

**UNIFIED BUDGET,  
RESULTS AND  
ACCOUNTABILITY  
FRAMEWORK (UBRAF)  
PERFORMANCE MONITORING  
REPORT 2016:  
ORGANIZATIONAL REPORTS**

**Additional document for this item:**

- i. UNAIDS Performance Monitoring Report: Synthesis (*UNAIDS/PCB (40)/17.5*)
- ii. Independent Evaluation of the Partnership between Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (*UNAIDS/PCB (40)/CRP3*)

**Action required at this meeting:** included in UNAIDS/PCB (40)/17.5

**Cost implications of decisions:** none

## CONTENTS

ACRONYMS .....	3
INTRODUCTION .....	5
UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR) .....	6
UNITED NATIONS CHILDREN’S FUND (UNICEF) .....	13
WORLD FOOD PROGRAMME (WFP).....	21
UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP) .....	26
UNITED NATIONS POPULATION FUND (UNFPA).....	34
UNITED NATIONS OFFICE ON DRUGS AND CRIME (UNODC) .....	41
UNITED NATIONS ENTITY FOR GENDER EQUALITY AND THE EMPOWERMENT OF WOMEN (UN WOMEN) .....	45
INTERNATIONAL LABOUR ORGANIZATION (ILO).....	51
UNITED NATIONS EDUCATIONAL, CULTURAL AND SCIENTIFIC ORGANIZATION (UNESCO) .....	59
WORLD HEALTH ORGANIZATION (WHO).....	65
THE WORLD BANK.....	73
UNAIDS SECRETARIAT .....	81

## ACRONYMS

AIDS	acquired immunodeficiency syndrome
AP	Asia and Pacific
ARV	antiretroviral medicines
AU	African Union
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
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
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
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
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
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 Frameworks
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 2016 against the 20 outputs and the 5 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 made progress 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.

## United Nations High Commissioner for Refugees (UNHCR)

UNHCR has a mandate to lead and coordinate global action 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.

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, with a wide range of interventions and programmes, using AIDS-related competence and expertise it has developed over decades.

### Innovative testing strategies

3. UNHCR works to ensure that refugees and other populations who are affected by humanitarian emergencies have improved access to HIV testing and counselling through community-based services. In the Democratic Republic of the Congo (DRC), for example, UNHCR participated in the national campaign for post-conflict communities that enabled more than 11 000 refugees and internally displaced persons to access free HIV counselling and testing.
4. To improve access to voluntary HIV testing, UNHCR works with nongovernmental organizations (NGOs) and community-based organizations (CBOs) to provide testing services, including for vulnerable populations. In Nepal, UNHCR worked with *Première Urgence Internationale* and Malteser International to ensure voluntary HIV counselling and testing were provided free of charge in five temporary shelters for new arrivals and for vulnerable and most-at-risk populations, such as sex workers. In Mexico, UNHCR referred refugees and asylum seekers to HIV and sexually transmitted infection (STI) testing and treatment services. This was done in collaboration with reception transit centres and safe shelters, and by providing individual and group counselling.
5. In Pakistan, UNHCR worked with vulnerable and high-risk communities, including prisoners, sex workers, people who inject drugs, adolescents and young people, truck drivers and transgender populations, to improve access to HIV counselling and testing services and reduce stigma and discrimination. Throughout 2016, 26 stigma-reduction workshops and outreach activities for voluntary HIV testing were conducted with those groups.
6. UNHCR supports the continuum of care for populations moving from high-burden cities to refugee camps, including continued antiretroviral therapy (ART) and prevention, testing and care services.

## **HIV services in humanitarian emergencies**

7. During 2016, UNHCR supported continued HIV services for refugees and other displaced populations affected by humanitarian emergencies in 48 of its operations. This included a 65% increase in patients who were supported to receive ART. UNHCR strengthened programmes to improve adherence to ART, supporting peer-led community interventions in Egypt, Ethiopia, Kenya, Malawi, Rwanda, South Sudan, Uganda and Zambia. In the second half of 2016, UNHCR worked with national HIV programmes and field-based partners to restart ART for 1,943 newly arrived South Sudanese refugees, including 386 children living with HIV in hard-to-reach areas of north-eastern DRC previously lacking any HIV services; 400 Congolese have also accessed ART through this intervention. UNHCR ensured that key HIV-related services were available to 149 322 refugees and asylum seekers in Malaysia. UNHCR advocates for emergency-affected communities to be included in national HIV programmes, plans and legislation.
8. Data management was strengthened at field level for HIV and reproductive health indicators by updating UNHCR's health information system. Standards and indicators were revised, along with the way data are collected, analysed and visualized, to improve quality and timeliness and enable evidence-informed decision-making. HIV and reproductive health indicators have been aligned with Global AIDS Response Progress Reporting (GARPR) indicators. Individual, facility and camp-level data are collected using mobile phones/tablets and computers, collated and analysed in real time and made available at all levels. The system will roll out in eight countries by the end of 2017 and in all 48 UNHCR operations by the end of 2019, using the health information system.
9. UNHCR strengthened HIV prevention programmes, investing in those focused on young people and key populations. At the Kakuma refugee camp in Kenya, UNHCR and partners worked with young people through the My Health My Choice programme, a community-based, group-level intervention developed for youth aged 13–17 years. The intervention focused on reducing the incidence of HIV, STIs and unplanned pregnancy. HIV prevention projects aimed at adolescents and young people were implemented in Cameroon, Ethiopia, Ghana, Pakistan, Rwanda, South Sudan, Ukraine and Zambia.
10. UNHCR presented research on HIV in humanitarian settings at the International AIDS Conference in Durban, and updated and rolled out an online training module on HIV in humanitarian settings for its staff and partners.

## **Medicines and commodities**

11. UNHCR provided technical input to strengthen health systems, including those that procure and distribute HIV-related commodities, and provided logistical support for access to commodities during emergencies.
12. UNHCR works with UNFPA to provide male and female condoms to populations affected by humanitarian emergencies. In 2016, more than 9.6 million condoms were distributed to refugees, internally displaced people and other populations affected by humanitarian emergencies, both inside refugee camps and in out-of-camp settings.



### **Comprehensive eMTCT services**

13. UNHCR advocates for refugees, asylum seekers and other populations affected by humanitarian emergencies to have equal access to elimination of mother-to-child transmission (eMTCT) services available to host communities, for both urban and out-of-camp populations and those in camps. UNHCR achieved a global coverage of prevention of mother-to-child transmission (PMTCT) of 77% while more than 75% of reporting countries had PMTCT coverage of more than 80%.
14. In 2016, UNHCR supported the provision of eMTCT services for more than 20 000 pregnant women in Dadaab and Kakuma refugee camps. UNHCR also helps implementing partners provide eMTCT services in low-prevalence settings. In Yemen, working with International Medical Corps and Charitable Society for Social Welfare, UNHCR ensured that eMTCT services for pregnant women in urban and camp-based settings were of equal quality to those provided for host populations.
15. One of the key priorities for the 2016 Unified Budget, Results and Accountability Framework (UBRAF) funding in Malawi was strengthening eMTCT services within the two refugee camps, including upgrading maternal health facilities and improving capacity in maternal and sexual and reproductive health (SRH) services. As a result of UBRAF funding, comprehensive eMTCT services are provided to refugees and the host communities surrounding the camps.
16. UNHCR completed guidance on PMTCT in humanitarian settings, which will be rolled out to its staff and other humanitarian partners in 2017 through an online distance-learning tool.

### **Combination prevention**

17. UNHCR works to ensure that populations affected by humanitarian emergencies have access to comprehensive HIV prevention services in and out of camp. In South Sudan, more than 62 000 refugees and the surrounding host communities received HIV prevention information in 2016, and 64 340 male condoms and 1,200 female condoms were distributed.
18. UNHCR takes community-based approaches to ensure HIV prevention services are accessible to populations of concern. In Malaysia, UNHCR continued to support HIV prevention among refugees and asylum seekers at community level, using a team of community health workers. Those workers were stationed at NGO clinics, the main HIV referral centre and at the UNHCR office to disseminate information on HIV prevention and provide links to other services, including SRH services and psychological and livelihoods support.
19. UNHCR works to increase national capacity to deliver integrated SRH services, especially for marginalized or vulnerable adolescents and young people in humanitarian settings. UNHCR worked in Cameroon, the DRC, Ethiopia, Ghana, Kenya, Pakistan, Rwanda, South Sudan, Ukraine and Zambia to provide youth-friendly HIV services to adolescents and young people in and out of camp.
20. UNHCR also collaborates with UNFPA to ensure that refugees, internally displaced persons and populations of concern have improved access to HIV prevention services, including access to male and female condoms. In 2016, more than 9.6 million

condoms were distributed to refugees, internally displaced persons and other populations affected by humanitarian emergencies, in refugee camps and in out-of-camp settings.

21. UNHCR partners with UNFPA to strengthen youth-friendly HIV services in humanitarian settings. In Ghana, UNHCR, UNFPA and the Government collaborated to bolster reproductive health services in two regions hosting refugees, using the revised manual on adolescent health and development.

### **HIV prevention among key populations**

22. UNHCR works with key populations among refugees, asylum seekers and people affected by humanitarian emergencies to provide HIV prevention, continuation of treatment and care services and programmes to reduce stigma and discrimination in camps and out-of-camp settings. In Pakistan, UNHCR worked with key populations, including prisoners, sex workers, people who inject drugs, adolescents and young people, truck drivers and transgender populations to improve access to HIV counselling and testing and to reduce stigma and discrimination. In the Middle East and Northern Africa region, UNHCR supported interventions for sex workers, including HIV and STI prevention programmes and efforts to avert deportation. Approaches included strengthening the recruitment of sex workers through snowballing (using initial contacts to reach others) and referrals from community informants, enhancing their empowerment through peer-led activities, improving flexibility in timing and structure of training and counselling sessions to reach more people, and improving the monitoring and evaluation of programmes.
23. UNHCR conducts sensitization activities within refugee camps to increase knowledge about HIV prevention and to reduce stigma and discrimination. In Kenya, sex workers, long-distance truck drivers and migrants in the vicinity of the camps were provided with HIV information and voluntary counselling and testing services, and condoms were distributed.
24. UNHCR works with people who inject drugs in populations affected by humanitarian emergencies. In Pakistan, UNHCR helps the Legend Society run a detoxification centre in the city of Quetta for locals and refugees. In 2016, 9,354 people who inject drugs were reached with voluntary counselling and testing services. Through a harm-reduction project, 71 840 syringes and 79 818 condoms were distributed within the community.
25. UNHCR advocated for punitive laws, policies and practices to be removed, including overly broad criminalization of HIV transmission and other obstacles to key populations' access to services.

### **Gender-based violence**

26. UNHCR provides services to clinically support survivors of rape and sexual violence in humanitarian emergencies. It promotes access to sexual and gender-based violence (SGBV) prevention and redress mechanisms, and SRH services, including through the minimum initial service package for emergencies. This provides post-exposure prophylaxis to survivors of sexual violence in conflict, violence prevention and care, trauma recovery and mental health services, and expanded services for survivors of gender-based violence. In 2016, global post-exposure prophylaxis coverage for

reported instances of sexual violence reached 88%. In the United Republic of Tanzania, UNHCR provided medical and psychosocial services to SGBV survivors. In 2016, 585 survivors among Burundian and Congolese refugees accessed clinical care, including post-exposure prophylaxis. To ensure a continued comprehensive response to SGBV, UNHCR provides refresher courses for health staff and partners on the clinical management of rape survivors.

27. UNHCR supports community-based activities to promote SGBV awareness and prevention both in camps and out of camp. In Rwanda during 2016, 509 cases of SGBV were identified from refugee camps and urban locations. Survivor-centred case management services were provided in accordance with SGBV-localized standard operating procedures and established referral pathways. Services included safety and security, material support, psychosocial support, and medical and legal services. Survivors requiring medical treatment were referred to UNHCR health partners and national structures, known as “Isange One Stop Centres”, where services include screening for HIV and other STIs. In the Mahama Burundian emergency camp, SGBV survivors have access to community-based protection in the form of sociotherapy groups. UNHCR’s legal aid partner provides assistance, and survivors are offered immediate access to safe spaces and counselling.
28. UNHCR continued to advocate with national and provincial actors to ensure refugees are mainstreamed into SGBV programmes, research and studies. In South Africa, UNHCR efforts on World AIDS Day 2016 focused on preventing SGBV, peaceful coexistence and access to justice, reaching more than 1,000 refugees and asylum seekers.
29. In Georgia, information sessions were conducted by partner NGO Avangard in three districts, for schoolchildren, teachers, survivors of domestic violence and women’s groups.
30. In Syria, more than 3,000 SGBV awareness activities reached 90 000 women and girls, boys and men. UNHCR helped establish 70 community-based committees serving 175 000 people, and initiated 70 advocacy actions to prevent and respond to SGBV.

### **Legal and policy reforms**

31. During 2016, UNHCR promoted access to asylum procedures; protection from expulsion, arbitrary detention, unlawful restrictions on freedom of movement, including the right to return regardless of HIV status; and an end to mandatory testing for asylum seekers, refugees, internally displaced persons and other marginalized groups. UNHCR seeks to include emergency-affected communities, including refugees and internally displaced persons, in national HIV programmes, plans and legislation.
32. UNHCR advocated against the exclusion of forcibly displaced populations from government HIV programmes and the use of mandatory HIV testing among these populations in South Sudan. As a result, refugees are now included in relevant government HIV policies, programmes and funding proposals, including the country’s Global Fund applications and the UN Interim Cooperative Framework. There were no reported cases of mandatory HIV testing of refugees.

33. In the South Governorate of Yemen, UNHCR, with UNAIDS and the National AIDS Programme, successfully advocated in 2016 to end mandatory HIV testing of refugees and asylum seekers during asylum procedures, and refugees living with HIV are now able to renew their identity cards. Advocacy was also undertaken to reduce stigma and discrimination in government hospitals and health facilities and to deal with mandatory HIV testing before surgery and during pregnancy. Efforts were also directed at other discriminatory practices, such as the denial of treatment, refusal of admission to hospitals, refusal to operate or assist in clinical procedures, and physical isolation in hospital wards.
34. Advocacy to end the practice of mandatory HIV testing of refugees and asylum seekers as part of asylum procedures continued in four countries in the Middle East and North Africa.

**UNHCR 2016 expenditure**

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	1 868 000	18 928 600	20 796 600
SRA 5: Gender inequality and gender-based violence	360 000	7 327 200	7 687 200
SRA 6: Human rights, stigma and discrimination	222 000	4 274 200	4 496 200
<b>Grand total</b>	<b>2 450 000</b>	<b>30 530 000</b>	<b>32 980 000</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	351 000	0%	1 740 954	0%
AP	176 250	70%	1 868 110	22%
EECA	-	0%	503 717	35%
ESA	952 600	100%	12 960 076	98%
LAC	-	0%	203 489	33%
MENA	341 150	0%	5 192 618	1%
WCA	629 000	78%	8 061 035	56%
<b>Grand total</b>	<b>2 450 000</b>		<b>30 530 000</b>	

## 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.

### Innovative testing strategies

35. With UNICEF support, lessons learned from best practices in paediatric index case testing (providing HIV testing to children in a family where a father or mother has been found to be HIV-positive) in six countries in West and central Africa (Cameroon, Chad, Côte d'Ivoire, DRC, Nigeria and Togo) were shared across the region, including via a webinar organized with a Kenyan research team.
36. Operational research on the effectiveness of a family-centred approach in identifying children and linking them to paediatric HIV services was conducted in the DRC. Preliminary results indicate a need for increased interventions and investment to boost awareness and demand, improve uptake of services and retain more children in care. Providers were found to lack counselling skills when disclosing HIV status to children. Also emphasized was the importance of fathers/male guardians knowing their children's HIV status and supporting their lifelong care.
37. In East Asia and Pacific, UNICEF developed guidelines and programme documents, as well as advocacy and communication, to help adolescents access HIV testing and counselling services. Those efforts included a district municipality services manual jointly developed with UNFPA in Cambodia and the protocol for proxy consent for social workers in the Philippines. In China, UNICEF supported a youth-led HIV testing campaign, which reached 20 000 adolescents in one week.

### Access to treatment cascade

38. In West and central Africa, UNICEF designed a monitoring and evaluation framework to introduce longitudinal monitoring (data on the same subject gathered repeatedly) and evaluation tools for paediatric HIV treatment in four countries (Central African Republic, Chad, Côte d'Ivoire and Togo), in line with WHO's 2015 strategic HIV guide. Additional funds were mobilized to implement the tools.
39. In eastern and southern Africa, UNICEF provided technical and programming support to Ethiopia, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe to introduce point-of-care diagnostics, including developing an implementation toolkit for countries, facilitating developing country exchanges and learning, and reviewing Kenya's national point-of-care plan.

40. In Malawi, UNICEF worked with WHO to develop a national paediatric/adolescent HIV road map. This followed on a bottleneck analysis and data abstraction exercise (where a particular body of data is reduced to a simplified representation of the whole) done in 2016 under the “All In” initiative, a partnership for reaching adolescents with specific HIV services. The framework will guide the implementation of interventions that aim to reduce new HIV infections and accelerate access to care and treatment for children and adolescents.

#### **90–90–90 for children and adolescents**

41. In order to strengthen knowledge on delivering effective HIV paediatric services, UNICEF supported operational research on the family-centred approach to improving the treatment cascade, or the care continuum, in the DRC. Findings will inform scale-up in other West and central African countries.
42. A treatment literacy guide on prevention and treatment of HIV in pregnant women, mothers and children was disseminated in collaboration with the International Community of Women Living with HIV and the global Inter-Agency Task Team. It will equip community health and social workers and parents with knowledge and skills to promote healthy behaviours, dignity and HIV prevention interventions for women and their children. Three Fast-Track countries for child survival (Cameroon, Côte d’Ivoire and Nigeria) began implementing paediatric and adolescent HIV case-finding models, including effective, timely links to treatment. UNICEF helped the Nigerian state of Adamawa pilot the HIV/tuberculosis (TB) screening tool as part of the adapted integrated community case management of childhood illness guidelines and tools.

#### **HIV services in high-burden cities**

43. In East Asia and Pacific, UNICEF engaged in advocacy and with new partners. A five-year work plan with Government and civil society organizations in China addressed HIV prevention, treatment and care for high-risk adolescents, including service gaps, capacity building, and legal, policy and social environments.
44. UNICEF generated data and provided technical support for the second phase of the “All In” age- and gender-disaggregated data assessment to strengthen national and subnational evidence-informed planning. UNICEF Pacific supported the Solomon Islands in rolling out second-generation sentinel surveillance for HIV and syphilis. The new system provides strategic information to meet global reporting obligations and help guide the HIV and STI programme.

#### **HIV services in humanitarian emergencies**

45. Building on its strong procurement, supply and emergency capacity, UNICEF ensured the continuity of ART services, gender-based violence prevention and care of pregnant women and mothers in humanitarian and fragile settings. Maintaining its advocacy and technical assistance, UNICEF in West and central Africa kept HIV high on the agenda in existing and emerging regional emergency programmes, and provided input to a number of reference documents.
46. UNICEF, through its regional technical support in eastern and southern Africa, guided the country offices in Lesotho, Mozambique, Namibia, Swaziland and Zimbabwe to improve monitoring of the impact of drought on HIV prevention and treatment, bolster

ART adherence and retention strategies, improve case finding by testing children at nutrition treatment centres, and enhance prevention for adolescents in high-burden drought-affected areas. UNICEF mobilized funding to support work in Mozambique and Zimbabwe, and provided technical assistance via a joint HIV and nutrition mission to Lesotho to improve monitoring and programming during a drought.

### **Medicines and commodities**

47. Technical guidance and expanded partnerships at global and regional levels were used to provide seven countries (Ethiopia, Kenya, Malawi, Mozambique, Uganda, United Republic of Tanzania and Zimbabwe) with the knowledge and skills to develop a policy and regulatory framework to integrate the point-of-care HIV diagnostic technology for early infant diagnosis in national HIV laboratory systems. Supported by the global health initiative UNITAID, the point-of-care project has been extended for four years and expanded to include viral load testing. The DRC and Senegal have also joined.
48. Through its procurement services, UNICEF in Ukraine provided timely supplies for HIV treatment, including for PMTCT and paediatric HIV services. Savings from UNICEF's large-quantity procurement allowed the government to reprogramme the emergency fund grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to obtain additional antiretroviral medicines (ARVs) for a total amount of almost US\$ 1.14 million, thereby increasing treatment access for patients. This included ARVs for 3,000 children who previously lacked access to paediatric formulations. UNICEF-procured ARVs also ensured uninterrupted supplies for up to 45 000 patients receiving treatment in Ukraine.

### **Comprehensive eMTCT services**

49. UNICEF in West and central Africa supported five countries (Cameroon, Chad, DRC, Mali and Sierra Leone) to expand decentralization and integrate PMTCT in maternal, newborn and child health programmes, thereby Fast-Tracking effective coverage. With additional funding from Norway and Sweden, the Option B+ project to strengthen facility-community links for access to PMTCT services and retention in care was evaluated in the former province of Katanga in the DRC and Côte d'Ivoire, with findings influencing the roll-out of Option B+.
50. UNICEF supported seven countries (Ethiopia, Kenya, Malawi, Mozambique, Uganda, United Republic of Tanzania, Zimbabwe) to introduce point-of-care diagnostic technology to monitor viral load. Routine viral load tests improve treatment quality for children and adults on ART, and increase access to early infant diagnosis in hard-to-reach areas. With UNICEF guidance and policy advocacy, a national forum on eMTCT and paediatric ART was held in Cameroon, while Ghana launched a policy and guidelines review to improve HIV integration in reproductive, maternal, newborn, child and adolescent health services.
51. A unique ID assessment (national patient identifier system) in Cambodia, Lao People's Democratic Republic and Myanmar contributed to a regional community of practice through improved case management and longitudinal reporting across the continuum of care to address loss to follow-up, and over/under reporting. Lessons were learned in adopting sustainable information and communications technology with government buy-ins; a web-based patient management system to be tested and scaled up across



Myanmar will improve HIV care and data management for ART.

52. In support of *Start Free Stay Free AIDS Free*, UNICEF supported several countries in eastern and southern Africa to review programmes and develop plans to move towards eMTCT. UNICEF and WHO conducted a joint mission to Rwanda to support the Government in developing its 2016–2018 eMTCT plan. Remote support was provided to Kenya, Lesotho, Malawi and the United Republic of Tanzania. UNICEF also continued to give technical and programming assistance to Malawi and Uganda to strengthen Option B+ programming, including retaining more pregnant women and mothers living with HIV and their babies in care, through innovative community-facility links, male involvement and longitudinal monitoring. This work will be documented and shared throughout the region during 2017.

### **Combination prevention**

53. UNICEF worked with UNITAID on the provision of pre-exposure prophylaxis (PrEP) for older adolescents who are at substantial risk of HIV infection, through a US\$ 38 million grant for Brazil, South Africa and Thailand. At demonstration sites, service providers were trained in expanding services for adolescent girls and men who have sex with men, and in strengthening prevention among key populations. They were also familiarized with clear guidelines to ensure that PrEP is delivered safely in accordance with the latest global recommendations.
54. UNICEF technical input on generating data led to an HIV biobehavioural survey focusing on adolescents and youth in four countries in South Asia (Bangladesh, Maldives, Nepal and Pakistan) and generated new data in an adolescent assessment and decision-maker tool in Nepal.
55. In UNICEF's Middle East and North Africa region, the "All In" initiative to reach young people in Djibouti, Iran, Morocco, Tunisia and the United Arab Emirates resulted in national strategic frameworks based on the adolescent and HIV situation assessments. Eight countries in West and central Africa (Burkina Faso, Cameroon, Chad, Côte d'Ivoire, DRC, Gabon, Guinea-Bissau and Nigeria) endorsed the initiative in 2016, and rolled out the adolescent assessment and decision-makers tool, part of "All In"'s global toolkit. UNICEF in eastern and southern Africa worked to empower and engage adolescents, especially girls, through the "All In" process. The work entailed pre-consultations and induction sessions to equip leaders of adolescent networks to have air their views in public health forums in the Tanzanian mainland and Zanzibar (with UNFPA and UNAIDS), as well as bottleneck analyses in Namibia (with UNAIDS). Adolescents took part in "All In" processes in Kenya and Rwanda with support from UNICEF country offices.

### **Youth health and education needs**

56. With UNICEF technical and financial support, Youth LEAD, an Asia Pacific network of young key populations, developed the TeenGen leadership curriculum for at-risk adolescents aged 13–17 years. Training is being rolled out during 2017 in priority countries in Asia and the Pacific. In 2016, on Chinese Valentine's Day, UNICEF, UNAIDS and UNFPA partnered with the China Center for Health Education to mobilize youth and community organizations to conduct an online survey, which generated more than 5,700 responses. Findings were analysed and shared via youth networks, informing community action to promote condom use. In addition, more than 140

student volunteer groups provided HIV and SRH education, bringing the safe sex message to 30 000 rural teens and helping dispel myths about HIV.

