2010-2011 UNAIDS UBW
United Nations Population Fund (UNFPA)
Broad Activity Achievement Report
UNFPA 2010-2011 Total Expenditure

<table>
<thead>
<tr>
<th>Total 2010-2011 Budget</th>
<th>2010-2011 Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>179,731,289</td>
<td>21,665,187</td>
</tr>
</tbody>
</table>

Broad Activity 1: Support for capacity building of UNFPA COs, UNCTs, regional and national key population organizations (e.g., youth serving and youth led; sex work networks; women and girls focused, networks of women living with HIV) to facilitate policy dialogue and inclusion in inter-agency and intergovernmental fora, development of National AIDS Strategies and Action Plans and development frameworks, and implementation and monitoring of programmes and services.

Achievements

Strong engagement in HIV interagency mechanisms such as global IATTs and working groups and Joint UN Teams on HIV/AIDS at country level have produced better results and improved interagency and inter-programmatic work from intensive advocacy to change policy and legislation through capacity building of partners and communities.

HIV and sex work

- UNFPA funded the participation of community nominated sex workers in consultations on key global policy guidelines for their expert technical input, promoting the experience based evidence of sex workers and strengthening sex work networks and organisations. Sex worker networks and organisations were engaged globally, regionally and at the country level in joint missions, training of staff, advocacy, policy development and implementation. (cross-reference BA4,9,10)

- The UNAIDS Advisory Group on HIV and Sex Work launched its report during the Programme and Coordinating Board of UNAIDS meeting in December 2011. The report provides short guidance on key issues agreed through consensus between the UN, sex work networks and independent experts to inform national responses.

- UNFPA with partners completed the consultation draft of monitoring and evaluation operational guidelines on HIV prevention for sex workers, men who have sex with men and transgender people for utilisation at the national, sub-national, and local level. It is expected to be released in 2012.

- In Jamaica, UNFPA was key to the development and maintenance of the MARPs Technical Working Group resulting in national mobilization, networking and collaboration among government and nongovernment agencies responding to sex workers, men who have sex with men, people who use drugs and transgender people.

- UNFPA also led the establishment of the Caribbean HIV and Sex Work Technical Working Group (SWTWG) whose key purpose is to enhance and accelerate mobilization around the response to HIV and Sex Work in the Caribbean region, improving coordination and coherence, networking, and technical exchange. Key partners are PANCAP, the Coalition of Caribbean Health Ministers, the Caribbean Coalition of National AIDS Programme Coordinators, the Caribbean Sex Workers Coalition, the Coalition of Caribbean Parliamentarians, the Caribbean Chief Medical Officers, the Caribbean Network of Persons Living With HIV (CRN+), CVC, CHAA, UNFPA, PAHO, UNDP, UNAIDS Secretariat, UNIFEM, CAREC, Caribbean Broadcast Media Partnership, and USAID among others. Two regional meetings have been held with a roadmap developed to frame the work for the next biennium. A capacity building workshop for the Caribbean Network of Sex Workers was held bringing together 28 sex workers from 7 countries to strengthen their network and to advocate for increased access to health services. A 2 day meeting was held in the Caribbean bringing together 52 programme managers from 11 countries as a part of the Regional Network of Programme Managers and Policy Makers responding to the need to advocate for better sexual and reproductive health and rights of sex workers. Also in the Caribbean, the Georgetown Declaration on HIV and Sex Work was developed, accepted and disseminated for Advocacy as an outcome of the Sex Work Regional Technical Working Group.
Gender and women

- In 2010, UNFPA revised its Strategic Framework on Gender Mainstreaming and Women’s Empowerment and updated its guidance to staff on how to integrate HIV and gender into policy dialogue with partners as well as into programming initiatives. This resulted in improved integration of work on gender and HIV by UNFPA staff and partners.
- HIV positive women leaders from Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, Uruguay, Venezuela, received capacity strengthening on advocacy and human rights, and implemented related activities on GBV and SRH. Women living with HIV were also supported to engage in policy dialogue shaping strategic plans, including at the CSW and GNP+/ICW for eMTCT programming.

Young people/youth people most at risk

- As part of monitoring agency support to and engagement with civil society, the revised UNFPA Development Results Framework includes an indicator measuring the number of community-led organisations/networks supported by UNFPA to engage in programmes addressing the HIV and SRH needs of young people and sex workers.
- Financial support was provided for capacity building of the HIV Young Leaders Fund which is enabling a new leadership among young people most affected by HIV including through 23 grants to community projects in 19 countries since 2010 and encouraging youth-led initiatives in advocacy, peer-based services and community mobilization and youth provided technical support.
- With UNFPA support, YouthLEAD was initiated by Seven Sisters (the Coalition of Asia Pacific Regional networks on HIV/AIDS) in 2010 to strengthen the leadership and advocacy skills of young people from key populations. A network of focal points in over 15 countries support each other to raise the issues of young key affected populations (YKAPs) at national and regional level. YouthLEAD has successfully participated in multiple high-level policy events, including the Asia Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support where they successfully convinced government delegates to include wording in the consultation resolution on removing restrictions for YKAP accessing HIV prevention services such as age restrictions and mandatory parental consent.
- UNFPA conducted advocacy and established partnerships to promote issue related to young people among the international technical community through inputs into intergovernmental processes and international conferences and supported young people’s participation in these processes and events, including the World Youth Conference, Africa Youth Forum and the International AIDS Conference in Vienna. Numerous youth led organizations/network received capacity building for effective advocacy and to engage in the design, implementation, and monitoring of programmes addressing both SRH and HIV needs, including the regional Africa Youth and Adolescent Network on Population and Development, Southern African Youth Movement, African Union Youth Volunteer Corps, Y-PEER, and national Youth Advisory Groups. (cross-reference BA11)
- UNFPA in collaboration with UNICEF and UNESCO, organised a capacity building workshop of 70 Curriculum Development Specialists from the Ministries of Education and UN staff responsible for youth from Ten SADC Countries (Botswana, Kenya, Namibia, Lesotho, South Africa, Uganda, Zambia, Zimbabwe, Swaziland and Malawi) to design and implement effective sexuality education and HIV prevention among young people in the educational settings. As a result, Lesotho, Swaziland, South Africa, Uganda and Zambia have already incorporated lessons learned into their curriculum reviews while Zimbabwe opted to develop a sexuality education policy first.

