

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	ACRONYM	DEFINITION
ANC	antenatal care	NACS	Nutrition Assessment, Counselling and Support
APF	Asia Pacific Forum	OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ART	Antiretroviral Treatment	OST	Opioid Substitution Therapy
ARVs	Antiretroviral Drugs	OVC	Orphans and Vulnerable Children
ASRH	Adolescent Sexual and Reproductive Health	PCB	UNAIDS' Programme Coordinating Board
AVAC	AIDS Vaccine Advocacy Coalition	PEPFAR	United States President's Emergency Plan for AIDS Relief
BPPS	Bureau for Policy and Programming Support (UNDP)	PLHIV	People living with HIV
CCO	Committee of Cosponsoring Organizations	PMTCT	Prevention of Mother to Child Transmission
CHAI	Clinton Health Access Initiative	PREP	pre-exposure prophylaxis
CISP	International Committee for the Development of People	RH	Reproductive Health
CND	Commission on Narcotic Drugs	RHCS	Reproductive Health Commodity Security
COTU-K	Central Organization of Trade Unions in Kenya	SADC	Southern African Development Community
CSE	comprehensive sexuality education	SDGs	Sustainable Development Goals
CSOs	civil society organizations	SERAT	Sexuality Education Review and Analysis Tool
DOT	Directly Observed Therapy	SGBV	sexual and gender-based violence
EHRN	Eurasian Harm Reduction Network	SOGIE	sexual orientation and gender identity/expression
EMIS	education management information systems	SOPs	Standard Operating Procedures
eMTCT	Elimination of Mother to Child Transmission	SRGBV	school related gender-based violence
ESA	East and Southern Africa	SRH	Sexual and Reproductive Health
EUP	early unintended pregnancy	STIs	Sexually Transmitted Infections
GBV	gender-based violence	UBRAF	Unified Budget, Results and Accountability Framework
GNP+	Global Network of People Living with HIV	UHC	Universal Health Coverage
HCV	Hepatitis C Virus	UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
HHD	HIV, Health and Development (UNDP)	UNAIDS	Joint United Nations Programme on HIV/AIDS
HIV	Human Immunodeficiency Virus	UNDAF	United Nations Development Assistance Framework
HIVDR	HIV drug resistance	UNDP	United Nations Development Programme
HTC	HIV Testing and Counselling	UNESCO	United Nations Educational, Scientific and Cultural Organization
IATT	inter-agency task team	UNFPA	United Nations Population Fund
ICT	information and communication technology	UNHCR	United Nations High Commissioner for Refugees
IDP	internally displaced people	UNICEF	The United Nations Children's Fund
ILO	International Labour Organization	UNITAID	International Drug Purchase Facility
INWUD	International Network of Women Who Use Drugs	UNODC	United Nations Office on Drugs and Crimes
ITGSE	UN International Technical Guidelines on Sexuality Education	USAID	United States Agency for International Development
JPMS	Joint Programme Monitoring System	VCT	Voluntary Counselling and Testing
LEAs	legal and policy environment assessments	VMMC	voluntary medical male circumcision
LGBTI	lesbian, gay, bisexual, transgender and intersex	WASH	Water, Sanitation and Hygiene programmes
MMT	methadone maintenance treatment	WFP	World Food Programme
MOPAN	Multilateral Organization Performance Assessment Network	WHO	World Health Organization
MSM	Men who Have Sex with Men	WHRIN	Women Harm Reduction International Network

REPORT OF THE CHAIR OF THE UNAIDS COMMITTEE OF COSPONSORING ORGANIZATIONS, PHUMZILE MLAMBO-NGCUKA, UNITED NATIONS UNDER-SECRETARY-GENERAL AND EXECUTIVE DIRECTOR OF UN WOMEN

Delivered by Lakshmi Puri
United Nations Assistant Secretary-General and Deputy Executive Director of UN Women

40th Programme Coordinating Board
27 June 2017

Your Excellences, Ambassadors,
His Excellency Mr Kwaku Agyeman-Manu, the Minister of Health of Ghana and Chair of the PCB in 2017,
Mr Michel Sidibé, Executive Director of UNAIDS,
PCB members,
UNAIDS family colleagues and members of the CCO,
and First Lady of Panama, who has shown that women truly lead and should be leading this big mission.

I represent and speak on behalf of Phumzile Mlambo-Ngcuka, Under-Secretary-General of the United Nations and Executive Director of UN Women, and the current Chair of the UNAIDS Committee of Cosponsoring Organizations, who was, unfortunately, unable to be here as the Executive Board of UN Women is commencing.

I am honoured to speak on behalf of the cosponsors. Let me first say a word of appreciation to Michel for his strategic vision and tireless efforts in leading the Joint Programme. Through difficult times towards ending the AIDS epidemic by 2030, Michel, your personal dedication and commitment to achieving this goal are exemplary. As CCO we join you in conveying the message to the PCB that we are ready “to embrace the opportunity to shape the future” – the future which is going to be AIDS free.

I would also like to congratulate Ghana for its role as the PCB Chair and the United Kingdom as the Vice-Chair. We are certain that with your able leadership, the 40th PCB will reach its desired outcomes.

Let me pay tribute to our dear friend who was our brother-in-arms in fighting AIDS – Prof. Babatunde Osotimehin. In Babatunde’s passing, we lost a global advocate for the rights of women and young people. We send our deepest condolences to his family, friends, colleagues, UNAIDS family and all whose lives have been touched by his remarkable work.

I would like to acknowledge the outgoing members of the CCO – WHO Director-General, Dr Margaret Chan – and those who have already left: WFP Executive Director, Ms. Ertharin Cousin and UNDP Administrator, Ms. Helen Clark – all of whom contributed significantly to the progress we see today.

Let me extend a warm welcome to the incoming WHO Director-General, Dr Tedros Adhanom Ghebreyesus and UNDP Administrator, Mr Achim Steiner, as well as WFP’s Executive Director, Mr David Beasley, who join the UNAIDS family.

I would like also to express our heartfelt congratulations to Ms Jan Beagle as she assumes her next assignment as the United Nations Under-Secretary-General for Management. We acknowledge her significant contribution to the effective governance of the Secretariat as well as her generous efforts in coordinating the relationship with cosponsors.

I. Global challenges, HIV response and the 2030 Agenda opportunities

The world continues to face challenges to sustainable development, including conflict, the refugee and migrant crisis, and climate change adaptation and mitigation, among others.

Many of these challenges have a differentiated and disproportionate impact on women and girls.

Growing conservatism presents a serious risk to upholding human rights, particularly in relation to women's bodily autonomy and sexual and reproductive health and rights, which are critical in the context of fighting HIV and AIDS.

Humanitarian emergencies, exacerbated by hunger, widespread sexual violence, persistent gender inequalities and human rights violations drive new HIV infections and increase HIV-related vulnerabilities, particularly for women and girls and young people.

But the 2030 Agenda for Sustainable Development presents a huge new opportunity. These challenges are closely linked, which is why the 2030 Agenda calls for an integrated multi-sectoral inclusive approach. The cosponsors continue to play a major role: each of us have responsibility to support the implementation and achievement of the 2030 Agenda and its 17 Goals and 169 targets in an interrelated and synergetic way; each according to its comparative advantage and strength, bringing together and maximizing collaborative advantage and synergies. The Joint Programme presents a role model for taking forward.

The Joint Programme is a rare example of a coordinated, comprehensive and highly integrated response to a health and development issue across the entire UN system. Despite competing priorities and reduced resources, the Joint Programme remains highly committed to the vision of ending AIDS by 2030 and will continue to build synergies, maximize efficiencies, prioritize joint work and take AIDS out of isolation for more sustainable and impactful changes.

The opportunity of the SDGs means integrated responses across policies, strategies and programmes of work, with human rights, gender equality and women's empowerment prioritized and mainstreamed across the SDGs.

As we look back, the gains in the HIV response, including increase in access to treatment, and the decrease in mortality and morbidity, especially among children, are extraordinary.

But we are still far from closing the final chapter in ending AIDS.

- Over the last five years, new infections have not declined significantly and prevention programmes require critical investment.

- HIV prevention programmes are still limited in scale.

I express my full support to the Global Prevention Coalition that will undoubtedly reinvigorate our collective efforts to scale up prevention efforts.

To build stronger accountability and garner broad political support, we urgently need targets for prevention that are as ambitious as those for treatment.

We agree that there should be a right to prevention as much as there is a right to treatment and as we fast-track prevention and treatment we should – simultaneously and with the same level of determination – fast-track human rights and gender equality and women’s empowerment.

The numbers of new HIV infections tell us that we have not done enough for women, particularly for young women and adolescent girls.

- Globally, AIDS remains a leading cause of death among women of reproductive age.¹
- Every four minutes three young women become infected with HIV.²
- Globally, only 3 in every 10 adolescent girls and young women have comprehensive and accurate knowledge about HIV.³

When we look at gender equality and women’s empowerment dimensions, we must not forget that the 2030 Agenda has both emphasized the essential role of gender equality and women’s empowerment for sustainable development in all its dimensions and at the same time it has identified gender equality and women’s empowerment as a goal in itself. The HIV response must do the same.

Addressing the issue of comprehensive sexuality education is critical.

That is why I am pleased to announce that the Joint Programme is collaborating on the revised International Technical Guidance on Sexuality Education, which will be updated to reflect emerging evidence that sexuality education programs are up to five times more effective when they address gender and power. UNESCO and UN Women will jointly launch the guidance at the 2017 UN General Assembly.

To address the chronic under-investment in women and girls, UN Women has been advocating for transformative financing for gender equality and women’s empowerment in terms of scale, scope and quality.

Joining forces with our cosponsor partners and the Secretariat, UN Women will build on our expertise and leadership on financing for gender equality, including gender-responsive budgeting, and apply it to the HIV response.

¹ WHO Global Health Observatory: 10 leading causes of death in females.

http://www.who.int/gho/women_and_health/mortality/situation_trends_causes_death/en/

² UNAIDS 2017. When Women Lead Change Happens.

³ UNAIDS 2015. On the Fast-Track to end AIDS by 2030. Focus on location and population.

We must have a closer look at the root causes of new HIV infections among women. Understanding key structural and social drivers behind lack of power to negotiate safer sex, to have full control over their sexual lives, their bodily integrity, set out both in the Beijing Platform for Action and in SDG target 5.6 on universal access to sexual and reproductive health and reproductive rights, and to enjoy equal access to economic resources is essential to understand how to reduce new HIV infections among young women and adolescent girls to less than 100,000 per year.

In parallel, we need to focus on reaching men, both to improve their health-seeking behaviour and to support responsible actions for their own and their partners' health.

The role communities play in the HIV response is indispensable. And all of us cosponsors are involved in working and touching the lives of communities and supporting their agency. The networks of women living with HIV and care givers alliances remain significantly underfunded. Along with their essential work, the empowerment and leadership of women, particularly those living with HIV, require specific attention.

One area where the leadership of women has been notably improved is in the UNAIDS Secretariat itself.

I warmly commend the Secretariat on its efforts to meet the targets of the UN-SWAP on gender parity through the UNAIDS Gender Action Plan.

- 48% of the UNAIDS Country Directors are currently female. It is more than global average among the Resident Coordinators.
- And UNAIDS participation in the International Gender Champions initiative is an important example of supporting women's leadership.
- We congratulate the United Kingdom on taking up and all the member states for adopting the Decision Point and we hope you will progress beyond noting, beyond encouraging, towards actually being more deterministic about gender parity in the PCB. But I recognize that this is the first great step.

Bringing together the comparative advantages and unique mandates of 11 cosponsoring organizations, coordinated by the Secretariat, the Joint Programme, I want to assure you, is fit-for-purpose to implement the 2030 Agenda and aligns with the recommendations of the Quadrennial Comprehensive Policy Review resolution.

It is clear that when it comes to addressing the challenges of HIV we are stronger together.

II. CCO reflection on the refinement of the Joint Programme model

On behalf of the cosponsoring agencies, let me, once again, thank Michel and Helen for their leadership and strategic vision as co-conveners of the Global Review Panel and acknowledge the substantial input of the two Co-Chairs of the Panel: Honorable Dr. Awa Coll-Seck, Minister of Health, Republic of Senegal and Ambassador Lennarth Hjelmåker, Special Ambassador for Global Health, Sweden.

At the 43rd CCO meeting in April 2017, the Heads of Agencies welcomed the report of the Panel and collectively agreed on the next steps.

The annual minimum of US\$2 million per year for each cosponsor ensures a basic level of predictability and security. At the same time, we all must be cognizant of the impact of this decision and what can be realistically delivered for implementation of the 2016-2021 UNAIDS Strategy.

The financial shortfall has already led to a worrisome 25% drop in capacity among the cosponsors since 2015. Each one of us is contributing the maximum from our side in terms of our non-core to this work, but there is no way we can meet this gap or fill this gap. This gap will deepen to almost 40% by 2019 based on projections. This is a very grim scenario.

Ensuring a strong UNAIDS Secretariat is imperative. Equally, strong cosponsors with adequate capacity and ability to prioritize this are equally important to protect the integrity of the Joint Programme and deliver the UNAIDS Strategy.

We, therefore, call on all donors to rise to the challenge. Like others, I welcome Germany's announcement in terms of doubling its contribution and I am calling others to do likewise.

The CCO is fully committed to engage and collectively implement the joint resource mobilization strategy. We look now to the Board for the necessary political support for the additional resources required to meet our goals. Meanwhile, the Joint Programme must consider contingency plans in the event that resource mobilization targets are not fully met.

The focus on countries remains crucial. Country envelopes must have adequate emphasis on ending stigma, upholding human rights and promoting gender equality. Investments should also be made in non-Fast-Track countries, given the influence of structural and social drivers on the epidemic. Investments must be made to ensure prioritization of populations in greatest need particularly key populations.

The Joint Programme's Annual Peer Review engaged PCB members for the first time earlier this year, and we are pleased by the richness of the dialogue that took place. It is important to institutionalize this process to enhance sharing of results and accountability. Also, unique this year, the CCO Report includes Annexes that highlight priorities and results of the cosponsoring organizations and the collective efforts of the Joint Programme.

III. Conclusion

In conclusion, I would like to reiterate that the 2030 Agenda for Sustainable Development consolidates the efforts of the Joint Programme to collaborate across sectors and to invest at the intersections of HIV and other development challenges and opportunities.

Innovative and more efficient ways of mainstreaming HIV across all relevant SDGs will undoubtedly help to translate the ambitious commitments of the Political Declaration on HIV/AIDS and the UNAIDS Strategy into concrete actions and accountabilities and impact.

The drop in financing is not a good sign. It is indicating either that we have not done enough or HIV is no longer a global priority. And we are hearing from you that both of these are not so.

We should not relent. We must meet the 90-90-90 targets for treatment and achieve the ‘three zeros’: zero new HIV infections, zero AIDS-related deaths, and zero discrimination. With a sense of urgency, the CCO members believe we have come a long way, but we have miles to go. It could easily regress.

Despite challenges, we strongly recommit to the effective implementation of the Joint Programme and the Action Plan for further refinement of the Joint Programme operating model in line with the key priorities of the UN reform.

Only together will we win against AIDS and bring justice, gender equality and human rights to all, including the right to health.

Thank you.

ANNEX - Agencies Progress Reports

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)

UNHCR, the UN Refugee Agency, is a global organization dedicated to saving lives, protecting rights and building a better future for refugees, forcibly displaced communities and stateless people. UNHCR strives to ensure that all refugees are able to access life-saving and essential healthcare. This can include HIV prevention, protection and treatment, reproductive health services, food security and nutrition, and water, sanitation and hygiene services. Our dedicated staff works in 128 countries around the world, from major capitals to remote and often dangerous locations.

Ensuring universal access to HIV protection, prevention, care and treatment services as well as comprehensive integrated reproductive health services are key components of UNHCR Protection and assistance activities. UNHCR has been a cosponsor of UNAIDS since 2004 and is a partner of the Global Fund to Fight AIDS, Tuberculosis and Malaria in delivering HIV services in humanitarian contexts. UNHCR supports substantial HIV and related programmes in Africa, Asia, the Americas, the Middle East and parts of Europe.

A. UNHCR's Global Health Strategy: delivering within a framework of public health, protection and community development

UNHCR's HIV and reproductive health programmes are delivered within a framework of public health, protection and community development. The [UNHCR Global Strategy for Public Health 2014 - 2018](#) outlines UNHCR's key priorities for HIV and reproductive health programming at global, regional and country level.

Significant progress has been made in improving access to comprehensive HIV and reproductive health services in the past 5 years, particularly in terms of integrating refugees, IDPs and other populations affected by humanitarian emergencies into national health systems to improve access to HIV and reproductive health services.

Our teams at global, regional and country level will continue to work with communities to ensure populations affected by humanitarian emergencies are not left behind as we contribute towards achieving the targets set out in the SDGs and the UNAIDS 2016 -2021 strategy.

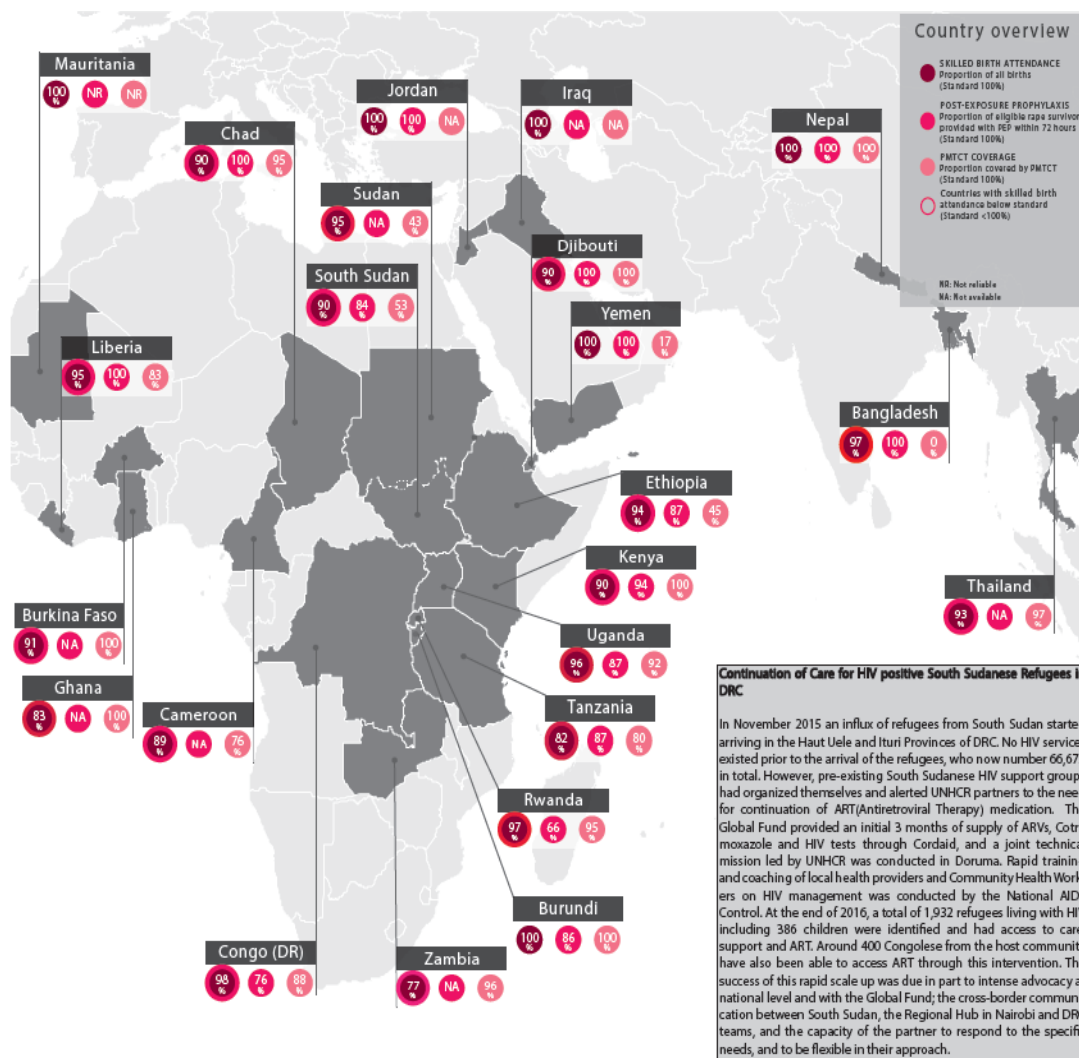
KEY PRIORITIES FOR HIV AND REPRODUCTIVE HEALTH **UNHCR PUBLIC HEALTH STRATEGY 2014 – 2018**

1. Reduce transmission of HIV using a protection and rights-based approach
2. Facilitate universal access to antiretroviral therapy
3. Facilitate the elimination of mother-to child transmission of HIV
4. Improve access to comprehensive reproductive, maternal and newborn health services

B. Highlights of results in 2016

UNHCR worked in over 48 countries to provide comprehensive integrated HIV and reproductive health services to our populations of concern. Annual reporting on all of our public health programmes at both global and country level, including reproductive health and HIV, can be found at <http://twine.unhcr.org/ar2016/>. Our data is collected through Twine, UNHCR's web based data platform which combines different streams of information to inform evidence based decision making in the humanitarian sector. Some of the key data and highlights of our achievements in 2016 include:

- **Expanded relationship with the Global Fund** – UNHCR has now strengthened its collaboration with the Global Fund to support HIV, TB and malaria services to populations affected by humanitarian emergencies in Africa and the Middle East.



• **Scaled up access to HIV treatment at the onset of humanitarian emergencies** – Increased access to ART has led to increased need for services for the continuation of HIV treatment in areas affected by emergencies. In 2016, the number of people living with HIV UNHCR supported to access HIV treatment increased by 65%.

• **Successful advocacy for the protection and human rights of people living with HIV in emergencies** – UNHCR promoted access to asylum procedures, protection from expulsion, arbitrary detention, unlawful restrictions on freedom of movement, including the right to return regardless of HIV status, and an end to mandatory testing for asylum seekers, refugees, internally displaced persons and other marginalized groups. In the South Governorate in Yemen, UNHCR, with UNAIDS and the National AIDS Programme, successfully advocated to end mandatory testing of refugees and asylum seekers in 2016 as part of asylum procedures, and refugees living with HIV are now able to successfully renew their ID cards. Meanwhile UNHCR supported services for the clinical management of sexual violence in 27 countries.

• **Improved data collection for evidence based decision making** – Data management was strengthened at field level for HIV and reproductive health indicators through the update of UNHCR's health information system. Standards and indicators were revised, along with the way data are collected, analysed and visualized, to improve quality and timeliness and enable evidence-based decision-making. HIV and reproductive health indicators have been aligned with Global AIDS Response Progress Reporting (GARPR) indicators.

• **Scaled up HIV prevention programmes with key populations and adolescents** - UNHCR collaborated with UNFPA to ensure populations of concern had improved access to HIV prevention services. In 2016, more than 9.6 million condoms were distributed in refugee camps and out-of-camp settings.

• UNHCR worked to increase national and local capacity to deliver integrated SRH services, especially for marginalized/vulnerable adolescents and young people as well as key populations in humanitarian settings. In 2016, UNHCR worked in DRC, Cameroon, Ethiopia, Ghana, Kenya, Rwanda, South Sudan and Zambia to provide youth-friendly HIV services to adolescents and young people in and out of camp.

• **Integration of HIV into Reproductive Health Services** - Reproductive healthcare continued to be a major focus. In 2016, 86 percent of surveyed country operations achieved the standard of at least 90 percent of deliveries occurring in health facilities, an improvement from 68 percent in 2014. The proportion of country operations which achieved more than 90 percent coverage of antenatal clients being offered HIV testing also increased to 57.3 percent in 2016, from 41 percent in 2015.

C. Case Study: Supporting populations living with HIV in Ukraine

Gesha and Anna Gvozd thought they were prepared for anything. Living with HIV, with a disabled son, they had battled for years to maintain their health and build a happy life with their three children. But when conflict broke out in their home town of Luhansk in 2014, their fragile world fell apart and they knew they would need to find somewhere safer to live.

Their main concern was the welfare of their sons: Gleb, 12, Ivan, 8, and Igor, 7. But Igor, who is

deaf and autistic, worried them the most. “We understood that we need to settle our kids at school,” said Gesha, 41, who tested positive for HIV in 1997. “But especially we were worrying about our youngest one, because he needs special care.”

The couple also understood the importance of looking after their own health. Gesha contracted HIV as a former drug user almost 20 years ago, and Anna was diagnosed during her second pregnancy. They knew that changing or stopping treatment could damage the immune system and increase the risk of infection.



And while Ukraine has one of the highest rates of HIV in Europe, discrimination is widespread. Getting the correct care in Luhansk had been difficult enough. Now internally displaced, and with the added stigma of HIV, the family had no idea where to turn.

For months, they lived with friends and at one point even stayed in a hotel with no heating. Today, thanks to friends, church groups and local journalists, the family live in a small apartment on an estate in Kiev. To their great relief, they were able to register as internally displaced persons and were issued with a document certifying their status, which gave them access to health care.

The conflict in eastern Ukraine has uprooted more than two million people, inside Ukraine and beyond its borders. About 500,000 people fled the fighting – one in four of the Luhansk region’s residents – many for Russia and others within Ukraine. In 2014, about 30 per cent of new HIV cases were registered in the Donetsk and Luhansk regions, according to the World Bank.

Since 2014, UNHCR has supported a project for displaced people with specific needs in the Luhansk region. UNHCR partners provided support to nearly 500 people living with HIV and at risk of HIV from non-government controlled areas and so-called ‘grey zones’ to enable access to medical services, social benefits and employment at their new place of residence. The project also conducted a series of information and prevention events at hospitals, schools and universities in the Luhansk region to reduce stigma towards people with HIV and increase their knowledge of how and where they can get help.

D. Knowledge products



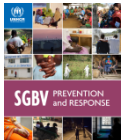
[UNHCR Public Health 2016 Annual Overview](#)

Key global and country level results in public health, HIV and reproductive health, nutrition and WASH



[2016 Toolkit on HIV and Emergencies in West Africa](#)

Practical guidance on preparedness, contingency planning and response



[UNHCR SGBV Prevention and Response Training Package](#)

A Training Package designed to help facilitators deliver introductory, interactive training on the prevention of and response to sexual and gender-based violence



[Cash based interventions for health programmes in refugee settings: A review](#)

A review of existing evidence and recommendations on cash interventions for health



[Improving newborn care in humanitarian settings](#)

Provides key recommendations coming out of a baseline assessment in newborn and neonatal care in humanitarian settings in Kenya, Jordan and South Sudan



[PMTCT in Humanitarian Settings – Part I: Lessons Learned and Recommendations](#)

Provides recommendations to staff implementing PMTCT services in humanitarian settings



[PMTCT in Humanitarian Settings – Part II: Implementation Guide](#)

Provides guidance on the implementation of PMTCT services in humanitarian settings



[Web story on Ukraine](#)

A web story highlighting the challenges faced by displaced populations living with HIV in Ukraine

THE UNITED NATIONS CHILDREN'S FUND (UNICEF)

UNICEF new HIV Programme Strategic Vision (2017-2021)

In 2016, UNICEF developed a new HIV Programme Strategic Vision that proposes a number of shifts in focus:

1. A differentiated response for country and programme prioritization:

- **Track and advocate** (63 or 50 per cent of countries): UNICEF country offices will analyse the status of 'the HIV epidemic and response' to advocate with partners to invest in addressing critical gaps.
- **Target** (27 or 22 per cent of countries): UNICEF will analyse and respond to the challenges and opportunities presented by variations in the functioning of health, protection, education and community to address inequities among marginalized groups or populations that are left out.
- **Intensify** (35 or 28 per cent of the countries): UNICEF will programmatically address issues of scale where epidemiologic evidence indicates the need for improved coverage, access and/or quality HIV services to support an appropriate public health response and meet global, regional and country goals.

2. Targeted integration with joint results and clear accountabilities. UNICEF's maternal and child health, protection and educational sectors will have clear, funded and monitored indicators to drive HIV efforts, and the HIV-specific programme will demonstrate and document their impacts on child survival, protection and education.

3. Intensified partner leveraging. Currently, nearly 85 per cent of global HIV financial investment is from domestic resources, PEPFAR and the Global Fund. UNICEF will engage these partners and others to leverage results for children.

4. Strengthened UNICEF leadership to facilitate ongoing learning through a learning collaborative. UNICEF will promote and support the generation and dissemination of programme evidence and experiences, including innovations to improve performance and quality as well as to sustain and accelerate the response.

A. Highlights of HIV programming results for children, adolescents and mothers in 2016

1. Preventing mother-to-child transmission of HIV: A Success Story

The Global Plan demonstrated that with political commitment and resources, remarkable progress in addressing HIV among women and children worldwide can be achieved. These results occurred as countries rapidly transitioned to the 'test and start' approach using the simplified 'one pill once a day' fixed-dose combination treatment delivered for life (known as Option B+). UNICEF and WHO continued to support countries to scale up the 'test and start' approach for pregnant and lactating women using the Option B+ regimen. In 2016, with support from Sweden and Norway, UNICEF continued to support strengthening of community facility linkages to improve early access to ANC and PMTCT services as well as retention of PMTCT mothers and their children in care in 4 countries (Cote d'Ivoire, DR Congo, Malawi and Uganda).

Findings from the evaluation of this project were shared and helped define national scale-up of

Option B+, including defaulter tracing, individual and group peer support, male engagement, longitudinal retention monitoring in many countries. Additional support, such as targeted food assistance also proved effective. Innovative communication strategies were used to expand outreach and return to care those clients lost to follow-up. Engaging with local organizations to improve the care-seeking environment through male partners and supporting access to community-based HIV testing and ART distribution also bolstered results.

In addition, UNICEF's ability to leverage often scarce or limited funding to achieve transformative change was praised in a 2016 independent evaluation of its engagement in PMTCT and paediatric HIV care and treatment programmes. UNICEF has played a critical role, with partners, in programme scale-up through its targeted advocacy and the provision of substantive financial and technical support to country-level partners. Such work has taken place across a broad range of areas, spanning policy development, programme planning, and support for knowledge-building activities. The evaluation found strong evidence of UNICEF's leadership on issues related to HIV in children, especially in programme areas. The evaluation concluded that UNICEF is seen as a 'trusted and reliable partner' in initiatives aimed at strengthening coordination at global and country levels.



Queen, 34, discovered she was HIV-positive when she was 26 years old, but thanks to a PMTCT programme, she gave birth to Neo, who is free of HIV. They live near Johannesburg, South Africa.

©UNICEF/South Africa/Scherbrucker/2014

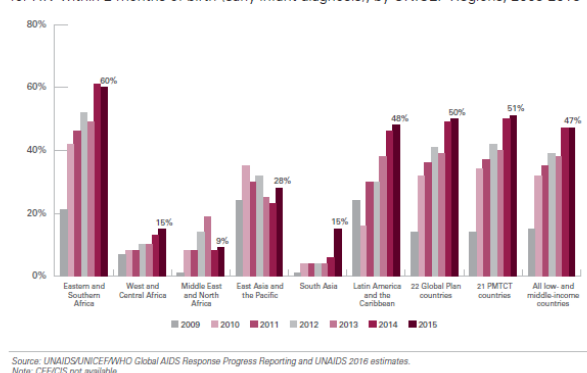
2. Leveraging Resources and Innovations for Paediatric HIV

Determining an early HIV diagnosis in infant and young child remains challenging as the test is mainly done using complex technology in a laboratory with available technical expertise and not at the point of service. Hence despite the need for immediate treatment in children with HIV to reduce HIV related mortality and increased investments in sample transportation systems, it often takes weeks, if not months, for HIV test results to get back to caregivers or their clinics. Gaps in early HIV diagnosis in children also occur in what is known as the 'final test'. This HIV antibody test should be administered to all HIV-exposed children at 18–24 months of age even if the child originally tested negative in the first few weeks of life, to ascertain the final HIV diagnosis. Hence many children with HIV are missed because of poor follow up and retention in care.

Comprehensive, ongoing case-finding efforts among infants and young children through provider initiated testing are therefore vital to improving HIV outcomes in children.

UNICEF work in many of the countries in 2016 prioritised early diagnosis in infants and young children using community and health platforms for timely linkage of sick children with HIV to life saving HIV treatment. Some of the interventions advanced with key partners such as USAID in 2016 included integration of HIV testing and treatment in platforms for community management of childhood illnesses and acute malnutrition as well as systematic follow up of mother baby pairs.

FIGURE 6
Percentage of infants born to pregnant women living with HIV receiving a virological test for HIV within 2 months of birth (early infant diagnosis), by UNICEF Regions, 2009-2015



Since 2012 and with support from UNITAID, UNICEF and CHAI (the Clinton Health Access Initiative) has been working with 7 countries in Eastern and Southern Africa to introduce point-of-care diagnostics. In 2016, through development of guidance and tools and expanded engagement of partners at global, regional and country levels, the seven countries (Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe) were supported to develop policies, regulatory frameworks and guidelines for integrating and placement of point of care platforms for early infant diagnosis and viral load within national HIV laboratory systems, building on lessons learnt from introducing point of care CD4 machines. Pilot studies were also conducted in Malawi and Mozambique and evidence of effective integration shared at international HIV conferences. A joint procurement plan was also developed under the leadership of UNICEF Supply Division to harmonise engagement with industry and pricing.

Progress made resulted in the UNITAID extension of the project to 3 additional countries: Cameroon, the Democratic Republic of the Congo and Senegal and for an additional 4 years. Efforts in the 10 project countries will focus on expanded and effective use of both early infant diagnosis and viral load platforms within strengthened national diagnostics systems.

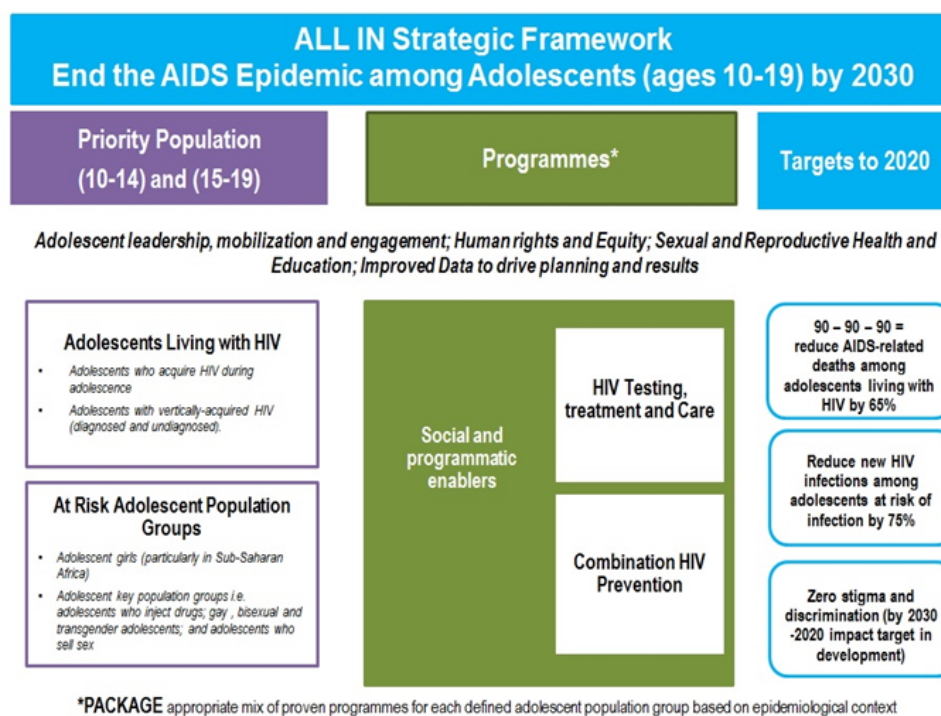
3. [All IN to #EndAdolescentAIDS](#): Galvanising Partnerships for Enhanced Adolescent HIV Responses

As part of efforts to reverse growing trends of new infections and deaths among adolescents aged 10 to 19, UNICEF has been providing critical global leadership. Since the launch of All IN framework (see chart below) by UNICEF and UNAIDS in 2015, UNICEF has prioritized programming for comprehensive HIV prevention, treatment and care among adolescents in all regions. Through this initiative, by the end of 2016, UNICEF and partners had supported 25 countries (out of which 24 are Fast Track countries) to undertake All IN data assessments to abstract adolescent data from different sectors to inform HIV programmes.

Through UNICEF's advocacy for multi-sectoral collaboration to reduce adolescent HIV risk and vulnerability as well as to improving health outcomes, the in-country All IN work galvanised engagement of multiple sectors including health, education, local government and social welfare, adolescent networks and civil society.

All IN strategic framework

Vision: **ZERO New Infections; ZERO Deaths; ZERO Discrimination**



The results from the All IN assessments in addition to identifying equity gaps improved awareness, increased engagement and fostered better coordination of stakeholders and provided a platform for adolescent participation.

B. A country case study

Real-time innovation to support South Africa in the 'last mile' to eliminate vertical transmission

South Africa has made tremendous gains in preventing mother-to-child transmission of HIV over the past decade. Most notably, the vertical transmission rate fell from 8 per cent in 2008 to 1.5 per cent as per programme data in 2015. That improvement contributed to a 79 per cent decline in the number of new infections among children, from an estimated 78,000 infections in 2004 to 16,000 infections in 2013.

Working closely with the National Department of Health, provincial health departments and the National Institute of Communicable Diseases, UNICEF led the conceptualization, design and roll-out of a tracking project supporting government efforts to obtain even better results. The project used RapidPro, a UNICEF-developed open-source platform of applications that can help governments deliver vital real-time information and connect communities to life-saving services.

Under the initiative, mobile technology is used to gather key information regarding each infant PCR positive laboratory test that will be analysed to identify localized gaps contributing to HIV transmission. Later, the collective data and information gathered can be used to design responses to address those gaps, targeting public resources more effectively.

The pilot project was implemented from May to September 2016 in three districts of KwaZulu-Natal, the South African province with the highest overall HIV prevalence. A total of 400 infants in those three districts tested HIV PCR-positive for the first time during the five-month period, and 367 (91.8 per cent) had data for analysis. Among the notable findings were that 60 per cent of mothers were first diagnosed prior to conception or at their first antenatal clinic visit. More than one third (37.3 per cent) transmitted despite receiving more than 12 weeks of ART, and of those, almost one half had been diagnosed before conception. A high share (70 per cent) of all women had no viral load result documented.

Overall, two thirds of mothers who transmitted HIV to their infants did so despite receiving PMTCT services. This highlights the critical need to improve services during antenatal care and to prevent post-partum infections. Moreover, the results suggest that the focus of maternal care needs to shift towards viral load monitoring and retention in treatment and care.

C. 2016 Publications



[Seventh Stocktaking Report on Children and AIDS](#)



[U-Report HIV poll results](#)



[Global Vision and Strategic Direction of UNICEF's HIV Response in the Next Strategic Plan, 2018-21](#)



[Long-Term Investment for Infants: Keys to a Successful Early Infant Male Circumcision Programme for HIV Prevention and Overall Child Care](#)



[Integration of HIV in child survival platforms: a novel programmatic pathway towards the 90 90 90 targets](#)



[Adolescent Under the Radar in the Asia Pacific Response](#)



[Report of the 2nd Regional Consultation on Fast-Tracking eMTCT and Pediatric ART in WCAR, Ndjamena](#)



[Series of policy briefs on social protection & adolescents](#)

WORLD FOOD PROGRAMME (WFP)

The World Food Programme (WFP) is the largest humanitarian agency tackling hunger worldwide. It has nearly 14 000 staff, who reach more than 80 million people with food assistance each year. WFP supports national and regional efforts to ensure food security for all, including the poorest and most vulnerable children, women and men. It works with a range of partners, such as governments, United Nations agencies, nongovernmental and international organizations, civil society and the private sector, to reach its goal.

As a UNAIDS Cosponsor, WFP shares the vision of achieving zero new HIV infections, zero discrimination and zero AIDS-related deaths. WFP's HIV work is focused on linking food and health systems for impact on HIV/AIDS. WFP maintains a holistic approach to HIV/AIDS programming, leveraging multiple context-appropriate entry points, including: food and nutrition support, social safety nets, technical support to governments and national partners, school meals, and supply chain and logistics support services. WFP is also mandated to co-lead in addressing HIV in humanitarian emergencies with the United Nations High Commissioner for Refugees (UNHCR).

A. Fit-for-purpose to deliver on Agenda 2030

In support of the 2030 Agenda, WFP is implementing a new and comprehensive architecture to re-align WFP's strategy, programme structure, financial management and reporting. This Integrated Roadmap with its Strategic Plan provides the overall framework for WFP's contribution to achieving zero hunger. It prioritizes two goals – SDG 2 on achieving zero hunger, and SDG 17 on partnering to support implementation of the 2030 Agenda. At the country level, Country Strategic Plans guide WFP's strategic, programmatic and governance directions.

WFP's work in HIV is guided by the WFP HIV policy and the UNAIDS Strategy 2016-2021. WFP addresses HIV through multiple entry points linked to SDG 2 and SDG 17, leveraging its expertise in emergency responses, social protection, supply chain, nutrition, adolescents and young people. WFP also provides technical support and advises governments on integrating food security within national HIV and TB efforts and supports building national capacity. In addition to national governments, WFP works with a range of partners at country, regional and global level, including UN agencies, non-governmental organizations, academia and private sector.

B. Highlights of results in 2016

1. *El Niño and other emergency responses*

WFP categorized the situation in the Southern Africa as a Level 3 Emergency in 2016. Intense El Niño conditions, coupled with multi-year drought, led to a food security crisis that impacted an estimated 40 million people. PLHIV are particularly vulnerable to food insecurity and malnutrition. Food/economic insecurity can pressure households into harmful coping strategies, which drives new infections. In response WFP collected data and developed an Advocacy Brief to share with the Special Envoys on El Niño and Climate and donors; worked with partners to

include HIV responses in SOPs for climate related emergencies; formed the IATT sub-working group on the El Niño Emergency; joined an OCHA-led group to lobby for HIV responses and engaged with PEPFAR. The substantial advocacy efforts at global and regional level in southern Africa resulted in a PEPFAR grant of approximately USD 24 million to address the impacts of El Niño related food insecurity in five countries – Zimbabwe, Malawi, Mozambique, Swaziland and Lesotho. With these funds WFP plans to reach over 225,216 food insecure and malnourished beneficiaries.

This work, which will continue in 2017, focuses on management of acute malnutrition (SAM/MAM) in PLHIV through existing Nutrition Assessment, Counselling and Support (NACS) programs. Additional elements of the response included the procurement /supply chain management of specialized nutritious food, provision of technical assistance to Ministries of Health, and data collection.

In other humanitarian contexts, WFP ensured that food security and related needs were adequately addressed among displaced, refugee and other emergency affected populations. In many food insecure contexts, including the Democratic Republic of the Congo, Lesotho and Ukraine, WFP helped malnourished and/or food-insecure people on ART; in Côte d'Ivoire, WFP's assistance to more than 6000 people improved the nutritional status of those receiving ART, resulting in treatment adherence estimated at 99%.

2. Social protection and safety nets

WFP empowered people living with HIV through its HIV-sensitive social protection programmes at country level. It assisted governments to design, operationalize and evaluate cost-effective food security sensitive safety nets for PLHIV and other vulnerable populations, including in fragile and challenging operational contexts.

For example in Ethiopia, WFP has worked with PEPFAR to provide social safety nets and economic strengthening services and nutritional assessment, counselling and support (NACS), to PLHIV, OVC and PMTCT clients. Engagement in economic strengthening activities has proven to be a robust predictor of improved retention to HIV care, adherence to ART, access to health services and health related quality of life.

In El Niño-affected countries, WFP supported people living with HIV/TB and their families to compensate for the loss of income-earning potential. For example, in Zimbabwe, WFP food assistance reached more than one million beneficiaries, including orphans and vulnerable children and people living with HIV.

WFP targeted children and adolescents through its school meals, which drove school attendance in a number of countries (2015: 17.4 million children in 62 countries), including South Sudan, where over 200,000 children were reached through WFP's Food for Education programme in 2016. The primary objectives of these programmes are not HIV/AIDS per se, but to alleviate short-term hunger, increase retention and enrolment and enables students to stay in school in order to improve educational outcomes. But, by staying in school longer, young people are less exposed to violence, alcohol, substance abuse, unprotected sex, sexual abuse, early pregnancy, HIV and STIs.

3. Supply chain partnerships for HIV and health impact

Given WFP's logistics expertise, deep field presence, and history of providing logistics support to Global Fund (GFATM) grants, WFP and the GFATM signed a MoU for a logistics partnership in 2014. This partnership has enabled improved access to HIV and other health related commodities, especially during emergencies, through the use of WFP's deep field supply chain networks. WFP is working with Global Fund implementing partners – including UNDP in Zimbabwe and Chad, UNFPA in Yemen and the Partnership for Supply Chain Management in Burundi – to prevent stockouts of HIV treatment and prevention supplies and health commodities. These supply chain partnerships are ideal examples of working towards SDG 17 and illustrate how WFP's supply chain can be leveraged for HIV- and health-related impacts. They also reflect the “New Way of Working” and delivering as one UN in action. In 2017 WFP hopes to expand these partnerships in order to reach the last mile and ensure commodities and medicines reach the most vulnerable.

C. Case study

Strong winds, severe dry spells, droughts, erratic rainfall patterns – either delayed rains or intense rains followed by flash floods – pose a significant challenge to smallholder farmers across Malawi.

Jelita, an elderly subsistence farmer in Lilongwe, Malawi, became the primary caregiver to five of her grandchildren after Jelita's youngest daughter and husband died of AIDS related causes. Jelita's daughter died only a month after delivering her fifth child.

Before the start of each agricultural season, Jelita plants maize, soy beans and vegetables with the hopes of growing enough food to support her family through to the next harvest. In a normal season, Jelita harvests about twenty 50kg bags of crops, enough to cover the family for the whole year. Due to drought last year she only harvested six 50kg bags, which was not enough to sustain her family through to the next harvest.



“Since 2013, we noticed that our maize harvest has been gradually declining both in terms of quantity and quality for each passing year because of the dry spells. Last year we did not receive good rains and our maize wilted. As a result, we harvested six bags of maize, which lasted for four months only. Since October last year, we have been depending on casual labor and gifts from relatives for our daily food. We often eat only one meal per day and sometimes sleep without eating. Thanks to WFP and its NGO partner, the International Committee for the Development of People (CISP), from January 2016 we have been receiving food assistance and now we are living a normal life,” says Jelita.

In response to the prevailing food insecurity resulting from the impact of both floods and drought in early 2015, with lower than expected crop production, WFP and the Government of Malawi are providing food assistance to roughly 2.8 million affected people across 25 districts, including

Lilongwe, where Jelita resides.

The response package includes i) a food basket consisting of cereals, pulses, vegetable cooking oil and fortified blended food known as Super Cereal Plus for children under the age of two, and pregnant/breastfeeding women, or equivalent cash-transfers to buy the food items in order to support immediate needs, and ii) complementary activities like irrigation farming, afforestation, drought resistant crop production and village savings and loans to restore the livelihoods and strengthen household and community resilience in the medium to long term. CISP is also promoting village savings and loans as one of the complementary activities, Jelita being one of the recipients.

“Through our group savings, I took a loan of about MK 50,000 (USD 72) and started a small business selling farm produce and small dried fish. Thanks to the initiative, I sell beans and fish which give me some money to support my family. I am very thankful to CISP and WFP for this initiative, which will help reduce hunger.”

D. Highlights knowledge products produced in 2016



[El Niño emergency – a challenge to end AIDS by 2030? Time to act!](#)

Advocacy brief produced by the IATT on HIV in Emergency Contexts

Assessing the return on investment of a food-based intervention for patients initiating antiretroviral therapy in Eastern and Southern Africa – research paper in collaboration with London School of Hygiene and Tropical Medicine – to be finalized in 2017



Ending AIDS by 2030: Partnerships and Linkages with SDG 2 – chapter in the book Nutrition and Health in a Developing World, published January 2017

E. Way forward

In 2017, WFP will continue its efforts to address the needs of food insecure PLHIV and vulnerable people through leveraging its multiple context-appropriate entry points. In the current funding environment, its focus will increasingly be in UNAIDS Fast Track countries as well as emergency affected countries, where programmes to address the needs of emergency affected populations are in place.

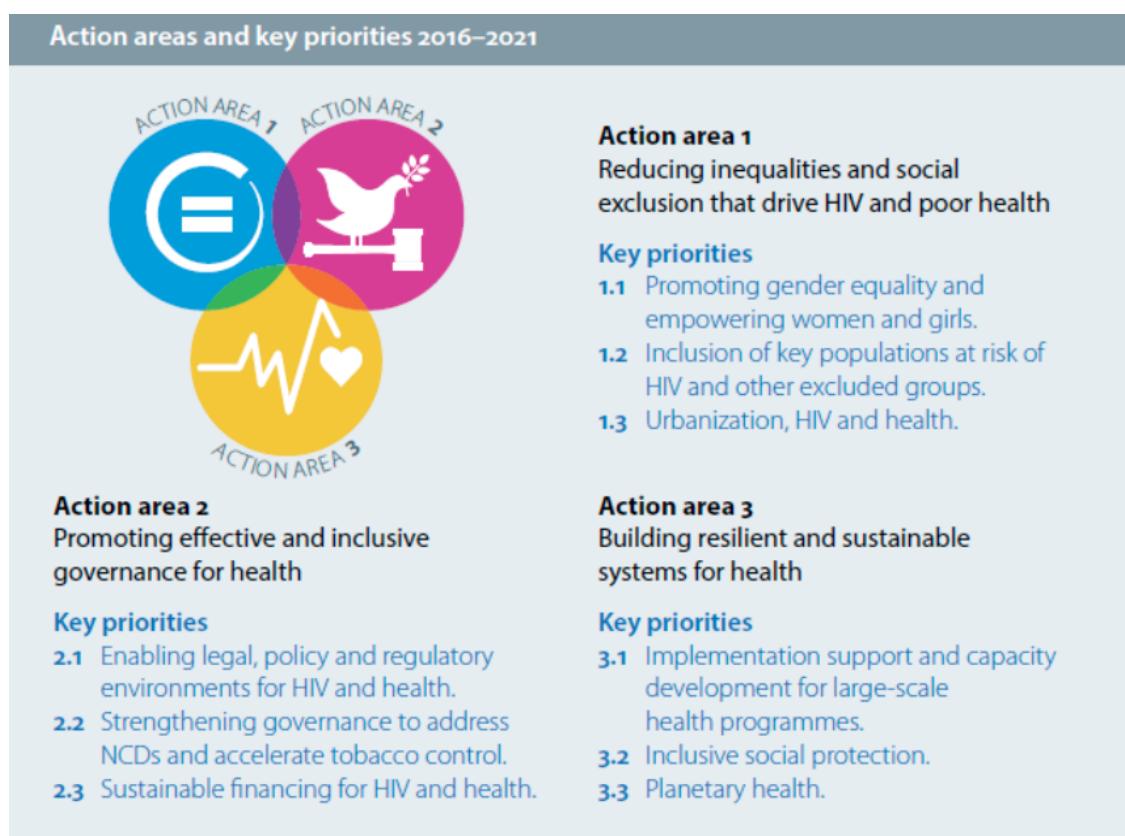
Across the world, a record 70 million people are estimated to need emergency food assistance in 2017. Of particular concern is the drought in the Horn of Africa. Over 11.1 million people in Kenya, Ethiopia and Somalia currently require emergency food assistance. Initial reports from the region indicate that PLHIV have been particularly hard hit and this has led to increases in malnutrition and to PLHIV dropping out of treatment. WFP will continue to scale up its response in the region (funding permitted) and target vulnerable and malnourished PLHIV with food and nutrition support and cash based transfers, while at the same time advocating for further resources to meet the unprecedented needs.

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

A. Fit-for-purpose to deliver on Agenda 2030

UNDP's work in HIV and health is guided by the 2030 Agenda for Sustainable Development, and the [UNDP Strategic Plan 2014-2017](#) and the [HIV, Health and Development Strategy Note 2016-2021: *Connecting the Dots*](#). The strategy, which contributes to UNDP's vision of eradicating poverty and reducing inequalities and exclusion, is also in line with the strategies of key partners such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund and WHO.

As a development agency, UNDP focuses on addressing the social, economic and environmental determinants of health, which are primarily responsible for health inequalities. An integrated team operating at global, regional and country levels undertake UNDP's work in HIV and other areas of health. The work falls within three inter-connected areas of action:



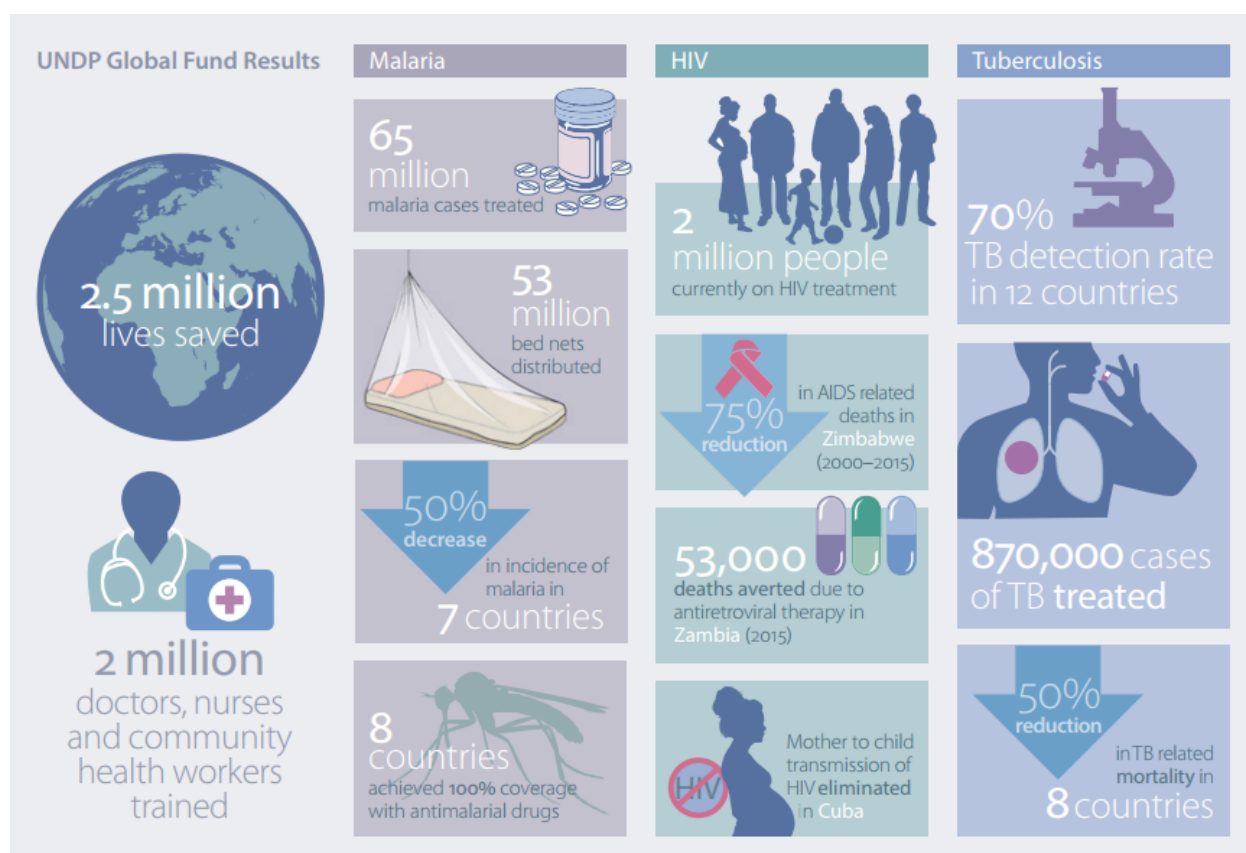
The UNDP Bureau for Policy and Programming Support (BPPS) has established a SDG Technical Support Team to support countries in the roll-out of the 2030 Agenda. In 2016, the team has supported nine countries missions, with another 40 scheduled for 2017. The HIV, health and Development Group has been supporting the country missions by providing an analysis of the HIV and health situation in-country and identifying strategic opportunities for inclusion of HIV and health issues in the country roadmaps that are being developed.

UNDP has also developed a prospectus on SDG 3 (ensuring healthy lives for all) that outlines our service offerings—an integrated package of policy and programme support services— part of a compendium of resources to support SDG implementation.

B. Highlights of results in 2016

1. UNDP-Global Fund partnership

UNDP plays a special role in the partnership with the Global Fund supporting the implementation of Global Fund programmes on an interim basis in a select number of countries facing significant capacity constraints, complex emergencies, donor sanctions or other difficult circumstances. The Global Fund resources managed by UNDP reflected in the UBRAF are non-flexible and contribute to the achievements of UBRAF outputs at the country level as well as outcomes and targets in the UNAIDS Strategy. In addition to the traditional interim Principal Recipient role, UNDP is also providing support to a number of countries with a range of other health implementation support services related to the Global Fund programmes from core UBRAF resources and restricted AIDS funds. This includes: support to management of funding for 15 Country Coordinating Mechanisms and 1 regional oversight mechanism, and support services to governments managing Global Fund grants.



2. Being LGBT

The 'Being LGBTI in Asia' initiative endeavours to address inequalities, violence and discrimination as a result of sexual orientation, gender identity or intersex status and it promotes universal access to health and services for the LGBTI community. The programme is implemented in partnership with the Embassy of Sweden (Thailand), USAID, United Nations Educational, Scientific and Cultural Organization (UNESCO), International Labour Organization (ILO), United Nations Human Rights Office of the High Commissioner (OHCHR) and the Asia Pacific Forum (APF). The programme conducted a multi-country study on the state of LGBTI rights in the region. It engaged with 130 government departments, 357 civil society groups, 17 national human rights institutions and 88 private sector organizations across 33 countries in policy dialogue. The study will contribute to the improvement of LGBTI inclusion in development.

Following on the success of 'Being LGBTI in Asia' UNDP supported the development of similar programmes in 14 countries in Africa and in Eastern Europe. In Africa, the programme titled "Sexual Orientation, Gender Identity and Rights in Africa", is supported by USAID and implemented together with OHCHR. It aims to enhance the knowledge, partnerships and capacities of communities, civil society and states to reduce human rights violations and negative attitudes towards the LGBTI community across Africa. "Being LGBTI in Eastern Europe" is financially supported by USAID. It aims to reduce the inequalities and exclusions experienced by LGBTI people in Albania, Bosnia and Herzegovina, Macedonia and Serbia, by strengthening the evidence base, developing advocacy approaches and instruments and facilitating dialogues between national decision making bodies and LGBTI civil society organizations.

3. Global Commission on HIV and the Law

The report of the Global Commission on HIV and the law, published in 2012, continues to provide an important framework for on-going efforts by the UN and civil society to promote a rights-based response to the HIV epidemic at country level. For example, under the leadership of UNDP, UNAIDS Cosponsors and the Secretariat worked with governments and civil society to conduct national dialogues in 62 countries on the legal and policy barriers to HIV services for people living with HIV and key populations. Following-up on the recommendations of the Global Commission and in partnership with governments and civil society, UNDP conducted legal and policy environment assessments (LEAs) to determine the nature and extent of legal barriers to accessing HIV services for people living with HIV and key populations. The LEAs have been completed and validated in 52 countries. The follow-up to the LEAs brought about a number of positive results. For instance, in 2016 the National Assembly in Seychelles voted to decriminalize the activities of men who have sex with men by removing the related section (Section 151) from its penal code; the Ghana AIDS Commission Bill which stipulates among other things strengthening the legal backing of the AIDS Commission, the establishment of an AIDS fund and the inclusion of anti-stigma provisions, was passed into law by the Ghanaian Parliament. In the Democratic Republic of Congo criminalization of HIV transmission was removed and approved by Parliament. In the Arab States, UNDP collaborated with IDLO to

establish a Middle East Network for Legal Aid to support civil society organizations that provide legal aid to key populations and people living with HIV. In support of the Global Fund HIV grant in Panama, UNDP conducted human rights training for health care providers, correctional services and civil society.

C. Case Study

Case Study: Adiba, the female nurse bringing critical care to underserved communities



This is Adida, she is training to be a nurse in a country where most women haven't finished primary school. Nurses are hard to find in Adida's home village in rural Nuristan Province in eastern Afghanistan. In this isolated region, health facilities are limited and security concerns prevent many trained healthcare professionals from working in the area. A lack of health facilities in rural areas of Afghanistan, combined with a scarcity of female health workers, means that many women do not receive the healthcare they desperately need. According to WHO, around 40 percent of health facilities in Afghanistan are without female staff, a significant problem in a country where community norms often mean that women are not allowed to receive care from male health workers. But women like Adida are set to change this situation. Along with 200 classmates, she will graduate from nursing school this year and will go to work in some of the poorest villages in her home province. Set up by the Afghan Ministry of Public Health with support from UNDP and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the school is training a new generation of female healthcare workers.

D. Highlights of knowledge products produced in 2016



[HIV, Health and Development Strategy Note 2016-2021: *Connecting the Dots*](#) elaborates UNDP's work on HIV and health in the context of the 2030 Agenda for Sustainable Development.



[Checklist for Integrating Gender into the Processes and Mechanisms of the Global Fund to Fight AIDS, TB and Malaria](#) – Contributes to the evidence base required to make a strong investment case for increased gender-sensitive interventions in all three diseases.



[Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for collaborative interventions](#) – Part of the Joint Programme key populations tools offering advice on implementing HIV and sexually transmitted infection programmes for sex workers, men who have sex with men, transgender people, and people who inject drugs.



[Investing in a Research Revolution for LGBTI Inclusion](#) - Joint UNDP-World Bank discussion paper on critical research and knowledge gaps with regard to human rights and inclusion for LGBTI people to ensure that they are included in development agendas.



[United Nations Secretary-General's High-Level Panel on Access to Medicines report](#) - the report provides recommendations for remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies.



[UNDP Partnership with the Global Fund | Annual Report](#) – the annual report highlights the achievements of the partnership, and its work to respond to HIV, TB and malaria in challenging contexts.



www.UNDP-GlobalFund-CapacityDevelopment.org - online resource on Global Fund capacity development, transition, and strengthening legal and policy environments.



[Reflections on Drug Policy and its Impact on Human Development: Innovative Approaches.](#)



[Guidelines for the examination of patent applications relating to pharmaceuticals](#) - guidance for countries to enhance the functioning and transparency of the patent system for access to affordable lifesaving treatment.



[UNDP and WHO policy briefs: Health promotion in the Sustainable Development Goals](#) – a set of four policy briefs to discuss how aspects of health promotion – healthy cities, action across sectors, social mobilization, and health literacy – can support 'win-wins' for health and sustainable development in the context of Agenda 2030.

E. Looking ahead to 2017

In light of the shifting trends in HIV and health financing for low-and middle-income countries, the financial situation of UNAIDS and the opportunities and challenges presented by the 2030 Agenda, the HHD Group undertook a strategic review and realignment exercise in the latter part of 2016. With an eye on gender parity, a more efficient and sustainable structure now in place, we will be even more strongly positioned to: (1) provide policy and programme support consistent with the vision, values, goals and targets of the 2030 Agenda including the commitment to leave no one behind, (2) do more cross-team, cross-regional and South-South work, (3) continue strengthening linkages between the policy work and our Global Fund partnership, (4) increase our focus on previously underserved regions and UNAIDS Fast Track countries, (5) strengthen linkages between UNDP's HIV/health, gender, fragility, DRR/crisis and environment work and (6) expand our work and partnerships on leaving no one behind, including increasing the evidence base on high impact integrated approaches for addressing the social and economic determinants of HIV and health.

UNITED NATIONS POPULATION FUND (UNFPA)

UNFPA strives to deliver a world in which every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled. Working on the ground in some 150 countries, UNFPA expands the possibilities for women and young people to lead healthy and productive lives.

Addressing HIV is integral to UNFPA's goals of achieving universal access to sexual and reproductive health, and realizing human rights and gender equality. UNFPA promotes integrated HIV and sexual and reproductive health services for young people, key populations, and women and girls, including people living with HIV. UNFPA also supports the empowerment of people to claim their human rights and to access the information and services they need. UNFPA's work on HIV engages and empowers all the communities it is mandated to serve.

A. An integrated approach to HIV and sexual and reproductive health (SRH)

UNFPA supports countries as they work towards achieving the sustainable development goals within Agenda 2030. Guided by UNFPA's Strategic Plan 2014-2017, UNFPA assists countries to deliver integrated sexual and reproductive health and rights, including HIV services free of stigma and discrimination. UNFPA's work on HIV at global, regional and country levels covers three integrated areas of SRH/HIV programming:
















UNFPA Integrated HIV/SRH Approach



B. Highlights of results in 2016

UNFPA has achieved a variety of SRH, HIV and gender-related results during the first three years of our current strategic plan cycle (see below Figure). Reductions have occurred in maternal deaths – including AIDS-related deaths, unplanned pregnancies, female genital cutting as well as reducing transmission of HIV and other sexually transmitted infections. Improvements in SRH services have increased access to family planning, antenatal care, trained birth attendance and adolescent SRH services, including for HIV/STIs.

Key results achieved during 2014-2016

 93,000 maternal deaths averted*	 113 million couples protected for one year from unwanted pregnancies*	 35 million unintended pregnancies prevented*	 11 million unsafe abortions prevented*	 54 million users of family planning*
 39,217 fistula repair surgeries supported**	 8.2 million pregnancies and deliveries assisted by 23,500 UNFPA-supported midwives****	 33.4 million adolescents provided with integrated sexual and reproductive health services**	 272,000 girls saved from female genital mutilation***	 \$884 million direct health-care costs avoided by providing contraceptives*
 Over 16 million women and girls in humanitarian crises reached with sexual and reproductive health services and services to prevent gender-based violence**	 903 maternity tents or homes operationalized in humanitarian settings****	 1,232 mobile clinics provided in humanitarian settings***	 915 safe spaces supported in humanitarian settings***	 188,498 new HIV infections and 8.3 million sexually transmitted infections prevented through provision of 16.5 million female and 1,024 million male condoms****

*Estimates using Marie Stopes International and USAID models.
 **UNFPA country reports (2014-2016)
 ***UNFPA country reports (2015-2016)
 ****UNFPA estimates

1. Working with young people and adolescents

UNFPA has supported diverse programmes empowering young people and ensuring provision of services for them. From 2013 to 2016 the number of countries with laws and policies that enable adolescents to exercise their rights increased from 74 in 2013 to 100 in 2016. Thirty two countries made commitments in 2016 to prioritise adolescent health, including improving reproductive, maternal, newborn and child health, and 94 countries had participatory platforms in place that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes. In 2016, fifty-five countries had in place social and economic programmes, empowering adolescent girls to increase their economic autonomy and asset building skills, thus reducing their risk of child marriage.

Between 2014–2016, 33.4 million adolescents were provided with integrated SRH/HIV services. Through provision of male and female condoms, over 188,000 HIV infections and 8.3 million sexually transmitted infections were prevented. During 2016, UNFPA distributed 9.7 million female condoms, 403 million male condoms, together with 13 million sachets of personal lubricant – to prevent condom breakage and reduce genital trauma. UNFPA prequalified 30 male and four female condom manufacturers for provision of international quality standard condoms to member states.

Together with UNESCO and other partners, UNFPA supported comprehensive sexuality education (CSE) across programme countries with the goal of safeguarding the health and well-being of adolescents and youth. Eighty-one countries provided CSE aligned with international standards within their school curricula. At the global level, a CSE Advocacy Hub was developed to share online tools and promote inclusion of young people in social movements and high level platforms, especially marginalized young people. A high level meeting was conducted by UNFPA's Eastern and Southern Africa Office in collaboration with the Southern African Development Community (SADC) Parliamentary Forum and UNESCO. The meeting built capacity of 40 SADC parliamentarians on the ESA Commitment to scale up CSE and SRH for young people so they advocate for the harmonization of laws and policies in their respective countries. Also in ESA region, "iCAN" - a regional CSE resource package, was finalised with SAfAIDS, for young people living with HIV and out-of-school youth. These resources were further tailored and adapted for use in Lesotho, Namibia and Zambia. In Cambodia, a draft health education syllabus including CSE is undergoing ministerial review, and a multi-media initiative "Love9" reached 1.7 million youth, increasing knowledge on HIV/STIs, contraceptives and where to access health services. In 8 ESA countries, the "Safeguard Young People" Programme reached over 586,000 young people with SBCC/CSE programmes, and nearly 350,000 young people with ASRH services. Nearly 37 million condoms were distributed. Seven ESA countries mapped geographic "hot spots" – geographical concentrations of young populations and schools, to better focus prevention campaigns.

UNFPA also supported "TuneMe", a youth engagement platform to increase access to adolescent SRH and rights information in Botswana, Malawi, Zimbabwe, Swaziland and Namibia. In collaboration with Youth Union in Vietnam, UNFPA supported six youth-led initiatives to deliver SRH and HIV information to vulnerable youths. In Swaziland, UNFPA supported youth serving and youth-led interventions to reach 60,000 young people with integrated SRHR/GBV/HIV information and services in 60 communities including via mobile outreach and social media.

Throughout 2016, UNFPA worked with adolescents and young people to ensure their meaningful

participation in high level global events: the High Level Meeting on HIV/AIDS; a youth pre-conference at the 2016 International AIDS Conference; UNFPA/SG's Envoy on Youth' meeting on *"Measuring the state of youth in the SDGs: tracking global indicators relevant to youth development and well-being"*, and others.

2. Working with key populations at-risk of HIV

Since 2014 UNFPA has supported and built the capacity of sex worker-led civil society organizations (CSOs) in 47 countries in governance, project management, advocacy and providing HIV and STI services for sex workers. Specific examples in 2016 include technical support to training of sex worker trainers from eight African countries on condom programming with the Sex Worker Academy Africa as well as a similar model in Indonesia for local sex worker trainers. UNFPA supported HIV/STI programmes working with migrant and cross-border sex workers, and mobile clients in China, Kenya and Ukraine, among others. In 2016, 54 UNFPA country offices reported implementation of condom programming, including for key populations.

Capacity was built on utilizing HIV programming implementation tools for sex workers and for men who have sex with men in 15 UNFPA ESA field offices. For example, in Kenya, an integrated package of HIV and SRH care for sex workers and their clients enabled more than 4,500 female sex workers and 500 clients to access services in Kilifi County. More than 1 million male condoms, 10,000 female condoms and 14,000 lubricant sachets were distributed. In Uganda, key population HIV and SRH services were developed through the Fast-Track Cities initiative, with 60,000 members of key population groups accessing them. Sensitization of police officers in Malawi reduced wrongful arrests of sex workers by 80% in 2016 compared to 2015. In Harare, a 24-hour clinic was set up to provide integrated services for sex workers and other key populations who have experienced sexual assault and other violence. In Botswana, UNFPA's partnership with a CSO representing LGBT people, linked these key populations to care through people-focused, non-stigmatising health facilities.

In the EECA region, UNFPA continued to support and strengthen capacities of key population CSOs including the Eurasian Coalition on Male Health's successful Global Fund regional proposal. UNFPA supported translation of the sex worker and MSM implementation tools into Russian and 5 further local languages, circulating copies to in-country partners and supporting trainings to build CSO capacity in use of the tools. Tajikistan provided STI services to 6,668 MSM and 5,596 sex workers. In Sudan UNFPA helped train 150 NGO staff members in use of the sex workers and MSM tools. These outreach and peer educators reached 62,000 sex workers and 47,650 men who have sex with men, of whom 10,556 and 6,337 received HIV testing services respectively.

UNFPA Asia-Pacific regional office developed an [online key population resource](#) (the Connect Effect) to share information on key population SRH/HIV programmes. Several countries empowered sex worker organizations and provided HIV/SRH services. In the Philippines, 3,100 female entertainment workers were reached with family planning services and 1,700 provided with information on HIV, family planning and GBV. In Pakistan, UNFPA supported HIV/family planning services for sex workers with information for more than 1,000 sex workers and 576 attending SRH clinics. In Mongolia, 58,000 mobile persons and 3,000 sex workers were reached with HIV/STI services, reducing syphilis infection rate in sex workers by two thirds, down to 10 per 10,000.

3. Integrating SRH and HIV including elimination of mother to child transmission

In 2016, UNFPA continued to provide technical and financial support to regions and countries to promote the integration and linkages of SRH/HIV policies, programmes, services and advocacy. Through a GF grant, UNFPA supported ten ESA countries in provision of integrated SRH-GBV-HIV/STI and TB services, including HIV test-and-treat referral. UNFPA supported 13 countries in compiling infographic snapshots detailing SRH and HIV linkages – summarizing progress in mainstreaming HIV within broader SRH services and identify opportunities for further linkages.

UNFPA provided input to the GF technical brief on reproductive, maternal, neonatal, child and adolescent health, ensuring a comprehensive approach and inclusion of elimination of mother-to-child transmission services (EMTCT). UNFPA supported strengthening of SRH services within Global Fund proposals and implementation in 14 priority countries, progressing toward EMTCT including family planning, condom programming, and STI management including eliminating neonatal syphilis. UNFPA completed a job aid to guide the delivery of comprehensive EMTCT services.

The Global Programme to End Child Marriage was supported in 15 countries, reaching 65,000 girls with SRH knowledge and services. Integration with gender based violence programmes also continued, with 90 countries having GBV prevention, protection and response integrated into national SRH programmes. Forty seven countries engaged men and boys, promoting gender equality, involvement in SRH and HIV/STI prevention. Within humanitarian settings, 83 per cent of countries experiencing emergencies had in place an inter-agency coordinating body to respond to GBV. Over 16 million women and girls in humanitarian crises were reached with SRH and GBV services.

In collaboration with the University of Pretoria, a comprehensive analysis was completed of laws and policies affecting ASRHR in 23 countries across ESA region, aiming to harmonize legislation. This was validated by key stakeholders for subsequent adoption by SADC and EAC. A high level meeting was conducted by UNFPA's ESA Office to present findings of the laws and policy review, share a new Regional Legal Framework and develop a road map for its adoption.

In Latin America, UNFPA, UNAIDS, UNICEF and UNDP jointly completed a regional study of laws and policies affecting youth and adolescents' access to SRH/HIV services. The study has been an important tool for informing evidence-based advocacy.

C. Case study

UNFPA worked with UNAIDS and the World Bank to successfully advocate for revitalized political commitment for HIV prevention in East and Southern Africa. Working closely with the Minister of Health of Zimbabwe – a regional champion on prevention, the UN held two advocacy forums with Ministers of Health and senior officials. Political leaders committed to reinvigorating HIV prevention through implementation of a comprehensive combination prevention agenda. ESA Ministers of Health also committed to increasing funding for HIV prevention from both domestic and development assistance, agreeing to align their prevention targets with global targets within the 2016 Political Declaration on ending AIDS. Within this enhanced supportive political environment, UNFPA, USAID and the Reproductive Health Supplies Coalition have begun scale-up of condom

supply to reach the HLM target of 20 billion male and female condoms in low- and middle-income countries by 2020. Working with commercial condom manufacturers, public sector donors, representatives of government, and non-government and multilateral organizations, a multi-sector coalition has been formed – Africa Beyond Condom Donation. Progress was made in 2016, including market and willingness-to-pay studies, due for completion in early 2017. At country level, there have been high-level consultations to create a supportive environment for this increased involvement of the private sector.

D. Key knowledge products produced in 2016



Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for collaborative interventions - tools offering advice on implementing HIV and sexually transmitted infection programmes for sex workers, men who have sex with men and transgender people.

The Connect Effect. Online resource in Asia Pacific region, for sharing key population guidance and South-South exchange of country programming examples

Paper: Kiragu K, Collins L, Von Zinkernagel D et al. Integrating PMTCT into maternal, newborn, and child health and related services: experiences from the global plan priority countries. *J Acquir Immune Defic Syndr.* 2017 May 1;75 Suppl 1:S36-S42. doi: 10.1097/QAI.0000000000001323.
<https://www.ncbi.nlm.nih.gov/pubmed/28398995>

Paper: Wolf C, Adams D, Dayton R et al. Putting the t in tools: a roadmap for implementation of new global and regional transgender guidance. *Journal of the International AIDS Society* 2016, 19 (Suppl 2):20801
<http://www.jiasociety.org/index.php/jias/article/view/20801>



Ending the AIDS epidemic for adolescents, with adolescents 2016.
<http://www.unfpa.org/publications/ending-aids-epidemic-adolescents-adolescents>



National SRH/HIV linkages snapshots (25):
<http://srhhivlinkages.org/documents-by-category/#srh-hiv-linkages-documents-by-category>
(see under “SRH and HIV Linkages”)

Safeguarding Young People (SYP)

Countries' SYP video reports:
<https://drive.google.com/drive/folders/0B4rD8WLzuPIEY202YUpRbjJrMVU>

Music:
<https://drive.google.com/drive/folders/0B4rD8WLzuPIEYnISMkpOVmNXZjQ>

SYP publications, including 2015 annual report:
<https://drive.google.com/drive/folders/0B4rD8WLzuPIENHJNbVRxQUcwWkE>



Online guide to engaging men and boys in SRHR including family planning
<http://www.unfpa.org/resources/engaging-men-sexual-and-reproductive-health-and-rights-including-family-planning>



Tool for action: Strengthening civil society organizations and government partnerships to scale up approaches to engaging men and boys for gender equality and sexual and reproductive health and rights
<http://www.unfpa.org/publications/strengthening-civil-society-organizations-and-government-partnerships-scale-approaches>

UNITED NATIONS OFFICE ON DRUGS AND CRIMES (UNODC)

A. Highlights of results in 2016

- **Priority 1: High-Level Advocacy**

UNODC and its partners engaged national policymakers, drug control agencies, public health, justice, civil society including scientific community and organizations of people who use drugs in an evidence-informed dialogue on HIV, drug policies and human rights and strengthened collaboration between public health, criminal justice and prison administration, and civil society organizations for increasing investment in public health and human rights based responses to HIV in prisons.

UNODC jointly with national and international partners supported Member States in effectively addressing HIV and drug use, and HIV in prisons in the context of the 59th session of the Commission on Narcotic Drugs (March, 2016), the Special Session of the General Assembly on the World Drug Problem (April, 2016), the 25th session of the Commission on Crime Prevention and Criminal Justice (May, 2016), and the UN General Assembly's High-level Meeting on Ending AIDS (June, 2016).

UNODC organized a scientific consultation "Science addressing drugs and HIV: State of the Art. An update" in the margin of the Commission on Narcotic Drugs (CND) 59th session (March, 2016). Its scientific statement summarizing the latest scientific evidence was presented at the side events of the UNGASS on the World Drug Problem and at the High-Level Meeting on Ending AIDS.

UNODC, together with UNAIDS secretariat and UNDP, contributed to and participated in events for the preparation towards the UNGASS on the World Drug Problem "UNGASS 2016 on the World Drug Problem: focus on people, public health and human rights", organized in New York, Geneva and Vienna and hosted by Permanent Missions of Switzerland, Norway and Colombia.

- **Priority 2: Technical Assistance & Capacity Building**

Support for legal, policy and practices reforms

UNODC advocated for alternatives to incarceration for people who use drugs, including related legal and policy changes. For example, in Myanmar, UNODC had provided technical assistance for reviewing the Narcotic drugs and psychotropic substance law (1993) and conducted related consultations. These efforts contributed to the amendment of the draft law, including the removal of compulsory registration for people who use drugs, in keeping with the recommendations of the Global Commission on HIV and law, shifting from punitive to public health -based approach and reducing penalties for small drug offenders. Also with UNODC support, in Namibia a Prisons Health Policy was launched.

Since 2013, UNODC has trained law enforcement agencies and built partnerships between Law Enforcement and Civil Society and Community-Based Organizations to support HIV prevention, treatment and care for people who inject drugs in 23 countries. To date, UNODC has reached over 2000 police officers (400 in 2016), over 600 CSO and CBO representatives (100 in 2016) and over 300 health, education and social sector staff (50 in 2016) with training on how to

cooperate for facilitating access to harm reduction services for people who inject drugs and on how to introduce referrals as alternatives to incarceration. In 2016, the countries covered with the training were Belarus, Kazakhstan, Ukraine, Tajikistan and Uzbekistan. Moreover, UNODC's efforts have contributed to institutionalizing HIV training, including by mainstreaming gender, as part of the curricula of national police academies, for example in Belarus, Kazakhstan, Moldova and Ukraine.

Training of Service Providers

UNODC supported Member States and civil society in providing public health and human rights-based and gender responsive HIV services for people who use drugs. For example, with UNODC's support, opioid substitution therapy was scaled up in community settings in Kenya and in prisons in Viet Nam. UNODC jointly with civil society built the capacity of country programme managers to address the specific needs of women who inject drugs, for example in Afghanistan, Pakistan and Nepal.

UNODC assisted in implementation of programmes and built the capacities of health care providers to reduce HIV transmission in prisons including sexual, blood-borne and Mother-to-Child transmission in provision of quality HIV services in prisons in line with 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" and contributed to operationalizing the United Nations Standard Minimum Rules for the Treatment of Prisoners (the *Nelson Mandela Rules*, adopted by the UN GA in December 2015) in 23 countries in Sub-Saharan Africa, MENA, Asia and EECA regions. For example, in Nepal, the 15 key interventions for HIV prevention, treatment and care in prisons were included in the Standard Operating Procedures on HIV in Prisons.

- **Priority 3: Supporting the engagement of Civil Society Organizations**

In the context of the joint 'UNODC-CSO Group on Drug Use and HIV', collaborative efforts were focused on the implementation and scaling up of evidence-based HIV prevention, treatment and care for people who inject drugs. Despite of the unexpected financial shortfall in core UBRAF funding as of mid-2016, UNODC supported over 80 CSOs worldwide.

UNODC together with INPUD led the development of the guide "Implementing Comprehensive HIV/HCV services with people who inject drugs: Practical Approaches for Collaborative interventions (I-DUIT)".

For example, with UNODC support, in Vietnam workshops on partnership building and community/home based care for people who use drugs were implemented, in South Africa CSOs were engaged in the development of a new national drug control masterplan, and new regional networks of people who use drugs were engaged in the work of the UNODC-CSO Group on Drug Use and HIV.

B. Key challenges

People who inject drugs and people in prisons are socially marginalized and subjected to violations of their human rights, stigma and discrimination, which continue to undermine effective implementation of HIV prevention, treatment and care services for these two key populations.

Legal, policy and law enforcement practices often are accountable for high barriers for the provision and access to evidence-based HIV interventions for PWID, in particular needle and syringe programmes and opioid substitution therapy. In many high priority countries for PWID and HIV the engagement of community based organizations is often insufficient, or totally absent.

In many countries, HIV and other relevant health services in prisons are severely limited or are not available at all. Injecting and non-injecting stimulant drug use (cocaine, amphetamines, new psychoactive substances) is increasing worldwide and countries are in need for evidence-based guidance on how to address risks for HIV transmission associated with stimulant drug use.

Cut in core UBRAF funding to UNODC has led to severe austerity measures including significant scaling down of delivery of technical assistance to high priority countries, limited efforts to advocate among and build capacity of key partners such as prison health service staff, law enforcement officials and community based organizations. Major financial risks continue to endanger the implementation of UNODC HIV/AIDS mandates.

C. Country case study

CASE STUDY: IMPROVED HEALTH OUTCOMES FOR FEMALE PATIENTS AND THEIR NEWBORNS THROUGH OPIOID SUBSTITUTION THERAPY (OST) ALONG KENYA'S COASTAL REGION

Estimates suggest there are over 18,000 people who inject drugs in Kenya. Although females who inject drugs comprise less than 10%, almost 1 in 2 females is living with HIV. Because of their high HIV vulnerability, Kenya's methadone programme relaxed its eligibility criteria to include all opioid dependent females: injecting and non-injecting.

In 2015, through UNODC and USAID/PEPFAR support, Kenya's Ministry of Health and concerned County Governments introduced Medically Assisted Therapy (OST) for people who use/inject drugs in Coastal region which has a high HIV and drug use burden. Over 1,100 opioid dependent persons were accessing methadone services at Malindi and Mombasa by March 2017. Of the 142 (12%) female patients enrolled, 90% were of reproductive age. At enrollment, all females were screened for HIV, tuberculosis, viral hepatitis, syphilis and pregnancy. To assure optimal treatment retention and outcomes, female OST clients were encouraged to bring their male partners who use drugs for possible enrollment in the methadone programme.

Between February 2015 and March 2017, 13 (9%) patients had been reported pregnant. To ensure better birth outcomes, methadone dosages of pregnant clients are reviewed monthly with treatment for underlying co-morbidities. Antenatal care is accessed through referral within the primary health care facility. By the end of March 2017, nine pregnant clients (including 4

living with HIV) had given birth.

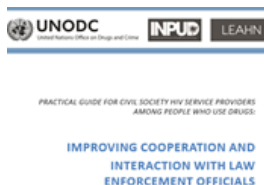
The results suggest that opioid substitution therapy programme has improved health outcomes among pregnant women who use drugs; Thanks to the good follow up during pregnancy, only one infant developed Neonatal Abstinence Syndrome (NAS) and subsequently received appropriate treatment and care. In addition to dispensing antiretroviral therapy (ART) through Directly Observed Therapy (DOT) and administration of nevirapine to infants as per the Kenya ART protocol, replacement feeding was encouraged for all HIV exposed infants whose mothers could not ensure exclusive breastfeeding. All babies born from the mothers in the OST programme and who took part in the antenatal care and in the ART were confirmed HIV-free at 6 months of age.

D. Key knowledge products produced in 2016



A tool “Implementing Comprehensive HIV/HCV services with people who inject drugs: Practical Approaches for Collaborative interventions (I-DUIT)”, developed jointly by UNODC, INPUD and representatives of community organizations, WHO, UNAIDS Secretariat, UNFPA, UNDP, and the Office of the U.S. Global AIDS Coordinator, was finalised in 2016. The purpose of the tool is to provide practical advice on implementing HIV prevention, treatment and care programmes for people who inject drugs.

http://www.unodc.org/unodc/en/hiv-aids/new/publications_drugs.html



UNODC, jointly with Law Enforcement and HIV Network (LEAHN) and International Network of People Who Use Drugs (INPUD), produced “Practical Guide for Civil Society HIV Service Providers among People Who Use Drugs: Improving Cooperation and Interaction with Law Enforcement Officials” (April 2016). The guide is designed to provide representatives from CSOs and other partners, who provide HIV services for PWID, practical guidance on how to work with police and to increase advocacy skills for interacting with law enforcement authorities.

http://www.unodc.org/documents/hiv-aids/2016/Practical_Guide_for_Civil_Society_HIV_Service_Providers.pdf



UNODC produced and launched a guidance document “Addressing the specific needs of women who inject drugs - Practical guide for service providers on gender-responsive HIV services” in partnership with the International Network of Women Who Use Drugs (INWUD), Women Harm Reduction International Network (WHRIN) and the Eurasian Harm Reduction Network (EHRN).

http://www.unodc.org/unodc/en/hiv-aids/new/publications_drugs.html

UNITED NATIONS ENTITY FOR GENDER EQUALITY AND THE EMPOWERMENT OF WOMEN (UN WOMEN)

Created in July 2010, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) promotes gender equality not just as an inalienable human right but as a central tenet of social, economic and cultural development. It provides a strong and resonant voice for women and girls at the local, regional and global levels and stands behind women's equal participation in all aspects of life, focusing on five priority areas: increasing women's leadership and participation; ending violence against women; engaging women in peace and security processes; enhancing women's economic empowerment; and making gender equality central to national development planning and budgeting.

In June 2012, UN Women became the eleventh Cosponsor of UNAIDS, an important step towards ensuring that gender equality is at the heart of global action on HIV. UN Women's strategic approach to HIV includes providing technical and financial support to Member States and women's organizations, particularly organizations of women living with HIV, in the area of gender equality and HIV. To reduce the vulnerability of women and girls to HIV, UN Women seeks to address the challenges that stem from unequal power relations between women and men.

A. Delivering 2030 Agenda

2030 Agenda for Sustainable Development places a strong emphasis on gender equality and women's empowerment as a stand-alone goal and throughout the agenda, and reinvigorates efforts to eliminate gender inequalities that hamper women and girls' ability to confront HIV and mitigate its impact. UN Women 2014-2017 Strategic Plan is fully relevant to 2030 Agenda and prioritizes work to ensure national strategic plans for HIV/AIDS incorporate gender-responsive actions with budgets and women living with and affected by HIV engage to include their priorities in HIV strategies and budgets.

UN Women strives to reach those 'furthest behind first' by ensuring national HIV strategies are informed by sex- and age-disaggregated data and gender analysis; up-scale what works in tackling the root causes of inequalities, and support women and girls in all their diversity to meaningfully engage in decision-making in HIV responses at all levels. More specifically, UN Women's work is aimed at:

- Amplifying the voices of women living with HIV and young women and adolescent girls, including those living with HIV, promoting their leadership in decision-making.
- Integrating gender equality into the governance of the HIV responses (including policies, laws, national HIV strategies, institutions, budgets, and monitoring and evaluation frameworks).
- Promoting women's economic empowerment to prevent HIV and mitigate its impact.
- Addressing the intersections between HIV and violence against women.
- Promoting access to justice for women living with and affected by HIV, including access to property and inheritance rights.

Civil society is a key constituency for UN Women. It plays a vital role in promoting gender equality and women's rights at all levels. UN Women partners with international, regional

and national networks of women living with HIV, women's organizations, alliances and coalitions of women caregivers, legal and human rights organizations, and community development, grass-roots and media organizations to increase the influence of women living with HIV, to promote their leadership and meaningful participation in all decisions and actions in the response to the epidemic.

B. Highlights of results in 2016

1. Women living with HIV at the heart of HIV response

UN Women considers participation and engagement of the networks of women living with HIV as central to transforming the national HIV responses. Institutional strengthening and access to sustainable financing are essential for effective and consistent advocacy by the networks of women living with HIV. In 2016 UN Women continued to advocate for greater participation and build the leadership capacity of women living with HIV, including young women and adolescent girls, to define a common agenda and to participate more meaningfully in HIV policy and programming at national, regional and global levels:

- To shape more gender-transformative national HIV responses UN Women facilitated engagement of women living with HIV in gender-responsive design of the national and local HIV strategies and monitoring frameworks in 8 countries: China, Kazakhstan, Morocco, Sierra Leone, South Africa, Tajikistan, Uganda and Ukraine. In South Africa, the draft of the 2017-2022 Strategic Plan on HIV, Tuberculosis and STIs prioritizes issues and actions to address gender inequalities and reduce new infections among young women and girls. At the same time, UN Women invests in strengthening institutional capacity of the networks of women living with HIV, that has resulted in their stronger organizing and access to decision-making in 13 countries: China, Cameroon, Indonesia, Kazakhstan, Moldova, Mozambique, Rwanda, Senegal, Tajikistan, Tanzania, Thailand, Viet Nam and Ukraine. In Ukraine, UN Women built a cadre of 50 women living with HIV activists from 3 regions, with 3 of them becoming Deputy Chairs of the Coordinating Councils on HIV and Tuberculosis. In Viet Nam and Indonesia, women living with HIV now serve as voting members of the Global Fund Country Coordination Mechanisms.
- To support national and local planning to implement 2030 Agenda, UN Women partnered with the International Community of Women Living with HIV to ensure over 200 women living with HIV from 10 countries – Belarus, Democratic Republic of Congo, Kazakhstan, Kenya, Mozambique, Namibia, Russia, Thailand, Ukraine and Zimbabwe – are voicing their priorities and engaging with policy-makers to influence localizing the Sustainable Development Goals (SDGs). A Guide to the SDGs for the Network of Women Living with HIV was developed and disseminated; it outlines key strategies to ensure SDGs implementation works for women living with HIV. Because of this capacity building initiative, in Ukraine, the national network of women living with HIV developed an advocacy strategy and voiced their priorities throughout the national and local SDGs consultations. These priorities also helped to shape a first-ever 'shadow' report to the Committee of the Convention on Elimination of All Forms of Discrimination Against Women on behalf

of several organizations of women living with HIV in all their diversity. Olena Stryzhak, Head of the Ukrainian 'Positive Women' welcomed the engagement in the localizing 2030 Agenda that helped women learn advocacy skills and assume new roles as agents of change: "It significantly contributed to the principle of the 2030 Agenda of leaving no one behind."

- In partnership with the International Planned Parenthood Federation, UN Women's "*Engagement+Empowerment=Equality*" effort resulted in building leadership capacity of over 1,000 young women and adolescent girls, including 250 living with HIV, in Malawi, Kenya and Uganda. Through mentoring, capacity building and peer support, young champions engaged in the design and validation of the *All-In* national assessments on the status of HIV among adolescents. In Uganda, the young women leaders successfully advocated for reflecting such issues as, gender-based stigma and discrimination against young women and adolescent girls, child marriage and economic empowerment of young women living with HIV in the country assessment. Additionally, in just 9 months, the young champions reached thousands of young women through outreach activities including through social and print media. They now feel more confident in raising their priorities with the community leaders and decision-makers.

2. *Transforming unequal gender norms to prevent HIV and mitigate its impact*

Recognizing that unequal gender norms continue to influence HIV epidemic, UN Women addresses structural barriers that undermine women and girls' access to services, their economic and legal rights, their opportunities to live a life free of violence and make informed decisions on their own sexual and reproductive health. In 2016, UN Women contributed to building evidence on the impact of harmful gender norms on women's increased vulnerability to HIV, to inform future national HIV policy and programming. UN Women also implemented interventions to promote equal gender norms to enable women and girls to prevent HIV and mitigate its impact, including women's economic empowerment.

- UN Women commissioned '*Key Barriers to Women's Access to HIV Treatment: A Global Review*', conducted by ATHENA Network, Salamander Trust and AVAC. Women living with HIV led the design and implementation of the Global review as they are best positioned to frame and prioritize the issues and areas that should be interrogated. A Global Reference Group of 14 women living with HIV from 11 countries guided the review throughout all phases – a literature review, community dialogues and country case studies – involving over 200 women living with HIV from 17 countries. The findings revealed gaps in sex-disaggregated data collection and persistent gender-related barriers in women's treatment access and adherence across their lifecycle, including at the micro-level, violence, stigma and discrimination, and low treatment literacy; at the meso-level, lack of access or control over resources and care responsibilities, fear of disclosure, and of HIV-related employment refusal or dismissal; at the macro-level, the impact of punitive laws. Treatment access efforts must be informed by evidence that lay out the effect of unequal gender norms and institutional biases that hinder women's access to

treatment.

- UN Women improved sustainable livelihoods of women living with or affected HIV through fostering access to and control over economic resources. UN Women Fund for Gender Equality grantee in Tanzania economically empowered over 3,000 rural women affected by HIV through developing their business skills, enabling them to launch their own small businesses, access legal support and HIV services and have more control over decision-making in the household and community. In Uganda, a series of entrepreneurship trainings developed and delivered by UN Women has equipped young women living with HIV with essential social and economic skills, and improved their self-esteem and confidence. Trainings have been accompanied by ongoing mentorship and supportive supervision to the beneficiaries. Young women not only started their own businesses but also accessed additional government grants for entrepreneurs. These efforts have contributed to building women's self-confidence, improving their decision-making power and economic independence, and, thus, helping them to prevent HIV, or, as in the case of Uganda, improving livelihoods and economic security of women living with HIV.

3. Preventing violence against women and girls to prevent HIV

Violence against women and girls is a cause and consequence of HIV infection. In 2016, UN Women worked with the UN system, national AIDS coordinating bodies and the networks of women living with HIV to integrate actions addressing HIV in the national action plans on ending violence against women and/or national strategies on gender equality. UN Women continued investing in community-driven approaches that yielded evidence to demonstrate what works most effectively in addressing intersections between violence against women and HIV. UN Women also worked with the countries to end harmful practice of child marriage to reduce HIV vulnerability and risk among young women and adolescent girls.

- In 14 countries – Brazil, China, Cote D'Ivoire, Egypt, Indonesia, Jamaica, Kyrgyzstan, Moldova, Morocco, Paraguay, State of Palestine, Uruguay, Viet Nam and Ukraine – UN Women efforts resulted in the generation of evidence on how violence against women is linked to an increased HIV risk, that was used to inform the design and implementation of the national action plans on ending violence against women and national strategies on advancing gender equality to integrate HIV. UN Women support in Viet Nam led to adoption of the 2016-2020 National Thematic Project on Violence Prevention and Response – an operational framework to implement the 2016-2020 National Action Plan on Gender Equality. The Project recognizes sexual violence against women in public spaces, introduces specific measures to implement integrated violence and HIV services and establishes multi-stakeholder coordination mechanism.
- The UN Trust Fund to End Violence Against Women, managed by UN Women, supported *SASA!* implementation in Kenya, Haiti and Tanzania. A community mobilization initiative, *SASA!* engaged men and women and resulted in preventing violence and HIV. After the successful results from its pilot and impact evaluation in Kampala, Uganda, interest to use the methodology is growing and it is being used in

over 60 countries. In addition to expanding evidence-based implementation of gender-transformative interventions preventing violence and HIV, UN Women's support also helps identify strategies to adapt *SASA!* in diverse contexts.

- With UN Women support, Malawi, a country with one of the highest rates of child marriages in the world, has taken a major step to end the practice. In early 2017, the Parliament unanimously adopted a constitutional amendment that raises the minimum age of marriage from 15 to 18 years. The amendment aligns the Constitution with the 2015 Marriage, Divorce and Family Relations Act. UN Women played a pivotal role in lobbying for an end to the discriminatory practice.

C. Case Study



Beneficiaries of the project express their commitment in a group activity after completing the trainings. Photo: Eris Igira/UN Women

Rural young women living with HIV break stigma and build businesses in Uganda

Married for 17 years, Mwatum Kitui Longok had no idea she was living with HIV until she got herself tested. Stigma and discrimination marred her daily reality; even her children faced societal exclusion.

After visiting a health centre for counselling, she learned about the Karamoja Economic Empowerment project (KEEP).

Joining the young women's group, supported by UN Women, brought a beacon of light. "At first we used to meet and talk in whispers because we didn't want to be identified as living with HIV. Soon we saved money and started lending to each other at low interest rates to start small individual businesses," shares Longok, a mother of six, from Moroto, a remote district located in Karamoja sub-region, north-eastern Uganda. Catherine Lopuka explains, "I didn't know that I could run a successful business. I now know how to calculate profit and loss and how to do book-keeping. I also opened a personal bank account after the training to save some of my money."

Stigma and discrimination remains a major barrier to reduce new HIV infections among young women and girls, who are often unwilling to seek help. According to the estimates by the Ministry of Health in Uganda, in 2015, there were 29,509 new HIV infections among young people aged 15-24, with 64 per cent (18,894) of the newly infected being young women and girls.⁴

Recognizing the challenges, UN Women developed a series of trainings to empower

⁴ Ministry of Health, Uganda.

women living with HIV in Karamoja. The trainings were accompanied by ongoing mentorship and supportive supervision to the beneficiaries. The pilot trainings with 70 participants from the Moroto district in March 2016 showed early results in terms of improved self-esteem, confidence and entrepreneurial skills. Some women's groups have already started businesses. One of the groups, which set up a store to sell dry grains and cereals to local retailers, has now been shortlisted for government grants to help women entrepreneurs meet the operational costs, expand their stock or start new business ventures. The beneficiaries also reported increased level of confidence and self-esteem within their families and communities, as well as greater economic security.

Following these successful outcomes, UN Women is planning to expand the initiative in other remote districts, engaging more young women living with HIV.

E. Knowledge products produced in 2016



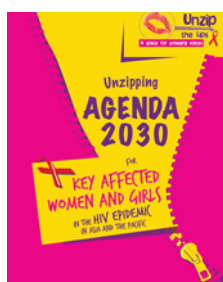
COMPREHENSIVE | UP-TO-DATE |
REVIEWED
Explore our site to find valuable resources, cutting-edge research, and breaking news on the gender equality dimensions of HIV/AIDS. This site aims to

UN Women has re-designed and re-launched its [Gender Equality and HIV/AIDS web-portal](http://genderandaids.unwomen.org/) on the World AIDS Day-2016. The web portal contains cutting-edge research, training material, advocacy tools, current news, personal stories, and campaign actions on the gender equality dimensions of the HIV epidemic.

Link to the web-portal: <http://genderandaids.unwomen.org/>



UN Women and the International Community of Women Living with HIV (ICW) [Guide to the Sustainable Development Goals for the networks of women living with HIV](http://www.iamicw.org/resources/document-library/a-guide-to-the-sustainable-development-goals-for-networks-of-women-living-with-hiv) provides the networks of women living with HIV with key information about the SDGs and strategies of how to engage in country-level processes around SDGs implementation, monitoring and accountability. Link to the resource: <http://www.iamicw.org/resources/document-library/a-guide-to-the-sustainable-development-goals-for-networks-of-women-living-with-hiv>



UN Women, UNDP, the UNAIDS Secretariat in partnership with the Unzip the Lips and the International Community of Women Living with HIV in Asia and the Pacific developed Unzipping Agenda 2030 for Key Affected Women and Girls in the HIV Epidemic in Asia and the Pacific and a related video, identifying the opportunities for monitoring and tracking of the progress towards SDGs for women and girls in the context of HIV.

Link to the resource: <http://asiapacific.unwomen.org/en/digital-library/publications/2016/06/unzipping-agenda-2030#view> and the video: <http://asiapacific.unwomen.org/en/digital-library/publications/2016/06/unzipping-agenda-2030#view>



UN Women's [Essential Services Package for Women and Girls Subject to Violence](#), developed in partnership with UNFPA, WHO and UNODC, provides service delivery guidelines to ensure the delivery of high-quality services, particularly for low- and middle-income countries, for women and girls experiencing violence, including in the context of HIV. The package was rolled out by UN Women in Asia and the Pacific.

Link to the resource: <http://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence#view>



UN Women, UNESCO developed and launched a [Global Guidance on School-related Gender-based Violence](#), which aims to provide a comprehensive, one-stop resource on school-related gender-based violence and HIV including clear, knowledge-based operational guidance, diverse case studies and recommended tools for the education sector and its partners working to eliminate gender-based violence and prevent HIV in and around schools.

Link to the resource: <http://www.unwomen.org/en/digital-library/publications/2016/12/global-guidance-on-addressing-school-related-gender-based-violence#view>



UN Women in collaboration with UNFPA, UNDP and the UNAIDS Secretariat produced regional [Policy and Programme Guidance: HIV and GBV Preventing and responding to linked epidemics in Asia and the Pacific](#). The guidance provides a summary of the latest global targets and evidence on HIV and gender-based violence in the region, presents case studies on emerging good practice, ideas for cross-collaboration and guidance for advocates, programmers and policy-makers working toward achieving gender equality, ending AIDS and eliminating violence.

Link to the resource: <http://asiapacific.unwomen.org/en/digital-library/publications/2016/11/hiv-and-gender-based-violence>

INTERNATIONAL LABOUR ORGANIZATION (ILO)

A. Background

In the CCO report for 2016, the ILO is prioritising three key areas of its work. These include: scaling up HIV testing; scaling up social protection coverage and strengthening mainstreaming of HIV into other areas of the ILO's work. For each priority area, the report provides examples of three clear results for 2016.

B. Highlights of results in 2016

PRIORITY 1: Scaling up the VCT@WORK Initiative

Result 1:	1.1 million women and men tested for HIV in 2016
Result 2:	17,773 tested positive and were 17,615 were referred to treatment services
Result 3:	Cumulatively 4.1 million women and men workers have tested for HIV since 2013 through the VCT@WORK Initiative

VCT@WORK Initiative



1.1 million took the HIV test in 2016

After many years of prioritising support to countries to create supportive legal and policy environments to facilitate workers access to HIV services, the ILO, after a review of its programmes, took the decision to launch the VCT@WORK Initiative. This Initiative leverages the improved legal and policy environment and contributes more concretely towards the achievement of the 90-90-90 treatment targets. In June 2013, the International

Labour Conference supported the launch of the VCT@WORK Initiative by the UNAIDS Executive Director and the ILO Director General.

To protect workers and facilitate the uptake of HIV testing within the confines of the workplace, GNP+ and the ILO jointly developed operational guidelines for the VCT@WORK Initiative based on the following principles: consent; confidentiality; counselling; connection to care; gender equality and women's empowerment; meaningful engagement of people living with HIV; and inclusion of key populations. The guidelines were widely disseminated to all partners. In 2016, the VCT@WORK Initiative was implemented in the following countries: Cambodia; Cameroon; China; Congo Democratic Republic; Egypt; Guatemala; Haiti; Honduras; India; Indonesia; Kenya; Mozambique; Nigeria; Russia Federation; South Africa; Tanzania; Ukraine; and Zimbabwe.

In 2016, strategic partnerships were forged with many Cosponsors and country partners including ministries of labour, employers' organizations, business coalitions, workers' organizations, civil society organizations and networks of people living with HIV, national AIDS authorities, health service providers, social security institutes and private sector corporate organizations. HIV testing was focussed on the following: hotspots, regions with high HIV incidence, mobile and migrant workers along transport corridors in Southern Africa, entertainment establishments in the Asia region, as well as sectors where there are

a considerable number of migrant workers such as the rail, oil and coal industries in parts of Eastern Europe. HIV testing was undertaken as part of multiple disease screening or wellness programmes to reduce the levels of stigma and increase the appeal and uptake of testing. HIV testing is undertaken throughout the year with special emphasis on days such as World AIDS Day, Occupational Safety and Health Day, May Day, etc. Even though the main focus was on promoting HIV testing, in some countries, the focus was also to discourage mandatory HIV testing. For example, the ILO, WHO and UNAIDS in China drafted a report *“From mandatory HIV testing for access to work to voluntary testing and counselling at work”*. In 2016, a total of approximately 1.1 million workers, comprising 60% men and 39% women, undertook the HIV test through the Initiative. Approximately 17,773 tested positive and were referred to treatment and care services. The VCT@WORK Initiative is closing the gender gap in HIV testing by testing more men (than women) in the workplace. Based on feedback from networks of PLHIV, the next challenge is to work closely with managers/employers to ensure that workers living with HIV are given adequate time to collect their medication from external sources in a context of confidentiality. Cumulatively, the VCT@WORK Initiative has mobilized approximately 4.1 million workers and their families to undertake HIV testing since its launch in June 2013.

PRIORITY 2: Scaling up Social Protection Coverage for vulnerable populations

- | | |
|-----------|--|
| Result 1: | Launch of a Global partnership for Universal Social Protection by the ILO and World Bank |
| Result 2: | Development of the Social Protection Assessment Tool |
| Result 3: | Country support to make NSPFs HIV-sensitive |



Scaling up Social Protection Coverage for vulnerable populations (including PLHIVs)

In 2016, the ILO prioritised its work in Social Protection and focussed on global advocacy, the development of tools and tailored country support. Three results are presented as examples.

Result 1: Launch of a Global partnership for Universal Social Protection by the ILO and World Bank

A strong consensus is developing around social protection as a primary development priority which is contributing to health and wellbeing, productivity, poverty eradication, reduction in inequalities and building social peace. In 2016, the ILO and the World Bank launched a global partnership for Universal Social Protection which provides a renewed momentum to earlier collaboration between the two agencies to scale up social protection coverage. The shared objective of the two Agencies is “to increase the number of countries that can provide universal social protection, and support countries to design and implement universal and sustainable social protection systems.” As a follow up, the ILO launched a flagship Social Protection Floor Initiative with focussed action in 21 target countries. In Zambia for example, the ILO is supporting the Government of Zambia to extend social protection to workers in the informal economy. The package includes maternity insurance which is improving access to people living with HIV in Zambia. An estimated one million

people (including PLHIVs) are expected to benefit from this package in 5 years. There are other similar country examples.

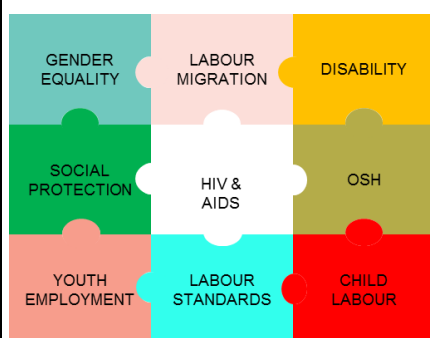
Result 2: Development of the Social Protection Assessment Tool

To take advantage of the growing country momentum around scaling up Social Protection services for vulnerable populations, the ILO, UNAIDS Secretariat, UNICEF, World Bank, WFP, UNDP, WHO, PEPFAR and other partners developed a HIV and Social Protection Assessment Tool which is being used for rapid assessments of new or existing social protection schemes to establish their sensitivity to HIV. The Tool has already been used in 6 countries and the ILO is supporting countries to assess the HIV sensitivity of their Social Protection initiatives.

Result 3: Country support to make national Social Protection Floors HIV-sensitive

In 2016, the ILO and partners provided tailored HIV-sensitive programming support to 12 fast track countries ranging from: conducting social protection studies to assess coverage of PLHIV and other vulnerable populations; drafting social protection policies, implementation of new social protection schemes; and drafting of social protection bills. One country example is in Rwanda, where the ILO is supporting the implementation of maternity insurance and improved access to social protection for people living with HIV. The expected beneficiaries in 5 years are 300,000 vulnerable people (including PLHIV).

PRIORITY 3: Enhancing the mainstreaming of HIV into other areas of the ILO's work	
Result 1:	Mainstreaming HIV issues into the International Labour Standard on Violence
Result 2:	Mainstreaming HIV into other areas of the ILO's work
Result 3:	Strategic merger of ILOAIDS Branch and the Gender, Equality and Diversity Branch



In line with the principle of taking AIDS out of isolation, the ILO has consistently mainstreamed HIV into other areas of its work at global, regional and country levels since the ILOAIDS Branch was established. However in 2016 the emphasis on mainstreaming HIV was enhance, due to an increased focus under the 2030 Sustainable Development Agenda on “leaving no one behind”, while also responding to the decreasing financial resources available. Three examples of mainstreaming are provided in this report.

Result 1: Mainstreaming HIV issues into the International Labour Standard(s) on Violence and Harassment

The ILO Governing Body has approved a standard-setting item on violence and harassment in the world of work, with the first discussion taking place in June 2018. A tripartite expert meeting was held in 2016, which adopted strong conclusions, recognising that while violence and harassment can potentially affect everyone, it affects specific groups disproportionately, where certain conditions exist. Imbalanced power relationships, including due to gender, race and ethnicity, social origin, education, health and poverty could lead to violence and harassment. Discrimination based on these and other grounds, including disability, HIV status, sexual orientation and gender identity, migrant status and age, were also recognized as important factors. HIV issues have been mainstreamed into the standard setting process and it is expected that the final International Labour Standard (or standards) will have HIV mainstreamed.

Result 2: Mainstreaming of HIV into other areas of the ILO's work

HIV issues have been mainstreamed into guidance and handbooks in other areas of the ILO's work. For example a 2016 ILO practical guide on *promoting diversity and inclusion through workplace adjustments*. The guide covers four categories of workers including: workers with disabilities; workers living with or affected by HIV; pregnant workers and workers with family responsibilities; and workers who hold a particular religion or belief. The guide can be assessed at http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_536630.pdf

HIV has also been mainstreamed into an ILO Self-Training Handbook on Wash@Work. The link between health and access to safe water, sanitation and hygiene (WASH) is well documented and since workplaces represent a major focus in the life of workers and employers, access to WASH in workplaces can contribute greatly to both occupational and general health. Workers living with HIV and other immunocompromised persons are likely to get sick from germs at the workplace related to poor sanitation. The handbook provides information on how PLHIVs can, within the context of the workplace, have access to good hygiene and sanitation. It can be accessed at http://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/publication/wcms_535058.pdf

Result 3: Strategic merger of ILOAIDS Branch and the Gender, Equality and Diversity (GED) Branch

To further take AIDS out of isolation, the ILO has strategically merged the ILOAIDS Branch with the Branch which focuses on gender, equality and diversity. Merging the two branches under a single leadership has strengthened the mainstreaming of HIV into ILO's other work areas. As a result of the merger, the visibility of HIV issues in the draft ILO Programme and Budget for 2018 – 19 is much higher than in the current ILO Programme and Budget 2016 – 17.

C. CASE STUDY: A joint approach to enhancing access to HIV testing and Social Protection for Workers in Kenya

Background

The ILO is prioritising both the scaling up of HIV-sensitive Social Protection and the VCT@WORK Initiative in Kenya and the approach has been to build synergies between the two priorities. An innovative approach towards enhancing access to HIV testing in the informal economy and facilitating access to national social protection schemes has thus been developed.

Salient features of the strategy

To reach out to truckers, the ILO is partnering with the Central Organization of Trade Unions in Kenya (COTU-K), Kenya Long Distance Truck Drivers', Allied Workers' Union/Highway Community Health Resource Centre and Swedish Workplace HIV/AIDS Programme. This partnership provides HIV testing services along the northern transport corridor (Mombasa to Busia). Hotspots for sex workers have been identified as locations for onsite HIV testing and counselling (HTC) services.

For hair and beauty salon workers, the ILO is partnering with the Kenya Union of Hair and Beauty Salon Workers, an affiliate of COTU-K and the AIDS Healthcare Foundation. Union officials have been trained on HIV management in the workplace. Onsite integrated HTC services are provided in workplaces, along with awareness on the benefits of enrolling with the National Hospital Insurance Fund (NHIF). The union also mobilizes workers to become members of the Savings and Credit Cooperative (SACCO), encouraging them to save a portion of their income.

The Federation of Kenya Employers, through its Clustered HIV Enterprise Programmes (CHEP) Networks in Mombasa, Uasin Gishu and Laikipa Counties, reaches out to their member companies to scale up the HIV response at their workplace and beyond. VCT@WORK initiatives are organized targeting the informal economy workers from the Jua kali sector (small traders and artisans) with an integrated component of social protection. Officials of NHIF and National Social Security Fund (NSSF) from the specific counties are invited to sensitize workers on the importance of enrolling in the schemes. Wherever possible, workers are provided support for the onsite registration in NHIF.

Results

Between July 2013 and December 2016:

- Over 74,000 workers (44,000 men and 30,200 women), majority being in the informal economy, took the HIV test. Over 1000 found HIV positive were referred to access treatment and social protection.
- Over 10,500 male and 8,000 female informal economy workers were enrolled with NHIF. Over 6,000 male and 5,100 female informal economy workers were enrolled with NSSF through different HIV testing events.
- Around 500 hair and beauty salon workers have become members of SACCO and can source and access loans.

Lessons Learned

Integration of HIV, health services and social protection helps reduce stigma and discrimination.

Onsite HIV testing and enrolment into social protection schemes enhances the uptake of HIV services and coverage of social protection programmes amongst informal economy workers.

Workers in the informal economy are generally not aware of the benefits of social protection schemes, and the process of enrolling in them. Likewise, they are not aware about the benefits of timely HIV testing.

Next Steps

Building on the positive experience and partnerships that have been established, the ILO is expanding the VCT@WORK Initiative in other high and medium burden counties.

Under the UNDAF outcome on social protection, the ILO is scaling up the integration of HIV and social protection in more counties targeting workers from formal as well as informal economy.

D. ILO Knowledge Products produced in 2016



Educated Empowered and Inspired (2016) captures the impact of a Sida-funded multi-country integrated economic empowerment and HIV programme targeted mainly at vulnerable young women and sex workers along busy hotspots and transport corridors in the epicentre of the HIV epidemic. In addition to achieving significant HIV-related impacts, the programme led to increased financial independence, increased expenditure on nutrition, education and health, and improved negotiation skills among the women. The proportion of women who adopted risk reduction behaviours increased from 39% (baseline) to 81% (2015). Educated Empowered and Inspired can be accessed at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_456923.pdf



Promoting Diversity and Inclusion through workplace adjustments (2016) promotes reasonable adjustments in the workplace. Reasonable adjustments are an essential component for promoting diversity and inclusion at the workplace. The need for reasonable adjustments may arise from family responsibilities, religious requirements, a temporary or permanent disability, HIV status or some other causes. This practical guide is a flexible tool which can be used to reasonably accommodate people with disabilities, PLHIV, pregnant mothers, workers who hold a particular religious belief, etc. This guide is an example of taking AIDS out of isolation and addressing the issue as part of other issues. It can be accessed at http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_536630.pdf



WASH@Work: A self training handbook (2016) is a combined training and action tool designed to inform governments, employers, and workers on the needs for WASH at the workplace. The tool is designed to encourage all stakeholders to participate in making their workplace safe, healthy, and productive. Workers with HIV/AIDS and other immunocompromised persons may be more likely to get sick from germs at the workplace related to poor sanitation. Guidance is provided to PLHIVs on how to halt or minimise the contact with germs in the workplace. The handbook can be accessed at http://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/publication/wcms_535058.pdf



The briefing note on including HIV provisions into public and private insurance schemes is an advocacy tool to promote HIV-sensitive social protection schemes. The briefing note provides some case studies and success stories on how HIV has been integrated into social protection schemes and increased coverage for people living with HIV. The briefing note is being used by the ILO to support tailored advocacy as member States are supported to develop or scale up their national social protection floors. Scaling up HIV-sensitive social protection is critical to achieving universal health coverage. It can be accessed at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_537099.pdf

UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO)

UNESCO is a specialised agency of the United Nations. It was founded with the mission of contributing to peace and security by promoting international collaboration through education, science and culture. As one of the six founding UNAIDS Cosponsors, UNESCO is responsible for supporting the contribution of national education sectors to ending AIDS and promoting better health and well-being for all children and young people.

A. Description of top 3 priorities and related key results

UNESCO uses its comparative advantage with the education sector to advance young people's health and well-being. In 2016, UNESCO launched its new Strategy on Education for Health and Well-Being, which is aligned to the UNAIDS Fast-Track Strategy and to the Sustainable Development Goals, with a specific focus on the mutually reinforcing linkages between SDG 4 (Education), 3 (Health), and 5 (Gender Equality). The Strategy establishes two strategic priorities for UNESCO's work over the 2016-2021 period:

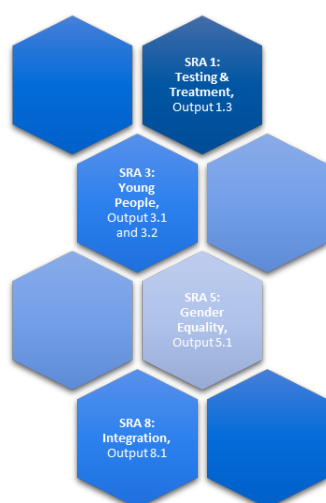
Strategic Priority 1: All children and young people benefit from good quality comprehensive sexuality education

- Preventing HIV and other sexually transmitted diseases
- Promoting awareness of HIV testing, knowing one's status, and HIV treatment
 - Strengthening puberty education
- Preventing early and unintended pregnancy
- Developing attitudes, values and skills for healthy and respectful relationships

Strategic Priority 2: All young people have access to safe, inclusive, health-promoting learning environments

- Eliminating school-related violence and bullying, including based on gender, gender identity and sexual orientation
 - Preventing health- and gender-related discrimination towards learners and educators
- Increasing awareness of the importance of good nutrition and quality physical education
 - Preventing use of harmful substances

Strategic Priority 1: All children and young people benefit from good quality comprehensive sexuality education

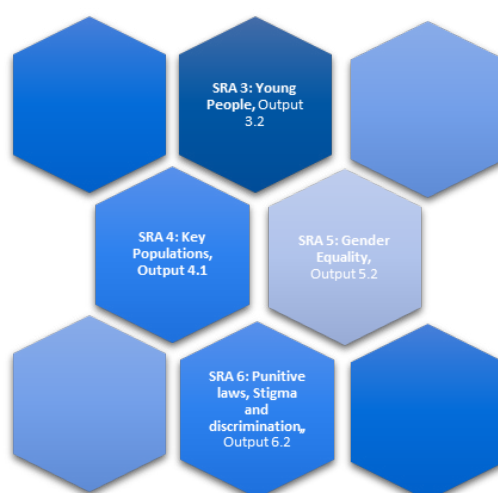


Graphic: Main UBRAF contributions

Key results in 2016:

- UNESCO is leading efforts to update the **UN International Technical Guidelines on Sexuality Education (ITGSE)**. A global technical stakeholder consultation was hosted by UNESCO in October 2016 with more than 60 participants, and a CSE Advisory Group has been established including key cosponsor partners such as UNAIDS, UNFPA, UNICEF, UN Women and WHO, along with partners from academia, the education sector and networks of youth advocates. The updated ITGSE will be published in 2017 and will reflect new evidence and good practices, and will reinforce the focus on areas such as early pregnancy, puberty, and gender equality.
- Over **30 African countries** have received UNESCO training to integrate core HIV indicators in their **Education Management Information Systems (EMIS)**, and 9 countries (Cote d'Ivoire, Ghana, Botswana, Lesotho, Namibia, Tanzania, South Sudan, Swaziland and Zambia) have completed the integration. Of these, Zambia and Namibia are now collecting and reporting EMIS data.
- The capacities of **20 Eastern & Southern African** countries to provide quality CSE was strengthened through follow-up to the 2013 ESA Ministerial Commitment, which was reaffirmed at the 2016 AIDS Conference through the "Let's Step up and Deliver" Call to Action. 15 of 21 countries are now providing CSE in primary and secondary school and 18 of 21 countries have CSE teacher training programs. Overall, teacher training courses have reached over **421,200 teachers**, including through teacher resource packs, scripted lesson plans, and an online course. Advocacy tools to strengthen community and parent engagement have benefitted 12 countries, and a radio and TV program series on CSE, SRH and HIV prevention has reached over **5 million people**.
- In **West & Central Africa**, ICT-based training tools were used in 277 training institutions to support CSE delivery to over **92,000 students** in **5 countries**.
- In **Latin America**, UNESCO provided technical support to the Brazil, Guatemala, Peru, Jamaica and Haiti to strengthen teacher training and advocacy for CSE, and a subregional consultation was held with 8 countries from Central America, Cuba and Dominican Republic on **CSE, puberty and menstruation education**.
- In **Asia Pacific**, in partnership with UNFPA, CSE implementation reviews were completed in China, India and Thailand, collecting data from over **18,500 students**, 1180 teachers and principals and 578 schools. Findings were presented at the 2016 Women Deliver Conference.
- In **Eastern Europe and Central Asia**, UNESCO launched a new parent education project, "Mama Mia! Being the parent of an adolescent!" with Psychologies magazine and the social media platform OK.RU, which attracted over **90,000 viewers**. As part of an ongoing "Virtual Classroom" project, the first of 5 video cartoons was released in December 2016 addressing HIV prevention, transmission, testing and treatment. Within 3 days it was viewed by over **100,000 people**.

Strategic Priority 2: All young people have access to safe, inclusive, health-promoting learning environments



Graphic: main UBRAF contributions

Key results in 2016:

- In December 2016, UNESCO and UN Women launched joint global guidance on preventing and addressing school related gender-based violence (SRGBV). The guidance was developed under the auspices of the global partners working group on SRGBV, co-chaired by UNESCO and UNGEI. A capacity development workshop was held for UNESCO staff in Africa to familiarize them with the guidance. As a result, **Zambia** trained government personnel on SRGBV, **India** conducted an assessment of SRGBV, and in **Russia**, curricula and a teacher toolkit on SRGBV was introduced in Chelyabinsk province.
- An International Ministerial meeting on **education sector responses to violence on the basis of sexual orientation and gender identity/expression (SOGIE)** was held in May 2016 in Paris. It resulted in a Call for Action that has been endorsed by 56 countries. The meeting was the occasion for the launch of the report “Out in the Open: education sector responses to violence based on SOGIE.” A video and infographic were released under the hashtag #OutInTheOpen, which trended on Twitter and generated over 2820 tweets and an **audience of 20 million**. At country level, a variety of research and advocacy initiatives were taken in connection to the initiative. For example, UNESCO supported the Ministries of Education of Indonesia and Viêt Nam to undertake research on SRGBV and SOGIE-related violence, and in Latin America, UNESCO produced a publication and teacher facilitation guide on SOGIE violence in schools.
- In 2016, UNESCO collaborated with UNODC and WHO to develop a joint publication: [“Good Policy and Practice in Health Education: Education sector responses to the use of alcohol, tobacco and drugs”](#).

B. Case study: Strengthening the national provision of CSE in schools in Zambia



The government of Zambia is spearheading a major project that aims to strengthen the delivery of CSE to young people from ages 10 to 24, including those living with HIV and with disabilities. By increasing access to high- quality, age-appropriate sexuality education and services, the project ultimately seeks to contribute to improved SRH outcomes for Zambian adolescents and youth.

Since 2014, a revised curriculum with integrated CSE has been rolled out in Grades 5 to 12 in all schools across the country. CSE has also been successfully integrated into pre-service training for primary teachers. In-service teachers also receive capacity building in effective delivery of CSE.

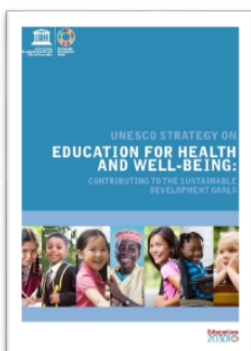
To date, over 25,000 teachers have been trained in effective delivery of CSE at classroom level. Teaching and learning materials have also been produced by the Ministry of Education for all grades, and National and Provincial Standards Officers have been trained to monitor the quality and delivery of CSE at school level.

A baseline survey examined knowledge levels among teachers and students, as well as their attitudes. It also provided a picture of the current status of CSE provision in the education sector, and the degree to which it facilitates access to SRH services for adolescents and young people.

In addition to the standard teacher training, curriculum and materials that are consistent across all schools, these 'champion schools' also offer peer-education programmes and clear links to health services. This variation will also provide opportunities for comparison and analysis of outcomes between the two types of programming.

Building ownership that uses evidence, particularly the baseline survey results, has proven essential to the implementation process. Considering the project's scale and level of ambition, the engagement of multiple sectors – including ministries of health, education, development, youth and sport, as well as non- governmental organizations and other partners – has likewise proven vital in enhancing both ownership and sustainability.

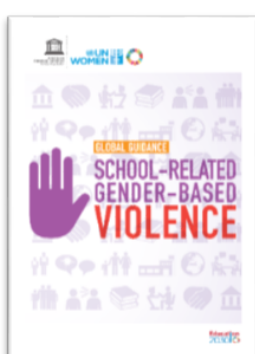
C. Key 2016 Knowledge Products



UNESCO Strategy on Education for Health and Well-Being - Contributing to the sustainable development goals

This publication updates previous UNESCO strategies and expands on UNESCO's work on HIV and on promoting comprehensive sexuality education and safe and inclusive learning environments, placing more emphasis on the role of schools in promoting health. More specifically, it reflects recent developments in the global education, HIV and health agendas, and is aligned with the new UNAIDS 2016-2021 Strategy and the Sustainable Development Goals, in particular SDG 3 Health, SDG 4 Education and SDG 5 Gender Equality.

<http://unesdoc.unesco.org/images/0024/002464/246453e.pdf>



Global Guidance on addressing School-Related Gender-Based Violence

It aims to provide a comprehensive, one-stop resource on school-related gender-based violence including clear, knowledge-based operational guidance, diverse case studies and recommended tools for the education sector and its partners working to eliminate gender-based violence in and around schools.

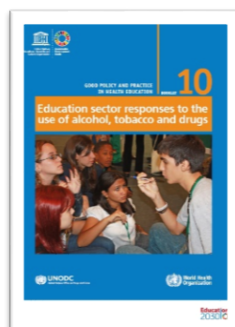
<http://unesdoc.unesco.org/images/0024/002466/246651e.pdf>



Out in the Open – Education sector responses to violence based on sexual gender identity-expression

This publication summarises the main findings of a global review - provides an overview of the most up-to-date data on the nature, scope and impact of, actions to address, homophobic and transphobic violence in educational settings. It also provides education sector stakeholders with a framework for planning effective responses as part of wider efforts to prevent and address violence.

<http://unesdoc.unesco.org/images/0024/002447/244756e.pdf>



Education sector responses to the use of alcohol, tobacco and drugs – Good Policy and Practice in Health Education

It provides the context and rationale for improved education sector responses to substance use, presents evidence-based and promising policies and practice, and suggests issues to consider in sustaining and scaling up effective responses. The intended audience is education sector and school health policymakers, planners and curriculum developers, as well as school health personnel.

<http://unesdoc.unesco.org/images/0024/002475/247509E.pdf>



Early and Unintended Pregnancy – Recommendations for the education sector

This brief contains the summary of recommendations from an evidence review to support the education sector to prevent and respond to EUP. The full evidence review including all the references cited in this brief will be available in the following months.

<http://unesdoc.unesco.org/images/0024/002484/248418E.pdf>



Being a Young Person: Comprehensive Sexuality Education – the video

The video outlines how comprehensive sexuality education (CSE) helps young people develop the knowledge and skills to make conscious, healthy and responsible choices about relationships and sexuality.

<https://www.youtube.com/watch?v=eV92ALv-TGw&feature=youtu.be>

D. Funding and accountability

UNESCO is committed to the principles of transparency, accountability and cost-effectiveness. In addition to the narrative and financial reporting on core and non-core resources that is provided via the JPMS and to the UNAIDS PCB, UNESCO also provides biannual reporting to its own Executive Board, in addition to a specific biennial report on its role as a UNAIDS Cosponsor.

The majority of UNESCO's non-core resources are received through bilateral grants which are earmarked for specific objectives and countries. UNESCO's non-core resources also include funds from projects and programmes for which HIV have been mainstreamed, through technical backstopping support by HIV and health staff. Core UBRAF funding provides UNESCO with the flexibility needed to adapt to the ebb and flow of earmarked donor support, ensuring consistent coverage of priority countries and issues.

WORLD HEALTH ORGANIZATION (WHO)

WHO is a founding Cosponsor of the UNAIDS Joint Programme and the health sector lead within the Joint Programme. WHO directs and coordinates international health by: providing leadership on matters critical to health; shaping the health research agenda; defining norms and standards for health; articulating policy options for health; providing technical support and building capacity to monitor health trends (Figure 1). Within the Joint Programme WHO works closely with Ministries of Health on HIV prevention, testing, treatment and care and ensures critical health sector resources and systems capacities are leveraged for HIV goals.

WHO works across the Joint Programme in numerous ways including shared responsibility with UNICEF and others on the elimination of mother-to-child transmission; shared responsibility with UNDP and the UNAIDS Secretariat on addressing discrimination in the health sector; and in close collaboration with the UNAIDS Secretariat on epidemic monitoring and strategic information. WHO is also a lead contributor to other work areas within the health sector including: innovative prevention and key populations; HIV and health service integration; and gender-based violence. WHO is an active partner of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and a cosponsor and host of several other international health partnerships.

A. WHO Core Functions

Figure 1: WHO Core Functions



1. Striving for strategic alignment and WHA-PCB policy coherence

In May 2016 the 69th World Health Assembly adopted the 2016-2021 global health sector strategy on HIV which is fully aligned to the UNAIDS multisectoral strategy and the key mechanism for policy coherence between the UNAIDS Programme Coordination Board and the World Health Assembly. UNAIDS Deputy Executive Director, Jan Beagle, made a strong intervention in support of the health sector strategy during WHA69 deliberations.

2. WHO leading the health sector response to Agenda 2030

WHO has an extensive reach with 149 field offices in countries, territories or areas. Countries without a WHO office are either covered by the respective WHO Regional Office or a nearby country office. Within WHO HIV has continued to shift from a 'control' to an 'elimination' agenda alongside other communicable diseases including hepatitis, malaria and tuberculosis as part of an organizational response to Agenda 2030 which includes universal health coverage (UHC) at the heart of its health goals. SDG target 3.8 sets out to achieve universal health coverage through inclusion of financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. It means that all people should receive the HIV services they need, which are of sufficient quality to make a difference, without people incurring financial hardship. UHC provides the overarching framework for the global health sector strategy 2016-2021.

Achievement of the ambitious SDG targets requires intensified action in countries. WHO is uniquely placed to combine its specialized technical focus on setting norms and standards with its role in supporting country implementation of public health programmes - a core function of WHO. Much of this work requires strong partnership within and beyond the Joint Programme, including with bilateral programmes and nongovernmental organizations. In recent years significant progress has been made in setting and consolidating global norms and standards for HIV. Armed with a comprehensive portfolio of WHO guidelines and tools to guide national HIV responses greater attention is now clearly focused on country implementation and capacity building.



B. Highlights of 2016 results

The major milestone HIV achievement of 2016 occurred when with over 18 million of the estimated 36.7 million people living with HIV were accessing antiretroviral therapy (ART). This was facilitated by a rationalization in the use of treatment, with WHO's 2016 guidelines on the use of antiretroviral drugs (ARVs) recommending treatment for all people living with HIV regardless of clinical or immunological status, and promoting a single preferred first-line ART regimen.

Uptake of "Treat All" has been rapid, with the majority of low- and middle-income countries having revised or taken steps to revise guidelines to adopt this recommendation.

In November 2016 WHO published the *Prevent HIV, Test and Treat All* progress report for 2016, <http://www.who.int/hiv/pub/progressreports/2016-progress-report/en/> as part of its

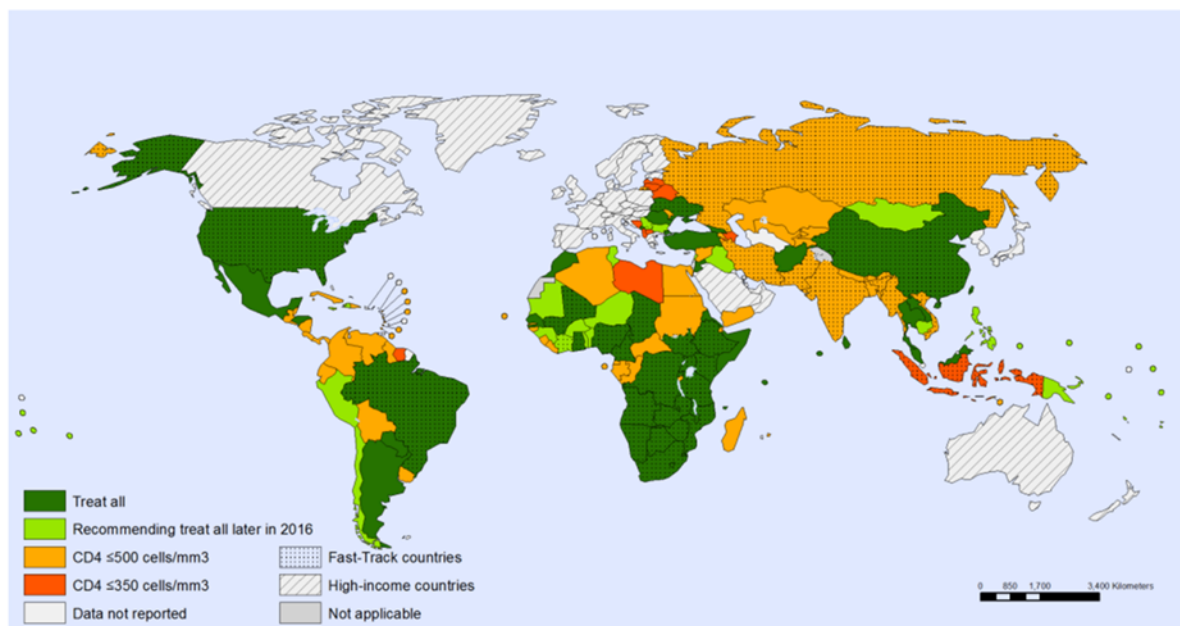
commitment to full transparency of WHO's contributions to the UBR AF results.

WHO backs country action with a **continuum of support**, from issuing global guidelines and promoting policy changes to synthesizing strategic information, mobilizing country partnerships and facilitating capacity-building.

The 2016 progress report documents rapid uptake of new WHO policies throughout the year, with 45 low- and middle-income countries adopting the “treat all” recommendations of the 2016 WHO consolidated guidelines on ARV drugs and another 31 low- and middle-income countries indicating their intentions to do so (Figure 2).

Figure 2. More than half of all low and middle-income countries and 80% of Fast Track countries adopted the WHO “treat all” policy by the end of 2016

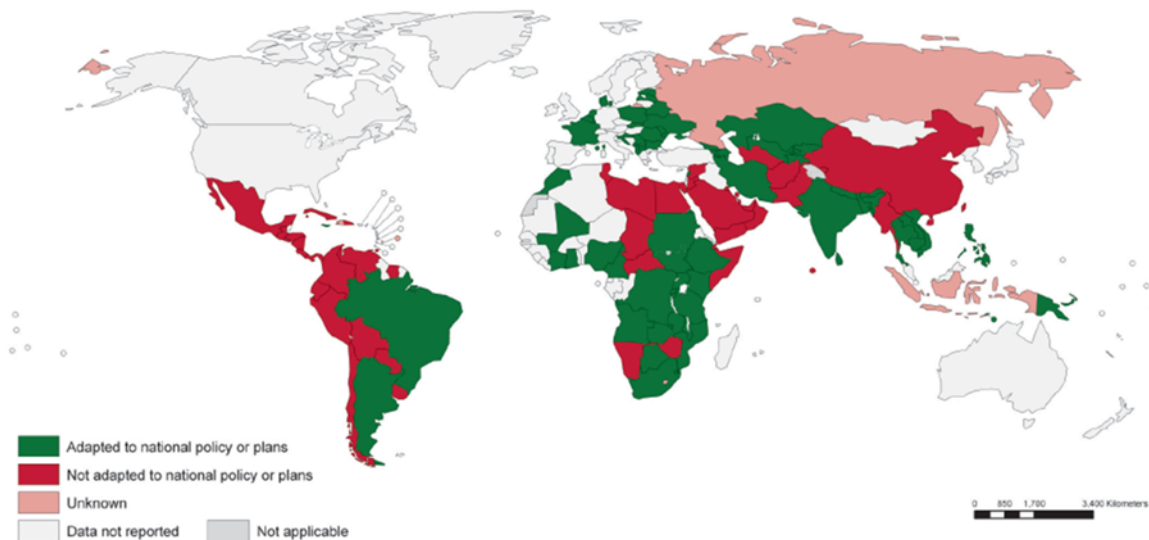


The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Information Evidence and Research (IER)
World Health Organization

 **World Health Organization**
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Figure 3. Countries adapting WHO key population guidelines in national HIV policies or plans as of October 2016



In 2016 WHO trained more than 700 people through regional capacity building events in the use of updated guidelines focused on the use of ART in treatment and prevention, HIV testing services, key populations and strategic information. An external evaluation demonstrated that more than 90% of countries were satisfied with WHO technical support, and the majority saw WHO as the technical provider of choice.

Countries in all regions, including most Fast-Track countries, are extensively using WHO technical support to update key policies on testing and treatment, for example, strengthen systems including for human resources, monitoring and evaluation and strategic information, review their national programmes and update their national strategies. More than 90% of Fast-Track countries used WHO support to adapt their treatment policies, 88% did so to update their testing policies and 56% drew on WHO support to implement service packages for key populations (Figure 3).

1. Intensifying leadership on HIV-related drug resistance (HIVDR)

In 2016 WHO issued a report highlighting low levels of HIV treatment adherence and retention rates that may contribute to an increase in drug resistance. Data from more than 12 000 clinics in 59 countries showed that while patients were being prescribed WHO-recommended antiretroviral (ARV) drugs, many were missing routine check-ups and disappearing from patient records. WHO reported that up to 2010, HIVDR levels remained moderate at 7% in low- and middle-income countries. More recently countries have reported levels at or above 10% among people who are ART-naïve starting HIV treatment, and up to 40% among people starting first-line ART with prior ARV drug exposure. The report updates the first global report on HIVDR, released by WHO in 2012, and establishes key initiatives to strengthen monitoring and response to the emerging threat of HIVDR

2. Implementing in countries through Global Fund collaboration

In 2016 WHO and the Global Fund collaboration was shaped by two frameworks: a cooperation agreement to provide technical support to countries applying for funding through the Global Fund's new funding model; and participation in a focused *Implementation Through Partnership* Initiative.

WHO support around the new funding model enabled countries to produce high-quality and technically sound concept notes to access funding during the allocation period. WHO supported the development of 45 concept notes for HIV, 29 for co-infection with TB and HIV, and 10 for health systems strengthening from 2014-June 2016. In total 173 deliverables or support missions were completed for HIV.

Throughout 2016 WHO worked in collaboration with the Global Fund, and other partners, collaborated on the *Implementation Through Partnership* initiative to increase the effectiveness and efficiency of implementation in the 20 high-impact countries that account for 55% of the Global Fund's allocation portfolio under the new funding model.

For each country, a set of actions to improve implementation was identified, and partners agreed to sponsor or support specific activities. The progress of implementing the activities was tracked and reported monthly to all initiative partners.

Overall, 117 specific activities were identified for the 20 high-impact countries across the three diseases and WHO played a critical role in: sponsoring 59 actions and supporting another 51, thus playing a part in 110 of 117 activities identified through the initiative process, which is 94% of all activities; providing timely and effective support to countries, with most actions being completed on time or ahead of schedule.

The initiative led to improvements in grant disbursement and grant absorption rates. Almost 90% of Fast-Track countries, and 68 countries in all regions, used WHO support to access funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2016 WHO support to 20 focus countries led to a 46% rise in their HIV funding disbursements from the Global Fund within 12 months and brought their HIV results in line with those of other grant receiving countries.

By the end of 2016, WHO had prequalified more than 250 finished pharmaceutical products for treating HIV-related conditions, 29 active pharmaceutical ingredients, and two male circumcision devices. Since 2013, more than 100 countries have drawn on WHO technical support to develop concept notes for their Global Fund grant applications. The quality of funding applications improved, resulting in grants totaling \$2 billion for country HIV programmes.

C. Case Study: HIV self-testing: from evidence - to guidance - to implementation

WHO first explored the potential of HIV self-testing in 2013 by convening a global expert consultation. At this meeting, HIV self-testing was defined as a process where individuals collect their own saliva or blood specimen, perform a test and interpret the result, often in private or with someone they trust. Experts highlighted the importance of HIV self-testing as it showed potential to reach people at high risk for HIV who may not otherwise test including men in high prevalence settings - only 40% of men living with HIV have tested compared to 52% of

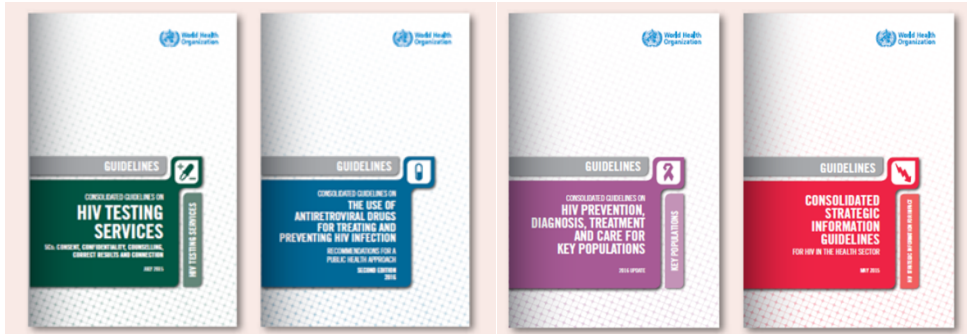
women living with HIV - health workers, young people and serodiscordant couples and key populations. After the consultation WHO reviewed and synthesized available evidence; and, provided global guidance encouraging countries to implement HIV self-testing in the context of operational research as of 2014. Since the development of this guidance, more countries started to introduce or develop national HIV self-testing policies and regulatory frameworks. These advances in policy development and country experiences led to WHO issuing global guidance on self-testing in 2016 on how to implement HIV self-testing in the most ethical, acceptable and effective manner. The guidance supports the introduction of HIV self-testing as a formal HTS intervention using quality-assured products that are approved by WHO and official local and international bodies. It also positions HIV self-testing as an important approach that will help close the testing gap and achieving the UN's 90 –90 –90 and 2030 global goals.

In 2016 WHO also partnered with UNITAID on self-testing and released the second edition of the landscape report on HIV self-testing documenting the experiences of 16 countries that have adopted HIV self-testing policies to date. Additionally, the WHO Prequalification of in vitro diagnostics (IVDs) Programme consulted on the first sample dossier for HIV self-testing technologies to guide manufacturers then issued standards and a pathway for prequalification of HIV rapid diagnostic tests for self-testing in 2016.



HIV self-testing kit demonstration in Malawi : WHO/T.Namjilsuren

D. WHO: Key 2016 HIV Publications



- Global health sector strategy on HIV, 2016-2021. June 2016.
<http://www.who.int/hiv/strategy2016-2021/ghss-hiv/en/>
- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition. June 2016.
<http://www.who.int/hiv/pub/arv/arv-2016/en/>
- Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations 2016 update. July 2016.
<http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>
- Prevent HIV, Test and Treat All progress report for 2016. November 2016.
<http://www.who.int/hiv/pub/progressreports/2016-progress-report/en/>
- Guidelines on HIV self-testing and partner notification. December 2016.
<http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/>

THE WORLD BANK

With 189 member countries, staff from more 170 countries, and offices in over 130 locations, the World Bank Group is a unique global partnership: five institutions working for sustainable solutions that reduce poverty and build shared prosperity in developing countries. The World Bank Group's Health, Nutrition and Population Global Practice provides financing, state-of-the-art analysis, and policy advice to help countries expand access to quality, affordable health care. It also prioritizes protecting people from falling into poverty or becoming poorer due to illness; and promoting investments in all sectors that form the foundation of healthy societies.

The global movement toward universal health coverage (UHC) provides an umbrella under which the World Bank Group (WBG) works with governments and development partners to ensure all people receive quality, affordable care without suffering financial hardship. UHC aims to achieve better health and development outcomes in line with the Sustainable Development Goals (SDGs). SDG 3 includes a target to “achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.” Our work to help countries achieve UHC is closely linked to our work to end preventable maternal and child mortality by 2030; reduce stunting and improve nutrition for infants and children; strengthen health systems; and of course prevent and treat communicable diseases such as HIV and AIDS.

The World Bank is a founding Cosponsor of UNAIDS, and a key partner of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The World Bank is the lead on support to the planning, efficiency, effectiveness and sustainability of the global AIDS response, as well as the co-lead on social protection with UNICEF and prevention of sexual transmission with UNFPA. The World Bank leverages its large multisectoral portfolio of lending activities to finance the HIV response, facilitate its mainstreaming and ensure that AIDS is taken out of isolation. Beyond financing, as a knowledge institution, the World Bank is a key provider of strategic information, analysis, technical support and policy guidance for governments and implementers.

A. Fit for purpose: a highly rated multisectoral agency, leveraging finance and knowledge for the HIV response

The World Bank has received consistently high ratings from independent reviews over the past decades and has been assessed as one of the highest performing multilateral institutions.

Most recently, the government of Australia completed a Multilateral Performance Assessment in which the WBG received strong ratings reflecting in particular its strong policies and technical capacity; convening power and “platform” role in the provision of global public goods; and strong transparency and accountability mechanisms. The World Bank achieved the highest ratings in all 6 categories of the assessment. <http://dfat.gov.au/about-us/publications/Pages/performance-of-australian-aid-2015-16.aspx>. Similarly, in the 2016 Multilateral Aid Review conducted by the United Kingdom, the World Bank is described as achieving “exceptional results” and is among the only 3 agencies - with the Global Fund and the Gavi alliance- to achieve the highest ratings in both indices of the review, including organisational strength.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573884/Multilateral-

[Development-Review-Dec2016.pdf](#)

The 2016 Aid Transparency Index (ATI), ranked the World Bank (IDA) for the second consecutive year in the top (“very good”) category. In 2016 the World Bank was ranked as number 6, with a score of 86, among the only 10 donors that, according to the ranking, have lived up to the Busan commitment on aid transparency. <http://www.publishwhatyoufund.org/2016-aid-transparency-index>. The Multilateral Organization Performance Assessment Network (MOPAN) 2015-2016 review also concluded with very high ratings as the World Bank achieved either a Highly Satisfactory rating (7KPIs) or Satisfactory rating (5KPIs) against the 12 MOPAN key performance indicators. <http://www.mopanonline.org/assessments/worldbank2015-16/index.htm>.

Finally, one can also note the results of the survey provided by the research organization Aid Data of recipient country policymakers, and their views of the utility, influence and helpfulness of various aid agencies http://aiddata.org/sites/default/files/publication_full_2.pdf. The study shows the influence that the World Bank has on policy making “According to nearly 6,750 policymakers and practitioners, the development partners that have the most influence on policy priorities in their low-income and middle-income countries (...) large multilateral institutions like the World Bank, the GAVI Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.”

The World Bank total lending portfolio reached \$61 billion in FY 2016, with \$16.2 billion in commitments for IDA which provides interest free loans and grants the world 77 poorest countries. During the period from fiscal year 2000 to 2016, the World Bank invested US\$35 billion in the Health, Nutrition and Population (HNP) thematic areas alone. The Bank currently manages an active HNP portfolio of \$11.9 billion. Those funds, provided to governments, finance a wide range of projects that contribute to the HIV response, from health system strengthening to HIV sensitive social protection systems. The UBRAF funding enables the Bank to facilitate the integration of HIV prevention, treatment and care into those multisectoral investments, in health systems, education, gender, social protection, transport and infrastructure at country level. Thanks to the UBRAF, the World Bank is able to provide additional technical assistance, strategic knowledge and policy guidance in support of the HIV response, in the context of an organization that is consistently assessed as performant, transparent and efficient.

B. Highlights of results in 2016

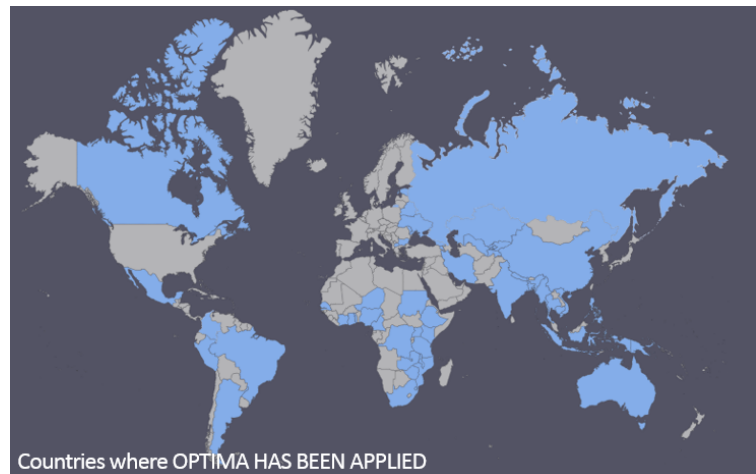
The World Bank is putting a strong emphasis on the issue sustainability, efficiency and effectiveness of the AIDS response as it recognizes that funding landscape has dramatically shifted in recent years. In order to help governments finance program scale up with limited resources, and support countries transition from international financing to a bigger share of domestic financing, the World Bank is spearheading a major work program on improving HIV technical efficiency, allocative efficiency and sustainability.