57. Responding to increasing concern about HIV among adolescents in Mongolia, UNICEF introduced adapted training modules on STIs and HIV prevention, enabling peer educators to reach 4,000 students with key messages. The outreach experience was presented at a regional forum and selected for replication in six provinces with local government support. In Thailand, the joint UNICEF-Path2Health e-platform provided SRH information to more than 20 000 adolescents, and online counselling to 4,600.
58. UNICEF Philippines and various partners rolled out a prevention strategy to improve knowledge, access to testing and condom use among young key affected populations in that country. The strategy formed part of the “All In” initiative and was piloted in Quezon City. It included integrating HIV discussions in grade 8 health classes at four schools, using reference material developed by the national Education Department’s Division of City Schools, the Quezon City Health Department, the Department of Health, UN agencies, civil society and youth groups. Teachers and counsellors received HIV training to reduce their discomfort with discussing certain topics with students. They were also briefed on conducting risk assessments, making referrals for accessing condoms and free HIV testing and counselling.

#### **HIV services for key populations**

59. UNICEF in western and central Africa sustained its technical assistance and advocacy in 2016, and succeeded in positioning the human rights of migrants and asylum seekers high on the agenda of a European Asylum Support Office conference in Malta. Office staff members were sensitized to the issues, based on events and experiences from the West and central Africa region. UNICEF also presented on the practice of child marriage in the region, and its impact on the SRH of girls and migrants. As a result, the research group on asylum seekers from West and central Africa in Europe was made aware of human right issues pertaining to child marriage, its prevalence in western and central Africa (among the highest in the world) and on related vulnerability to HIV.
60. UNICEF, along with the Global Fund, UNAIDS and UNFPA, supported a fifth round of integrated biological and behavioural surveillance (IBBS) in Pakistan. Mapping was completed in 2015, and surveillance and field-team training was conducted in 23 cities in 2016. For the IBBS, the minimum age of respondents was reduced to 13 years to generate data on adolescent key population, and inform evidence-based HIV services.
61. Rapid tests for HIV are being introduced at youth-friendly centres targeting at-risk adolescents in the Islamic Republic of Iran, with support, advocacy and capacity building from UNICEF. A community-based model programme was designed with the Iranian Red Crescent Society for adolescents at higher risk of sexual transmission of HIV associate with the use of amphetamine-type stimulants.

## **Women and girls**

62. In Thailand, UNICEF supported national partners to develop a web-based surveillance system and database to track teenage pregnancy. In western and central Africa, an innovative family-centred approach was included in the national HIV paediatric plans of six countries (Cameroon, Chad, Gabon, Ghana, Liberia and Nigeria) to involve men in the health care of family members, particularly mothers during pregnancy and breastfeeding.

## **Gender-based violence**

63. In 2016, UNICEF, together with the U.S. Centers for Disease Control and Prevention, provided technical support to countries in eastern and southern Africa for national prevalence surveys on violence against children, including analysing links between violence and HIV. In Botswana, voluntary HIV testing was part of the survey. UNICEF provided significant technical assistance for training interviewers and team leaders, and in Uganda, also in the preliminary analysis of results. The survey included oversampling of adolescent girls to correct for bias in the original dataset. Findings will be used as part of an advocacy tool to increase access to prevention and response services related to violence against children, and to make referrals to HIV services.

## **Technological and service delivery innovations**

64. UNICEF used mobile technologies to increase demand for HIV services and to monitor their use. Its “U-Report”, for example, is a groundbreaking social messaging tool that encourages young people globally to speak out on what matters to them. “U-Report” has 2.4 million registered users and is live in more than 25 countries.
65. The use of digital platforms appears to be encouraging young people to engage more openly about sexual health issues. Other projects include Mwana in Zambia and MomConnect in South Africa, as well as mobile health clinics for gay and transgender boys and girls in Brazil, and the HIM project for gay and bisexual adolescent boys in Bangladesh. They are strong examples of how UNICEF’s innovative work has provided the proof of concept that governments need to adopt and scale up effective HIV prevention and treatment for adolescents.
66. In Ukraine, UNICEF supported the development of an online app featuring a virtual reality sexual encounter between two adolescents. It was developed as part of efforts to promote safer sex and HIV testing among adolescents, and led to more than 100 000 requests for information on HIV and/or an HIV test. Lesotho has also used information and communications technology to encourage young people to donate blood and take an HIV test.
67. In India, UNICEF continues to support a virtual paediatric HIV telemedicine initiative (remote diagnosis and treatment), by linking paediatric centres of excellence with peripheral ART centres in Maharashtra and Karnataka states, leveraging government capacity. A proof-of-concept study, carried out with technical support from UNICEF, has shown significant differences in the quality of paediatric HIV care between ART centres that are linked to telemedicine and those that are not linked.

### **HIV-sensitive social protection**

68. In an effort to guide dialogue on HIV-sensitive social protection, UNICEF in eastern and southern Africa has collaborated with the University of Oxford in England to produce six policy briefs on social protection outcomes for children infected and affected by HIV.
69. On social protection programming, UNICEF's work in eastern and southern Africa helped strengthen inclusive, HIV-sensitive systems in Malawi, Mozambique, Zambia and Zimbabwe. In East Asia and the Pacific, the UNICEF regional office supported multisectoral visits in Indonesia to monitor the implementation of HIV law and a national action plan for children affected by AIDS, with a focus on education. Recommendations addressed inadequate sectoral coordination, inconsistent data and limited awareness of HIV law, and the need for inclusive education for affected children.

## UNICEF 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	971 164	40 206 309	41 177 473
SRA 2: Elimination of mother-to-child transmission	934 401	11 320 489	12 254 890
SRA 3: HIV prevention among young people	962 271	11 993 531	12 955 802
SRA 4: HIV prevention among key populations	822 158	8 239 969	9 062 127
SRA 5: Gender inequality and gender-based violence	262 437	148 579	411 016
SRA 7: Investment and efficiency	109 349	2 149 041	2 258 390
SRA 8: HIV and health services integration	437 395	19 551 084	19 988 479
<b>Grand total</b>	<b>4 499 175</b>	<b>93 609 002</b>	<b>98 108 177</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	1 698 111	0%	8 336 136	0%
AP	527 184	46%	6 767 038	46%
EECA	274 811	30%	3 182 031	30%
ESA	861 885	66%	42 143 078	80%
LAC	332 208	0%	708 657	41%
MENA	174 083	34%	2 240 472	34%
WCA	630 893	57%	30 231 589	57%
<b>Grand total</b>	<b>4 499 175</b>		<b>93 609 002</b>	

## World Food Programme (WFP)

WFP is the largest humanitarian agency tackling hunger worldwide. It has almost 14 000 staff who reach approximately 80 million people with food assistance each year. WFP supports national and regional efforts to ensure food security for all, including the poorest and most vulnerable children, women and men. It works with a range of partners, including Governments, United Nations agencies, nongovernmental and international organizations, civil society and the private sector. As a UNAIDS Cosponsor, WFP shares the vision of achieving zero new HIV infections, zero discrimination and zero AIDS-related deaths. WFP's HIV work is focused on linking food and health systems for impact on AIDS outcomes. WFP maintains a holistic approach to HIV programming, leveraging multiple context-appropriate entry points, including food and nutrition support, social safety nets, technical support to governments and national partners, school meals, and supply chain and logistics support services. WFP is also mandated to co-lead in addressing HIV in humanitarian emergencies with UNHCR.

### Access to treatment cascade

70. In 2016, WFP's HIV work continued to focus on linking food and health systems, providing food assistance for improved health outcomes such as nutritional recovery for malnourished people living with HIV and TB, retention in care programmes and treatment success. Its support comes via integrating food security in national AIDS plans, technical assistance, advocacy and communication, partnerships, and capacity building and implementation.
71. In 2016, WFP provided technical assistance to several governments to integrate food and nutrition services in the HIV response, including through developing national guidelines on nutrition assessment, counselling and support; analysing nutrition among people living with HIV with baseline survey (food security and vulnerability assessment) results; and training health staff on nutrition assessment, counselling and support (NACS). The countries included Burundi, DRC, Ethiopia, Ghana, Guinea, Kenya, Myanmar, Rwanda, Sierra Leone, South Sudan, Swaziland, Tajikistan and Uganda. WFP also implemented its food-by-prescription programmes (providing food for malnourished people to retain them in drug therapy) in Cameroon, Central African Republic and Swaziland.
72. WFP advocates for integrating HIV testing in food security support services. For example, in Liberia in late 2016, WFP was designated the Global Fund Sub-Recipient to improve capacity to address the nutritional needs of people living with HIV and/or TB. Providing nutritional support to more than 100 000 people is also expected to increase coverage of HIV testing and counselling. WFP, in partnership with the Zambia Civil Society Scaling Up Nutrition Alliance, examined the barriers that prevent adolescent girls from accessing HIV and nutrition services. Issues identified in the baseline study included poor utilization of testing and counselling services, low condom use, limited youth-friendly services and inadequate behaviour change programmes related to HIV and nutrition. WFP contracted the Alliance, which does not usually serve as an HIV platform, to develop and roll out advocacy activities to address those issues.

### **HIV services in humanitarian emergencies**

73. WFP provided support (including food, cash and vouchers) at individual and household levels to improve access and adherence to HIV treatment. In humanitarian contexts, WFP ensured that food security and related needs, including HIV and TB services, were adequately addressed among displaced, refugee and other emergency-affected populations. In food-insecure contexts, including the DRC, Lesotho and Ukraine, WFP assisted malnourished and/or food-insecure people who were receiving ART. In Côte d'Ivoire, WFP's assistance to more than 6,000 people improved the nutritional status of those who were receiving ART, resulting in treatment adherence estimated at 99%.
74. WFP leads the Inter-Agency Task Team on food, nutrition and HIV, and co-leads with UNHCR the Inter-Agency Task Team on HIV in humanitarian contexts. In 2016, WFP and UNHCR teamed up to address the needs of people living with HIV in EI Niño-affected countries. Substantial global and regional advocacy resulted in a United States President's Emergency Plan for AIDS Relief (PEPFAR) grant of approximately US\$ 22 million to respond to food insecurity in Lesotho, Malawi, Mozambique, Swaziland and Zimbabwe. This work, which continues in 2017, focuses on assessing and treating severe and moderate acute malnutrition in people living with HIV through existing NACS programmes, including nutrition screening and referral in communities, and assessment, counselling and treatment in clinics. Additional elements include supply chain management/procuring specialized nutritious food, technical assistance for health ministries and data collection.

### **Medicines and commodities**

75. WFP worked with Global Fund implementing partners (including UNDP in Zimbabwe and Chad, UNFPA in Yemen, and the Partnership for Supply Chain Management in Burundi) to prevent stock-outs of HIV commodities. Examples of working towards Sustainable Development Goal (SDG) 17, these supply chain partnerships illustrate how WFP's supply chain can be leveraged for HIV and health results. They reflect the "New Way of Working", where partners inside and outside the UN system work towards collective outcomes, and the UN delivers as a single initiative. In 2017, WFP hopes to expand these partnerships to ensure that food, medicines and other necessary commodities reach the most vulnerable populations.

### **Comprehensive eMTCT services**

76. WFP works with partners to integrate food and nutrition support in the PMTCT programmes and maternal, newborn and child health services that are provided to pregnant malnourished women. This is done mainly through technical assistance to governments, including support to develop guidelines and educational materials. In many contexts, WFP focuses its food and nutrition support on pregnant and lactating women, PMTCT clients and children. This can have an improve PMTCT adherence, and support improved health outcomes for newborn babies. In Ethiopia, for example, 96% of PMTCT clients receiving WFP food assistance in 2016 attended all their clinical appointments and 99% of babies were HIV-negative.
77. At global level, WFP is a member of the Child Survival Working Group, one of the sub-working groups of the Inter-Agency Task Team eMTCT. As part of the working group, WFP addresses food- and nutrition-related issues in the context of eMTCT and paediatric HIV treatment, including in humanitarian settings. In Somalia, WFP and

UNICEF jointly held sensitization sessions on PMTCT for partners, including local NGOs, the Ministry of Health, the AIDS Commission and regional TB programmes.

### **Youth health and education needs**

78. WFP contributes to strengthening country capacity to meet the HIV-related health and education needs of young people and adolescents through its school meals and its partnership with UNFPA and UNICEF. WFP's school meals benefit more than 17 million school children annually. In South Sudan, for example, more than 200 000 children were reached through the Food for Education programme in 2016. Children who manage to remain in school longer are less likely to be exposed to violence, alcohol substance abuse, sexual abuse, HIV and STIs, and are less likely to have early sexual debut or become pregnant as teenagers.

### **Technological and service delivery innovations**

79. WFP uses innovative technologies to collect and manage data on its programmes and beneficiaries, and for resource mobilization. SCOPE is the WFP digital management platform, which is used to register beneficiaries, set up interventions, plan distribution, transfer entitlements and report on distribution. WFP is exploring activities for people living with HIV, including the Food by Prescription programme, using SCOPE in Somalia.
80. Mobile vulnerability analysis and mapping is another innovative platform, which is being used in South Sudan, among other countries, to capture data on HIV and TB programme attendance, food deliveries and distribution, and NACS indicators.
81. Through its Share the Meal mobile app, WFP has collected funds for more than 11 million meals since mid-2015, including for school children in Malawi, pregnant and lactating women in Syria, and El Niño-affected school children in Lesotho. People living with HIV are among the most vulnerable in all supported population groups.

### **Decentralization and integration**

82. WFP's core mandate within the Joint Programme is to integrate food security in HIV programming and HIV in humanitarian responses. WFP delivers on those mandates by working with governments to ensure food security support is provided to people living with HIV/TB through national strategies and programmes, and by ensuring that the needs of people living with HIV are considered in all humanitarian responses.
83. In El Niño-affected Lesotho, WFP was instrumental in integrating food and nutrition security, HIV and gender in the vulnerability assessment and analysis performed by the Ministry of Health. This brought together evidence on the effects of drought and food insecurity on people living with HIV and other vulnerable groups, and paved the way for the mobilization of resources from PEPFAR, the United States Agency for International Development (USAID) and the Global Fund. In several countries, including Swaziland, WFP supported health ministries to integrate food and nutrition security into national maternal, newborn and child health services by providing technical assistance and coordinating implementation of NACS services.



### **HIV-sensitive social protection**

84. In 2016, a study by WFP and the London School of Hygiene and Tropical Medicine on the investment returns of food-based interventions for ART patients in eastern and southern Africa, suggested that investment in ending hunger could contribute to improved treatment adherence and retention in care, and to reduced HIV transmission. It also found that investing in HIV and food interventions could enhance the efficiency of HIV treatment and prevention efforts.
85. At country level, WFP empowers people living with HIV through its HIV-sensitive social protection programmes. It assists governments in designing, implementing and evaluating cost-effective food security and nutrition-sensitive safety nets for people living with HIV and other vulnerable populations, including in challenging contexts. For example, in Ethiopia, WFP worked with PEPFAR to provide NACS, social safety nets and economic empowerment services to people living with HIV, orphans and vulnerable children and PMTCT clients. Engagement in economic empowerment activities has proved a robust predictor of improved retention in HIV care, adherence to ART, access to health services and health-related quality of life.
86. In El Niño-affected countries, WFP supports people living with HIV/TB and their families to compensate for the loss of income-earning potential. For example, in Zimbabwe, WFP food assistance reached more than one million beneficiaries, including orphans and vulnerable children and people living with HIV.

## WFP 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	1 075 424	7 500 500	8 575 924
SRA 2: Elimination of mother-to-child transmission	42 845	4 570 000	4 612 845
SRA 3: HIV prevention among young people	59 983	2 500 000	2 559 983
SRA 5: Gender inequality and gender-based violence		465 000	465 000
SRA 7: Investment and efficiency	36 504		36 504
SRA 8: HIV and health services integration	1 397 688	12 721 500	14 119 188
<b>Grand total</b>	<b>2 612 444</b>	<b>27 757 000</b>	<b>30 369 444</b>

**Table 2: Expenditure by region (In US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	754 361	0%	882 500	0%
AP	142 079	38%	1 293 500	25%
EECA	50 161	0%	1 148 500	75%
ESA	790 694	88%	13 886 000	87%
LAC	304 926	0%	109 000	0%
MENA	128 520	0%	692 000	0%
WCA	441 703	23%	9 745 500	0%
<b>Grand total</b>	<b>2 612 444</b>		<b>27 757 000</b>	

## 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.

### HIV testing and treatment

87. At the end of 2016, UNDP was managing 38 Global Fund grants, covering 21 countries, and 4 regional programmes, covering 29 countries. UNDP plays a unique role in the partnership with the Global Fund, supporting programme implementation on an interim basis in a select number of countries that are facing serious capacity constraints, complex emergencies, donor sanctions or other difficulties. The Global Fund resources that are managed by UNDP reflected in the UBRAF are non-flexible and contribute to the achievements of UBRAF outputs at country level, as well as to outcomes and targets in the UNAIDS strategy.
88. The UNDP-Global Fund partnership has saved an estimated 2.5 million lives. Two million people living with HIV are receiving ART through UNDP-managed grants—equivalent to 1 in 6 people on HIV treatment in sub-Saharan Africa. In 2016, 3.5 million people took an HIV test and 714 000 pregnant women were receiving ARVs to prevent MTCT, a 12% increase since 2015.
89. UNDP continues to outperform all other implementers of Global Fund grants combined: 96% of UNDP grants are rated A1, A2 or B1 (i.e. they exceeded expectations, met expectations or were deemed adequate) by the Global Fund, with 70% rated A1 or A2 (compared with 38% of grants that receive those ratings for other implementers). UNDP's approach of combining operational strength, capacity development and policy expertise for large-scale health programmes is helping countries achieve SDG 3 and deliver development results.
90. Despite operating in fragile and conflict-affected contexts, UNDP continues to bring a combination of high performance, results and value for money to its partnership with the Global Fund. For example, UNDP achieved significant reductions in the prices of procured HIV medicines, bringing down the cost of the most common treatment combination to US\$ 100 per patient per year in Equatorial Guinea, Haiti, Mali, South Sudan, Zambia and Zimbabwe. This is saving US\$ 25 million that can be used to bring ART to an additional 250 000 people.
91. UNDP works to strengthen the capacity of national counterparts to ensure efficient public health systems and quality services for all. UNDP-managed grants are implemented using national systems, including treatment protocols and quantification,

warehousing and supply chain systems, treatment and prevention services, and national regulatory frameworks. By avoiding parallel structures, UNDP helps develop and sustain public health system capacity.

92. As the co-chair of the Global Fund's working group on challenging operating environments, and by building on experiences and lessons from implementation in fragile, crisis and post-crisis countries, UNDP was instrumental in advancing principles for tailoring Global Fund interventions. This was reflected in a new policy on challenging operating environments adopted in April 2016, which introduced flexibilities for streamlined access to funding, implementation and reporting.
93. In Africa, UNDP supported the African Union Model Law on Medical Product Regulation, which was adopted in 2016 to promote and protect public health. The law seeks to harmonize medicine regulation and share work among countries to ensure faster, more predictable and transparent approval for access to life-saving commodities.
94. In March 2016, UNDP, along with UNAIDS and the UN Economic and Social Commission for Asia and the Pacific (ESCAP), organized a regional consultation on access to affordable medicines, diagnostics and vaccines. Experts discussed initiatives to link health, industrial and trade policies, and their implications for medical technologies.
95. Through policy reform and targeted trainings, UNDP helped strengthen key population services in urban settings and municipal/city action plans in 5 urban entities in the DRC, Ouagadougou in Burkina Faso (with UNAIDS and the community support programme Programme d'Appui au Monde Associatif et Communautaire (PAMAC)), three urban entities in Mozambique, 19 in South Africa (as part of the Joint UN Team on HIV) and 3 in the United Republic of Tanzania (including Njombe, with transnational action research project AMICALL). Technical support was provided to finalize the Islamabad City HIV Act. At a global level, UNDP helped key population umbrella organizations and country missions participate in the Cities Ending the AIDS Epidemic initiative.

#### **HIV prevention among young people**

96. Building on the report of the Global Commission on HIV and the Law, UNDP partnered with the "All In" initiative led by UNICEF and UNAIDS to review age of consent laws in the 25 countries that contribute 80% of all new HIV infections among adolescents. The review is aimed at helping countries improve legal and policy environments for adolescents so that laws are harmonized and reflect the evolving capacity, age and maturity of adolescents, irrespective of sexual orientation or gender identity.

#### **HIV prevention among key populations**

97. UNDP led and supported efforts to:
  - decriminalize consensual same-sex activities in Seychelles, following a legal environment assessment;
  - develop a HIV strategic framework for Zambia focusing on key populations and lesbian, gay, bisexual, transgender and intersex people (LGBTI);
  - increase voluntary testing and work with key populations in the DRC, following

- legal changes and judicial decisions;
  - add lubricants to national health commodities;
  - adopt the national sex worker HIV plan in South Africa;
  - start voluntary testing and counselling of most-at-risk adolescents without parental consent in three Asia Pacific countries;
  - initiate opioid substitution treatment in prison policies and programmes in Malaysia and Viet Nam;
  - adopt harm reduction policies in Cambodia and Thailand;
  - reduce detentions of sex workers in China and Viet Nam;
  - incorporate training at national levels in six Asia Pacific countries; and
  - oppose bills with discriminatory provisions against men who have sex with men in Kazakhstan, Kyrgyzstan and Zambia, and bills against sex work in Kyrgyzstan and Tajikistan.
98. In Africa, UNDP continued to support the Africa Key Population Experts Group, which represents sex workers, gay and other men who have sex with men, people who use drugs, and transgender people. The model framework developed by the group has been adopted by regional bodies such as the East African Community and the Southern African Development Community to shape their strategies, and by key population organizations and other national-level actors to inform the planning, implementation and monitoring of HIV programmes.
99. In Afghanistan, through a partnership with the Global Fund, UNDP helped provide HIV prevention services to populations who traditionally had limited access to health services. The programme reached more than 40 000 gay and other men who have sex with men, and transgender persons with STI diagnosis and treatment, and provided voluntary counselling and testing to almost 10 000 people. UNDP advocacy led to those populations being included in national, integrated HIV bio-behavioural surveillance and the HIV strategy for the first time.

### **Gender inequality and gender-based violence**

100. Gender equality and women's empowerment are key elements of the 2030 Agenda. UNDP strengthened action on gender-based violence and HIV, including through a regional initiative in Latin America and the Caribbean to gather evidence of discrimination against women and girls living with and affected by HIV.
101. In 20 countries, UNDP with WHO provided support to integrate and strengthen national policies for gender-based violence, the harmful use of alcohol and HIV. The collection of evidence on gender-based violence and HIV policy frameworks in Belarus, Botswana, Ghana, Malawi and Sierra Leone led to national policies being adopted or revised to reflect the issues' importance. Sierra Leone, Zambia and Zimbabwe have drafted national alcohol strategies that address the association between alcohol use, HIV transmission, HIV treatment and gender-based violence, while Belarus, Botswana, the DRC, Malawi and Zambia have integrated alcohol use into their Global Fund programmes.
102. UNDP provided technical inputs on key populations and gender to the Global Fund five-year strategy, as well as inputs to the drafting of key performance indicators. It developed two discussion papers on gender and malaria, and on gender and TB, respectively, each of which summarized the evidence base, described the ways in which gender impacts the risk and effects of malaria and TB (including those that

intersect with HIV), and highlighted data and implementation gaps. The papers are intended to support practitioners, civil society and government partners to make an investment case for improved programming. UNDP also developed a toolkit for gender and human rights training, which was piloted in Namibia with the aim to roll it out in other countries.

103. As an interim Global Fund principal recipient, UNDP has supported countries to promote gender equality and empower women and girls. In South Sudan, where conflict regularly leads to displacement and where violence is rife, the UNDP-Global Fund partnership has supported programmes to train health workers to respond to gender-based violence, including referring survivors to services. With UNDP support, Côte d'Ivoire set up a gender desk in 11 police stations to improve prevention and response to gender-based violence. UNDP assessed violence against women and the law in 20 Middle East and North African countries to determine whether they aligned with international standards and were working in practice.

### **Human rights, stigma and discrimination**

104. Several countries conducted legal environment assessments with UNDP support in 2016, including Angola, Botswana, Côte d'Ivoire, Senegal, Sierra Leone, Zambia and Zimbabwe. In Burkina Faso, recommendations from the assessment were developed into a national action plan, which the UN Country Team will use for advocacy to amend the HIV-related law that continues to criminalize HIV transmission.
105. In Bhutan, a multistakeholder dialogue on HIV and the law, organized in partnership with the STI and HIV/AIDS Prevention and Control Programme, and a national legal environment assessment provided recommendations to remove barriers to the HIV response and gender equality. The dialogue and review are informing human rights and gender programming under the national Global Fund programme. In the Lao People's Democratic Republic, a HIV and law dialogue and a legal review, in line with recommendations from the Global Fund concept note, helped to develop the new penal code. In Pakistan, technical support helped formulate the Islamabad Capital Territory HIV and AIDS Prevention, Treatment and Protection Act 2016, which was introduced to Parliament for review.
106. As part of its partnership with the Global Fund in South Asia, UNDP engaged with regional and national human rights institutions on a common action plan to promote and protect human rights for sexual orientation and gender identity. These institutions will report annually on the plan, developed 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). Institutions in Bangladesh and Nepal established dedicated positions to address violations against key populations.
107. In 2016, UNDP collaborated with the International Development Law Organization to support civil society organizations that provide legal aid for people living with HIV and key affected populations. The result was the Middle East Network for Legal Aid, which will support networking and knowledge sharing between national civil society organizations, and build the capacity and quality of their services.
108. Following recommendations by the Global Commission on HIV and the Law, the capacity of 14 district-level registrars of the Ghana Centre for Human Rights and

Administrative Justice—the national human rights body—was strengthened.