Lessons learned

- Harmonizing and coordinating efforts among sex worker networks, civil society, continues to be a challenge in all regions although ESCAP has demonstrated excellent leadership on promoting non stigmatised management of key populations.
- Punitive laws, policies and practices, lack of linkages between HIV and sexual and reproductive health for key populations, lack of commitment from government, national and international agencies, donors, and many sections of civil society continue to be a challenge in most countries for sex workers, men who have sex with men and transgender people.
- There is no substitute for direct engagement of women living with HIV, sex workers, men having sex with men, transgender people, young people in challenging and changing attitudes, and shaping rights-based approaches.
- Uganda found that integration of HIV into other health interventions including SRH is largely catered for at policy level, feasible at service delivery levels but constrained by structural issues especially at Ministry of Health level that impact on integrated programming and that lack of national data on MARPs constrains advocacy for expanded service delivery.
- In Ethiopia strategies to address sex workers, men who have sex with men and other key populations are considered necessary to reduce the general prevalence.
- Rwanda provides the example of a Gender Based Violence (GBV) – One Stop Centre: In working closely with hospital staff, the police and the judiciary and providing the necessary training and institutional support, UN agencies and its partners are helping ensure the kind of “accessible, compassionate, respectful and confidential services” which can be documented and systematized, thus becoming an appropriate model for scale up. In conjunction with close attention to prevention and policy, creating such a scalable model is the essence of good gender-mainstreaming approach.
- Operational research in Swaziland revealed that a number of interventions targeting sex workers and MSM exist in Manzini Mbabane corridors. Their concentration in the region and the lack of an operational framework, standardized training manual and technical guidelines needs to be addressed to improve the quality of services and accuracy of information and coordination.
Evaluation

- UNFPA’s Asia and Pacific Regional Office commissioned an evaluation of the relevance, effectiveness, efficiency and sustainability of HIV focal point posts from UBW funds. Twenty three full time staff are supported in 16 Country Offices with technical support from the Regional and Sub-Regional level. At the end of 2011, 7 countries have absorbed the posts into their country teams. The review team found that two-thirds respondents rated the overall performance of HIV posts in the region very good (25%) or good (42%). Most considered HIV Focal Posts relevant (79%), effective (62%) and efficient (64%). Overall, 69% of stakeholders considered UNFPA HIV Posts provided value for money. There was a universal agreement (96%) that the posts should continue.

- Three evaluations were conducted, showing special administrative advantages and commitment to the HIV prevention work of Ministry of Railways in China, critical needs to address key populations in Thailand and development of appropriate sex work related policies and documents including revision of the Ordinance on sex work contributed to scaling up effective interventions in Vietnam.

- The UNFPA country office in Russia conducted a joint evaluation of comprehensive services for sex workers, SRH services for women living with HIV and Y-PEER.

- The Regional Y-PEER Programme in Eastern and Central Europe was evaluated at ten years.

- Peru conducted an evaluation of their Multisectoral Strategic Plan for the prevention and control of STIs and HIV 2007 - 2011 and identified the following:
  - The plan was not as multisectoral as anticipated and had a strong health sector focus.
  - It did not have a monitoring and evaluation plan to measure the impact of the strategy.
  - During the implementation the strategy did manage to reach those most at risk, but at the same time it was noted that the quality of care for most vulnerable groups had many shortcomings and that there is still discrimination and abuse in health services.

Related Case Studies: HIV decline in Zimbabwe

Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,485,586</td>
<td>$747,071</td>
<td>$1,720,963</td>
<td>$7,953,620</td>
</tr>
</tbody>
</table>

Broad Activity 2: Strengthening national systems through capacity building of national partners for forecasting, procurement, quality assurance, warehousing and storage, distribution and logistic management information systems for RH commodities.

Achievements

- The Global Programme for Reproductive Health Commodity Security (GPRHCS) supported 56 countries with contraceptives for family planning including condoms for dual protection and essential lifesaving medicines to avert stock outs and shortfalls.

- During the biennium over $240 million was mobilized from different donors, for ensuring reliable supplies of quality commodities and capacity development with systems strengthening for services in priority countries.

- Of the 20 countries in East and Southern Africa (ESA) funded through GPRHCS: 14 countries have an RHCS Strategic Plan that is being implemented; 17 countries have a budget line for RHCS; 9 countries have updated their CCM accounts to date and only 2 countries (Kenya and Zimbabwe) experienced stock outs of commodities. All Countries have a coordination mechanism either as standalone or integrated within existing SRH and essential medicines/pharmaceuticals coordination committees.

- 2 regional trainings (in Cairo and Lebanon) conducted for capacity building for country participants in forecasting, procurement, quality assurance, warehousing and storage, distribution and logistics management information systems for RH commodities.

- A regional RHCS workshop organized to promote domestic resources allocations and system strengthening for improved management of RH commodities with participants from Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Kosovo, Macedonia, Moldova, and Ukraine.

- Advocacy efforts for the creation of a budget line for RH commodities resulted in inclusion of contraceptives on Essential Drugs List in Angola and to a public budget line for procurement of 5% of contraceptive needs through state/common fund resources in Mozambique. Azerbaijan utilized cost benefit and cost effectiveness studies to successfully get RH commodities included within the EDL. Burundi created a budget...
line to procure female condoms. Peru incorporated the FC in the Health Technical Standard for the Management of STI enabling the use of domestic funds to procure FCs.

- MOU was signed between Panamanian Government and UNFPA for procurement of SRH supplies, condoms, lubricants and others through UNFPA achieving savings between 60% and 80% in the purchase of condoms. Also, a Contribution and Co Financing Agreement for the purchase of contraceptives and condoms and a three year Acquisition Agreement for condoms and other SRH supplies with the National Aids program were negotiated.

- Georgia initiated mobile RH teams to increase access to FP, commodities and HIV/STI prevention via home/community visits.

