as opposed to individual small scale evaluations.

Ensuring the sustainability of high-quality, proven effective and efficient service delivery models is the thread that ties this area of support together. It includes working with countries to ensure sufficient government fiscal capacity to continue program implementation, especially if donor funding for health continues to show signs of flat-lining and decline. This also includes encouraging regulated private sector engagement in contributing to the human, financial, and infrastructure resources required to build and operate a mix of affordable and accessible service delivery options.

Key results

- The World Bank leveraged $2.5 billion in funding through UBRAF support (60% of all UNAIDS Cosponsor resources combined) which financed standalone HIV projects focused primarily on prevention, or HIV components of projects in health, transport (sustainable development), education, and social protection sectors.
- Conducted a Fiscal Analysis of Investments in Male Circumcision in the Eastern and Southern Africa region which suggests that male circumcision programs are cheaper in the long run, even though the drive to expand male circumcision absorbs more financial resources upfront.
- Is actively supporting the accelerated scale-up of this new HIV prevention technology and specifically has: a) Increased governments' funding allocations to VMMC (voluntary medical male circumcision); b) Improved delivery efficiency of VMMC services; c) Supported improved effectiveness of VMMC programmes; d) Supported better understanding of long-term fiscal space consequences of VMMC investment; e) Scaled-up of VMMC through Bank funded programmes with HIV component.
- Pursued the advocacy for VMMC investment and scale-up at country level: in Malawi, the Bank successfully advocated for a VMMC component in the new $28 million Nutrition and HIV/AIDS project.
- Developed HIV Implementation Efficiency Guidelines to help countries deliver HIV services most efficiently -at the lowest cost-, while maintaining service quality and optimising management and organisational processes (resulting in the reduction of HIV service provision costs by at least 20%), and undertook Program Efficiency studies in multiple High Impact Countries
- Jointly with the UNAIDS Secretariat, conducted an HIV financial sustainability study which estimated that one adult HIV infection costs Jamaica US$ 5,800, and thus spurred the government into action to raise more resources for HIV.
- Developed a program on implementation science to improve coverage and

quality of key HIV services

- Finally, the World Bank supported several countries to improve the efficiency of their HIV response efforts

Priority 2: Allocative Efficiency, Return on Investment (ROI) and Social Protection (Approximately 30% of total)

Background

Allocative efficiency analyses are used to improve the allocation of resources to produce the types of outputs that will have the greatest impact on program outcomes. This requires understanding how scarce productive resources are allocated among and within alternative uses for prevention, treatment, and care and helping countries focus more intensely on programmes that have proven effectiveness. These analyses combine several building blocks including epidemiological and HIV response assessments, and high quality rigorous economic analyses. Return on Investment studies are the economic bi-products of these analyses and are used to make a case for investing in HIV by establishing evidence of cost-effectiveness and optimal allocations of limited resources across combinations of programs, for greatest epidemiological impact. To guide policy-makers in making appropriate investment decisions, Return on Investment studies were conducted, using mathematical modeling informed by behavioral and epidemiological data and international observations in comparable settings of relative costs and influence of specific programs to evaluate the potential impact of the program on averting new infections. The results present critical data for countries to invest their HIV resources in a way that will save money and avert the most infections.

Ensuring the allocation of funding and demonstrating return-on-investment in Social Protection, which for the World Bank comprises both social assistance and social insurance programs, is a powerful tool to reduce poverty and vulnerability due to HIV. In 2012, the World Bank released a new 10-year strategy for social protection in Africa (2012-2022). The vision is to help governments build country-owned national social protection systems. Leaning on this strategy, the World Bank provided $3.4 billion in funding for Social Protection globally, including HIV-sensitive social transfers.

Key results:

- The World Bank evaluated the potential impact of programs on averting new infections through ROI studies conducted in four countries. In Indonesia the study showed investment in the HIV/AIDS response over the period 2000-2010, averted approximately 290,000-400,000 HIV infections, corresponding to a 53-61% reduction in population incidence, costing around US$300-400 in direct prevention funding per infection averted (focused on MARPs). Financial investment in HIV is estimated to have a total future return on investment of

$0.55-0.63 for every US$1 invested (3% discounting).