109. In the DRC, the capacity of magistrates, lawyers, police, health workers and key population activists (sex workers, LGBTI people) in matters dealing with human rights, HIV and the law was strengthened. As a result of UNDP's work with the judiciary and magistracy, the country reported several judgements on the criminalization of voluntary HIV transmission at the local court of Kalamu, and high courts of Mbuji-Mayi (Kasai-Oriental province) and Goma (North Kivu province).
110. The “Time Has Come” package, developed by UNDP and WHO to reduce stigma and discrimination in health care settings, was included in national HIV training programmes in Bhutan, India, Indonesia, Nepal, Philippines and Timor-Leste. Through national training workshops and local-level follow-up trainings in 12 countries, almost 400 health care providers were instructed in 2016. The rollout of the training was supported through the Multi-Country South Asia Global Fund HIV Programme and the ISEAN-Hivos Multi-Country HIV Programme.

### **Investment and efficiency**

111. UNDP, with research consortium STRIVE, continued to support cross-sectoral co-financing for HIV, health and development synergies in countries. The methodology encourages government departments to pool resources for mutually beneficial structural interventions, leading to more efficient allocation of resources. In late 2016, UNDP agreed to a two-year global project with the Government of Japan to build on previous years' results and implement the cofinancing approach in seven sub-Saharan African countries (Ethiopia, Ghana, Kenya, Malawi, South Africa, United Republic of Tanzania and Zambia). The project focuses on tackling social determinants of health and on increasing universal access to affordable, quality health services through an efficiently financed expansion of social protection schemes. UNDP has secured early results in Malawi (costed, defined expansion of social cash transfers, with UNICEF), the United Republic of Tanzania (costed, defined expansion of the Tanzania Social Action Fund, with World Bank) and South Africa (co-financing included as a strategy in its draft National Strategic Plan 2017–2022 on HIV, TB and STIs).
112. UNDP also strengthened partnerships with STRIVE once again, the Millennium Development Institute and others, addressing tobacco and noncommunicable diseases (NCDs), which led to two global joint programmes that focus on multisectoral governance for health and development (with WHO, and with the WHO Framework Convention Secretariat). UNDP continued its engagement in country missions of the UN Interagency Task Force on NCDs (in Kyrgyzstan, Oman, Paraguay, Turkey, Viet Nam and Zambia), and in the Framework Convention on Tobacco Control needs assessment missions (in Bolivia, Costa Rica, El Salvador and Lebanon).
113. UNDP supports countries on environmentally sustainable systems and practices, and is piloting the use of solar panels in health facilities as part of its Global Fund implementation support. Zambia's main warehouse storing HIV medicines and other essential drugs for more than 800 000 people now benefits from solar power through UNDP support. Also in Zambia, UNDP is scaling up Solar4Health to power 1,000 health facilities, thereby improving access to care. With resources from the Global Fund, UNDP is working on a pilot Solar4Health project in Sudan and Zimbabwe.

## **HIV and health services integration**

114. Building the capacity of workers to respond to country health needs is key to health-system strengthening. Through the UNDP-Global Fund partnership, two million doctors, nurses and community health staff were trained to lead the HIV response.
115. In South Sudan, UNDP is involved in broader efforts to improve health systems, helping to strengthen the capacity of the Government to deliver maternal health services incorporating HIV, benefiting close to 450 000 women. Antenatal care coverage increased from 53% in 2015 to 61% in 2016, an important achievement in a country where a woman has a one-in-seven chance of dying in childbirth.
116. UNDP increased collaboration with the Global Fund to respond to links between infectious and non-infectious diseases. It developed a guidance note on HIV, TB and NCD co-morbidities, which has been piloted in Belarus with the support of the Government, the Global Fund and WHO. UNDP raised the profile of comorbidities at high-level events, including the 2016 UNAIDS PCB and the Prince Mahidol Award Conference 2017, where a UNDP side session on integrated services examined LGBTI access to HIV prevention in Asia.
117. UNDP continued its technical and policy support to the UN system to improve preparedness and responses to health emergencies. Inputs to the Secretary-General's report, strengthening the global health architecture, included proposals on the need for full UN system engagement and resource support.
118. UNDP's HIV and health team sensitized staff working on social protection. UNDP's October 2016 publication, *Leaving no one behind: a social protection primer for practitioners*, examines HIV vulnerability, key populations and health, and the team ensured that HIV-sensitive social protection and cross-sectoral co-financing was included in cash-based programming. This increases the focus on HIV-sensitive social protection in country programming, though resources are needed for follow-up.



## UNDP 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	548 538	1 436 842	1 985 380
SRA 3: HIV prevention among young people	52 115	359 210	411 325
SRA 4: HIV prevention among key populations	737 375	2 514 473	3 251 848
SRA 5: Gender inequality and gender-based violence	781 452	2 394 736	3 176 188
SRA 6: Human rights, stigma and discrimination	1 541 721	2 993 420	4 535 141
SRA 7: Investment and efficiency	259 450	1 317 105	1 576 555
SRA 8: HIV and health services integration	218 221	957 894	1 176 115
<b>Grand total</b>	<b>4 138 872</b>	<b>11 973 681</b>	<b>16 112 553</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	1 173 378	0%	1 380 715	0%
AP	451 919	30%	3 324 876	70%
EECA	486 768	20%	945 274	20%
ESA	1 112 272	80%	3 541 914	90%
LAC	370 757	35%	812 138	20%
MENA	247 172	10%	634 868	25%
WCA	296 606	30%	1 333 896	35%
<b>Grand total</b>	<b>4 138 872</b>		<b>11 973 681</b>	

## UNDP Global Fund grants

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	-	66 092 350	66 092 350
SRA 3: HIV prevention among young people	-	40 672 216	40 672 216
SRA 4: HIV prevention among key populations	-	30 504 162	30 504 162
SRA 5: Gender inequality and gender-based violence	-	26 691 141	26 691 141
SRA 6: Human rights, stigma and discrimination	-	25 420 135	25 420 135
SRA 7: Investment and efficiency	-	7 626 040	7 626 040
SRA 8: HIV and health services integration	-	38 130 202	38 130 202
<b>Grand total</b>	-	<b>235 136 246</b>	<b>235 136 246</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	-	0%	1 020 893	
AP	-	0%	7 190 611	0%
EECA	-	0%	17 238 921	0%
ESA	-	0%	170 917 544	100%
LAC	-	0%	11 700 435	50%
MENA	-	0%	13 309 489	28%
WCA	-	0%	13 758 354	100%
<b>Grand total</b>	-		<b>235 136 246</b>	

## 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. Working on the ground in some 150 countries, UNFPA expands the possibilities for women and young people to lead healthy and productive lives.

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

### Medicines and commodities

119. Through improved forecasting and planning, and work with suppliers, UNFPA guarantees the best price for commodities. It manages the prequalification of condoms with WHO, and publishes the list of prequalified manufacturers of male and female condoms, which Member States and procurers use to buy international standard condoms. In 2016, UNFPA prequalified 30 male and 4 female condom manufacturers, compared with 27 male and 2 female in 2015.
120. UNFPA convened a meeting of heads of national authorities responsible for condom regulation and laboratories responsible for testing in 11 African countries. Quality challenges were discussed and a scientific forum was established to promote the use of personal lubricants to prevent condom breakage and discomfort.
121. Improving access to condoms and providing technical and financial assistance to countries remain priorities for UNFPA. In 2016, UNFPA supplied 9.7 million female and 403 million male condoms and 13 million sachets of personal lubricant. It is estimated that UNFPA condom procurement and programming averted almost 190 000 new HIV infections and 8.3 million STIs in 2014–2016.
122. To improve condom availability, UNFPA Johannesburg, with the Botswana Country Office, conducted a tour to a manufacturer in Gaborone, which has since been connected to UNFPA's procurement service branch for possible entry into the prequalification programme. Efforts to prequalify a South African-based manufacturing company are well-advanced.
123. UNFPA's East and Southern Africa Regional Office commissioned a multicountry, total market approach study to better differentiate commodity supplies, including: free-to-user public sector condoms for socially excluded urban and rural poor; socially marketed and other subsidized condoms for populations who can afford cost-sharing; and commercial condoms for those who can afford higher prices.
124. In Mozambique, UNFPA remained one of the largest contributors of contraceptives in the country, procuring 56% of contraceptives required, including condoms, in 2016. The contribution of the state budget to contraceptive needs increased from 3% in 2015 to 9.5% in 2016 due to advocacy from UNFPA.

### **Comprehensive eMTCT services**

125. UNFPA supported a range of interventions to strengthen SRH services within Global Fund proposals and their implementation in 14 priority countries towards eliminating mother-to-child transmission. These interventions address family planning, condom programming and STI management, including eliminating neonatal syphilis. UNFPA provided input to the Global Fund technical brief on reproductive, maternal, newborn, child and adolescent health, ensuring a comprehensive approach that includes eMTCT services. It completed a tool for professionals for delivering comprehensive PMTCT services, covering the four prongs, and helped revise delivery guidance for HIV services.
126. Midwives are crucial to PMTCT services such as testing, counselling and contraception. As a partner in Uganda's midwifery programme, UNFPA helped recruit 90 midwives in 30 hard-to-reach districts, supported training for 50 midwives who were recruited through a district bonding system and for 20 tutors, and developed the capacity of 18 institutions to train midwives to international standards. Skilled birth attendance and numbers of new family planning users have increased in 25 supported districts.

### **Combination prevention**

127. UNFPA remained on course to increase access to sexual and reproductive health and rights (SRHR), especially for women and young people. An evaluation of its support from 2008 to 2015 found that UNFPA had helped increase the availability of SRH services for adolescents and young people. In 2014–2016, 33.4 million adolescents were provided with integrated SRH services, and more than 16 million women and girls in humanitarian crises were reached with SRH services and services to prevent gender-based violence. Training in health and education sectors, strengthening adolescent and youth-friendly services, empowering young people and engaging communities, including faith-based ones, are common actions in programme countries.
128. In 2016, more than 150 000 young people benefited from UNFPA-supported mobile health clinics in Myanmar, Nigeria, South Africa and Uganda. In eastern and southern Africa, through the Safeguard Young People programme, UNFPA reached half a million young people in eight countries with social and behaviour change communication and comprehensive sexuality education (CSE) programmes, including 811 000 out-of-school young people. Almost 350 000 received adolescent SRH services and 37 million condoms were distributed. Seven countries now have maps identifying clinics, schools and hot spots of young populations. UNFPA supported the youth programme for the 2016 International AIDS Conference. More than 200 young people from 26 countries attended the pre-conference, where they received information on CSE and SRH laws and policies. UNFPA, working with the University of Pretoria, analysed laws and policies affecting adolescent SRHR, with the aim to harmonize legislation in 23 eastern and southern African countries.
129. In 2016, TuneMe, a youth engagement platform that helps young people access adolescent SRHR information, was launched in Botswana, Malawi, Namibia, Swaziland and Zimbabwe. In Swaziland, UNFPA supported community-based SRH clubs under the Girls Leading Our World and Brothers Reaching Out initiatives to reach greater numbers of adolescents and youth. In Viet Nam, UNFPA and the Youth Union supported six youth-led initiatives to deliver information on SRH and HIV.

130. UNFPA supported the inclusion of a range of interventions to strengthen SRH services within Global Fund proposals, including condom programming and managing STIs, and provided technical inputs to the Global Fund Adolescent Action Plan, ensuring a comprehensive approach to adolescent SRH services.
131. To increase the number of male and female condoms in low- and middle-income countries to 20 billion by 2020 and meet the High-Level Meeting target, UNFPA and the Reproductive Health Supplies Coalition continued work with more than 70 condom manufacturers, public sector donors, representatives of government, NGOs and multilateral organizations, which together formed a multisector coalition, the Africa Beyond Condom Donation. Progress included market and willingness-to-pay studies and country high-level consultations. Support for condom programming continued in 59 countries via assessments, updated national strategies, coordination mechanisms, procurement and awareness campaigns such as “CONDOMIZE!”.

### **Youth health and education needs**

132. In Asia and the Pacific, Youth LEAD, founded with UNFPA support but now an independent organization, operates in 19 countries, with a focus on young populations that are at risk of or affected by HIV. The organization is an important example of improved regional capacity to advocate for adolescent and youth priorities as part of development frameworks.
133. UNFPA, the International Planned Parenthood Federation (IPPF) and the key populations project LINKAGES, brought together young panellists from eight countries to discuss their specific needs and challenges. Discussions led to agreed actions to address the unmet needs of young key populations, including: funding for “wrap-around” services (e.g. transportation, food, clothing and health education services); organizing UN partners and youth networks to help document best practices; fostering engagement with young key populations, including as researchers on projects; integrating best practices into LINKAGES; and developing a global strategy. UNFPA and LINKAGES will co-convene a technical advisory group to coordinate work.
134. In Botswana, UNFPA advocated for adolescents, young people and key populations such as female sex workers and men who have sex with men to be included as candidates for PrEP in HIV clinical care guidelines.
135. Building on the 2015 results and updated global guidance for adolescent SRH services, a draft programming document on HIV and SRHR of young key populations in eastern Europe and central Asia was developed to aid programming in nine countries and stimulate similar activities in the region and beyond. The Y-PEER youth education network continued to be an important vehicle to share information with youth and bring together communities, fostering open discussions on CSE.
136. CSE was supported across programme countries, with the goal to safeguard the health and well-being of adolescents and youth. At global level, a CSE Advocacy Hub shares online tools and promotes inclusion of young people, especially those who are most marginalized, in social movements and high-level platforms. In ESA, iCAN CSE resources were finalized with the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), for young people living with HIV and out-of-school youth. The resources were adapted in Lesotho, Namibia and Zambia. In Cambodia, a

draft health education syllabus that includes CSE is undergoing ministerial review, and the multimedia initiative Love9 reached 1.7 million youth, increasing knowledge on HIV/STIs, contraceptives and on where to access health services.

137. In Nigeria, the web-based Global Mobile Project, “DaSubjectMatter”, is being implemented by Planned Parenthood Federation Global and with support from UNFPA. It uses mobile technology and social media to reach adolescents and youth with SRH information, linking them to trained providers for friendly, high-quality services in public and private facilities across 12 states.

### **HIV services for key populations**

138. Since 2014, UNFPA has supported and built the capacity of sex worker-led civil society organizations in 47 countries around governance, project management, advocacy and the provision of HIV and STI services for sex workers. Examples in 2016 included technical help to train trainers from 8 African countries on condom programming with the Sex Worker Academy Africa, and a similar model in Indonesia for sex worker trainers. UNFPA supported HIV/STI programmes working with migrant and cross-border sex workers, and mobile clients in China, Kenya and Ukraine, among others. In 2016, 54 UNFPA Country Offices reported applying the implementation phase (working group, situation analysis, national integrated strategy, costed operational plan) of condom programming.
139. Capacity to use implementation tools for sex workers and for gay and other men who have sex with men was strengthened in 15 UNFPA field offices in eastern and southern Africa. In Kenya, an integrated package of HIV and SRH care for sex workers and their clients enabled more than 4,500 female sex workers and 500 clients to access services in Kilifi County. More than 1 million male condoms, 10 000 female condoms and 14 000 lubricant sachets were distributed. In Uganda, key population HIV and SRH services were developed through the Fast-Track Cities initiative, with 60 000 members of key population groups accessing them. Reduced harassment enabled sex workers to access HIV services more easily. Sensitization of police officers in Malawi reduced wrongful arrests of sex workers by 80% in 2016 compared with 2015 levels. In Harare, a 24-hour clinic provides integrated services for sex workers and other key populations who have experienced sexual assault and other violence. UNFPA’s partnership with CSO LeGaBiBo (Lesbians, Gays and Bisexuals of Botswana) linked key populations to care through friendly health facilities.
140. In eastern Europe and central Asia, UNFPA continued to strengthen capacities of key population organizations, including sex worker and gay and other men who have sex with men network organizations, SWAN and ECOM, as well as the Eurasian Women’s Network on AIDS. UNFPA supported ECOM’s successful Global Fund regional proposal. It also helped translate the gay and other men who have sex with men implementation tool (MSMIT) into Russian and (along with the sex worker tool, SWIT) into Georgian, Kyrgyz, Tajik, Turkish and Macedonian. Copies were circulated to in-country partners and training was provided to enable organizations to use the tools. Simplified versions are increasing the training of service providers in Georgia and Kyrgyzstan. In Latin America, UNFPA Ecuador built the capacity of six sex worker organizations.

141. In Sudan, UNFPA helped train 150 NGO staff members in SWIT and MSMIT. These outreach and peer educators reached 62 000 sex workers and 47 650 gay and other men who have sex with men, of who 10 556 and 6,337 received HIV testing services, respectively. UNFPA helped Sierra Leone distribute condoms for sex workers and for gay and other men who have sex with men, and undertook an economic empowerment programme for sex workers to increase their livelihood options. In Togo, peer educators and mobile outreach staff delivered SRHR to sex workers.
142. In Asia and the Pacific, an online information-sharing resource for key populations (Connect Effect) was introduced. Several countries empowered sex worker organizations and provided HIV/SRH services. In the Philippines, 3,100 female entertainment workers were reached with family planning services and 1,700 were provided with information on HIV, family planning and gender-based violence. In Pakistan, UNFPA supported HIV-family planning services for sex workers with information for more than 1,000 sex workers and 576 attending SRH clinics. Bangladesh developed HIV/SRH programmes, and in Mongolia, 58 000 mobile persons and 3,000 sex workers were reached with HIV/STI services, activities that contributed to reducing syphilis in sex workers from 30 per 10 000 in 2012 to 10 per 10 000 in 2016.
143. In November 2016, UNFPA, WHO, USAID and IPPF convened the first consultation on personal lubricants. The meeting brought together more than 80 manufacturers, researchers and technical experts, sexual health advocates and educators, and international organizations that procure lubricants. They outlined the broad technical specifications and guidelines for non-toxic, long-lasting, condom-compatible lubricants that are safe and acceptable for all users and sexual practices.
144. By the end of 2016, UNFPA trained and assessed more than 80 personnel to deploy to humanitarian crises as GBV programme specialists, coordinators and information management officers. This investment in surge capacity means UNFPA will be among the first responders to deploy to any crisis.

### **Gender-based violence**

145. With partners, UNFPA continued to roll out the essential services package for responding to gender-based violence and supporting victims through counselling, HIV/STI prophylaxis and testing services. An implementation toolkit was developed, with training in eastern Europe and the Middle East. Global mapping on gender-based violence was published, reviewing the extent of advocacy and policy guidelines, capacity development, knowledge management and service delivery. In Uganda, UNFPA supported social mobilization for preventing and responding to gender-based violence, reaching 2.5 million stakeholders and community members through the SASA! (anti-violence against women) approach, community activists, male action groups, peer educators, cultural and religious leaders and a media campaign.
146. UNFPA strengthened responses to Universal Periodic Review recommendations on gender and SRHR, ensuring protective systems for gender-based violence and protecting victims' rights. In Belarus, UNFPA supported a multisectoral task group to draft a comprehensive law to prevent domestic violence. In Haiti, UNFPA supported the Ministry of Women Affairs create a clearing house for gender-based violence-related data.

147. UNFPA worked with civil society organizations in 47 countries to support programmes that engage men and boys on gender equality, and to promote SRHR. An online tool was published for engaging men and boys in SRH and family planning.
148. UNFPA provided technical inputs to mainstream gender equality in the new Global Fund strategic plan, ensuring a comprehensive approach to gender inequalities and reducing the vulnerability of women and girls to HIV. UNFPA also supported the inclusion of interventions to strengthen SRH services within Global Fund proposals, including those that aim to prevent and respond to gender-based violence.

#### **HIV health care discrimination eliminated**

149. UNFPA provided inputs to the United Nations Development Group Frontier Dialogue on ending HIV-related discrimination in health care settings, led by the UNAIDS Secretariat and WHO. The dialogue resulted in recommendations for UN agencies to work together to sensitize health care providers and increase acceptance in health care settings of people living with HIV and key populations.
150. UNFPA updated the “In Reach” training materials to sensitize UN country teams to support and work with key populations who are at risk of HIV infection. Updates included normative guidance and their adaptation for national-level roll out, planned for 2017.

#### **Efficiency and effectiveness of the HIV response**

151. In 2016, a UNFPA-commissioned study on male condom use to prevent unwanted pregnancy and transmission of STIs, including HIV, examined the health impact of investment in condoms, scale-up costs and cost-effectiveness based on three scenarios for 81 countries during 2015–2030. An annual gap between current and desired use of 10.9 billion condoms was identified. The research found that meeting all demand for condom use would have a large health impact by preventing unintended pregnancy, HIV and other STIs: 90% condom use among high-risk groups over 15 years could avert 17 million HIV infections, 420 million unintended pregnancies and 700 million STIs.

#### **Decentralization and integration**

152. In 2016, UNFPA continued to provide technical and financial support to regions and countries to integrate and link policy, programmes, services and advocacy between SRH and HIV. The goal is to join SRH and HIV services or operational programmes to maximize collective outcomes. UNFPA expanded work with 10 eastern and southern African countries to provide integrated SRH, gender-based violence, HIV and STI services, including HIV test and treat referral.
153. UNFPA supported 13 countries to compile infographic snapshots that detail SRH and HIV links through 150 indicators, nine of which have been endorsed thus far by countries. An additional 25 snapshots are being drafted, mostly in sub-Saharan Africa.



## UNFPA 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	133 068	244 834	377 902
SRA 2: Elimination of mother-to-child transmission	37 556	550 783	588 339
SRA 3: HIV prevention among young people	2 814 823	17 061 431	19 876 254
SRA 4: HIV prevention among key populations	1 563 328	5 899 464	7 462 792
SRA 5: Gender inequality and gender-based violence	41 254	2 378 728	2 419 982
SRA 6: Human rights, stigma and discrimination	323 907	521 766	845 673
SRA 7: Investment and efficiency		531 840	531 840
SRA 8: HIV and health services integration	341 237	7 464 088	7 805 325
<b>Grand total</b>	<b>5 255 173</b>	<b>34 652 934</b>	<b>39 908 107</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	1 756 240	0%	12 094 085	0%
AP	520 312	33%	1 502 492	68%
EECA	765 497	7%	1 108 897	5%
ESA	988 639	64%	13 020 315	69%
LAC	467 577	43%	1 963 495	1%
MENA	209 088	0%	3 952 715	0%
WCA	547 820	46%	1 010 935	15%
<b>Grand total</b>	<b>5 255 173</b>		<b>34 652 934</b>	

Note: Non-core expenditures may understate contributions, given outstanding country reports. Estimates across UNFPA expenditure suggest under-reporting with a potential total of approximately US\$ 50 million.

## 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.

As a Cosponsor of UNAIDS, UNODC is the convening organization for HIV prevention, treatment, care and support among people who use drugs and people in prisons and other closed settings. UNODC collaborates with national and international partners, including civil society and other UNAIDS Cosponsors, to support countries in developing and implementing interventions that are designed to guarantee that vulnerable and marginalized populations can access optimum HIV services. In addition, UNODC works to ensure that people who use drugs, including young people, women and people living with HIV, are meaningfully involved in programme design and implementation.

### **HIV services for key populations**

154. In 2016, UNODC advocated for increased investment in prison health care and better collaboration between public health, criminal justice, prison administration and civil society organizations to ensure public health and human rights-based approaches to HIV in prisons, and engaged with national and international partners; for example, at the 25th Commission on Crime Prevention and Criminal Justice and the International AIDS Conference (AIDS 2016).
155. Member States, CSOs and other partners received assistance to develop and adopt HIV strategies and programmes in line with the joint UNDP, UNODC, ILO, WHO and UNAIDS policy brief on HIV prevention, treatment and care in prisons and other closed settings. With UNODC support, Namibia launched a health policy for prisoners, in Viet Nam the first prison methadone maintenance therapy service unit was opened, and the policy brief's 15 key interventions were included in Nepal's standard operating procedures on HIV in prisons.
156. UNODC provided technical input for Harm Reduction International's human rights-based tool to prevent ill treatment in prisons, and in collaboration with the African Correctional Services Association and the African HIV in Prisons Partnership Network, helped countries use the revised United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).
157. In line with international recommendations, UNODC built the capacity of health care providers to supply quality HIV services in prisons. For example, working with the International Committee of the Red Cross in the Middle East and North Africa, UNODC co-facilitated two regional workshops on health in detention for senior prison managers and doctors.

158. UNODC helped CSOs provide technical assistance for implementing and scaling up evidence-based HIV prevention, treatment and care for people who use drugs and in prison settings. Within its work through the UNODC-CSO Group on Drug Use and HIV, UNODC supported further expansion by engaging regional networks of people who use drugs in central and eastern Europe and central Asia (Eurasian network), Europe, Asia, North America, South Africa and East Africa.
159. UNODC disseminated the results of literature reviews on HIV and the use of amphetamine-type stimulants, HIV and cocaine use, and HIV and new psychoactive substance use, including through the *World drug report 2016*, and presentations at the 59th session of the Commission on Narcotic Drugs (March 2016), the UN General Assembly special session (UNGASS) on the world drug problem (April 2016) and the UN General Assembly High-Level Meeting (HLM) on Ending AIDS (June 2016).

### **Harm reduction package for people who inject drugs**

160. UNODC promoted opportunities for stakeholders to contribute to the preparatory process for UNGASS 2016 by sharing practical expertise and experiences from their work among people who inject drugs as an input for consideration in the negotiations of the UNGASS outcome document.
161. The second consultation on science addressing drugs and HIV was organized by UNODC in the margins of the 59th Commission on Narcotic Drugs. A statement, summarizing the latest scientific evidence, was presented at UNGASS 2016 and at the HLM.
162. In 2016, UNODC continued strengthening partnerships between law enforcement and other sectors, CSOs and community-based organizations (CBOs) in UNODC high-priority countries (selected to maximize the impact of UNODC investments on HIV among people who inject drugs). Some 400 law enforcement officers, more than 100 CSO and CBO representatives and 50 professionals from health, education and social sectors from six countries (Armenia, Belarus, Kazakhstan, Tajikistan, Ukraine and Uzbekistan) received training to build knowledge and skills, helping them interact with people who inject drugs, use police referral services as an alternative to incarceration, and understand the workplace risk of HIV faced by law enforcement officials.
163. Working with the Law Enforcement and HIV Network and the International Network of People Who Use Drugs, UNODC produced a [guide](#) to promote cooperation between CSOs working among people who use drugs and law enforcement officials. The guide will help CSOs and other partners work with the police and law enforcement authorities and increase their advocacy skills to enhance access and uptake of services by people who inject drugs/people who use drugs.
164. Through the joint UNODC-CSO Group on Drug Use and HIV, efforts were focused on implementing and scaling up evidence-based HIV prevention, treatment and care for people who inject drugs. Despite the unexpected shortfall in core UBRAF funding as of mid-2016, UNODC supported more than 80 CSOs worldwide. In Viet Nam, for example, workshops on partnership building and community/home-based care for people who use drugs were held, and in South Africa, CSOs were engaged in developing a national drug control master plan.

165. UNODC produced a [guidance document](#) on the specific needs of women who inject drugs, working in partnership with the International Network of Women Who Use Drugs, Women Harm Reduction International Network and the Eurasian Harm Reduction Network. The document, offering practical help for service providers on gender-responsive HIV services, was officially launched at the International AIDS Conference. Also at AIDS 2016, UNODC, with the International Network of Women Who Use Drugs, organized a capacity-building workshop on mainstreaming gender into services for people who inject drugs, which was attended by more than 100 participants.

## UNODC 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment		214 483	214 483
SRA 3: HIV prevention among young people		107 242	107 242
SRA 4: HIV prevention among key populations	3 107 551	4 343 298	7 450 849
SRA 5: Gender inequality and gender-based violence		160 863	160 863
SRA 6: Human rights, stigma and discrimination		536 210	536 210
<b>Grand total</b>	<b>3 107 551</b>	<b>5 362 096</b>	<b>8 469 647</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	862 500		405 927	0%
AP	717 984	89%	276 638	47%
EECA	265 670	18%	846 388	75%
ESA	536 610	100%	3 585 875	100%
LAC	242 989	52%	49 772	59%
MENA	308 159	15%	197 496	0%
WCA	173 639	100%		0%
<b>Grand total</b>	<b>3 107 551</b>		<b>5 362 096</b>	

## United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

Created in July 2010, 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 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 11th Cosponsor of UNAIDS, an important step towards ensuring that gender equality is at the heart of global action on HIV.

### Access to treatment cascade

166. The UN Women-commissioned global review, *Key barriers to women's access to HIV treatment*, presenting its findings and recommendations at the International AIDS Conference (AIDS 2016) during a session in the Women's Networking Zone. Work was guided by a global reference group of 14 women living with HIV and comprised a literature review, quantitative and qualitative data collection and analysis through community dialogues, and country case studies. The review engaged more than 200 women living with HIV from 17 countries. Results revealed gaps in sex-disaggregated data collection and persistent gender-related barriers in women's treatment access and adherence through their lives. At the micro-level, these included fear of violence, stigma and discrimination and low treatment literacy; at the meso-level, lack of access or control over resources and care responsibilities, fear of disclosure and HIV-related employment rejection or dismissal; and at the macro-level, the impact of punitive laws. Several enablers were also identified, including peer support to enhance access.

### Combination prevention

167. UN Women increased country capacity to meet the HIV-specific needs of young women and girls, supporting young women advocates define a common agenda and participate in HIV policy and programming at global and regional levels. UN Women's Engagement + Empowerment = Equality effort helped build the leadership skills of 1000 young women and adolescent girls, including 250 living with HIV, in Kenya, Malawi and Uganda. Through mentoring, capacity building and peer support, young women advocates designed and validated assessments for the All In initiative, a partnership to reach adolescents with HIV services designed for their specific needs. In nine months, the advocates reached thousands of young women through activities, including via social and print media. These young women now feel more confident raising their priorities with community leaders and decision-makers.
168. More than 3,000 young women and girls across six countries (Cameroon, China, Liberia, Mozambique, Republic of Moldova and Sierra Leone) improved their advocacy skills and knowledge on gender equality, HIV and gender-based violence through UN Women-facilitated interactive debates, comics and TED Talks (spreading ideas, usually through short, powerful talks), among other initiatives. Many continue advocacy and outreach with their contemporaries to prevent HIV and gender-based violence. For

example, an adolescent girl champion from Sierra Leone addressed the launch of the African Union campaign to end child marriage.

### **Youth health and education needs**

169. UN Women facilitated opportunities for young women and adolescent girls to take part in intergovernmental processes, including the 60th session of the Commission on the Status of Women (CSW) and in developing the 2016 Political Declaration on Ending AIDS. With UN Women support, young women advocates, including those living with HIV, engaged in the first CSW Youth Forum. In the forum's youth-agreed conclusions, advocates succeeded in highlighting the need to secure spaces to engage and organize young women living with HIV, to end gender-based violence fuelling HIV, remove discriminatory laws on HIV transmission, and eliminate discrimination in health care settings, particularly forced and coerced sterilization.
170. Through UN Women support at AIDS 2016, young advocates called for action to end early marriages and gender-based discrimination in health care settings, and promote meaningful participation of young women living with HIV. As a result of UN Women support, 19 young leaders working on HIV—more than half of them women—took part in the Women Deliver 4th Global Conference, and raised the priorities of young women in the HIV response.

### **HIV services for key populations**

171. Women who use drugs and are living with HIV influenced global agenda-setting and advocacy forums thanks to UN Women. At research institute RTI International's conference on ending gender inequalities, women from Indonesia, Kenya, Uganda and Ukraine echoed the global call to scale up evidence-based interventions, advocacy and funding to address the intersecting issues of HIV, drug use and violence.

### **Harm reduction package for people who inject drugs**

172. UN Women enhanced the leadership skills of women who use drugs, including those living with HIV, to take part in national HIV responses. UN Women strengthened capacity of the Asian Network of People who Use Drugs to design and implement gender-transformative HIV programming. In the United Republic of Tanzania, UN Women advocated for a woman who used drugs to be appointed to the harm-reduction committee in Temeke District Council to ensure the needs of these women are integrated into local planning and programming.

### **Women and girls**

173. UN Women investment in Egypt, Kyrgyzstan, Morocco and the State of Palestine built evidence on the impact of harmful gender norms, particularly on women's health and vulnerability to HIV, to inform HIV planning and programming. The UN Trust Fund to End Violence against Women supported implementing SASA! in Haiti, Kenya and the United Republic of Tanzania. A community mobilization approach, SASA! was developed by Ugandan nonprofit organization Raising Voices for preventing violence against women—a core driver of HIV—by addressing the imbalance of power between men and women, and boys and girls.
174. To shape more gender-transformative national HIV responses, UN Women supported

the design of strategies and monitoring and evaluation frameworks, and facilitated engaging women living with HIV in these processes in eight countries (China, Kazakhstan, Morocco, Sierra Leone, South Africa, Tajikistan, Uganda and Ukraine). UN Women's support to the Tanzania Commission for AIDS led to a 2016–2018 HIV and AIDS Gender Operational Plan being adopted, which has received funding from domestic and other sources. With UN Women assistance, Morocco's 2017–2021 national AIDS strategy focuses on violence and HIV intersections, prevention, access to information and treatment for women, and promoting the rights of women living with HIV. In Uganda, work by UN Women led to a dashboard, improving gender-sensitive monitoring of the HIV response.

175. Support for national AIDS coordinating authorities in nine countries (Cambodia, Cameroon, China, Malawi, Morocco, Nigeria, South Africa, the United Republic of Tanzania and Ukraine) led to gender-sensitive HIV planning and institutions. In China and the United Republic of Tanzania, for example, as a result of UN Women backing, local AIDS councils collaborated with rural women living with HIV groups so their priorities inform responses. Technical support to the South African National AIDS Council Women's Sector ensured that a draft of the 2017–2022 strategic plan integrates action on gender inequalities and new infections among young women and girls.
176. UN Women invested in capacity strengthening of women living with HIV, thereby involving them in responses at national, regional and global levels. A meeting of global experts, led by UN Women, on putting gender justice at the centre of the Fast-Track response, agreed to ensure gender equality and HIV was prioritized in the High-Level Meeting on HIV/AIDS and the Commission on the Status of Women, and beyond. UN Women has backed the Women's Networking Zone since its inception and provided support during AIDS 2016, increasing the visibility of women's organizations and providing space for advocacy for greater accountability, funding and implementation to advance priorities.
177. Investment in institutional capacity of women living with HIV networks resulted in improved access to decision-making in 12 countries (Cameroon, China, Indonesia, Kazakhstan, Mozambique, Republic of Moldova, Rwanda, Senegal, Tajikistan, Thailand, Viet Nam and Ukraine). UN Women supported the feminist leadership school of the International Community of Women Living with HIV to support women in China, Indonesia, Thailand and Viet Nam to engage more effectively in national responses, Convention on the Elimination of all forms of Discrimination against Women (CEDAW) reporting and Global Fund concept note development. In Ukraine, UN Women built a cadre of 50 women activists living with HIV, with some becoming deputy chairs and members of local coordinating councils on HIV and TB.

### **Gender-based violence**

178. Work by UN Women generated evidence in 13 countries on how gender-based violence is linked to an increased HIV risk (Brazil, China, Côte d'Ivoire, Egypt, Indonesia, Jamaica, Kyrgyzstan, Morocco, Paraguay, Republic of Moldova, State of Palestine, Uruguay and Ukraine). This was used to help design and implement national action plans on gender violence and equality strategies. For example, Uruguay adopted a plan on equal opportunities and rights that includes action to eliminate sexual violence as part of HIV prevention efforts emphasizing youth.



179. In 14 countries (Argentina, Cameroon, El Salvador, Kazakhstan, Kyrgyzstan, Malawi, Paraguay, Peru, Republic of Moldova, United Republic of Tanzania, Tunisia, Ukraine, Uruguay and Viet Nam) UN Women's support led to women living with HIV taking a role in drafting and implementing national and local gender-equality strategies and GBV national action plans. In Viet Nam, the women living with HIV network collaborated with the Government in adopting a national thematic project on gender-based violence prevention and response, an operational framework to implement the 2016–2020 Action Plan on Gender Equality. The project recognizes sexual violence against women in public spaces, introduces specific measures to implement integrated gender-based violence/HIV services and establishes a multi-stakeholder coordination mechanism.
180. UN Women's work with traditional and community leaders in Malawi, Senegal, Uganda and Zimbabwe increased their involvement in HIV prevention among girls and ending child marriage. In Malawi, the paramount chiefs developed a unified by-laws framework to guide implementing and monitoring gender equality, and gender-based violence and HIV laws and policies at community level, with particular focus on enforcing the marriage, divorce and family relations bill that increased marriage age from 15 to 18. With UN Women support, Malawi's constitution was also amended to raise the marriage age to 18 years.
181. UN Women, the UNAIDS Secretariat and partners provided technical assistance to the Southern African Development Community as it drafted and tabled a CSW resolution on women, the girl child and HIV. The resolution, which acknowledges women and girls' vulnerabilities in the context of HIV, was adopted at the 60th session of the CSW. UN Women ensured Member States, the chair for the resolution, and the UNAIDS Secretariat had the relevant evidence and technical guidance to support including gender equality priorities in the Political Declaration on Ending AIDS, which was adopted at the High-Level Meeting in June 2016.

### **Access to rights and justice**

182. The Convention on the Elimination of all forms of Discrimination against Women is a powerful instrument for articulating, advocating and monitoring women's human rights. With UN Women support, women living with HIV contributed to country reporting on CEDAW. In Ukraine, they cowrote a shadow report, submitted on behalf of women living with HIV, sex workers and women who use drugs. Advocates will present the report at the CEDAW session in 2017. The Viet Nam network helped develop the monitoring framework of the 2015 CEDAW concluding observations.
183. UN Women work resulted in improved legal aid and access to justice for women living with HIV in China, Malawi, Uganda, Viet Nam and Zimbabwe. In Uganda, UN Women mobilized 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. UN Women also assisted elders involved in informal justice to better understand the HIV-specific needs of women and girls, and to promote women's rights. This work led to greater trust in informal justice mechanisms at local level, faster review of complaints, including from women living with HIV, and improved coordination with the formal justice system. In Viet Nam, UN Women helped identify gender-specific bottlenecks in accessing legal aid, resulting in a set of recommendations for reform.

### **Efficiency and effectiveness of HIV response**

184. More than 200 women living with HIV from 10 countries (Belarus, the DRC, Kazakhstan, Kenya, Mozambique, Namibia, Russian Federation, Thailand, Ukraine and Zimbabwe) learned about the SDGs and helped introduce them at national level, with the UN Women and ICW partnership playing a key role in the process. In-country workshops and online mentoring and technical guidance were instrumental in ensuring that networks of women living with HIV raised gender equality priorities at national SDG dialogues and participated in technical working groups. UN Women led similar efforts in Kazakhstan, Rwanda, Tajikistan and Ukraine. In Ukraine, women living with HIV convened dialogues with decision-makers at national and local levels, prepared a position paper highlighting their priorities, surveyed 1,000 women living with HIV to identify their gender-equality needs, and successfully advocated for integrating these priorities into local HIV planning in five regions.

### **HIV-sensitive social protection**

185. UN Women improved the sustainability of livelihoods for women living with HIV by fostering their control over economic resources. For example, with the help of the UN Women's Fund for Gender Equality grantee in the United Republic of Tanzania, more than 3,000 rural women living or affected by HIV developed skills that enabled them to launch their own businesses, access legal support and HIV services, and have more control over decision-making at home and in their communities. In Uganda, entrepreneurship training by UN Women has equipped young women living with HIV with essential social and economic skills, improving their self-esteem and confidence. Training has been accompanied by continuing mentoring and supervision. As a result, this group has started their own businesses and is accessing government grants for entrepreneurs.

## UN WOMEN 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	25 600	200 000	225 600
SRA 3: HIV prevention among young people	136 810	954 810	1 091 620
SRA 5: Gender inequality and gender-based violence	1 381 920	8 094 610	9 476 530
SRA 6: Human rights, stigma and discrimination	83 550	1 291 247	1 374 797
<b>Grand total</b>	<b>1 627 880</b>	<b>10 540 667</b>	<b>12 168 547</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	182 274		1 246 636	
AP	261 094	67%	1 774 335	51%
EECA	219 930	24%	438 000	39%
ESA	463 342	100%	2 383 782	82%
LAC	228 664	47%	1 770 826	39%
MENA	24 765	0%	793 343	0%
WCA	247 811	100%	2 133 745	63%
<b>Grand total</b>	<b>1 627 880</b>		<b>10 540 667</b>	

## 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.

### Innovative testing strategies

186. HIV testing remained an ILO priority. The VCT@WORK initiative (voluntary, confidential HIV counselling and testing for workers) implemented with partners continued to mobilize workers, and their families and communities, to test for HIV in Cambodia, Cameroon, China, the DRC, Egypt, Guatemala, Haiti, Honduras, India, Indonesia, Kenya, Mozambique, Nigeria, Russian Federation, South Africa, Ukraine, United Republic of Tanzania and Zimbabwe. Approximately 1.2 million people were tested in 2016.
187. Testing was scaled up in the Russian Federation, focusing on hotspots. Strategic partnerships with Russian Railways in the Chelyabinsk and Sverdlovsk territories promoted the initiative to branch workers. Three Irkutsk Oil Company sites, the Tuapse Refinery factory and five Siberian Coal Energy Company mines provided access to HIV testing for vulnerable staff. In partnership with government ministries, HIV testing was also promoted during national occupational safety and health week. Overall in 2016, 32 915 workers (55% men, 44% women) undertook HIV testing as part of VCT@WORK.
188. In Nigeria, the National Labour Congress, with ILO and partners help, developed proposals to secure a second tranche of US\$ 100 000 from the National Agency for the Control of AIDS for testing initiatives in six high-burden states. Through this and other partnerships, the ILO supported HIV testing for 31 734 people (56% women, 43% men) in Enugu, Kaduna, Rivers State, Abuja and Sokoto.
189. HIV testing was mainstreamed into BizAIDS, the South Africa Business Coalition on Health and AIDS skills training programme, for 176 micro enterprises in Waterberg district. With partners, the ILO and partners helped create demand for testing in several outlets. VCT@WORK was promoted by the Presbyterian Church, and among taxi owners, drivers and other informal workers. Altogether, 21 626 workers (68% women, 31% men) were tested in 2016.
190. In Cambodia, the ILO and partners, with the Cambodia Business Coalition on AIDS and the Khmer HIV/AIDS NGO Alliance (KHANA), focused on mobilizing key and vulnerable populations. A total of 40 577 people (64% women, 36% men) were tested for HIV.

191. In Mozambique, building on a partnership between HIV services and forums, Centers for Disease Control and Prevention and the ILO, testing was promoted along transport hotspots, reaching border posts in South Africa and Swaziland, and targeting young workers, sex workers and clients, cross-border traders and migrant workers. In 2016, 8,569 workers (68% men and 31% women) took an HIV test.
192. In Ukraine, the Ministry of Social Policy became the first national executive authority to provide access to testing for all staff. Partnering with other UN agencies, the ILO and partners supported incorporating HIV testing in the 2017–2021 Kyiv City HIV programme. In 2016, 4,395 workers (60% men, 39% women) undertook testing.

### **Combination prevention**

193. The ILO and partners prioritized combination prevention programmes in 2016. In Botswana, Cambodia, Cameroon, China, DRC, Egypt, Guatemala, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Russian Federation, South Africa, Swaziland, Uganda, Ukraine, United Republic of Tanzania, Viet Nam, Zanzibar and Zimbabwe, workers were reached with HIV services through a combination of structural, behavioural and biomedical components, the key to achieving sustained outcomes.
194. In the Russian Federation, with ILO and partners support, HIV were mainstreamed into the national training programme for workers. For example, the ILO, in partnership with the Ministry of Health and employer and workers' organizations, developed an electronic education module on HIV and the "world of work" for the Ministry of Labour and Social Protection. It will be included in the training tools for workplaces during occupational safety and health week.
195. With ILO and partners assistance, Viet Nam's Ministry of Labour, Invalids and Social Affairs reviewed policies on the rights of venue-based entertainment/sex workers, and subsequently developed technical guidance to support HIV programmes aimed at reaching workers in five provinces.
196. ILO and partners work in Ukraine helped develop HIV workplace programmes for the maritime sector workers union and Kyiv's emergency medical care centre, through a project funded by the Swedish development cooperation agency Sida to reduce HIV stigma and discrimination and protect men and women from unacceptable forms of labour.
197. In Uganda, ILO support included developing an HIV resource guide for the hotel and hospitality industry and its dissemination in 10 districts, and providing condom access in 80 hotels. A public-private partnership between the ILO, the Uganda AIDS Commission and the private beverage company Hariss International resulted in HIV education messages on mineral water bottles. Similar innovative PPPs are being sought to promote HIV education and prevention information on exercise books and stationery.
198. With ILO support, Zanzibar formulated a national employment code on HIV in 2016, based on ILO Recommendation 200.

199. In India, the ILO and partners worked with the National AIDS Control Organization (a division of the Ministry of Health and Family Welfare), resulting in 14 memorandums of understanding for mainstreaming HIV in ministry work. As a result, more than 20 million migrant, mobile and seasonal workers in the public sector are being reached with HIV programmes and policies.

### **HIV services for key populations**

200. The ILO and partners supported evidence-based interventions to reach key populations with HIV services in Cambodia, Cameroon, China, DRC, Guatemala, Haiti, India, Indonesia, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Russian Federation, Swaziland, South Africa, United Republic of Tanzania, Uganda, Viet Nam and Zambia. Approaches included generating strategic information, mainstreaming HIV into structural programmes, policy review, implementation planning, hotlines, and using sport as a medium to reach people.
201. The ILO and partners helped 280 young women and commercial sex workers in the Tanzanian district of Kyela learn about HIV and how to start a business using ILO training tools. The ILO leveraged entrepreneurship programmes with a view to making women HIV sensitive. Sex workers were provided with alternative sources of income.
202. In Indonesia, the ILO, with the Centre for Population and Policy Studies, published findings of a study on discrimination at work on the basis of sexual orientation and gender identity within the context of HIV, with specific recommendations for the Government.
203. In India, technical support was provided for a multistate study on discrimination among lesbian, gay, bisexual and transgender people at work. It revealed many instances against men who have sex with men, in formal and informal workplace settings. The study, part of the approach to generate strategic information, includes recommendations for a multipronged response.
204. With technical and financial backing from the ILO and partners, a policy review by Viet Nam's Ministry of Labour, Invalids and Social Affairs of venue-based entertainment/sex workers proposed a programme to protect workers' rights as part of national action on prostitution. As a result of the review, support was provided to draft a 2016–2020 national action plan on sex work.
205. In Cambodia, the ILO and partners continue to provide normative support to the Ministry of Labour and Vocational Training on implementing Prakas 196. This regulation on working conditions and occupational safety and health rules for entertainment service enterprises ensures that workers – including sex workers, men who have sex with men, and lesbian, bisexual, transgender or intersex people – work in conditions where their rights are protected. Implementation guidelines for Prakas 194 were drafted in 2016.
206. In Kenya, the ILO with LVCT Health (an indigenous HIV prevention organization), the Swedish Workplace HIV/AIDS Programme and sex workers and their clients (truck/bus drivers), organized an HIV-testing initiative. Peer-led take-up of voluntary counselling and testing (VCT) services by sex workers and other key populations improved at hotspots along the northern transport corridor, with more than 20 000 condoms

distributed.

### **Women and girls**

207. The ILO supported countries to transform unequal gender norms and remove systemic barriers to gender equality by implementing interventions tailored for women and men in Cambodia, Cameroon, China, DRC, Guatemala, Honduras, Kenya, Malawi, Swaziland, South Africa, Uganda Ukraine, United Republic of Tanzania and Zambia.
208. Between 2011 and 2016, the ILO, in partnership with Sida and UNAIDS, implemented an economic empowerment programme among hard-to-reach populations in Malawi, Mozambique, South Africa, United Republic of Tanzania, Zambia and Zimbabwe to reduce their vulnerability to HIV. Efforts focused on practical ways to supplement HIV education to address the barriers faced by people in poor communities and along transport corridors. More than half of the beneficiaries were women; the proportion who reduced sexual partners rose from 56% (2011) to 74% in 2015, while the proportion adopting HIV risk-reduction strategies went up from 31% to 81%.
209. In Uganda, gender has been mainstreamed in ILO-supported HIV workplace programmes targeting the hotel and hospitality industry. These include: providing female condoms for workers; establishing female models to guide workers who have been sexually assaulted or harassed; revised schedule times to protect workers from the dangers of working late; raising awareness on post-exposure prophylaxis (PEP, taking antiretroviral medicines after being potentially exposed to HIV); and encouraging female workers to upgrade their skills to compete favourably for management positions.
210. In Ukraine, gender equality has been a constant of the Sida-funded ILO project on reducing HIV discrimination to protect women and men from unacceptable work. Half the members of the project's national tripartite advisory committee are women, its training programme includes gender aspects of HIV, and of the 300-plus beneficiaries of capacity development activities at least 60% were women.
211. The ILO provided technical and financial support to the Honduran Private Enterprise Council and the chamber of commerce association to mainstream gender in human-resource management. Some 658 management experts from six regional departments were supported to more effectively address gender-based workplace discrimination with tools and capacity building.
212. In the United Republic of Tanzania, the ILO and partners provided a US\$ 50 000 grant as part of a comprehensive HIV programme for vulnerable youth affected and infected with HIV in transport corridors. It will improve economic activities and generate decent employment, and is expected to benefit 402 adolescent girls and young women and 135 men. The target group received ILO training on entrepreneurship.
213. At global level, the ILO governing body placed a standard-setting item on violence against women and men at work on the agenda for the International Labour Conference in June 2018. A tripartite meeting of experts, convened to provide guidance, discussed violence at work and established links between violence and HIV. Efforts are being made to mainstream HIV into the new international labour standard on violence in the world of work.

## Legal and policy reforms

214. ILO provided tailored support to 18 countries to undertake HIV-related legal and policy reforms, particularly on non-discrimination legislation, policies and codes of practice for the workplace. This included drafting anti-stigma national strategies, policies and frameworks (Africa region) and providing legal aid services (Asia region) to vulnerable workers who may have experienced some form of discrimination in employment because of their real or perceived HIV status. For example, finalizing employment HIV non-discrimination regulations in Uganda, and developing conduct guidelines on HIV in Zanzibar and a labour policy in Lesotho.
215. To fast-track the uptake of VCT, and create an environment for doing so, the ILO and partners provided support to stimulate legal and policy reforms in Cambodia, Cameroon, Lesotho, Mozambique, Nigeria, Russian Federation, South Africa, Swaziland, Uganda, United Republic of Tanzania, Viet Nam and Zimbabwe.
216. In Uganda, working with the Ministry of Gender, Labour and Social Development, the ILO and partners helped finalize employment HIV non-discrimination regulations. These align with Decent Work Country Programme output to improve the legislative policy environment for non-discrimination at work. Regulations await formal gazetting by the Attorney General's office.
217. In 2016, with ILO input, the Lesotho Ministry of Labour and Employment integrated all policies related to employment and labour – including for HIV – into one document, referred to as the Labour Policy. Comments provided by the ILO were informed by its 2015 *Handbook on HIV and AIDS for labour inspectors*, and the ILO recommendation on HIV and the world of work.
218. In South Africa, the ILO, with other organizations, supported the National AIDS Council (SANAC) in improving the services of the HIV/AIDS and TB Stigma Legal Clinic. Collaboration resulted in a booklet to promote the clinic. A review of the South Africa National Standard on wellness and disease management (including HIV and tuberculosis), referred to as SANS 16001, was also initiated. The ILO, as a member of the technical committee put together by the South African Bureau of Standards, is providing technical inputs for the new standard, which should be adopted in 2017.
219. In Haiti, the textile sector has increased awareness on HIV-related discrimination and the rights at work of people living with HIV. Two non-discriminatory HIV policies have been adopted at enterprise level and a sector policy drafted for the industry. More than 10 000 workers are accessing HIV services, with more than 50 000 male condoms distributed in workplaces.
220. In India, technical assistance was provided for a multistate study on discrimination among lesbian, gay, bisexual and transgender people at work. It identified instances of discrimination in the workplace, and makes recommendations on how to address it.
221. In Indonesia, the ILO, with the Centre for Population and Policy Studies, published findings of a study on discrimination at work on the basis of sexual orientation and gender identity within the context of HIV. It highlights increasing conservatism in the country, with many LGBT people experiencing stigma and discrimination at all levels of employment (looking for jobs, going through the recruitment processes, maintaining



jobs and seeking promotion). This includes comments or jokes about gender identity, social marginalization, bullying by other LGBT people, blackmail and physical violence. The report includes specific recommendations for the Government.

222. In Viet Nam, UNAIDS, UN Women and ILO jointly organized a workshop to build capacity on legal aid law advocacy for people living with HIV, sex workers and people using drugs. ILO input was informed by its Recommendation 200, on HIV and the world of work.
223. At global level, the ILO participated in a United Nations Human Rights Council panel discussion to review progress on the human rights response to the epidemic, and the challenges to ending AIDS as a public health threat by 2030, organized with UNAIDS Secretariat support. Protecting human rights at work by applying international labour standards and implementing workplace policies and programmes is critical, according to the ILO. The text can be accessed at [http://www.ilo.org/aids/Whatsnew/WCMS\\_459142/lang--en/index.htm](http://www.ilo.org/aids/Whatsnew/WCMS_459142/lang--en/index.htm)

### **HIV-sensitive social protection**

224. Since Recommendation 202 on social protection floors was adopted, the ILO has provided advice and technical assistance to approximately 100 countries to implement the nationally defined sets of basic social security guarantees. HIV-related support extended social protection programmes to vulnerable populations, including those living with HIV, in Cambodia, Cameroon, Egypt, India, Indonesia, Kenya, Nigeria, Rwanda, South Africa, the United Republic of Tanzania, Viet Nam and Zambia.
225. In Zambia, the ILO is supporting the Government to extend social protection to workers in the informal economy. This includes maternity insurance, which is improving access to protection for people living with HIV in Zambia. An estimated one million people are expected to benefit from the package within five years.
226. The ILO supported implementing maternity insurance for people living with HIV in Rwanda, and improved access to social protection; 300 000 vulnerable people are expected to benefit in five years.
227. In Cambodia, the National Social Security Fund (NSSF) of the Ministry of Labour and Vocational Training started a social health insurance scheme for workers in the formal economy. The contribution started in October 2016 to cover workers' health expenses. The ILO social protection team has provided technical support for the NSSF.
228. In Viet Nam, sex workers' access to social assistance (vocational training, livelihood loans and health services including HIV-related care) has been assessed. Study results will inform the Government's evidence-based policy for more effective, accessible services.
229. The ILO took part in a planning retreat on the Kenya UNDAF (United Nations Development Assistance Framework) outcome on social protection. This was in partnership with a Ministry of Labour social protection retreat. Key activities for 2016–2018 were identified, including support for a comprehensive social protection bill, a sector review, and increased access to social protection for formal and informal workers.

230. At global level, the ILO, UNAIDS, United Nations Research Institute for Social Development, UNDP, HelpAge International, STOP AIDS NOW! (called Aidsfonds since December 2016) and Housing Works organized a panel discussion at the World Health Assembly in 2016 on fast-tracking social protection. The event increased the visibility of HIV-sensitive social protection activities in the run-up to the HLM in New York.

## ILO 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	727 908	804 771	1 532 679
SRA 3: HIV prevention among young people	669 952	767 251	1 437 203
SRA 4: HIV prevention among key populations	251 215	635 802	887 017
SRA 5: Gender inequality and gender-based violence	652 954	745 873	1 398 827
SRA 6: Human rights, stigma and discrimination	259 162	778 892	1 038 054
SRA 8: HIV and health services integration	239 487	867 998	1 107 485
<b>Grand total</b>	<b>2 800 678</b>	<b>4 600 587</b>	<b>7 401 265</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	1 170 458	0%	941 775	
AP	369 430	86%	828 022	91%
EECA	138 216	100%	280 506	98%
ESA	741 663	100%	1 681 530	100%
LAC	142 599	77%	197 096	50%
MENA	16 457	0%	19 950	0%
WCA	221 855	100%	651 708	96%
<b>Grand total</b>	<b>2 800 678</b>		<b>4 600 587</b>	

## United Nations Educational, Cultural and Scientific Organization (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. UNESCO is one of the six founding UNAIDS Cosponsors and is responsible for leading efforts to support countries in scaling up the education sector response to HIV.

UNESCO's Strategy on Education for Health and Well-Being is aligned to the SDGs and the UNAIDS Fast-Track strategy, and establishes the goal of supporting the contribution of national education sectors to ending AIDS and promoting better health and well-being for all children and young people. It also outlines UNESCO's two strategic priorities for health education in the 2016–2021 period; ensuring that children and young people benefit from quality comprehensive sexuality education that includes HIV education, and that all children and young people have access to safe, inclusive, health-promoting learning environments.

### **90–90–90 for children and adolescents**

231. UNESCO helps children, adolescents and young people understand why HIV testing and treatment are necessary, and what they can achieve. In Botswana, Kenya, Lesotho, Namibia, Swaziland and Uganda, UNESCO worked with the Southern Africa HIV and AIDS Information Dissemination Service to develop and roll out an adolescent treatment literacy toolkit. Young people, teachers and the community receive support to share information and strategies on HIV prevention, care and treatment in a simple, entertaining way that promotes the rights and dignity of young people living with HIV.
232. In Zimbabwe, UNESCO supported the development of the Zvandiri mobile app, which enables young people living with HIV to share information, track adherence and connect with services at health facilities.
233. UNESCO's work contributes to the 90–90–90 targets by promoting health literacy, which encourages health-seeking behaviour, including testing and adherence to treatment for HIV and STIs. It supports measures that keep young people living with HIV in school, such as creating safe spaces and referrals to youth-friendly health services. In 2016, UNESCO collaborated with Israel's Mount Carmel International Training Centre to train more than 50 specialists on how to prevent violence in schools and discrimination against children and young people living with HIV. In Brazil, UNESCO worked with young civil society representatives from the National Network of Adolescents and Young People Living with HIV and AIDS to promote a strengthened national response for young people. In Haiti, UNESCO helped the education ministry create health clubs in 100 schools to instruct 4000 young people on hygiene and well-being, SRH and HIV prevention.

### **Combination prevention**

234. UNESCO is leading efforts to update the *International technical guidance on sexuality education*. A global technical stakeholder consultation was hosted in October 2016 with more than 60 participants, and a CSE advisory group established, including Cosponsor partners such as UNAIDS, UNFPA, UNICEF, UN Women and WHO. The updated guidance, scheduled to be published in 2017, reflects new evidence and good practices, and reinforces focus on areas such as early pregnancy, puberty and gender equality.
235. In Africa, 30 countries have been trained by UNESCO to integrate core HIV indicators in their education management information systems (EMIS). Of these, nine have completed the integration, those being Botswana, Côte d'Ivoire, Ghana, Lesotho, Namibia, South Sudan, Swaziland, the United Republic of Tanzania and Zambia. Namibia and Zambia are now collecting and reporting EMIS data.
236. UNESCO supported the strengthened capacity of eastern and southern African countries to provide quality CSE following the 2013 ESA Commitment, which was reaffirmed through the ministerial call to action, Let's Step Up and Deliver, at the International AIDS Conference. Progress against 2015 targets indicate that 15 of 21 eastern and southern Africa countries provide CSE in primary and secondary schools, and 18 have CSE teacher training programmes (training courses reached 421 200 teachers). In the United Republic of Tanzania, more than 8,500 pre- and in-service teachers received training, and 13 000 CSE and HIV-prevention materials were distributed in 1,000-plus schools, which should benefit 8.6 million school-age children, 49% of them female.
237. In western and central Africa, a regional conference for representatives from 17 countries resulted in a call for action to strengthen CSE and access to SRH services, which has been followed up in nine countries. Information and communications technology (ICT) tools were used in 277 training institutions to deliver CSE to more than 92 000 students in five countries. Côte d'Ivoire and Togo applied the sexuality education review and assessment tool (SERAT) to national programmes, and a teacher training guide was published in partnership with ministries of education in Cameroon and Chad.
238. In partnership with UNFPA and UNICEF, CSE implementation reviews in China, India and Thailand collected data from more than 18 500 students, 1,180 teachers and principals, and 578 schools. In Latin America and the Caribbean, UNESCO technical assistance in Brazil, Guatemala, Haiti, Jamaica and Peru strengthened teacher training and advocacy for CSE.

### **Youth health and education needs**

239. As part of a Joint Programme with UNFPA and UN Women to empower adolescent girls and young women, UNESCO received a five-year grant from the Republic of Korea for projects in Mali, Nepal and the United Republic of Tanzania to expand access to education, CSE and safe learning environments. In five districts of Nepal, for instance, UNESCO is mainstreaming CSE and gender-based violence prevention in school policies and teacher training, and promoting out-of-school services, which should help more than 300 000 girls.

240. In 2016, UNESCO strengthened the education sector response to early and unintended pregnancy, a key concern and one frequently resulting in girls leaving school, stigma and discrimination. Global guidance developed with UNFPA and WHO helps stakeholders identify ways to prevent early and unintended pregnancy, and ensure pregnant and parenting girls can continue their education in supportive environments. Workshops were held in Johannesburg in 2016 with national programme officers from 13 African countries, and in Dakar in early 2017. In South Africa, technical assistance from UNESCO is helping the Department of Basic Education develop a learner pregnancy policy, following a recent HIV, STIs and TB policy.
241. UNESCO is helping countries scale up puberty and menstrual hygiene education. Poor school facilities and understanding contribute to absenteeism and stigma, with studies showing that in some countries more than half of adolescent girls do not know what menstruation is when it first occurs. In 2016, a UNESCO good policy and practice document on puberty education was translated into Spanish and presented at a consultation with eight countries from central America, and Cuba and Dominican Republic.
242. In Côte d'Ivoire, Ghana, Nigeria and Togo, UNESCO collaborated with Ministries of education, youth and culture to develop culturally appropriate classroom activities on gender and diversity. In China, UNESCO researched CSE and access to SRH services for young people with disabilities, with a workshop planned for 2017 to share findings.

#### **HIV services for key populations**

243. UNESCO, in collaboration with UNODC and WHO, led development of a good practice and policy booklet on education sector responses to substance use. A follow-up to a joint publication and 2015 expert group meeting in Istanbul, it will be published in 2017. The work was presented at the UN General Assembly Special Session (UNGASS) on the world drug problem, and at a meeting in June 2016 organized by WHO and the Government of Turkey on preventing substance use among young people. The guidance is particularly relevant to adolescents and young people from key populations.
244. Similarly, UNESCO's work to prevent violence in schools on the basis of sexual orientation and gender identity/expression (SOGIE) benefits all students, but especially those identifying as LGBT, who are more vulnerable to violence and bullying, and more likely to miss classes or drop out of school as a result. Combatting SOGIE-related stigma and discrimination in schools also helps dispel myths about HIV.
245. UNESCO also works to empower young people living with HIV and combat stigma and discrimination. In the Congo, UNESCO improved the effectiveness of more than 300 adult educators and 260 youth leaders to teach CSE, who in turn reached more than to 25 000 out-of-school young people. This included 285 adolescent refugees who sell sex, who were provided with CSE and toolkits to help them re-enter school.

## **Gender-based violence**

246. In 2016, UNESCO focused on strengthening the education-sector response to school-related gender-based violence, including on the basis of sexual orientation and gender identity/expression. In December, UNESCO and UN Women launched international guidance, developed under the auspices of the global partners working group on school-related gender-based violence, co-chaired by UNESCO and United Nations Girls' Education Initiative (UNGEI). A workshop for UNESCO staff in Africa familiarized them with the guidance, with the result Zambia trained government personnel on school-related gender-based violence, India carried out an assessment, and in the Russian Federation, a curricula and teaching toolkit was introduced in Chelyabinsk province, one of the country's most HIV-affected regions. UNESCO's Beirut office undertook a desk review on school-related gender-based violence in nine Middle East countries, and a case study in State of Palestine. In the DRC, UNESCO supported a magazine for young people on the response to HIV and gender-based violence, and discussion groups were organized at six higher education institutes. In Asia and the Pacific, UNESCO collaborated with Plan International, UNICEF, UNGEI and UN Women to publish the Connect with Respect curriculum tool to help teachers address school-related gender-based violence, which reached more than 15 000 people via a social media campaign.
247. With support from the Netherlands and Norway, an international ministerial meeting on education-sector responses to SOGIE-based violence was held in May 2016, resulting in a call for action that has been endorsed by 56 countries. A report was launched, and a video and infographic released under #OutInTheOpen, which trended on Twitter and generated an audience of 20 million. In Asia and the Pacific, research was undertaken with education ministries from Indonesia and Viet Nam, and UNESCO and UNDP co-convened national consultations in China, Indonesia, Philippines and Thailand. In Thailand, UNESCO is also collaborating with Plan International on a three-year programme that will benefit more than 5,000 students, parents and teachers. In Latin America, a publication and teacher's guide on SOGIE violence in schools was produced.

## **Technological and service delivery innovations**

248. As part of efforts to scale up quality CSE, UNESCO is exploring several innovative media and ICT approaches. In the ESA region, work has been continuing to identify pragmatic, cost-effective approaches to ICT-based education, including teacher training, with more than 2000 in-service teachers completing an online CSE course. In the western and central Africa region, ICT-based training tools were used in 277 training institutions to deliver CSE to 92 000 students in five countries. In both regions, the online tools were complemented with resources and a teaching guide. UNESCO also supported teacher training on CSE in Argentina through a 180-hour online course.
249. In eastern Europe and central Asia, UNESCO and UNAIDS collaborated on several media initiatives, including four live-streamed talk shows with psychologists and celebrities addressing parent-child relationships, puberty, sexuality, CSE and HIV prevention. To help teachers deliver HIV education, UNESCO and UNAIDS also collaborated on a HIV video lesson. UNESCO developed two 'edutainment' videos that aired on the Nowchpok YouTube channel and were viewed by more than 550 000 young people, and produced a video cartoon on HIV prevention, transmission, testing and treatment that was viewed by more than 100 000 people in three days.

250. The media has also been used widely in other regions. In eastern and southern Africa, advocacy tools to strengthen community and parent engagement have helped 12 countries, and a radio and TV series on CSE, SRH and HIV prevention has reached more than five million people. In the DRC, UNESCO supported 24 radio and 48 TV broadcasts aimed at young people on HIV prevention, CSE and SRH.

#### **Decentralization and integration**

251. There is growing recognition of the need for a comprehensive approach to coordinating education and health. Integrating health, including HIV, into the education agenda, and vice versa, are key objectives for UNESCO. The Global Education First Initiative identifies health as one of the core outcomes of good quality education, while the 2015 Incheon declaration (which sets out a vision for education for the next 15 years) states that quality education enables citizens to lead healthy lives. This relationship is a central focus of UNESCO's new strategy on education for health and well-being, and the cross-cutting approach that contributes to SDGs 3, 4 and 5.



## UNESCO 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	92 053	393 504	485 557
SRA 3: HIV prevention among young people	1 744 331	5 149 983	6 894 314
SRA 4: HIV prevention among key populations	115 067	533 276	648 343
SRA 5: Gender inequality and gender-based violence	345 200	4 000 655	4 345 855
SRA 6: Human rights, stigma and discrimination	80 547	317 874	398 421
SRA 8: HIV and health services integration	57 533	392 704	450 237
<b>Grand total</b>	<b>2 434 731</b>	<b>10 787 996</b>	<b>13 222 727</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	743 045		2 877 446	0%
AP	391 387	82%	2 100 634	67%
EECA	223 919	70%	86 473	38%
ESA	534 028	92%	4 232 174	75%
LAC	249 315	65%	893 601	68%
MENA		0%	96 669	0%
WCA	293 037	64%	500 996	69%
<b>Grand total</b>	<b>2 434 731</b>		<b>10 787 993</b>	

## World Health Organization (WHO)

WHO plays a critical role within the United Nations system as the directing and coordinating authority for international health. Its wide-ranging remit involves providing leadership on increasingly complex global health matters, producing health guidelines, norms and standards, monitoring and assessing health trends and shaping the health research agenda. It is committed to providing technical support to countries and helping them to address pressing public health issues.

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, and HIV/tuberculosis coinfection, and jointly coordinates work on eliminating mother-to-child transmission of HIV with UNICEF.

### Innovative testing strategies

252. In the past three years, 90% of Fast-Track countries and 70 countries overall have drawn on WHO technical support to adapt testing guidelines to their own contexts. In 2016 WHO led all Joint Programme work on HIV testing services, including roll-out of the consolidated guidelines launched in December 2015, and presented new recommendations on HIV self-testing and assisted partner notification in a supplement to the guidelines.
253. WHO is a key partner of STAR (HIV Self-Testing Africa Project), the largest HIV testing programme of its kind in Malawi, Zambia and Zimbabwe that aims to distribute two million self-testing kits through a range of approaches.
254. WHO developed a clearing house of information on HIV self-testing, cataloguing the 150-plus global projects and tracking policy and practice in countries.
255. WHO held HIV testing update and training workshops in all regions. It reviewed new national testing strategies and the policies of more than 20 countries, and supported quality assessment and improvement to increase the effectiveness of a mix of approaches, and models of community and lay-provider testing.

### Access to treatment cascade

256. WHO's global health sector strategy 2016–2021, adopted at the 69th World Health Assembly in 2016, aligns with the UNAIDS multisectoral strategy. It provides a framework for country health sector strategies and policies for the Fast-Track period. Treatment access is a strategic focus, and there has been success in treatment scale-up supported by the WHO "Treat All" recommendation. In 2016, more than 18 million people accessed ART, leading to a global coverage of an estimated 46%, and a 26% decrease in annual HIV-related deaths since 2010. Progress in treatment is variable, however, with some regions and countries falling behind, namely the west and central areas of Africa and eastern Europe and central Asia, and masks a lack of progress in reducing the annual number of new HIV infections (1.9 million in 2015). Treatment coverage is lower for men, compared with women, in every region.
257. WHO launched its consolidated guidelines on the use of ARVs for treating and preventing HIV infection (it recommends treating all HIV-positive persons, regardless

of CD4 cell count) and quickly translated new science into policy and practice. The guidelines include 52 new recommendations covering adult, paediatric, adolescent and pregnant women testing, treatment and care, and 10 new service delivery recommendations to support differentiated models of care. These recommendations promote rapid initiation of ART and innovative testing and diagnostic platforms. WHO led seven regional dissemination meetings that reached more than 100 countries and almost 700 stakeholders. By October 2016, more than 80% of all Fast-Track countries had adopted a “Treat All” policy; implementation was slower but gaining pace.

258. WHO agreed with partners on 10 key cascade indicators to assess gaps in efforts towards achieving the 90–90–90 targets. WHO convened 25 high-burden countries, covering 85% of the epidemic, to identify testing and treatment gaps, analyse cascades and prioritize actions to address these nationally and subnationally. This contributed to global strategic information on cascade gaps and country access plans. Cascades have been developed for the Fast-Track countries, several of which are serving as the basis for new national strategic plans and for developing the Global Fund concepts.
259. A focus of WHO’s 2016 ART guidelines has been to increase TB case detection by promoting the strategic placement of Xpert MTB/RIF diagnostic testing in HIV settings and upgrading algorithms to increase detection and reduce mortality.

#### **90–90–90 for children and adolescents**

260. WHO continues to play a leading technical role in global efforts to scale up treatment for infants, children and adolescents. In 2016, the HIV department developed and disseminated evidence-based normative guidelines that promoted earlier testing closer to the point of care to enable earlier treatment. Technical support for country adoption and adaptation was provided, particularly for key innovations such as birth testing, point-of-care early infant diagnosis, early treatment, optimal drug use and adolescent health-friendly services.
261. WHO has invested in promoting improved coordination among stakeholders developing drugs and formulations for infants, children and adolescents, which is expected to accelerate approvals. WHO collaborated with partners of the Inter-Agency Task Team to support product selection and introduction.
262. WHO helped develop and endorsed the *Start Free Stay Free AIDS Free* framework. It partnered with the International AIDS Society to prioritize research to define a global agenda for testing treatment and care for children and adolescents living with HIV. WHO advanced a new global strategy for adolescents, Global AA-HA!, which has a focus on HIV prevention and will be presented at the 2017 World Health Assembly.

#### **HIV services in high-burden cities**

263. WHO technical guidelines and implementation tools for new policies in the Fast-Track Cities Initiative included: HIV self-testing and partner notification; strategic information, such as the top 10 indicators to monitor impact; and the use of ARVs as outlined in the 2016 consolidated guidelines. WHO recommendations include “Treat All”– and PrEP for people who are at substantial risk of HIV infection.

### **HIV services in humanitarian emergencies**

264. As a member of the IATT on HIV in emergencies, WHO:
- participated in the annual meeting on HIV and emergencies in January 2016;
  - supported development of an adaptation document of the WHO 2016 consolidated ART guidelines for emergency settings (pending);
  - supported documentation of experiences in applying differentiated service delivery to conflict settings (scheduled for June 2017);
  - contributed to guidelines on responding to child and adolescent sexual abuse (to be published in the second quarter of 2017);
  - provided technical assistance to the UN Medical Directors to update UN post-exposure prophylaxis kits.

### **Medicines and commodities**

265. WHO supports a public health approach to HIV treatment by promoting standardized and simplified ART, less toxic drugs and convenient and effective ARV regimens. With availability of once-daily, fixed-dose combinations, people living with HIV who adhere to treatment can expect a near-normal life expectancy. According to the WHO/UNAIDS Global AIDS Response Progress Reporting tool, in 2016 more than 90% of low- and middle-income countries and all 35 Fast-Track countries had adopted the WHO-recommended preferred first-line ARV regimen (TDF/XTC/EFV). The 2016 WHO consolidated ARV guidelines added other options (integrase inhibitors) associated with fewer drug interactions, higher virological efficacy, lower treatment discontinuation rates and a higher genetic resistance barrier. However, the efficacy and safety of these options are being evaluated for pregnant women, TB coinfection and young children. Clinical and pharmacokinetic studies continue and first results are expected in mid-2017.
266. WHO guides the development of short-, medium- and long-term ARVs. Each year it convenes a think tank at the Conference on Retroviruses and Opportunistic Infections to review treatment optimization priorities for adults. Discussions inform updates of its consolidated guidelines on ARVs. For children, the Paediatric ARV Drug Optimization meeting develops the updated IATT formulary list to provide a signal to markets and outline pathways and priorities for developing paediatric ARVs, which may have a small market but great life-saving potential.
267. WHO led price reporting on HIV drugs and diagnostics, providing market information, profiles on benchmarked prices to countries, and convening manufacturers, countries and partners to optimize country access. It provided procurement and supply chain management support and quantification to 47% of Fast-Track countries.
268. WHO continued to support countries by reviewing programmes and national strategic plans to strengthen and align procurement and supply chain management for an uninterrupted supply of HIV testing kits and ART in TB services, and isoniazid preventive therapy in HIV services.

### **Comprehensive eMTCT services**

269. In collaboration with WHO regions and other UN agencies, WHO has prioritized the eMTCT of HIV, developed global guidance on process indicators for achieving

validation, and validated seven countries for eMTCT of HIV and/or syphilis: Anguilla, Armenia (HIV only), Belarus, Cuba, Montserrat, Republic of Moldova (syphilis only) and Thailand. Additional countries are scheduled for validation in 2017, and two WHO regions (Pan American Health Organization, Western Pacific Region) are advancing programming for triple eMTCT of HIV, syphilis and hepatitis B.

270. WHO helped low- and middle-income countries implement “Treat All” guidance via in-country technical assistance and workshops for inter-country exchange. These included a meeting of 20 countries in Victoria Falls, Zimbabwe, in August 2016 on gathering knowledge and best practices from B+. Participants discussed PMTCT, including new recommendations on infant prophylaxis and validation of eMTCT, and operational considerations for future programming, such as viral-load monitoring, PrEP in HIV-negative women, and integrating TB services within PMTCT.
271. WHO developed normative guidance on PrEP in HIV-negative pregnant women in high-risk settings, optimal frequency of testing in pregnant and breastfeeding women, strategic use of new ARVs, particularly integrase inhibitors, and best practices to improve ART adherence and retention.
272. WHO supported the *Start Free Stay Free AIDS Free* framework, working with UNAIDS and PEPFAR to develop technical support on priority interventions to reduce new HIV infections among children to 40 000 by 2018, and 20 000 by 2020.

### **Combination prevention**

273. WHO leads Joint Programme work on voluntary medical male circumcision (VMMC). In 2016 WHO supported 14 priority countries on their VMMC programme for adolescent boys and young men. WHO developed a 2016–2021 strategic action framework that embeds VMMC more broadly in combination prevention and includes adolescent sexual health and links to innovations for adolescent girls and young women.
274. WHO is active in combination prevention for adolescent girls and young women, and throughout 2016 it provided technical leadership on the appropriate, safe and most effective use of PrEP to countries in eastern and southern Africa. WHO provided technical support to ministries of health in Kenya, Mozambique, Namibia, South Africa, Swaziland and Zimbabwe in exploring the evidence as they consider, design and implement PrEP programmes for adolescent girls and young women, including those who sell sex.
275. WHO prioritized work with young key populations in all regions, supporting pragmatic, inclusive, safe and supportive service delivery. Technical briefs on young men who have sex with men, young transgender people, young people who inject drugs and young women who sell sex have been translated into Arabic and disseminated in the eastern Mediterranean region.

### **Youth health and education needs**

276. WHO supported integrating HIV prevention activities within schools and other educational institutions. This included increasing knowledge about VMMC and linking it to services, and increasing access to tetanus for boys and girls and to human

papillomavirus vaccination, with an initial focus on girls.

### **HIV services for key populations**

277. WHO prioritized HIV prevention, testing and treatment for key populations, updating 2014 consolidated guidelines for this group with new recommendations for PrEP and “Treat All” on HIV prevention, diagnosis, treatment and care.
278. WHO focused on rolling out the guidelines and developing a target-setting tool for use in regions and countries. It supported the development of implementation tools (MSMIT, TransIT and IDUIT), produced communication materials, including slide decks and web pages, and strengthened data collection.
279. WHO helped countries develop a key populations training manual for health care workers and implement training of trainers, supported global meetings on differentiated service delivery for key populations, and developed a strategic principles document on this.
280. It provided strategic information on key population indicators and target setting, and helped validate the global database on key population size estimates. WHO had a special focus on key population cascades to promote service access.

### **Harm reduction package for people who inject drugs**

281. In 2016, WHO released consolidated guidelines on integrating collaborative TB and HIV services in a comprehensive package of care for people who inject drugs. These had been developed with UNODC, the UNAIDS Secretariat and other stakeholders, and were presented at an International AIDS Conference workshop in Durban, where models of effective integrated care were discussed.
282. WHO provided technical and advocacy support, making the case for a public health focus on drug policy, for the 2016 UNGASS on drugs.

### **Women and girls**

283. Throughout 2016 WHO finalized its consolidated guidelines on the sexual and reproductive health and rights of women living with HIV, which were launched in 2017, engaging communities of these women in the process. The guidelines offer evidence-based recommendations for the rights of all women living with HIV, with a focus on settings where the health system has limited capacity. They provide good practice statements on operational and service delivery.

### **Gender-based violence**

284. WHO incorporated the need to recognize and mitigate vulnerability to gender-based violence in policy briefs and guidance developed for PrEP, testing (including HIV self-testing) and key population HIV services.
285. Guidelines for the clinical management of child and adolescent sexual abuse are due to be launched in 2017 following meetings of the guidelines development group and systematic reviews of evidence throughout the previous year.

### **HIV health care discrimination eliminated**

286. WHO, with the UNAIDS Secretariat, launched the Agenda for Zero Discrimination in Health Care in March 2016. WHO worked with Ministries of Health in countries in the African and eastern Mediterranean regions to develop training programmes to reduce stigma and for inclusive and respectful services for key populations in health care settings.
287. *The Bulletin of the World Health Organization* published a review on transgender health and human rights, titled Ensuring an inclusive global health agenda for transgender people. WHO's systematic review of evidence and knowledge gaps on the disease burden in sexual and gender minorities was published in the *International Journal for Equity in Health* in January 2016.

### **Technological and service delivery innovations**

288. WHO consolidated ARV guidelines, adding options such as integrase inhibitors, which are associated with fewer drug interactions, higher virological efficacy, lower treatment discontinuation rates and a higher genetic resistance barrier. However, their efficacy and safety are still being evaluated for pregnant women, TB coinfection and young children. WHO guides the development of short-, medium- and long-term ARV optimization at annual think tanks that inform updates on its consolidated guidelines and prepare industry. WHO is monitoring uptake and potential side effects of integrase inhibitor dolutegravir as it is introduced in Botswana, Brazil, Kenya, Nigeria and Zimbabwe.
289. Differentiated service delivery models for HIV care were introduced in 2016 WHO guidelines. These simplify and adapt HIV services across the cascade of care to reflect preferences and expectations of groups of people living with HIV while reducing burdens on the health system. Some 37% of low- and middle-income countries have already adopted differentiated service delivery models that reduce the frequency of clinic visits and enable stable patients to collect their ARVs.
290. The 2016 consolidated ARV guidelines included several recommendations on diagnostics to support patient management, including:
- when to scale down CD4;
  - use of viral load, and dried-blood-spot specimens for viral load;
  - early infant diagnosis at birth;
  - point-of-care early infant diagnosis testing and the use of rapid diagnostic tests for infants and young children; and
  - mHealth (mobile health) interventions.
291. WHO, with the Centers for Disease Control and Prevention, developed a handbook on improving the quality of HIV-related point-of-care testing, ensuring the reliability of test results. WHO helped countries develop prioritized plans for scaling up for viral load and EID and appropriate use of rapid diagnostic tests among children.
292. WHO's work on HIV testing included support for prequalification of HIV self-testing devices, including regular market landscape reporting and clinical utility criteria and developing normative guidance to support a range of community-based testing services. WHO led work on oral PrEP containing tenofovir disoproxil fumarate,

including a review of efficacy, safety and acceptability data to support guidelines development. WHO developed materials and tools on implementation guidance, including post-market surveillance and safety monitoring, and reviewed service delivery platforms for PrEP across populations.

293. WHO reviewed data for VMMC devices and coordinated post-market surveillance and safety monitoring. This enabled potentially adverse events to be minimized by changing use and providing guidance for tetanus vaccination. WHO revised a manual for male circumcision under local anaesthesia for release in 2017.

### **Decentralization and integration**

294. WHO led joint agency initiatives on differentiated service delivery models for HIV care, which were introduced in 2016 guidelines for treating HIV infection. In November 2016 WHO jointly convened a technical consultation on these models for specific populations and settings, with a focus on pregnant and breastfeeding women, children, adolescents and key populations.
295. WHO provides guidance and support on monitoring and evaluation systems at district and local level, integrating HIV indicators into district health information systems (DHIS 2), providing monthly dashboards for key countries such as Kenya, and developing guidelines on person-centred patient and case monitoring to build individual-level monitoring systems. This enables decentralized planning and individual support for HIV and chronic health care. WHO supported 82% of Fast-Track countries in national- and district-level programme reviews, 85% of Fast-Track countries with national- and district-level cascade analysis, and monitoring and evaluation systems for decentralized services.
296. WHO continued to advocate for joint TB and HIV programming and helped countries move towards integrated care through technical assistance and programme reviews. In coordination with the Global Fund, WHO convened a workshop in Nairobi where representatives from 11 countries shared best practices and identified actions and technical assistance needed to implement and monitor the revised TB/HIV and latent TB indicators. WHO convened an African regional meeting in Ethiopia where TB and HIV programme managers from 21 countries explored synergies to achieve global targets.



## WHO 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	3 652 054	15 013 986	18 666 040
SRA 2: Elimination of mother-to-child transmission	279 920	4 533 963	4 813 883
SRA 3: HIV prevention among young people	292 951	3 719 431	4 012 382
SRA 4: HIV prevention among key populations	707 945	6 724 855	7 432 800
SRA 5: Gender inequality and gender-based violence		861 815	861 815
SRA 6: Human rights, stigma and discrimination		2 558 028	2 558 028
SRA 7: Investment and efficiency	716 089	4 339 270	5 055 359
SRA 8: HIV and health services integration	616 820	2 569 152	3 185 972
<b>Grand total</b>	<b>6 265 779</b>	<b>40 320 500</b>	<b>46 586 279</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	1 848 787		12 874 557	0%
AP	1 242 649	59%	7 794 817	49%
EECA	694 119	32%	1 224 232	38%
ESA	1 094 052	73%	7 837 801	82%
LAC	231 223	19%	1 703 513	19%
MENA	339 500	21%	2 472 832	11%
WCA	815 449	81%	6 412 746	53%
<b>Grand total</b>	<b>6 265 779</b>		<b>40 320 500</b>	

## 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.

### **Innovative testing strategies**

297. Through its analytical work, the World Bank continued to build evidence on innovative testing and treatment implementation. In South Africa, the ART programme performance evaluation helps government decision-making for the roll-out of interventions. It is designed to provide robust effectiveness data and implementation learning in the HIV treatment cascade.

### **Access to treatment cascade**

298. The World Bank funded major health system strengthening to improve service access and quality, including HIV testing and treatment. Operations include HIV-specific actions and funding for testing and treatment as part of broader health projects. In Nigeria, Saving One Million Lives aims to increase the utilization and quality of high-impact reproductive and child health interventions, including HIV counselling and testing during antenatal care. In Swaziland, the Health, HIV/AIDS and TB Project aims to improve access and quality of health services, with a focus on primary health care, maternal health and TB, and to increase social safety net access for orphans and vulnerable children.

### **90–90–90 for children and adolescents**

299. Through its lending portfolio, the bank funded major health system strengthening to improve primary health care services, with a focus on child health. Projects in Nigeria, the United Republic of Tanzania and Zambia improved care for women and children, monitored HIV at facilities, and addressed immediate and systemic, and medium-term bottlenecks to service delivery for young children. Through the Health Results Innovation Trust Fund and the Global Financing Facility, it is a major financier of eMTCT programmes.

### **HIV services in high-burden cities**

300. Size estimation and programmatic mapping provided data to scale up key population programmes in cities. Studies, such as one conducted in Côte d'Ivoire for the cities of Abidjan, Bouake and San Pedro, offer programme managers, planners and implementers granular information needed to fast-track services.

301. The World Bank completed allocative efficiency studies at provincial, national and regional level and pioneered city-level studies. The Johannesburg study provided epidemic projections (HIV prevalence, related mortality, incidence, people living with HIV) and programmatic projections (people living with HIV on ART, people living with HIV virally suppressed). The analysis responded to the Fast-Track Cities initiative by assessing the HIV care cascade and future needs to reach 2020 and 2030 targets. It concluded, among other things, that the Johannesburg Health District needs to double ART scale-up to reach 2020 targets. In national studies, the World Bank can increase allocative efficiency by 20–40%, akin to a 20–40% budget increase, without additional resources from Finance Ministries.

#### **HIV services in humanitarian emergencies**

302. The World Bank funded health system strengthening to provide HIV-related services in humanitarian emergencies. In Lebanon, it is funding an emergency primary health care project to restore access to essential services for poor people affected by the influx of Syrian refugees, including those living with HIV. The World Bank is increasing its work in fragile, conflict and violence settings and is the largest development financier in such contexts.

#### **Medicines and commodities**

303. The World Bank provided funding to improve supply chain management and laboratory capacity in Africa through operations such as the East Africa Health Laboratories Network project. These aim to establish at country or regional level a network of efficient, accessible public health laboratories for the diagnosis and surveillance of TB, HIV and other communicable diseases. The World Bank finances better access to medicines and commodities as part of a broader health project. Kenya's Health Sector Support project to improve planning, financing and procurement of pharmaceutical/medical supplies, includes HIV testing and ART.

#### **Comprehensive eMTCT services**

304. In 2016, the World Bank funded and coordinated more than 30 maternal and child health projects to integrate PMTCT into SRH services, and increase uptake of primary maternal and child health services, including for HIV.
305. Through its results-based financing programme, the bank funded services to improve uptake of antenatal and PMTCT services in multiple countries. Ensuring a pregnant woman accesses quality antenatal clinic services, is tested for HIV and delivers at a health facility, are important steps in eMTCT. The programme expands the quality and reach of health care services in the poorest countries by linking financing to results. It focuses on paying for outputs and outcomes (e.g. increasing the percentage of women having a trained health worker deliver their baby) rather than for inputs or processes.
306. In Zimbabwe, the results-based financing grant increased coverage of maternal and child health interventions, including for HIV-positive mothers and children, in targeted rural and urban districts. The population coverage is about 4.1 million people. Urban pilot districts are supported through a demand-side maternal health voucher for the poorest households in Harare and Bulawayo, enabling testing of a targeted results-based intervention that reduces financial barriers for women and children to high-impact services, and improves their quality.

307. In Uganda, vouchers increased access to skilled care—primary reproductive health services, nutrition, PMTCT and HIV counselling services—during pregnancy and delivery for poor women in rural and disadvantaged areas.
308. In 2016, the World Bank supported projects in Nigeria, the United Republic of Tanzania and Zambia providing financing to improve primary health care, monitoring HIV at primary health care facilities, and addressing immediate, systemic and medium-term bottlenecks to service delivery for pregnant women, lactating mothers, newborns and young children at primary care and community levels.

### **Combination prevention**

309. World Bank funding supported combination prevention in multiple countries. In Malawi, the Nutrition and HIV/AIDS Project tackles significant causes of disease burden by implementing and scaling up the most cost-effective nutrition and HIV prevention interventions via public sector and community delivery systems. The World Bank provides fiduciary guidance and contributes to the pooled fund that supports HIV service delivery and coordination costs associated with the National AIDS Commission. The project is a major source of financing and technical assistance for Malawi's VMMC action plan.
310. Projects such as the Southern Africa Trade and Transport Facilitation Project (covering Botswana, the DRC, Malawi, Mozambique, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe) received financing for scaling up HIV services.
311. The World Bank developed evidence to improve the design of combination projects, and provided technical assistance to help countries define projects. It supported studies highlighting the importance of incentivizing VMMC demand. One in Malawi showed national policies and programmes can change perceptions and create demand. In South Africa, the World Bank MMC analysis demonstrates that financial savings are spread over long periods, and MMC can contain HIV costs. The bank generated evidence on the impact of incentives (conditional and unconditional cash transfers) on HIV outcomes, including reducing new HIV infections, and improving uptake and adherence to biomedical HIV interventions.

### **Youth health and education needs**

312. Combination prevention for young people remained a key part of the bank's global focus on HIV. By 2016, it had invested US\$ 46 billion in education. World Bank funds are helping to "crowd in" larger resources from governments and development partners, resulting in harmonized education programmes and lower transaction costs. Through this lending portfolio, the World Bank can strengthen the HIV education needs of young people via improved SRH curriculum, and better trained teachers and access to education for girls, particularly those most at risk of acquiring HIV (from low-income households, disadvantaged ethnic groups and fragile or conflict-affected contexts).
313. Adolescent SRH, one of five focus areas of the World Bank's Reproductive Health Action Plan, has implications for reducing poverty. Early age sexual debut, particularly for females, increases the risk of STIs including HIV, unplanned pregnancies, and maternal mortality and morbidity. The World Bank financed projects and conducted

analysis in six countries with a high adolescent SRH burden (Bangladesh, Burkina Faso, Ethiopia, Nepal, Niger and Nigeria) to investigate their socioeconomic profile and SRH status (and its determinants) from a demand and supply perspective, assess adolescent-friendly initiatives, and recommend country-specific policies to improve services.

314. World Bank analysis of VMMC focused on demand creation, cost-effectiveness and return on investment, and on the impact of age-specific interventions. It modelled the impact of combination prevention on youth in several countries, including Namibia and Zimbabwe. In South Africa, analysis focused on age-targeting, confirming its importance in making the HIV response more sustainable. Evidence of a higher epidemic impact in adolescent boys compared with adult men made the case for circumcising males at school age.
315. The bank focused on prevention for young people through its work on social protection. It led landmark social protection studies that showed conditional cash transfers can reduce STIs and HIV for young people.

#### **HIV services for key populations**

316. The World Bank financed comprehensive HIV prevention programmes for key populations. In Nigeria, the HIV/AIDS Program Development Project provides funding to scale up prevention interventions for sex workers and increase access to HIV counselling, testing, care and support services. Similar large-scale operations targeting sex workers and men who have sex with men received funding in 2016, including in India and Niger. Key population programmes are integrated in lending for SRH. In Burkina Faso, the Reproductive Health Project includes a component targeting key populations. Additional financing provided in 2016 supported a package of health services via results-based financing and reinforcing reproductive health and HIV care.

#### **Harm reduction package for people who inject drugs**

317. World Bank lending operations financed a package of harm-reduction services for people who inject drugs. In India, funding for the National AIDS Control Support helps increase safe behaviours among high-risk groups and procure opioid substitution therapy drugs. The World Bank financed HIV programmes for people who inject drugs in Cebu, the Philippines, and in Viet Nam, including the national strategic plan and methadone maintenance treatment.
318. World Bank analysis provides evidence for effective harm-reduction policies. It has supported studies on the cost-effectiveness and impact of harm-reduction services for people who inject drugs. Among those it disseminated in 2016 was one comparing drug relapse rates between compulsory drug detention centres and voluntary drug treatment centres, and another on the cost-effectiveness of a Malaysian harm-reduction programme. The report comparing the compulsory approach with voluntary-based "Cure & Care" clinics providing methadone services showed opioid-dependent persons in compulsory drug detention centres relapse faster than those treated with evidence-based treatments. Evidence on the return on investment of the needles and syringe exchange programme and methadone maintenance therapy in Malaysia has boosted the Government position in introducing these previously controversial programmes.

## **Women and girls**

319. The World Bank began to implement its Gender Equality Strategy 2016–2023 following consultations with more than 1000 stakeholders in 22 countries. The strategy addresses constraints to the HIV response, such as inadequate investment and prioritization of care services, including for HIV prevention and treatment. It focuses on improving human endowments through health, education and social protection, enhancing the ability of women to exert control over their lives, and engaging men and boys. The Bank takes gender equality into account in its analysis, content, and monitoring and evaluation work. This translates into financing for multiple targeted actions. In Uganda, for example, it finances a project to empower women and adolescent girls, and improve access to quality reproductive, child and maternal health services, including for HIV.
320. The World Bank provided evidence to support gender-transformative HIV strategies. It financed and conducted studies in several African countries on the social drivers of transmission in young women. These included a trial of incentives (cash transfers, and/or a lottery system) to adolescent girls and their families to determine the impact on retention in school and risk of HIV infection.

## **Gender-based violence**

321. World Bank lending contributes to gender-based violence prevention programmes, such as the Great Lakes Emergency Sexual and Gender-Based Violence & Women's Health Project. This project aims to expand services to mitigate the impact of sexual violence and gender-based violence, and interventions targeted at poor and vulnerable females, including those at high risk of acquiring HIV or already HIV-positive. As part of this project, the bank provides support to Burundi, the DRC and Rwanda.
322. The Bank helped countries address gender-based violence in HIV strategies through the umbrella facility for gender equality, a multidonor trust fund dedicated to strengthening awareness, knowledge and capacity for gender-informed policy-making.

## **Access to justice and rights**

323. World Bank funding empowered disadvantaged groups and upheld their rights, in particular, to HIV and health services. In Indonesia, the Citizens Voice for Government Accountability project improves maternal, newborn and child health outcomes, including PMTCT, through better governance and service delivery.

## **HIV health care discrimination eliminated**

324. The World Bank supported a study in Uganda on how information engages beneficiaries and leads to better health care and outcomes. Health education was found to significantly reduce stigmatization.
325. The Bank has taken a more comprehensive approach to including sexual orientation and gender identity in its management and operations. The SOGI Task Force coordinates research with Cosponsors on the legal discrimination of identity-based minority groups, including sexual minorities. SOGI considerations have been included in strategic documents, such as systematic country diagnostics and partnership frameworks in Thailand, Uruguay and the western Balkans, and in Brazil's Bahia

inclusion project to deliver HIV and health services and address victimization of LGBTI. In October 2016, the Bank appointed its first SOGI global adviser to provide leadership and technical guidance to staff and enhance coordination with civil society, UN agencies and other partners.

### **Efficiency and effectiveness of HIV response**

326. The World Bank emphasizes sustainability, efficiency and effectiveness in the HIV response in a dramatically altered funding landscape. To help governments finance programme scale-up with limited resources, and to support countries transition from international financing to greater domestic financing, the Bank led a programme to improve HIV allocative efficiency and sustainability.
327. Technical efficiency studies to improve HIV services and interventions were carried out, and programme effectiveness evaluated. The second phases of impact evaluation studies on ART adherence in South Africa and creating demand for VMMC in Malawi continue. The World Bank developed a tool to assess the financial sustainability of national HIV programmes and helped governments produce strategies, including integrating HIV and universal health coverage.
328. In 2016, the Bank worked on more than 10 allocative efficiency studies across six regions. In Europe and central Asia, it analysed the effect of reallocating HIV resources in Belarus following the Optima study. It was estimated these reallocations will avert an estimated 3200 new infections by 2018, and 25 000 by 2030. A rapid analysis of ARV prices in Bulgaria, and an analysis of programmes for people who inject drugs, were conducted. In western and central Africa, the Bank completed studies in Cameroon, Côte d'Ivoire and Togo, which underlined the need for additional efforts to close treatment gaps, and for continued investment in key population prevention and treatment programmes.

### **Technological and service delivery innovations**

329. The World Bank emphasizes eHealth to relieve service delivery bottlenecks and improve access and quality of health services, including HIV treatment and prevention services. It funds the eGabon project, which aims to improve the timeliness and availability of information to better deliver public health services, and the development and roll-out of eHealth applications and services, and information and communication technology services more generally.
330. Through its analysis, the bank provides evidence for using innovative tools and approaches in the HIV response. In 2016, it evaluated a smartphone app in a randomized controlled trial in Johannesburg. In Malawi, the Bank is supporting the Ministry of Health and National HIV/AIDS Commission in a human resources for health analysis of staffing profiles and productivity using the WHO staffing-need tool at facility and community level. An ART adherence study in South Africa tested several service delivery modalities for decentralized medication provision, including adherence clubs, the central chronic medicine dispensing and distribution scheme, and the central dispensing unit scheme. It uses a biomarker for effectiveness (viral suppression) and accumulates information on implementation processes, client views and the opinions of health care staff.

### **Decentralization and integration**

331. The World Bank provides financing, analysis and policy advice to help countries expand access to quality, affordable health care. The Bank aims to strengthen health systems at all levels, with support provided to decentralize and integrate HIV-related services into primary health care centres and SRH. Projects financed in 2016 included one in Ghana to improve the utilization of maternal, child health and nutrition services at primary care-level in target regions.
332. In 2016, the Bank disseminated country studies on policy options for universal coverage financing in Africa. The goal was to help the governments of Côte d'Ivoire, Kenya, Nigeria and United Republic of Tanzania and their development partners ensure the financial sustainability of HIV initiatives within the context of universal health coverage amid declining international health financing.

### **HIV-sensitive social protection**

333. The World Bank's new annual lending on social protection programmes reached US\$ 3.6 billion in the fiscal year 2016, including US\$ 2.5 billion in International Development Association countries, targeting the world's poorest. Its lending portfolio of more than US\$ 12 billion for social protection provides funding for systems in 70-plus countries. Projects included: Swaziland Health, HIV/AIDS and TB Project to increase social safety nets for orphans and vulnerable children; a conditional cash transfer programme in the Philippines that improved poor children's enrolment in basic education and provided maternal care, including PMTCT, to families; and Mexico's cash transfer programme that pays families who send children to school and access vaccination and health services.
334. The Bank continued to increase the evidence base in support of HIV-sensitive social transfers, building on its studies investigating how conditional cash transfers can reduce STIs, shown to be effective in Lesotho, Malawi and the United Republic of Tanzania.



## World Bank 2016 expenditure

**Table 1: Expenditure by strategy result area (in US\$)**

Strategy result area	Core expenditure	Non-core expenditure	Grand total
SRA 1: HIV testing and treatment	813 000	919 159	1 732 159
SRA 2: Elimination of mother-to-child transmission		534 800	534 800
SRA 3: HIV prevention among young people	281 000	822 199	1 103 199
SRA 4: HIV prevention among key populations	343 169	909 159	1 252 328
SRA 5: Gender inequality and gender-based violence	56 000	225 000	281 000
SRA 7: Investment and efficiency	1 675 000	1 116 119	2 791 119
SRA 8: HIV and health services integration	959 000	1 071 560	2 030 560
<b>Grand total</b>	<b>4 127 169</b>	<b>5 597 996</b>	<b>9 725 165</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	650 000		250 000	0%
AP	869 292	83%	1 638 902	68%
EECA	144 882	60%	345 032	5%
ESA	1 738 585	100%	1 466 386	93%
LAC	144 882	40%	603 806	51%
MENA			86 258	0%
WCA	579 528	65%	1 207 612	73%
<b>Grand total</b>	<b>4 127 169</b>		<b>5 597 996</b>	

## UNAIDS Secretariat

### Leadership, advocacy and communication

#### *Repositioning the AIDS response: keeping HIV high on the global agenda*

335. In 2016, the UN General Assembly HLM adopted a political declaration to accelerate the response and end the epidemic by 2030. The Political Declaration builds on the UNAIDS Strategy 2016–2021 and provides directions to accelerate efforts to reach the 90–90–90 Fast-Track targets by 2020.
336. For the HLM in New York in June 2016, the Secretariat supported a review of the achievements of MDG 6 and efforts to map the trajectory of the SDGs to end AIDS by 2030. It organized panels and side events, including a discussion on financing and sustaining the end of AIDS that explored how to front-load investments in high-burden and low-prevalence countries. It was concluded that without sustainable financing, gains made risk being lost and the epidemic prolonged indefinitely. The Executive Director positioned UNAIDS to lead the way in developing a strategic investment approach for domestic and international spending.
337. Other Secretariat initiatives included:
- a panel – Leaving no one behind: ending stigma and discrimination through social justice and inclusive societies – during the HLM in New York, and a [panel](#) at the thirty-first session of the Human Rights Council, mandated by its [resolution 30/8](#), to discuss progress and challenges in addressing human rights concerns in the context of the AIDS response;
  - a side event—“HIV and security: past, present and future”—that strengthened the HIV and humanitarian action agenda in the political declaration on HIV;
  - briefings on financing the AIDS response with civil society and nongovernmental organizations, and negotiations with ambassadors and regional groups;
  - a meeting attended by more than 160 participants to highlight the leadership role of cities and showcase urban innovations to achieve Fast-Track targets.
338. A joint event with PEPFAR, GAVI, the vaccine alliance, and the Organisation of African First Ladies promoted access to integrated SRHR and HIV services, including cervical cancer screening, for adolescent girls and young women, which was included in the political declaration.
339. High-level advocacy continued at the 21<sup>st</sup> International AIDS Conference in Durban (AIDS 2016) in July at the ministerial level to reinforce leadership and progress in the AIDS response during a plenary session and at several pre-conference events with members of civil society organizations.
340. UNAIDS senior management met heads of state, health and finance ministers, and other government, national and civil society partners to promote the UNAIDS call for an accelerated global response, shared responsibility and global solidarity, and to ensure no one is left behind. With the Government of Côte d'Ivoire, UNAIDS spearheaded three major events to advance the 90–90–90 agenda for children.
341. The Secretariat strengthened engagement with BRICS countries (Brazil, China, India, the Russian Federation and South Africa). At the close of the [2016 BRICS Summit](#) in

Goa in October, leaders acknowledged the need for further cooperation in the HIV and TB responses.

342. Ahead of World AIDS Day, the report [Get on the Fast Track: the life-cycle approach to HIV](#) was launched, providing innovative analysis of data and information.

### ***HIV prevention and treatment***

343. The UNAIDS [Prevention gap report](#), launched ahead AIDS 2016, highlighted key achievements, challenges and opportunities in global efforts towards HIV prevention. Member States adopted the target of [reducing new HIV infections to fewer than 500 000 globally by 2020](#), to accelerate prevention outreach and promote access to tailored comprehensive prevention services for all women, girls and key populations. It encourages countries with high HIV incidence to ensure 90% of those at risk are reached by comprehensive prevention services, three million people at high risk of HIV infection access PrEP, an additional 25 million young men are voluntarily medically circumcised by 2020, and 20 billion condoms are available in low- and middle-income countries. Member States committed to ensure financial resources for prevention are adequate and constitute no less than one quarter of AIDS spending globally. A directive to UNAIDS staff to fast-track HIV combination prevention as a core priority triggered significant advocacy efforts in priority countries, including Ethiopia, Malawi, Swaziland and Zimbabwe, which held dedicated national prevention consultations.
344. UNAIDS and African television operator StarTimes reached millions of people with World AIDS Day messages. UNAIDS produced two short videos promoting the life-cycle approach to HIV prevention that were broadcast in English and French.
345. [Start Free Stay Free AIDS Free](#), the super-Fast-Track framework developed to focus on paediatric ARVs and broader HIV prevention and treatment for children, mothers and adolescents, was launched in a number of countries, including Cameroon, Namibia and Zimbabwe. The Secretariat developed the website and brochure, coordinating work with PEPFAR, the Elizabeth Glaser Pediatric AIDS Foundation, faith-based organizations and UN partners, among others. UNAIDS appointed the First Lady of Namibia, Monica Geingos, as UNAIDS Special Advocate for Young Women and Adolescent Girls to champion the initiative.
346. The Secretariat, with WHO, worked on validating eMTCT of HIV and syphilis, ensuring that human rights, gender equality and community engagement considerations are an indispensable element of the process. By the end of 2016, about 20 countries in the Caribbean, central Asia, eastern Europe and South-East Asia were on track to be validated for HIV or syphilis elimination, or both, over the next few years; Armenia, Belarus, Montserrat and Thailand were validated for eMTCT of HIV.
347. UNAIDS International Goodwill Ambassador Victoria Beckham and her son Brooklyn visited Kenya with Born Free Africa and UNAIDS to raise HIV awareness. Their visit focused on preventing new HIV infections among newborn children and keeping their mothers healthy, and the urgent need to promote testing, prevention and treatment for young people, especially adolescent girls and young women.
348. The Secretariat has driven the [UNAIDS treatment agenda](#) through the 90–90–90 target and associated work streams. It provided leadership and support in developing diagnostic and forecasting tools to implement HIV treatment guidelines, and advocated

for treatment coverage of people living with HIV, including initiatives to secure affordable medicines and develop domestic pharmaceutical production of HIV and other medicines and health commodities with a focus on Africa. During a meeting organized in the Vatican in May 2016, a statement was provided by Pope Francis to widen access to testing and treatment services.

349. In collaboration with partners, the Secretariat and WHO produced guidance on care and support, the non-ART services essential to improved well-being and fewer deaths among people living with HIV—an important policy shift to clarify the approaches required for rapid scale-up and immediate linkage to treatment, in line with the 2016 WHO guidelines. The guidance (translated into French, Spanish, Russian and Chinese) highlighted the “wraparound” HIV services that enhance ART effectiveness and treatment adherence. It also responded to increased civil society organization calls for UNAIDS to consider care and support as an essential package of HIV treatment and prevention and related goals.

### ***Human rights, gender equality and non-discrimination***

350. UNAIDS strove to shape human rights-based and gender transformative responses through critical forums such as the HLM, the Human Rights Council and the World Health Assembly, and by engaging with the African Commission and other regional bodies. The Secretariat initiated strategic dialogue, convening partners such as HIV Justice Worldwide, the Office of the United Nations High Commissioner for Human Rights (OHCHR) and Amnesty International, and leading efforts to address the misuse of criminal law and its impact on health, including through a global scientific statement on HIV and the law. The Secretariat also worked to advance HIV-related human rights through innovation, including leveraging pro bono legal support for the AIDS response, through a memorandum of understanding with international law firms that resulted in almost half a million pounds of donated legal services. To promote local ownership and sustained access to justice efforts for people living with HIV and other affected populations, the Secretariat, with the International Development Law Organization, has worked towards strengthening the capacity of university professors and legal clinics to support legal services in Uganda and the United Republic of Tanzania.
351. On 2016 [Zero Discrimination Day](#), the Secretariat, with WHO and Global Health Workforce Alliance, jointly launched the Agenda for Zero Discrimination in Health Care. Partners such as governments, civil society, United Nations, professional health care associations and donors work for accountability and political commitment to end intersectional discrimination in health care. Achievements included:
- development of a draft interagency statement on elimination of discrimination in health care, with WHO;
  - launch of [equalhealth4all](#), a virtual platform with some 120 members from more than 50 organizations for sharing evidence, tools and best practices;
  - launch of [www.zeroHIVdiscrimination.com](http://www.zeroHIVdiscrimination.com), serving as an e-repository for useful tools to assess and address HIV-related discrimination in health care;
  - a session at Prince Mahidol Award Conference, bridging the agenda and broader universal health coverage movements, and a parallel session at the 2017 World Health Assembly.
352. On [Human Rights Day](#) in December, UNAIDS urged the world to stand up for the rights of those most discriminated against and marginalized, and for an end to stigma,

discrimination and rights violations against everyone. On the [International Day of the Girl Child](#), UNAIDS supported a UN call for better age- and sex-specific data to improve the health and well-being of girls aged 10–19 years.

353. In March, the Commission on the Status of Women (CSW) Resolution 60/2 on women, the girl child and HIV was approved, foreshadowing the Political Declaration with its commitment to gender equality and women and girls' empowerment. Throughout the process, UNAIDS Secretariat worked closely with UN Women, the Southern African Development Community who tabled the resolution, and the African Union Office. UNAIDS helped with an action plan to implement the resolution, and ministry staff from 15 countries developed specific plans addressing gender equality and HIV.
354. UNAIDS supported the #WhatWomenWant campaign led by the ATHENA network, which created momentum on social media, culminating in a popular side event during the HLM. The campaign, which aims to amplify women's voices, had a virtual reach of more than 13 million accounts on Twitter in the six weeks up to the New York meeting, with 120 000 people engaging in five Twitter chats from May to July.
355. The Secretariat leveraged global platforms that more broadly addressed gender equality, and included HIV and SRHR. At the 4th Women Deliver Conference, the Secretariat helped review 106 youth scholarship applications to Women Deliver, financially supported six scholarships and engaged young SRHR and AIDS activists. UNAIDS joined the Young Women's Christian Association to stage the first Human Rights Council youth forum, resulting in a declaration strongly positioning HIV and SRHR. The Secretariat also secured and prepared the HIV and SRHR work stream in the CSW young people's pre-conference, resulting in SRHR and HIV being included in the declaration.
356. With the University of KwaZulu-Natal and a consortium of CSOs, UNAIDS has strengthened the capacity of civil society groups to address violence against women in the context of HIV, based on the WHO and UNAIDS 2013 tool. An implementation framework (ALIV(H)E), applied in India, Kenya, Malawi, South Africa, South Sudan and Zimbabwe will be available in 2017. In support of the annual 16 Days of [Activism against Gender Violence](#), UNAIDS urged action to keep girls in school, end gender-based violence and reduce girls' vulnerability to HIV.
357. Advocacy briefs were developed to summarize and standardize 36 country gender assessment reports, enabling national governments, civil society and affected communities to identify priority areas and ensure a gender-transformative response to the TB and HIV epidemics. In June 2016, UNAIDS and the Stop TB Partnership launched the TB/HIV gender assessment tool. UNAIDS provided technical input on key populations and gender to the Global Fund five-year strategy, and to the drafting of key performance indicators and developing technical briefs. Together with WHO, it also successfully advocated for dedicated catalytic funding opportunities for human rights, key populations and gender-focused programming through the Global Fund.
358. UNAIDS led advocacy on an integrated approach HIV, human papillomavirus and cervical cancer, promoting it at the HLM, the World Cancer Congress and AIDS 2016. Global partners like vaccine alliance Gavi, the Organisation of African First Ladies against HIV/AIDS, PEPFAR, Pink Ribbon Red Ribbon, WHO and civil society joined the call for taking AIDS out of isolation. A specific target for cervical cancer was included in the Political Declaration. UNAIDS also contributed to Pink Ribbon Red

Ribbon, highlighting UNAIDS' leadership in community-driven approaches to women's health.

### ***Advocacy to promote HIV in the global health and development landscape***

359. The Secretariat established media outreach and communication strategies to promote UNAIDS and HIV in the global health and development landscape at technical conferences and high-profile events. Social media and online platforms are increasingly integrated in UNAIDS' corporate communications.
360. For a third year, UNAIDS won prizes at the British Medical Association book awards. [How AIDS changed everything](#) was runner-up in the President's Choice Award and highly commended in the public health category. The [Cities ending the AIDS epidemic](#) report was launched in New York, detailing evidence from more than 30 cities on their progress towards the 2020 targets.

### **Partnerships, mobilization and innovation**

#### ***Strengthening dialogue with governments, communities and stakeholders***

361. The Secretariat reinforced dialogue with key donors, strengthening partnership with governmental sectors and parliamentarians, and with national civil society groups. Dialogue between donors and countries and regions has been reinforced, through country visits and interaction with local development cooperation offices.
362. Working with WHO, a Secretariat consultation with pharmaceutical companies, national governments and civil society on forecasting for ARVs and diagnostics for HIV treatment and prevention fed into guideline implementation.
363. The Secretariat partnered with the Friedrich-Ebert-Stiftung Foundation and the Southern African Social Protection Experts Network to expand HIV-sensitive social protection in the Southern African Development Community (SADC) region by training a cadre of experts. The partnership included participation in a Johannesburg meeting in October on comprehensive social protection systems for the SADC region.
364. The Secretariat has a memorandum of agreement with the International Association of Schools of Social Work, which guides collaboration that connects people living with HIV, at risk and affected by HIV to essential services, and makes services work for them. In 2016, UNAIDS and IASSW published a joint report, [Getting to zero: global social work responds to HIV](#), a collection of peer-reviewed scientific articles showing how social workers are central to the HIV response and charting the way for country collaboration with them.
365. The UNAIDS publications, [Stronger together, Governments fund communities and Invest in advocacy](#), helped integrate community HIV responses in national AIDS plans, while partners were convened at global, regional, national and subnational levels for coherent action to end intersectional discrimination in care.
366. The Secretariat led planning and delivery of a PCB thematic session on the critical role of communities in the AIDS response, including the background note and collecting



more than 60 case studies.

***Giving voice to vulnerable populations against punitive laws and human rights violations***

367. The Secretariat facilitated developing country cooperation to advance human rights. A report was launched of the first dialogue between the Inter-American and African commissions on human rights, OHCHR and UNAIDS on better protecting the rights of LGBTI people.
368. Support was provided for the co-publication, [\*Dignity, freedom and grace\*](#), to help faith-based organizations better understand human rights and sexual and reproductive health in addressing HIV-related stigma and discrimination.

***Prioritizing partnerships with global development partners***

*Supporting countries accessing and implementing Global Fund grants.*

369. The Secretariat worked to ensure the Global Fund strategic framework 2017–2022 aligns with the UNAIDS Fast-Track strategy to end AIDS by 2030 and the SDGs. UNAIDS collaboration with the Global Fund was recognized by partners, including at the Global Fund replenishment meeting in Montreal.
370. Through the Global Fund's Implementation Through Partnership project, the Secretariat was responsible for coordinating 19 actions and supported another 44 to resolve bottlenecks in disbursing funds. Collaboration with Global Fund technical partners, particularly WHO, the Stop TB partnership and UNDP, is managed through regular meetings, information sharing and platforms such as the joint working group. UNAIDS Secretariat has a key role in bringing Cosponsor inputs to the board of the Global Fund, where UNAIDS represents the Joint Programme. UNAIDS advocacy has been critical to support grant applications for highest-impact investment.
371. A Secretariat brochure and a publication with country case studies highlighted the partnership with the Global Fund, and results achieved on the ground. At country level, UNAIDS plays a key role as broker, including mobilizing for inclusive country dialogue with meaningful participation of civil society, convening the UN Joint Teams on AIDS and coordinating technical partners to support funding application development and Global Fund country processes.
372. When countries encounter difficulties in securing Global Fund resources or implementing grant programmes, UNAIDS can draw on its established relationships to overcome hurdles. UNAIDS supports improved governance and accountability around the Country Coordinating Mechanisms, helping to ensure processes meet Global Fund requirements. It has supported the development of oversight committees to support country-owned monitoring capability for timely, appropriate use of grants.
373. UNAIDS provided technical support in coordination with other partners, including through Technical Support Facilities, to assist countries in funding application development, and grant-making and implementation.
374. UNAIDS, with the Global Fund and WHO, led regional workshops on resource

allocation modelling, and collaborated with the Global Fund on improving modelling capacity to inform decision-making in 16 countries in Africa and Asia.

375. UNAIDS supported programming of social protection in the work of the Global Fund. Malawi, South Africa, the United Republic of Tanzania and Zambia, among others, were supported to include HIV-sensitive social protection, cash transfers, and care and support services in their proposals. In South Africa, a proposed multi-million dollar project to prevent HIV infections in King Cetshwayo District of KwaZulu-Natal through combination social protection, care and support will target 20 000 adolescent girls and young women.

#### *Working with PEPFAR*

376. PEPFAR has fully embraced the vision and strategy articulated by UNAIDS, and there is an unprecedented level of alignment between UNAIDS goals and targets to Fast Track the end of AIDS and PEPFAR's strategy and operational guidelines to achieve epidemic control in highly-impacted countries. PEPFAR and UNAIDS work closely to help countries implement data-driven investment approaches in national planning processes, so that resources are directed to the locations and populations most affected by the epidemic. The Secretariat supported over 20 PEPFAR countries during the PEPFAR Country Operational Planning (COP) process and is a key partner in the expanded COP process overall. It engages jointly in policy advocacy with countries for the implementation of "test and start", based on WHO guidance which recommends ART for everyone living with HIV at any CD4 cell count, in an effort to improve health outcomes. The UNAIDS Secretariat also works closely with PEPFAR and a cross-section of U.S. partners to ensure that the core principles of the Fast Track agenda help inform the U.S. domestic response to the epidemic. The Secretariat has also supported and been involved in the Inter-agency Working Group on stigma and discrimination established by PEPFAR and USAID, and the Technical Advisory Group on stigma, discrimination and violence affecting key populations, established by LINKAGES.
377. The *Start Free Stay Free Be Free* initiative was developed with PEPFAR to drive continued focus and results for paediatric ARV access and broader HIV prevention and treatment for children, mothers and adolescents. It builds on and reflects the lessons learned from the *Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive*. The Secretariat provided strategic leadership and coordinated various streams of work with PEPFAR, the Elizabeth Glaser Pediatric AIDS Foundation, faith-based organizations, foundations and key partner governments. The initiative was launched at the High-Level Meeting on AIDS at an event that included the participation of the UNAIDS and UNICEF Executive Directors, the First Lady of Namibia, the Minister of Health of South Africa, the Minister of Public Health of Thailand, and the U.S. Global AIDS Coordinator. In December, a high-level ministerial dialogue was organized in Geneva with nine Ministers or Vice Ministers (Equatorial Guinea, Guinea (Conakry), Lesotho, Malawi, Mozambique, Namibia, Nigeria, Swaziland and Uganda), with the objective of identifying critical next steps and necessary support for accelerating progress towards the goals of *Start Free Stay Free AIDS Free*.
378. UNAIDS continues to work closely with PEPFAR on support to community engagement in the response to HIV, as well as programming to address the social and economic drivers of the epidemic. This includes country support and



engagement related to social protection, economic empowerment and access to education for adolescents in the ten countries participating in PEPFAR's DREAMS initiative (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe). UNAIDS provides technical leadership and brokers partnerships for combination social protection services that optimize prevention and treatment results.

### ***Engaging with civil society***

379. The Secretariat supported civil society-convened events and conferences on HIV-related human rights, highlighting UNAIDS policies and data. Efforts to promote an enabling environment included:

- A side event at the HLM, where mayors, civil society and urban stakeholders met with private-sector companies to explore leveraging innovations and financing for ending AIDS in cities. Technologies in information, mobile and data apps, science, pharmaceuticals and diagnostics were illustrated;
- As a member of the international steering committee of the Robert Carr Fund for civil society networks, the Secretariat guided strategy and facilitated receipt of funds;
- In the lead-up to the HLM, the Secretariat helped plan a hearing for civil society and other stakeholders, and facilitated their participation in thematic panels and side events. An African civil society common position was integrated into HLM outcome negotiation;
- The Red Ribbon Awards and UNAIDS community dialogue space during the International AIDS Conference showcased 10 outstanding community-based responses from various countries. This offered connections to grass-roots civil society organizations and linked UNAIDS country offices to global work;
- A Secretariat-led initiative bringing together five faith-based organizations supported consultations hosted by the Vatican to strengthen language on scaling up paediatric HIV treatment for the Political Declaration, and commitment by pharmaceutical companies to work with UNAIDS on affordable paediatric formulations;
- The Secretariat led development of tools for community engagement. These included guidelines, [models of domestic funding](#) mechanisms for community responses, reference documents on [investing in advocacy](#), and indicators of community engagement in national programmes to prevent mother-to-child transmission. An e-tool on analysing evidence from the People Living with HIV Stigma Index using a reproductive, maternal, newborn, child and adolescent health lens was also developed, along with a trainer's manual for community health team supervisors to better engage people in national programming, a literacy guide addressing barriers to service for pregnant women and an annotated bibliography of community-based service delivery costing methodologies.

### ***Collaboration with other partners***

380. The Secretariat continued to engage with a diverse range of partners, including IAPAC, Centre for the AIDS Programme of Research in South Africa, United Nations Human Settlements Programme (UN-Habitat), Centers for Disease Control and Prevention, African Development Bank, New Partnership for Africa's Development, MAC AIDS Fund, German Healthcare Partnership and Xinhua news agency. Partners

were encouraged to renew commitments to accelerate the HIV response at city and country levels, mobilize additional resources and influence investments in crucial locations for key populations and other left-behind groups.

381. The Secretariat provided briefings for two American AIDS umbrella advocacy groups (Global AIDS Policy Partnership and Federal AIDS Policy Partnership), and hosted a round table with the Kaiser Family Foundation on ways to engage with the HLM and advocate for political commitment to ending AIDS in the US and beyond.
382. A [joint event with United Nations Conference on Trade and Development \(UNCTAD\)](#), organized at the World Investment Forum, on access to medicines in Africa through local pharmaceutical manufacturing, brought together ministerial and private-sector representatives. The Secretariat-prepared Nairobi Statement on investing in access to medicines was signed by UNCTAD, UNAIDS and African Union health and trade ministers.
383. Partnership with telecommunications operator Orange resulted in a memorandum of understanding to collaborate on a mobile technology platform to improve data collection. A programme was developed and a treatment situation room established in Côte d'Ivoire. UNAIDS and partners will use M-Tew (Mobile Training EveryWhere), a web-based platform that can be integrated into health systems at scale, enabling staff to communicate with clients via text/voice messages. PEPFAR and the Global Fund are interested in the Secretariat's situation room concept and contributing to country roll-out.
384. Funds to UNAIDS from the Swedish International Development Cooperation Agency strengthened the AIDS response in the eastern and southern Africa region, including community engagement and human rights-based approaches in reproductive and maternal and child health interventions.
385. At the 21st International AIDS Conference in Durban in 2016, the Secretariat and partners launched GenEndIt to engage a younger audience in activism to end AIDS. High-profile partners include the Charlize Theron Africa Outreach Project, Elton John AIDS Foundation, the Sentebale charity founded by Prince Harry of the British royal family. The Secretariat appointed AIDS activist Kenneth Cole as a UNAIDS International Goodwill Ambassador.
386. UNAIDS Secretariat and Anglo American, one of the world's leading mining companies, joined together to support ProTESTHIV, a global initiative that encourages people to get tested for HIV. Announced at AIDS 2016, the partnership promotes the voluntary HIV testing, care and support for people living with HIV and broader HIV prevention programmes. During the AIDS conference the campaign reached a total of 6.3 million people through social media. Executive leadership revamped the call for testing at a meeting in Geneva later in the year, while World AIDS Day was used to reinforce testing with employees. These interventions motivated the company's HIV testing rates to go up to 86%, well above 2015 data.
387. UNAIDS Secretariat teamed up with Boiler Room TV—the world's leading community of underground music fans—to promote ProTESTHIV encouraging young people to get tested for HIV. The event was live streamed and reached 2.7 million young people worldwide. Housing Works provided HIV testing on site.

388. Working in partnership with the InterContinental Hotel Geneva, Maison Cartier and Design Miami, UNAIDS Secretariat organized its second fundraising gala at the opening vernissage of Art Basel.
389. Celebrity engagement—Prince Harry and Rihanna supported ProTESTHIV on World AIDS Day, who got over one million likes on Instagram alone.

### ***Strategic information***

390. UNAIDS brings an evidence-based, global perspective to the HIV response, helping decision-makers engage constructively. The Secretariat played a key role in developing and analysing strategic information products, highlighting areas of innovation and mapping audiences for such products.
391. One priority in 2016 was to measure the financing gaps of 116 low- and middle-income countries (LMICs) to Fast-Track the AIDS response and define options. Components included updating HIV 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.
392. The update on investment needs to end AIDS by 2030 and to finance the Fast-Track response were consistent with the UNAIDS 2016–2021 Strategy, SDG target 3.3 and WHO 2015 ART guidelines update. Needs are estimated at US\$ 26.2 billion by 2020, which requires increased and front-loaded resources, significant efficiency gains and higher programme effectiveness. The financing gap by 2020 was estimated at US\$ 7.2 billion, in addition to 2015 levels of HIV resource availability. Resource analysis enabled proposals for a streamlined model of care, lower ARV prices, updated service provision data and updated unit costs.
393. The resource needs update helped the Global Fund define resource mobilization targets for its replenishment exercise. Investment analyses were completed in five countries and are under way in 10 others. Cost analysis on HIV testing and counselling and prevention of mother-to-child transmission was completed in Kenya, Rwanda, South Africa and Zambia. Desk reviews for fiscal-space analyses to identify domestic financing targets and discussions with the 33 low- and middle-income Fast-Track countries were completed. Working with the International Red Cross Federation, expenditures per unit of community-based service delivery for ART and testing were analysed in Haiti, Lesotho, Malawi and Myanmar. UNAIDS supported the costing of expenditures per unit on services for gay and other men who have sex with men in Argentina, Brazil, Dominican Republic, Ecuador, Guatemala, Paraguay and Peru.
394. UNAIDS Economic Reference Group (ERG) projects included a feasibility study on integrating HIV into the National Health Insurance Fund in South Africa. Five policy briefs on sustainable financing, transitions and integrated HIV and universal health coverage financing are available via the [ERG website](#). The ERG conducted analyses of countries in transition to higher income levels, collaborating with WHO on HIV and universal health care, and with the Global Fund, USAID and PEPFAR on transition preparedness assessments.
395. Support to 160 countries to produce HIV estimates keeps UNAIDS at the forefront of reporting on the epidemic. The results have highlighted the slow decline in new infections and shifted the focus of the response towards prevention. Specific economic and epidemiological analyses were prepared to support the Secretariat's advocacy and positioning, including studies on the level of homophobia in more than 160 countries, the economic cost of homophobia, the link between poverty, inequality and HIV, and between human rights violations and vulnerability to HIV infection, and the economic returns of the Fast-Track initiative.



396. The Secretariat developed a concept around the new global AIDS monitoring tool for national rapporteurs to automate visualization of country data. The methodology to estimate out-of-pocket HIV expenditures in low- and middle-income countries was revised using GARPR reports; exploratory work on country estimates based on Demographic and Health Surveys was initiated. Data from 72 countries reporting domestic public AIDS expenditure in the 2016 GARPR cycle were used to estimate domestic public expenditure on HIV in low- and middle-income countries.
397. As part of initial steps to pilot a performance-oriented resources tracking (PORTIA) framework, a project to estimate domestic private expenditures was undertaken to support the Dominican Republic's application to the Global Fund; other pieces of PORTIA were piloted in Malawi and Panama.
398. The Secretariat, global experts and country representatives discussed how to integrate HIV in health financing at a WHO meeting in April 2016, for example, which looked at how a collaborative agenda on fiscal space, public financial management and health financing might be implemented. The meeting discussed options for integrating HIV services into universal health coverage and national insurance benefits. There is a costing exercise to determine the price tag of the health-related SDGs, consistent with previous HIV resource needs estimates by the Secretariat.
399. The HIV situation room, which builds on data in the District Health Information System and other systems was supported in Kenya and will be improved and rolled out in Côte d'Ivoire and five additional countries. UNAIDS situation rooms are used to collect real-time data to monitor progress on the 90–90–90 treatment targets to end the AIDS epidemic. The Secretariat is collaborating with the private sector to integrate community data into national monitoring and evaluation systems and tools, such as situation rooms.
400. The Secretariat worked with partner organizations to develop a model that can be used in countries that do not easily feed into traditional UNAIDS epidemiological modelling tools. This improved global estimates in 2016 for Europe, North America and Latin America. Another achievement was the calculation of the distribution of new infections by key population and time trends.
401. The [AIDSinfo](#) online resource was updated to include more subnational data and treatment cascades. The Secretariat supported countries to develop 160 Spectrum (the software used to produce HIV estimates) files, including subnational estimates for 10 countries and case-reporting data for 62. Staff from six countries in Asia and seven in sub-Saharan Africa were trained to estimate the impact of national strategic plans.
402. The UNAIDS Secretariat provided data and analysis (epidemiological and on HIV finances, legal environment stigma and discrimination reduction and other critical enablers) for the following seven 2016 flagship reports:
- [Fast-Track update on investments needed in the HIV response](#)
  - [Do no harm: health, human rights and people who use drugs](#), which includes strategic information to advocate for an appropriate response
  - [Global AIDS update 2016](#)
  - [On the fast-track to an AIDS-free generation](#)
  - [The cities report](#), with data from more than 50 cities to assess progress in the HIV response

- [Prevention gap report](#), with critical data and messages to refocus on prevention
  - World AIDS Day 2016 report, [Get on the Fast-Track – the life-cycle approach to HIV](#).
403. Other 2016 publications that feature strategic information, data and analysis included:
- [A synthesis report of existing research and literature on intellectual property](#), which builds on an extensive literature review from 2001–2016 and covers factors affecting the availability, affordability and accessibility of treatment and diagnostics for HIV and coinfections in low- and middle-income countries;
  - The 90–90–90 progress report, [An ambitious treatment target to help end the aids epidemic](#);
  - The [key populations atlas](#) online tool, produced with the Global Fund, WHO and the Centers for Disease Control, provides data for local-level action by policy-makers;
  - Guidance to enhance [HIV prevention efforts among adolescent girls and young women](#) in high-prevalence countries, advising on design, delivery and measuring effective combination prevention programmes;
  - An annual update of the [2015 donors bilateral disbursements for LMICs](#), which was launched with the Kaiser Family foundation. UNAIDS estimates on multilateral and philanthropic disbursements were added to estimated total international global flows at US\$ 8 billion for LMICs in 2015 (out of a total US\$19 billion available);
  - [The Global Plan progress report, On the Fast-Track to an AIDS-free generation](#), detailed advances in reducing paediatric infections;
  - ACT!2015, a youth-led social action initiative supported by UNAIDS, and the PACT (global alliance of youth organizations working on HIV), refocused on strengthening young people’s skills to generate strategic information for policy change advocacy;
  - Publications produced for the HLM, including a snapshot on [Women and girls](#), and papers on [Children, adolescent girls and young women: preventing new HIV infections](#) and [Breaking the silo: empowering adolescent girls and young women to access integrated health care services](#). For AIDS 2016 in Durban, an updated briefing booklet on CSE, gender equality and women’s empowerment and sexual and reproductive health and rights was produced;
  - Contributions to practical guidance, [Implementing comprehensive HIV and STI programmes with transgender people](#), and support for a supplement in the *Journal of the International AIDS Society*, [Implementing comprehensive HIV and STI programmes with transgender people](#), informed prevention thinking to address increasing HIV rates among the group;
  - A reference document, [HPV, HIV and cervical cancer: leveraging synergies to save women's lives](#), was developed with WHO and the Global Coalition on Women and AIDS;
  - A reference document, [Eliminating discrimination in health care](#);
  - The impact of new information and communication technology on programmes for gay men and other men who have sex with men was reviewed and recommendations for future programming made; and
  - The Secretariat contributed to a joint [UNAIDS-Department of Peacekeeping Operations report](#) on UN responses to AIDS in conflict and post-conflict settings.

### **Coordination, convening and country implementation support**

404. The Secretariat facilitated and coordinated support to countries, subnational locations and cities for addressing gaps and challenges in programme implementation to meet Fast-Track and HLM targets, and to end AIDS by 2030. Working with Cosponsors,

partners and academia, examples of Secretariat support include the following:

- Identification of gaps and provide solutions to challenges that impede delivery of impactful, inclusive prevention and treatment services;
- Political and technical support to make the 'case' for programme optimization and accelerated service delivery;
- Data collection on UN support, and reporting to governments to help meet HIV targets;
- International and domestic guidance on resource mobilization;
- Integration of innovation in service delivery and strategic information;
- Promotion of sustainability and transition planning;
- Development of guidance to implement the Fast-Track approach in cities, and outline actions needed to accelerate the HIV response to meet targets;
- Mid-term review of three technical support facilities and to assess potential alternative business models, as well as develop a prioritization framework for technical support;
- Development of a human rights, gender equality and community engagement tool for validating eMTCT of HIV and/or syphilis, to enable the Global Validation Advisory Committee to assess whether eMTCT criteria have been met in a manner consistent with human rights;
- Assisting the Global Fund initiative to scale up human rights programmes in 20 countries and producing evidence of health impacts;
- Technical assistance to address human rights barriers and crises, including:
  - a. supporting Indonesia and the United Republic of Tanzania to address crises and shrinking space for civil society
  - b. engaging with the Czech Republic health ministry to discourage criminal charges for exposure to HIV against men who have sex with men living with HIV who had a sexually transmitted infection in the previous 12 months
  - c. providing expertise to develop/amend relevant laws in Lao People's Democratic Republic, Papua New Guinea, Russian Federation, South Africa, Tajikistan and Turkmenistan
  - d. filing three *amicus curiae* (friend of the court) briefs on mandatory testing, criminalization of same sex conduct and coercive sterilization in the East African Court of Justice, Kenya and South Korea
  - e. providing evidence and support in cases of alleged HIV-related travel restrictions in Canada, China, Northern Cyprus and Serbia.

405. Other examples of Secretariat support include leadership and technical help to develop HIV investment cases, country concept notes to mobilize financial resources from the Global Fund and resource allocation modelling. With Global Fund collaboration, investment documents were developed in Bangladesh, Cambodia, Indonesia, Myanmar and Philippines, while regional training workshops on resource allocation modelling for national staff were held in these countries, and in Nepal, Thailand and Viet Nam, to inform decision-making and planning. A further workshop was held in Johannesburg for staff from Botswana, Kenya, Malawi, Mozambique, Namibia, Nigeria, Swaziland and the United Republic of Tanzania.

406. Six cities were helped with proposals to Fast-Track the HIV response and strengthen service delivery. Funding for these projects, and other activities to achieve commodity security in Africa, has been mobilized from the MAC AIDS Fund. With Secretariat support, protocols were developed for implementing test and treat, and community counselling for key populations in India. Successful advocacy resulted in the



Government releasing 6 billion Tanzanian shillings to the AIDS Trust Fund for 2016–2017.

407. On the side lines of the HLM, UNAIDS, with the Economic Community of West African States, the Economic Community of Central African States and partners, called for urgent support to enable countries in western and central Africa to meet Fast-Track targets by 2020. The Secretariat coordinated an emergency plan for the region, to be implemented with *Médecins Sans Frontières* (Doctors Without Borders) and the Cosponsors. Under the plan, at least 850 000 people, including 60 000 children, who have been diagnosed with HIV infection but not yet enrolled in care will receive sustained, quality ART—equal to an estimated 65% of previously tested but untreated people. The plan envisages a further 250 000 people living with HIV, including 60 000 children, are newly tested, know their status and linked to ART. An additional 100 000 pregnant women living with HIV will receive ART.
408. The [Joint UNAIDS-Department of Peacekeeping Operations \(DPKO\) report](#) on implementing Security Council Resolution 1983 was widely disseminated. Focusing on the United Nations peacekeeping operations and collaboration with other UN entities, the specific activities and roles of other entities, including UN Country Teams, have been added where information and data were available. The Secretariat developed guidance on HIV and humanitarian affairs to serve as a training tool for all UNAIDS field staff and partners. In addition, a database of 150 professionals (local and international partners), HIV experts from DPKO and UNAIDS focal points, and members from Inter-Agency Task Teams (IATT) was created as a source for networking in emergency contexts.
409. Timely and quality support through the technical support facilities enabled countries to advocate for policy changes, remove barriers to implementation and support the Fast-Track approach.
410. Countries throughout southern Africa are developing robust, inclusive and results-focused national strategies and investment cases, providing a solid framework for change. The African Union's roadmap on shared responsibility and global solidarity for AIDS, tuberculosis and malaria has stimulated domestic resources to constitute 70%-plus of AIDS budgets in many countries, while the Agenda 2063 includes critical steps in national development that will contribute to ending AIDS by 2030. UNAIDS Addis Ababa liaison office, with the African Union and Economic Commission for Africa, helped restructure the regional coordination mechanism (which strengthens policy and programme coherence of the United Nations) and coordinated the activities of the Commission on the Status of Women with UN Women, UNICEF, UNFPA and WFP, in addition to the African Union system.
411. The UNAIDS Secretariat continues to coordinate the work of the IATT on Social Protection, including focusing support to regions and countries to strengthen programming on HIV-sensitive social protection. In collaboration with the United Nations Research Institute for Social Development, the Secretariat published *Social protection: advancing the AIDS response* in May 2016.
412. UNAIDS Secretariat support that was provided through the Joint Teams included:
  - In Papua New Guinea, a Joint UN plan was formulated with active support of the Cosponsors;
  - In India, the Joint Team helped the transition from MDGs to SDGs, and to position

- HIV in the work of Cosponsor agencies;
- In Ukraine, with Joint Team support, UNAIDS worked with UNDP and UNICEF to address problems in procuring ARVs; 19 normative acts were changed by the Government;
  - In Lesotho, the Joint Team supported the Ministry of Education and Training to scale up comprehensive sexuality education for young people in and out of school;
  - In Zimbabwe, the UNAIDS Country Office worked with UN partners to create a joint programme on youth, with HIV as one of its pillars;
  - Joint UN Regional Teams on AIDS continued to collaborate through working groups (e.g. on treatment, elimination of mother-to-child transmission, youth and key populations, emergency response) based on common objectives outlined in the annual workplans.
413. Closed cooperation between UNAIDS Country Directors and PEPFAR helped advance joint support to country responses. Regional reviews of country operational plans convened by PEPFAR improved dialogue between government, civil society, and multilateral partners and agencies, enhancing alignment and impact.
414. UNAIDS is also broadening its outreach, with a focus on country-level interventions. It is supporting the One Million Community Health Workers ([1mCHW](#)) campaign, to sustainably expand access to HIV services via the community extension service in the Millennium Villages (a project to strengthen prevention of mother-to-child HIV transmission services) in Kenya's Siaya County.
415. The collaboration with researchers at Mexico's National Institute of Public Health on the costs, technical efficiency and determinants of efficiency of HIV prevention services in Kenya, Rwanda, South Africa and Zambia continues to provide advice for decision-makers.
416. Discussions with global experts and country representatives on integrating HIV in the health-financing sphere have continued. A meeting in Montreux sponsored by WHO, for example, looked into options for integrating HIV services into the universal health coverage/national insurance benefits package, and determining the price tag of health-related SDGs, consistent with the previous HIV resource-needs estimates by the Secretariat.
417. The United Nations Development Group endorsed [a collection of good practices in developing countries and triangular cooperation for sustainable development](#), in which UNAIDS work is well referenced via case studies involving: Cambodia, India, Indonesia and Thailand, through a global transfer community-to-community learning project on HIV, and a developing country learning exchange on HIV prevention; Lao People's Democratic Republic and Thailand, through the Lao-Thai collaboration in HIV nutrition; and the Latin America and Caribbean region, through a horizontal technical cooperation group for bolstered universal access to prevention, treatment, care and support. The good practices collection provides concrete examples of integration, multisector cooperation, broad partnerships, and evidence and rights-based approaches, all critical to the 2030 Agenda and areas where UNAIDS can demonstrate added value.

## **Governance and mutual accountability**

418. During its 38th meeting, the UNAIDS Programme Coordinating Board approved the 2016–2021 UBRAF in support of the 2016–2021 strategy. The revised UBRAF is simpler, has stronger links between resources and results, clear criteria for allocating resources, fewer outputs, improved regional priorities, clarity on the roles of Cosponsors and the Secretariat, and an explicit theory of change. The number of indicators has been reduced to 20 with better attribution to collective results and renewed attention for independent assessment and evaluation. The 2016–2021 UBRAF indicator guidance standardizes and improves data collection by country teams.

### ***Engaging with donors***

419. The UNAIDS leadership engaged with 40-plus donors to secure resources for UBRAF and key initiatives, including the following:
- Relations with key decision-makers in donor countries were strengthened through dialogue, briefings, missions and continuous engagement with government officials, parliamentarians, civil society and the private sector;
  - Targeted communication materials on UNAIDS role and outreach was developed;
  - multiyear agreements were negotiated with several key donors, resulting in additional funds received from them;
  - Activities with the private sector and engagement with Goodwill Ambassadors, VIPs and other celebrities resulted in additional resources and increased visibility and mobilization of decision-makers;
  - External donor reviews (Multilateral Organisation Performance Assessment Network, Irish Aid, the UK's Multilateral Development Review, and Dutch and Australian reviews) recognized the positive role and work of UNAIDS; and
  - The participation of donors, celebrities and others on field visits strengthened commitment to continued funding for AIDS and increased visibility of UNAIDS work.

### ***Coordinating governance to strengthen political engagement and strategic direction***

420. The 39th PCB was preceded by the [Start Free Stay Free AIDS Free high-level ministerial dialogue](#). Attended by health ministers from nine African countries and chaired by UNAIDS Executive Director and the United States Global AIDS Coordinator, it promoted leadership in ending AIDS among adolescents and preventing new HIV infections among children by 2020.
421. A field visit to Geneva witnessed aspects of the Swiss AIDS response. The trip emphasized interplay between national and local responses (federal and cantonal), and government and civil society, the need to focus on key populations and harm reduction, and the importance of well-funded responses for results. Visits to service delivery points, the university hospital and the local prison, and briefings from local authorities and partners, highlighted the strengths and challenges of Swiss approaches.
422. The PCB field visit to China examined the country's ambitious targets to end its epidemic by 2030. Delegates visited sites in Beijing where access to HIV prevention, testing and treatment services has been scaled up, including prevention of mother-to-child transmission and community-based responses.
423. The PCB thematic session (38<sup>th</sup> meeting) emphasized the need to scale up the role of communities in the AIDS response—as trailblazers of change, and in service delivery and advocacy—thereby raising their profile among Member States.
424. During the dedicated thematic day (PCB 39<sup>th</sup> session), the Board focused on the state of the epidemic among people living with HIV and people aged 50 years and older who are at risk of HIV infection, the impact of ageing with HIV, and related health and social-sector responses. There was consensus on the need to support programmes and health-system structures for growing numbers of older people living with HIV.
425. The Committee of Cosponsor Organizations and Global Coordinators met to promote

coherence across the Joint Programme on strategy and on other key issues, enabling discussions on difficult points, including financial constraints.

426. A second financing dialogue helped strengthen partnerships with existing and potential donors and others to mobilize funding for UNAIDS.
427. The Secretariat emphasized UNAIDS' involvement in intergovernmental and interagency processes, including the Chief Executives Board (high-level committee on management, the UNDG Assistant Secretary-General advisory group), the UN Economic and Social Council and the Quadrennial Comprehensive Policy Review (QCPR), and leveraged the Joint Programme's experience within these policy and reform initiatives. UNAIDS contributed to discussions leading to the resolution being adopted.

***Strengthening accountability across the spectrum of Joint Programme activities***

428. Following an external audit, the Secretariat received a clean opinion on the 2015 accounts, confirming appropriate internal mechanisms and controls.
429. The Secretariat collaborated with WHO's internal oversight services (IOS) on operational and financial management reviews and implementing the IOS 2016 audit plan, following up on the recommendations in nine internal audit reports (130 recommendations have been satisfactorily addressed, 125 are being implemented).
430. A joint inspection unit report on fraud prevention included 16 recommendations; most have been addressed by adopting WHO policy and definitions, establishing the UNAIDS Risk Management Committee, and training staff on contracting and ethics.
431. An updated I-Track business application tool automates finance quality compliance control for procurement, including information technology and human resources approvals, and delegation mechanisms. Users can follow their request through the procurement process.
432. The Secretariat achieved compliance with the International Aid Transparency Initiative and data are now available online at <https://www.iatiregistry.org/publisher/un aids>.
433. The Secretariat developed a quality assurance guideline in line with PCB recommendations to include external perspectives and data validation in UBRAF monitoring, evaluation and reporting processes, and made this available to JPMS users.
434. In line with the UNAIDS evaluation plan for 2016, the following evaluations were carried out:
  - Review of Technical Support Facilities for eastern and southern Africa, western and central Africa, and Asia and the Pacific;
  - Evaluation of UNAIDS' programme in eastern Europe and central Asia;
  - Evaluation of UNAIDS' partnership with the Global Fund.
435. Joint Programme reporting presented to the 38th PCB included infographics on travel restrictions, a report on partnership with the Global Fund, eMTCT, investment cases in Asia Pacific, and on support for civil society, along with 22 thematic reports and 30

country summary reports made available on the web portal [Investing for results](#). Funding levels and trends reflecting expenditure and UBRAF indicators data were presented to the PCB and financing dialogue.

436. UNAIDS strategic information coordinating bodies were supported, including three reference groups on estimates and projections, monitoring and evaluation, and economics. The indicator working group, which is part of the monitoring and evaluation reference group, helped reach consensus on measurement and accountability by stakeholders. In addition, UNAIDS continues to be involved with the UN Evaluation Group, the Global Fund and WHO evaluation activities and working groups.

***Aligning resources to improve efficiency and effectiveness of the AIDS response***

437. The Secretariat repositioned the organization to make it more fit for purpose for the SDG era to efficiently implement UNAIDS Strategy and the Political Declaration within current financial constraints. The repositioning resulted in a headcount reduction of 13%, while some 120 staff members have been reassigned to new positions. The Secretariat monitors staffing levels and efficiencies in deployment. The Human Resources Strategy and the Gender Action Plan were updated, and staff development supported.
438. Budgets were aligned with available resources. Monthly budget reviews included estimates and projections across all Secretariat levels, with all expenditures monitored. Cost efficiency, effectiveness and accountability were emphasized through financial and staffing reviews, updates for managers and communications to staff.
439. Innovative approaches to reduce costs included developing apps used at the HLM, the PCB and AIDS 2016, and launching the contact system, UNAIDS Connect.
440. Secretariat efforts on gender balance in the workplace and career development opportunities for women continue to be recognized through the UN System-wide Action Plan on Gender Equality and the Empowerment of Women (SWAP) and the Secretary-General's report on improvements in women's status in the UN system. The Secretariat engaged in Pilot 2.0 SWAP to test and validate the process. The Gender Action Plan will extend to March 2018.

## Secretariat 2016 expenditure

**Table 1: Expenditure by Secretariat function (in US\$)**

Secretariat function	Core expenditure	Non-core expenditure	Grand total
S1: Leadership, advocacy and communication	38 329 782	10 492 710	48 822 492
S2: Partnerships, mobilization and innovation	22 196 770	7 488 914	29 685 684
S3: Strategic information	21 240 009	3 220 892	24 460 901
S4: Coordination, convening and country implementation support	24 958 754	9 812 992	34 771 746
S5: Governance and mutual accountability	33 114 237	1 205 511	34 319 748
<b>Grand total</b>	<b>139 839 552</b>	<b>32 221 019</b>	<b>172 060 571</b>

**Table 2: Expenditure by region (in US\$)**

Region	Core expenditure	% Fast-Track countries	Non-core expenditure	% Fast-Track countries
Global	71 562 212	0%	8 815 456	0%
AP	13 073 208	42%	5 937 909	61%
EECA	4 832 370	20%	2 952 198	0%
ESA	20 298 877	75%	9 963 080	26%
LAC	9 777 469	23%	284 023	59%
MENA	3 699 883	9%	597 401	0%
WCA	16 595 533	44%	3 670 952	18%
<b>Grand total</b>	<b>139 839 552</b>		<b>32 221 019</b>	

[End of document]