- In 2010, final draft of international standard for female condom was circulated for review and approval by ISO Committee; WHO, UNFPA and FHI convened a workshop in Bangkok for manufacturers, donors and international agencies to review and discuss requirements and procedures to produce and procure quality assured female condoms for public sector. In 2011, the Female Condom Technical Review Committee comprised internationally recognized experts representing research institutes, manufacturing community, testing laboratories, clinical scientists, statisticians, regulatory authorities and programme managers in the field, drafted the first technical criteria for assessing products for approval for bulk procurement by international organizations and a consensus definition of clinically significant failure modes for female condoms. This document is intended to facilitate approval processes of female condoms in the pipeline.

- In 2010, UNFPA conducted two regional workshops (Ecuador and Dominican Republic) for national laboratories and regulatory authorities to address issues with commodity product rejection due to variations in the procedures, tests, testing standards and requirements. In 2011, the workshops were expanded to Africa where UNFPA trained 44 participants from 20 Eastern and Southern African countries. In follow up, countries established networks of lab technicians to share protocols and training materials in the regions.

- Rwanda undertook a review of the national condoms supply chain system to improve accessibility and availability of condoms for community based HIV/AIDS groups and all other HIV/AIDS partners at the decentralized level.

**Lessons learned**

- Government and national partners’ active engagement and commitment are key to effective LMIS.

- Linkages between SRH and HIV policies, programmes and services need to be clearly defined within LMIS processes.

- RHCS training of government personnel and social marketing of RH commodities have proven very beneficial and contributed to increased commodity availability.

- Working with UNHCR reduced disruption of commodity supply in humanitarian/emergency situations. Pakistan provides an example where integrating HIV into RH services in humanitarian settings proved to be very successful.

- There is a lack of government commitment/funding for condom programming in many Central Asian countries, with poor, rural areas particularly underserved for FP and contraceptives. There is a danger of a contraceptive shortfall in the public health sector in coming years. Action is needed to secure emergency supplies of essential contraceptives in the absence of MoH budgets for these. Registers and Reporting forms (both paper and electronic) need to be updated to improve data held in client registers.

- Several new types of female condoms are in various stages of development, only few entered the market. Only FC1 and FC2 have been approved for public sector procurement by WHO/UNFPA and USFDA. Manufacturers of these new female condoms urgently need support and guidance to enable them to undertake the required research, quality assurance testing and clinical trials required to produce quality products and compile the required documentation needed for country regulatory and bulk procurement approvals.

**Evaluation**

- A thematic Evaluation for CP6 (2006-2010) HIV Component was conducted in China by an independent national evaluator in 2010. The evaluation in China revealed that guidelines were critical to improve condom quality.

- The evaluation in Timor-Leste in 2010 showed a similar finding that guidelines contributed to improvement of district managers’ capacities to manage programme, of infrastructure of the health facilities, and of quality of the Logistic Management Information system (LMIS) thus resulting in continuation of commodity supply.

- In Uganda, a condom mapping exercise for UNFPA supported districts was conducted. A pilot study was conducted to establish acceptability and feasibility of re-introducing the Female Condom in Uganda. A comprehensive gap analysis for HIV and RH related commodities was conducted in preparation for the Global Fund Round 10 country proposal.

**Expenditure**

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$334,319</td>
<td>$727,116</td>
<td>$261,272</td>
<td>$1,322,707</td>
</tr>
</tbody>
</table>

UNFPA Broad Activity Achievement Report [2010-2011 UNAIDS UBW]
Broad Activity 3: Advocacy and capacity building to mainstream gender equality into sexual and reproductive health and HIV prevention policies, programmes and services through addressing women’s and girls’ vulnerabilities, male participation, gender-based violence and improved protection systems including in humanitarian and post-emergency settings.

Achievements

GBV/VAW

- The Interagency Working Group on Women, Girls, Gender Equality and HIV has implemented the Universal Access for Women and Girls Now! to assess, analyze and take action to address gaps and barriers to universal access to HIV prevention, treatment, care and support in ten countries. As a result UA Now! has strengthened partnerships, including through the convening of multiple stakeholders in country task teams to help communicate the needs of women living with HIV in UA Now!

- The Interagency Working Group on Gender Equality and HIV in partnership with MenEngage Alliance, Sonke Gender Justice and ATHENA Network convened 2 consultations (2010 Nairobi, 2011 Istanbul) with 31 countries for Integrating Programming to Address Gender-Based Violence and Engage Men and Boys to Challenge Gender Inequality in National AIDS Strategies and Plans. Participants were drawn from Ministries of Health and/or Women/Gender, and National AIDS Councils (NACs), civil society and the national UN offices. As a result, the consultations were able to achieve 1) consensus and understanding regarding the mutually reinforcing cycle of gender-based violence and HIV, and the potential role of engaging men and boys for gender equality to interrupt and halt this cycle and strengthen the national AIDS response; 2) analysis of existing country plans, and 3) country level action plans to support the integration attention to gender-based violence, and the engagement of men and boys for gender equality, in National Strategic Plans on HIV and AIDS and other relevant national policies and plans. Plans are in place to follow up in countries to identify areas for support and monitor progress.

- UNFPA supported a multi-stakeholder consultation in St. Vincent for more than 15 Caribbean countries to share successful experiences in GBV prevention, including how HIV factors into the issue.

- In the promotion and protection of women’s human rights broadly and to a life free of violence in particular, UNFPA supported the UN Special Rapporteur on VAW to undertake global research on the interpretation and implementation of the international law principle of the due diligence obligations of States was undertaken. The findings of the research report will inform the 2013 thematic report of the SRVAW to the Human Rights Council.

- UNFPA supported the development and implementation of national communication strategies and campaigns against GBV in Armenia, Benin (including refugee camps and IDPs), Belize, Botswana, Brazil, Burundi, Ethiopia, Georgia, Guyana, Haiti, Lesotho, Madagascar, Mozambique Namibia, Somalia (including refugee camps; disseminating the educational short-film & guide: Suha and Karim), Tanzania, Trinidad and Tobago, Tunisia (including refugee camps; disseminating the educational short-film & guide: Suha and Karim), Uruguay, Zambia. Arab States raised awareness on Women and HIV and established partnership with CSOs and government counterparts through Let’s Talk Campaign targeting and 10 Days of Activism campaign reaching over 2 million people.

- Health service providers trained on care protocols for survivors of GBV, including PEP, in Bangladesh, Bolivia, the Dominican Republic (80), Ecuador (50), Kazakhstan, Malaysia, Suriname (15), Uzbekistan.

- UNFPA published a manual of lessons learned based on the UNFPA initiated multi-stakeholder joint programming on VAW in 10 pilot countries, bringing together UN country teams, governments and civil society that has resulted in the formulation of gender plans and adoption of national legislation and policies.

Engaging men and boys

- Partnership continued with the Institute for Development Studies at University of Sussex and national partners on the ground in Kenya, Uganda and India to mobilize male activists through the Mobilising Men Initiative. This programme pioneered efforts to mobilise men to challenge and change the institutional policies and cultures that enable and enact sexual and gender based violence. For a report on the initiative see 2012 publication: Mobilising Men in Practice: Challenging sexual and gender-based violence in institutional settings

- UNFPA developed Strategic Guidance for Engaging Men and Boys to address internal capacity building around the male involvement approach including on addressing the issue of HIV.

- UNFPA has finalized the UNFPA-Promundo Men and Boys toolkit titled ‘Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action’, which gives hands-on, practical information for implementing projects that result in increased involvement of men and boys, and developed an electronic game Breakaway to raise awareness of boys and young men of gender equality and HIV.

- The development of an Africa Regional Framework on working with men and boys for the promotion of Gender and RH/HIV contributing to related UN Secretary-General Initiatives resulted from UNFPA supported workshop for 92 participants from 30 countries.

- Eastern Europe and Central Asia region conducted a regional gender transformative workshop to build capacity in government and NGO/CSOs (Armenia, B&H, Kosovo, Kyrgyzstan, Tajikistan, Ukraine). Three countries also took part in an Engage men and boys integrative strategic planning meeting (Moldova, Russia, Kazakhstan). An on-line package was developed for integrating GBV responses within health services including addressing HIV risk (see http://www.respondgbvceeca.org/). A regional meeting on gender equity compiled recommendations, including related to HIV. See http://eeca.unfpa.org/public/pid/6719

- UNFPA’s support to male participation resulted in: Workplace Action Groups against GBV in Botswana, a Civil Society Network for Men as partners in gender equality and for HIV prevention in Mozambique, a gender based research study on male involvement in GBV responses within humanitarian settings in Eastern and Southern African countries linked to the SG’s UNITE campaign, the establishment of a male network providing boys and men information about GBV and HIV in Guyana, a men’s desk within the Bureau of Women’s Affairs in Jamaica and two men's desks to increase the involvement of men in GBV, SRH and HIV issues within the Papua New Guinea National Council of Women.

UNFPA Broad Activity Achievement Report [2010-2011 UNAIDS UBW] Page 5 of 27
Lessons learned

- To ensure that national action plans to address gender-based violence and national AIDS plans draw strength and effectiveness from each other, it is necessary to develop stronger links between relevant national agencies (i.e. AIDS authorities) and key civil society organizations, including those that engage men and boys. Many countries still do not analyse GBV data, nor use it sufficiently in their HIV response and national programmes to change harmful gender norms and practices, including gender-based violence, need strengthening and funding.

- Cost and availability remain the main obstacles to wider use of the female condom. High level political support is lacking or insufficient in many countries. Female condoms are often not included in the national essential drug lists nor accompanied with a budget line in national budgets.

- It is critical that throughout implemented interventions, programmes and policies, adequate attention and opportunity is given to challenging harmful gender norms, stereotypes and behaviours particularly given knowledge those inequitable-gender relations in the ability to negotiate safe sex and expectations of intimate relationships fuel transmission of HIV.

- In Eastern Europe and Central Asia, gender issues can be raised via multi-stakeholder consultations, promoting national ownership and evidence based advocacy (from gender disaggregated surveys). Integration of gender issues within HIV trainings provides deeper understanding for peer educators and internalization of human rights concept and principles. Barriers include weak national structures, lack of gender awareness in health care providers and persistent resistance to gender equality among religious/state leaders.

- Utilizing media, social media and other technologies has proven to be successful in reaching targeted populations with Gender, SRH and HIV messaging.

Evaluation

- In Dominican Republic, UNFPA in coordination with UNAIDS, conducted a study showing that education is a protective factor that reduces the chance of becoming HIV positive; women with at least an eighth grade education reduced their risk of becoming HIV positive by 84%; and women experiencing violence are more likely to be HIV positive.

- UNFPA conducted a literature review to gain a better understanding of the extent and ways in which socio-cultural factors are preventing, or enabling, the realization of the rights of migrant women to access SRH information and protection from violence in Cambodia, Thailand, Vietnam and Laos. The review also documented examples of good practice that can be used to inform the programming of UNFPA and other development partners in the country and broader region.

- In Zambia, the end-evaluation of the 6CP indicated that the activities of the SMAGs and other community groups sponsored by UNFPA were effective in promoting male participation and the mobilization of communities towards the reduction of GBV in the target areas.

Related Case Studies: An evaluation of Zimbabwe’s National Behaviour Change programme

Expenditure

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,144,198</td>
<td>$390,347</td>
<td>$1,615,775</td>
<td>$3,150,320</td>
</tr>
</tbody>
</table>

Broad Activity 4: Advocacy and training to reduce stigma and discrimination and promote human rights in the context of HIV and sex work including through in-reach training in collaboration with UN, government and civil society partners.

Achievements

- In Reach Training reached UN Country Teams from 37 countries across Eastern and Southern Africa and Eastern Europe and Central addressing stigma, discrimination and HIV risk and vulnerability of sex workers, men who have sex with men, people who use drugs, prison populations and transgender people. The training has been developed by UNFPA, UNDP, UNICEF, UNODC and the UNAIDS Secretariat. The Africa Sex Worker Alliance attributes some of the significant increase of engagement of UN staff, especially from UNFPA and UNDP, to In Reach Training.

- The UNAIDS Civil Society Partnership Strategy was developed in partnership and holds all Cosponsors accountable for including key populations organisations and networks in our work.

- Sex workers from around the world were supported to participate in the Regional Dialogues of the Commission on AIDS and the Law. Their input is reflected in the Report of the Commission. UNFPA funded UNDP to produce an advocacy film of the sex worker contribution to the regional dialogues for advocacy purposes. In addition, UNFPA provided technical support to the constitutional law commission to review national laws that criminalize sex work and men who have sex with men in Papua New Guinea and in Malawi engaged in advocacy for a new law against discrimination of PLWHA.
• UBRAF 2012-2015 more strongly reflects strengthening community organizations of men who have sex with men, sex workers and transgender people; ensuring service access that are of quality, are affordable, are accessible, and are non-judgemental; and improving current law enforcement and judiciary responses to human rights violations suffered by key populations.

• UNFPA supported human rights protection for female, male and transgender sex workers and men who have sex with men through training and advocacy, including by sex work organisations, with police, local authorities, NGOs, establishing human rights protection volunteers, journalists, border communities in Bangladesh, China, Dominican Republic, Kyrgyzstan, Mongolia, Myanmar, Papua New Guinea, Peru, South Africa, Sri Lanka, Thailand, Turkmenistan.

• In Latin America, UNFPA strengthened human rights protection transgender people, men who have sex with men and sex workers through mass media campaigns, such as “Diverse people, equal rights” in Colombia reaching 5 million people, on Day against Homophobia in Mexico, situated analyses in Haiti on men who have sex with men. In Peru, 1000 copies of a module to sensitize and inform the police and law enforcement personnel about sex work, human rights, stigma and discrimination strategies were distributed in 4 regions, and a draft law on sex work was developed and delivered to key parliamentarians and presented to parliament. 150 Health Care Workers in the Caribbean were trained to increase provision of quality health care services for men who have sex with men.

• Transgender people were supported to establish a global body for inclusion in policy and programmatic decision making with UNDP, UNFPA, UNAIDS Secretariat and the GFATM.

• The PLHIV Stigma Index was published for advocacy purposes in Russia, a law for PLHW rights was developed in Sudan and support group counsellors were trained in sexual reproductive health and life skills in Jamaica.

• A regional consultation HIV in men who have sex with men and transgender people for Eastern Europe and Central Asia was held in Kyiv, Ukraine to identify issues, advocate for human rights and plan responses/community mobilisation resulting in the formation of ECOM.

• UNFPA Country Offices supported condom programmes to address supply, demand and access within a rights based approach to increase access to condoms for key populations including in Burundi, Malawi, and Zambia.

• UNFPA provided support for prison populations in Mauritius, Mozambique and Zambia

• UNFPA Kenya is leading joint efforts in a HIV-prevention services program for truckers.

• In the DRC, UNFPA trained 300 uniformed services staff to address sexual gender based violence and protecting PLWH.

• In Burundi, UNFPA supported the government and civil society to promote the education and protection of the rights of 37, 522 AIDS orphans as well as their access to health services. Training was provided to 1,000 members of the committee in charge of the protection of orphans’ rights. As a result of this activity, 424 orphans were able to fully exercise their rights and access the needed information and services.

**Lessons learned**

• In Reach Training is a good vehicle for discussing the stigma and discrimination that key populations experience, including from UN staff. However, it seems that country level implementation in future may reach with greater success than regional level implementation in the absence of solid commitment from the UNAIDS regional Cosponsors and the RST.

• UNFPA Uganda has reported difficulty in implementing work with sex workers and other key populations following its participation in advocacy efforts protesting the introduction of legislation outlawing homosexuality.

• The existence of a legal framework to protect against HIV related stigma and discrimination does not, in and of itself, mean the removal of stigma and discrimination; there needs to be active awareness raising of such legislation and compliance should be monitored.

• Opportunities exist to further improve health care workers’ attitudes toward key populations and to develop user-friendly services.

• Most sex workers experience gender-based and sexual violence. It is recommended that GBV prevention is integrated in all HIV interventions and that GBV programmes include attention to violence against sex workers and other key populations.

• Media people play important roles in reduction of stigma and discrimination but needs to be carefully managed to avoid portraying people as victims.

• Involvement of law enforcement officers in promoting and protecting the human rights of key populations needs to be expanded: key populations report law enforcement officers in all countries systematically abuse their human rights.

• Evaluations and other research in Zimbabwe and South Africa highlight the HIV risk and vulnerability of sex workers and stress the need to target sex workers within generalized epidemics.

• In Namibia the cooperation between different UN agencies and NGOs and led to a good platform for advocacy.

• UN interagency support for men who have sex with men enabled creation of ECOM and development of supportive systems and resources (UNDP, UNAIDS, WHO, UNFPA)
The highly integrated approach developed in Peru addressing sex workers has resulted in the development of a roadmap for a multisectoral approach between sex worker organisations, the UN led by UNFPA, regional governments, the Ombudsman’s Office, health regional directors, HIV/AIDS regional staff, police, municipalities, the Crime Prevention Attorney, among others. Consensus positions have been reached on sex work that promote their human rights and reducing violence against female and transgender sex workers has been an immediate focus. This approach has been in place for three years and has led to concrete reductions in stigma and discrimination.

Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,034,114</td>
<td>$70,549</td>
<td>$184,639</td>
<td>$1,289,302</td>
</tr>
</tbody>
</table>

Broad Activity 5: Strengthening linkages between sexual and reproductive health and HIV/AIDS by promoting linkages using evidence base, providing technical support and capacity building to countries, and disseminating guidance tools and promising practices to identify and implement key policy and programme actions

Achievements

- Understanding was enhanced of how to link SRH and HIV policies, systems, and service delivery leading to strengthened national capacity to scale up linked SRH and HIV programmes including countries determining SRH and HIV linkages national priorities and shaping related national plans. 23 countries in 2010/11 assessed linkages at the policy, systems, and service delivery levels, utilizing the Rapid Assessment Tool for SRH and HIV Linkages, contributing to national plans to strengthen linkages. Sixteen summaries have been prepared and made available highlighting the process, findings, lessons learned, recommendations, and way forward (Bangladesh, Benin, Belize, Botswana, Burkina Faso, Cote d’Ivoire, Lebanon, Kyrgyzstan, Malawi, Morocco, Pakistan, Russian Federation, Swaziland, Tanzania, Tunisia, and Uganda). To assess progress in linking SRH and HIV at the country level, 17 impact assessments have been undertaken with the first phase of countries to implement the rapid assessment (Bangladesh, Benin, Belize, Botswana, Burkina Faso, Cote d’Ivoire, Lebanon, Kyrgyzstan, Malawi, Morocco, Pakistan, Russian Federation, Swaziland, Tanzania, Tunisia, Uganda and Vietnam).

- Countries shared experiences and good practices (e.g., case studies in India, Indonesia, and Swaziland and examples in Botswana and Zimbabwe plus linkages regional analyses (Africa and Asia Pacific)), ICASA capacity building sessions) and identified and implemented key actions to improve health, human rights, and gender equality. Capacities to understand and further the SRH and HIV linkages agenda were strengthened through: a series of global and regional consultations; 40,000 hits between July and December 2010 to an updated SRH and HIV linkages web portal (www.srhhivlinkages.org); strategic partnerships (IAWG SRH and HIV Linkages, networks representing PLHIV and key populations); advocacy on linkage issues (comprehensive PMTCT especially Prongs 1 and 2, integrated services including for youth, community involvement, HSS for HIV-prevention, MNCH and the relationship between SRH, HIV and maternal mortality) at events such as the 26th PCB Thematic session, IAC 2010, HLM June 2011, regional consultations, ICASA; CARMA launched in 35 countries; and strengthened evidence base for implementing linkages in generalized, low and concentrated epidemics. At ICASA, commitment was obtained by policy makers and partners present and details of follow up and strengthening of linkages were outlined.

- UNFPA supported 7 countries (Botswana, Lesotho, Namibia, Swaziland, Malawi, Swaziland, Zambia and Zimbabwe) to secure European Union funding to strengthen SRH and HIV policy and service linkages/integration as well as the documentation of lessons learned and best practices for replication region wide to improve quality of national responses to SRH/HIV and inform decision making on funding allocation and policy choices and development. Relevant National Reference Committees, National Technical Advisory Committees and sub-committees (Monitoring and Evaluation and Communication/Advocacy sub-committees) were established to coordinate, provide technical support and monitoring/evaluation as well as oversight of implementation. The committees supported development of detailed implementation plan for 2011/14; inception reports, monitoring and evaluation frameworks, advocacy, communication and visibility plans

Capacity building examples

- Comprehensive Condom Programming: strategy and policy development, acceptability case studies, programming including integration into FP, HIV and MC programmes, peer education, demand creation, communication, VCT, procurement, and/or distribution programmes in Zimbabwe, Zambia, DRC, Rwanda, Mozambique, Comoros; Brazil, Eritrea, Bolivia, and Ecuador. see also report for BA 2 and BA 6.
  - Male Circumcision: Zimbabwe (National Strategy), Uganda (National Safe MC Policy and Communication Strategy), Rwanda (operational plan), Zambia
  - Sensitization and training of service providers in Swaziland, Botswana, DRC (uniformed personnel services in VCT and FP); Lesotho (food providers with WFP), Swaziland (mobile integrated health services reaching mainly young people and women); Mauritius and Rwanda (trained medical and para-medical practitioners in integrated SRH-HIV/AIDS services); Botswana (sensitization of service providers); Comoros (drug procurement for STI treatment); Ethiopia (Adolescent Health TWG design and running comprehensive YFS), Tanzania (integrated approaches); El Salvador (sexuality education skills). Yemen (SRH needs of most at risk populations); and Argentina (SRH guide for women living with HIV).
  - YFS in Ethiopia, Guyana, Georgia and Costa Rica (prevention of adolescent and teen pregnancy and HIV). Geracao BIZ in Mozambique reported 349,894 young people attended YFS, of whom, 71,040 were tested for HIV and 1,120,234 condoms were distributed.
  - FP and HIV integration in Tanzania, Benin, Kazakhstan, DRC (through youth network), Suriname (trained 81 midwives, nurses and health assistants); Jamaica (roadmap for policy integration and creation of a Sexual and Reproductive Health Authority).
  - SRH/HIV service delivery in Uganda (couples and key population groups), Malawi (gender/SRH/HIV integration plan, South Africa, Ecuador, El Salvador (strengthened alliances and networks), Peru (studies on PLHIV access to services), Dominican Republic, Uruguay (60% of the health institutions have a SRH team trained; baselines constructed and system developed for monitoring and evaluation of the SRH
law implementation), Suriname (policy review), Sudan (SRH/HIV Technical Working Group established); RH/FP services for PLHIV and key populations in Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Serbia, Tajikistan, Turkey, Turkmenistan, Ukraine, and Uzbekistan; Training Obs/RH/GPs and support groups in SRH/HIV/STI (Macedonia, Moldova, Tajikistan) plus needs/services for PLHIV (Belarus, Kosovo) (eg utilising WHO protocols on SRH services for PLHIV, strengthening delivery of services by family medicine doctors), BiH (strategy and service integration), Moldova (strategy review), Belarus (programme mapping enabling HIV issues to be incorporated within the new RH Strategy), STI management in Guatemala and Kosovo

- Stigma and discrimination reduction for PLHIV and/or most at risk populations in DRC, Mauritius, Seychelles, Costa Rica (Action, Outreach and Advocacy Plans of the National Policy on Sexuality), Trinidad and Tobago (most at risk populations survey planned), support to local networks of PLHIV in Kosovo, Turkey, Russia, and Ukraine.

- Education and awareness activities in Swaziland (integrated curriculum development for gender, SRH and HIV); Zambia and Botswana (procurement of videos and IEC material for young people and strengthened YFS), Lesotho and Rwanda (general IEC for condom promotion), Paraguay (IEC materials), Belarus (SRH for PLHIV), Kosovo (SRH for PLHIV), and Moldova (RH rights and sex education). In Eritrea 369 trained people deployed to 329 remote villages sensitized 130,000 people on SRH and HIV.

- Integration plans were completed in Senegal, Mali, Togo and Guinea Bissau; National RH/HIV linkages and integration strategy was endorsed by the MOH (Uganda). In addition, a workshop on SRH and HIV Linkages/Integration with 80 participants from 18 countries, resulting in good understanding of SRH and HIV linkages to ensure that Global Fund round 9 proposals were reprogrammed around PMTCT and proposals for Round 10 were developed to accommodate integrated linkages on SRH and HIV/AIDS.

- Baseline linkages data was collected for EECA countries (Albania, Armenia, Azerbaijan, Belarus, Bosnia & Herzegovina, Bulgaria, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Macedonia, Moldova, Russia).

- The human rights of people living with HIV and key populations were advanced and stigma addressed through partnerships with GNP+, ICW, NSWP, MSMGF, INPUD; HIV Prevention Report Cards for Key Populations and What Works series (Afghanistan, Cambodia, India, Indonesia, Iran, Macedonia, Mozambique, Nigeria, Pakistan, and Suriname); Love, Life, and HIV DVD toolkit; and PLHIV Stigma Index implementation (India, Kenya, Mexico, Swaziland and Sudan).

- UNFPA support in Uruguay contributed to 60% of the health institutions around the country having the SRH team trained to lead the implementation the national SRH strategy in their respective institutions which includes coordination with other institutional areas such as the Gender Based Violence Service, the Health Adolescent Department and the STI services including HIV.

- In Lesotho at least 7,124,000 free-issue male condoms were distributed and field educators reached 50,000 clients.

- In Eritrea 369 trained people deployed to 329 remote villages sensitized 130,000 people on SRH and HIV.

- UNFPA thematic funds (UBW, MHTF, GPRHCS) conducted an integrated strategic review and planning resulting in increased harmonization, effectiveness and efficiency.

**Lessons learned**

- Countries are at different levels of integration at policy, systems and service provision. The cooperation from the MoH and the NAC are essential.

- A strong legal framework and political will are crucial to advance in the implementation of public policies; however, strong changes at the level of health care management and care assistance require advocacy actions and capacity strengthening.

- Policy must translate into service and service level integration must include attention to wider structural, gender and human rights issues. A multi-disciplinary multi-function team approach to integration deliberations can be effective in advancing the agenda at the governance level.

- Integrated services and multi-sectoral approaches are indispensable to reach most at risk populations and engagement of people living with HIV and key populations including young people must be ensured.

- Strengthening linkages should be included as part of broader health system strengthening mechanisms eg SWAp. Wherever RH programmes/services are strengthened efforts should ensure these are tailored/suitable for PLHIV as one means of mainstreaming HIV). WHO protocol on SRH services for PLHIV is recommended.

- Evidence base on cost effectiveness of linkages and integration requires strengthening; more applicable indicators need to be developed and tested.

- Ineffective logistical and supply systems are obstacles to effective service delivery of integration.

- While integrating HIV in MNCH is a key linkage, learning HIV status, promote safer behaviours, and optimizing the connections between HIV and STI services must all be addressed. Key activities to improve SRH and HIV Linkages include (a) adaptation of the Rapid Assessment Tool (RAT) to fit concentrated epidemic status, (b) adapt WHO Six Building Blocks as the Frame work for further analysis, (c) ensuring recommendations from the RAT are followed, and (d) advocacy for increased funding from the Government sector.

**Evaluation**

- Cost effectiveness study of linkages is being conducted in collaboration with the Integra Initiative in Kenya, Malawi, and Swaziland. It will provide the baseline to allow an assessment of whether cost saving have resulted from linking SRH and HIV services and the scope and scale of these savings. (The INTEGRA Initiative – a project with the London School of Health and Tropical Medicine (LSHTM) and the Population
Council

- Evaluation in China in 2010 suggested NPFPC to mainstream HIV prevention issues into daily family planning work.
- Evaluations were conducted in Nepal and Vietnam of which results will be available in 2012.

**Expenditure**

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,215,822</td>
<td>$272,953</td>
<td>$3,119,330</td>
<td>$5,608,105</td>
</tr>
</tbody>
</table>

**Achievements**

For Sub-Saharan Africa, donors made available nine male condoms for every adult male of reproductive age and 1 female condom for 13 women of reproductive age to protect themselves from HIV or unintended pregnancy. Donor support for male condoms remains constant: 2.7 billion in 2009 and approximately 2.8 billion in 2010. Consequently, many countries experienced stock-out.

- Global access to female condoms decreased from 50 million female condoms in 2009 to 35 million in 2010. The donor community significant reduced their support to 18 million in 2010 as compared to 38 million in 2009.
- The Condom IATT Demand Generation Working Group (co-led by UNFPA and FHI, with representatives from Durex Network, Population Services International (PSI), SUPPORT, CEDPA, USAID, Columbia University, Johns Hopkins University and IPPF) developed and field-tested, with participants from 21 Dutch- and English-speaking Caribbean countries, a standard Condom Demand Generation Framework to customize effective male/female condom demand generation. One month following the field-validation workshop, three countries developed condom demand generation strategies. In 2011, 8 of the 17 priority countries for Young People have begun implementation of the condom demand generation framework targeting young people. (cross-reference BA11)
- UNFPA supported the development of tools to improve condom programming such as Condom Costing Tool to facilitate the development of costed operational plans and work plans and improve resource mobilization efforts and an M&E Framework (jointly developed with FHI, JSI, PSI, SUPPORT, USAID, MSI, Measure Evaluation, UNAIDS and World Bank) to monitor implementation, evaluate impact, and track progress at global and country levels.
- UNFPA organized two donor meetings during the HLM in New York and the FP Conference in Dakar to stress the gap on male and female condom access resulting in Denmark and the UK committing to $10 million and 5 million pound respectively to support the intensification of male and female condom programming, especially in Sub-Saharan Africa.
- UNFPA and partners’ CONDOMIZE! Campaigns to raise awareness and destigmatize condoms were organized at:
  - IAC 2010 (25,000 delegates) – The CONDOMIZE! Campaign “love smart, play safe” educated conference participants about the correct use of male and female condoms and lubricants; dispelled myths and misinformation; and distributed 1 million condoms in 100 hours. Social media - website, Facebook, Twitter, YouTube- was used to increase the reach. Media coverage: http://english.cntv.cn/program/news/20100722/163313.shtml; http://www.unfpa.org/public/home/news/6344
  - ICASA 2011 (10,000 delegates) – The CONDOMIZE! Campaign “Condomize! don’t compromise”. UNFPA and The Condom Project (TCP) — in collaboration with the ICASA Secretariat and DKT International, Family Guidance Association of Ethiopia, the Female Health Company and Populations Services International made this Condomize! the most visible event of the conference. The campaign distributed condoms (200,000 PSI condoms and 400,000 ICASA branded condoms), lubricants, t-shirts (3000), educational CDs (6000) and IEC leaflets (6000) and condom cases (6000), but the highlight was the community dialogue space where thousands were freely sharing their challenges with inadequacy of condoms supplied in Africa, the inaccessibility of lubricants and female condoms or the intolerance and violence against MSM or sex workers. http://www.newbusinessethiopia.com/index.php?option=com_content&view=article&id=661:unfpa-launches-condomize-campaign-at-icasa-conference&catid=27:health&Itemid=52; http://www.safaids.net/content/condom-campaign-africa-launches-icasa-2011; http://www.keycorrespondents.org/2011/12/08/condom-campaign-for-africa-launches-at-icasa-2011/
  - Caribbean HIV Conference: 2000 regional programme managers and policy makers exposed reached with condom innovations in social and behaviour change communication.