- Designed a strategy for systems building for better Social Protection programs in Africa, taking into account the effects of HIV and AIDS on households in Africa.
- Supported the Malawi Third Social Action Fund project to improve the livelihoods for poor households including PLHIV, within the framework of improved Local Governance at community, local authority, and national levels. Determined the extent to which safety nets in southern Africa were sensitive to HIV vulnerability, using analysis results to build and operationalise an HIV-sensitive social protection system in Swaziland. Similar recommendations were made for implementation in South Africa and Botswana to systematize the support provided to people living with HIV, orphans and vulnerable children, and the communities they live in support HIV sensitive and sustainable cash transfer systems: in Kenya and Swaziland, the Bank is building cash transfer systems to support orphans affected by AIDS in sustainable ways.

Priority 3: Financing, Strategic Planning, including evidence and economic analyses (Approximately 30% of total)

Background

The World Bank continued to leverage UBRAF funds to increase the availability and enhance the efficiency and effectiveness of prevention and care financing provided to countries through its funding operations. Bank HIV financing was channelled through stand-alone projects, as well as through HIV components of projects in the health sector (through results-based financing for health systems strengthening), education, social protection, and sustainable development sectors (including urban development and transport).Through the UBRAF, Bank financing additionally supported the implementation by government, of actionable recommendations ensuing from analytic work and technical support described herewith. With the addition of a special provision for HIV grants within IDA13, the Bank provided increased levels of funding to countries for HIV prevention and care, around the current $2.5 billion mark.

Making strategic decisions is key to making HIV financing work. New guidance on "National AIDS Strategies and Implementation for Results" were developed which expressly drive hard choices to prioritise actions and where money is to be spent when addressing difficult and controversial issues; for example reducing resources spent on generic action and putting more resources towards addressing the needs of key affected populations. The Investment Approach to AIDS Strategy and Implementation, supports national governments and their funding partners, in ensuring greater returns on investment, and calls for three main areas of investment that will have the most impact on HIV and AIDS, basic programme activities, critical

enablers and synergies with other development sectors. This approach forms the basis of the new generation of NSPs.

Key results

- The World Bank published ground-breaking research in the Lancet showing that small cash payments to young girls in Zomba, Malawi, reduced HIV transmission by about half. Related results were reported about demand-side incentive-based programmes for HIV prevention in Lesotho and Tanzania, and for supply-side incentives in Rwanda, and have shown the promise of a new type of HIV prevention approach – using incentives and behavioural economics to improve HIV prevention decisions.
- Co-led with UNDP, UNFPA, and UNODC, economic analyses of "The Global Epidemics of HIV in Men who have Sex with Men[54]", "The Global Epidemics of HIV in Sex Workers[55]", and "The Global Epidemics of HIV in People Who Inject Drugs[56]" issued as part of the World Bank "Directions in Development" series. The publications rigorously assessed the effectiveness of interventions and demonstrated favourable returns on investment.
- Supported countries to project the fiscal dimensions of AIDS and plan future AIDS financing (examples include South Africa, Botswana, Swaziland, Uganda and Jamaica).
- Assisted numerous countries globally to undertake epidemic intelligence studies to understand where their emblematic "last 1,000 new infections" occurred so they can target these infections better with proven approaches. In Nigeria, such studies led to intensified focus on the 12 of 37 states and territories that contribute over half of new infections.
- Undertook a synthesis of most-at-risk-population epidemic trends in the WHO Euro region, which includes Russia and Central Asia where the epidemic is expanding.
- Undertook peer reviews of National AIDS Strategies to help countries make their responses more evidence based, prioritized and costed.
- Provided US$225 million primarily for HIV prevention in Nigeria, using UBRAF funds to leverage further contributions from partners
- Supported the development of NSP 3G in partnership with the Secretariat through targeted technical assistance provided to countries in the areas of (i) Costing; (ii) Development of epidemiological databases and references; (iii) Development of Results Frameworks; (iv) Analysis of data quality; (v) Implementation efficiency; and (vi) Budgetary allocation efficiency

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[54] http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/MSMReport.pdf
[55] http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongSexWorkers.pdf
[56] http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongPeopleWhoInjectDrugs.pdf