Agenda item 6.1

UNAIDS/PCB (42)/18.9

UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK (UBRAF)

Performance Monitoring Report 2016-2017: Organizational Reports

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Additional document for this item:

i. UNAIDS Performance Monitoring Report 2016-2017: Synthesis *(UNAIDS/PCB (42)/18.10)*

Action required at this meeting: included in UNAIDS/PCB (42)/18.10

Cost implications of decisions: none

Contents

ACRONYMS

AIDS	acquired immunodeficiency syndrome
AP	Asia and Pacific
ART	antiretroviral therapy
ARV	antiretroviral medicines
AU	African Union
CBT	cash based transfers
CD4	cluster of differentiation 4
CEDAW	Committee on the Elimination of Discrimination against Women
CSE	comprehensive sexuality education
CSO	civil society organization
DPKO	Department of Peacekeeping Operations
ECOM	Eurasian Coalition on Male Health
EECA	Eastern Europe and central Asia
EID	early infant diagnosis
EMIS	Education Management Information System
eMTCT	elimination of mother-to-child transmission (of HIV)
ERG	Economic Reference Group
ESA	Eastern and southern Africa
GARPR	Global AIDS Response Progress Report
GBV	gender-based violence
HIV	human immunodeficiency virus
HPV	human papillomavirus
HTC	HIV testing and counselling
IATT	Inter-Agency Task Team
IAPAC	International Association of Providers of AIDS Care
ICT	information and communication technology
ICW	International Community of Women Living with HIV/AIDS
IDPs	Internally displaced persons
IEC	Information, education and communication

IPPF	International Planned Parenthood Federation
JPMS	Joint Programme Monitoring System
LA	Latin America
LGBTI	lesbian, gay, bisexual, transgender and intersex
LMIC	low- and middle-income countries
MAM	moderate acute malnutrition
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MERG	Monitoring and Evaluation Reference Group
NCDs	noncommunicable diseases
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCB	Programme Coordinating Board
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission (of HIV)
PrEP	pre-exposure prophylaxis
QCPR	Quadrennial Comprehensive Policy Review
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SAM	severe acute malnutrition
SDG	Sustainable Development Goal
SERAT	sexuality education review and assessment tool
SGBV	sexual and gender-based violence
Sida	Swedish International Development Cooperation Agency
SOGI	sexual orientation and gender identity
SRGBV	school-related gender-based violence
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection

TB	tuberculosis
TSF	Technical Support Facility
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	United Nations Joint Programme on AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UN ESCAP	(United Nations) Economic and Social Commission for Asia and the Pacific
UHC	universal health coverage
UNGASS	UN General Assembly Special Session
USAID	United States Agency for International Development
VMMC	voluntary medical male circumcision
WCA	West and central Africa
Cosponsors	
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
ILO	International Labour Organization
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization
WB	World Bank

INTRODUCTION

1. This organizational report forms the second part of the Performance Monitoring Report. It highlights achievements in the 2016-2017 biennium against the 20 outputs and the five Secretariat functions of the 2016–2021 UBRAF, the UNAIDS 2016–2021 Strategy and the global targets established by the 2016 Political Declaration on Ending AIDS.

2. The report presents information on the key achievements of Cosponsors and the Secretariat. It describes progress made against the Strategy, first by considering the accomplishments and expenditures of the 11 Cosponsors, and then by reviewing the UNAIDS Secretariat's contributions and expenditures.

3. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was established to draw on the experience and strengths of the Cosponsors in developing coherent strategies and policies, providing assistance to build country and community capacity and mobilizing political and social support for action to prevent and respond to AIDS, while involving a wide range of sectors and institutions at the national level.

4. UNAIDS is an innovative partnership of 11 United Nations Cosponsors and the UNAIDS Secretariat. Its strength derives from the diverse expertise, experience and mandate of its Cosponsors and the added value of the Secretariat in leadership and advocacy, coordination and accountability.

UNAIDS' mission is to lead and inspire the world in achieving universal access to HIV prevention, treatment, care and support by:

- **Uniting** the efforts of the United Nations System, civil society, national governments, the private sector, global institutions and people living with and most affected by HIV.
- **Speaking out** in solidarity with the people most affected by HIV in defence of human dignity, human rights and gender equality.
- **Mobilizing** political, technical, scientific and financial resources and holding ourselves and others accountable for results.
- **Empowering** agents of change with strategic information and evidence to influence and ensure that resources are targeted where they deliver the greatest impact and bring about a prevention revolution.
- **Supporting** inclusive country leadership.

United Nations High Commissioner for Refugees (UNHCR)

UNHCR, the UN Refugee Agency, is a global organization whose mandate is to lead and coordinate global action in humanitarian contexts to protect the rights and well-being of tens of millions of refugees, internally displaced persons and other people of concern, including the stateless, asylum seekers, returnees and those living in surrounding host communities. UNHCR strives to ensure that refugees are able to access life-saving and essential healthcare. Active in more than 120 countries, UNHCR makes a unique contribution to the international AIDS response. The agency reaches people who may have become more vulnerable to HIV owing to displacement and exposure to conflict situations. Using HIV -related competence and expertise it has developed over decades, it has a wide range of interventions and programmes, including HIV prevention, protection and treatment; reproductive health services; food security and nutrition; and water, sanitation and hygiene services.

UNHCR has been a UNAIDS Cosponsor since 2004, and UNHCR and WFP co-convene the Division of Labour area of HIV services in humanitarian emergencies. UNHCR is also 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.

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

5. 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 levels. Significant progress has been made in improving access to comprehensive HIV and reproductive health services in the past five years, particularly in terms of integrating refugees, internally displaced people (IDPs) and other populations affected by humanitarian emergencies into national health systems to improve access to HIV and reproductive health services. UNHCR's teams at global, regional and country levels will continue to work with communities to ensure populations affected by humanitarian emergencies are not left behind as the agency contributes towards achieving the targets set out in the Sustainable Development Goals (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.

Highlights of results in 2016-2017

6. UNHCR worked in over 35 countries to provide comprehensive integrated HIV and reproductive health services to its populations of concern. Annual reporting on all its public health programmes at both global and country levels, including reproductive health and HIV, can be found at http://twine.unhcr.org/ar2017/. UNHCR's 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 2017 include:

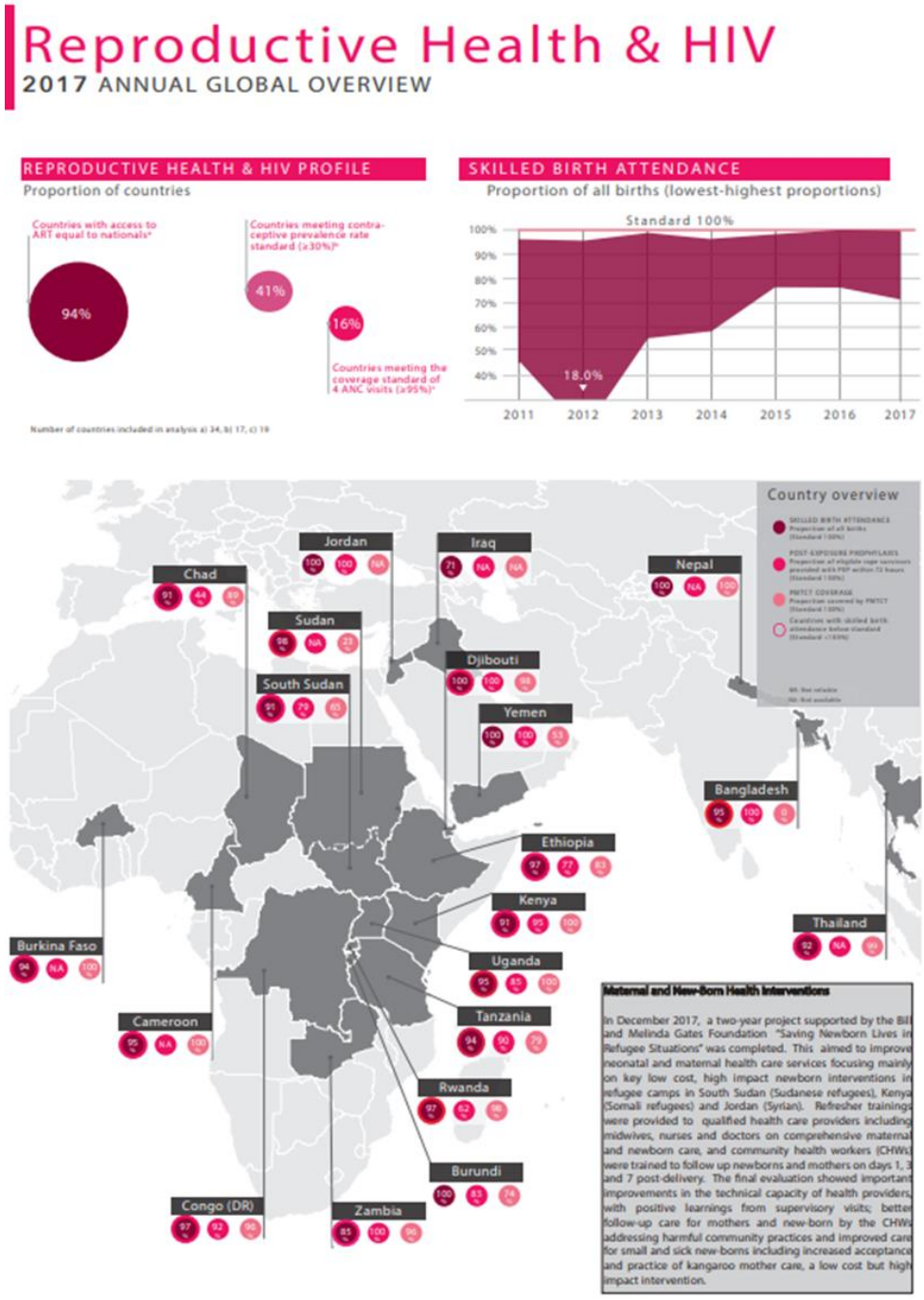


Figure 1: HIV services provided by UNHCR in humanitarian emergencies

Key achievements by Strategy Result Area

7. UNHCR provided support during 2016 and 2017 to ensure the continuation of HIV services for refugees and other displaced populations affected by humanitarian emergencies in more than 50 of its operations. Some of the key results are outlined below:

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative HIV testing and counselling programmes *[Output 1.1]*

8. During 2016-2017, UNHCR continued to work to ensure that refugees and other populations affected by humanitarian emergencies have improved access to HIV testing and counselling services, through community-based services for populations of concern in UNHCR operations. For example, in 2017 in South Sudan, UNHCR provided support for the scale up of HIV testing services in six camps and two referral hospitals, where more than 15 600 people were tested throughout the year. UNHCR also continued to work with vulnerable and high-risk groups to strengthen their access to HIV counselling and testing services for refugee and host communities.

HIV-related services in humanitarian emergencies *[Output 1.5]*

9. Following the implementation of the "Treat All" guidelines, there was an increase of over three times (from 3357 in 2014 to 10 581 in 2017[1]) in the number of patients supported by UNHCR to access antiretroviral therapy (ART). Increased access to ART has led to increased need for services for the continuation of HIV treatment in areas affected by humanitarian emergencies. After the massive refugee influx from South Sudan to Uganda the Ministry of Health, UNHCR and other partners provided treatment through UNHCR-supported clinics to 12 019 people (3967 refugees and 8052 host population) in 2017. Of these, 2616 people arriving from South Sudan were linked to treatment in the refugee settlement facilities in West Nile.

10. UNHCR is also working with various partners to scale up and strengthen regional and country-level responses addressing HIV. In 2017, UNHCR was a sub-grantee of a 21-month US$ 2.8 million regional grant with the Intergovernmental Authority for Development (IGAD) on HIV and tuberculosis (TB) in Djibouti, South Sudan, Sudan and Uganda, and a partner in Kenya and Ethiopia. The grant focuses on scaling up HIV and TB services in 13 refugee camps and aims to improving the availability and utilization of HIV and TB services, through complementing existing UNHCR funded programmes. Key 2017 achievements of this grant included 414 992 refugees aged 15 years and older receiving HIV testing and results; 6978 of whom were supported to access ART, and the identification of 2178 cases of TB (all forms). HIV testing, ART uptake and TB case finding have considerably improved since 2015. Other achievements included improved coordination mechanisms with refugee stakeholders, and improved linkages with national HIV and TB programmes and supply chain management.

[1] In sites where this information is collated

11. In Rwanda, UNHCR successfully mobilized a US$ 2.09 million grant in 2017 from the Global Fund, which enabled continued access to HIV screening, care and treatment; TB screening and management; as well as malaria prevention to new arrival Burundian refugees. Among these, 13 388 refugees aged 15 years and older in camp, reception centres and urban areas were tested for HIV. Of the 953 persons identified as living with HIV, 97% were enrolled in treatment services including nutrition support. UNHCR conducted research on adherence in two refugee camps in Zambia which demonstrated the strength of the programme; among refugees sampled 78.8%, had adherence levels of at least 95% in the four days prior to the interview. UNHCR also provided recommendations to facility and community-based partners on how adherence can be improved for both refugees and the surrounding host communities, which will be scaled up during 2018 and will include a focus on management of side effects; strengthening privacy and confidentiality in health facilities; improved nutritional and livelihood support; and reducing stigma and discrimination in camp settings. In 2016-2017 UNHCR supported peer-led community interventions to improve adherence in several countries including Egypt, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Uganda and Zambia.

12. Data management systems were significantly strengthened at field level for HIV and reproductive health indicators through the on-going revision and update of UNHCR's health information system (HIS). Updates were made to standards and indicators as well as the way data is collected, analysed and visualized, leveraging the latest developments in information technology to improve data quality and timeliness to enable evidence-based decision making. Relevant HIV indicators have been revised and aligned with the latest Global AIDS Response Progress Reporting (GARPR) indicators. The system was feature tested and piloted in five countries in 2017 and will be rolled out in all UNHCR operations by the end of 2018.

Medicines and commodities *[Output 1.6]*

13. UNHCR provides technical inputs to strengthen health systems, including for procurement and distribution of HIV related commodities and provided logistical support for access to commodities during emergencies.

14. UNHCR works with UNFPA to provide both male and female condoms to populations affected by humanitarian emergencies. In 2016-2017, over 9.6 million condoms were distributed to refugees, IDPs and other populations affected by humanitarian emergencies both inside refugee camps and in out-of-camp settings.

15. In 2017, there were new influxes of refugees in Angola (34 000) and Zambia (14 000) from the Democratic Republic of Congo (DRC). Timely interagency assessments and responses to these emergencies were mounted in order to offer the Minimum Initial Services Package (MISP) for reproductive health. This included support to survivors of sexual violence and essential HIV services, such as continuation of ART treatment and other essential prevention and care activities, including the availability and distribution of condoms. Overall, it is estimated that UNHCR supported services for the clinical management of sexual violence in 27 countries.

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Comprehensive PMTCT services *[Output 2.1]*

16. UNHCR advocates for equal access by refugees, asylum seekers and other populations affected by humanitarian emergencies to prevention of mother-to-child transmission (PMTCT) services, in urban settings, out-of-camp and camp settings. In 2017, UNHCR conducted a review of HIV prevention policies and practices in ten operations from different regions, including a key focus on PMTCT in humanitarian settings. It was found that six of the operations targeted in the study provided PMTCT services for refugees through the national health facilities, five provided early infant diagnosis (EID) and eight reported that ART stock-outs never occurred. UNHCR in Tanzania has defaulter follow-up systems implemented by community health workers. UNHCR in Lebanon provides follow-up systems through national services, while in Malawi, Rwanda and Zambia adherence partners visit patients in case a scheduled dose is missed.

17. In 2017, UNHCR achieved a global PMTCT coverage (proportion of first time antenatal clinic (ANC) visits who were pre-test counselled) of 86% whilst over 65% of reporting countries had PMTCT coverage of over 80%. In several operations, progress towards PMTCT has been hampered by low rates of retention in care. In order to overcome this, UNHCR established mother support groups (MSGs) to improve rates of retention in care as well as mobilise community support in camp settings in countries including Ethiopia, Kenya, South Sudan, Tanzania and Zambia.

18. UNHCR also supports implementing partners to provide PMTCT services in low prevalence settings. For instance, in Yemen, UNHCR implementing partners (International Medical Corps (IMC) and the Charitable Society for Social Welfare (CSSW) ensured that PMTCT services were available to pregnant women in urban and camp-based refugee centers at the same level as the host population.

19. Additionally, UNHCR completed an online distance-learning tool on PMTCT in humanitarian settings, which will be rolled out to UNHCR staff and other humanitarian partners in 2018.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

20. During 2017, UNHCR conducted a global review of HIV prevention practices and policies, including a survey on behavioural change programming, PMTCT, male circumcision and HIV prevention for key populations and young people in ten country operations. This review will feed into an update of prevention policies and guidelines in 2018.

21. UNHCR works to increase national and local capacity to deliver integrated services for adolescents and young people in humanitarian situations. In 2016, 86% of surveyed country operations achieved the standard of at least 90% of deliveries occurring in health facilities, an improvement from 68% in 2014. In 2016, UNHCR worked in Cameroon,

DRC, Ethiopia, Ghana, Kenya, Rwanda, South Sudan and Zambia to provide youth-friendly HIV services to adolescents and young people in and out of camp. In 2017, adolescent-friendly sexual and reproductive health services were strengthened in Rwanda and Tanzania, through piloting an adapted adolescent friendly toolkit in camp settings aiming at, inter alia, strengthening health facility capacity, peer education, community referral mechanisms and stakeholder consultation.

22. In South Sudan in 2016, more than 62 000 refugees and the surrounding host communities were reached by UNHCR with HIV prevention information. More than 64 340 male condoms and 1200 female condoms were distributed.

23. UNHCR utilises community-based approaches to ensure HIV prevention services are accessible to populations of concern. For example, in Malaysia in 2016, UNHCR continued to support HIV prevention among refugees and asylum seekers at community level through a team of community health workers. Health workers were stationed at NGO clinics, the main HIV referral centre and UNHCR office to disseminate information related to HIV prevention, as well as provide linkages to other services, including sexual and reproductive health (SRH) services, psychological and livelihoods support.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV prevention among key populations *[Output 4.1]*

24. UNHCR works with sex workers, men who have sex with men, people who inject drugs, and other at-risk populations among refugees and asylum seekers, both within refugee camps and in out-of-camp settings, to provide HIV prevention activities; continuation of treatment and care services; and programming to reduce stigma and discrimination. For example, in Kenya in 2016 and 2017, sex workers amongst refugees and the host communities were provided with HIV information through sensitization, HIV counselling and testing services, family planning and sexually transmitted infection (STI) services, condom distribution, and other prevention services.

25. During 2017, UNHCR conducted a review of sex work programming in Malawi and Mozambique. The review found that sex work was widespread in camp settings and that there was a lack of comprehensive knowledge about issues surrounding HIV and SRH, low levels of condom use and a lack of alternative livelihood options. In many instances, it was also found that there was a lack of access to sex worker-friendly SRH services. In order to address this, UNHCR will scale up community-based programming aimed at improving SRH services for sex workers in 2018. UNHCR has also been working with key populations such as sex workers, people who inject drugs and transgender populations in several countries (including Iran, Kenya, Malawi, Mozambique and Pakistan) to provide outreach to improve access to HIV services and reduce stigma and discrimination.

26. In 2017 in Rwanda and Tanzania, UNHCR piloted youth-friendly SRH services in clinics in camp settings in order to improve access and usage of reproductive health and HIV prevention services among adolescents and young people. Services were based on guidelines that are being developed by UNHCR on adolescent SRH in humanitarian

settings. Over 10 000 adolescents and young people were reached through this programme in Rwanda. This approach will be scaled up to other operations in 2018.

27. UNHCR also works with people who inject drugs among populations who are affected by humanitarian emergencies. During 2017, UNHCR distributed 133 569 syringes to people who inject drugs, distributed 53 989 condoms and provided 31 879 information, education and communication (IEC) materials for prevention of HIV among people who inject drugs in Pakistan.

28. UNHCR also worked with LGBTI populations in both camp and urban settings in 2016-2017, focusing particularly on improving the protection of internally displaced LGBTI persons, as well as promotion of HIV prevention. For instance, in Ukraine, protection training was held in 2016 with UNHCR and protection staff from partners, focusing on protection challenges for displaced LGBTI persons, as well as health issues, including HIV. The training led to the establishment of a referral pathway with a network of LGBTI NGOs. In 2017, UNHCR continued to focus on protection issues among LGBTI IDPs. In 2017, UNHCR Ukraine supported the NGO “Tema”, which represents the interests and concerns of the LGBTI community. Additionally, UNHCR has developed joint initiatives with the Argentinean Federation for LGBTI persons (FALGBT), which provides assistance to LGBTI population in matters related to access to the health system, including HIV prevention and treatment.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender-based violence *[Output 5.2]*

29. In all operations in 2016-2017, UNHCR continued to provide or support services for the clinical management of rape and sexual violence in humanitarian emergencies. UNHCR promotes access to sexual and gender-based violence (SGBV) prevention, redress mechanisms and SRH services, including through the provision of the MISP for reproductive health at the onset of the emergencies. This includes the provision of Post-exposure Prophylaxis (PEP) and other health services for survivors of sexual violence in conflict, violence prevention and care, psychosocial support and mental health services for survivors.

30. In 2017, global PEP coverage of reported instances of refugee sexual violence increased to 89% compared to 86% in 2015. Furthermore, in Nepal, in 2016 UNHCR provided protection training to camp-based state actors including armed and national police to tackle issues including child protection and SGBV. Meanwhile, in Bangladesh in 2016 and 2017, a comprehensive programme was implemented to strengthen community-based protection and prevention, including the creation of women’s support groups and community-based shelters for GBV survivors.

31. UNHCR regularly partners with national and international NGOs to provide community-based services to survivors of SGBV, as well as increasing awareness. For example, in Iran during 2017, UNHCR partnered with HAMI NGO to establish a comprehensive social centre for Afghan refugees. Through this intervention, 6,532 refugees received psychological and legal counselling, social work services and training on life skills, HIV prevention and awareness of domestic violence.

32. UNHCR also undertook advocacy activities to increase awareness of issues surrounding SGBV in humanitarian settings. For instance, during 2016-2017, under the "16 Days of Activism against Gender-Based Violence" campaign, UNHCR and its partners organized a number of awareness raising events, seminars, flash mobs and trainings, targeting students, young adults and women of different ethnic groups, in more than 30 countries around the world. During August and September 2017 in Ukraine, UNHCR (together with the creative agency, PROVID, and the International Women Human Rights Centre 'La Strada Ukraine') launched the first wave of a social campaign "Stop the Silence". The campaign intends to draw attention to SGBV, particularly in the area affected by the armed conflict. The campaign reached over 1.5 million people.

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Legal and policy reforms *[Output 6.1]*

33. UNHCR successfully advocated for the protection and human rights of people living with HIV in emergencies. During 2016-2017, UNHCR promoted access to asylum procedures and 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, IDPs and other marginalized groups. This was achieved through various fora, including protection clusters.

34. UNHCR also continued to facilitate the inclusion of emergency affected communities such as refugees, IDPs and surrounding host populations in national HIV programmes, plans and legislation. As a result, up to 25% of the beneficiaries accessing services in refugee camp-based facilities globally were from the surrounding host populations.

35. UNHCR also advocated for the removal of punitive laws, policies and practices during 2016-2017, including towards ending the practice of mandatory testing in four countries in the Middle East and North Africa, which continue to conduct mandatory HIV testing of refugees and asylum seekers as part of asylum procedures.

36. UNHCR also took active measures to ensure inclusion of newly arrived refugees in national services. In Rwanda during 2017, UNHCR actively engaged in the Country Coordination Mechanism (CCM) and other national fora to successfully advocate for Burundian refugees' inclusion in the national HIV programme with additional support provided through the Global Fund. UNHCR is also an active member of the UN Joint Team and the President's Emergency Plan for AIDS Relief (PEPFAR) team to contribute to the discussions on strategies and plans for HIV programming for refugees in the country.

37. In Yemen during 2017, UNHCR collaborated with the National AIDS Programme (NAP) to provide continued advocacy on stigmatization and discrimination against people living with HIV, through a sensitization campaign targeting the directorates of several hospitals in Sana and Aden (including military hospitals). The key topics of this campaign included the denial of treatment or refusal of admission to the hospital and mandatory HIV testing before any surgery and during pregnancy.

38. In South Africa during 2017, HIV training, peer educator activities and outreach was undertaken across the country, to mobilise refugees and asylum seekers to identify and meaningfully address stigma and discrimination within communities and in health care, reaching over 1000 persons.

UNHCR 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	3 691 000	38 973 537	42 664 537
SRA 5: Gender inequality and gender based violence	708 113	14 904 178	15 612 291
SRA 6: Human rights, stigma and discrimination	500 887	9 333 929	9 834 816
Grand Total	**4 900 000**	**63 211 644**	**68 111 644**

Table 2: By region (US$)

Region	Core	% FT countries	Non-core	% FT countries
Global	710 531		2 253 664	
AP	538 114	37%	3 415 135	51%
EECA	2 487	100%	1 181 730	15%
ESA	2 140 973	92%	24 585 435	96%
LAC	150 569	10%	632 423	21%
MENA	385 812	0%	15 055 772	0%
WCA	971 514	74%	16 087 484	63%
Grand Total	**4 900 000**		**63 211 644**	

Case study

Provision of HIV services to conflict populations in Uganda

With the support of UNHCR, Uganda has made significant progress in the response to the HIV epidemic in the context of conflict populations and new arrivals. The country hosts one of the largest refugee populations in Africa (nearly 1.4 million refugees and asylum seekers at the end of 2017) and has worked to ensure adequate delivery of health services to affected populations. In line with the Comprehensive Refugee Response Framework (CRRF), promoted by UNHCR, access to public health services - including HIV testing and treatment in refugee settlements - is integrated into the local government District Health Services as part of broader national health policies and guidelines.

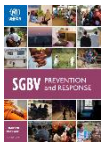
In collaboration with its partners, UNHCR has supported the development of a model plan designed to address HIV affected populations in a comprehensive manner. A particular emphasis on treatment has led to a systematic improvement in the care provided to persons living with HIV. Most notably, UNHCR-supported clinics providing treatment to 12 019 people, including 3967 refugees in 2017. UNHCR also closely collaborated with Uganda's District Health Offices to ensure accurate and sustainable delivery of required care for populations in need.

UNHCR further worked to implement the national strategy through which people living with HIV were initiated on ART, irrespective of their CD4 count. As a result, in 2017, UNHCR-supported ART sites initiated 5291 new clients, of whom 2744 were refugees, mainly from South Sudan. Specific focus was given to pregnant women and infants in the framework of PMTCT services. In 2017, almost 98% of the 60 063 pregnant women newly enrolled in ANC received HIV tests, and 93% of HIV exposed infants were administered ART treatment within 72 hours of birth.

Recent efforts by UNHCR to overcome stigma and discrimination have also led to a more equitable access to treatment and prevention for refugee populations, with a particular emphasis on new arrivals. UNHCR advocated for the inclusion of refugees in the national HIV programme through an integrated approach to addressing HIV in settlements and upon arrival. It participated in various technical working groups and collaborated with the Ministry of Health, other UNAIDS Cosponsors, the UNAIDS Secretariat, and other partners to include refugees in national policies and funding proposals. As part of the emergency response, newly arrived refugees are privately and confidentially assessed for immediate health needs including TB and HIV treatment continuation. Those found to be on treatment are linked to existing care facilities in refugee settlements and receive treatment equivalent to Ugandan nationals. Upon entry, refugees are also guaranteed access to HIV testing services and ARVs from the Ugandan national programme.

These multifaceted strategies have positively contributed to the HIV response for refugees and surrounding host communities in Uganda and has significantly strengthened HIV testing and linkages to care, early treatment initiation and PMTCT among both local and refugee populations. This has actively contributed to narrowing the gap between refugee and host populations in terms of access to public health services.

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
	**2014 – 2018 Public Health Strategy** The UNHCR Global Strategy for Public Health encompassing four major related sectors (i.e. public health, HIV and reproductive health, food security and nutrition, water, sanitation and hygiene) that are of vital importance in providing protection and services to refugees and other persons of concern.

United Nations Children's Fund (UNICEF)

UNICEF believes that promoting the rights of the child and caring for the world's children form the foundation of human development. Active in more than 190 countries, it uses its global authority to work with partners at all levels to try to ensure that children have the best start in life and can, as adolescents, flourish in an environment free from poverty, inequality, discrimination and disease.

UNICEF, a founding Cosponsor of UNAIDS, is the leading voice for children in the global AIDS response. It aims for a generation in which all children are born free from HIV, and where children and adolescents living with and affected by the virus have access to the treatment, care and support they need to thrive. UNICEF's AIDS response for children strives to ensure that neither age, poverty, gender inequality nor social exclusion determine access to HIV prevention, treatment and care.

UNICEF's main strategies and core approaches

39. Review of the progress and the gaps in the AIDS response in 2017 allows for a more nuanced view of the HIV situation that can in turn drive a differentiated approach to programming. Across all three of UNICEF's programmatic areas – PMTCT, paediatric treatment and prevention of HIV infection among adolescents, data trends show that countries and regions are facing very different HIV epidemics in terms of scale, impact, progress and needs – underscoring the context-specific nature of the challenge and the required response.

40. The relative success of PMTCT service scale-up is evidenced by the fact that from 2015 to 2016, the share of pregnant women living with HIV who received effective ARVs for PMTCT increased in all six regions[2] comprising most of the developing world. Overall however the increases were modest suggesting that we need to go beyond just focusing on initiating ART in pregnant women and extend the work of PMTCT programming to preventing incident HIV in pregnant and breastfeeding women and ensuring that, once started, women are retained and care and remain adherent to treatment for life. Children continue to acquire HIV despite prevention efforts, and their access to ART is lower than that of their mothers. Identification of these children remains challenging. Regional trends in paediatric ART coverage varied as well, but in all regions, coverage was and continues to be significantly lower among children than adults. The one exception is the Middle East and North Africa, where coverage is generally low, but rates are higher among children than among adults. A notable concern is the recent slow pace or even stalling of improvement in some regions since 2014. The share of children aged 0–14 years living with HIV who are on ART was at 53% in Latin America and the Caribbean in 2016, which was about the same share as the previous two years. The situation is similar in South Asia, where the 33% coverage level in 2016 has barely changed since 2013. In terms of the second decade of life, progress has been modest at best. Only about one third (36%) of adolescents aged 10–19 years who were living with HIV had access to ART in 2016. Prevention efforts among adolescents have struggled to show impact and the rate of new HIV infections in this age group has barely declined since 2010.

41. The disparities between regions and the relatively stagnant progress between 2015 and 2016 drove UNICEF in 2017 to rethink its approach and implementing strategies with a

[2] The six regions are Eastern and Southern Africa, West and Central Africa, East Asia and the Pacific, South Asia, Latin America and the Caribbean, and the Middle East and North Africa

sense of new urgency. UNICEF began to introduce a **needs-driven, risk-informed and differentiated HIV/AIDS programme** strategy, which was no longer business as usual. This program approach is founded on four pillars: a) data and evidence for a differentiated context-specific response, b) program integration for sustained results, c) partnership for innovation and d) knowledge leadership for global learning. UNICEF's value-add as a trusted broker with partners, especially at district and community level, moved the needle in all four of these areas to generate greater gains in HIV outcomes for children, adolescents and pregnant women at regional and national level. Through the efforts of UNICEF and partners, children and adolescents worldwide in 2017 continued to benefit from expanded access to HIV treatment and prevention services and support. The gains have been uneven, however – a situation that highlights the opportunities and challenges moving forward as countries scale up their responses.

Highlights of HIV programming results for children, adolescents and mothers in 2016 - 2017

42. Throughout 2017, UNICEF continued to be central to global, regional, and national efforts to strengthen, expand and sustain HIV responses among children and adolescents worldwide. Based on the priorities outlined in the UNICEF 2014–2017 Strategic Plan, the organization has focused its technical support, learning and expertise on both the first and second decades of life.

43. The achievements of UNICEF and partners in supporting pregnant and breastfeeding women are particularly notable. By the end of 2017, a total of 10 countries and territories had been validated by WHO for eliminating mother-to-child transmission (eMTCT) of HIV. Many others are nearing this milestone, including several countries in sub-Saharan Africa with relatively high HIV burdens.

44. Strong, consistent prioritization and planning in programs to deliver PMTCT services resulted in three quarters of all pregnant women living with HIV having access to effective antiretroviral medicines (ARVs) in 2016 (the latest year for which data were available at the time this report was being written). The impact has already been tremendous, driven in large part by the coordinated, collaborative work of UNICEF and partners in rolling out the "Option B+" or "Treat All" policy in which all pregnant women are tested for HIV and immediately initiated on ART if they are found HIV-positive. An estimated 1.6 million new infections have been averted since 2010 due to the direct benefits of Treat All programming, including expanded access to the most effective ARVs and other PMTCT services, such as adherence and retention support for new mothers during and after breastfeeding.

45. The 'last mile' of ending mother-to-child transmission of HIV worldwide is a longstanding priority for UNICEF and will present a major challenge, but the recent (and ongoing) rapid scale-up of access has put this global health goal within reach. With this in mind, UNICEF in 2017 focused considerable attention on regional gaps and differences that are often obscured by the more optimistic global figures that signal success toward many PMTCT targets and indicators. West and central Africa is one such focus region. Pregnant women's access to effective ARV regimens for PMTCT, at just 49%, lags far behind the global statistic. The West and central Africa (WCA) region also has not fared as well in other critical areas relevant to the HIV response over the first decade, including EID – as evidenced in the relatively low share (20%) of infants born to women living with HIV who received a virological test for HIV within two months of birth. That level of

coverage is less than half the global coverage of 43% in 2016, a level that itself is viewed as representing a poor response.

46. UNICEF's efforts in this region helped to galvanize support for a WCA "Catch-up Plan", endorsed at an Africa Union Summit in July 2017, which includes several goals of direct relevance to children, pregnant women and mothers. One major goal that UNICEF and its partners greatly contributed to in 2017 – and will continue to do so in 2018 – is to double the number of children (aged 10-14) on ART by the end of 2018 compared with 2016.

47. Successes and progress in the second decade have been more modest in general. Only about one third (36%) of adolescents aged 10–19 years who were living with HIV had access to ART in 2016. Prevention efforts among adolescents have also struggled to show impact and the rate of new HIV infections in this age group has barely declined since 2010.

48. UNICEF's response is driven by a sense of urgency that is at the core of the All In to End Adolescent AIDS initiative ('All In') launched by UNICEF with UNAIDS in 2015 and ramped up in 2017. All In is aligned with a series of 'super-fast-track' targets to be reached by 2018 and 2020. Target-setting and awareness-raising have helped to stimulate additional partner and government resource allocations aimed at HIV prevention and treatment among adolescents. New and innovative technologies and interventions offer renewed hope that with increased attention and support, a wide range of options can promote substantial improvements in every context. Countries' efforts to meet the UNAIDS Fast-Track targets, with their 90-90-90 treatment targets, depend on such a trajectory.

49. In 2017, for example, UNICEF and partners joined efforts to expand availability of and access to point-of-care (POC) diagnostic technologies, PrEP and social media solutions. The organization has sought to use such innovative approaches, as well as improved data gathering and analysis, to better understand and respond to gaps that are associated with social, economic, legal and cultural factors.

50. Adolescent girls and young women are a case in point. Their heightened vulnerability to HIV is evident globally and especially in sub Saharan Africa. No country in that region can have an effective, sustained HIV response that clearly moves toward 'ending AIDS' without aggressively tackling all the barriers that make it so difficult to safeguard the health and overall well-being of adolescent girls and young women.

51. UNICEF in 2017 broadened and deepened its efforts to respond to these complex challenges in multi-faceted ways. Social protection programs, many of which include cash transfers, are one approach that has been shown to lower HIV risk and vulnerability among adolescents (especially girls) and improve adherence and retention. Diversity is also seen as critical in how and where services are delivered; for example, peer-led support provided by communities can often be more acceptable and friendly for young people. By embracing and initiating cross-cutting approaches, UNICEF has been delivering on the integration that is envisaged by the SDGs. Although HIV is not a top-line target, the progress that is made toward several of the SDGs will directly affect children, pregnant women and adolescents living with or highly vulnerable to HIV.

Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative testing and counselling programmes *[Output 1.1]*

52. In 2017, UNICEF supported national and community level efforts to increase demand for HIV testing and implement a strategic mix of facility and community-based approaches to achieve the 90-90-90 targets. For example, in East Asia and the Pacific, UNICEF supported the re-engineering of HIV testing and treatment models, including integrated national testing and service delivery approaches that increase access to HIV testing. Examples include the O2O initiative targeting adolescents in China; enhanced MNCH platforms for pregnant women, people with TB and key populations in Indonesia; mass testing initiatives at public festivals and gatherings in Myanmar; and proxy consent in Philippines.

53. In eastern and southern Africa (ESA), UNICEF is introducing new POC HIV diagnostic technologies to improve access to early infant HIV diagnosis in seven countries, and is providing an opportunity to integrate infant testing with viral load testing and TB diagnosis in Malawi, Mozambique and Zimbabwe.

Access to treatment cascade *[Output 1.2]*

54. In both ESA and WCA regions, UNICEF supported policy and strategy development during 2016-2017, targeting children, adolescents (especially girls and young women) and pregnant and breastfeeding women, in collaboration with WHO. The overarching goal was to align national HIV treatment policies with global guidelines to achieve the 90-90-90 treatment targets.

55. In 2017, UNICEF invested in strengthening health and community systems in both regions as well as in data quality assessment; revision, development and dissemination of HIV guidelines and standard operating procedures (especially in low performing districts); and promoting strategic service integration to improve the treatment cascade for girls and young women – through the integration of HIV into nutrition and sexual and reproductive health services (in Cameroon, Kenya, Lesotho, Malawi, Namibia, Swaziland and Zambia).

56. In concentrated epidemics, UNICEF supported the development of systems to monitor metrics for improving quality of care in the private sector, through an electronic Patient Management System. This resulted in increased linkages to care and reduced loss-to-follow up in Myanmar as well as enhanced linkages to peripheral antiretroviral treatment centres for quality paediatric HIV/AIDS care in India. Meanwhile, evidence informed response planning - supported through integrated bio-behavioural surveys and a better understanding of the epidemic and patterns of spread of HIV from key populations to the general public - was achieved in Pakistan and the Maldives.

57. In Europe and Central Asia, UNICEF continued to support capacity building of HIV Paediatric and Adolescent care providers, through horizontal cooperation seminars, which brought cutting edge knowledge on HIV care and treatment to the region.

90-90-90 targets for children and adolescents *[Output 1.3]*

58. In 2017, in Europe and Central Asia, UNICEF's work to engage adolescents, especially those living with HIV, in leadership programmes has increased their participation in decision-making processes and enabled enhanced peer-to-peer support and strengthened community systems. In Latin America and the Caribbean, UNICEF also collaborated with civil society organizations to strengthen mentorship and peer support programmes for 'teen mothers' to provide them with treatment literacy and other life skills needed to improve adherence to medication.

59. UNICEF continued to provide additional support and services for adolescents living with HIV in Russia, Ukraine and Tajikistan, by producing and translating the Adolescents & HIV manual into the local language and distributing it to health workers providing psychosocial support.

60. In ESA, UNICEF applied differentiated programming approaches to yield various outcomes. In Malawi male community engagement programs called 'male motivators' were put in place to increase uptake of HIV and SRH services and promote PMTCT services. In South Africa, an automated system sending customized infant HIV results enabled district program managers to track HIV positive infants and follow up on early ART initiation. The UNICEF U-report platform was used to enable collection and communication of age and sex disaggregated data on peer educators outreach activities and the utilization of HIV and SRH services in Zambia. An HIV/TB integrated community case management model in Nigeria also demonstrated that the community is an important entry point to screen and link children- at-risk for TB and HIV.

Fast-track HIV services in high burden cities *[Output 1.4]*

61. UNICEF assisted selected high-burden cities and urban areas to improve and expand service delivery and access for people living with and most affected by HIV, including vulnerable adolescents. In 2017, this was achieved through engagement with municipalities in urban settings. For example, through the Mayor's initiative (Kyiv-Ukraine) and the implementation of the Youth Aware Strategy (Rio de Janeiro, Brazil), where efforts were made to increase adolescents and youth access to HIV testing, immediate initiation ART and treatment retention.

62. UNICEF also contributed to strengthening political leadership through high-level advocacy, communication and consultations, especially with youth and adolescents, including through data-driven assessments and community mobilization (Abidjan, Cote d'Ivoire and Yaoundé, Cameroon). In 2017, UNICEF additionally provided technical support to develop service delivery models targeting vulnerable adolescents (Jakarta, Indonesia) and scaled up psychosocial support and ART retention interventions for children and adolescents living with HIV (Dar es Salaam, Tanzania).

HIV services in humanitarian emergencies *[Output 1.5]*

63. An area of focus for UNICEF in 2017 was addressing HIV in humanitarian settings in Eastern and Southern Africa, to meet its Core Commitments for Children in Emergencies. Comprehensive HIV programming during a drought in Zimbabwe, including an integrated vulnerability assessment, led to cross-sectoral programming with other UNICEF Sectors (including Health, Water, Sanitation and Hygiene, Nutrition and Protection).

64. UNICEF supported HIV testing while providing nutrition treatment services, traced lost-to-follow-up cases in ART clinics and continued HIV education in communities. Furthermore, UNICEF's Nutrition and HIV Sectors have been collaborating to improve both health and nutrition outcomes of children, including in emergency settings.

65. In Malawi, support has been provided to the institutionalization of HIV testing and linkage to HIV treatment in community nutrition rehabilitation centres. As part of post-disaster support in Malawi, UNICEF also used communication for development approaches to address sexual abuse, transactional sex, forced marriage and parental neglect among adolescent girls and boys affected by floods. In Nigeria UNICEF provided procurement of HIV test kits for pregnant women and returnees in camps. Support was also provided to link them to care and treatment. A multi-sectoral collaboration was facilitated to address HIV vulnerabilities of adolescents and youth and the "Adolescent Kit for Expression and Innovation in Emergencies" was rolled out in 2017.

Medicines and commodities *[Output 1.6]*

66. During 2017, UNICEF continued supporting the provision of life-saving HIV treatment and diagnostics for people living with HIV in the non-government-controlled areas of Ukraine. UNICEF delivered 56 tonnes of antiretroviral treatment and commodities, valued over USD 4.7 million, in order to support the development of national procurement and supply management systems for ARVs and ensure continuity of services for populations in need.

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Comprehensive eMTCT services *[Output 2.1]*

67. In response to renewed efforts driven by the UNAIDS *Start Free Stay Free AIDS Free* Framework, UNICEF and partners are supporting 23 high-burden countries in sub-Saharan Africa, India and Indonesia, to align national and global targets as well as to define how to reach them. In these countries, UNICEF is supporting better use of data to advance differentiated PMTCT responses to further drive down infections. For example, in South Africa, with over 95% of pregnant women living with HIV receiving effective ARVs in 2016, UNICEF supported introduction of district level monitoring of key PMTCT indicators, through data dashboards to identify low performing areas, to address programme bottlenecks.

68. To improve retention of women in PMTCT care, UNICEF is also supporting the use of SMS clinic appointment reminders (MomConnect) in South Africa to improve retention in care. In Cote d'Ivoire, DRC, Malawi and Uganda, UNICEF, supported intensification of peer support and defaulter tracing through community mentor mothers. These efforts have demonstrated increased uptake of services and better retention in care.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

69. In order to advance targeted combination prevention among adolescents in ESA, in Zambia, UNICEF supported a bottleneck analysis of the 'condom use cascade', followed by condom campaigns through radio, U-report and other platforms as well as distributing condoms through a peer education system.

70. UNICEF also supported governments to leverage specific funding from the Global Fund to operationalize programmes for adolescent girls and young womeN who are at risk of HIV in 13 countries in Africa. UNICEF supported applications, country level analysis and prioritization and is supporting implementation of evidence-based prevention, treatment and care for adolescent girls and young women.

71. In East Asia and the Pacific, UNICEF co-hosted a capacity development workshop for government health policymakers, community outreach workers, adolescents/young key populations and health service staff from China, Indonesia and the Philippines. The workshop contributed to improving knowledge and understanding on innovative technologies and novel service-delivery approaches, including PrEP, HIV self-testing and community-based testing to reach at-risk adolescents.

Youth health and education *[Output 3.2]*

72. In 2017, based on the result of the “All In” analyses, UNICEF continued to work with countries to provide policy and technical support to revise national and subnational HIV response plans and define evidence-based service delivery packages. These packages are tailored to the needs of adolescents and young people and gaps in the response. Examples of such support include Cash Plus Programmes in Tanzania, to improve access to and retention in services and support to Teen Hubs in Jamaica.

73. UNICEF also engaged in mass communication in 2017, reaching over 500 000 young people in South Asia, including in Afghanistan, Bangladesh, India, Nepal and Pakistan with HIV-related messages, through digital social media using the #WetheFuture platform on Facebook and Twitter.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

74. UNICEF provided support to programming for vulnerable adolescents and young key populations through different context-specific projects. In Indonesia, LOLIPOP improved linkages to services, including HIV testing for young key populations. In Myanmar, UNICEF supported increased access to HIV testing, prevention and treatment services among adolescents and young key populations, including those who identified as transgender.

75. Meanwhile, in Malawi, the “I am clever, intelligent, and sharp” campaign encouraged young men who have sex with men to practice safe sex and take actions to know their HIV status. In Iran, Adolescent Wellbeing Clubs known as ALL IN Centres provided SRH and HIV testing services and offer substance abuse prevention and life skills education. In Bangladesh, UNICEF in partnership with CBO conducted HIV awareness sessions for migrant workers and tackled the HIV issue in the context of migration.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality *[Output 5.1]*

76. Highlighting the importance of programming for economic empowerment to reduce vulnerability among adolescent mothers, UNICEF’s technical and financial support in 2017 to initiatives such as “I Am Alive” (Jamaica) resulted in improvements in knowledge and contraceptive use, improved self-reported quality of life and feelings of empowerment amongst its beneficiaries. Similarly, the provision of girls’ sports for development programmes, psychosocial and treatment adherence support through 'Teen clubs' in Malawi and Namibia improved HIV, SRH knowledge, skills and service uptake. Results also included use of modern contraceptives and decreased alcohol and drug use among HIV positive adolescent girls. With UNICEF’s support, Cote d’Ivoire, DRC, Malawi and Uganda documented promising practices for enhancing positive male partner involvement in PMTCT/SRH.

Gender-based violence *[Output 5.2]*

77. In ESA and WCA, UNICEF support included GBV prevention and skills building in humanitarian setting as well as GBV prevention and life skills education for out-of-school adolescents through peer education programmes. Development of core packages for GBV and violence prevention services was also undertaken as part of the HIV combination prevention strategy targeting adolescent girls and young women.

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Technology and service delivery innovations *[Output 7.2]*

78. In WCA, five countries adapted innovative mHealth approaches (U-Report SMS) to bridge knowledge gaps and increase uptake of HIV services. In Cameroon, Côte d’Ivoire, the DRC and Nigeria, UNICEF advocated for increased allocation of resources towards high-burden geographic areas, through its “All In” Initiative. In subnational operational plans, these countries have introduced innovative approaches to identify adolescents and young people who are most vulnerable and at higher risk of HIV and track their utilization of high-impact HIV prevention services.

79. In Thailand, the digital platforms Love Care Station and LINE, as well as We Chat in China, were used to provide adolescent friendly knowledge on sexual reproductive health, HIV and counselling. A respondent-driven sampling (RDS) survey also used We Chat as a platform to collect data on adolescent men who have sex with men aged between 15-19 in China. In ESA, UNICEF continues to expand and improve U-Report

platforms for interactive HIV and SRH support for adolescents and young people in several countries.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

HIV sensitive social protection *[Output 8.2]*

80. Building on promising evidence that unconditional cash transfers can have an impact on sexual behaviour and risk-taking when poverty is a driving factor, UNICEF is supporting governments in ESA to strengthen linkages between social protection programmes and HIV outcomes for prevention, treatment and care. HIV-Sensitive Social Protection programmes (funded from non-core UBRAF funds) provided an opportunity to integrate HIV-sensitive interventions (C4D, case management and referral systems, community peer approaches) within existing cash transfer programming in Malawi, Mozambique, Zambia and Zimbabwe.

81. In Tanzania, UNICEF has conceptualized and is supporting implementation of a “cash plus” programme, which builds on the national government cash transfer programme, with additional components for livelihoods and economic empowerment education on SRH, HIV, GBV prevention; and linkages to services.

82. Using UNICEF’s comparative advantage in broader issues affecting adolescents, it promoted integrated case management as an entry point to reach children affected by or living with HIV, in order to offer a comprehensive package of services and referrals. In West Africa, technical guidance to promote HIV-sensitive social protection policy, contributed to the development of HIV-sensitive social protection policies in ten countries

UNICEF 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	2 494 296	62 490 604	64 984 900
SRA 2: Elimination of mother-to-child transmission	2 213 067	29 138 775	31 351 842
SRA 3: HIV prevention among young people	1 873 874	22 485 962	24 359 836
SRA 4: HIV prevention among key populations	1 214 742	9 714 137	10 928 879
SRA 5: Gender inequality and gender-based violence	415 111	1 149 657	1 564 768
SRA 7: Investment and efficiency	263 216	4 316 263	4 579 479
SRA 8: HIV and health services integration	1 680 916	40 398 626	42 079 542
Grand Total	**10 155 222**	**169 694 024**	**179 849 246**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-T rack countries
AP	1 520 092	40%	12 743 840	47%
EECA	1 013 763	30%	6 558 348	46%
ESA	1 912 183	92%	74 542 378	74%
Global	3 310 355		9 125 492	
LAC	805 537	41%	2 096 507	39%
MENA	355 807	34%	3 495 597	34%
WCA	1 237 485	62%	61 131 862	61%
Grand Total	**10 155 222**		**169 694 024**	

Case Studies

Family-centred approaches to identifying children with HIV in the DRC and Zimbabwe

It is critical that children living with HIV are tested and started on appropriate treatment as early as possible. Yet most children and younger adolescents largely depend on their caregivers and support networks to access health care, including HIV testing services. Identifying a family member living with HIV can be an effective strategy for finding undiagnosed cases of HIV among children and adolescents in their families and identifying those who may be at risk for HIV infection.

A family-centred approach means that for every client recently identified as HIV-positive (or already in care and treatment), an inquiry is made about the status of family members, so they can be provided with family counselling and testing, support with HIV disclosure within the family setting, and family case management at the health-facility level. When one or more family members do not know their status, they are invited for testing and linked to prevention or treatment services. However, specific approaches can vary as deemed relevant for the local context, as can be seen in UNICEF-led initiatives in the DRC and Zimbabwe.

Working with the ministries of health in those two countries, UNICEF coordinated operational research with a range of interventions aimed at rolling out effective family-centred approaches. Its support included training, supervision and mentoring for facility staff and community health workers, as well as the introduction of new tools and adaptation of the registers to collect additional information.

In Zimbabwe, the core part of the approach was to simply ask the HIV-positive client to bring family members back for testing or to take them to any testing point of their choice and return with results. This was complemented with weekend visits for school-going children and peer support to extend HIV testing and treatment to older adolescents.

In the DRC, a more active approach was used with HIV-positive adults and children over a period of six months, with two options offered: home-based testing or return to the facility for testing. Transport money was provided for family members who needed this support to return to the facility. In parallel to this intervention, a retrospective analysis of the records of 1,057 patients admitted to four hospitals between 2008 and 2015 was undertaken to see the extent to which family testing was taking place in the country and to identify ways to strengthen the family-centred approach.

As of March 2017, the positive impact on the health of many children has been substantial, especially in the DRC, where the family testing was implemented in four urban and semi-urban health facilities (in Kinshasa, North-Kivu and North Katanga). A large number of children living with HIV were identified, with an average yield of 1.5 children for every adult living with HIV (index case). A total of 631 children were identified through inquiries among 309 adult clients living with HIV on ART. Of those children, 375 were screened (59 per cent) and 161 were identified as HIV-positive (43 per cent). Of the 161 positive cases, 159 (99 per cent) started treatment. In the Bindura and Makoni Districts of Zimbabwe, 520 children were identified in eight rural health facilities from among 602 adults living with HIV. Of those children, 277 were screened (53 per cent) and 9 were found to be HIV-positive (3 per cent). All nine children who tested positive were put on treatment.

One of the most important elements that contributed to successful linkage to treatment was greater engagement of other community workers involved in social services – e.g., those working with programmes providing cash transfers and supplementary food – to assist with linkages for those in need. A well-resourced patient follow-up system, using community workers and complemented by health provider-led home visits, supported implementation of the family-centred approach.

Reaching young key populations at risk for and living with HIV in Indonesia: Early lessons learned from the LOLIPOP project

From 2011 to 2015, reported new HIV infections in Indonesia increased annually by 13.1% among older adolescents (aged 15–19) and by 11.8% among young people (aged 20–24). The risk of infection is particularly high among members of young key populations, aged 15–24, yet most individuals in these population groups have never been tested for HIV, and clinical care and engagement among them is difficult due to stigma and social conservatism.

In 2015, the national Ministry of Health, with support from UNICEF Indonesia, initiated a demonstration project called LOLIPOP (Linkages for Quality Care for Young Key Populations) that is now active in four cities – Bandung, Denpasar, Jakarta and Surabaya – with the aim of closing HIV prevention and treatment gaps in young key populations. Specific objectives include improving the enabling environment for young key populations; increasing awareness of and access to services (e.g., for testing and adherence support); strengthening health-care provider capacity to deliver services; and utilizing strategic information to foster adaptive learning and continuous programme improvement.

Early results have been promising, although uneven. In Bandung, the country's third-largest city, analysis of an age-disaggregated national HIV testing and treatment dataset showed a 43% increase in access to HIV testing among adolescents and young people from key populations (aged 15–24) between 2015 and 2017. Linkage to treatment did not show the same improvement, however. One barrier cited is age of consent policies that require parental consent for those younger than 18 years of age to get an HIV test and to access treatment. Another is directly associated with fear of disclosure: even individuals who are old enough to initiate treatment on their own do not always do so because of the possible consequences of family members or others finding out they are taking HIV medications.

Nevertheless, the notable success in increasing testing and awareness seems likely to translate into substantial improvements in treatment access over time, especially among young key populatios aged 18 and older. Several factors have contributed to the project's initial positive outcomes. For one, social media has been an important vehicle for generating demand for services, with current and potential clients also using LOLIPOP social media platforms to interact. The project has directly contributed to improved quality of care and reduced stigmatization by increasing awareness among health workers of the specific needs and vulnerabilities of young key populations. The Bandung AIDS Commission and the Bandung Health Office are jointly developing the city's HIV strategy, which is inclusive and supportive of young key populations.

Drawing on these early lessons, one priority as the project scales up further in Bandung and other Indonesian cities will be to integrate critical interventions into the project's services, such as offering PrEP as a prevention method. The social media strategy will be enhanced and expanded through capacity-building of networks of young key populations to include real-time monitoring of utilization of services and health outcomes among young key populations; online counselling; and peer-led communications and support. Broader social and political engagement to address policy barriers (e.g. age of consent restrictions) remains critical to enable further scale-up. One notable observation is that the involvement of young key populations as 'champions' in LOLIPOP has greatly contributed to the successful branding and attitude changes among service providers, by demonstrating the leadership skills of young key populations themselves.

Knowledge Products 2017

	Addressing the Global HIV Epidemic Among Pregnant Women, Mothers, Children and Adolescents: UNICEF's Global HIV Response 2018 – 20
	Step Up the Pace: Towards an AIDS-free generation in West and Central Africa
	Children and AIDS: Statistical Update
	POINT OF CARE HIV DIAGNOSTICS: BRINGING FASTER RESULTS FOR EARLY AND MORE EFFECTIVE TREATMENT: Accelerating Access and Integration of Innovative Point of Care Diagnostics for HIV in National Diagnostics Programmes
	HIV Point-of-Care Diagnostics Toolkit
	Considérations essentielles pour l'adoption de techniques de dépistage du vih sur le lieu de soins au sein des systèmes nationaux de santé

World Food Programme (WFP)

Assisting 80 million people in around 80 countries each year, the World Food Programme (WFP) is the largest humanitarian agency tackling hunger worldwide, delivering food assistance in emergencies and working with communities to improve nutrition and build resilience. 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 the goals of Agenda 2030.

As a Cosponsor of The Joint United Nations Programme on HIV/AIDS (UNAIDS), WFP has contributed to joint responses to HIV/AIDS for over a decade. 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, nutrition, social protection and health systems for impact on HIV and AIDS. WFP maintains a holistic approach to HIV programming, leveraging multiple context-appropriate entry points including: food and nutrition support, social safety nets, emergency preparedness and response, technical support to governments and national partners, school meals, and supply chain and logistics support services. Under the updated 2018 UNAIDS Division of Labour, WFP is responsible for ensuring that food and nutrition issues are integrated into all (system-wide) responses to HIV and co-convenes work on HIV-sensitive social protection with the International Labour Organization (ILO) and on addressing HIV in humanitarian contexts with the Office of the United Nations High Commissioner for Refugees (UNHCR).

WFP's Strategy/Core Approach to HIV and AIDS

83. In 2017, it maintained its holistic and gender-responsive approach to HIV programming, leveraging its context-specific entry points and partnerships to provide food and nutrition support to vulnerable people living with HIV, including in humanitarian emergencies; support to pregnant women receiving prevention of mother-to-child transmission services; school meals and other activities for addressing the needs of children and adolescents while promoting school attendance and reducing risk-taking behaviour; support to HIV-sensitive social safety nets in several regions; technical support to governments and national partners, including work with national HIV/AIDS councils; and support to supply chains to prevent stock outs of HIV treatment and prevention commodities in humanitarian settings and fragile contexts, working with partners that include the Global Fund to Fight AIDS, Tuberculosis and Malaria. WFP addresses HIV through various entry points and partnerships that are consistent with the Sustainable Development Goals (SDGs). Improving the nutrition status and food security of people living with and affected by HIV is also a way of leveraging work towards several SDGs – on poverty alleviation, health, zero hunger, education and gender equality – and facilitating the eradication of AIDS in an era of competing priorities through more integrated, systems-based approaches that involve interventions at all levels, from the people and households directly effected by HIV to national governments.

Highlights of results in 2016-2017

84. In 2017, WFP assisted[3] 355 000 people living with HIV, TB patients and their household members in 24 countries (including many impacted by emergencies) through HIV-specific programmes. In addition, many more vulnerable people living with and affected by HIV were assisted through WFP's HIV-sensitive general assistance programmes.

[3] In 2016, WFP assisted 318,555 people living with HIV, TB patients through HIV-specific interventions in 24 countries, and many more through in-kind assistance.

85. The situation for people living with HIV in conflict affected Eastern Ukraine is critical, with the majority of people living with HIV severely food insecure and living in extreme poverty. Health and HIV facilities were relocated and the quality of services in many facilities remains poor. Eastern Ukraine has the highest HIV and TB/MDRTB prevalence rates in the country, and the conflict is driving new infections.

86. In order to reduce food insecurity and improve adherence by linking food, health and social protection systems, WFP worked with the All Ukrainian Network of People Living with HIV (at the country and global levels) to provide Cash Based Transfers (CBT) via e-vouchers to 6826 people living with HIV (about 17 600 household members) in 2016-2017. This resulted in improved food security in two thirds of beneficiaries, increased adherence to ART in 34% of those enrolled and led viral suppression in line with the third 90 in most beneficiaries.

87. In 2016 WFP categorized the situation in Southern Africa as a Level 3 Emergency (the highest internal Emergency Classification). Intense El Niño conditions, coupled with multi-year drought, led to a food security crisis that impacted an estimated 40 million people. People living with HIV are particularly vulnerable to food insecurity and malnutrition, which can pressure households into adopting harmful coping strategies that drive new infections. In response to this emergency, WFP formed an Inter-Agency Task Team (IATT) on HIV in Emergencies sub-working group on El Niño and joined an OCHA-led group to lobby for HIV responses. Data was also collected and an advocacy brief developed to share with the Special Envoys on El Niño and Climate, and donors. WFP additionally worked with partners to include HIV responses in the Inter-Agency Standing Committee's Inter Agency ENSO Standard Operating Procedures for climate related emergencies[4].

88. These substantial advocacy efforts at the global and regional levels resulted in a grant from the United States PEPFAR of USD 25 million for addressing the impacts of El Niño-related food insecurity in five countries – Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe. The work, which continued in 2017, focused on assessment and treatment of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) in people living with HIV through existing programmes providing nutrition assessment, counselling and support for adolescents and adults living with HIV. Activities included nutrition screening and referrals in communities and assessment, counselling and treatment at clinics. Through the PEPFAR grant, in 2016 and 2017 WFP managed supply chains for specialized foods and supported 349 099 malnourished and food-insecure people affected by HIV, including orphans and other vulnerable children (OVC) and clients of PMTCT programmes in five UNAIDS fast-track countries.

89. WFP contributes to strengthening national capacities to meet the goals for HIV prevention among young people and adolescents through its HIV-sensitive school meal programmes and its country-level partnerships with UNFPA and UNICEF. WFP's school meals benefit more than 17 million school children annually. In Malawi, more than 990 000 children were reached in 13 districts. By staying in school longer, many of these young people are less exposed to high-risk behaviour that can lead to acquiring HIV.

[4] Inter-Agency ENSO Standard Operating Procedures for 92nd IASC WG

Research in Botswana and Swaziland found that women and girls who lack sufficient food are 70% less likely to perceive personal control in sexual relationships, 50% more likely to engage in intergenerational sex, 80% more likely to engage in survival sex, and 70% more likely to have unprotected sex.[5]

Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative testing and counselling programmes *[Output 1.1]*

90. WFP advocates for the integration of HIV testing in food and nutrition support services. In many contexts, improved food security can increase attendance for HIV testing and counselling, as well as adherence to treatment. In 2017, WFP provided technical assistance to governments with a view to integrate food and nutrition services into HIV responses through the development of national guidelines on nutrition assessment, counselling and support for adolescents and adults living with HIV, including in Kenya, Lesotho, Rwanda, Liberia, Somalia and Swaziland.

91. Work on testing and counselling by WFP and all Joint Programme partners complements WFP's work to augment the treatment cascade. WFP's HIV programming is gender-responsive and focuses on linking food and nutrition, treatment and health systems through the provision of food assistance for better health outcomes, such as nutritional recovery for people living with HIV and/or TB and retention in care programmes. WFP contributes to the HIV treatment cascade in a variety of ways. These include providing technical support, capacity building and assistance to governments; advocating for the inclusion of food and nutrition security in comprehensive national and international plans; developing multi-stakeholder partnerships on issues ranging from emergencies to supply chains; and working with civil society to meet the needs of vulnerable people living with HIV.

HIV treatment cascade *[Output 1.2]*

92. There is a correlation between food insecurity and treatment adherence, retention and success. People living with HIV who initiate treatment while severely malnourished are two to six times more likely to die in the first six months of treatment than those who are not malnourished when they initiate treatment. Additionally, people living with HIV often have reduced appetites, are less able to absorb nutrients and have reduced access to food due to morbidity. WFP provides in-kind food assistance, cash and vouchers at the individual and household levels to enable improved access and adherence to treatment. In other contexts, WFP treats SAM and MAM in people living with HIV. Examples of WFP's nutrition interventions for HIV impact include:

    - In Swaziland, WFP reached 134 000 HIV-impacted beneficiaries. A total of 2500 SAM and MAM clients received therapeutic or supplementary food through 87 clinics;

[5] Weiser, S.D., et al. 2007. Food Insufficiency is Associated with High-Risk Sexual Behavior among Women in Botswana and Swaziland. PLoS Medicine 4, 1589–1597, 2007; discussion 1598.

- In Zimbabwe, WFP provided food and nutrition support to treat 27 400 cases of MAM in ART/TB adult patients and children;
- 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%;
- In Guinea-Bissau, WFP provided nutrition support to 2000 malnourished clients on ART and 500 malnourished clients under TB treatment, as well as food assistance packages to their food insecure households reaching a total of 8500 beneficiaries in 2016. Cash transfers were also provided to 3000 household members of the same ART clients in 2017. These combined food, nutrition and cash interventions contributed to reducing the ART default rate to 7.94% in 2017;
- In Myanmar, post-distribution monitoring in 14 townships revealed that nutrition counselling and food provision led to increased adherence and improvement in Body mass index (BMI) in over 60% of the beneficiaries.

93. WFP works in partnership with civil society, government, people living with HIV networks and donors like the Global Fund to maximise impact on treatment while improving food and nutrition security for people living with HIV. A prime example of this can be seen in Sierra Leone, where WFP has been implementing a Nutrition Assessment, Counselling and Support (NACS) programme, which integrates nutrition rehabilitation into ART and TB DOTS packages. The program is funded through the Global Fund and is implemented in collaboration with the National AIDS Secretariat (NAS), the Network of HIV Positives in Sierra Leone (NETHIPS), the Civil Society Movement Against TB (CSMART-SL) and the National AIDS Control Program (NACP). Between 2016 and 2017, WFP received USD 3.7 million from the Global Fund and reached 23 000 TB clients and 15 000 people living with HIV on ART with food assistance. The partnerships between WFP and the Networks played a crucial role in resource mobilisation, advocacy, implementation and HIV/TB response during emergencies. WFP and the Networks are exploring possible engagements in resilience building and safety net programmes, which could contribute to a more sustainable impact on the lives of individuals affected by TB and HIV. This intervention has improved the health and nutrition status of beneficiaries and augmented treatment outcomes.

94. WFP also targeted food insecure people living with HIV on ART to prevent default and encourage adherence in Ukraine, Rwanda, Côte d'Ivoire and many other countries. An example of this programming can be seen in Liberia, where as a Global Fund sub-recipient, WFP provided food security support to more than 100 000 people, which improved retention in care.

95. In addition to providing direct assistance, WFP also works to train and build capacity in healthcare staff and community care workers to provide NACS services to ART clients. In Ethiopia, 72 health institutions were capacitated to provide Nutrition Assessment and Counselling (NAC) to all people living with HIV and NACS services to malnourished people living with HIV as a standard service. Community systems strengthening was also done to put in place an effective referral mechanism to link malnourished people living with HIV to treatment and clinical NACS services. 15 000 people living with HIV in health institutions received NACS services and 500 people living with HIV classified as having SAM received Ready to Use Therapeutic Foods as a treatment for SAM. All clients receiving specialized foods were educated on the proper utilization of specialized foods for rapid recovery. Outcome data collected on the recovery rate of clients on NACS services indicated that the malnutrition recovery rate in 2017 was 84.9%, an

improvement of 7.5% from previous years. At community level, community resource persons provided ART adherence counselling, nutrition assessment and basic education on nutrition, water hygiene and sanitation for 17 000 people living with HIV. Some 2000 (12%) were identified as having malnutrition through community level screening and were linked to health institutions for further assessment and clinical nutrition and HIV care.

96. WFP has carried out several formative studies in Latin America on the food and nutrition security of people living with HIV. For example, in 2017, WFP Guatemala implemented a study in seven Comprehensive Care Units that included 120 children and 272 adults living with HIV who were being assisted by the Ministry of Public Health. Similar to other countries where these studies have taken place, WFP provided the technical expertise and financial support in collaboration with several partners like the Association for the Prevention and Study of HIV/AIDS (APEVIHS), a local NGO, the National Program for the Prevention and Control of STIs, HIV and AIDS, UNAIDS Secretariat, UNICEF and HIVOS. The findings of these studies have provided a framework for advocacy actions for the food security and nutrition for people living with HIV. Generating evidence has become a key aspect needed to strength the HIV response, to improve adherence to treatment (90-90-90 cascade), to target interventions to improve nutritional food security and to reduce vulnerability. In multiple countries in the LAC region the scientific and empirical information generated in collaboration with WFP has provided important inputs for Ministries of Health and other government agencies to strengthen treatment related interventions /programmes. The information has been used to:

- Develop protocols and action plans such as the First, Second and Third Level Care Guidelines.
- National Strategic Plans for HIV/AIDS.
- National Prevention Strategies and legal reforms relating to HIV.
- Evidence that led to Global Fund grants for 2018-2021 in Guatemala, El Salvador and Dominican Republic.

90-90-90 targets for children and adolescents *[Output 1.3]*

97. In several countries, including Burundi, Ghana, and Malawi, WFP's nutritional support targets children and adolescents living with HIV. WFP also provided HIV-sensitive food and nutrition support to millions of children across various Fast Track Countries and in emergency contexts. Support to children takes a variety of different forms ranging from the provision of specialized foods to school meals. WFP aligns itself with the H6 and Every Women and Every Child initiatives and believes that food and nutrition support plays a critical role in the treatment cascade for children.

HIV-related services in humanitarian emergencies *[Output 1.5]*

98. During humanitarian emergencies, forced displacement, food insecurity, poverty, sexual violence, breakdown of the rule of law and the collapse of health systems may lead to increased vulnerability to HIV infection or interruption of treatment. Given the scale and scope of humanitarian emergencies (including in Fast Track countries), the number of people vulnerable to HIV in these situations is estimated to have increased.

99. WFP and UNHCR co-lead the IATT on HIV in Emergencies, which aims to improve preparedness and responses during emergencies. In many humanitarian, refugee and other food-insecure settings, including but not limited to: South Sudan, Rwanda, DRC,

Uganda, Central African Republic, Haiti, Myanmar, the Horn of Africa, the Lake Chad basin and countries impacted by El Niño, WFP worked with partners to provide food and nutrition support (through in-kind assistance, nutrition interventions, cash or vouchers) to food-insecure and malnourished people, including those on ART and TB treatment.

100. In many humanitarian and food insecure contexts, WFP provides nutrition support through the provision of specialized nutritious foods to malnourished people on ART. For example, in the DRC in 2016-2017, WFP partnered with local and international NGOs to provide nutritional support to over 21,000 malnourished people living with HIV/TB patients, including those displaced by conflict.

101. As highlighted above, in 2016-2017, PEPFAR provided WFP with over US$ 25 million to support the food and nutrition component of WFP's El Niño HIV response activities, supporting over 349 099 beneficiaries affected by HIV in five countries in Southern Africa.

102. As described previously WFP also worked with the All Ukrainian Network of People Living with HIV (at the country and global levels) to provide Cash Based Transfers (CBT) via e-vouchers to 6826 people living with HIV in conflict impacted Eastern Ukraine.

103. In 2017, the Horn of Africa faced a serious drought affecting Ethiopia, Somalia and Kenya, with an estimated 15 million people in need of emergency food assistance and at catastrophic levels of food insecurity and malnutrition. It was established that people living with HIV were potentially at risk in these countries. The UN Joint Teams in the three countries worked to ensure inclusion of HIV clients into ongoing emergency programme responses, including nutrition and food assistance for malnourished and food insecure people living with HIV. In Kenya, the UN Joint Team successfully advocated for inclusion of HIV into the Drought Flash Appeal and helped raise the profile for HIV in the Arid and Semi-Arid Lands (ASAL) with government and humanitarian partners. They further commissioned a rapid assessment on the impact of the drought on HIV and AIDS, and the findings of assessment will be utilized (in 2018) to advocate with all relevant partners at national and county levels to strengthen the HIV response in all the ASAL counties.

104. In the last two years, the importance of addressing HIV in humanitarian settings has received more political support than ever before, as highlighted in the UNAIDS strategy for 2016–2021, the two reports to the Programme Coordinating Board presented by the UNAIDS Executive Director in 2017 and the engagement in emergency responses of PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

105. There is now a global consensus that, given the number, magnitude and scope of humanitarian emergencies in Fast Track countries in 2016-2017, the End of AIDS will be out of reach unless we address the needs of people living with HIV in humanitarian contexts. WFP and UNHCR will continue to lead the IATT on HIV in Emergencies and further advocate for this issue at global and regional levels and respond to the needs of people living with HIV, including refugees in countries impacted by conflicts and disasters. The IATT is also currently working to update the global data on the number of people living with HIV impacted by emergencies in order to better tailor response and advocacy efforts.

Medicines and commodities *[Output 1.6]*

106. WFP and the Global Fund maintain a MoU for logistics partnership. This partnership enables improved access to HIV-related commodities, especially during emergencies, through the use of WFP's deep field supply chain networks. One key component of the MoU tasks WFP with building the capacity of Global Fund implementers to strengthen distribution systems to prevent stock outs. Since the start of 2016, WFP has provided four separate air freights and three ocean freights from Asia, Europe and Southern Africa to Burundi and Yemen, serving to prevent HIV treatment stock outs. In 2017, WFP provided engineering support to Global Fund Principal Recipient UNDP in Zimbabwe and Guinea-Bissau.

107. The provision of supply chain services to health actors is one example of WFP's contribution to SDG 17 and leverages new and innovative approaches to tackling chronic constraints in supply chains. In 2016-2017, the Bill & Melinda Gates Foundation (BMGF), WFP and partners launched SOLVE (Supply Optimization through Logistics Visibility & Evolution) a multi-stakeholder partnership led by BMGF and enabled by WFP to accelerate on-the-shelf availability of reproductive health commodities through sustainable solutions across 17 countries.

108. The availability of HIV prevention commodities will be critical to reaching the goals set forth in the UNAIDS Strategy. WFP aligns itself with the work being undertaken by the Prevention Coalition and UNFPA and will continue to support other initiatives relating to commodities for health that improve the lives of women and children.

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Comprehensive eMTCT services *[Output 2.1]*

109. Demand-side barriers to access and adherence to PMTCT services[6] include food insecurity. Comprehensive services that integrate food assistance enable more women to start and adhere to PMTCT programmes. WFP works with governments to support PMTCT programmes and provide mother-and-child health and nutrition services to vulnerable pregnant women. WFP programmes in many contexts target pregnant and lactating women, PMTCT clients and children and can have impacts on adherence to PMTCT and on health outcomes for newborn babies.

110. In South Sudan, WFP provided nutrition support to 8000 pregnant and lactating women through its PMTCT programme, and an additional 225 000 pregnant and lactating women were treated for acute malnutrition through the targeted supplementary feeding programme. Development of national guidelines on maternal, infant and young child nutrition has created a platform for improving the quality of mother-and-child nutrition services, especially for women and children affected by HIV.

111. WFP works together with partners to integrate food and nutrition support into PMTCT programmes and MNCH services. This is mainly done through technical assistance to governments, including by supporting the development of guidelines and educational materials. For example, in Liberia, WFP supported the Government of Liberia to develop an Essential Package of Health Service (EPHS), which placed a strong emphasis on all

6. O'Hlarlaithe, M., Grede, N., de Pee, S. and Bloem, M. 2014. Economic and social factors are some of the most common barriers preventing women from accessing maternal and newborn child health (MNCH) and prevention of mother-to-child transmission (PMTCT) services: A literature review. *AIDS and Behaviour*, 18(Suppl. 5): S516–S530.

material and child health services. In line with EPHS, in 2017 WFP reached 800 PMTCT clients and 1600 PMTCT household members in Liberia through the provision of food assistance to support treatment adherence.

112. In Ethiopia, 99.8% of the PMTCT clients receiving WFP food assistance in 2017 attended all their clinical appointments and 99.6% of the newborn babies were negative. At the global level, WFP is a member of the Child Survival Working Group (CSWG), which is one of the sub working groups of the IATT on eMTCT. As part of the CSWG, WFP addresses food and nutrition related issues in the context of eMTCT and paediatric HIV treatment, including in humanitarian settings.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Youth health and education *[Output 3.2]*

113. As highlighted above WFP contributes to strengthening national capacities to meet the goals for HIV prevention among young people and adolescents through its HIV-sensitive school meal programmes and its country-level partnerships with UNFPA and UNICEF. WFP's school meals benefit more than 17 million school children annually. For example, in the Fast Track country Malawi, more than 990 000 children were reached in 13 districts.

114. In Zambia, in partnership with the Scaling up Nutrition (SUN) Civil Society Network, WFP investigated the barriers that hinder adolescent girls' access to HIV and nutrition services. Gaps identified included low utilization of HIV testing and counselling services, low condom use, limited youth-friendly services and inadequate behaviour change programmes for addressing both HIV and nutrition issues among adolescents. In 2017, WFP supported the establishment of adolescent technical working groups in two districts to enhance support to and inclusion of adolescent girls in nutrition and HIV programming.

115. In Cameroon, over 25 000 young people, adolescents and adults living with HIV on treatment (ART/TB/PMTCT clients) benefitted from monthly nutrition education sessions to prevent acute malnutrition and to support those already malnourished with adequate messages to overcome their situation. Combined with more than 600 home visits, the initiative supported adherence to ART.

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Sustainability, efficiency, effectiveness and transitions *[Output 7.1]*

116. WFP is constantly researching how to deliver programming more effectively. In 2016-2017, WFP and the London School of Hygiene and Tropical Medicine (LSHTM) completed a study on the investment returns of food-based interventions for ART patients in Eastern and Southern Africa. The findings suggest that investment in ending hunger could contribute to improved treatment adherence, retention in care and reduced HIV transmission, and co-investing in HIV and food interventions could enhance the efficiency of HIV treatment and prevention efforts.

Technology and service delivery innovations *[Output 7.2]*

117. In line with WFP's on-going innovation and digital transformation agenda, WFP is expanding its digital beneficiary system and is developing an application for the electronic registration, tracking and management of beneficiaries of community-based management of acute malnutrition programmes. The application known as SCOPE Conditional On-Demand Assistance, (SCOPE CODA). SCOPE CODA merges identity and programme management functions to support improved management for nutrition treatment and health programming for all stakeholders, from frontline workers to managers to national ministry officials to global stakeholders. The application provides frontline workers with an agile and robust tool that registers, tracks and manages clients and their package of services at points of delivery, while providing managers and other stakeholders with a unified platform on which they can base decisions to improve programming and increase collaboration and synergies.

118. SCOPE CODA is now piloting in Uganda and South Sudan. While the application was developed initially for malnutrition treatment, it is presently being expanded to match on the ground realities and national priorities to ensure that malnutrition treatment is mainstreamed in essential health services and with other vulnerable populations, including people living with HIV and those treated for TB. In 2017, WFP prioritized people living with HIV for registration at food distribution centres, and this is still under way in Somalia.

119. Another innovative platform is mobile Vulnerability Analysis and Mapping (mVAM), which is used in South Sudan and other countries to capture data on HIV/TB programme attendance, food deliveries and distribution, as well as Nutrition Assessment, Counselling and Support (NACS) indicators.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

Decentralization and integration *[Output 8.1]*

120. WFP works together with national governments and other partners to decentralize and integrate HIV and food/nutrition systems and to improve the sustainability and effectiveness of HIV programmes, particularly through the provision of technical support and capacity building programmes. Examples form three distinct regions include:

- In Myanmar, WFP supported the Ministry of Health and Sports to integrate food and nutrition interventions into National AIDS Programme (NAP) activities. In 2017, WFP aimed to enhance the treatment adherence/access, health outcomes and nutritional recovery of people living with HIV through the provision of food and nutrition support and counselling. Through this programme, WFP also contributes to the reduction of socio-economic barriers that limit the access and adherence of people living with HIV treatment. A total of 11 000 TB patients and people living with HIV received WFP food and nutrition support, including nutrition promotion sessions and counselling.
- In Ethiopia, WFP assisted the national government to maintain its electronic data on the country's multisectoral HIV response. WFP trained 400 staff members in the Ministry of Health to support the full-scale implementation of the database.
- In Lesotho, WFP provided technical support to the Ministry of Health (MoH) to strengthen a nutritional technical working group that works to integrate HIV in its

programmes. Through this support, WFP, in collaboration with the Elizabeth Glaser Paediatric AIDS Foundation (EGPAF), assisted the MoH in quantifying data on clients in need of nutritional assistance, with focus on people living with HIV.

HIV-sensitive social protection *[Output 8.2]*

121. At country level, WFP contributes to the empowerment of people living with HIV through its HIV-sensitive social protection programmes, including by supporting national governments in designing, operationalizing and evaluating cost-effective food security, safety net and social protection mechanisms for people living with HIV and other vulnerable populations. Social protection programmes are increasingly recognized as facilitators of improved HIV prevention and treatment outcomes. For example, a study of 1100 adolescents aged 10–19 years living with HIV in South Africa showed that three elements of social protection – food and nutrition support through the provision of two meals a day, attendance in an HIV support group, and a high level of parental/caregiver supervision – were associated with improved treatment adherence.[7]

122. WFP contributes to the empowerment of people living with HIV through its HIV-sensitive social protection programmes, including by supporting national governments in designing, operationalizing and evaluating cost-effective food security, safety net and social protection mechanisms for people living with HIV and other vulnerable populations.

123. In Ethiopia, WFP has worked with PEPFAR to provide NACS, social safety nets and economic strengthening services to people living with HIV, 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.

124. In Eastern Ukraine, WFP worked with the All Ukrainian Network of People Living with HIV (at the country and global levels) to provide CBT via e-vouchers to people living with HIV. This resulted in improved food security status in two thirds of beneficiaries, increased adherence to ART and reductions in viral load. This project achieved the third 90 (viral suppression) in the target group.

125. In 2017, WFP at the global level also partnered with a NGO, Kheth'Impilo, to support the implementation of two jamborees, which take a supermarket approach to providing communities with access to a range of health, food and social protection services. At these jamborees, beneficiaries are able to access HIV testing services, assess their nutritional status, receive food and/or nutritional assistance and access a holistic package of social protection services to support treatment adherence. In 2017, over 7000 beneficiaries were reached through this programme.

126. During 2016, WFP Dominican Republic prioritized activities for women affected by HIV and their families through a joint working agreement established between the Ministry of Agriculture and WFP. Additionally, the results of a research project on the status of food and nutrition security of people living with HIV, conducted by WFP and the Pardee Graduate School assisted the National Council on HIV/AIDS with its advocacy efforts to

[7] Cluver, L.D., Toska, E., Orkin, F.M., Meinck, F., Hodes, R., Yakubovich, A.R. and Sherr, L. 2016. Achieving equity in HIV-treatment outcomes: can social protection improve adolescent ART-adherence in South Africa? *AIDS Care*, 28(Suppl. 2): 73–82.

include women with HIV on the country's biggest social safety net protection programme. This work led to:

- The inclusion of 2000 women living with HIV as well as their children into the national social protection programme (Progresando con Solidaridad -PROSOLI).
- Improved nutrition for all beneficiaries.
- Improved adherence to ART from 35% to 65%.

WFP 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	1 760 757	29 857 730	31 618 487
SRA 2: Elimination of mother-to-child transmission	121 451	8 495 813	8 617 264
SRA 3: HIV prevention among young people	148 584	2 524 743	2 673 327
SRA 5: Gender inequality and gender-based violence		465 000	465 000
SRA 7: Investment and efficiency	106 868		106 868
SRA 8: HIV and health services integration	2 183 577	28 823 462	31 007 039
Grand Total	**4 321 237**	**70 166 748**	**74 487 985**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	1 462 133		882 500	
AP	175 745	31%	3 441 323	9%
EECA	70 161	0%	1 148 500	75%
ESA	1 349 334	52%	45 968 851	26%
LAC	475 395	0%	154 000	0%
MENA	198 694	0%	1 215 801	0%
WCA	589 774	17%	17 355 773	0%
Grand Total	**4 321 237**		**70 166 748**	

Case study

Hunger, HIV and Conflict: A Vicious Circle in Eastern Ukraine

Svitlana is one of many severely food insecure, conflict-affected people living with HIV who receive WFP and Network assistance. © WFP/Julia Dymkovskaya

The world will not achieve the Sustainable Development Goals—which include the target of ending AIDS by 2030—without people attaining their right to health. The right to health is interrelated with a range of other rights, including the right to food.

However, today far too many people living with and affected by HIV have been denied these rights due to the breakdown of food, health and social systems during humanitarian emergencies.

This vicious circle can be seen perfectly in the case of Svitlana, a single mother of three from Eastern Ukraine. In September 2017, she fled the conflict-affected region of Donetsk and is currently an internally displaced person in Kramatorsk. Svitlana learned that she was HIV positive while pregnant with her third child. Since the conflict started, she has lived in a state of constant fragility, poverty and food insecurity, only receiving approximately €2 per day of government assistance to support her three children and her own basic needs. She, like so many vulnerable women, always puts the needs of her children first, sometimes going without food for the day.

Due to the conflict, many facilities have been forced to close or relocate, which has reduced the accessibility of HIV treatments. The conflict has also led to increased poverty and food insecurity in people living with HIV.

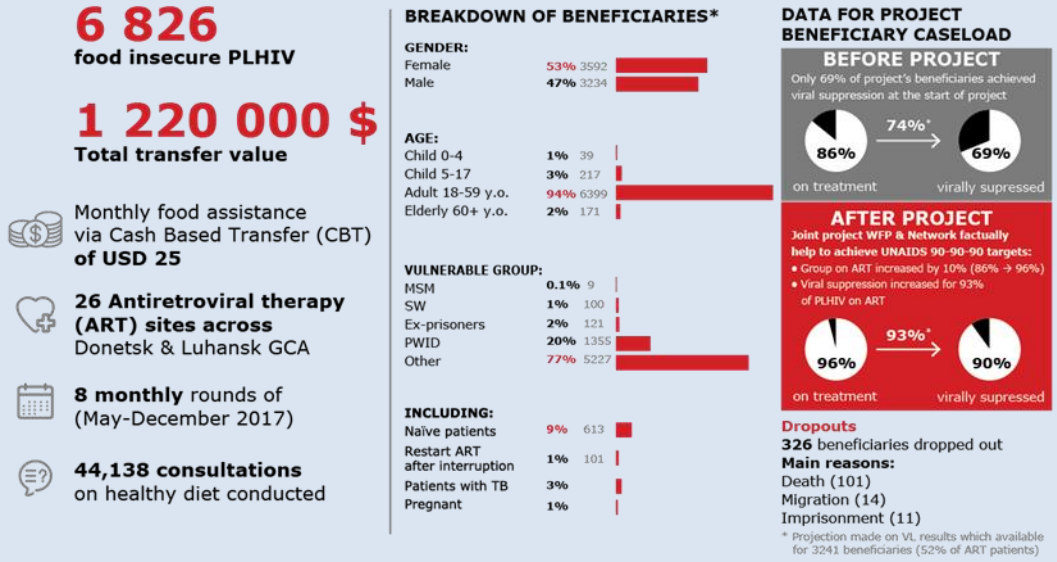
In order to improve food security and ensure that vulnerable individuals like Svitlana stay on life-saving HIV treatment, WFP partnered with the All-Ukrainian Network of People Living with HIV to roll out a food-assistance programme via cash transfers, targeting severely food insecure, emergency-affected beneficiaries on Antiretroviral HIV treatment. WFP is currently targeting 6826 severely food insecure, conflict-affected, people living with HIV, including IDPs and children in two areas under Ukrainian government control (about 17 600 household members) with cash-based transfers.

These transfers depend on beneficiaries attending required medical visits and adhering to treatment. Results (see graphic) clearly demonstrate that this assistance improved food security, encouraged adherence, led to dropouts restarting treatment and reduced viral load in the target group.

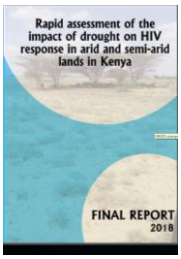
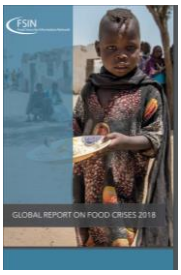
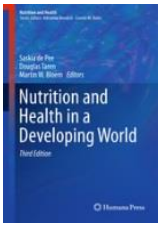
Svitlana is one of many severely food insecure, displaced people living with HIV affected by conflict worldwide. Most people struggle to meet their basic needs. Food and nutrition assistance provided by WFP is critical in ensuring people living with HIV and affected by emergencies stay on treatment, which is key to saving lives, preventing new infections and reducing instances of tuberculosis.

HIV remains one of the world's most serious challenges. Many of the 35 UNAIDS priority Fast-Track countries – 35 countries that together account for more than 90% of people acquiring HIV infection and 90% of people dying from AIDS-related causes worldwide – are also affected by what

are known as Level 2 and Level 3 emergencies, the latter representing the most severe form. WFP's role in the HIV response is becoming more important in a world where emergencies, displacement, insecurity and disasters are the new normal. WFP currently has Level 3 emergencies activated in four Fast-Track countries (DRC, Nigeria, South Sudan and Myanmar) and Level 2 emergencies in three Fast-Track countries (Mali, Ethiopia and Kenya).



Knowledge Products

	**Rapid assessment of the impact of drought on HIV response in arid and semi-arid lands in Kenya** – The rapid assessment on the impact of drought in arid and semi-arid regions of Kenya was an activity undertaken by the National AIDS and STI Control Program (NASCOP) in collaboration with UNICEF, UNAIDS and WFP – work done in 2017 to be finalized in 2018.
LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE	**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 – finalized in 2017.
	**FSIN: Global Report on Food Crises 2018** – The FSIN is a neutral global technical platform co-sponsored by the Food and Agriculture Organization (FAO), the World Food Programme (WFP) and the International Food Policy Research Institute (IFPRI) for exchanging expertise and facilitate capacity development on food and nutrition security measurement and analysis.
	**Ending AIDS by 2030: Partnerships and Linkages with SDG 2** – chapter in the book Nutrition and Health in a Developing World, published January 2017

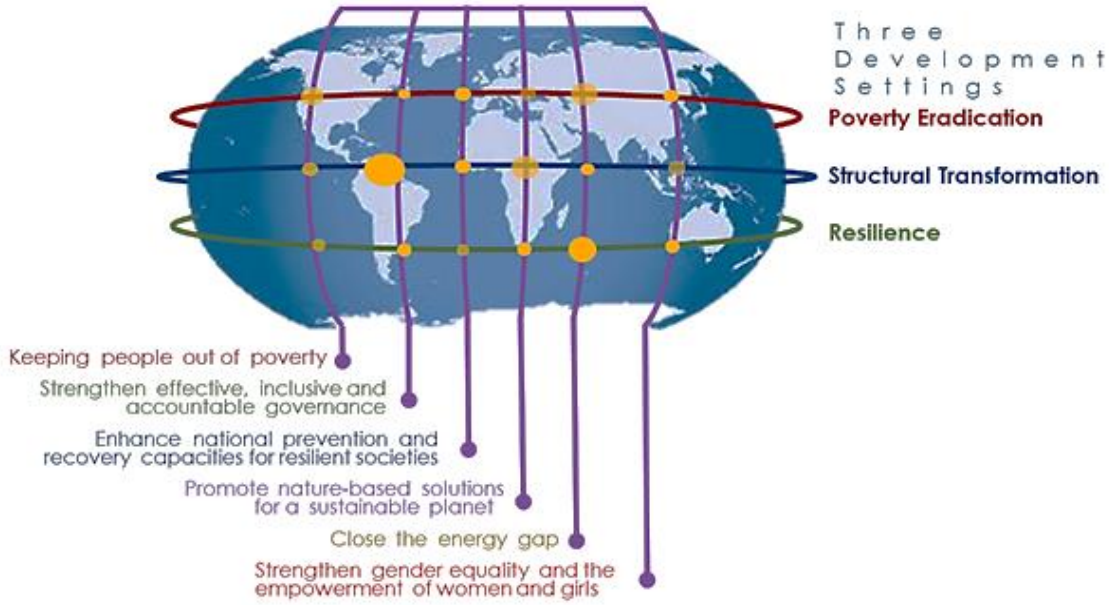
United Nations Development Programme (UNDP)

The UNDP is the United Nation's global development network, advocating for change and connecting countries to knowledge, experience and resources to build better lives. It is on the ground in 177 countries and territories, working with governments and people on their own solutions to global and national development challenges. As these countries and territories strengthen local capacity, they draw on the UNDP and its partners to bring about results.

UNDP is a founding Cosponsor of UNAIDS, a partner of the Global Fund and a cosponsor of several other international health partnerships. As the lead on human rights and law in the Joint Programme, UNDP's work on HIV and health leverages the organization's core strengths and mandates in governance, and human and capacity development to complement the efforts of specialist health-focused UN agencies.

127. UNDP's work in HIV and health is guided by the 2030 Agenda for Sustainable Development, the 2018-2021 UNDP Strategic Plan and the HIV, Health and Development Strategy Note 2016-2021: *Connecting the Dots*.

128. The 2018-2021 UNDP Strategic Plan describes how UNDP will deliver its support to programme countries to achieve the 2030 Agenda and the SDGs and related agreements. It will tailor support to specific contexts and needs, across the 170 countries and territories in which UNDP works.



129. The Strategic Plan is framed around the following components:

- Three broad linked development settings, or development outcomes.
- Six signature solutions that define UNDP's core work and cut across development settings.

- Two platforms, including a country support platform for the SDGs and a global development advisory and implementation services platform, which together serve as modes of delivery of integrated solutions.
- An improved business model that enables the delivery of the Strategic Plan.

130. The principles and strategic objectives of “leaving no one behind” and “reaching the furthest behind first” cut across the Strategic Plan and results framework. It includes ambitious targets that aim to benefit the most marginalized and vulnerable groups, whether it is in the context of multi-dimensional poverty, access to basic health services, or vulnerabilities associated with demographics.

131. Health is a cross-cutting issue across the signature solutions and there is a specific Strategic Plan output which focuses on strengthening capacities at national and sub-national level to promote inclusive economic development and deliver basic services, including HIV and related services.

132. 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:

Action areas and key priorities 2016–2021

Action area 1
Reducing inequalities and social exclusion that drive HIV and poor health

Key priorities
- **1.1** Promoting gender equality and empowering women and girls.
- **1.2** Inclusion of key populations at risk of HIV and other excluded groups.
- **1.3** Urbanization, HIV and health.

Action area 2
Promoting effective and inclusive governance for health

Key priorities
- **2.1** Enabling legal, policy and regulatory environments for HIV and health.
- **2.2** Strengthening governance to address NCDs and accelerate tobacco control.
- **2.3** Sustainable financing for HIV and health.

Action area 3
Building resilient and sustainable systems for health

Key priorities
- **3.1** Implementation support and capacity development for large-scale health programmes.
- **3.2** Inclusive social protection.
- **3.3** Planetary health.

Highlights of the UNDP-Global Fund Partnership

133. UNDP's partnership with the Global Fund makes a powerful contribution to the 2030 Agenda and the commitment to leave no one behind. UNDP's integrated approach combining policy, implementation and capacity development support assists countries in building resilient and sustainable health systems that deliver essential health services, especially in challenging operating environments and fragile contexts. As of December 2017, UNDP was managing 34 Global Fund grants as interim Principal Recipient, covering 18 countries and three regional programmes covering another 27 countries. UNDP's role as Global Fund Principal Recipient (PR) is an interim arrangement. To date, UNDP has fully transitioned out of the interim PR role, handing over to national entities in 30 countries.

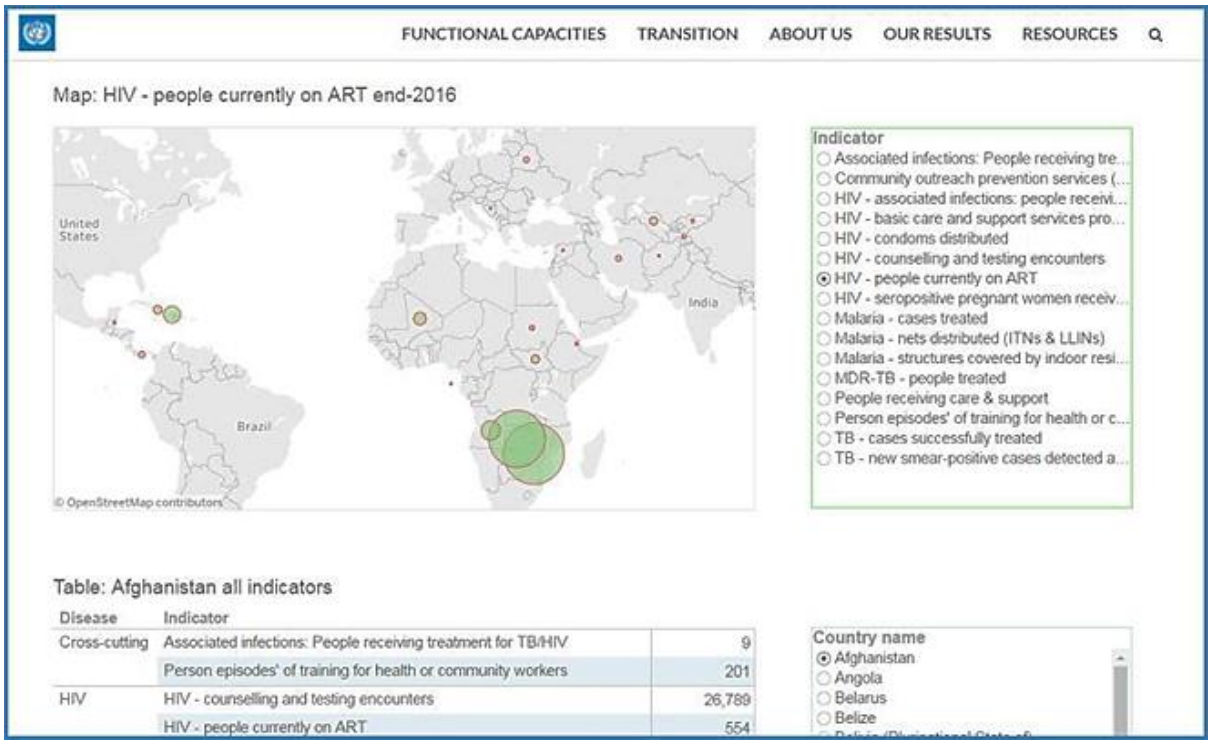
134. UNDP's partnership with the Global Fund has saved 3.1 million lives since the beginning of the partnership in 2003. In 2017, 2.2 million people were receiving HIV treatment. In 2016-2017, 13 million people received HIV counselling and testing, 210 000 pregnant women received HIV treatment to prevent mother-to-child-transmission of HIV, 180 000 people received treatment for STIs and 82 million condoms were distributed. In addition, during the biennium, UNDP-managed Global Fund grants reached 2.4 million people with behaviour change communication services and supported the training of 81 000 doctors, nurses and community health workers.

135. TB has now surpassed HIV as the world's deadliest infectious disease in all but the lowest income countries. In 2016-2017, the partnership between UNDP and the Global Fund has helped countries successfully detect and treat 100 000 new smear-positive TB cases, and treated 156 000 people for HIV/TB co-infections. Since the beginning of the partnership there has been a 50% decrease in TB-related deaths in eight countries (Tajikistan, Sao Tome and Principe, Turkmenistan, Syrian Arab Republic, Bosnia and Herzegovina, Haiti, Bolivia and Kyrgyzstan) where UNDP is managing or has managed grants.

136. Leveraging UNDP's partnership with the Global Fund, a growing number of countries are requesting UNDP's support for strengthening the resilience and sustainability of health systems. In 2017, this included 20 countries asking for support on procurement and supply management of medicines and other health products.

137. UNDP's partnership with the Global Fund is carried out with a wide range of partners, including other UNAIDS Cosponsors such as UNFPA, UNICEF, UNHCR, WFP, and WHO, as well as civil society and the private sector.

138. All of the data above including detail for each country can be viewed via an interactive dashboard and map at http://www.undp-globalfund-capacitydevelopment.org/en/results/browse-portfolio-results/ (see screenshot). For a summary of these results and health outcomes for each country and the portfolio as a whole, see http://www.undp-globalfund-capacitydevelopment.org/en/results/



Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Mechanisms to ensure access to medicines and commodities strengthened *[Output 1.6]*

139. In November 2015, the United Nations Secretary General announced the appointment of a High-Level Panel on Access to Medicines. UNDP served as the Secretariat for the High-Level Panel, in collaboration with the UNAIDS Secretariat, developing a report with a simple and powerful message: no one should suffer because they cannot afford medicines, diagnostics or vaccines. The report has been welcomed by the Secretary General, several UN Member States and civil society groups and was included in a resolution of the UNGA in December 2016, as well as a 2016 resolution of the Human Rights Council. In 2017, UNDP, in close partnership with UN Member States, continued to support the organisation of side-events on the margins of various meetings in Geneva and New York. The side-events advanced advocacy on the need to rethink regulatory paradigms in the context of increasing access to medicines but also in the context of addressing emerging threats such as antimicrobial resistance, future public health challenges, as well as the need to stimulate health technology innovation.

140. UNDP has been supporting countries to adapt their national laws and policies to ensure that only high-quality patents are granted. To this end, the UNDP developed guidelines for the examination of pharmaceutical patent applications. These guidelines are for countries to enhance the functioning and transparency of the patent system for timely

and affordable access to lifesaving treatment. The guide was used to train at least 80 patent examiners from Vietnam in 2016.

141. UNDP has also supported countries in strengthening legal and policy environments and undertaking assessments, to improve access to affordable medicines and support regional collaboration and experience sharing. For example, in Thailand, a South-South collaboration report on experiences and lessons from achieving universal access to antiretroviral treatment under the country's universal health coverage system was launched to support equity-oriented universal health coverage efforts in other countries.

142. An ASEAN-wide regional consultation, organized in partnership with the Malaysia Competition Commission, helped to build capacity of government officials - including competition authorities and MoH - on the use of competition law to promote access to health technologies. UNDP also developed an issue brief on the use of competition law to promote access to affordable health technologies. In Indonesia, capacity of government officials was enhanced to address access to affordable medicines in the context of supporting effective universal health coverage and its financial sustainability. Capacity was also built on use of a medicine price comparison methodology, as a policy tool to promote evidence-based decision-making on medicines procurement and price negotiations.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

143. UNDP, together with STRIVE[8] and the London School of Hygiene and Tropical Medicine continued to support cross-sectoral co-financing for HIV, health and development synergies. In late 2016, UNDP agreed a two-year global project with the Government of Japan to build on previous years' results and implement the co-financing approach in seven sub-Saharan African countries (Ethiopia, Ghana, Kenya, Malawi, South Africa, Tanzania, and Zambia). The project focus is on tackling social determinants of health and increasing universal access to affordable, quality health services, including through efficiently financed expansion of social protection schemes (national or district-level).

144. In 2016-2017, UNDP (1) sensitized national governments and sister UN agencies to the concept and project, strengthening buy-in, joint ownership and multi-partner structures, (2) supported country-specific co-financing plan development in all project countries, and (3) elevated co-financing in global technical support for sustainable development, namely through the UN Development Group common Mainstreaming, Acceleration and Policy Support (MAPS) approach to support countries to implement the 2030 Agenda for Sustainable Development and related guidance.

145. Key UNDP-supported results relevant to HIV prevention from project countries include: South Africa included co-financing as a component in its National Strategic Plan 2017–2022 on HIV, TB and STIs. It plans to apply the co-financing approach to HIV prevention interventions, and more specifically cash transfer programmes for young women aged 15-24.

[8] http://strive.lshtm.ac.uk/

146. Zambia has provisionally identified bringing reliable, clean energy to health clinics to ensure people get the lifesaving health services they deserve. This work builds upon UNDP's Solar for Health initiative, which installs solar energy photo-voltaic systems on health clinics, ensuring constant and cost-effective access to electricity, while also mitigating the impact of climate change and advancing multiple SDGs.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

147. The Africa Key Populations Expert Group (Expert Group) is comprised of 35 individuals representing four key population communities—men who have sex with men, people who use drugs, sex workers and transgender people—from 16 countries in Africa. Supported by UNDP, the Expert Group work supports efforts to promote social inclusion and change the norms that perpetuate unequal power relations. In 2015, the Expert Group developed a model strategic framework on HIV for key populations that, which has been used by such regional bodies as the East African Community and the Southern Africa Development Community to inform their strategies and programmes.

148. Key population organizations and national-level actors are also using the framework to inform the planning, implementation and monitoring of HIV and health programmes. In South Africa, the Expert Group representatives influenced the language used in the South African National Strategic plan and facilitated the development of the National Sex Work HIV Plan. In Senegal, Expert Group representatives helped design a project on managing and sensitizing the risks related to drug use and adopting practices to lower the risks for active users.

Harm reduction services for people who inject drugs *[Output 4.2]*

149. UNDP has supported the UN Secretary-General's initiatives to strengthen system-wide actions to support implementation of the 2016 UNGASS on drugs' recommendations on health, human rights and sustainable development. As part of these efforts, UNDP is partnering with the International Centre for Human Rights and Drug Policy (HRDP) at the University of Essex to develop International Guidelines on Human Rights and Drug Control.

150. In 2016 and 2017, UNDP and HRPD convened four consultations with UN Member States and entities, UN and regional human rights mechanisms, civil society and academia to provide feedback on draft guidelines on human rights and drug policy and to share country and regional perspectives on rights violations experienced by communities affected by international drug control efforts.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality *[Output 5.1]*

151. In 2016 and 2017, UNDP worked to ensure that institutions and public servants are equipped to understand the particular needs of women and girls in HIV prevention, treatment and access to justice, with a focus on removing systemic barriers that place women and girls at higher risk of HIV and/or poor outcomes.

152. UNDP is working with the Global Fund on expanding work to strengthen Country Coordinating Mechanism (CCM) capacity on gender issues related to HIV, TB and malaria. This builds on a pilot CCM training on gender held in Namibia in mid-2016, in collaboration with the Global Fund. Discussions are ongoing with the CCM in South Sudan to implement this training in 2018.

153. In its role as interim Global Fund Principal Recipient, UNDP has supported countries to promote gender equality and empower women and girls. For example, in Afghanistan, the UNDP-Global Fund partnership is supporting NGOs that are training women to become community health nurses, promoting expanded access to health services for women in a culture that discourages treatment by a health care worker of the opposite sex.

Gender-based violence *[Output 5.2]*

154. UNDP has laid out a strong foundation for addressing GBV within the context of HIV, health and development and has contributed to increased awareness and evidence base on the linkages between GBV and HIV. In 2017, a GBV portal was created, providing information to be accessed by country offices of UNDP for technical support and knowledge sharing to improve programmatic activities. In 2018, it is envisioned that the portal will be made available externally for use by partners.

155. In 2016 and 2017, UNDP strengthened evidence and action on GBV and HIV. For example, in the Arab States, UNDP conducted an assessment of violence against women and the law. The assessment covered three types of laws (criminal law, family law and labour law) in 20 Arab Countries[9] to determine if they are in line with international standards and are working in practice.

156. In South Sudan, UNDP supported a programme to train health care workers to respond to GBV and refer survivors to a range of appropriate services. In addition, the programme supported a number of behavioural change communication initiatives aimed at preventing GBV and supporting the use of GBV services, through radio. These messages were translated into multiple languages, including those spoken by internally displaced populations.

157. In 2017, UNDP, in partnership with the LINKAGES project and the University of the West Indies, completed a regional study on GBV, key populations and HIV in Barbados, El

[9] Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen

Salvador, Haiti, and Trinidad and Tobago. The findings show that laws and policies remain a challenge in eliminating violence directed at key populations.

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Legal and policy reforms *[Output 6.1]*

158. UNDP continued implementation of the Global Fund Africa Regional HIV Grant for Removing Legal Barriers to Access, forming a partnership with four African CSOs10 to strengthen the legal and policy environment in order to reduce the impact of HIV and tuberculosis on key populations in ten countries in Africa (Botswana, Côte D'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda and Zambia), including by training lawyers and legal workers in documenting human rights violations, strategic litigation and policy advocacy. Lawyers who have participated in these trainings successfully represented clients in key cases in 2017.

159. For example, in Botswana, SALC-trained lawyers were part of the legal team in a landmark case in which a High Court ordered the Registrar to change the gender marker on the identity document of a transgender man from female to male, a significant step towards protecting the dignity of transgender people. UNDP's collaboration with UNAIDS and coordinated advocacy efforts by national and regional civil society organizations including ARASA and SALC were critical to this achievement.

Legal literacy, access to justice and enforcement of rights *[Output 6.2]*

160. As part of its partnership with the Global Fund in South Asia, UNDP, with the Asia Pacific Forum of National Human Rights Institutions and 17 Human Rights Commissions, including five from South Asia (Afghanistan, Bangladesh, India, Nepal and Sri Lanka) developed an action plan to promote and protect human rights in the context of sexual orientation and gender identity. Human rights institutions in Bangladesh and Nepal established dedicated positions to address violations against at-risk populations, a first for the region.

161. In 2016, UNDP, with IDLO, supported the engagement of CSOs providing legal aid for people living with HIV and key populations in the MENA region. This led to the establishment of the Middle East Network for Legal Aid (MENAL) to support networking and knowledge and experience sharing among CSOs in the region and to build CSO's capacity to improve the quality of services provided.

162. In 2016 and 2017, UNDP strengthened the capacity of 34 district-level registrars of the Ghana Centre for Human Rights and Administrative Justice (CHRAJ) – the Ghanaian national human rights body – on HIV related stigma and discrimination and the online stigma and discrimination reporting system. As a follow-up action to the passage of the Ghana AIDS Commission law, UNDP provided technical and financial support to engage with 20 leaders of the National Association of Persons living with HIV on the law's key anti-stigma provisions.

HIV-related stigma and discrimination in health care *[Output 6.3]*

[10] The AIDS and Rights Alliance of Southern Africa (ARASA), Enda Santé (ENDA), Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN), and the Southern Africa Litigation Centre (SALC)

163. In 2016-2017, *The Time Has Come* training package, developed by UNDP and WHO to reduce stigma and discrimination against LGBTI people in health care settings was adopted into national HIV training programmes in Bhutan, Indonesia, India, Nepal, the Philippines, and Timor-Leste. UNDP has supported trainings of trainers in 12 countries, reaching some 400 health care providers in 2016 and almost 1500 since 2014. The roll-out of the training was supported through the Multi-Country South Asia Global Fund HIV Programme and the ISEAN-Hivos Multi-Country HIV Programme.

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Sustainability, efficiency, effectiveness and transitions *[Output 7.1]*

164. UNDP worked with regional entities in Eastern and Southern Africa to advance sustainable financing for HIV and health. As a member of the East African Community (EAC) technical working group on Sustainable Financing for Health, UNDP supported the analysis and development of an action plan for sustainable financing for universal HIV and health coverage. Similarly, UNDP supported the Southern Africa Development Community to develop a framework of action on sustainable financing for HIV and health. UNDP's support to develop sustainable financing approaches for HIV and health extended to 10 countries in Eastern Europe and Central Asia. UNDP supported governments and civil society to develop roadmaps for social contracting to facilitate implementation of jointly prioritized interventions by civil society, government and other partners.

165. In 2016, UNDP additionally worked with the African Development Bank to support 11 countries to integrate HIV, health and gender into environmental impact assessment (EIA) processes. This work offers other health financing opportunities that can increase domestic financing for health. For example, UNDP has strengthened the capacity of a SADC-funded project in Botswana that focuses on mainstreaming HIV, gender and human rights into three core non-health sectors: infrastructure and works; minerals, energy and water resources; and transport and communications. UNDP guidance on integrating health into EIA processes was updated in 2016 to capture the many lessons learned since the initiative began in 2012.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

Decentralization and integration of HIV related services *[Output 8.1]*

166. In 2017, UNDP's HIV and Health Team ensured inclusion of HIV-sensitive social protection and cross-sectoral co-financing within its broader organizational offer on cash-based programming. This work sets the stage for increased attention to HIV-sensitive social protection in UNDP's in-country programming, but resources are needed for follow through.

167. Finally, UNDP was a guest editor for a new supplement in the Journal of the International AIDS Society (JIAS), Paediatric and Adolescent HIV and the Sustainable Development Goals: the road ahead to 2030. This special issue examines paediatric and adolescent HIV interventions and their synergies across the SDGs. Areas covered include the effects of combined service provision on HIV-mortality in adolescents in

South Africa, the need for adolescents and young people to be meaningfully engaged as leaders of the HIV response, and the impact of criminalization of drug use and punitive policy environments on adolescents' health and HIV transmission risks.

UNDP 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	1 012 629	3 500 381	4 513 010
SRA 3: HIV prevention among young people	93 863	1 562 941	1 656 804
SRA 4: HIV prevention among key populations	1 516 459	6 297 627	7 814 086
SRA 5: Gender inequality and gender-based violence	1 405 459	5 490 044	6 895 503
SRA 6: Human rights, stigma and discrimination	2 866 929	7 292 459	10 159 388
SRA 7: Investment and efficiency	517 246	3 036 721	3 553 967
SRA 8: HIV and health services integration	407 901	1 989 663	2 397 564
Grand Total	**7 820 486**	**29 169 836**	**36 990 322**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	2 170 618		2 852 769	
AP	1 000 035	30%	7 900 254	61%
EECA	900 466	13%	2 166 857	14%
ESA	2 057 579	56%	9 485 942	84%
LAC	685 859	26%	2 099 047	20%
MENA	457 241	10%	1 438 686	14%
WCA	548 688	28%	3 226 281	35%
Grand Total	**7 820 486**		**29 169 836**	

UNDP Global Fund Grants 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment		174 436 104	174 436 104
SRA 3: HIV prevention among young people		99 678 468	99 678 468
SRA 4: HIV prevention among key populations		50 007 288	50 007 288
SRA 5: Gender inequality and gender-based violence		62 750 518	62 750 518
SRA 6: Human rights, stigma and discrimination		64 757 637	64 757 637
SRA 7: Investment and efficiency		20 738 541	20 738 541
SRA 8: HIV and health services integration		90 580 204	90 580 204
Grand Total		**562 948 760**	**562 948 760**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	-	-	1 020 893	
AP	-	-	23 661 429	0%
EECA	-	-	42 261 380	0%
ESA	-	-	407 735 367	98%
LAC	-	-	24 305 927	27%
MENA	-	-	31 158 859	18%
WCA	-	-	32 804 905	83%
Grand Total			**562 948 760**	

Case Study

Having fled the civil war in Somalia seven years ago, Fatouma lives in the Ali Addeh refugee camp with her mother and her four brothers and sisters. The camp is home to 14,546 people, the majority seeking refuge from conflict in nearby Somalia, Ethiopia and Eritrea.

“At the beginning, I was feeling chest pains, and I had a fever. I was feeling so very tired; I could not move at all. And then I started coughing all the time, so I went to the health centre in the camp.

At the health centre, Fatouma was diagnosed with TB. After two months at the hospital of Ali Sabieh, one-hour drive away from Ali Addeh refugee camp, she was able to return to her family and continue her treatment at the camp's health centre.

“I was afraid I would never be healthy again. The health centre at the camp were provided the drugs from the hospital weekly, so every morning for the last four months of my treatment, I went to the health centre to take my TB medicine,” she explains.

In line with its HIV, Health and Development Strategy, and as outlined in the UNDP Strategic Plan 2018-2021, UNDP partners with the Global Fund to support and strengthen multi-sectoral national responses to TB in 11 countries by providing integrated policy, programme and capacity development support. Working closely with national governments and civil society organizations, this partnership has resulted in 850,000 people receiving treatment for TB and 19,139 people receiving treatment for multi-drug resistant TB.

Ending TB by 2030 will require a partnership approach, which strengthens the capacity of national health systems. UNDP, UNHCR and the Global Fund are working closely with the Government of Djibouti to ensure camp populations and host communities affected by TB have equal access to the treatment, care, and support they need.

Knowledge products

	**HIV, Health and Development Strategy 2016-2021: Connecting the Dots** elaborates UNDP's work on HIV and health in the context of the 2030 Agenda for Sustainable Development.
	**UNDP Support to the Implementation of Sustainable Development Goal 3** - UNDP has worked with the United Nations Development Group (UNDG) to create a strategy for effective and coherent implementation support of the new sustainable development agenda under the acronym 'MAPS' (Mainstreaming, Acceleration and Policy Support). This prospectus outlines UNDP service offerings on HIV and health.
	**Advancing Human Rights, Equality and Inclusive Governance to end AIDS** – This Issue Brief provides a short overview of the report of the Global Commission on HIV and the law as well as a snapshot of country-level outcomes that the work on following up on the Commission's recommendations has contributed to through support by UNDP, working in partnership with UN Member States, civil society, UNAIDS cosponsors, the UNAIDS Secretariat, and other partners.
	**Advancing the Human Rights and Inclusion of LGBTI People: A Handbook for Parliamentarians** sets out relevant human rights frameworks for the inclusion of LGBTI people and highlights the role of parliamentarians in implementing Agenda 2030.
	The **Discussion Papers on Gender & Malaria and Gender & TB** summarize evidence showing how gender impacts on malaria and TB risks and effects (including those that intersect with HIV), and highlights data and implementation gaps.

United Nations Population Fund (UNFPA)

UNFPA strives for a world in which every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled. Addressing HIV is integral to UNFPA's goals of achieving universal access to sexual and reproductive health and realizing human rights and gender equality. Working on the ground in some 150 countries, UNFPA expands the possibilities for women and young people to lead healthy and productive lives, empowering individuals and communities to claim their human rights and access the information and services they need without stigma, discrimination or violence. Leaving no one behind, means everyone counts. UNFPA promotes integrated HIV and SRH services for young people, key populations, women and girls, and people living with HIV. UNFPA also supports innovative platforms and solutions for development challenges working closely with government, civil society, and the private sector towards strengthening national ownership, capacity and accountability.

168. The intrinsic connections between HIV and SRHR are well-established, and have numerous benefits, especially as HIV is predominantly sexually transmitted and therefore part of sexual and reproductive health. Preventing and treating HIV contributes to people attaining the highest attainable standard of health. Linking HIV and SRHR responses is a key delivery platform for HIV prevention and critical for reaching human rights, gender equality, and health targets for the Sustainable Development Goals.

169. In many countries, women - including those living with HIV or highly marginalized - do not have equitable access to good-quality health services and face multiple and intersecting forms of stigma and discrimination. They are also disproportionately vulnerable to violence, including violations of their sexual and reproductive rights.

170. Integrated sexual and reproductive health services increase access to prevention information and uptake of services. Pregnant women attending ante-natal care clinics can access HIV and syphilis testing. Linking comprehensive sexuality education with SRH services improves knowledge on HIV and has shown to improve uptake of services. Similarly joining HIV awareness campaigns such as CONDOMIZE! with testing opportunities can increase uptake. The roll-out of large-scale social behaviour change, HIV testing and treatment, VMMC and STI control programmes, and efforts to increase access to affordable contraception all offer opportunities for integrating condom promotion and distribution for triple protection from HIV, STIs and unintended pregnancies.

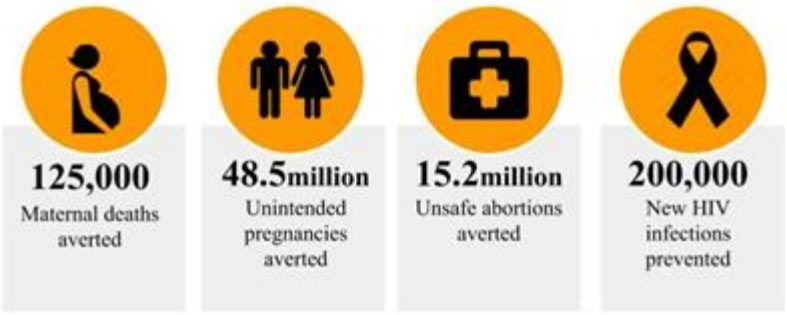


Figure 2: Key results from family planning commodity distribution, 2014-2017

Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Fast-track HIV services in high burden cities *[Output 1.4]*

171. Key population communities often congregate in urban locations for a number of reasons, and urban-based HIV services can have relatively good reach, provided these services are accepted by these local key population communities. Social contracting for delivery of HIV services by known and trusted NGOs remains an important mechanism for accessing key population groups within urban settings. Provision of people-focused, non-judgmental, community-led and integrated services are also key for increasing acceptance and uptake. Working with UNDP and other development partners, UNFPA supported rights-based and integrated SRH/HIV services for key populations and young people at risk of HIV in a number of cities and urban sites during 2016 and 2017. As an example, in ESA services were provided through a 24 hour clinic in Harare in Zimbabwe; a drop-in centre in Kilifi in Kenya (accessed by 2573 sex workers and 135 male clients during 2017); sex worker-friendly health facilities in Eastern Cape, South Africa, with 1258 contact visits during 2017; provision of six key population drop-in centre hubs in Uganda; and training of health care workers in providing condoms to sex workers in urban clinics in Rwanda. In Bangladesh, UNFPA facilitated provision of integrated SRH/HIV services for key populations through 142 drop-in centers run under the umbrella of AIDS STD Programme. This facilitated brothel-based sex workers' access to HIV/STI services. In Moldova in Eastern Europe, integrated SRH/HIV services were provided for people living with HIV and key populations by eight NGOs through a social contracting model. With Global Fund support, UNFPA in Tajikistan supported provision of HIV/STI/SRH services for key populations through a series of "Trust Point" drop-in centers. The Trust Point model is subsequently being rolled-out in Tajikistan for delivery of integrated services to key populations through primary health care services.

172. The local sex worker network in Jakarta, Indonesia was supported by UNFPA in designing a Global Fund proposal for educating and empowering sex workers to reduce their risk of HIV and violence. UNFPA in the Philippines undertook KAP surveys of young men who have sex with men in three cities: Quezon, Cebu and Davao. Across Latin America, Mexico City is included within a multi-site proposal for roll-out of PrEP for men who have sex with men and transgender people in Mexico, Brazil and Peru - to reduce HIV transmission in these key populations.

HIV-related services in humanitarian emergencies *[Output 1.5]*

173. UNFPA is committed to ensuring that the reproductive and maternal health needs of women are not overlooked during a humanitarian crisis. In 2017, emergency reproductive health kits, containing equipment and supplies to support the reproductive health of populations in crises, were provided to over 50 countries, up from 47 countries in 2016, as part of UNFPA support in humanitarian responses. Kits included contraceptives and equipment for family planning service provision (male and female condoms, injectables, pills, IUDs and emergency contraceptives), and are estimated to have prevented over 97 000 unintended pregnancies among women and adolescent girls in perilous conditions.

Key achievements for access to and utilization of sexual and reproductive health, 2014-2017

Enabling environment created

47 countries

developed health-care worker protocols and standards on sexual and reproductive health for young people

82 countries

developed midwifery workforce policies based on international standards

36 countries

developed a costed integrated national action plan for sexual and reproductive health

45 countries

had budgeted humanitarian contingency plans that contain sexual and reproductive health, including services for survivors of sexual violence

20 countries

developed costed supply chain management strategies

Institutions and systems strengthened

30 countries

had functional logistics management information systems for reproductive health commodities

59 countries

implemented comprehensive condom programming

47 countries

engaged sex worker-led organizations in implementing sexual and reproductive health programmes for sex workers

Individuals reached

41 million

women and girls benefited from sexual and reproductive health services and from prevention and care services for gender-based violence in humanitarian settings

Over 32,000

midwives were educated and trained

100,000

women and young people with disabilities utilized sexual and reproductive health services in 2017

113 million

couple-years of protection generated

174. Working with UNHCR, UNFPA undertook a stakeholder assessment of sex work in humanitarian settings in order to better understand the humanitarian response needs of people selling sex in both camps and urban re-settlement areas, Guidance was also provided for HIV programming with sex workers within the Rohingya refugee camps in Cox's Bazaar, Bangladesh.

175. UNFPA also continued providing information and education, condom programming, and strengthening the HIV response in the context of humanitarian crises globally. In the EECA region, UNFPA has provided life-saving humanitarian support and assistance for the affected populations: life-skills education, voluntary counselling and testing, prevention and treatment of STIs through the provision of condoms, drugs and other supplies, and creation of 'safe spaces' where adolescents (including youth IDPs and key populations) can freely access information, services and peer support networks. During 2017 in Ukraine, UNFPA strengthened the HIV/STI component of emergency SRH services for most vulnerable women and adolescent girls including from key populations and IDPs, who were affected by the armed conflict in eastern Ukraine. Capacity building occurred of networks and organizations of young key populations to address HIV and SRHR needs. Specifically, UNFPA improved the capacity of local NGOs to provide effective outreach and referral for sex workers and young women selling sex in exchange for shelter or food, to access integrated SRH/HIV/STI services in Donetsk and Luhansk regions.

Medicines and commodities *[Output 1.6]*

176. UNFPA Supplies leverages UNFPA's comparative advantage in procurement as a high volume buyer and pooler of significant donor resources. Through its market-shaping efforts, improvements in forecasting and planning and work with suppliers, UNFPA accesses the best price possible of quality-controlled condoms and lubricants. UNFPA also manages the prequalification programme for male and female condoms on behalf of and in conjunction with WHO and created publically available lists of prequalified manufacturers which better ensure procured condoms meet internationally acceptable quality standards. In 2016 and 2017, UNFPA had 30 male condom manufacturers and four female condom manufacturers on the prequalification list. Provision of procurement services for the Global Fund continues to ensure quality commodities including condoms from suppliers who comply with environmental standards.

177. Access to male and female condoms, the only effective triple protection tools to stop HIV, STI and unintended pregnancy, continues to be priority for UNFPA. The Fund remains the multilateral organization that supplies the largest numbers of male and female condoms and lubricants to the developing countries, mainly Sub-Saharan Africa. In the biennium of 2016 and 2017, UNFPA supplied 1.13 billion male condoms, 22.27 million female condoms, 117.16 million sachets for personal additional lubricants. Between 2014 and 2017, 30 countries had functional logistics management information systems for reproductive health commodities and 59 countries implemented comprehensive condom programming. In addition, Family Planning 2020, where UNFPA is a key partner and co-chairs the reference group, enabled more than 309 million women and adolescent girls to use modern contraception by 2017, an increase of 38.8 million since the launch of the partnership in 2012.

178. To provide national stakeholders and program managers with evidence to guide the development of programmatic guidelines or arguments for condom access to young people, UNFPA commissioned or undertook four systematic reviews:

- An international desk review on HIV, STIs, and condom knowledge, attitudes and practices of university students found that condom use was reported as higher during the last sexual intercourse than at the first sexual intercourse. And, although the majority of students had heard about HIV and STIs, comprehensive knowledge of sexual health, HIV, and STIs was limited.
- UNFPA contracted the University of Zimbabwe to evaluate evidence on the safety of personal lubricants when applied rectally and vaginally and the effect of lubricants on sperm motility and the effect of osmolality on the safety of personal lubricants. This review was the basis of the global consultation of personal additional lubricants aimed at outlining the specifications of the formulation of non-toxic lubricants guiding UNFPA and WHO services to countries.
- The review of Condom Availability Programs (CAP) in high schools found that CAP does not increase sexual activity, nor lead to a greater number of sexual partners, or lower the age of sexual initiation.
- Wide-ranging findings on practices and products in the study on the practices and preferences of women for wet or dry sex led to the development of a classification system clearly defining a list of seven vaginal practices and identified five main reasons for such practices.

179. To explore the expansion of the commercial condom market in Africa, UNFPA in collaboration with USAID, the Reproductive Health Supplies Coalition, and the ILO, gathered more than 70 commercial condom manufacturers, public sector donors, and representatives of NGOs, government, and multilateral organizations. The result was the creation of a multi-sector coalition named Africa Beyond Condom Donation, to meet a bold target to increase the number of male and female condoms in low- and middle-income countries to 20 billion by 2020 in line with the 2016 Political Declaration target.

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Comprehensive eMTCT services *[Output 2.1]*

180. Pillars 1 and 2 of comprehensive packages to eliminate mother to child transmission of HIV are well addressed in SRHR service settings including midwifery. UNFPA is particularly working to strengthen the delivery of family planning services to the last mile - this means ensuring a choice of contraceptive options, including those that can be safely used by women living with HIV, is available at all service delivery points. A particular focus is on strengthening the reproductive health commodity supply chain, including in humanitarian settings.

181. UNFPA is working with programme countries, particularly those with the highest unmet need for family planning, to develop sustainable human-rights based family planning programmes that meet the needs of all their populations, including marginalized groups. In addition, UNFPA is sharpening its focus on increasing domestic financing.

182. In the biennium of 2016 and 2017, contraceptives provided by UNFPA are estimated to have:
    - Reached 28.3 million people.
    - Averted 26.7 million unintended pregnancies (15 million in Fast Track countries).

- Averted 8.08 million unsafe abortions (4 million in Fast Track countries).
- Averted 64 000 maternal deaths (47 102 in Fast Track Countries).

183. Good practices occurred in many countries in terms of health system strengthening to enable progress towards eMTCT. In Kenya, two national frameworks were prepared on: (i) eMTCT (2016-2021), with associated curriculum development; and (ii) SRH/HIV/SGBV linkages (2018-2022). Peer educators worked with first time mothers to improve antenatal/postnatal care including contraception, HIV testing and referral of first time young mothers (FTYM) for ART and prevention of vertical transmission. In Swaziland, over 34 000 adolescent girls were reached with a Prong 1 intervention providing integrated SRH/HIV information, including on safer sex and use of condoms. Contraception for women living with HIV was also scaled up (Prong 2). In Haiti, 41 health care providers were assessed for HIV skills, with 29 receiving training to improve PMTCT. UNFPA in DRC worked with a local network of People living with HIV to build capacity of 150 young women and girls on SRH/HIV issues including EMTCT and contraception. Nigeria was supported to improve EMTCT services via capacity building of midwives for improved RMNCH interventions. In Togo, eight new NGOs were supported through a social contracting model to provide HIV testing services for adolescent girls and young women, with contraception provided, including for clients identified as living with HIV (Prong 2).

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Youth health and education *[Output 3.2]*

184. The paucity of data on the prevalence of HIV among young key populations in itself indicates a lack of attention to the issue of adolescents and young people. At the same time, young people have great capacity to contribute to the AIDS response including policy dialogue and political advocacy; peer learning, exchange and networking; community mobilization; programme design and delivery; research and strategic information; coordination, monitoring and accountability.

185. UNFPA, in its new strategic plan 2018-2021, prioritized the empowerment of adolescents and youth to attain universal access to sexual and reproductive health. Over the past biennium, UNFPA continued facilitation and capacity development with youth organizations and networks to strengthen their advocacy and participation in policy processes. More concretely, the resource hub for youth participation and advocacy was updated and expanded in 2016 and 2017. The comprehensive sexuality education (CSE) Hub has 194 active members and additionally 800 followers on the official Facebook page. Progress was also made on the youth leadership publication, which is a comprehensive multimedia youth leadership toolkit, the objective of which is to bring together key tools and models that will support young people in becoming leaders and driving change.

186. The increased prioritization of adolescents and youth at global, regional and country levels enabled more adolescents to access sexual and reproductive health services. In 2017, over 5 million adolescents and youth accessed sexual and reproductive health information and services in UNFPA priority countries. In 2017 in Zimbabwe, a total of 24 096 girls were recruited into girls only clubs known as Sista2Sista clubs where 518 156

person exposures to Sista2Sista clubs were achieved by mentors. Young leaders from UNFPA Kenya youth advisory panel, the Kenyan Chapter of the African Youth and Adolescent Network on Population and Development (AfriYAN) and the network of young people living with disabilities were able to inform the revision of the National Training Manual on Adolescent Youth Friendly Services (AYFS) and the development of the National Adolescent Sexual Reproductive Health Costed Policy Implementation Framework. In Haiti, 2311 adolescent girls benefited from regular life skills training, sexual and reproductive health information, gender-based violence prevention information in one urban slum in Carrefour and in Anse-a-Pitres, a small town bordering Dominican Republic. UNFPA supported development and use of youth-led technology and innovative approaches in SRHR, including HIV prevention and CSE such as the "I-Design" Tool developed in Thailand for young people to train them on Sexuality, Gender and Human Rights.

Key achievements for adolescents and youth, 2014-2017

Enabling environment created

16 countries

developed laws and policies that allow adolescents access to sexual and reproductive health services

23 countries

in Africa had roadmaps and/or country profiles for the demographic dividend

Institutions and systems strengthened

38 countries

aligned all national comprehensive sexuality education curricula with international standards

30 countries

implemented skills-building programmes for adolescent girls at risk of child marriage

47 countries

established participatory platforms that advocate increased investments in marginalized young people

Individuals reached

1.3 million

marginalized girls in UNFPA priority countries benefited from life-skills programmes in 2017

39 countries

where national statistical authorities had the capacity to analyse and use disaggregated data on adolescents and youth

187. UNFPA has also been a supportive partner of the Global Accelerated Action for the Health of Adolescents (AA-HA!) to help governments plan healthcare interventions to meet the needs of adolescents.

188. In strong partnership with UNESCO, the UN Revised International Technical Guidance on Sexuality Education (ITGSE) was finalized, launched and promoted at regional and global levels in 2017, providing an excellent example of joint work by a number of UN agencies. Based on the latest scientific evidence, the ITGSE reaffirms the position of sexuality education within a framework of human rights and gender equality, assisting education policymakers in all countries to design accurate and age-appropriate curricula for children and young people aged 5–18+. This joint work has also catapulted the need to develop complementary guidance for CSE in out of school settings, which UNFPA is leading. In tandem, the preparatory high-level meeting for the 2019 Global CSE Summit was also conducted jointly with the Norway Government, to establish a network of CSE-friendly member states. In programming, 38 countries report alignment all national comprehensive sexuality education curricula with international standards.

189. In Kenya, UNFPA provided technical and financial support to Ministry of Education and Sports (MOES) to integrate sexuality education as one of the key strategic interventions in the new five year Education Sector Strategic Plan (2017-2022). The plan also highlights sexuality education as one of the key areas of research that the Ministry will invest in during this period. UNFPA also provided technical support to MOES to review and finalize the School Health Policy, which regulates the delivery of sexuality education in school settings.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

190. UNFPA is a global ally of key population communities, working to support community mobilization to a mount more effective responses to HIV including through network Secretariats including the Network of Sex Work Projects (NSWP), the Global Forum on Men Who Have Sex with Men and HIV (MSMGF), and the International Reference Group on Transgender Women and HIV (IRGT). UNFPA lent technical expertise to the strategic directions of MSMGF, a community evaluation framework for the SWIT and an assessment of condom availability for the global Network of Sex Work Projects.

191. Between 2014 and 2017, 47 countries engaged sex worker-led organizations in implementing sexual and reproductive health programmes for sex workers.

192. HIV/STI programming with key populations has been strengthened via building capacity of implementing partners to utilise key population HIV/STI programming guidance, based primarily on the key population HIV implementation tools (summarized as the SWIT, MSMIT, TRANSIT and IDUIT). Following 2016 training in Eastern and Southern Africa region, UNFPA developed tailored, summary guides for utilizing the MSMIT and SWIT tools across ESA region. Fifteen ESA countries were supported to include sex worker and other key population programmes within Global Fund proposals. Comprehensive and rights-based SRH/HIV services were provided for sex workers and men who have sex with men populations including in Botswana, Kenya, Lesotho, Malawi, Namibia,

Rwanda, South Africa, Uganda, Zambia and Zimbabwe. Services were also provided for transgender people and people who inject drugs in many of these countries, complemented by peer-led community outreach to key population communities. The Southern Africa Development Community was supported to draft a key population strategy, with sensitization training for SADC members planned in 2018.

193. TRANSIT, the tool for supporting transgender people, was translated into Spanish and distributed in thirteen Latin American countries. TRANSIT-based trainings were carried out with trans-led CSOs and allied service providers – regionally in Latin American (eight countries), Southern Africa (six countries), as well as in India. In the Asia Pacific region UNFPA supported key population programming in Bangladesh, China, Indonesia, Myanmar, Nepal and Pakistan, strengthening delivery of integrated SRH and HIV prevention services, predominantly with and for sex workers and men who have sex with men. Multi-country small island state programmes in the Pacific and the Caribbean supported key population networks and built capacity for community-led HIV prevention programming.

194. UNODC, the International Network of People who Use Drugs (INPUD), UNFPA and other development partners finalised and published guidance on implementing comprehensive HIV and HCV programmes with people who inject drugs completing the set of implementation tools focused on key populations.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender-based violence and gender equality *[Output 5.2]*

195. Gender equality and the empowerment of women and girls continues to be a key pillar of UNFPA's Strategic Plans. Millions of women and girls increased their demand for rights.

196. In 2017, UNFPA assumed sole leadership of the GBV Area of Responsibility (AoR), the global level forum for coordination on GBV prevention, risk mitigation and response in humanitarian settings, which functions as part of the Global Protection Cluster. UNFPA also hosted a global expert meeting in Nairobi in October 2017, on the continuum approach for addressing GBV, with participation from 23 countries. UNFPA has also been working on GBV prevention and response for marginalized women and girls, such as indigenous populations and women and girls with disabilities. In 2016, UNFPA initiated a global programme to promote the human rights and social inclusion of adolescents and young people living with disabilities, entitled WE DECIDE: Young Persons with Disabilities - A Programme for Equal Opportunities and a Life Free of Violence. In Brazil, needs, demands, and expectations of women living with HIV/Aids presented during the II National Conference of Women's Health (2017) were converted in resolutions. New processes and procedures concerning comprehensive women's health care are expected in 2018 and following years based on National Conference resolutions. UNFPA further supported inclusion of a range of SRH service strengthening interventions within Global Fund proposals, including on prevention and response to GBV.

197. Responses to the Universal Periodic Review recommendations on gender and SRHR were also strengthened, ensuring protective systems to respond to GBV and protect the

rights of survivors. UNFPA additionally contributed to the UN Violence Prevention Framework and supported data collection on violence, together with finalisation of the SDG indicators on GBV. Additionally, UNFPA developed a corporate Gender Strategy in 2017, which recognizes the link with HIV. The Strategy will be formally launched in 2018.

Key achievements for gender equality and the empowerment of women and girls, 2014-2017

Enabling environment created

25 countries

integrated reproductive rights into gender equality national action plans

29 countries

in which civil society organizations implemented accountability mechanisms to address reproductive rights

56 countries

integrated gender-based violence prevention, protection and response into national sexual and reproductive health programmes

Institutions and systems strengthened

31 countries

had functioning tracking and reporting systems for reproductive rights obligations

32 countries

in which civil society organizations supported the engagement of men and boys in programmes on gender equality

77 per cent of countries

affected by a humanitarian crisis in 2017 had a functioning inter-agency, gender-based violence coordination body as a result of UNFPA guidance and leadership

Individuals reached

Over 700,000[11]

women and girls, including **4,400 disabled** women and girls subjected to violence, accessed essential services in 2017, with support from UNFPA

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

HIV-related stigma and discrimination in health care [Output 6.3]

198. Ending discrimination in health care settings, as outlined in the UN Joint Statement, clearly sets a direction to eliminate judgmental and non-rights-based approaches to health care delivery. In part from UNFPA support and advocacy between 2014 and 2017, 16 countries developed laws and policies that allow adolescents access to sexual and reproductive health services.

[11] In 35 UNFPA priority countries

199. Strengthening evidence-based research on global and country level accountability mechanisms for SRHR, UNFPA supported documenting case studies on countries supporting National Human Rights Institutions (NHRIs) review SRHR issues and a global analysis of how SRHR issues were reflected and taken action on in the second cycle of the Universal Periodic Review (UPR) and also helped helped strategically position SRHR in intergovernmental negotiations including at the Human Rights Council. 96% of the global and regional development agendas developed during 2017 addressed sexual and reproductive health, reproductive rights, gender equality, the needs of adolescents and youth, and population dynamics.

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Technology and service delivery innovations [Output 7.2]

200. UNFPA has embraced innovation as a corporate priority and sees innovation as an indispensable engine to bring about transformative change for women, girls, and young people.

201. In partnership with OpenIDEO, UNFPA launched a crowd-sourcing challenge to find new ways to improve the SRH of young people. A total of 256 solutions leveraging mHealth platforms, new data applications and SRH commodities were crowdsourced. Top ideas will receive support to take promising and proven solutions forward.

202. In South Africa, UNFPA, in partnership with loveLife, has piloted a mHealth innovative solution in 40 clinics in the Eastern Cape and KZN provinces. The mobile platform aimed at reaching young people with quality SRHR and HIV prevention information and link them to appropriate services in their communities. The platform currently has more than 85 000 registered users and almost 1000 young people were referred to services through the platform. In Uganda, the mHealth solution was tested in 2016 and deployed in 2017 to reach and improve timely follow-up with pregnant girls to access life-saving maternal health services. The programme strengthens linkages between communities and district health care systems to improve their health outcomes.

203. In Bhutan, in collaboration with Ministry of Health and Ministry of Education, UNFPA supports the online information on SRHR through the existing mobile apps called “mPower Youth” targeting adolescents and youths. In Botswana, in collaboration with Ministry of Health and Wellness access to SRH information and skills among young people through the Tune Me platform and the weekly and interactive youth led radio show (Don’t get it twisted) to provide young people with SRH/HIV information. In Swaziland, TuneMe has more than 16 000 users since its launch in July 2017. In ESA, over 3 million young people gained SRHR information through the app TuneMe.org and related social media.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

Decentralization and integration of HIV related services *[Output 8.1]*

204. UNFPA has mainstreamed HIV within its new Strategic Plan 2018-2021. This includes supporting country capacity to deliver integrated SRH/HIV information and services, including within humanitarian settings.

205. UNFPA has supported health system strengthening in numerous countries, primarily at the primary health care level, for provision of more/fully integrated SRH and HIV services. This has occurred through strengthening coordination mechanisms, development of guidelines and resources, assessment and restructuring of health facilities, coordination of procurement of commodities, and capacity building of health care providers. Under UNFPA's co-convenership of the Global HIV Prevention Coalition, the Prevention 2020 Roadmap was developed and launched with action accelerated in 25 Prevention Coalition countries 100-day plans drafted in 2017. SRHR/HIV integration is a foundation platform for delivering on the 5 prevention pillars.

206. The linkages project in 10 ESA countries aims to promote efficient and effective linkages between HIV and SRHR policies and services as part of strengthening health systems and to increase access to and use of quality services. In Botswana, fully integrated, comprehensive SRH/HIV/SGBV services are provided by 251 trained health care workers within 88 facilities across three of 12 health districts. Lesotho has also built capacity of providers and reached 17 184 people with SRHR/HIV/SGBV services during 2017. Malawi added 5 new integrated services in 2017, giving a total of 12 facilities offering an integrated SRH/HIV package. Zambia has developed an integrated SRHR/HIV/SGBV policy as part of their drive for universal health coverage - 88 midwife graduates, 96 student nurses and 130 existing PHC nurses have been trained in integrated service provision. In South Africa 10 PHC facilities have been assessed and 150 HCWs trained, with planned incremental roll-out in 2018. Family planning and HIV services have been provided in an integrated manner in Tanzania and Swaziland, where 300 health care providers were trained in integrated FP/HIV care, and 200 nurses were trained in ASRH/HIV/GBV care. Overall 37 877 adolescents received outreach SRH/HIV services and 1250 adolescent girls were trained in SRH/HIV/GBV rights and needs, through the “Girls Leading Our World” Programme.

207. By 2017, Namibia has restructured a fifth (62) of its primary health care facilities, to provide integrated SRHR/HIV services, with individual health care providers allocated to working in a dedicated manner with individual clients within single clinic rooms (no requirement for clients to move between providers). Provision of family planning, mainly to adolescent girls and young women increased by 14.7%, with reduced waiting times, reduced visit times, improved client satisfaction and provider-client communication, reduced discrimination and more equitable shared workload for providers within participating clinics. China has initiated a policy gap analysis of HIV, STI, FP and RH service needs and identified opportunities for integration commencing 2018, including addressing lack of FP services for key populations and lack of condoms within tertiary education institutions. Progress has also been supported in other regions, for example Kyrgyzstan has trained 262 PHC providers in integrated SRH/HIV services and

Colombia has trained 60 providers for improved SRHR/HIV outcomes including for improving maternal health within indigenous women.

208. UNFPA also worked with the “SheDecides” movement to further strengthen agency and autonomy of adolescent girls and young women to strengthen control over their sexual and reproductive health choices. Tanzania has also focused on integrated FP/HIV services, but also has integrated cervical cancer screening with HIV testing as cancer risk markedly increases in women living with HIV. During 2017, in Zanzibar, 470 women living with HIV were screened with two identified as VIA positive and referred for treatment.

209. UNFPA worked together with WHO and OHCHR on the published updated guidance on SRHR for Women living with HIV.

UNFPA 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	274 342	2 145 538	2 419 880
SRA 2: Elimination of mother-to-child transmission	105 982	8 153 601	8 259 583
SRA 3: HIV prevention among young people	4 361 236	41 264 127	45 625 363
SRA 4: HIV prevention among key populations	2 752 401	11 215 060	13 967 461
SRA 5: Gender inequality and gender-based violence	61 933	7 987 910	8 049 843
SRA 6: Human rights, stigma and discrimination	448 150	1 752 688	2 200 838
SRA 7: Investment and efficiency	995	748 714	749 709
SRA 8: HIV and health services integration	466 413	15 228 843	15 695 256
Grand Total	**8 471 452**	**88 496 481**	**96 967 933**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% FT countries
Global	2 539 075		28 042 854	
AP	948 145	30%	6 271 785	64%
EECA	1 167 511	9%	3 558 566	5%
ESA	1 695 612	56%	34 427 851	74%
LAC	701 429	45%	3 473 702	5%
MENA	364 458	0%	6 811 278	2%
WCA	1 055 222	62%	5 910 445	74%
Grand Total	**8 471 452**		**88 496 481**	

Case studies

HIV Prevention Case Study – Shining the light on girls and young women at risk

© UNFPA Swaziland
Caption: Takhona learned to protect herself from HIV from UNFPA's SYP programme.

SHISELWENI, Swaziland – More than one in five adults in Swaziland are HIV-positive, according to the most recent data, and the rates are highest among women. Women and girls have significantly higher rates of HIV infection. A third experienced sexual violence before age 18. And, girls in Swaziland face high teen pregnancy rates, which far exceed the global average. Despite these statistics, young people – and young women in particular – often lack the information and services they need to keep themselves healthy and safe. Takhona, 17, says that, until recently, she did not know anything about HIV or STIs. "I believed, before, that having sex, you just enjoy. Nothing can happen. I didn't know about pregnancy and HIV and STIs," she said. Takhona is from Shiselweni, one of the poorest regions in Swaziland. In secondary school, she says, they started drinking alcohol, often before class. "I was just trying to relieve stress by taking alcohol," she explained. She was soon misbehaving in class and threatened with expulsion.

A friend introduced Takhona to Safeguard Young People (SYP), a UNFPA-supported programme in ESA that brings information about sexual and reproductive health to vulnerable youth. Through the programme Takhona was empowered to make changes. She also talked to her friends and mother about what she had learned. Last year, Takhona finished secondary school and plans to become a teacher. "What I wish for Swazi girls, I wish for them a bright future and better standard of living," Takhoma told UNFPA. "And actually, I'm looking to my own very bright future."

There are steep barriers to receiving care, especially for young people. Many health centres have not adopted practices that welcome young people, especially girls and young women. Stigma limits their access to sexual and reproductive health care, including HIV testing and prevention. UNFPA is working to facilitate young people's access to youth-friendly integrated SRHR/HIV/GBV information and services. In Swaziland, nearly a quarter of all health facilities in the country now provide youth-friendly services. UNFPA works closely with National Emergency Response Council on HIV and AIDS (NERCHA) to develop the ASRH guidelines and AYFHS standards as well as the roll out of LSE for both in and out school youth. UNFPA has also supported Family Life Association of Swaziland (FLAS) and Khulisa Umntfwana to provide/outreach services to the young people reaching them where they are including traditional events such as reed dance and Incwala.

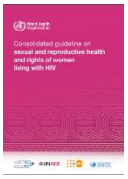
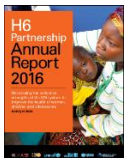
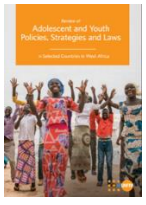
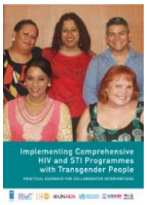
SYP is currently implemented in eight countries (Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe). In 2017 SYP reached 1.16 million young people in and out of school with face to face CSE/SRHR information; 1.75 million young people used SRH services, including HIV testing and treatment; and 3 million young people gained SRHR information through the TuneMe.org app, social media and the SYP music project.

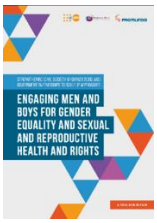
UNFPA Georgia advocates for Health, Rights and Well-Being

"*In reality, potentially anyone can become a victim of discrimination, so we should know our rights and how to behave in a particular situation. The better informed we are, the more effective our response to these challenges." (YKP; MSM)*

In response, to the heightened vulnerability of young people, especially young key populations, UNFPA Georgia initiated a series of advocacy meetings and workshops to adapt at the national level the programme tool "Health, Rights and Well-Being" jointly developed with IPPF, along with the MSMIT and SWIT, and to capacitate the community organizations, young key populations and service provider/outreach workers who are engaged delivering the HIV preventive and SHR services. Over 2017, 82 participants (six workshops) representing organizations of harm reduction service organizations, SRH service providers, community organizations (LGBT, HIV+, sex workers), young key populations received important capacity building for the rollout to better address the country's challenges in ensuring the health of its young people through improving access to youth friendly health care services, including sexual and reproductive health services, and quality CSE encompassing human rights, health life style and RH issues.

Knowledge Products

	Global Sexual and Reproductive Health Package for Men and Adolescent Boys		Health, Rights and Well-being
	HIV Prevention 2020 Road Map		Consolidated guidance on sexual and reproductive health and rights of women living with HIV
	H6 Partnership Annual Report 2016		The Safeguard Young People Programme: Three years on
	Review of Adolescent and Youth Policies, Strategies and Laws		mplementing 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.

	**Ending the AIDS epidemic for adolescents, with adolescents 2016.**		**SRH/HIV linkages snapshots (25)**
	**Online guide to engaging men and boys in SRHR 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**

- The Case for investing in the male condom
- The Status of HIV Prevention in 2017 (Infographics of 40 countries)
- 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
- The Connect Effect. Online resource in Asia Pacific region, for sharing key population guidance and South-South exchange of country programming examples
- SRHR & HIV LINKAGES TOOLKIT (see under “SRH and HIV Linkages”)
- Safeguarding Young People (SYP)
- Countries’ SYP video reports:
- Music:
- SYP publications, including 2015 annual report:

United Nations Office on Drugs and Crime (UNODC)

UNODC is committed to promoting health, justice and security by being a global leader in the response to illicit drugs, transnational organized crime and terrorism, which have emerged as major threats to individuals, communities and countries. Using its many years of experience, and its technical and political credibility, UNODC strives to ensure that such initiatives are designed and implemented in a proactive, focused and effective manner.

UNODC is the UNAIDS convening agency for HIV prevention, treatment and care for people who use drugs and for ensuring access to comprehensive HIV services for people in prisons and other closed settings. Together with national and international partners, UNODC supports countries in their efforts towards ending AIDS by 2030 through: 1. Advocacy; supporting reform, development and implementation of effective legislation and policies to facilitate access to evidence-informed HIV services, reducing stigma and discrimination, and promoting human rights and evidence-based public health-centred approaches to drug use and HIV, and to HIV in prisons and other closed settings; 2. Technical assistance; supporting the development and implementation of comprehensive evidence-informed gender- and age-responsive strategies and programmes; and 3. Partnerships; brokering multisectoral alliances between drug control, justice, prison administration; law enforcement, health, civil society organizations (CSOs) and community-based organizations (CBOs).

Key achievements by Strategy Result Area

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

210. In order to ensure continuity of HIV services for people in contact with the criminal justice system, in 2016-2017, UNODC advocated for strengthening collaboration between public health, criminal justice, prison administration and civil society organizations. This included advocacy at side events of the 25th and 26th sessions of the Commission on Crime Prevention and Criminal Justice held in 2016 and 2017.

211. UNODC also assisted in development, adoption and implementation of strategies and programmes on HIV in the criminal justice system, in line with the UNODC/ILO/UNDP/WHO/UNAIDS Policy Brief HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. For example, in Namibia a Prisons Health Policy was launched, in Vietnam the first methadone maintenance therapy service unit in prisons was opened and scaling up of OST in prisons was technically supported and in Nepal the 15 key interventions for HIV prevention, treatment and care in prisons were included in relevant HIV Standard Operating Procedures.

212. UNODC continued implementation of the HIV in prisons programme in Sub-Saharan Africa (Angola, Ethiopia, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Tanzania, Zambia and Zimbabwe). To date, the project has built the capacity of over 30 000 policy-makers and provided support and training to over 33 000 prison inmates and prison health staff. In 2017, UNODC initiated a new phase for the project for 2017–2020.

213. UNODC also implemented training for senior officials of various line ministries and directorates in Egypt, Morocco and Tunisia, as well as conducting three workshops on health in detention, in collaboration with International Committee of the Red Cross. UNODC also implemented training to address the health needs of women in prisons in Morocco and built the capacity of the staff of National Centre for Disease Control and civil society organizations in Libya.

214. In Ukraine, UNODC supported regular training of prison staff on HIV, human rights, stigma and discrimination, as part of existing staff training and development schemes. This included the development of an on-the-job training manual on HIV, as well as facilitating a training-of-trainers workshop. In cooperation with the National Police of Ukraine and the Ukraine National Academy of Internal Affairs, UNODC additionally produced learning material (video), which has, to date, reached over 14 000 police officers in the country.

215. UNODC supported CSOs in the implementation and scaling up of evidence-based HIV services for people who use drugs as well as in prison settings, including in the context of 'UNODC-CSO Group on Drug Use and HIV'. For example, UNODC built the capacity of civil society and community-based organizations working among people who use drugs in 12 African countries and of women who use drugs in Indonesia.

216. Through the 2016 World Drug Report and at relevant high-level meetings of the UN Governing bodies organized in 2016 and 2017, UNODC also disseminated results of literature reviews on HIV and amphetamine-type stimulants use, HIV and cocaine use, and HIV and new psychoactive substances (NPS) use.[12]

Harm reduction services for people who inject drugs *[Output 4.2]*

217. In March 2016, UNODC organized a scientific consultation 'Science addressing drugs and HIV: State of the Art: An update' in the margins of the Commission on Narcotic Drugs (CND) 59th session. The scientific statement was presented at the UNGASS on the World Drug Problem (April 2016) and at the High-Level Meeting on Ending AIDS (June 2016).

218. During the biennium, UNODC further strengthened partnerships between law enforcement, CSOs and CBOs, and disseminated the Practical Guide for Civil Society HIV Service Providers among People Who Use Drugs: Improving Cooperation and Interaction with Law Enforcement Officials. The guide was jointly produced with Law Enforcement and HIV Network (LEAHN) and International Network of People Who Use Drugs (INPUD) in 2016.[13]

219. In 2016–2017, UNODC trained over 650 law enforcement officers, 200 representatives of CSO and CBOs, and nearly 200 members of parliament and representatives of health, education and social sectors on interacting with people who inject drugs, implementing

[12] http://www.unodc.org/documents/hiv-aids/2017/1_Stim_HIV_Syst_Lit_rev_Part_1_methodology_and_summary.pdf
http://www.unodc.org/documents/hiv-aids/2017/2_Stim_HIV_Syst_Lit_Rev_Part_2_ATS.pdf
http://www.unodc.org/documents/hiv-aids/2017/3_Stim_HIV_Syst_Lit_Rev_Part_3_Cocaine_and_Crack-Cocaine.pdf
http://www.unodc.org/documents/hiv-aids/2017/4_Stim_HIV_Syst_Lit_Rev_Part_4_-_New_Psychoactive_Substances.pdf
http://www.unodc.org/documents/hiv-aids/2017/5_Stim_HIV_Syst_Lit_rev_Part_5_Prevention_and_treatment.pdf

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

police referral services as an alternative to incarceration, and addressing HIV at the workplace. Training was carried out in Afghanistan, Armenia, Belarus, Kazakhstan, Nigeria, the Republic of Moldova, South Africa, Tajikistan, Tanzania, Ukraine and Uzbekistan. UNODC also developed an e-learning tool for HIV training among law enforcement officials.

220. In Egypt, South Africa, the United Republic of Tanzania and Vietnam, UNODC also trained over 230 service providers to improve access to HIV services for people who inject drugs. In 2016-2017, the efforts of the UNODC-CSO Group on Drug Use and HIV were focused on implementation and scaling up of evidence-based HIV prevention, treatment and care for people who inject drugs.

221. UNODC supported over 80 CSOs worldwide and produced 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).[14]

222. In partnership with the International Network of Women Who Use Drugs, UNODC developed a training programme on addressing the specific needs of women who inject drugs and trained over 70 service providers, managers and outreach workers in Egypt, Indonesia and Vietnam. The training events were followed by policy-level dialogues with national stakeholders.

223. UNODC workshops and policy dialogues engaged people who inject drugs in the response to HIV and trained more than 120 representatives of Governments, civil society and community-based organizations in Egypt, South Africa, Tanzania and Vietnam.

224. UNODC also organized technical consultations on HIV and stimulant drug use in Brazil, Ukraine and Vietnam, bringing together over 100 representatives from national HIV/AIDS programmes, drug control and law enforcement agencies, and governmental and non-governmental organizations.

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Legal and policy reforms *[Output 6.1]*

225. UNODC contributed to the work of the UNAIDS Global HIV Prevention Coalition and the development of the UNAIDS HIV Prevention 2020 Roadmap as a basis for a country-led movement to scale up HIV prevention programmes as part of a comprehensive response to meet global and national prevention targets and commitments, including for prison inmates and people who inject drugs.

226. At the country level, UNODC backed efforts to update national drug policies. For example, in Myanmar, UNODC supported three rounds of drug policy consultations convened by the Ministry of Home Affairs, the Myanmar Police Force and the Central Committee for Drug Abuse Control. The consultations lay the foundation for a new drug

[14] http://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf.

policy and for related legal reforms. UNODC provided expert inputs to develop human-rights-centred and health-focused approaches, promoting the adoption of the comprehensive package of HIV prevention, treatment and care services for people who inject drugs and encouraging discontinuation of the compulsory registration of people who use drugs.

227. In Nigeria, UNODC supported the inclusion of evidence-based activities to address HIV among people who inject drugs in the national drug control master plan and the national policy for the control of viral hepatitis. Furthermore, UNODC contributed to the inclusion of such activities in the workplan of the Economic Community of West African States for 2016–2020. In addition, UNODC jointly facilitated access to legal services for people who inject drugs, with the Coalition of Lawyers for Human Rights.

228. In Afghanistan, UNODC provided technical assistance to the Ministry of Public Health as it developed a national strategic framework for the prevention and control of HIV for 2016–2020. In addition, UNODC advocated for the removal of legal barriers hindering access to HIV services, including needle and syringe programmes, opioid substitution therapy and condom programmes in prisons.

229. In Ukraine, UNODC and its partners successfully advocated for the introduction of opioid substitution therapy in prison settings, which the Government approved in 2016.

UNODC 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment		433 161	433 161
SRA 3: HIV prevention among young people		216 582	216 582
SRA 4: HIV prevention among key populations	5 600 898	8 771 555	14 372 453
SRA 5: Gender inequality and gender-based violence		324 873	324 873
SRA 6: Human rights, stigma and discrimination		1 082 909	1 082 909
Grand Total	**5 600 898**	**10 829 080**	**16 429 978**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	2 539 075		28 042 854	
AP	948 145	30%	6 271 785	64%
EECA	1 167 511	9%	3 558 566	5%
ESA	1 695 612	56%	34 427 851	74%
LAC	701 429	45%	3 473 702	5%
MENA	364 458	0%	6 811 278	2%
WCA	1 055 222	62%	5 910 445	74%
Grand Total	**5 600 898**		**10 829 080**	

Case Study

In 2017, UNODC provided technical assistance in monitoring and evaluation of HIV services in prisons in Kyrgyzstan, Tajikistan and Vietnam. In consultation with national counterparts and other relevant partners in the three countries, UNODC assessed the relevant information and existing resources, identified needs and provided tailored technical assistance to improve existing or develop new methods and tools, adapted to the national context, for monitoring and evaluation of HIV services in prisons.

In Kyrgyzstan, UNODC supported development of a new electronic HIV and other health data monitoring and reporting system for the State Penitentiary System of Kyrgyzstan.

The assessment of the health data collection in the State Penitentiary System of the Kyrgyz Republic revealed that health data from prisons were collected using paper reporting forms, periodically submitted to the Medical Unit of the State Penitentiary System, and entered manually into a common form.

All business processes and data flows of the medical reports were reviewed. A web based “Automated System for Collecting Medical Reports” (ASCMR), based on the approved reporting forms of the penitentiary system was developed.

The newly developed unified electronic platform enables electronic data collection and reporting of all medical data from prisons. It will reduce the time required for data collection, reporting and dissemination nationwide from one month to 3-4 days only thereby significantly improving collection of the HIV strategic information within the State Penitentiary System and allowing for coordination that is more efficient between the penitentiary authorities and other relevant government entities. It will help ensure continuity of HIV services for people on admission to, transfer between and release from prisons, as well as the management of drug related overdose upon release from prison.

The new electronic platform has been presented to the management of the State Penitentiary System of the Kyrgyz Republic, as well as to the relevant country stakeholders and other partners, such as the Republican Narcology Center, the Republican AIDS Center, UNAIDS, UNDP, Global Fund and local NGOs.

Knowledge products

2016

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

2017

- http://www.unodc.org/documents/hiv-aids/2017/1_Stim_HIV_Syst_Lit_rev_Part_1_methodology_and_summary.pdf
- http://www.unodc.org/documents/hiv-aids/2017/2_Stim_HIV_Syst_Lit_Rev_Part_2_ATS.pdf
- http://www.unodc.org/documents/hiv-aids/2017/3_Stim_HIV_Syst_Lit_Rev_Part_3_Cocaine_and_Crack-Cocaine.pdf
- http://www.unodc.org/documents/hiv-aids/2017/4_Stim_HIV_Syst_Lit_Rev_Part_4_-_New_Psychoactive_Substances.pdf
- http://www.unodc.org/documents/hiv-aids/2017/5_Stim_HIV_Syst_Lit_rev_Part_5_Prevention_and_treatment.pdf

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.

UN Women's Strategy/Core Approach to HIV and AIDS

230. 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.

231. 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.

Highlights of 2016-2017 results

Meaningful participation of women living with HIV in the HIV responses

© Alina Yaroslavska
Natalia Kovnir, a woman-activist living with HIV, at the National Women's Forum on HIV and AIDS (19-21 September 2016, Odessa, Ukraine), supported by UN Women and other partners

232. UN Women invested in strengthening leadership capacity of women living with HIV in 20 countries[15] resulting in their influential engagement in HIV responses at national, regional and global levels. UN Women has been supporting the Women's Networking Zone (WNZ) since its first convening in 2006 and supported WNZ during the 2016 International AIDS Conference in South Africa and the 2017 ICASA in Cote D'Ivoire. These efforts increased the visibility of women's organizations at the conference and provided a space for them to advocate for greater accountability, funding and implementation of actions to advance women's priorities. Designed by and for women living with HIV, 89% of WNZ events were led by women.

233. In Uganda, in 2017, UN Women worked with the International Community of Women living with HIV-East Africa to mobilize, build leadership capacity and mentor representatives of 32 national and district-level networks and organizations of women living with HIV, particularly young women. As follow-up to the training and mentorship programme, women successfully advocated for integration of gender equality issues into design of the PEPFAR 2017 Country Operational Plan and review of the 2018-2025 HIV Prevention Roadmap for Uganda.

234. Through 2016-2017, in Cameroon, China, Kazakhstan, Morocco, Sierra Leone, South Africa, Tajikistan, Tunisia, Uganda, Ukraine and Zimbabwe UN Women helped to increase participation and meaningful engagement of the networks and organizations of women living with HIV to prioritize women and girls' priorities in the national HIV strategies, budgets and monitoring frameworks. For example, in Cameroon, with UN Women support, women's organizations influenced Cameroon's 2018-2022 National HIV Strategy to prioritize gender-responsive budgeting and M&E and include actions to reduce new HIV infections among adolescent girls, prevent violence against women and strengthen legal assistance for women and men living with HIV.

Transforming unequal social norms to prevent HIV and mitigate its impact

235. Over 2016-2017, UN Trust Fund to End Violence Against Women, administered by UN Women, awarded over US$ 2 million in grants to civil society in Cameroon, China, Cote D'Ivoire, Egypt, Haiti, Jamaica, Kenya, Myanmar, South Arica, Tanzania and Thailand for programming to prevent violence and HIV. Grassroot Soccer, a grantee of the Trust Fund in South Africa, used the power of football to educate and empower over 8,000 girls aged 13-16, including those living with HIV, with the final evaluation attesting to increased HIV knowledge and access to violence and HIV integrated services.

[15] 2016: Cameroon, China, Cote D'Ivoire, Indonesia, Jamaica, Kazakhstan, Malawi, Moldova, Mozambique, Nigeria, Rwanda, South Africa, Tajikistan, Tanzania, Thailand, Uganda, Ukraine and Zimbabwe; 2017: Cameroon, China, Indonesia, Jamaica, Kyrgyzstan, Malawi, Moldova, Mozambique, South Africa, Tanzania, Uganda, Ukraine, Viet Nam and Zimbabwe.

236. In Uganda, UN Women has launched an empowerment programme for adolescent girls and young women of 15-24 years, including those living with HIV. In 2016-2017, the programme provided young women and girls in Karamoja region with life-skills training to improve self-esteem, decision making competencies and knowledge in entrepreneurship, small and medium business management and financial literacy. All participants are linked to HIV prevention, care and treatment services. The intervention also educated the larger community to address norms and practices that predispose young women and girls to HIV and violence. In 2017, the programme benefitted 265 girls with early results demonstrating improvements in attitudes towards uptake and adherence to HIV treatment, an increased demand for HIV prevention commodities, an increased search for family planning information and services and reporting of violence cases.

© UN Women/Karin Schermbrucker
UN Women Executive Director Phumzile Mlambo-Ngcuka visits the United Nations Trust Fund-supported Grassroot Soccer SKILLZ Street intervention at the Yomelela Primary School, Khayalitsha Cape Town

Implementing Actions to Address Gender-based Violence and HIV

237. In 2016-2017, UN Women supported the design and implementation of the national action plans and policies on violence against women in Argentina, Paraguay, Peru and Viet Nam. In Viet Nam, UN Women brokered a space for the national network of women living with HIV to collaborate with the government and provide inputs to the National Thematic Project on gender-based violence prevention and response 2016-2020. The project is an operational framework to implement the 2016-2020 National Action Plan on Gender Equality. It recognizes sexual violence against women in public spaces, introduces specific measures to implement integrated gender-based violence and HIV services and establishes a multi-stakeholder coordination mechanism.

238. UN Women's work with traditional and community leaders in Malawi resulted in their increased engagement and commitment to preventing HIV among girls and ending child marriage. In 2017, UN Women and other partners successfully advocated for a ground-breaking amendment of Malawi's Constitution to raise the minimum age of marriage from 15 to 18 years. With UN Women's support, Paramount Chiefs developed a unified by-laws framework to guide implementation and monitoring of the constitutional amendment and 2015 Marriage, Divorce and Family Relations Bill at the community level, to eliminate child marriage and prevent HIV among adolescent girls.

239. ***Essential Services Package for Women and Girls Subject to Violence*** was launched by UN Women in partnership with UNFPA, WHO and UNODC, and rolled out by UN Women and other partners in Asia and the Pacific and Arab States. The package 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, ensuring access to post-exposure prophylaxis, HIV testing and treatment.

Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Access to treatment cascade *[Output 1.2]*

240. Women and girls face multiple forms of exclusion and discrimination that pose obstacles to accessing HIV services. In 2016-2017, UN Women invested in researching women's experiences of treatment availability and decision-making around uptake. For example, the ***Key Barriers to Women's Access to HIV Treatment: A Global Review*** was commissioned by UN Women and undertaken by AVAC, the ATHENA Network and Salamander Trust, revealing social and structural barriers for women's access to HIV treatment and adherence. The review surfaced issues such as: scarcity of existing data on women's experiences with HIV treatment, violence and fear of violence as a major barrier to women seeking care and treatment, the need for confidential and respectful presentation of antiretroviral therapy programmes and that many women continue to struggle with accessing health services that do not respect human rights. The findings of this review have been presented in an article published in the ***December 2017 volume of the Health and Human Rights Journal***.

241. The methodology of the review was unique as it was designed, led and governed by a Global Reference Group of 14 women living with HIV from 11 countries. Women living with HIV led all stages of the review, from designing the survey questionnaires to conducting the focus group discussions and validating findings. The review engaged over 200 women living with HIV from 17 countries.

242. Country case studies were conducted in Kenya, Uganda and Zimbabwe. The International Community of Women Living with HIV-East Africa led the case studies in Kenya and Uganda. In Uganda, good practices used by service providers to promote the enrolment and retention of women and girls were uncovered. These included the use of mobile phones, physical visits and follow-up, establishment of youth-friendly services, support groups, counselling, decentralization of services and group-based care models.

Strategy Result Area 3: - Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

243. UN Women supports the engagement and empowerment of adolescent girls and young women in national HIV responses. Through UN Women-facilitated interactive debates, comics, Ted Talks and other activities, in 2016-2017 over 3000 young women and adolescent girls across seven countries (Cameroon, China, Cote D'Ivoire, Liberia, Moldova, Mozambique and Sierra Leone) had their advocacy skills and knowledge on gender equality, preventing HIV and GBV improved.

244. Many of these young advocates continue to undertake advocacy and outreach to prevent HIV and GBV with their peers. For example, in China, in 2017 UN Women trained over 200 young women as peer educators to strengthen their capacity to promote gender equality, equitable gender relations and prevent violence against women and HIV. Twenty of these leaders designed, facilitated and monitored follow-up peer-to-peer trainings, coordinated social media campaigns and organized youth-exchange activities to reach peers. In 2017 UN Women also worked with 34 young peer educators, who conducted over 400 sessions in three regions of central and northern Côte D'Ivoire on issues related to gender equality, violence and HIV prevention, use of condoms, and referred over 500 young people to HIV testing and other services.

245. With UN Women's support, over 2016-2017 Jamaica's National Family Planning Board trained and mentored over 200 adolescent girls and young women and 168 young men from marginalized communities, including those living with HIV. Participants of the mentorship programme reported increased HIV knowledge and access to HIV and family planning services, as well as enhanced understanding of their sexual and reproductive rights.

Youth health and education *[Output 3.2]*

246. UN Women supported the mobilization of young women advocates to define a common agenda and participate in HIV policy and programming at global, regional and country levels. In 2016, UN Women's 'Engagement+Empowerment=Equality' effort resulted in building leadership capacity of over 1000 young women and adolescent girls, including 250 living with HIV, in Kenya, Malawi and Uganda. Through mentoring, capacity building and peer support, young champions engaged in the design and validation of the All-In assessments. In nine months, the young champions were able to reach thousands of young women through outreach activities, including through social and print media.

247. UN Women convened Youth Forums in preparation for the 60th and 61st sessions of the Commission on Status of Women (CSW) in 2016-2017. The Youth Forums provided a critical opportunity for young people and adolescents, particularly young women and girls (including those living with HIV) to openly and strategically discuss the challenges and opportunities in their local, national, regional and global contexts to achieve gender equality and sustainable development. The Youth Forums had thematic discussions on sexual and reproductive health and rights and HIV/AIDS, with specific recommendations included in the outcome documents.

248. At the 2016 International AIDS Conference, UN Women facilitated the participation of young women advocates living with HIV, who spoke at various sessions and side events, calling for accelerated action on ending early marriages, gender-based discrimination in health care settings and promoting meaningful participation of young women living with HIV. UN Women succeeded in creating a space for young women to engage in a dialogue with the Deputy of U.S. Global AIDS Coordinator and share their success and challenges in engaging in the national HIV responses. In follow-up to the International AIDS Conference, a small Youth Advisory Group was set up by UN Women and young women to continue engagement. As a result of UN Women support and advocacy, 19 young leaders working on HIV, over half of them young women, engaged in the Women Deliver 4th Global Conference (2016) and raised the priorities of young women in the context of HIV.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality *[Output 5.1]*

249. In 2016-2017, UN Women advocated for the integration of gender equality issues into national HIV strategies in 11 countries (Cameroon, China, Kazakhstan, Morocco, Sierra Leone, South Africa, Tajikistan, Tunisia, Uganda, Ukraine and Zimbabwe), ensuring inclusion of gender-responsive actions with budgets and indicators and meaningful participation of networks of women living with HIV. In two conflict-affected provinces of Ukraine, UN Women facilitated collaboration between local authorities and the networks of women living with HIV, which resulted in local budget allocations to community-led initiatives to prevent violence and HIV among women and girls. In Cameroon, Uganda, Viet Nam and Zimbabwe, UN Women helped to facilitate meaningful engagement of women living with HIV in the design of the Global Fund Concept Notes. In Zimbabwe and Uganda this support resulted in the approved Concept Notes prioritizing programming on adolescent girls and young women and HIV, with a total of US$ 8 million allocation in Zimbabwe and US$ 10 million in Uganda.

250. In 14 countries (Cambodia, Cameroon, China, Kenya, Malawi, Morocco, Nigeria, South Africa, Tunisia, Tanzania, Uganda, Ukraine, Viet Nam and Zimbabwe) in 2016-2017 UN Women collaborated with the national AIDS coordinating bodies, leading to more gender-sensitive HIV planning and institutions. For example, UN Women increased the capacity of 35 civil servants of Viet Nam Authority of HIV/AIDS Control and its six provincial AIDS centres, for gender-responsive M&E in HIV. This process allowed them to identify the gaps in sex-disaggregated data and lack of interventions and indicators to measure HIV response progress for women beyond mother-to-child transmission efforts. To operationalize the national HIV strategies UN Women also helped national AIDS coordinating bodies in Cameroon, Malawi, Tanzania, Uganda and Zimbabwe to adopt Gender and HIV implementation plans.

251. In 2016-2017, UN Women additionally invested in the capacity strengthening of women living with HIV in 20 countries (Cameroon, China, Cote D'Ivoire, Indonesia, Jamaica, Kazakhstan, Kyrgyzstan, Malawi, Moldova, Mozambique, Nigeria, Rwanda, South Africa, Tajikistan, Tanzania, Thailand, Uganda, Ukraine, Viet Nam and Zimbabwe), resulting in their meaningful engagement in HIV responses at national, regional and global levels. A global expert group meeting Putting Gender Justice at the Centre of the Fast Track to End AIDS, convened by UN Women, engaged 47 experts from networks of women living with HIV, women's organizations, academia and UN partners and resulted in a strategic discussion with key actions and agreements to ensure gender equality and HIV is prioritized in the High-level Meeting on HIV/AIDS, CSW and beyond.

252. In 2016, over 200 women living with HIV from 10 countries (Belarus, DRC, Kazakhstan, Kenya, Mozambique, Namibia, Russia, Thailand, Ukraine and Zimbabwe) increased their knowledge and engaged meaningfully in the SDGs at the national level, as a result of a partnership between UN Women and the International Community of Women living with HIV. In-country workshops, on-line mentoring and technical guidance were instrumental in ensuring the networks of women living with HIV gained critical knowledge on how to advocate for the inclusion of their perspectives in policy-making, to localize the 2030 Agenda and succeed in raising gender equality priorities at the national SDGs dialogues,

technical working groups, etc. A Guide to the SDGs for Network of Women Living with HIV was developed and disseminated.

Gender-based violence *[Output 5.2]*

253. 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. For example, in 2017, UN Women and other partners published a study on the impact of violence and HIV on indigenous women in Brazil and Paraguay. The study will be used to advocate for greater participation of indigenous women survivors of violence, particularly those living with HIV. The study highlighted unequal gender norms and discriminatory attitudes that prevail at the community level, driving violent behaviour, low levels of HIV knowledge among women as well as a lack of capacity and opportunities to participate in the national HIV response. The study also provided policy recommendations on how to prevent violence and decrease risk of HIV among women. These included strengthening access to accurate and comprehensive sexuality education and non-discriminatory HIV/SRH services - particularly post-exposure prophylaxis for survivors of sexual violence - and enhancing leadership capacity of indigenous women, including those living with HIV.

254. UN Women supported countries' efforts to prevent violence and HIV, particularly among disadvantageous groups of women and girls. In 2016-2017, UN Trust Fund to End Violence Against Women, administered by UN Women, awarded over USD2 million in grants to civil society in 11 countries (Cameroon, China, Cote D'Ivoire, Egypt, Haiti, Jamaica, Kenya, Myanmar, South Africa, Tanzania and Thailand), for programming to prevent violence and HIV and to strengthen responses to violence against women living with HIV. For example, Trócaire, a grantee of the Trust Fund, implemented SASA! Faith in four rural communities of Kenya. Twenty-eight community activists engaged with faith leaders to prevent violence and HIV among young rural women, particularly those with disabilities. A final evaluation of the project implemented by Jamaica AIDS Support for Life – another grantee of the UN Trust Fund – found a 32.4% increase in the number of women living with HIV, reporting improved health and access to violence and HIV and sexual and reproductive health services.

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Legal literacy, access to justice and enforcement of rights

255. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) is a powerful instrument for articulating, advocating and monitoring women's human rights. UN Women facilitated inputs and participation of the networks and organizations of women living with HIV in country reporting on CEDAW. For example, in Ukraine, with UN Women's support, women living with HIV co-authored the shadow report, which they presented to the CEDAW Committee members at the CEDAW session in 2017. A survey of 4000 women living with HIV was conducted in Ukraine, by the national network to assess how CEDAW implementation addresses the rights of women living with HIV. This work resulted in the CEDAW Concluding Comments to Ukraine calling for accelerated HIV prevention among women and girls and improved

access to GBV services for women to prevent HIV. In Viet Nam, the national network of women living with HIV contributed to the development and review of the monitoring framework of the 2015 CEDAW Concluding Comments.

256. Women and girls experience multiple forms of stigma and discrimination as well as rights violations, in the context of HIV. UN Women therefore worked to enhance access to legal aid for women living with HIV, to reduce gender-based stigma and discrimination in China, Malawi, Uganda, Viet Nam and Zimbabwe. In 2016, in Viet Nam, UN Women helped the national network of women living with HIV to analyse specific forms of discrimination women face in the context of HIV and identify gender-specific bottlenecks in access to legal aid. This analysis resulted in a set of recommendations to inform necessary amendments to the Legal Aid Law.

257. Meanwhile, access to justice for women living and affected by HIV remains a challenge in Uganda. According to the 2011 Gender Audit, when seeking justice, women face institutional biases, discriminatory attitudes and other barriers related to the lack of economic independence, care responsibilities and violence. UN Women therefore collaborated with judicial officers, lawyers and civil society in 2016-2017 to develop and disseminate a Gender Bench Book. Guided by the CEDAW and 'Maputo Protocol', the Gender Bench Book helps the judiciary to better understand needs and priorities of women in the context of HIV. Additionally, UN Women mobilized, enhanced capacity and mentored 60 cultural and community leaders and 78 women living with HIV in rural areas to identify women's rights violations and gender-based discrimination in the context of HIV. This work has resulted in increased trust in informal justice mechanisms at the local level, faster review of complaints, particularly from women living with HIV, and stronger coordination with the formal justice system.

258. In China, in 2017, UN Women collaborated with the National Centre for AIDS/STD Control and Prevention to design and pilot a Training of Trainers manual on gender-sensitive HIV services. Guided by the CEDAW provisions, the manual aims to enhance capacity of health care providers and policy-makers to promote elimination of stigma and discrimination and violence against women living with HIV.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

HIV sensitive social protection *[Output 8.2]*

259. UN Women has helped improve sustainable livelihoods for women living with HIV by facilitating their access to and control over economic resources. Throughout 2016-2017, UN Women's Fund for Gender Equality provided small grants to civil society organizations to economically empower women's groups in marginalized and impoverished communities, particularly women living with and affected by HIV. In Kyrgyzstan, the Fund for Gender Equality grantee strengthened business skills of 73 marginalized women (including women living with HIV, women who used drugs or were partners of drug users and women former prisoners). Five micro-grants were awarded to women's groups to develop business plans to set-up small enterprises and improve their livelihoods.

UN Women 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	63 629	294 047	357 676
SRA 3: HIV prevention among young people	180 138	1 917 716	2 097 854
SRA 5: Gender inequality and gender-based violence	2 497 632	15 004 649	17 502 281
SRA 6: Human rights, stigma and discrimination	158 449	3 622 795	3 781 244
Grand Total	**2 899 848**	**20 839 207**	**23 739 055**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	660 875		1 777 896	
AP	471 611	72%	4 933 107	25%
EECA	233 689	26%	1 143 870	24%
ESA	691 119	100%	5 174 111	72%
LAC	251 484	49%	2 424 539	35%
MENA	73 328	0%	1 794 859	0%
WCA	517 740	100%	3 590 825	57%
Grand Total	**2 899 848**		**20 839 207**	

Case study

Women's Voices and Priorities in the Zimbabwe Concept Note to the Global Fund to Fight AIDS, Tuberculosis and Malaria

Since 2015, UN Women has been facilitating women's organizations engagement with the Global Fund processes in Zimbabwe upon realizing women's priorities were not being adequately met in national HIV responses. Women and girls in Zimbabwe are disproportionately affected by HIV, with women (15 years+) making up 55% of all adults living with HIV and young women (15-24 years) facing 69% of new HIV infections in their age group (AIDSInfo 2017).

With UN Women's support in 2015-2017, through meaningful engagement and participation, women's organizations were able to voice their priorities for women and girls in the HIV response, increase their visibility and deepen their understanding of Global Fund processes. Their inputs to the Global Fund concept note led to the allocation of $8 million towards HIV programming for adolescent girls and young women, including the provision of be havioural change programmes, comprehensive sexuality education, community mobilization interventions and health services.

© UN Women
Members of the Women's Coalition writing Global Fund Concept Note

Leading up to the grant writing period, UN Women supported the Health Cluster of the Women's Coalition of Zimbabwe (WCoZ), a group working on HIV and health-related programming and advocacy, in fully understanding and participating in the Global Fund's grant writing process.

Ahead of the grant writing period, UN Women organized leadership training workshops, meetings with the Country Coordinating Mechanism (CCM) coordinator and government officials and a learning visit to Uganda's women's organizations, including a learning exchange with the International Community of Women living with HIV (ICW)-East Africa, to learn how gender equality and women's voices remain a strong part of the HIV response in Uganda and how they inputted the Global Fund Concept Note development process in Uganda. The *Transformative Leadership in HIV and AIDS* workshop focused on enhancing the knowledge of women leaders on tools and approaches used to integrate gender equality and women's empowerment issues into the national HIV response. The workshop's key outcome was an advocacy action plan, which prioritized a set of jointly agreed actions in the lead up to concept note development. Participants emphasized the need for coordinated and concerted advocacy around fast tracking alignment of laws to the new Constitution; ending child marriages; comprehensive sexuality education; addressing intimate partner violence; and access to comprehensive sexual and reproductive health services.

UN Women also facilitated meetings between the women's movement and the Minister of Health and Childcare to raise awareness on the lack of capacity-building and resources for women's organizations from the national HIV response and provide recommendations on how to improve women's participation and reduce new infections among adolescent girls and young women. The Minister of Health and Childcare committed to bringing the issue of funding women's organizations to the CCM and the need for the Global Fund to allocate more resources for interventions targeted at women and girls.

During the Global Fund Concept Note writing process in March 2017, UN Women continued to help women's organizations and young women activists in collating evidence and content to feed into the Global Fund Funding Request, along with ensuring the final request was gender-responsive. Through this process, the women's movement developed a key priorities document and suggested evidence-based gender-responsive interventions to be included in the request.

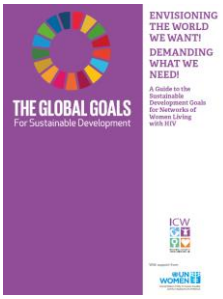
As a result, the women's inputs contributed to the allocation of $8 million towards HIV programming for adolescent girls and young women by the Global Fund. The funding is aimed to support:

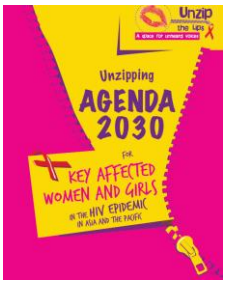
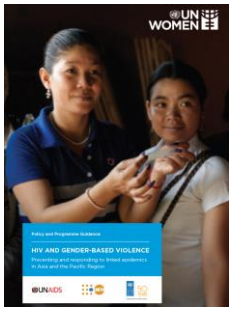
- Gender-based violence (GBV) prevention and treatment programs, including piloting the evidence-based SASA! model and establishing four one-stop centres for post-violence care for survivors of GBV;
- Behavioural change programs, including the modified DREAMS package supporting adolescent treatment supporters in communities;
- PrEP, HIV test kits and family planning commodities for adolescent girls and young women;
- Community mobilization and norms change interventions, including Sista2Sista Girls Mentoring Clubs;
- Interventions to keep girls in school, including the provision of reusable sanitary wear for in-school adolescent girls and young women;
- Provision of peer education services to young women (under 18 years).

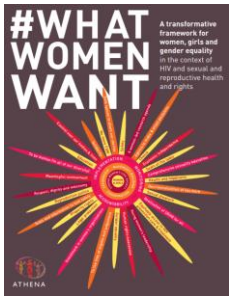
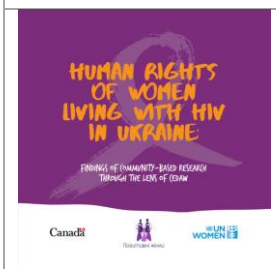
Key lessons learned also included the importance of:

- Women's representation in the CCMs and grant writing periods to advocate for key priorities and needs of women and girls in the context of HIV;
- Documenting evidence to not only establish what works but also demonstrate the collective voices and demands of women and girls in the HIV response;
- Effective, engaging and transparent coordination during the grant writing processes; and
- Capturing women's experiences in these processes for future learning.

Knowledge products

	UN Women has re-designed and re-launched its **Gender Equality and HIV/AIDS web-portal** 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** 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

	Commissioned by UN Women – **Key barriers to women's access to HIV treatment: A global review** – and undertaken by the AIDS Vaccine Advocacy Coalition (AVAC), Athena Network, and Salamander Trust – highlights the experiences of women living with HIV accessing treatment and quality care. Findings were published in the **Health and Human Rights Journal** in December 2017. Link to the resource: http://www.unwomen.org/en/digital-library/publications/2017/12/key-barriers-to-womens-access-to-hiv-treatment
	UN Women and the UNAIDS Secretariat along with other partners supported the **#WhatWomenWant: A Transformative Framework for Women, Girls and Gender Equality in the Context of HIV and Sexual and Reproductive Health and Rights**, that outlines a transformative framework to place gender squarely on the global development agenda, and summarizes the outcomes of the six-month ATHENA Network-led #WhatWomenWant campaign, that engaged 120,000 people in more than 40 countries. Link to the resource: http://genderandaids.unwomen.org/en/resources/2017/04/what-women-want---a-transformative-framework-for-women-girls-and-gender-equality-in-hiv-and-srhr
	UN Women supported a survey of 4,000 women living with HIV by the national Ukrainian women's network to assess how CEDAW implementation addresses the rights of women living with HIV. The findings of the survey are summarized in the *Human Rights of Women Living with HIV in Ukraine: Findings of Community-based Research Through the Lens of CEDAW* and informed the shadow report to the CEDAW Committee in 2017. Link to the resource: http://www.ewna.org/wp-content/uploads/2017/12/HIV-through-CEDAW-lens_eng.pdf

International Labour Organization (ILO)

The ILO is the specialized United Nations agency responsible for the world of work. Its aims are to promote rights at work, encourage decent employment opportunities, enhance social protection and strengthen social dialogue on work-related issues. As a Cosponsor of UNAIDS, and under the UNAIDS Division of Labour, ILO is the lead agency on HIV workplace policies and programmes and private sector mobilization. ILO recognizes that HIV has a potentially devastating impact on labour and productivity, and represents an enormous burden for working people, and their families and communities. The workplace offers a unique entry point to reach this large, vital and productive segment of the population including mobile, migrant and vulnerable workers. The organization has been involved in the HIV response since 1998.

Background

260. The 2016 -2017 biennium marked a shift in the focus of the International Labour Organization's (ILO) HIV programme which began to target a fewer number of Unified Budget Results Accountability Framework (UBRAF) outputs so to as to bring a critical mass of resources to achieve concrete results. A data driven rights-based gender-sensitive approach which concentrates significant resources on key and vulnerable working populations in fast track countries (mainly) was adopted.

The biennium marked a shift in the ILO's focus to a more targeted approach focussing on a limited number of UBRAF outputs

261. This report will cover: a short overview of the ILO's strategy and approach; highlights of the 2016 – 17 results at global and country levels by Strategic Results Areas (SRAs); presentation of a country case study; and knowledge products for 2016 – 17.

Strategy and Core Approach

262. The ILO's response to HIV and AIDS has evolved alongside the evolving HIV epidemic, the transition from the MDGs to the SDGs as well as the changing financial landscape for HIV programmes. The framework for ILO's programmes were/are the ILO Programme and Budget (2016/17 & 2018/19), the UNAIDS Strategy (2016 – 2021) and the 2016 United Nations Political Declaration on HIV and AIDS. The ILO's Programme and Budget (2018 – 19) includes HIV as a cross-cutting policy driver liked to many outcomes including 3, 7, 8 and 9. The UNAIDS Strategy (2016 – 21) explicitly includes a target to reduce discrimination in workplace settings (target 8) and promotes values and actions close to the ILO's mandate such as inclusive national HIV-sensitive social protection; access to HIV services for migrants (including labour migrants); combination prevention programmes for women and young women; and gender equality. The 2016 Political Declaration on HIV and AIDS makes specific reference to the principles enshrined in the ILO Recommendation n. 200 *(2010).*

263. Within the context of the UNAIDS UBRAF (2018 – 19) the ILO contributes to six outputs, four of which have been further prioritized. Similarly, within the context of ILO Programme and Budget (2017 – 18), HIV programmes contribute to ten outcomes, four of which have been prioritized. Figure 1 depicts the contribution of the HIV programme to the ILO and UNAIDS obligations.

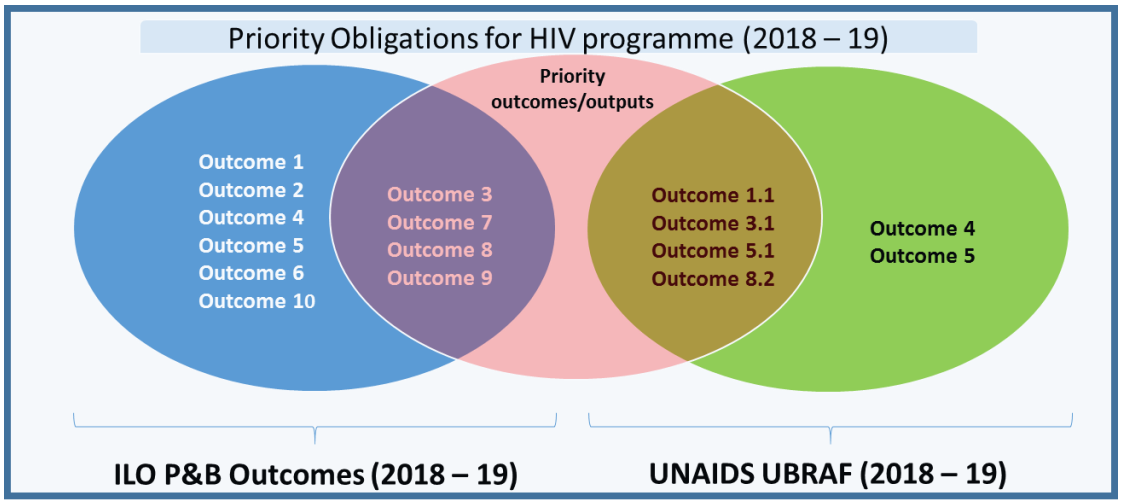


Figure 3: Priority areas for ILO's HIV and AIDS programmes (2018-2019)

264. With regard to the ILO's UNAIDS obligations, the priorities are:
- SRA 1 (Output 1.1): HIV testing;
- SRA 3 (Output 3.1): Combination prevention programmes;
- SRA 4 (Output 5.1): Gender equality & transforming unequal gender norms;
- SRA 8 (Output 8.2): HIV-sensitive Social Protection.

265. Even though the ILO contributed to all six UBRAF outputs, this report would, because of the limited number of pages, focus on the four prioritized outputs under the section on "Highlights of 2016 – 17". Even though some global level results would be highlighted, the emphasis would be on concrete country outcomes.

Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative HIV testing and counselling programmes *[Output 1.1]*

266. Considerable progress has been made in putting people living with HIV on life saving Antiretroviral therapy (ART), yet substantial challenges remain. Even though there are currently more people living with HIV on treatment than those waiting for treatment, some populations, including men and children, have been left behind. With 2020 less than 3 years away, accelerated action is needed to ensure the *90-90-90* targets are met. This provided the basis for the launch of the VCT@WORK Initiative.

267. For 2016 – 2017, the VCT@WORK Initiative was actively promoted in Botswana, Cambodia, Cameroon, China, Congo DR, Egypt, Guatemala, Haiti, Honduras, India, Indonesia, Kenya, Mozambique, Nigeria, Russian Federation, South Africa, Tanzania, Ukraine, Zambia and Zimbabwe among vulnerable workers. With a view to finding workers and their families living with HIV so as to refer them to treatment and care services, the ILO and partners focus

The VCT@WORK Initiative has mobilized over 4.3 million workers to test for HIV since its launch

their HIV testing services in communities with a relatively higher burden of HIV. Strategic partnerships were forged at the country level to drive the VCT@WORK Initiative. In 2016 – 17, the UNAIDS Secretariat, WHO, UNICEF, UNDP, UNESCO, Ministries of Health, National AIDS Authorities, Employers' organizations, Workers' organizations, networks of people living with HIV and multiple civil society actors mobilized 1,316,755 workers (30% women and 69% men) to test for HIV. Since the launch of the VCT@WORK Initiative, in 2013 by the UNAIDS Secretariat, the International Organization of Employers (IOE), the International Trade Unions Confederation (ITUC) and the ILO, 4,310,432 women and men workers have tested for HIV, 106, 592 have tested positive and 104,887 were referred to treatment and care services. The focus has been on sectors with mobile workers, migrant workers, seasonal workers and mining workers. The VCT@WORK Initiative has generated considerable momentum around HIV testing in the workplace. The strength of the VCT@WORK Initiative lies in its ability to reach more men than women with HIV testing, thereby closing the treatment gap for men.

268. To enhance the sharing and learning of experiences from different countries, the ILO drafted a VCT@WORK Initiative good practice document. This publication was widely disseminated to all the partners supporting the VCT@WORK Initiative. Some of the good practice examples include the following: providing tailored support to Trade Unions to champion HIV testing among their membership in Ukraine; building synergies between HIV testing and the registration for the national social protection floor in Kenya; positioning VCT@WORK within the context of a multi-disease screening initiative in Mozambique; working with umbrella associations such as the Hotel Association in Uganda to promote HIV testing among workers in the hospitality industry; and supporting large private sector companies like the Siberian Coal Energy Company in the Russian Federation and Coal India Limited in India to lead the private sector's HIV testing efforts. The ILO adopted a strong focus on country work and a few examples of the different aspects of the VCT@WORK initiative are provided below.

The strength of the VCT@WORK Initiative lies in its ability to reach more men than women with HIV Testing services

269. The HIV burden in mining communities South Africa is often higher than the national average. In this regard, the ILO and the UNAIDS Secretariat provided technical support to the Mining Health and Safety Council (MHSC) to implement the Masoyise iTB and HIV initiative (*Let's beat TB and HIV).* Through the Masoyise iTB and HIV initiative 242,404 working women and men were counselled for HIV and 139,051 agreed to test for HIV. By the end of Nov-2017 more than 35,000 people were on HIV Treatment since the beginning of Masoyise i-TB and HIV. Workers and community members who test positive are immediately linked to treatment and care services. Additionally, the ILO provided tailored technical support to the Department of Mineral Resources (DMR) to revise its reporting and monitoring form and strengthen its alignment to the *90-90-90* targets.

270. In Zambia, to institutionalize the VCT@WORK Initiative, the ILO supported the National HIV/AIDS/STI/TB Council (NAC) to develop a draft Framework for the Implementation of VCT@Work. The framework included the development of customized HIV Testing services (HTS) Tools for the Public and Private Sectors, including a monitoring and evaluation system. The Tools are being used to support HIV testing in Zambia.

271. In Nigeria, to ensure *Trade* Unions prioritise HIV testing, the ILO provided proposal development support to the National Labour Congress (NLC) to secure a second tranche of $100,000 from the National Agency for the Control of AIDS (NACA) to implement HIV testing initiatives in six high burden States in Nigeria. Through this effort and other partnerships, the ILO and partners supported HIV testing of 75181 people in Enugu, Kaduna, Rivers State, Abuja and Sokoto.

272. The ILO, National AIDS Control Organization (NACO) and partners undertook an analysis of HIV testing data in India in order to identify sectors in which workers are more likely to be living with HIV. The strategy was to build evidence for effective and efficient HIV testing, and focus the VCT@WORK initiative in sectors and communities where workers living with HIV can be identified and made to access life-saving treatment. The HIV prevalence of workers was 1.39% which was approximately four times higher than that of the general population. NACO developed Action Plans focussing on sectors where workers had higher prevalence in 23 States. The ILO is providing targeted support in five States (i.e. Mumbai, Jharkhand, West Bangal, Mashya Pradesh and Delhi) for HIV testing.

One opportunity the ILO is yet to explore is combining the VCT@WORK Initiative with Self Testing

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

273. Successful HIV prevention programs require a combination of evidence-based, mutually reinforcing biomedical, behavioral, and structural interventions. During the 2016 – 17 biennium, the ILO prioritized technical support to 24 countries to implement HIV combination prevention programmes. The countries are: Botswana, Cambodia, Cameroon China, Congo DR, Egypt, Guatemala, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Russia Federation, South Africa, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zanzibar and Zimbabwe. A few concrete country examples are presented along the three components of HIV combination prevention.

Successful HIV Prevention Programmes require mutually reinforcing biomedical, behavioural and structural interventions

274. The development of the Zanzibar Employment Code on HIV and AIDS, based on the ILO Recommendation No. 200 was one of the outcomes of the ILO's support to Zanzibar in the biennium. The Code is strengthening the work of labour inspectors and OSHA inspectors in monitoring HIV workplace programmes.

275. In Vietnam, the ILO focussed on strengthening the policy framework by providing tailored support to the Ministry of Labour, Invalids and Social Affairs (MoLISA) to review policies regarding the rights of venue-based entertainment/sex workers and the subsequent development of a technical guideline (which provides guidance on the protection of the rights of venue based sex workers) to support MoLISA's HIV programmes to reach sex workers in 5 provinces in Vietnam.

276. The ILO's support in India to corporate groups (private sector) led to the development and implementation of HIV workplace programmes for entire groups, benefiting their employees/families, contractual workers and workers in the supply chain. Peer education is a critical element of these programmes. Major private sector partners of the ILO include - Ambuja Cement, PepsiCo, J K Tyres Ltd, Apollo Tyres Ltd, Sab Millers, Crompton &Greaves, SRF group, Ballarpur Industries Ltd, Hindustan Unilever Ltd, Transport Corporation of India Ltd, Jubilant Organosys Ltd and Sona Koyo Steering Ltd. These partnerships have increased access to HIV services for millions of workers vulnerable to HIV.

277. In Mozambique, Lesotho and South Africa, the ILO implemented WHO/ILO HealthWISE, a practical, participatory quality improvement Tool for health facilities which encourages workers and managers to work together to improve workplaces and practices with low-cost solutions. In Lesotho, the ILO collaborated with the World Bank funded project Southern Africa Tuberculosis and Health Systems Support (SATBHSS) and the Ministry of Health (Lesotho) to implement the HealthWISE methodology in 5 key hospitals, namely Berea, Maluti, Mamohau, Ntsheke and Motebang hospitals. In Mozambique, the ILO is supporting the implementation of the HealthWise tool to promote the prevention of infectious diseases particularly HIV and TB and also reduce the levels of stigma and discrimination in health facilities. HealthWISE is being implemented in Maputo City and in Matola and targeting 900 health workers in Mozambique.

278. In Uganda, some of the concrete results from the ILO's support include: the development and finalization of the HIV & AIDS resource guide for the hotel and hospitality industry; the launch of the resource guide at the Annual General Meeting (AGM) of the Uganda Hotel Owners Association (UHOA); the dissemination of the resource guide in 10 districts including: Kampala, Iganda, Tororo, Mbale, Kabarole, Kasese, Masindi, Gulu, Sororti and Kumi; the provision of condoms to 80 hotels; and capacity development for managers and supervisors of 48 hotels in the hospitality industry in the districts on Moroto and Kotido (Karamoja region).

279. In Kenya, the ILO was a member of the Technical Working Group organizing the innovative Maisha County Football League which aimed at leveraging the power of football to mobilize young people for a nationwide campaign to "Kick Out HIV Stigma." The campaign is striving to end HIV stigma and link young people, people living with HIV and people affected by HIV to stigma-free HIV testing, treatment and care. The initiative was coordinated through NACC in partnership with key stakeholders including UNAIDS and other UN Joint Team on HIV and AIDS members. ILO supported mobilization of the private sector to raise resources for the initiative. The initiative reached over 10 million young people (15 – 24 years) with HIV information, and 2.8 million reached through the one-on-one mentorship programmes. Many tested for HIV and those who tested positive were linked to treatment and care services.

280. In India, a concrete outcome of the ILO's support to the National AIDS Control Organization (NACO) is the signing of 14 MOUs at the national level between NACO and the public sector undertakings (PSUs), for mainstreaming HIV and AIDS in the PSUs of these Ministries. An outcome of this partnership is that over 20 million migrant, mobile and seasonal workers in the public sector are being reached with HIV services and policies including VCT services with linkages to treatment and care.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Women and girls *[Output 5.1]*

The process leading to the adoption of the first International Labour Standard on Violence and Harassment against women and men in the world of work has commenced

281. The ILO and partners provided advocacy, technical advice, legal and policy review and reform and capacity development to promote gender equality and the empowerment of women and girls, including the most vulnerable and marginalized in over 60 countries. Country level action focussed on providing support to country partners to transform unequal gender norms for women and also LGBTI people. A few concrete results at the global and country levels are presented.

282. Leading up to the ILO's centenary celebration in 2019, the ILO launched the Women at work centenary initiative. A global report on Care Work and the Care Economy is being prepared in the context of the initiative. This report, which would include an analysis of the extent of paid and unpaid care and household work and its impacts on gender inequalities at work, will have HIV mainstreamed. Data on the impact of HIV on countries' health care needs and on the HIV burden on care workers has been produced to feed into the global report on Care work and the Care Economy, and for a report on the future of women at work to be launched in 2019.

283. In Tanzania, to reduce vulnerability to HIV, the ILO provided a US$ 50,000 grant as a revolving fund as part of a comprehensive HIV programme accessed by the vulnerable youth both affected by and infected with HIV in the transport corridors in order to start and improve the economic activities and generate decent employment for them. The fund is expected to benefit 537 (135 men 402 women) adolescent girls and young women and men beneficiaries of KIWOHEDE/SAUTI, Baylor and SUMASESU in Kyela, Mbeya and Makete. The target group received ILO training on entrepreneurship and developed business plans.

284. In the context of the Inter Agency Task Team (IATT) on Education, the ILO provided technical inputs into a comprehensive study on "Empowering the School Community to prevent and respond to school-related Gender Based Violence" considering the close link between GBV and HIV vulnerability. The findings of the study would be used to strengthen the education sector's leadership to prevent and respond to GBV by empowering school administrators and teachers, all of whom are workers. The study was supported by UNESCO, ILO, UN Women, GIZ and USAID.

285. Between 2011 and 2016, the ILO, in partnership with Sida and UNAIDS, implemented an innovative economic empowerment programme amongst hard-to-reach populations in transport corridors and communities in Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe with the aim of reducing their vulnerability to the HIV epidemic. Approximately 60% of the beneficiaries were women. The following are some of the outcomes of the initiative: the proportion of women who reduced sex partners rose from 56% (2011) to 74% in 2015 while the proportion of women who adopted HIV risk reduction strategies rose from 31% (2011) to 81% (2015).

286. In Uganda, gender has been systematically mainstreamed into the ILO-supported HIV workplace programmes targeted at the hotel and hospitality industry. Concrete examples of gender mainstreaming include the provision of female condoms for female workers; establishment of female model figures who provide guidance and protection to female workers who have been sexually assaulted or harassed; revision of the work-schedule time to protect especially female workers from the dangers of working late and leaving for home late from duty; raising awareness on Post Exposure Prophylaxis; and encouraging opportunities for female workers to up-grade skills in hotel management to compete favourably for management positions.

287. In Ukraine, in partnership with the UNAIDS Secretariat, gender has been systematically mainstreamed into the Sida-funded ILO project on reducing HIV stigma and discrimination to protect women and men workers from unacceptable forms of work. Concrete examples of gender mainstreaming include the fact that the National Tripartite Advisory Committee of the Project is represented by 50% of women, the training programme developed by the project included gender aspects of HIV and out of more than 300 direct beneficiaries of the capacity development activities at least 60% were women.

In Cambodia, the ILO supported programmes to improve working conditions of sex workers in the entertainment sector

288. In Cambodia, the ILO in collaboration with UNAIDS and the Cambodia Business Coalition on AIDS (CBCA) continued to provide technical support to the Ministerial AIDS Committee (MAC) of the Ministry of Labour and Vocational Training (MoLVT) in the implementation of the ministerial regulations (Prakas no. 086 and 194) which are empowering women (i.e. sex workers) by improving their working conditions within entertainment establishments. The implementation of Prakas no. 194 with employers' and workers' organizations provides improved health and safety for sex workers in entertainment establishments.

289. The ILO and the UNAIDS Secretariat supported a documentary review on policies and programmes addressing gender, HIV and migrants within the informal economy in South Africa, Swaziland and Botswana with a view to making recommendations to strengthen gender mainstreaming. The findings of the review were shared at a SADC knowledge-sharing workshop.

290. In Honduras, the ILO and UNAIDS Secretariat provided technical and financial support to the Employers' Organization (COHEP) and the Association of Chambers of Commerce of Honduras to promote the Guidelines on Gender Perspective and Human Resource Management. The capacity of 658 human resources management experts from 6 regional departments was built to address gender-based discrimination in the workplace. Good practices on addressing sexual harassment and promoting gender equality were promoted.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

HIV sensitive social protection *[Output 8.2]*

291. In 2016, the ILO launched a new global flagship programme for social protection. This programme is making Social Protection Floors (SPFs) a national reality in target countries that still have underdeveloped or fragmented social protection systems. The Social Protection Floor programme carries out assessments of social protection situations and provides recommendations to build nationally-defined social protection floors, supports the design of new schemes or reforms existing schemes, supports implementation and improves the operations of social protection systems. Concrete global and country level examples are presented below.

4 billion people living with any social protection benefit

World Social Protection Report (2017 – 19)

292. At the global level, the ILO published the World Social Protection Report (2017 – 19) with data from over 204 countries and territories. The report indicates that only 45% of the global population are effectively covered by at least one social protection benefit, while the remaining 55% – as many as 4 billion people – are left unprotected. The report reinforces the need to ensure that social protection systems are HIV-sensitive as this helps to overcome the policy and social barriers that otherwise leave behind people living with, at risk of or affected by HIV and AIDS. This includes, among other things, the effective combination of income support, where necessary, with measures to ensure effective access to health care, meeting both HIV-specific and general needs, in line with the ILO HIV and AIDS Recommendation, 2010 (No. 200), and Recommendation on Social Protection Floors (No. 202)

293. As part of global level advocacy, the UNAIDS Secretariat, UNRISD, the Global Fund and ILO organized a panel discussion on the theme: *HIV-sensitive Social Protection to realize the right to health and social security*. The panellists for the event were drawn from the Swaziland Mineworkers Association, the UNAIDS Secretariat and the ILO (the Social Protection Department). The objectives of the panel discussion was to: deepen understanding on HIV-sensitive social protection programmes; Identify the challenges and obstacles faced by people living with HIV and key populations, including LGBTI in accessing social protection programmes; highlight good practices of HIV-sensitive Social Protection programmes; and identify opportunities for expanding HIV-sensitive social protection programmes. The discussion ended with a commitment to ensure National Social Protection Floors are systematically made HIV-sensitive.

294. To strengthen global advocacy, the ILO, UNAIDS, UNRISD, UNDP, Helpage International, STOP AIDS NOW and Housing Works organized a panel discussion at the World Health Assembly (WHA) in 2016 on the theme Fast-Tracking Social Protection to End AIDS. The event provided an opportunity to increase the visibility of HIV-sensitive Social Protection activities in the run up to the High Level Meeting on HIV held in New York.

295. During the biennium, the ILO also published the Social Protection Floors. Volume 1: Universal Schemes which presents best practices and experiences from countries, for

practitioners and to provide the basis for more informed policy-making. The publications share 16 experiences from 12 countries covering healthcare, child allowances, maternity benefits, disability benefits and old age pensions. The publications show how social protection schemes, as part of national social protection floors in Lesotho, Rwanda and South Africa were used to address the needs of people living with HIV.

296. The UNAIDS Secretariat with support from UNICEF, the World Bank, ILO, WFP, UNDP, WHO, PEPFAR and others developed a HIV and Social Protection Assessment Tool, which has been used to conduct HIV-sensitivity assessments in over six countries in sub Saharan Africa. The Tool provides an overview of the HIV-sensitivity of Social Protection schemes where they exist and helps to build new HIV-sensitive schemes where they do not exist.

297. The following are some of the concrete results obtained from the implementation of the ILO Social Protection Floor: 26 member States developed new or improved social protection policies, financing strategies, governance frameworks and coordination mechanisms; 34 member States enhanced the knowledge base on social protection delivery; 13 member States set up new programmes to increase the coverage of contributory and non-contributory systems or to improve benefit adequacy; 5 member States included the extension of social protection in their integrated formalization strategies; 12 member States strengthened or reformed wage policies and collective bargaining to improve working conditions; and 19 member States developed or updated national OSH profiles, plans and policies.

298. In Kenya, the ILO in partnership with UNICEF and WFP supported the development of the draft comprehensive Social Protection Investment Plan (2030). The Plan covers the broader elements of social protection. The ILO provided technical inputs around the engagement of the social protection floor and employment issues. ILO inputs also addressed issues around HIV, employment injury, maternity protection and social health insurance.

299. In Kenya, the ILO in partnership with UNICEF, WFP, COTU(K), Kenya National Commission on Human Rights, Helpage, NSSF and NHIF supported the government to organize a Social Protection Legal Frameworks Forum and provided legal advisory support to the draft Social Protection Bill. The draft Bill is aimed at enhancing social protection coordination in Kenya

300. In Nigeria, the ILO is a member of the UN Group on Social Protection (SP) and provided technical input to the draft SP policy. The ILO also supported its constituents to provide their technical input into the document during National consultative meetings. The process is still on going and the ILO remains a key technical partner. The ILO worked closely with UNICEF, UNDP and UNAIDS alongside all relevant National stakeholders in this regard.

301. In Kenya, the ILO is a member of the UNDAF outcome on social protection, which comprises WFP, UNICEF, ILO and IOM and is part of the committee overseeing the county mapping and coordination exercise aimed at assessing social protection programmes in all the 47 counties. The mapping also identifies the coordination models with the aim of enhancing overall coordination of social protection programmes by the Social Protection Secretariat at the Ministry of East Africa Community, Labour and Social Protection (MoEACL&SP). The process of developing a comprehensive social protection Bill has also been initiated with ILO participating in the initial dialogue phase.

A social protection sector review has been commenced through support of UNICEF with ILO being part of the technical committee.

302. In Zambia, the ILO is providing support to the Government to extend social protection to workers in the informal economy. The package also includes maternity insurance, which is improving access to people living with HIV in Zambia. An estimated one million people are expected to benefit from this package within five years.

303. In Rwanda, 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 people vulnerable to HIV (including people living with HIV).

304. In Cambodia, the National Social Security Fund (NSSF) of the Ministry of Labour and Vocational Training (MoLVT) started a new scheme on HIV-sensitive social health insurance for workers in the formal economy from May 2016. Contributions started in October 2016 to cover the cost of health expenses for workers in the formal economy. The ILO Social Protection team is actively involved in the technical working group and provided technical support to the NSSF.

305. In Indonesia, the ILO and UNAIDS supported the National AIDS Commission to establish a task force to ensure coverage of people living with HIV and key populations under the national social protection scheme. The task force continues to monitor the implementation of the scheme. The ILO assisted a people living with HIV organization to develop promotional material to support improving access and reducing barriers of people living with HIV to social protection scheme.

ILO 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	1 139 624	1 594 708	2 734 332
SRA 3: HIV prevention among young people	1 144 088	1 803 801	2 947 889
SRA 4: HIV prevention among key populations	424 000	1 081 845	1 505 845
SRA 5: Gender inequality and gender-based violence	961 551	1 369 954	2 331 505
SRA 6: Human rights, stigma and discrimination	512 195	1 654 015	2 166 210
SRA 8: HIV and health services integration	403 111	1 723 740	2 126 851
Grand Total	**4 584 569**	**9 228 063**	**13 812 632**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	1 837 173		1 871 915	
AP	508 349	68%	1 680 928	91%
EECA	230 686	100%	559 096	98%
ESA	1 278 256	100%	3 430 169	99%
LAC	346 641	62%	357 739	31%
MENA	19 950	0%	26 627	0%
WCA	363 514	61%	1 301 589	96%
Grand Total	**4 584 569**		**9 228 063**	

Case Study

REDUCING STIGMA AND DISCRIMINATION IN HEALTHCARE SETTINGS

Introduction

Health services are workplaces which must be safe for all the workers in the health sector. Decent working conditions in the health sector must take into account workers' health and wellbeing, since the quality of care provided by health workers is partly linked to the quality of the work environment. If decent working conditions are not promoted, health sector workplaces can be unsafe for the workers working in the sector and this could lead to elevated levels of stigma and discrimination towards people living with HIV.

Decent working conditions will be achieved through a combination of institutional and individual factors. Individual and institutional factors such as the HIV-related knowledge levels of health providers, the access to preventive measures such as such as sterile rubber gloves, working autoclaves, and access to free HIV testing for providers, the general level of equipment in the healthcare setting as well as the perceived institutional support from the hospital management all contribute towards the levels of stigma and discrimination towards people living with HIV.

In China as in many countries, stigma and discrimination towards people living with HIV persists in some health services. The Chinese health care system is organized in along the lines of provincial, city, county, township, and village. Health care professionals in a village, township clinic, or county hospital typically have the most intimate relationships with patients at the local level, yet they have the least amount of medical training[16].

Addressing stigma and discrimination in healthcare settings is critical because, when present, it reduces access to and uptake of health services by people living with HIV. This means, even when health services are physically present, access by people living with HIV will be impeded.

Action Taken

The ILO and WHO have worked jointly to address working conditions in the healthcare sector. HealthWISE is a joint ILO/WHO tool which is a practical, participatory methodology for improving the quality of health facilities. To strengthen the institutional and individual capacities of healthcare facilities and workers, the ILO, the China Center of Disease Control (CDC), the China Labour Institute of MOHRSS, the China HIV and STD Prevention and Control Association and civil society organizations applied the HealthWISE toolkit to launch a HIV/OSH programme covering 20 hospitals and reaching 31,000 healthcare workers.

A 2-pronged approach was used.

The first prong focused on the health services and the establishment of strong Occupational Safety and Health and HIV structures. Building the capacity of health workers and the institutions to reduce stigma and discriminated towards people living with HIV. The specific actions included: mobilization and advocacy for 20 hospitals on HIV/OSH issues; establishment of steering committees with representation from people living with HIV; establishment of HIV/OSH task forces in each hospital; the creation of HIV and OSH Management Systems in each hospital; development and implementation guidelines on Management of Occupational Exposure to Blood Borne Pathogens; and the organization of a tripartite workshop to remove a discriminatory clause within the Medical Standard of Recruitment of Civil Servants in China.

The second prong focused on empowering people living with HIV and giving them a voice. Capacity was built in Non-Governmental Organizations (NGOs) partners in particular the He'rbutong Training and Education Center, and the National Women's Network against AIDS to

[16] HIV-Related Stigma in Health Care Settings: A Survey of Service Providers in China accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2795451/

expand the provision of legal services to people living with HIV. Information education and communication materials were developed to encourage people living with HIV to seek legal services. A handbook on the 100 frequently asked questions was developed and disseminated widely. People living with HIV were encouraged to have a voice and know their rights for Decent Work and Social Protection.

Results

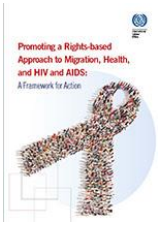
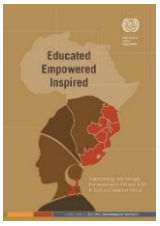
- NGO partners expanded their legal support services which offer legal protections to people living with HIV. Communication materials on the legal rights of people living with HIV were developed and disseminated
- In each of the 20 hospitals, bipartite HIV and OSH task forces were established to create policies and programmes which strengthen HIV and OSH Management systems in-line with ILO Standards
- OSH Committees where established in each of the 20 hospitals to improve upon the working conditions of all healthcare workers
- To reduce the levels of stigma and discrimination towards people living with HIV, Guidelines on the Management of Occupational Exposure to Blood borne pathogens in China were developed and adopted by the hospitals. These guidelines were based on the ILO/WHO Joint Guidelines on HIV/AIDS and Health Services
- ILO, MOHRSS and the China CDC built the capacity of healthcare workers in the 20 health facilities to facilitate a reduction in HIV discrimination and prevent occupational exposure to blood borne diseases

Conclusions and Lessons Learned

- An effective approach to addressing stigma and discrimination in healthcare settings must involve engaging the health facility and engaging the communities, including people living with HIV
- Making people living with HIV aware of their rights and encouraging them to have a voice strengthens the approach towards reducing stigma and discrimination
- Supporting health services to build their institutional capacities is a critical element in ensuring a conducive and enabling environment for the reduction of stigma and discrimination. Developing and applying evidence informed guidelines is critical to achieving sustainable outcomes.
- Strengthening the capacity of communities, as part of community systems strengthening is key to achieving sustainable outcomes
- Periodic monitoring of cases of discrimination is key to assessing the progress of each hospital in ensuring a safe and non-discriminatory environment
- A strong partnership with national stakeholders from the public and private sectors as well as civil society is key to providing a comprehensive and holistic approach to reducing stigma and discrimination in healthcare settings.

To effectively address stigma & discrimination in health settings, the health facility & the community, including people living with HIV must be engaged

Knowledge Products

	Migrants' access to health and HIV services can be improved only by adopting a human rights-based approach in the governance of the entire migration process. This publication analyses the interplay between fair labour migration policies, effective responses to HIV and broader health goals to be addressed in countries of origin, transit and destination; and presents a framework for action. Source: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_605763.pdf
	The Voluntary Counselling and Testing at work (VCT@WORK) initiative has reached over 6 million workers and family members. Of those, more than 4.1 million were tested for HIV and 103,000 referred to access anti retro-viral treatment. Source: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_583880.pdf
	Poverty, gender inequality and social exclusion continue to pose major challenges to HIV prevention efforts. Between 2011 and 2016, the ILO, in partnership with Sida, implemented an innovative economic empowerment programme amongst hard-to -reach populations in transport corridors and vulnerable communities in Southern and East Africa, with the aim of reducing their vulnerability to the HIV epidemic. This publication presents the outcomes of this innovative approach and the effects it had on its beneficiaries. Source: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_456923.pdf
	This guide aims to explain the concept of reasonable adjustments ("reasonable accommodation") and provide practical step-by-step guidance on how and when these should be provided in the workplace. HIV concerns are mainstreamed. Source: http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_536630.pdf
	The World Social Protection Report 2017-19 provides a global overview of recent trends in social protection systems, including social protection floors. Based on new data, it offers a broad range of global, regional and country data on social protection coverage, benefits and public expenditures on social protection. Source: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_604882.pdf
	This publication is one of the ILO's main contribution to the WASH4Work initiative, launched in the UN headquarters on World Water Day 2016 in collaboration with several UN-Water members and partners. This initiative seeks to create awareness among governments, employers and workers about these issues. HIV concerns are mainstreamed. Source: http://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/publication/wcms_535058.pdf

United Nations Educational, Scientific and Cultural Organisation (UNESCO)

UNESCO is a specialized 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.

306. 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

Key achievements by Strategy Result Area

Strategy Result Area 3: - Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination Prevention and Young People *[Outputs 3.1 and 3.2]*

307. UNESCO works to scale-up CSE as a core component of targeted combination prevention programming. In partnership with UNFPA, UNAIDS Secretariat, WHO, UN Women and UNICEF, UNESCO spearheaded the publication of the revised UN International Technical Guidance on Sexuality Education (ITGSE). The ITGSE was prepared with input from a Global CSE Advisory Group and integrates results of an evidence review, an online survey and a global technical consultation hosted by UNESCO in October 2016. It reflects new evidence and good practices, and reinforces the focus on areas such as early pregnancy, puberty, and gender equality.

308. Over 30 African countries received UNESCO training to integrate core HIV/CSE indicators in Education Management Information Systems (EMIS). 14 countries participated in a six-week online course run by UNESCO's International Institute for Educational Planning (IIEP) virtual campus in 2017, to build country capacity to integrate, collect, analyse and report on indicators through EMIS. As follow-up, UNESCO commissioned research to measure the delivery of CSE in the ESA region, using data collected from various sources. The findings from the research were used to develop an intensive one-week training of EMIS and policy staff in September 2017, where 12 countries participated.

309. A key success has been the adoption by the SDG 4 Technical Cooperation Group (TCG) of an indicator on the delivery of CSE (including HIV prevention education), to monitor progress against Education Thematic target 4.7. The Working Group included representatives from EI, OECD, UNESCO, Brazil, Germany, Oman and Sweden. Indicator 4.7.2 Percentage of schools that provided life skills-based HIV and sexuality education within the previous academic year will be included for reporting in 2018. Data on this indicator is already being collected in a number of ESA countries through EMIS, as well as by UNESCO's Institute of Statistics, through its annual Survey of Formal Education

310. The Commitment of Eastern & Southern African countries to provide quality CSE was reaffirmed at the 2016 AIDS Conference with the "Let's Step up and Deliver" Call to Action. Teacher-training courses have reached over 421 200 teachers across the ESA region.

311. In West & Central Africa a regional conference for representatives from 17 countries resulted in a Call for Action to strengthen CSE and access to SRH services, with follow-up in nine countries. New CSE curricula were developed in Senegal, DRC and Benin, and teacher training was strengthened in Cameroon, Chad, DRC, Cote d'Ivoire, Benin and Senegal.

312. In Eastern Europe and Central Asia, a series of 11 edutainment videos for adolescents on healthy lifestyle, HIV/STI prevention and relationships were produced in Russian, reaching over 8.5 million views in YouTube. In Latin America and the Caribbean, UNESCO reviewed CSE curricular content in 19 countries. Results were incorporated in

an online platform designed by IPPF and will inform future technical support for CSE. In Asia Pacific, UNESCO, UNFPA and UNICEF completed CSE implementation reviews in China, India and Thailand, collecting data from over 18 500 students.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV prevention among key populations *[Output 4.1]*

313. While UNESCO's work to prevent violence in schools on the basis of sexual orientation and gender identity/expression (SOGIE) benefits all students, it is particularly relevant to the needs of adolescent and young key populations, who are often more vulnerable to discrimination and bullying. On 17-18 May 2016 an International Ministerial meeting was held in Paris, bringing together Education Ministers from all world regions for the launch of the report "Out in the Open: education sector responses to violence based on sexual orientation and gender identity/expression". It is the first-ever UN Global Report on this type of violence. A total of 27 000 hard and electronic copies of the report have been disseminated. A Call for Action was also affirmed by 56 countries, with a video and infographic released under the hashtag #OutInTheOpen, which trended on Twitter and generated over 2820 tweets and an audience of 20 million.

314. Over the course of the biennium, UNESCO produced four regional publications (Asia Pacific, Southern Africa, Latin America and the Caribbean) and two national reports (Thailand and Vietnam) on SOGIE-based violence in schools. An Asia Pacific regional consultation on education sector responses to SOGIE-related violence was convened in 2017, with the participation of 30 delegates from nine countries. UNESCO also coordinated an LGBTI Pre-Conference prior to Education Internationals' (EI) 8th Asia Pacific Regional Conference. In Latin America, a publication and teacher facilitation guide on SOGIE violence in schools was produced and in Chile, UNESCO supported Ministry of Education efforts to develop guidelines for the inclusion of LGBTI people in the educational system. In India, UNESCO supported a study on the experiences of bullying among young transwomen and same-sex attracted males in Tamil Nadu.

315. In collaboration with UNODC and WHO, UNESCO is also working to strengthen the education sector response to substance use, by providing guidance to support schools and teachers to prevent school dropouts and expulsion, and refer students who are struggling with substance use to youth-friendly health services. Following a joint publication and expert-group meeting with UNODC and WHO in Istanbul in 2015, UNESCO published a good practice and policy booklet on education sector responses to substance use in 2017. It was presented at the UNGA Special Session on Drugs in April 2016, as well as at a meeting in June 2016 organized by WHO and government of Turkey and at the 60th Commission on Narcotic Drugs at UNODC in March 2017. The publication was referenced in the revised version of the International Standards on Drug Use Prevention developed by UNODC.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality and gender-based violence *[Outputs 5.1 and 5.2]*

316. In 2016-2017, a key focus for UNESCO has been on strengthening the education sector response to school-related gender-based violence (SRGBV), in line with the 2nd strategic priority of the UNESCO Strategy on Education for Health and Well-Being. In 2017, UNESCO produced a global guidance document on SRGBV, launched during the 16 Days of Activism against Violence Against Women. The SRGBV guidance was developed in collaboration with UN Women and the global partners working group on SRGBV, which UNESCO co-chairs with UNGEI.

317. Between 2016 and 2017, capacity-development workshops on the guidance were held in Johannesburg, Dakar, Harare and St Lucia, with a total of 40 countries represented. UNESCO and UNGEI also hosted a Global Learning Symposium in November 2017 in Dakar, bringing together stakeholders to share country experiences and plan the next phase of action for the SRGBV working group. The group met in January 2017 in Seoul, at the International Symposium on School Violence and Bullying, and at the annual conference of the Comparative International Education Society (CIES), in Vancouver.

318. The SRGBV guidance was used in teacher training workshops in Zambia, to support curriculum review in Kenya and as a key resource during a regional meeting hosted by UNESCO in Panama for MoE officials from Costa Rica, Guatemala, Honduras, Mexico, Nicaragua and Panama. In Moldova, a guide for educators on addressing violence in schools was developed, based on UNESCO's global guidance. SRGBV desk reviews were completed in Indonesia and Vietnam, while in India, UNESCO collaborated with the National Council of Educational Research & Training to produce a policy paper, toolkit and teaching and learning materials on SRGBV.

319. A new tool was developed and used to assess the education sector response to SRGBV in Cameroon, Senegal and Togo. The validation of the diagnoses in the three countries led to concrete action plans aimed at curricula, teacher training, regulation and sectoral planning. UNESCO's Beirut Office undertook a desk review on SRGBV in nine Arab States countries, along with a case study on SRGBV in Palestine. In DRC, UNESCO supported a magazine for young people on the response to HIV and GBV, with 3500 copies distributed to student and discussion groups organized at six higher education institutes.

320. In 2017, UNESCO and partners published recommendations on education sector responses to early and unintended pregnancy (EUP). EUP is a major concern for many education systems and can lead to stigma, discrimination, descholarization and as a result, an increased risk of HIV for adolescent girls and young women. The EUP guidance was developed in close consultation with UNFPA and WHO, and seeks to help education sector stakeholders identify ways to prevent EUP and ensure that pregnant and parenting girls can continue education in a safe and supportive school environment. The guidance has resulted in the adoption of school re-entry guidelines in Kenya. In South Africa, UNESCO provided technical and financial support to the Department of Basic Education to develop its first ever Pregnancy Prevention and Management Policy in schools. The Policy seeks to strengthen efforts in curbing EUP among learners and, in

case of a pregnancy, to provide a supportive environment to keep the girl learner in school and facilitate re-entry post-delivery.

UNESCO 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	193 935	778 223	972 158
SRA 3: HIV prevention among young people	3 393 858	9 763 392	13 157 250
SRA 4: HIV prevention among key populations	242 418	1 063 613	1 306 032
SRA 5: Gender inequality and gender-based violence	727 255	8 811 709	9 538 964
SRA 6: Human rights, stigma and discrimination	169 693	615 042	784 735
SRA 8: HIV and health services integration	121 209	915 669	1 036 879
Grand Total	**4 848 369**	**21 947 649**	**26 796 018**

Table 2: By region (US$)

Region	Core	% Fast-T rack countries	Non-core	% Fast-T rack countries
Global	1 167 451		5 551 546	
AP	748 642	43%	5 095 599	68%
EECA	573 518	27%	320 378	54%
ESA	1 208 521	41%	8 120 199	78%
LAC	470 654	34%	1 329 630	70%
MENA			162 023	0%
WCA	679 584	28%	1 368 273	77%
Grand Total	**4 848 369**		**21 947 649**	

Case study

UNESCO supports Ghana to produce HIV Alert Materials in Braille

UNESCO, in partnership with the Ministry of Education in Ghana, and Ghana Education Service (GES), has produced and distributed HIV and AIDS Alert materials for visually impaired students in Ghana.

HIV and AIDS Alert focuses on integrating lessons around HIV prevention into school lesson plans through peer education sessions, as well as reaching the community through School Management Committee (SMC) and Parent Teacher Association (PTA). It aims to ensure all students have the knowledge and skills they need around HIV testing, prevention and treatment. The current version of the HIV and AIDS Alert was developed by the Ministry of Education and Ghana Education Service, with support from UNESCO, UNICEF and UNFPA.

The conversion of teaching and learning materials into braille follows an HIV needs assessment study which showed that 72% of teachers for the visually impaired had not implemented HIV and AIDS Alert in their school while 73.2% of the students said teachers had never used the recommended methods of teaching around HIV and AIDS in Special Schools.

Director for Special Education at GES, Amina Achiaa, said visually impaired students are at higher risk of contracting HIV, and experience high levels of violence, stigma and discrimination.

“Education such as comprehensive sexuality education (CSE) has played a significant role in helping young people develop critical life skills to take control of their lives. Physically challenged people however, are often left out due to their special learning needs and the lack of appropriate learning resources and materials,” Ms Achiaa said.

“This affects their ability to adopt healthy behaviours and to avoid or respond effectively to situations about their health and well-being. The implication in terms of quality education is detrimental. It is associated with low enrolment, high absenteeism and low academic achievement.”

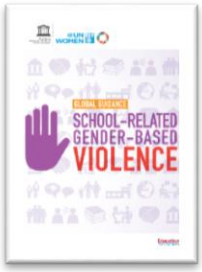
According to 2016 UNAIDS estimates, there are 290,000 people in Ghana living with HIV, including 32,000 children aged up to 14.

Following the conversion of the teaching and learning materials into braille, and pre-testing among visually impaired students and their teachers; materials on HIV and AIDS, CSE and SRGBV were distributed to schools and units for the visually impaired in Ghana.

Knowledge products

Revised UN International Guidance on Sexuality Education
EN: http://unesdoc.unesco.org/images/0026/002607/260770e.pdf
FR, SP, CH, RU, PT: in progress

School Violence and Bullying: Global Status Report
EN: http://unesdoc.unesco.org/images/0024/002469/246970e.pdf
FR: http://unesdoc.unesco.org/images/0024/002469/246976f.pdf



Global Guidance on addressing School-Related Gender-Based Violence
EN: http://unesdoc.unesco.org/images/0024/002466/246651E.pdf
FR: http://unesdoc.unesco.org/images/0024/002472/247236f.pdf
SP, CH, AR, PT: in progress

Out in the Open – Education sector responses to violence based on sexual orientation and gender identity-expression
EN: http://unesdoc.unesco.org/images/0024/002446/244652e.pdf
FR: http://unesdoc.unesco.org/images/0024/002446/244652f.pdf
SP (Summary):
http://unesdoc.unesco.org/images/0024/002446/244652s.pdf
Video:
https://www.youtube.com/watch?v=BJvnyBM2qMw&feature=youtu.be

Early and Unintended Pregnancy – Recommendations for the education sector
EN: http://unesdoc.unesco.org/images/0024/002484/248418e.pdf
FR: http://unesdoc.unesco.org/images/0024/002484/248418f.pdf
SP: (in progress)

Education sector responses to the use of alcohol, tobacco and drugs – Good Policy and Practice in Health Education
EN: http://unesdoc.unesco.org/images/0024/002475/247509E.pdf

UNESCO Strategy on Education for Health and Well-Being - Contributing to the sustainable development goals
EN: http://unesdoc.unesco.org/images/0024/002464/246453e.pdf
FR: http://unesdoc.unesco.org/images/0024/002464/246453f.pdf
SP: http://unesdoc.unesco.org/images/0024/002464/246453s.pdf

Being a Young Person: Comprehensive Sexuality Education – the video
https://www.youtube.com/watch?v=eV92ALv-TGw&feature=youtu.be

UNESCO Our Rights, Our Lives, Our Future: Campaign Video
EN: https://www.youtube.com/watch?v=XIkntHG_KDA

Reaching Out: Preventing and addressing school-related gender-based violence in Viet Nam
http://unesdoc.unesco.org/images/0024/002469/246927E.pdf

El bullying homofóbico y transfóbico en los centros educativos
SP: http://unesdoc.unesco.org/images/0024/002448/244841S.pdf

World Health Organization (WHO)

WHO's goal is to build a better, healthier future for people all over the world. WHO plays a critical role within the United Nations system as the directing and coordinating authority for international health. WHO provides leadership on increasingly complex global health matters, producing health guidelines, norms and standards, monitoring and assessing health trends and shaping the health research agenda.

Working through offices in more than 150 countries, WHO staff work with governments and other partners to ensure the highest attainable level of health for all people. WHO also ensures the safety of the medicines and health sector commodities required for an effective response to HIV.

The organization leads the global health sector response to the HIV epidemic. As a Cosponsor of UNAIDS, WHO takes the lead on HIV testing, treatment and care, HIV drug resistance, and HIV/tuberculosis coinfection, jointly coordinates work on eliminating mother-to-child transmission of HIV and paediatric AIDS with UNICEF, jointly works on SRHR and HIV with UNFPA, convenes on driving progress towards achieving Universal Health Coverage with the World Bank and, through a bilateral Memorandum of Understanding, partners with UNODC on harm reduction and programmes to reach drug users and prisoners.

321. The WHO draft Thirteenth General Programme of Work 2019-2023 will guide the next phase of WHO's work on HIV. It includes a specific focus on the acceleration and elimination of high impact communicable diseases including HIV and is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all people at all ages: 1) advancing universal health coverage; 2) addressing health emergencies and 3) promoting healthier populations[17]. Closely linked to the priorities of the WHO general programme of work are WHO Global Health Sector Strategies on HIV[18], Viral Hepatitis[19] and STIs[20], for 2016 to 2021, which include the three dimensions of universal health coverage as strategic directions: 1. interventions for impact - improving the range, quality and availability of essential health interventions and services; 2. delivering for equity – improving the equitable and optimal uptake of services in relation to need; and 3. financing for sustainability – allocating adequate resources, reducing costs and providing financial protection for those who need services. The strategies, adopted by the World Health Assembly in 2016, are aligned to the UNAIDS strategy and targets and guide health sector work on HIV until 2021.

Highlights of 2016-2017 results

322. Testing and treatment scale-up continued rapidly during this biennium with strong WHO support, with 20.9 million people receiving treatment by mid-2017, compared with 19.5 million in 2016. Progress towards the "90-90-90" targets was guided by new and updated WHO policies and guidelines, including those on: the use of antiretroviral drugs for treatment and prevention; patient monitoring and case surveillance; HIV-related drug

[17] World Health Organization Draft thirteenth general programme of work 2019-2013
http://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/

[18] World Health Organization Global Health sector strategy on HIV, 2016-2021
http://www.who.int/hiv/strategy2016-2021/ghss-hiv/en/

[19] World Health Organization Global Health sector strategy on Viral Hepatitis, 2016-2021
http://www.who.int/hepatitis/strategy2016-2021/ghss-hep/en/

[20] World Health Organization Global Health sector strategy on Sexually Transmitted Infections, 2016-2021
http://www.who.int/reproductivehealth/publications/rtis/ghss-stis/en/

resistance; key populations; HIV self-testing and partner notification; managing advanced HIV disease; and sexual and reproductive health and rights of women living with HIV. Monitoring the uptake and implementation of WHO guidance is now routine and has demonstrated significant country impact: by November 2017, 70% of 139 low- and middle-income countries were following HIV “treat all” guidance, 58% had fully implemented routine viral load testing, 40% had included dolutegravir in first-line antiretroviral therapy combinations and 27% had either implemented or were developing a policy on HIV self-testing.

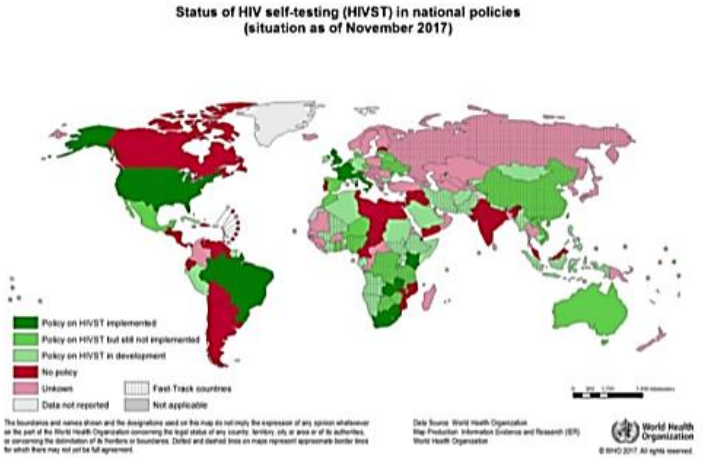
Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative testing and counselling programmes *[Output 1.1]*

323. Currently, it is estimated that 7.5 million people living with HIV are unaware of their status. Countries are increasingly looking for ways to rapidly expand access to and use of HIV testing services, especially for populations with low service coverage and at higher risk that would otherwise would not carry out a screening test. WHO considers HIV self-testing a potential game-changing intervention to increase knowledge of status and has focused on HIV self-testing since 2013. In 2016, WHO published the first global recommendations and guidelines for HIV self-testing (HIVST) and partner notification (PN) as a supplement to consolidated guidelines on HIV testing services[21].

324. WHO support to countries additionally enabled a rapid adoption of HIVST, with increasing numbers of countries developing policies for HIVST and starting implementation. WHO’s website www.hivst.org provides a repository of all HIVST programmes, national policies and research, tracks policy uptake and implementation and guides WHO’s approach to planning policy dialogue and technical assistance with countries (see map updating on the situation in November 2017).



[21] http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/

325. WHO also supported countries to improve the quality of testing, including use of WHO recommended testing strategies and the use of nationally validated testing algorithms, QI/ QA systems and re-testing before ART initiation.

326. In 2016, over 1.2 million babies were born to mothers living with HIV. Early, accurate and rapid diagnosis of HIV testing through Early Infant Diagnosis (EID) is a critical first step in identifying and providing treatment for HIV-infected children. This was discussed at a regional workshop with 16 countries on the Postnatal Package of Care for HIV-exposed Infants. In July of 2017, WHO published a brief on novel point-of-care tools for EID, suggesting sufficient evidence has been generated on the performance and patient impact of these technologies in both laboratory and field settings.

327. In response to tracking country need WHO held a major HIV testing services (HTS) dissemination meeting for 18 countries in Kenya in 2017. This included a focus on equitable and acceptable HTS for key populations. Regional HTS meetings for countries in EMRO, PAHO and WPRO were also held, in addition to a workshop on PN and HIVST for Indonesia. A series of community consultations on HIVST were organized to explore community concerns and issues relating to HIVST, addressing these so that communities are well prepared for HIVST as it is introduced in their countries. WHO also co-convened, with the UNAIDS Secretariat and the Global Fund, a major meeting in Senegal on HTS in West and Central Africa (WCA) as the region lags behind in their testing coverage and quality, particularly for key populations.

Medicines and commodities *[Output 1.6]*

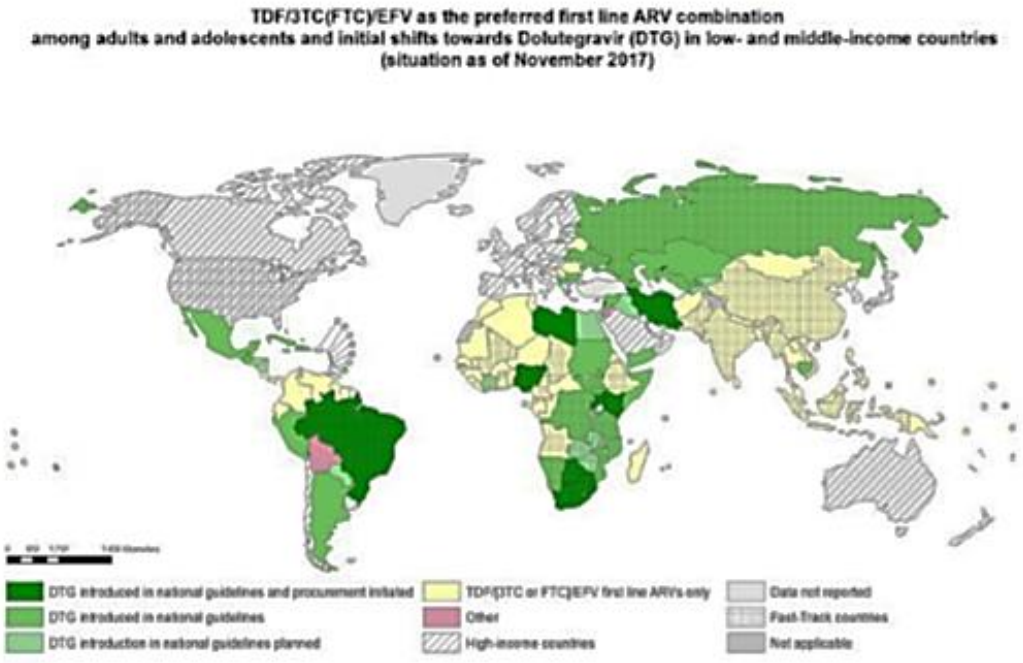
328. In 2016, WHO launched consolidated guidelines on the use of ARV drugs for treating and preventing HIV. Through this guideline, WHO recommends to “treat all” persons with HIV at any CD4 count and rapidly moved new science to policy and to practice. This guideline document included 52 new treatment and care recommendations covering adult, pediatric, adolescent, pregnant women as well as, 10 new service delivery recommendations in support of differentiated models of care. These recommendations promote rapid initiation of ARVs and the use of innovative testing and diagnostic platforms through a public health approach.

329. Data from November 2017 demonstrated that the proportion of low- and middle-income countries (LMIC) adopting policies to “treat all” in line with WHO guidance increased from 33% in 2016 to 70% during 2017. The data from the WHO HIV Country Intelligence Tool are based on reports from 139 LMIC. Countries are now putting the newly adopted policies into practice, with 69 countries (50% of all LMIC) already starting implementation.

330. A key challenge to reducing AIDS-related mortality is the persistent burden of advanced HIV disease, with more than a third of people starting ART with advanced immunosuppression (defined as CD4 cell count <200 cells/mm3). In response to this challenge, WHO released guidelines for responding to advanced HIV disease within a public health approach in July 2017 WHO.

331. Most countries are shifting to newer and better treatment regimens following WHO advice: 72% of LMIC adopted TDF + 3TC (or FTC) + EFV as the preferred first-line therapy, while an additional 40% of LMIC are making shifts to dolutegravir (DTG) containing regimens (see following map). In 2017, generic versions of DTG were launched in the market and will soon be available at a lower price point, also combined in

fixed-dose combination with TDF and 3TC. Many countries are moving to adopt DTG as part of their first-line treatment.



332. WHO recommends adopting drug regimens with high potency, lower toxicity, high genetic barriers to resistance, usefulness across different populations and lower cost. The programmatic transition to optimized drug regimens can improve the durability of the treatment and quality of care of people living with HIV. In July 2017 WHO published a technical update to support the transition to new antiretrovirals in HIV programmes.

333. WHO co-convened a third Conference ARV Drug Optimization in November 2017 to define the research necessary to optimize second- and third-line antiretroviral therapy regimens for adults in the next 5 years, and the sequencing and recycling of key products in a public health setting.

334. Better diagnostics, treatments and service delivery are essential to achieve the 90-90-90 targets by 2020 and by the end of the biennium routine HIV viral load monitoring was fully implemented in 58% of LMIC and partially implemented in 25% of LMIC with total volumes reaching 14 million in 2017. WHO agreed on ten key cascade indicators with partners to assess gaps towards achieving 90-90-90. WHO convened 25 high burden countries covering 85% of the epidemic to establish testing and treatment gaps, analyse cascades and prioritize actions to fill these nationally and sub nationally.

335. WHO convenes a Pediatric Technical Working Group, focused on HIV treatment optimization for children. This provides the opportunity to discuss in detail new data and research plans on new antiretroviral drugs and formulations as well as the potential role of emerging new options in the HIV drug pipeline (tenofovir alfenamide 'TAF', long-acting formulations) from a public health perspective. WHO also convened a third meeting on Pediatric ARV Drug Optimization (PADO 3) in 2016 to take stock of the progress made and to further advance the pediatric treatment optimization agenda. In this biennium it

provided a forum to foster cross-sector coordination across the continuum of drug development – from discovery to uptake – that is required to scale up ART for children.

336. Declining new HIV infections among children presents a disincentive for pharmaceutical companies to invest resources in developing suitable ARVs for children. Focused and coordinated action is required to make age-appropriate optimal formulations rapidly available to infants, children and adolescents living with HIV. Several consultations, led by WHO, have advanced the discussion on drug and formulation development for children, resulting in a more collaborative and coordinated response.

337. WHO worked in collaboration with the Elisabeth Glaser Pediatric AIDS foundation and provided enhanced technical assistance on treatment and care of children and adolescents living with HIV in 21 priority countries with a key regional meeting on the margins of ICASA 2018. In addition, WHO and AIDS FREE partners developed a global action plan launched on December 2017 to accelerate development and introduction of new pediatric formulations. WHO is also supporting introduction of the AA-HA! Framework to promote a stronger focus on improving service delivery for adolescents to ensure their specific needs are addressed. In this context WHO is promoting adaptation of differentiated care models to the needs of children, adolescents and their families.

338. Increasing levels of HIV drug resistance present a key challenge to reaching the 90-9090 target of viral load suppression. A WHO 2017 WHO HIV drug resistance report highlighted concerning trends in the levels of HIVDR across several regions that need to be addressed. HIV drug resistance detected in people starting ART, is increasing in low- and middle-income countries. In six of the 11 countries reporting nationally representative survey data (2014–2016), over 10% of individuals who initiated ART had virus resistant to efavirenz (EFV) and/or nevirapine (NVP), the WHO-recommended and widely used NNRTI antiretroviral (ARV) drugs as part of first-line ART.

339. A recent review shows that people with a virus resistant to EFV and/or NVP are more likely to fail to suppress and maintain viral load below 1000 copies/ml. They are also significantly more likely to experience virological failure or death, discontinue treatment, and acquire new HIVDR mutations. In 2017 WHO released guidelines for responding to the threat of HIV drug resistance within a public health approach. The guidelines recommend that countries with documented national prevalence of resistance to EFV or NVP at or above 10% should urgently move away from using these drugs in first line.

340. WHO supports countries to prevent, monitor and respond to HIVDR. The Global Action Plan on HIVDR, 2017–2021, developed in collaboration with partners and stakeholders, provides a five-year framework for action centred on five strategic objectives. The framework outlines key actions for all partners involved in the global response to HIVDR, and links to indicators to track implementation of the plan.

341. WHO continues to support countries to monitor, prevent and respond to HIVDR. In 20162017 30 countries have initiated HIVDR surveys following WHO methods. The WHO- coordinated Global Laboratory Network continues to expand. Currently 31 laboratories have been accredited by WHO for HIVDR testing; in 2017 three additional laboratories have been evaluated by WHO for designation. In 2016-2017 WHO developed a global HIVDR database, and in 2017 provided training to 26 countries on its function and use.

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Comprehensive eMTCT services *[Output 2.1]*

342. In 2017 WHO and UNICEF supported the Elimination of Mother to Child Transmission (EMTCT) last-mile agenda by promoting the use of data at the decentralized level to support the implementation of "differentiated EMTCT responses". Examples of "differentiated responses" include: introducing sub national data dashboards and performance reviews to address remaining programme bottlenecks in poor performing areas; improving the retention of pregnant and breastfeeding women initiated on antiretroviral treatment through SMS reminders for clinic appointments; and community-based support strategies.

343. Since 2015, WHO, at headquarters and regional offices, with support from UNAIDS and UNICEF, led a global process of validating countries in EMTCT of HIV and Syphilis as a public health problem. WHO serves as the secretariat for the Global Validation Advisory Committee (GVAC), a group of international experts in EMTCT including community representatives and human rights experts and convenes regular meetings to determine whether countries have met criteria for validation of elimination or steps along the path to elimination. The WHO EMTCT initiative is a leading example of service and programme integration. To date, 11 countries have been validated for EMTCT of HIV and/or syphilis. Surveillance indicators for EMTCT as well as STIs (gonorrhea and syphilis) have been incorporated into the Global AIDS Monitoring (GAM) allowing for integrated progress monitoring and all regions have established validation structures to support EMTCT. Two regions (WPRO, PAHO) have now committed to the triple elimination of MTCT of HIV, syphilis and hepatitis B. WHO will continue to play a critical leadership role in developing the normative elements required by the EMTCT agenda.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

344. WHO continues to lead normative work on PrEP and Voluntary Medical Male Circumcision (VMMC), supporting countries to implement these interventions as part of comprehensive HIV prevention programmes that monitors safety, uptake and coverage. Through the biennium WHO led, catalysed and coordinated with relevant partners to increase VMMC uptake among adult men.

345. WHO started the process of updating the global VMMC guidance, focusing on transitioning from the catch-up phase to the longer term sustainable phase. The focus will be on broadening the impact of VMMC services to include other HIV and health benefits. WHO continues to share information and enhance dissemination to accelerate uptake and shift directions in VMMC service delivery. WHO supports the Clearinghouse on male circumcision - a key tool for broader information dissemination including on accelerating uptake of VMMC

Youth health and education *[Output 3.2]*

346. WHO provided support to governments and partners considering implementing PrEP and HIV testing services for adolescent girls and young women. This included a one-year programme review of the South African PrEP programme, which in its first year showed less demand in the early stages than originally anticipated, although there were many additional benefits of the programme. Other support included reviewing policies and materials and the maintenance of a list of countries where TDF-containing regimens are approved for PrEP. Strategic and technical support and advice was also provided, in accelerating HIV services for adolescent girls and young women and their male partners, through a dissemination meeting on HIVST and APN guidance. The meeting included ministry and implementing partner representatives from 18 African countries. WHO will continue to provide support to the Global Fund in reviewing country proposals to ensure that priorities for adolescent girls and young women are included where needed.

347. WHO supported Global Fund programmes focused on adolescent girls and young women with policy guidance to increase the focus on and impact of adolescent girls and young women service packages. As a key contributor of the *Start Free Stay Free AIDS Free* framework, WHO fosters collaboration to address existing issues to increase access to critical commodities for age-appropriate testing and treatment of children and adolescents living with HIV.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

348. WHO has taken the lead in the development of normative guidelines and tools for key populations, which were brought together in Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care in 2014. In 2016 these guidelines, as well as the policy brief that goes with it, were updated. In 2017 WHO published examples of good practice of programmes serving key populations, along the prevention, testing and treatment cascade.

349. In 2017, WHO HQ and AFRO also reviewed all national strategic plans of countries in the African region on how policies and programmes include key populations. The report will be published in Q1 2018. WHO HQ HIV department is also leading the global hepatitis programme and started a working group with the aim to integrate responses for HIV, TB and viral hepatitis with harm reduction for people who use drugs.

Harm reduction services for people who inject drugs *[Output 4.2]*

350. The WHO HIV department, together with the departments of Substance Abuse and Access to Controlled Medicines, collaborated on UNGASS follow up and the outcome document. WHO prepared and then presented a report at the 2017 World Health Assembly (WHA) on efforts related to the UNGASS outcome document and the public health dimensions of the world drug problem.

351. WHO also provides direct country support on advocacy and implementation of the comprehensive package of nine interventions that has now been adapted to include community distribution of naloxone to manage opioid overdose and the structural

interventions outlined in the package for key populations. WHO supported countries with the development of national guidelines for opioid substitution therapy programmes as well as in some cases for the treatment of stimulants including in Myanmar.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality *[Output 5.1]*

352. As part of its contribution to leaving no-one behind, WHO's Gender, Equity and Human Rights (GER) Team, in conjunction with other WHO Departments, outlined four components of a Country Support Package, which provide country-level support to benefit all populations, health information systems, national health policies and strategies, and national health programmes. The tool is being used to promote gender work in countries highly impacted by HIV.

Gender-based violence *[Output 5.2]*

353. With support from PEPFAR, in October 2017 WHO issued guidelines for responding to children and adolescents who have been sexually abused, including recommendations for comprehensive post-rape care such as HIV PEP, Emergency contraception, STI treatment and mental health. 34. These guidelines are being disseminated to 13 countries (26-28 February 2018) with the highest HIV prevalence among adolescent girls and young women and are priorities for PEPFAR's DREAMS initiative and Global Fund's catalytic initiative to reduce HIV prevalence among adolescent girls and young women. Countries are developing plans for adapting the guidelines to their national context.

354. WHO will support uptake of GBV clinical guidelines for improving quality GBV services to women and to children and adolescents who have experienced sexual abuse in select countries in east and southern Africa, focusing on SRH and HIV providers.

355. WHO launched and disseminated a manual for health managers, strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. The manual is intended for health managers at all levels of health systems and is based on the WHO guideline Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013.

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

HIV-related stigma and discrimination in health care *[Output 6.3]*

356. In 2017 WHO significantly strengthened leadership advocacy to support efforts to eliminate HIV-related stigma and discrimination in health care. The Director-General delivered an intervention at the October 2017 Human Rights Council's Social Forum on Promotion and protection of human rights in the context of the HIV epidemic and other communicable diseases and epidemics. WHO also convened a cross-organizational working group to take forward this agenda.

357. WHO was a key contributor at the 2017 Prince Mahidol Award Conference and led a session on "Discrimination in Health Care - Determinants and Consequences". The session brought together leading figures from communities of women's rights, the right to health, HIV, and the health workforce, to engage in discussion on the challenges underpinning discrimination in health care and the imperative, as well as opportunities, for action. On-going work towards generating evidence on interventions effective in reducing HIV-related stigma and discrimination, as well as work towards a joint UN interagency statement on eliminating discrimination in health care, was shared.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

Decentralization and integration of HIV related services *[Output 8.1]*

358. WHO continued to support countries in joint programming and improving access to integrated TB and HIV services in 2017. The second joint meeting for TB and HIV Programme Managers, convened by WHO, brought together country participants from 25 countries in the African region. The meeting aimed to contribute to strengthening the health sector response and accelerate progress towards reaching universal access to HIV prevention, treatment, care and support. It also focused on accelerating the response to end TB in the African region and achieving SDG goals for HIV, TB and Viral Hepatitis.

359. To support TB and HIV programmes in joint planning and placement of integrated laboratory platforms for the diagnosis of both TB and HIV, an information note on considerations for adoption and use of multi-disease testing devices in integrated laboratory networks was developed.

360. WHO developed guidance to promote implementation of differentiated models of care for families and ensure that specificities attached to pregnant women, infants, children and adolescents are adequately captured in the country efforts to take treatment and care closer to patients and improving their quality of life.

361. In 2017, WHO progressed its work on ensuring a positive pregnancy experience, through the incorporation of HIV recommendations in normative guidance and dissemination. New ANC recommendations on supporting a positive pregnancy experience include recommendations on both syphilis and HIV screening as well as on the incorporation of PrEP.

362. WHO also published consolidated guidelines on sexual and reproductive health an rights of women living with HIV in 2017. The starting point for the guidance is the point at which a woman has learnt that she is living with HIV, and it therefore covers key issues for providing comprehensive sexual and reproductive health and rights-related services and support for women living with HIV. As women living with HIV face unique challenges and human rights violations related to their sexuality and reproduction within their families and communities, as well as from the health-care institutions where they seek care, particular emphasis is placed on the creation of an enabling environment to support more effective health interventions and better health outcomes. The guidance is designed to help countries to more effectively and efficiently plan, develop and monitor programmes and services that promote gender equality and human rights and hence are

more acceptable and appropriate for women living with HIV, taking into account the national and local epidemiological context.

363. WHO recognizes that the integration of targeted Sexual Health and STI/HIV prevention interventions in a combination prevention strategy is particularly important for key and vulnerable populations. In countries that are affected by a concentrated HIV epidemic and have a high STI burden, those populations should be at the centre of the national responses to the STI/HIV epidemic. With this regard WHO progressed a number of projects in 2017. For example, the final report and a peer reviewed article on the SIALON II (an integrated bio-behavioural survey of men who have sex with men in 13 European countries) methodology and results of the primary analysis of SIALON II data were published and disseminated. The results of the survey were used for the GARPR reporting process as well as for development of the regional HIV/AIDS epidemic scenarios. Secondary analysis of SIALON II data was also completed, and several peer review articles published. Finally in 2017, a systematic review was conducted on physical and sexual violence experienced due to sexual orientation and gender identity. The review included data from 74 studies conducted in 50 countries between 1995 and 2014. The prevalence of physical and sexual violence among all LGBTI groups ranged from 6% to 25%, and 5.6% to 11.4%, respectively. For transgender people specifically, the prevalence ranged from 11.8% to 68.2%, and 7.0% to 49.1%.

WHO 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	7 247 723	46 596 396	53 844 119
SRA 2: Elimination of mother-to-child transmission	1 718 187	13 968 116	15 686 303
SRA 3: HIV prevention among young people	472 734	5 036 353	5 509 087
SRA 4: HIV prevention among key populations	1 247 295	10 675 620	11 922 915
SRA 5: Gender inequality and gender-based violence		1 963 035	1 963 035
SRA 6: Human rights, stigma and discrimination	179 783	3 874 950	4 054 733
SRA 7: Investment and efficiency	1 435 223	9 606 957	11 042 180
SRA 8: HIV and health services integration	1 156 171	6 519 917	7 676 088
Grand Total	**13 457 116**	**98 241 344**	**111 698 460**

Table 2: By region (US$)

Region	Core	% FT countries	Non-core	% FT countries
Global	1 849 885		34 195 752	
AP	2 159 758	39%	18 900 234	31%
EECA	1 294 658	21%	3 587 540	39%
ESA	5 059 844	59%	20 980 973	45%
LAC	683 923	10%	3 619 542	11%
MENA	1 156 265	14%	4 911 770	8%
WCA	1 252 783	55%	12 045 533	33%
Grand Total	**13 457 116**		**98 241 344**	

Case study

Ensuring scaled-up effective use of PrEP

WHO has supported PrEP advocacy in many regions and communities including through partnership with APCOM to boost HIV prevention efforts in Asia
https://apcom.org/2016/04/28/msm-communities-call-for-national-prep-strategies-to-prevent-new-hiv-infections/

Pre-exposure prophylaxis or PrEP is the use of an antiretroviral medication to prevent the acquisition of HIV infection by uninfected persons. Oral PrEP has been shown to be efficacious in four randomized control trials and is high when the drug is used as directed. WHO first recommended that people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice, as part of comprehensive prevention in 2015 and has been supporting its scale-up since then. WHO has supported the inclusion of PrEP drugs (TDF/FTC;TDF/3TC and TDF) in the Essential Medicines List.

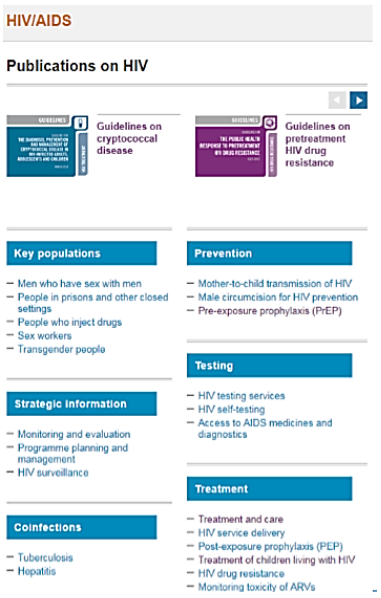
In 2017, WHO developed a modular PrEP implementation tool to help countries and programmes deliver PrEP safely and effectively. The modules are designed for a range of audiences, including clinical providers, counsellors, community and peer educators and PrEP users. This was launched at IAS (July 2017) and widely disseminated. WHO is also developing a mobile app and online PrEP training programming. WHO additionally convened a PrEP M&E meeting in Geneva in May 2017. A set of global indicators have been finalized, with inputs from countries, the Global Fund, PEPFAR and the Bill and Melinda Gates Foundation. A systematic review was carried out and a technical brief on Preventing HIV during pregnancy and breastfeeding in the context of PrEP was also developed. WHO has supported countries who are considering implementing PrEP as part of their comprehensive HIV prevention programme, for example, WHO supported the development and review of National PrEP guidelines in Botswana, DRC, Kenya, Lesotho, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe.

WHO, with support from UNITAID, also established the Global PrEP Coalition (GPC) designed to facilitate global dialogue and foster collaboration between stakeholders on pre-exposure prophylaxis (PrEP) as part of HIV combination prevention. It aims to ensure strategic and coordinated efforts in PrEP implementation across regions and countries and within countries. Coalition members include national, international and regional partners, who share a common vision on HIV prevention and remain committed to seeing PrEP effectively implemented as part of broader HIV combination prevention. The GPC is coordinated by WHO's Department of HIV Secretariat on matters pertaining to the implementation and scale-up of PrEP, with a strategic focus on policy-makers, providers, and current and potential PrEP users. Ensuring the appropriate, effective and safe use of PrEP is a central priority for the GPC, as is supporting safe and effective

PrEP implementation within comprehensive HIV and sexual and reproductive health services. Overall, the GCP's work will contribute to global targets to reduce new HIV infections, and serve as a platform to ensure that PrEP implementation efforts are effectively coordinated, that access is increased and equitable, and that the public health impact is maximized.

Knowledge products

Global health sector strategy on HIV, 2016-2021. June 2016. http://www.who.int/hiv/strategy20162021/ghss-hiv/en/	Treat all: policy adoption and implementation status in countries. November 2017. http://www.who.int/hiv/pub/arv/treat-alluptake/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/arv2016/en/	Guidelines on HIV self-testing and partner notification. December 2016. http://www.who.int/hiv/pub/vct/hiv-selftesting-guidelines/en/
Consolidated guidelines on personcentred HIV patient monitoring and case surveillance. June 2017. http://www.who.int/hiv/pub/guidelines/pers on-centred-hiv-monitoring-guidelines/en/	Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs.2016. http://www.who.int/tb/publications/integrating-collaborative-tb-andhiv_services_for_pwid/en/
Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. July 2017 http://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/	World Health Organization Draft thirteenth general programme of work 2019-2013 http://www.who.int/about/what-we-do/gpwthirteen-consultation/en/
Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. December 2016. http://www.who.int/hiv/pub/self-testing/hivself-testing-guidelines/en/	
Guidelines on the public health response to pretreatment HIV drug resistance. June 2016 and updated July 2017 http://www.who.int/hiv/pub/guidelines/hivdr - guidelines-2017/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/	

The World Bank

The World Bank provides financial and technical support to developing countries with the overarching aim of alleviating poverty within a generation and a health goal of ensuring everyone has access to essential services regardless of ability to pay.

The World Bank has long recognized the threat HIV poses to progress and development. It helps to define the global response and champions the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. As a UNAIDS Cosponsor, and under the UNAIDS Division of Labour, it is the lead agency for supporting the planning, efficiency, effectiveness and sustainability of the global AIDS response. The bank co-leads assistance provided on sexual transmission of HIV with UNFPA, and on social protection with UNICEF.

Key achievements by Strategy Result Area

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative testing and counselling programmes *[Output 1.1]*

364. Through its analytical work, the World Bank is building evidence around innovative testing and counselling programmes. In South Africa for example, the Adherence Guideline evaluation is intended to aid decision-making on the national roll-out of interventions across the continuum of chronic care. This impact evaluation will provide much needed effectiveness data on a more efficient approach to counsel, initiate on treatment and maintain on ART the millions of people living with HIV in South Africa. By using resources better and evaluation decentralisation options for drug refill, it will contribute to a more sustainable treatment response.

HIV treatment cascade *[Output 1.2]*

365. Through its US$ 11.5 billion health lending portfolio, the World Bank is funding major health system strengthening operations that aim to improve the access and the quality of services provided, including HIV testing and treatment. For example, in Nigeria, the Saving One Million Lives project aims at increasing the utilization and quality of high impact reproductive and child health interventions, including the provision of HIV/AIDS counselling and testing during antenatal care.

366. The Bank is also investing in fragile, conflict and violence (FCV)- affected countries, to enhance systems for access to the HIV treatment cascade. For example, in the Central African Republic, the Bank supporting increased utilization and improved quality of maternal and child health services, including HIV services, in targeted rural areas of the recipient's territory. Over 1.3 million people have been reached with basic health services under the project. The number of health facilities operating daily has reached 103. The project also provides specialized services to women victims of violence, with over 3300 reached between 2014 and 2016.

90-90-90 targets for children and adolescents *[Output 1.3]*

367. Through its lending portfolio, the World Bank is funding major health system strengthening operations that aim at improving access to and quality of services for

children and adolescents. For example, in 2016, the Bank supported projects in countries such as Nigeria, Tanzania and Zambia, where financing is provided to improve the quality of primary health care for women and children. This includes facilitating monitoring of HIV at PHC facilities and addressing immediate as well as systemic and medium-term bottlenecks to service delivery for young children at primary care and community levels.

368. In 2017, the World Bank approved USD105 million equivalent in non-reimbursable grants for the Government of Mozambique's Primary Health Care Strengthening Programme-for-Results. A recent assessment of the primary health care system in Mozambique indicated that despite some improvements, the country is not yet on track to reach the health Sustainable Development Goals. In response to these and other challenges, the Government developed a five-year programme (2017-2021 - the Investment Case) focused on Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition that prioritizes the Health Sector Strategic Plan. The Investment Case programme focuses on coverage, quality, and access to essential primary health care services, including HIV services, as well as data collection improvements and monitoring, among others.

Fast-track HIV services in high burden cities *[Output 1.4]*

369. Through its analytical work, the World Bank is providing evidence and direct technical assistance to help countries to better target high burden cities. For example, the World Bank conducted several size estimation and programmatic mapping studies that provide key data to inform the scale up of key population programmes in cities. The studies, such as the one conducted in Cote d'Ivoire for the cities of Abidjan, Bouake and San Pedro, provide programme managers, planners and implementers with the granular level of information needed to fast-track services at city level.

370. In 2016, the World Bank led an allocative efficiency HIV analysis, estimating what it would take in terms of programmatic targets and costs for the City of Johannesburg to meet the Fast-Track targets and demonstrate the impact that this would have. The analysis showed that achieving the Fast-Track targets would require an additional 135 000 diagnoses and 232 000 people on treatment by 2020 (an increase of around 80% over 2016 treatment numbers), however it would avert 176 000 infections and 56 500 deaths by 2030. The analysis also highlighted that while the scale-up in testing and treatment programmes over this decade has been rapid, these efforts must be doubled to reach 2020 targets in Johannesburg.

HIV services in humanitarian emergencies *[Output 1.5]*

371. Through its lending portfolio, the World Bank is funding health system strengthening operations that provide HIV-related services in humanitarian emergencies. For example, in Lebanon, the World Bank is funding an emergency primary healthcare restoration. The objective of the project is to restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees, including people living with HIV/AIDS. In the biennium 2016-2017, the World Bank scaled-up its impact on FCV-affected countries. Through the International Development Association (IDA), the Bank has doubled its resources for FCV-affected countries to more than USD14 billion. The Bank also introduced new financing mechanisms - including USD2 billion to support refugees and host communities in addition to USD2.5 billion to spur private enterprise.

Medicines and commodities *[Output 1.6]*

372. The World Bank is providing key funding resources for the improvement of supply chain management and laboratory capacities in multiple countries in Africa, through major operations such as the East Africa Health Laboratories Network project. The World Bank is also financing the strengthening of access to medicines and commodities as part of broader health projects. In Kenya for example, the Health Sector Support project aims to improve the effectiveness of planning, financing and procurement of pharmaceutical and medical supplies, including for HIV testing and ART programmes.

373. Starting in July 2017, IDA 18 included a three-year scaled-up commitment from the World Bank Group (WBG) to strengthen pandemic preparedness in at least 25 countries. The work has commenced with an initial focus on 11 countries, including Afghanistan, Cambodia, Ghana, Haiti, Kenya, Myanmar, Senegal, Sierra Leone, Sudan, Tanzania and Vietnam. The WBG is also working on a series of pandemic simulation exercises. Aimed at global and country policymakers, these exercises are intended to raise awareness of the threat posed by pandemics, test the systems that are currently in place, and drive increased investment for pandemic preparedness.

374. The WBG, with the support of Japan, Germany and the World Health Organization, has also developed the Pandemic Emergency Financing Facility (PEF), a quick-disbursing financing mechanism that provides a surge of funds to enable a rapid and effective response to a large-scale disease outbreak.

Strategy Result Area 2: New HIV infections among children eliminated and their mothers' health and well-being is sustained

Comprehensive eMTCT services *[Output 2.1]*

375. In 2016-2017, the World Bank funded and coordinated more than 25 Maternal and Child Health Projects across the world, to integrate PMTCT into SRH and increase the utilization of primary maternal and child health services, including for HIV/AIDS.

376. Through its results-based financing (RBF) programme, the World Bank has financed services to improve the uptake of antenatal and PMTCT services in several countries in Africa. For example, in Zimbabwe, the World Bank RBF grant is increasing coverage of key maternal and child health interventions, including for HIV positive mothers and children, in targeted rural and urban districts. The total population coverage of this RBF grant is approximately 4.1 million people.

377. In Uganda, another voucher project is increasing access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery. The project will largely benefit women from low income households who, in addition to the primary reproductive health services, will get access to nutrition, PMTCT and HIV/AIDS counselling services.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

378. The World Bank is providing funding to support the implementation of combination prevention in multiple countries, through HIV specific lending operations. For example, in Malawi, the Nutrition and HIV/AIDS Project tackles the most significant causes of disease burden in Malawi by focusing on implementing and scaling up the most cost-effective nutrition and HIV prevention interventions, through public sector and community delivery systems. The World Bank is also providing funding to combination prevention through its large multisectoral lending portfolio. For example, in the context of its infrastructure and transportation operations, with projects such as the Southern Africa Trade and Transport Facilitation Project (covering Botswana, Democratic Republic of Congo, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe), which incorporates financing for scale up of HIV services.

379. Finally, through its analytical work, the World Bank is building the evidence necessary to improve the design of combination projects, as well as providing direct technical assistance to help countries define their projects. The Bank is for example supporting studies showing the role of incentivizing VMMC demand. In Malawi, the study has initially shown the importance of national policies and programmes in changing perceptions about VMMC and creating a demand for it.

Youth health and education *[Output 3.2]*

380. The World Bank provides significant funding for education, lending USD2.85 billion for education in the 2017 fiscal year. Through this large lending portfolio, the World Bank is able to support the improvement of SRH curricula, better trained teachers and increased access to primary and secondary education for girls, in particular those most at risk of acquiring HIV. For example, in Nigeria, the WBG approved an additional USD100 million for the State Education Programme Investment Project, which will contribute to the return of students—particularly girls—to schools in the North East states of Borno, Yobe, Adamawa, Bauchi, Gombe, and Taraba. Together with partners, the project will also help identify out-of-school children, especially girls, and strategize on ways to bring them into school.

381. Adolescent Sexual and Reproductive Health (ASRH) is one of five areas of focus of the World Bank's Reproductive Health Action Plan, which recognizes the importance of addressing ASRH as a development issue with important implications for poverty reduction. The Bank is financing multiple health system projects and analytical products to address this issue. For example, through the GFF, Bangladesh is working across sectors to stem early marriage and early pregnancies to reduce maternal and neonatal deaths and improve the health and wellbeing of adolescents. The country directs its investments toward the education sector, to reduce drop out among female and disadvantaged students, by providing a range of support.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

382. The World Bank finances comprehensive HIV prevention programmes for key populations in multiple regions. For example, in Burkina Faso the Reproductive Health Project includes a specific component targeting key populations. The additional financing provided in 2016 supports the provision of a package of health services through results-based financing (RBF) and the reinforcement of reproductive health and HIV services. It helps finance the costs associated with the expansion of ongoing piloted strategies such as community-based targeting (CBT) of the poor and community-based health insurance (CBHI) and introduces new interventions to address the needs of key population groups vulnerable to HIV and AIDS.

383. Through its analytical work, the World Bank is supporting countries to improve HIV resource allocations for key populations. The World Bank conducted more than 15 allocative efficiency studies in 2016-2017 in partnership with the Global Fund, the Secretariat of UNAIDS and other cosponsors. Such studies provide governments with the evidence needed to appropriately reallocate budget to key populations. The World Bank also provided direct technical assistance to scale-up HIV services for Female Sex Workers, supporting countries in size estimations and programmatic mapping of Female Sex Worker.

Harm reduction services for people who inject drugs *[Output 4.2]*

384. The World Bank is providing financing to comprehensive harm reduction services for people who inject drugs through its lending operations. In India for example, the World Bank is providing ongoing funding to the National AIDS Control Support, to increase safe behaviours among high risk groups and ensure the procurement of oral substitution therapy (OST) drugs. The Bank is also financing a comprehensive HIV programme for People who inject drugs in Cebu in the Philippines and in Vietnam, including NSP and MMT programmes.

385. The World Bank is additionally providing key evidence though its analytical work for the design of effective and sustainable harm reduction policies. The World Bank has supported several studies investigating the cost-effectiveness and impact of harm reduction services for People who inject drugs. In the bienium 2016-2017, the World Bank finalized and further disseminated several studies, such as a study on the differences in drug relapse rates between compulsory drug detention centre-based treatment and voluntary drug treatment centres and a study on the Return on investment and cost-effectiveness of harm reduction program in Malaysia. The evaluation report generated evidence that opioid-dependent persons in CDDCs relapse to opioid use markedly faster than those treated with evidence-based treatments like methadone under the Care and Cure (C&C) approach, suggesting CDDCs have little role in the treatment of opioid use disorders.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality *[Output 5.1]*

386. In the biennium 2016-2017, the Bank Group implemented its new Gender Equality Strategy 2016-2023, following consultations with more than 1000 stakeholders in 22 countries. The new strategy addresses key constraints that are central to the HIV response, such as the inadequate investment in and prioritization of care services, including HIV prevention and treatment services, across the life cycle, from early childhood to old age. The majority of the World Bank operations now take gender equality into account in analysis, content, and monitoring and evaluation of our work. This translates into financing for multiple targeted actions through World Bank operations, for example in Uganda where the World Bank is financing a project to improve women and adolescent girls' empowerment and their access to quality reproductive, child and maternal health services including HIV services.

387. The World Bank, in partnership with the UNAIDS secretariat and co-sponsors, also regularly provides technical assistance to help governments improve their national AIDS strategic plans. Gender is a fully integrated focus of this technical assistance. For example, the World Bank has financed and conducted studies in several African countries to examine social drivers of transmission in young women, including a trial of different incentives (conditional and unconditional cash transfers, and/or a lottery system) provided to adolescent girls and their families to determine the impact on retention in school and risk of HIV infection. Finally, technical assistance provided through its Female Sex Worker programme in West and Central Africa helps bring focus and resources to female sex workers, a group traditionally underserved in HIV/AIDS Programs.

Gender-based violence *[Output 5.2]*

388. The World Bank contributes directly to GBV prevention programmes through operations such as the Great Lakes Emergency Sexual and Gender Based Violence & Women's Health Project. The WBG Executive Directors approved USD107 million in financial grants to Burundi, the Democratic Republic of Congo (DRC) and Rwanda to provide integrated health and counselling services, legal aid, and economic opportunities to survivors of sexual and gender-based violence (SGBV). The World Bank also help countries address GBV in their HIV strategies through the Umbrella Facility for Gender Equality (UFGE), which is a multi-donor trust fund dedicated to strengthening awareness, knowledge and capacity for gender-informed policy-making. In 2016-2017, the UFGE supported more than 70 activities in over 50 countries.

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Sustainability, efficiency, effectiveness and transitions *[Output 7.1]*

389. The World Bank is putting a strong emphasis on the issues of 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 allocative efficiency and sustainability.

390. In the biennium 2016-2017, the World Bank was working on more than 15 allocative efficiency studies across the 6 regions, at different stages of completion. This included a rapid analysis of ARV prices in Bulgaria as well as an analysis of implementation and allocative efficiency of programmes for people who inject drugs were conducted. In the West and Central Africa region, the World Bank completed 3 allocative efficiency studies in Cote d'Ivoire, Cameroon and Togo, underlying the need for additional efforts to close the significant treatment gap in the region, and stressing the need for continued investment on key population prevention and treatment programs.

Technology and service delivery innovations *[Output 7.2]*

391. Through its analytical work, the World Bank is also regularly providing additional evidence for the use of innovative tools and approach in the HIV response. In Malawi, the World Bank is supporting the Ministry of Health and the National HIV/AIDS Commission to undertake a Human Resources for Health analysis that will look at staffing profiles and productivity using the WHO Index of Staffing Needs (WISN) at facility and community level. As part of the ART adherence study conducted in South Africa, the evaluation tests several service delivery modalities for decentralized medication provision - Adherence Clubs (as an efficient mechanism for ART clients' drug refill), the Central Chronic Medicine Dispensing and Distribution scheme, and the Central Dispensing Unit scheme.

392. In partnership with the Secretariat and other cosponsors, the World Bank conducted several studies in 2016-2017 that provided additional evidence for the use of innovative tools and approach in the HIV response. Such studies include the evaluation of a smartphone app in a randomized controlled trial conducted by the Bank in urban Johannesburg.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

Decentralization and integration *[Output 8.1]*

393. As part of its overall Health strategy, the World Bank provides financing, state-of-the-art analysis, and policy advice to help countries expand access to quality, affordable health care. Typical projects financed by the World Bank in the biennium 2016-2017 include for example a project in Ghana that aim at improving the utilization of maternal, child health and nutrition services at the primary level of care in target regions. The immediate beneficiaries of such a project are women and children dependent on primary health services, in particular pregnant women and children under five, for whom HIV testing is promoted and available as well as PMTCT.

394. Recognizing that the path to UHC is specific to each country, the World Bank strategy includes promoting UHC and supporting developing countries' efforts to provide quality, affordable health care to everyone, regardless of their ability to pay, reducing financial risks associated with ill health, and increasing equity. In 2016, the World Bank finalized and disseminated a series of 4 country studies "HIV/AIDS And Universal Coverage Financing In Africa: Policy Options For Results And Sustainability".

HIV sensitive social protection *[Output 8.2]*

395. In September 2017, the World Bank Group's annual lending on social protection programmes reached USD13.5 billion (USD8.4 billion lending in IDA countries), targeting the world's poorest. These resources support safety net programmes, including cash transfers, public works, and school feeding programmes in more than 70 countries. Examples of projects conducted by the Bank in 2016 and 2017 include the Swaziland Health, HIV/AIDS and TB Project, which aims to increase social safety net access for OVC and a World Bank-supported cash transfer programme in Mexico, which provides monthly payments to families that send their children to school, meet vaccination requirements, and utilize health services.

The World Bank 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
SRA 1: HIV testing and treatment	1 275 566	1 932 314	3 207 880
SRA 2: Elimination of mother-to-child transmission	264 324	969 009	1 233 333
SRA 3: HIV prevention among young people	391 135	1 172 240	1 563 375
SRA 4: HIV prevention among key populations	497 358	1 737 911	2 235 269
SRA 5: Gender inequality and gender-based violence	56 000	623 356	679 356
SRA 7: Investment and efficiency	2 710 270	1 851 843	4 562 113
SRA 8: HIV and health services integration	1 135 216	2 932 584	4 067 800
Grand Total	**6 329 869**	**11 219 257**	**17 549 126**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
AP	1 306 336	82%	3 133 224	70%
EECA	197 327	62%	727 300	5%
ESA	2 804 972	100%	3 221 346	92%
Global	824 818		450 000	
LAC	232 291	40%	1 125 081	47%
MENA			155 761	0%
WCA	964 126	63%	2 406 545	67%
Grand Total	**6 329 869**		**11 219 257**	

Illustrations of UNAIDS Secretariat inputs to UBRAF Outputs

The UNAIDS Secretariat drives the global AIDS agenda, mobilizes political commitment and resources for the response to AIDS. It advocates for global health and social justice, putting civil society at the centre of the AIDS response, amplifying the voices of people and communities most affected by HIV to stand up for their rights and needs when they are not heard. UNAIDS strengthens the evidence base, support and advocacy for effective interventions, sustainable financing and scaled up community responses.

The UNAIDS Secretariat will strengthen its political advocacy and strategic policy advice, its normative and technical leadership, and its partnerships to support countries to make optimal use of domestic and international resources to fast-track the response to AIDS. UNAIDS is the custodian of strategic information and analysis on the state of the HIV epidemic and response at all levels. The Secretariat will sustain mobilization to ensure that AIDS policies, strategies and programming are evidence- and rights based so that no one is left behind.

Full reporting on achievements against the five Secretariat functions can be found in Part I. The Secretariat's functions at global, regional and country levels extend across the 20 UBRAF outputs and support overall Joint Programme achievements, according to UNAIDS' Division of Labour.

Strategy Result Area 1: Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment

Innovative testing and counselling programmes *[Output 1.1]*

396. Steady progress has been made towards the 90-90-90 treatment targets, with many countries in 2017 adopting treat-all. Policies will start to show effect in 2018. In June 2017, about 21 million people were on treatment, representing 53% of the total estimated number of people living with HIV (out of 81% target). This progress is a result of more stakeholders seeing HIV prevention beyond treatment, and inclusive of rights-based approaches that empower people to take decisions that prevent HIV infection and protect themselves, their partners and families.

397. The 25[22] low- and middle-income country members of the Global HIV Prevention Coalition received support to develop 100-day action plans encouraged by the prevention road map. The Secretariat assisted them with preliminary action to accelerate HIV prevention at country level, including strategic need assessments,

398. addressing policy and programme barriers, developing/revising national targets, and strengthening national prevention leadership. UNAIDS started mobilizing the East African Community, and invited the African Union to join the coalition.

399. UNAIDS is leading major initiatives endorsed by the African heads of state at the 29th African Union Summit in 2017. The community health workers initiative aims to recruit, train and deploy two million community health workers across Africa by 2020,

[22] Angola, Brazil, Cameroon, China, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Indonesia, Kenya, Lesotho, Malawi, Mexico, Mozambique, Namibia, Nigeria, Pakistan, South Africa, Swaziland, Uganda, Ukraine, United Republic of Tanzania, Zambia and Zimbabwe.

and the west and central Africa catch-up plan will accelerate HIV programmes to put the region on the fast-track to meet 2020 targets, tripling the number of people on treatment and improving access to it. The Secretariat coordinated partners, including Médecins Sans Frontières, governments of France, Luxembourg and Canada, WHO, UNICEF, NGOs, the Global Fund and PEPFAR, on technical assistance and issues in paediatric treatment, HIV testing, community involvement and removing user fees.

400. In December 2017, PAHO and UNAIDS launched *HIV prevention in the spotlight: an analysis from the perspective of the health sector in Latin America and the Caribbean*. Their first joint report says expanding access to all available prevention options would reduce new cases of HIV in the *region*, which since 2010 have remained at 120 000 every year

90-90-90 targets for children and adolescents *[Output 1.3]*

401. Building on the successes achieved under the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive, the Secretariat has co-convened, together with PEPFAR, Start Free Stay Free AIDS Free: a collaborative framework to accelerate the end of the AIDS epidemic among children, adolescents and young women by 2020, by accelerating prevention of vertical transmission, pediatric and adolescent treatment, and preventing new infections in adolescents and young women. Political leadership and partnerships have been at the heart of driving action. Consultations with a wide range of national partners and stakeholders, community members, women living with HIV, religious leaders, philanthropists, donors and private sector representatives of leading pharmaceutical and diagnostic companies have all contributed to building global consensus and momentum.

Medicines and commodities *[Output 1.6]*

402. Eight countries planning situation rooms were consulted on an initiative to estimate facility-based expenditures using existing health and management information systems (such as LMIS, DHIS). With minimal additional cost, this will provide continuous measurement of real-time services, showing the corelated facility expenditures. This can be cross-tabulated against relevant demographic variables to show spending levels, wastage and efficiencies when compared with other facilities or benchmarks. This initiative is conceptualized in sequential phases according to existing information systems: commodities such as antiretroviral medicines (ARVs), diagnostics and condoms, and after-service delivery costs, for example payroll.

403. A Secretariat triangulation exercise to ascertain if procuring generic medicines could support estimates of people on antiretroviral therapy (ART) concluded that for most countries where generics are accessible (sub-Saharan Africa, for example), volume of purchased generic ARVs is consistent with the reported number of people on treatment in the same number of countries. UNAIDS/WHO presented triangulation of people on ART and ARV procurements at a meeting with pharmaceutical companies.

Strategy Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV

Combination prevention *[Output 3.1]*

404. The Secretariat developed a mechanism to provide technical assistance for HIV prevention, and guidance and implementation tools for prevention programmes, including for young women, men and voluntary medical male circumcision, key populations, condom programmes and PrEP (pre-exposure prophylaxis). Action in priority countries to adopt national HIV prevention targets has also been supported.

405. The Secretariat worked with the Global Fund to develop a format for mapping intervention by age and geography for the new catalytic grants for supporting HIV programmes among adolescent girls and young women. These will be key for the Prevention Coalition's Works stream on adolescent girls and young women.

406. Enhancing access to financial mechanisms, the Secretariat enabled ministries of gender/women's affairs and education to re-engage with the Global Fund. It also provided information on the catalytic funding for adolescent girls and young women in 13 countries in the eastern and southern Africa region.

407. The Secretariat continues to coordinate the work of the Inter-Agency Task Team on social protection care and support and assists countries to strengthen programming on HIV-sensitive social protection. Zambia's Global Fund concept note targeted 3000 adolescent girls and young women with cash transfers to keep them in school and protect them from acquiring HIV. In Kenya, a similar programme is targeting 20 000 adolescent girls to increase their take-up of HIV services

408. The Secretariat supported the youth coalition The PACT to develop #uproot, a youth-led political agenda to increase visibility of the causes of risk and vulnerability – inequity, violence, exclusion and stigma and discrimination – that jeopardize young people's health, access to HIV and sexual and reproductive health (SRH) services and rights, and sustainability of the HIV response. With UNAIDS technical and financial support, #uproot developed briefs to challenge harmful policy, and a scorecard to track youth commitments in the 2016 Political Declaration. Other initiatives included an age of consent advocacy toolkit.

409. The Secretariat engaged new champions for HIV, including Prince Harry of the United Kingdom, for better advocacy and promotion to younger generations.

Strategy Result Area 4: Tailored HIV combination prevention services are accessible for key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants

HIV services for key populations *[Output 4.1]*

410. During the biennium UNAIDS played a leading role in a fundamental shift in data collection and analysis, including greater use of routinely collected programme data for surveillance and resource tracking, and the collection of real-time data from sub-national level to guide responses using a location-population approach that focuses human and financial resources on the geographic locations and populations in greatest need.

411. Size estimates, prevalence and programmatic indicators on key populations were compiled and disseminated through the Key Populations Atlas established in early 2017. It includes size estimates, prevalence and programmatic indicators about key populations and is accessible to the public via AIDSinfo.

412. In eastern and southern Africa (ESA), the Prevention Coalition boosted efforts to revitalize combination prevention, and included a road map launched by ESA health ministers in 2016. In November 2017, the Southern African Development Community (SADC) endorsed a regional strategy for HIV and AIDS prevention, treatment and care and sexual and reproductive health and rights (SRHR) among key populations. Ministers agreed on a prevention framework with guidance for target setting and a scorecard for monitoring, and sought a minimum 25% funding on HIV prevention.

413. Working with the International Federation of the Red Cross, expenditures per unit of community-based service delivery for ART and testing were collected in Haiti, Lesotho, Malawi and Myanmar. UNAIDS supported a costing exercise on services for gay and other men who have sex with men in Argentina, Brazil, Dominican Republic, Ecuador, Guatemala, Paraguay and Peru.

Strategy Result Area 5: Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV

Gender equality and gender-based violence *[Outputs 5.1 and 5.2]*

414. The Secretariat leveraged existing partnerships with regional mechanisms, such as the African Commission on Human and Peoples' Rights, to advance human rights. This resulted in the launch of the first African Commission Report on human rights and HIV in Africa, addressing emerging challenges including civil society space.

415. #WhatWomenWant was supported in leveraging social media to promote feminist leadership and ensure sustainable, transformative results. A feminist blog series for young women leaders to share expertise was developed. Using WhatsApp groups, virtual consultations and twitter chats, young women were engaged and accessed UNAIDS guidance on HIV prevention. The consultation and social media resulted in #WhatWomenWant: HIV prevention that works for adolescent girls and young

women, and a toolkit, Accountability in Action, putting women and girls at the centre via new social media, by the global ATHENA Network.

416. In 2017, ALIV[H]E was launched, linking initiatives on violence against women and HIV, the result of two years of evidence-informed community interventions. It provides step-by-step approaches to developing effective programmes, including monitoring and evaluation of violence against women and HIV responses. It is being used in the eastern and southern Africa and Middle East and North Africa regions.

Strategy Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed

Legal and policy reforms *[Output 6.1]*

417. With OHCHR, the Secretariat engaged UNDP and WHO to catalyse efforts to address the misuse of criminal law and other punitive laws that impact on HIV-related rights. An expert meeting in Italy discussed ways to collaborate to end laws that negatively impact on health and human rights. Through advocacy and strategic information, UNAIDS helped shape public policy on HIV, pushing boundaries in the face of reluctance to fight stigma and address the needs of key populations.

HIV-related stigma and discrimination in health care *[Output 6.3]*

418. In 2017, UNAIDS in Kazakhstan facilitated a national stakeholder consultation that fed into the development of a workplan to reduce stigma and discrimination, including in medical settings. The national plan includes development of anti-discrimination policies by the national AIDS centre, stigma and discrimination assessments and training of health-care workers in medical institutions and sensitizing postgraduate curricula for health care professionals. This national framework intends to improve access to services by people living with HIV and key populations.

419. In 2017, UNAIDS co-led development of a Joint UN statement on ending discrimination in health-care settings**,** which was issued by 12 UN agencies who committed to work together to support Member States in coordinated multisectoral action.

420. An Agenda and Campaign to end HIV-related discrimination in healthcare settings continued to be implemented. The report, *Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond,* launched by the Executive Director of UNAIDS in October 2017, during the Human Rights Council Social Forum highlights that, in order to reach all people living with, or at risk of, HIV and to link them with HIV prevention and treatment services, the world must step forward and confront discrimination.It shows that people living with HIV who experience high levels of HIV-related stigma are more than twice as likely to delay enrolment into care than people who do not perceive HIV-related stigma.

421. New discrimination targets in health-care settings were integrated in the Global AIDS Monitoring 2018. These indicators could provide further understanding of HIV-related health outcomes and improve interventions to reduce and mitigate HIV-related stigma and discrimination experienced during treatment and care.

422. UNAIDS Regional Support Team for Asia and Pacific joined with regional partners in May 2017 to conduct the Asia Regional Consultation at which HIV-related discrimination in health-care settings was addressed. Main outcomes included development of a regional platform and country actions plans to address stigma and discrimination in health-care settings. It is expected this regional intervention will support countries fast-track prevention, testing and treatment services.

423. With the Vietnam Administration for HIV/AIDS Control, supported the Ho Chi Minh City Provincial AIDS Center and the Viet Nam Network of People Living with HIV on an HIV-related stigma and discrimination assessment in selected health-care settings in late 2016. Survey results were used to develop manuals used to train workers. This intervention will reduce health-care providers' discrimination towards key populations and people living with HIV; empower civil society to demand discrimination-free health-care services; and increase access and uptake of HIV testing, prevention and treatment services and improve retention in care.

424. The Secretariat collaborated with Argentina's health ministry to establish a system to receive and respond to complaints related to discrimination and other barriers to treatment and/or social services confronting people living with HIV. Followed up in less than 48 hours, complaints are resolved via administrative means and/or referred to state or civil society organizations offering free legal services. The initiative includes activities to help people living with HIV know their rights and provincial AIDS programmes to respond to HIV-related discrimination and other violations.

Strategy Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information

Sustainability, efficiency, effectiveness and transitions *[Output 7.1]*

425. Investment returns on Global Fund grants were improved by strengthening focus on populations and locations. Secretariat support to Indonesia and Togo, for example, generated information on the needs, vulnerabilities and limited service uptake of key populations. Since 2016, more than 25 countries have generated strategic information on HIV epidemiology, programme coverage and finance at national and subnational levels, influencing investment decisions and national strategies. Data on key populations have enabled measurable targets in Global Fund applications, resulting in increased accountability and mobilization of resources for programming.

426. An online version of the AIDS spending module GAM was rolled out to facilitate data collection and management of indicator 8.1, which measures progress against the High-Level Meeting commitment 8 adopted in the 2016 Political Declaration, to "ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers". A supplement to GAM post-2015 was published in AIDS and Behaviour.

427. GAM was also used to update the domestic public spending on HIV database to adjust for non-reporting country/years. GAM includes the option to report the expenditure of commodities (for each specific service) separately from the service delivery and other components. In 2016, the financing gaps in 116 low- and middle-

income countries were measured. This involved updating international and domestic resource availability from 2000–2015, estimating resource needs to identify options for sustainable financing schemes, delineating policy options for countries moving to higher income levels, including HIV services within universal health coverage goals, and/or delineating options within national health insurance. This resource needs update helped the Global Fund define resource mobilization targets for its replenishment exercise.

428. The Secretariat will, in collaboration with the International Association of Providers of AIDS Care (IAPAC), implement a USAID-funded project to support the fast-track response in 20 high-burden cities.

429. UNAIDS, with the World Bank and UNDP, supported HIV allocative efficiency studies in 11 countries in eastern Europe and central Asia, and the follow-up action taken by countries. Armenia, Belarus and Georgia used the analysis to inform Global Fund concept notes, and Bulgaria and the former Yugoslav Republic of Macedonia used the findings to prepare for their transition to domestic funding.

430. Training was provided for government staff and national and international consultants from 21 countries (including 15 fast-track countries in eastern and southern Africa) with leading roles in implementing a National AIDS Spending Assessment in 2018.

431. The Secretariat partnered with the African Development Bank on transition and system strengthening. Countries will be supported to identify innovative financing mechanisms for HIV to reduce dependency on international aid, and to establish dialogue between ministries of finance and health/national AIDS programmes for adequate, efficient funding. Cambodia, Morocco, Mozambique and Senegal have been helped in developing multidimensional road maps for transition preparedness and sustainability. Work has been undertaken to help other countries, including Côte d'Ivoire, Jamaica, Kenya and the Philippines, take similar steps.

432. The Secretariat is a member of the global UHC2030 Group on Transition and Sustainability, where its experience of the complexity of transition has been invaluable. Over the reporting period, it advocated for concerted action by all players to avoid multiple transitions that may reverse country achievements.

Strategy Result Area 8: People-centred HIV and health services are integrated in the context of stronger systems for health

433. UNAIDS leveraged its role in the Pink Ribbon-Red Ribbon (PRRR) partnership to combat cervical and breast cancer. In the United Republic of Tanzania, the UNAIDS country office secured high-level political commitment for HIV and cervical cancer prevention and control integration, strengthening coordination and monitoring and evaluation of cervical cancer interventions and the engagement of the network of women living with HIV. In 2016–2017, they reached 31% of the national target in the current PRRR-supported regions, screening 30 000 women for cervical pre-cancer, and treating 56% of those who need it.

434. Through partnership with the UN Joint Global Programme of Cervical Cancer Prevention and Control, cervical cancer prevention and treatment will be included in the 2018–2020 Global Fund grant request.

435. Together with the Global Coalition on Women and AIDS (GCWA) and WHO, the Secretariat developed and launched advocacy briefs addressing the integration of services for HIV, human papillomavirus (HPV) and cervical cancer, and HIV and female genital schistosomiasis (FSG), a waterborne neglected tropical disease.

436. UNAIDS was a member of the Partner Action Group that oversaw the launch of the Implementation Through Partnership initiative in 2016, which included representation from a range of partners, including PEPFAR, GIZ Backup and the French 5% Initiative, and involved 20 countries in the eastern and southern Africa, west and central Africa ,and Asia and Pacific regions. UNAIDS was lead partner on 14 of the 40 HIV or HIV/TB specific actions, many of them for technical support.

437. Fourteen background publications provided the basis for five policy briefs on shared responsibility for financing the global response, integrating HIV and AIDS funding in universal health care, guiding principles for agreements to smooth the transition to domestic financing, managing the transition, and Kenya’s example of financing AIDS treatment through a health insurance fund.

UNAIDS Secretariat 2016-2017 Expenditure and Encumbrances

Table 1: By Strategy result area (US$)

Strategy result area	Core	Non-core	Grand Total
S1: Leadership, advocacy and communication	71 684 816	17 894 036	89 578 852
S2: Partnerships, mobilization and innovation	45 724 493	10 847 900	56 572 393
S3: Strategic information	39 564 629	6 103 275	45 667 904
S4: Coordination, convening and country implementation support	48 394 080	17 817 996	66 212 076
S5: Governance and mutual accountability	63 479 917	4 617 699	68 097 616
Grand Total	**268 847 935**	**57 280 907**	**326 128 842**

Table 2: By region (US$)

Region	Core	% Fast-Track countries	Non-core	% Fast-Track countries
Global	138 479 475		16 819 957	
AP	24 279 412	43%	11 392 300	78%
EECA	9 178 914	20%	5 437 548	0%
ESA	39 294 752	77%	15 684 077	32%
LAC	18 423 719	27%	609 811	50%
MENA	6 620 915	11%	1 343 885	0%
WCA	32 570 748	44%	5 993 329	13%
Grand Total	**268 847 935**		**57 280 907**	

Case study

Community groups are reducing stigma in health-care settings in Asia

Dy Sokha has a ready smile and calls out friendly greetings to doctors, nurses and patients as she walks through the bustling hallways of the Khmer Soviet Friendship Hospital in Phnom Penh, Cambodia. She is brightly dressed in a peach pink shirt and is a full-time counsellor with the ARV Users Association (AUA), a community-based organization providing services to people living with HIV.

“Sometimes at the beginning of a counselling session, the client won’t look at my face,” said Dy Sokha. “They put their face down; they scratch their fingernails. They are so shy. For these difficult cases, I must open up about myself.”

Dy Sokha was diagnosed with HIV about 20 years ago and began taking antiretroviral medicine in 2004. The HIV treatment improved her health significantly and now gives her the strength to lead a busy life as a counsellor.

“I have become a role model for my clients, as they can see I am successful and they understand that just because you have HIV, it does not mean you have to disappear from society,” she said.

AUA, which is active in seven hospitals in two provinces, is one of a few community-based HIV organizations in Cambodia whose staff work directly alongside health-care providers. While the organization provides a range of services, such as counselling on treatment adherence and HIV prevention, it places a particular focus on preventing stigma and discrimination in the hospitals in which it works.

85% of AUA’s 40 staff members are people living with HIV and so they know first-hand how discrimination can lead to social isolation and negatively affect a person’s health and well-being. The group facilitates connections between clients and health-care providers and holds regular meetings with hospital staff to provide feedback.

“We coordinate with different stakeholders to meet and encourage communication between people living with HIV, service providers and civil society,” said Sienghorn Han, Executive Director of AUA.

In 2015, AUA was trained by Asia Catalyst to document human rights violations in health-care settings. The cooperation was part of a study that Asia Catalyst conducted in four countries in Asia, which found discrimination evident in many areas, from denial of services and segregation to arbitrary additional fees for health services.

When AUA receives a discrimination case, it acts as a mediator, trying to find a solution that is acceptable to both health-care workers and clients.

“We keep good contact with all levels of the hospital,” said Dy Sokha. “The staff and I sit together—the doctor, the client and myself—to understand the problem in order to help the doctor do his or her best.”

AUA also holds counselling sessions with clients that aim to give them accurate information, as well as empower them to advocate for their rights and negotiate with health-care providers.

Bopha, who prefers to use a pseudonym and is living with HIV, found that AUA was especially helpful when she became pregnant in 2013. “AUA explained everything, especially how to take care of my pregnancy and how to disclose my HIV status to my doctor so that I could access antiretroviral medicines to prevent the transmission of HIV to my daughter,” she said.

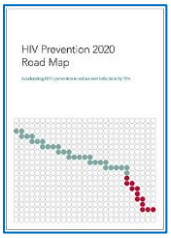
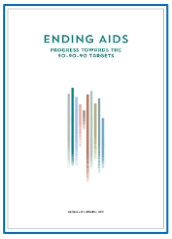
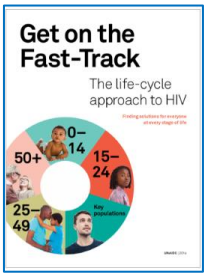
Cambodian health officials acknowledge that AUA provides services that help busy health-care workers. Ngauv Bora, Deputy Chief, Technical Bureau of the National Centre for HIV/AIDS, Dermatology and STDs, said, “For clients, AUA staff are like friends and they trust them more than the hospital counsellors. AUA is helping to create an enabling environment.”

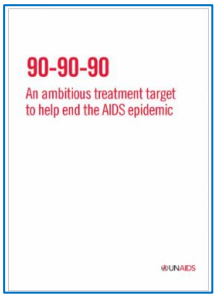
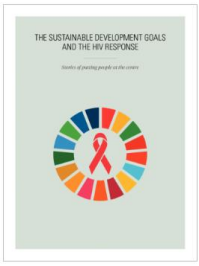
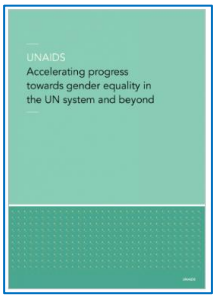
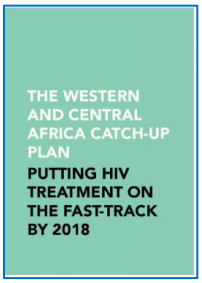
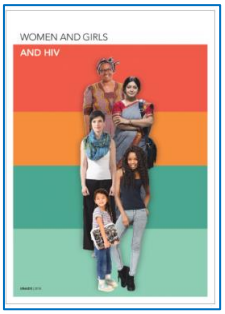
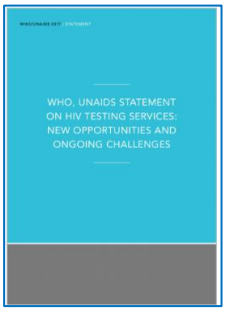
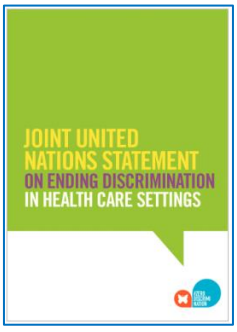
The organization is one of more than a dozen community groups that, along with health officials and international experts from 12 countries, participated in the first Asia Regional Consultation on

Addressing HIV-Related Stigma and Discrimination in Healthcare, which took place on 25 and 26 May in Bangkok, Thailand.

The regional consultation provided a platform for countries to achieve tangible objectives, with technical assistance from partners. Community organizations were recognized as crucial partners in the drive to eliminate stigma and discrimination.

Knowledge products

	**The H6 Partnership** A Catalyst for transformation in the United Nations to deliver health results for women, children and adolescents in support of the Sustainable Development Goals		**HIV Prevention 2020 Road Map** — Accelerating HIV prevention to reduce new infections by 75%
	**Ending AIDS:** progress towards the 90–90–90 targets		**UNAIDS DATA 2017** This edition of UNAIDS data contains the highlights of the very latest data on the world's response to HIV, consolidating a small part of the huge volume of data collected, analysed and refined by UNAIDS over the years.
	**Refining and reinforcing the UNAIDS joint programme model** This report offers practical solutions to transforming the way the Joint Programme works.		**Get on the Fast-Track — The life-cycle approach to HIV** In this report, UNAIDS is announcing that 18.2 million people now have access to HIV treatment. Increasing treatment coverage is reducing AIDS-related deaths among adults and children.

	**Start Free, Stay Free, AIDS Free** A super-fast-track framework for ending AIDS among children, adolescents and young women by 2020		**Fast-track commitments to end AIDS by 2030**
	**90–90–90 - An ambitious treatment target to help end the AIDS epidemic**		**The Sustainable Development Goals and the HIV response** Stories of putting people at the centre
	**UNAIDS: Accelerating progress towards gender equality in the UN system and beyond**		**The western and central Africa catch-up plan — Putting HIV treatment on the fast-track by 2018**
	**Social protection: a Fast-Track commitment to end AIDS** Guidance for policy-makers, and people living with, at risk of or affected by HIV		**Women and girls and HIV** We must work collectively to close the gaps that continue to leave women and girls behind.
	**WHO, UNAIDS statement on HIV testing services:** new opportunities and ongoing challenges		**Joint United Nations statement on ending discrimination in health care settings**

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