1. Allocative Efficiency

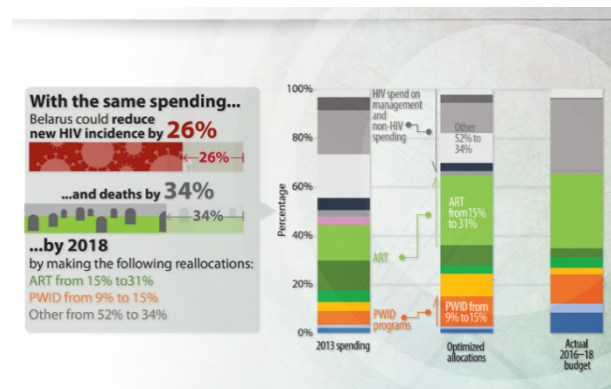
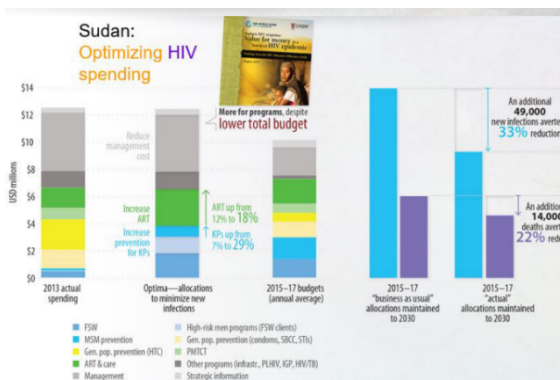
The World Bank has led and financed more than 40 allocative efficiency studies worldwide, with the objective of optimizing resource allocation in national strategic and operational plans, as well

as to support Global Fund concept notes.

The allocative efficiency work has directly influenced policy making, as the examples from Sudan and Belarus demonstrate. In both cases, governments realigned the allocation of resources to match more closely the optimal allocation recommended by the analysis. In Belarus for example, the follow up analysis conducted to estimate the effect of changes in budget allocations on new HIV infections



and deaths suggested that the improved budget allocation in the new national programme will avert an additional 3,200 new HIV infections and 1,800 AIDS deaths between 2016-18 and, if sustained, avert 25,000 new infections and 13,000 AIDS deaths by 2030 – a reduction by around a third compared to business as usual.



Allocative efficiency Sudan

Allocative Efficiency Belarus

2. Implementation efficiency

The World Bank provided technical support to improve the implementation efficiency of the HIV response. For example in South Africa where the World Bank conducted an analysis of the entire HIV care cascade to determine the best combination of interventions to achieve maximal population health.

South Africa Integrated HIV and Chronic Care Example

- ▶ Did a **systematic review** to identify 30 proven interventions for each cascade tier
- ▶ Derived **unit cost data** for each intervention
- ▶ Assessed current and possible **program coverage scale-up opportunities**
- ▶ Fed these data into an **epidemiological-economic optimization model** – Optima



The study collated detailed costing data and programmatic outcomes of 30 separate testing-, linkage-, retention-, care-, and treatment-related HIV interventions in South Africa, which were further broken down by urban/rural locality. The study developed a novel ‘cascade’ mathematical optimization model to test the hypothesis that the optimal allocation of projected future resources across the 30 identified interventions could potentially yield greater clinical outcomes towards attaining the UNAIDS 90-90-90 targets over 2017-2020 compared to current intervention focus areas.

Linked unit costs with data on program capacity and cascade stages that the services directly impact*

Program (urban and rural setting)	Unit cost (USD, 1 ZAR = 0.0630 USD)	Program Capacity (%)	Cascade flows affected
Client-initiated clinic-based testing	\$5.20	80	Diagnosis, linkage to care
Provider initiated testing	\$5.73	80	Diagnosis, linkage to care
Mobile testing	\$6.05	80	Diagnosis, linkage to care
Door-to-door testing	\$7.44	80	Diagnosis, linkage to care
Workplace testing	\$9.68	80	Diagnosis, linkage to care
Youth-friendly SRH testing	\$14.74	80	Diagnosis, linkage to care
Self-testing	\$4.41	80	Diagnosis, linkage to care
Laboratory CD4 testing	\$8.28	80	Linkage to care
Point-of-care CD4 testing	\$23.76	80	Linkage to care
Community support: link to care	\$2.66	80	Linkage to care
Tracing: pre-ART client	\$8.18	80	Linkage to care, pre-ART care
Pre-ART wellness program	\$5.00	80	Pre-ART care
Additional education (prof)	\$6.30	80	Pre-ART care, treatment consolidation
Additional education (lay)	\$1.26	80	Pre-ART care, treatment consolidation
Community support: pre-ART care	\$5.32	80	Pre-ART care

The preliminary findings suggest that the HIV care continuum can be improved markedly with the same level of resources. By optimally allocating resources and having HIV treatment eligibility criteria removed, it was estimated that the proportion of PLHIV achieving viral load

suppression by 2020 can be increased from 45% to 56% (52-59%) without additional funds; a 19% relative increase. Through improved resource allocation decisions, an estimated 87% (85-88%) of PLHIV will be diagnosed; 69% (67-72%) of them will receive ART, and 94% (90-95%) of them will be virally suppressed by 2020. An estimated 11% (9%-12%) of cumulative HIV infections and 9% (6%-11%) of AIDS-related deaths can be averted over 2017-2020.



3. Effectiveness

The World Bank conducted impact evaluations to strengthen evidence on effective HIV prevention and treatment interventions and delivery modalities. Early findings of current projects are already influencing policy and practice on HIV prevention in the region, for example:

The World Bank-led evaluation on mHealth resulted in a new “SmartLink” app to support HIV prevention and treatment in South Africa. The evaluation is providing lessons for a national health-system-wide app linked to the National Health Insurance scheme, and have shown that the mobile app can increase treatment initiation amongst young people – traditionally a difficult group of people to convince to take up health services.

South Africa | mHealth App

SMART Link

- More than **50%** of HIV cases surveyed use WhatsApp, Facebook and Twitter
- Patients are using smartphones to **access their personal health information** (possibly based on experiences of hard-to-obtain test results and perceived disconnect from the health care providers)
- Only **57%** of new HIV cases get linked to HIV care (A recent study confirmed linkage to care remains insufficient)*

Smart linkage to care randomised controlled trial

Evaluation: *Can a smartphone-enabled app improve linkage-to-care rates in newly diagnosed young HIV clients?*

36% aged 18–30 | 36% male | 44% from other countries in the region

Enrolment challenges

- No ID documents with them
- 1 in 15 persons tested are HIV+ (compared to 1 in 5 two years ago)
- Refusal to enrol in any study

Remedial strategies

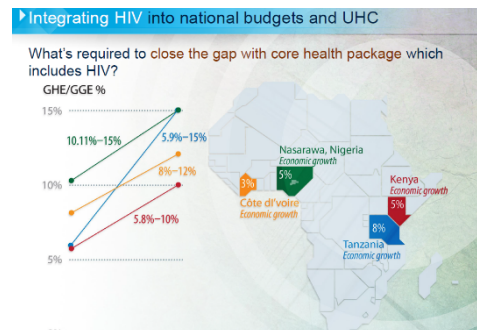
- Expanding number of sites five-fold
- Revising enrolment figures
- Dropping ID document criteria (in favour of other identification)
- Relevant communication materials

The World Bank-led evaluation on incentives for voluntary medical male circumcision (VMMC) in Malawi found that vouchers resulted in remarkable uptake. In the two evaluation districts, the odds of getting circumcised with a voucher were 7.32 times among young men aged 10–34 years,

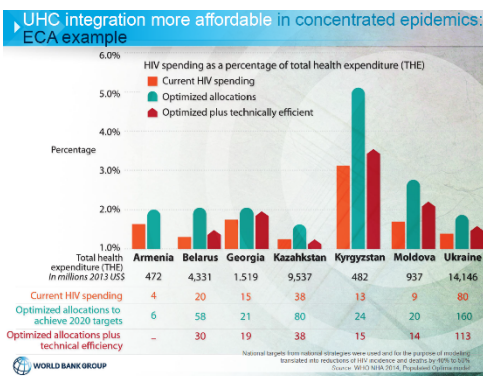
compared to control groups. The Government of Malawi is considering strategies for the roll out of a voucher scheme for VMMC throughout Malawi.

4. Sustainability and Integration

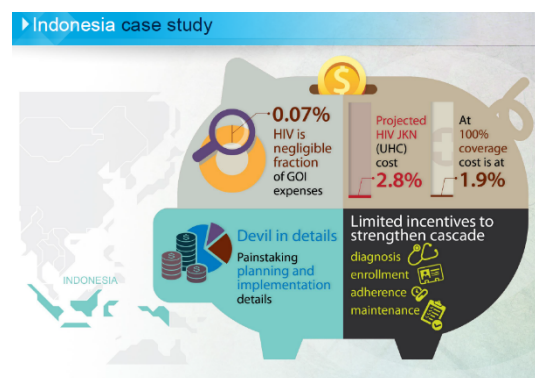
The World Bank is conducting multiple HIV integration, sustainability and financing studies to improve the integration of the HIV response in SRH and UHC and ensure its sustainability. The World Bank finalized for example a series of 4 country studies, “HIV/AIDS and Universal Coverage Financing in Africa”, to help the Governments of Tanzania, Cote d’Ivoire, Kenya and Nigeria assess the financial sustainability of HIV/AIDS interventions within the context of UHC.



The optimization work conducted in the ECA region shows how UHC integration remains obviously more affordable in concentrated epidemics. However, the Indonesia case study demonstrated that



the difficulty of integrating HIV into UHC is not limited to financial considerations but also to the magnitude of implementation challenges.

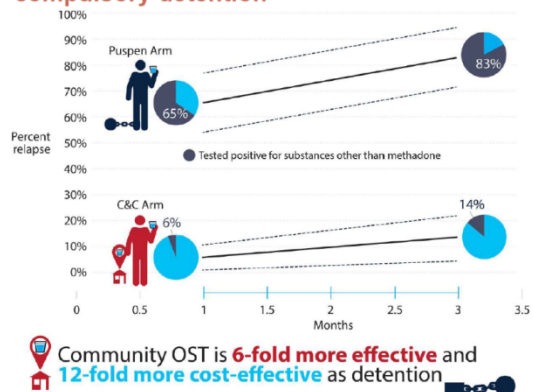


C. Case study

The World Bank generates knowledge and evidence for policy use. The World Bank is effectively using its core UBRAF resources to leverage, inform and guide the design and implementation of a large multisectoral portfolio of HIV sensitive grants, credits and loans. In that context, and beyond facilitating the mainstreaming of HIV response in health and other sectors, one of the Bank core mission remains the production of key evidence to influence policy decision. The Malaysia Drug rehabilitation program is an example of such a mission.

In Malaysia, The World Bank demonstrates the effectiveness of community OST versus compulsory detention and the Return on Investment of harm reduction programs. The World Bank conducted an evaluation comparing the compulsory approach to drug use with the voluntary-based Cure&Care clinics that provide methadone services. The study generated the evidence that opioid-dependent persons in CDDCs relapse to opioid use markedly faster than those treated with evidence-based treatments like methadone under C&C, suggesting CDDCs have little role in the treatment of opioid use disorders. CDDC participants had significantly more rapid relapse to opioid use post-release compared to C&C participants (median: 31 days vs 352 days). Furthermore, the return on investment studies conducted by the Bank generated the evidence that Malaysia's two harm reduction programs (NSEP and MMT) are cost-effective. A long term benefits projection for the period 2006-2050 indicates savings of approximately RM910 million in healthcare costs and an average return of RM1.13 for every ringgit invested in harm reduction programs.

What we know about **community OST** versus **compulsory detention**



Impactful evidence directly translates into policy change. The generated evidence on cost-effectiveness and return on investment of both the needles and syringe exchange program (NSEP) and methadone maintenance therapy (MMT) program in Malaysia has boosted the Malaysia government's position in introducing these previously controversial programs, and firmly put the two programs as the solid interventions to address the HIV epidemic among PWID in Malaysia. The impacts from the work on return on investment and cost-effectiveness of NSEP and MMT have gone beyond Malaysia, and have benefit Malaysia's neighbors. The WB has shared the results of this work with other countries in Southeast Asia that face similar HIV epidemic among PWID, particularly the Philippines where the results of the study has helped address earlier misperception and convince several high-level government officials in the Philippines to consider adopting such cost-effective interventions as NSEP.

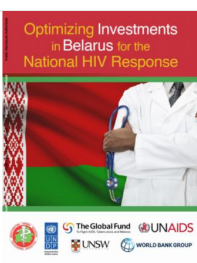
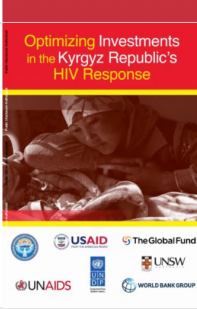
D. Highlights knowledge products produced in 2016







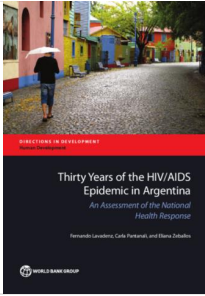
Ending AIDS in Johannesburg : An Analysis of the Status and Scale-Up Towards HIV Treatment and Prevention Targets

<https://openknowledge.worldbank.org/handle/10986/25685>

Johannesburg, one of South Africa's metropolitan municipalities and one of the 52 health districts has more people living with HIV (PLHIV) than any other city worldwide at ~600,000. This brief provides the key results of a modeling analysis estimating what it would take in terms of programmatic targets and costs for Johannesburg to meet the Fast-Track targets and demonstrate the impact that this would have.

	<p>Optimizing Investments in Georgia's HIV Response https://openknowledge.worldbank.org/handle/10986/24966</p> <p>Georgia has a concentrated but growing HIV epidemic. Over the past decade, HIV prevalence has increased among all population groups, particularly among men who have sex with men (MSM). If current conditions (behaviors and service coverage) are sustained up to 2030, the epidemic is expected to stabilize among female sex workers (FSWs)</p>
	<p>Value for Money in Ukraine's HIV Response : Strategic Investment and Improved Efficiency https://openknowledge.worldbank.org/handle/10986/24967</p> <p>Ukraine experiences one of the most severe HIV epidemics in Europe. An HIV allocative efficiency analysis has been carried out, which revealed that there are several key opportunities to change the course of Ukraine's HIV epidemic: Ukraine's current HIV response already makes strategic use of available resources (around US\$80 million in 2013) prioritizing Antiretroviral Therapy (ART) and prevention programs for people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW).</p>
	<p>Optimizing Investments in Belarus for the National HIV Response https://openknowledge.worldbank.org/handle/10986/25395</p> <p>This report summarizes the findings of an allocative efficiency analysis on Belarus' national HIV epidemic and response conducted in 2014-15. The report addresses core questions for resource allocation such "How can HIV funding be optimally allocated to the combination of HIV response interventions that will yield the highest impact?" or "What level of investment is required to achieve national targets, if we allocate resources optimally?".</p>
	<p>Optimizing Investments in the Kyrgyz Republic's HIV Response https://openknowledge.worldbank.org/handle/10986/25377</p> <p>This report summarizes the findings of an allocative efficiency analysis on the Kyrgyz Republic's national HIV epidemic and response conducted in 2014-15. The report addresses core questions for resource allocation such 'How can HIV funding be optimally allocated to the combination of HIV response interventions that will yield the highest impact?' or 'What level of investment is required to achieve national targets, if we allocate resources optimally?'.</p>
<p>AIDS at 35 : A Midlife Crisis https://openknowledge.worldbank.org/handle/10986/25836</p> <p>This year marks the 35th since AIDS was first identified and the epidemic faces a 'mid-life' crisis. It seems to us it is time to take stock of both the successes we have met and the challenges we face. In this editorial for the final issue of AJAR in 2016 we do this. We warned of the potential devastation AIDS would wreak across Africa, but this went unheard. We watched with dismay as colleagues and friends sickened and died, and the political leaders initially ignored what was to come. In this editorial we look at the best of times – where things went well; and the worst of times – where the challenges lie.</p>	
	<p>Value for Money in Ukraine's HIV Response: Strategic Investment and Improved Efficiency https://openknowledge.worldbank.org/handle/10986/2476</p> <p>Ukraine experiences one of the most severe HIV epidemics in Europe. This policy brief is a result of a team effort involving the State Institution Ukrainian Center for Socially Dangerous Disease Control of the MOH of Ukraine, and international partners. The study was part of the regional initiatives on HIV allocative efficiency analysis and funded and technically supported by the World Bank and UNAIDS.</p>

 <p>EVALUATING THE EVIDENCE FOR HISTORICAL INTERVENTIONS HAVING REDUCED HIV INCIDENCE: A RETROSPECTIVE PROGRAMMATIC MAPPING MODELLING ANALYSIS SYNOPSIS REPORT 2016</p> <p>UNAIDS, The Global Fund, Imperial College London, WHO, UNFPA, The World Bank</p>	<p>Evaluating the Evidence for Historical Interventions Having Reduced HIV Incidence: https://openknowledge.worldbank.org/handle/10986/25763</p> <p>A Retrospective Programmatic Mapping Modelling Analysis - Synopsis Report 2016 This multi-country study focuses on evaluating whether ART scale-up and changes in sexual risk behavior have contributed to the declining trends of HIV incidence and prevalence. The World Bank, UNAIDS, UNFPA, WHO, the Global Fund, and Imperial College London agreed upon specific criteria used to identify Botswana, Dominican Republic, Kenya, Malawi and Zambia as the five countries engaged in this study.</p>
 <p>Optimizing Investments in Kazakhstan's HIV Response</p> <p>UNAIDS, USAID, The Global Fund, UNSW, The World Bank</p>	<p>Optimizing Investments in Kazakhstan's HIV Response https://openknowledge.worldbank.org/handle/10986/24965</p> <p>As part of a Regional initiative, Kazakhstan conducted an Human Immunodeficiency Virus (HIV) allocative efficiency analysis to inform more strategic investment in HIV programs. Kazakhstan continues to experience a concentrated HIV epidemic in which the majority of new infections occurred among key populations, particularly PWID, MSM, prison inmates, FSW, and their clients.</p>
<p>Funding of Community-Based Interventions for HIV Prevention https://openknowledge.worldbank.org/handle/10986/24820</p> <p>Since the start of the HIV epidemic, community responses have been at the forefront of the response. Following the extraordinary expansion of global resources, the funding of community responses rose to reach at least US\$690 million per year in the period 2005–2009. Since then, many civil society organizations (CSOs) have reported a drop in funding. Yet, the need for strong community responses is even more urgent, as shown by their role in reaching the Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast-Track targets. In the case of anti-retroviral treatment, interventions need to be adopted by most people at risk of HIV in order to have a substantial effect on the prevention of HIV at the population level. This paper reviews the published literature on community responses, funding and effectiveness.</p>	
<p>The Use of Cash Transfers for HIV Prevention – Are We There Yet? https://openknowledge.worldbank.org/handle/10986/24181</p> <p>Poverty and social inequality are significant drivers of the HIV epidemic and are risk factors for acquiring HIV. As such, many individuals worldwide are at risk for new HIV infection, especially young women in East and Southern Africa. By addressing these drivers, social protection programs may mitigate the impact of poverty and social inequality on HIV risk.</p>	
 <p>When the Money Runs Out: Do Cash Transfers Have Sustained Effects on Human Capital Accumulation? The Cash Transfer Have Sustained Effects on Human Capital Accumulation? World Bank December 2016</p>	<p>When the Money Runs Out: Do Cash Transfers Have Sustained Effects on Human Capital Accumulation? https://openknowledge.worldbank.org/handle/10986/25705</p> <p>This study examines the medium-term effects of a two-year cash transfer program targeted to adolescent girls and young women. The findings point to both the promise and the limitations of cash transfer programs for sustained gains in welfare among young women.</p>
 <p>Evaluation of Harm Reduction Service Delivery in Cebu City, Philippines (2013–2015) Proposed by Paul Sanyal For the World Bank April 2016</p>	<p>Evaluation of Harm Reduction Service Delivery in Cebu City, Philippines (2013–2015) https://openknowledge.worldbank.org/handle/10986/24750</p>



Thirty Years of the HIV/AIDS Epidemic in Argentina: An Assessment of the National Health Response

<https://openknowledge.worldbank.org/handle/10986/22124>

This book delves into the combination of factors that make Argentina a success story in combating HIV/AIDS. It analyzes the national and inter-provincial burden of disease, the demographics of new HIV cases, the demand and supply-sides of service delivery, and conducts a cost-benefit analysis of the Argentine National HIV/AIDS Program from 2000 to 2010.



HIV Programs for Sex Workers: Lessons and Challenges for Developing and Delivering Programs

<https://openknowledge.worldbank.org/handle/10986/23190>

There is evidence that HIV prevention programs for sex workers, especially female sex workers, are cost-effective in several contexts, including many western countries, Thailand, India, the Democratic Republic of Congo, Kenya, and Zimbabwe. The evidence that sex worker HIV prevention programs work must not inspire complacency but rather a renewed effort to expand, intensify, and maximize their impact. The PLOS Collection "Focus on Delivery and Scale: Achieving HIV Impact with Sex Workers" highlights major challenges to scaling-up sex worker HIV prevention programs

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