UNFPA Broad Activity Achievement Report [2010-2011 UNAIDS UBW]  Page 10 of 27
- Development and expansion of the “www.allaboutcondoms.org” web site, introducing two components: the “condomize” online social networking campaign with a Facebook, Twitter, and YouTube presence and a condom education programme with interactive learning video games and educational materials in the six UN languages and sign language.

- Ethiopia ran a ‘safer life campaign’ with DKT targeting students, sex workers, drivers, military personnel and disabled people and distributed 15.8 million male condoms and 15,000 female condoms. In Uganda, over 2 million condoms were distributed by 200 passenger motorcycle riders (boda boda) in Kampala city.

### Lessons learned

There is a gap at global, regional and national levels on reporting mechanisms on condom accessibility, utilization, availability, and quality. Where indicators exist, they mostly refer to condom utilization by key populations and are not collected regularly.

- Condom taxes and tariffs are imposed in some countries and in others restrictive policies prevent access to condoms to some segments of the population.

- Working in close collaboration with social marketing organizations has proven to be very beneficial. Promotion is key to create demand for male and female condoms, to design attractive packages, sensitive messages, awareness campaigns, and to engage the media.

- Social networking software is an easy, inexpensive way to promote condom use, by-passing many state bottlenecks and being widely accessed by young people.

- Countries are challenged in projecting condom consumption resulting in condom stockouts or oversupply followed by difficult logistics reshipping condoms from one country to another.

- No funding has been injected into condom research for several decades including behavior, social or epidemiological research. These data are crucial to inform programme managers and decision-makers to understand sexual behaviours and other practices and beliefs that may influence HIV transmission.

- Lessons learnt from programme implementation to inform governments, partners and donors are rarely documented.

- Investing in the capacity building and retention of national staff is key to make a difference in CCP.

- A total market approach is best for strengthening demand for condoms, accessed from government, NGO and private sector/commercial sources.

- In extremely conservative environments, focused efforts to promote condom use for HIV prevention should be placed at the community level through an edutainment approach that is shifting from needs based to asset based approach as an alternative.

- A mapping of organizations in the Caribbean region involved in condom programming revealed the need for greater investment and partnerships to address supply management of condoms.

### Evaluation

- Vietnam finalized a country assessment of national condom programmes and another research on use of female condoms. The research results showed mixed perceptions and attitudes toward female condom use among women. Female condoms are new to most of the study participants. Technical research proposal for national survey on RTI/STI was developed. Findings of this survey will formulate a Programme of Action on RTI/STI Prevention and Control in the One Plan 2012-16.

- In Zimbabwe a study on male circumcision acceptability was conducted as part of the Behavior Change interim survey. The paper was presented at AIDS 2010.

- In Uganda a condom mapping exercise was undertaken for the UNFPA supported districts.

### Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,146,229</td>
<td>$18,826,783</td>
<td>$1,760,321</td>
<td>$22,733,333</td>
</tr>
</tbody>
</table>
**Achievements**

- UNFPA championed implementing eMTCT through the SRH/MNCH platform including by articulating the rationale and modalities for linking SRH and HIV, advocating to raise awareness that HIV is a leading cause of death among women of reproductive age, contributes to maternal mortality, and that family planning contributes to decreasing the numbers of HIV positive infants, keeps mothers alive, and has intrinsic benefits to women, resulting in strengthened policies and programmes. UNFPA contributed to development and implementation planning of the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive, ensuring that the goals and targets reflect MDG 3, 4, 5, and 6, including MDGSB for prong 2 of eMTCT.

- UNFPA participated actively in the IATT eMTCT, including its reconfiguration and working groups to align with the Global Plan, ensuring harmony of goals, targets, and a rights-based approach, particularly coordination with maternal health initiatives. Fostered collaboration between the HIV and maternal health communities through enhanced coordination mechanisms, joint planning, and implementation (e.g., H4+ and IATT eMTCT). Engaged networks of people living with HIV in eMTCT policy dialogue and programme planning.

- UNFPA led the development, adhering to the GIPA principle, of Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015 in support of the Global Plan including rationale, package of services, key entry points, checklists for national implementation, and strategies on SRH and HIV linkages; engaging communities, PLHIV, and men; and eliminating stigma and discrimination; and built national capacity to scale up eMTCT programmes through eMTCT policies, systems, and services linked to MNCH, and other SRH programmes (FP, STIs, CSE, GBV).

- The ICM Global Education Standards and the Essential Competencies of Basic Midwifery Practice (on which the Education Standards rely) were finalized in 2011. These competencies among others include antenatal care (competency # 3), which further includes treatment and support for HIV positive pregnant woman including measures to prevent mother-to-child transmission (PMTCT). UNFPA is supporting some 30 countries in ensuring that the midwifery teaching curriculum is fully aligned with these standards and 7 essential competencies. 15 countries have already fully modified their curriculum to include all competencies. Several countries like Burkina Faso, Ethiopia and others organized specific refresher trainings for practitioners and midwives to upgrade their skills on PMTCT and during the celebration of the International Day of the Midwife, free screenings and treatment was provided to pregnant women who were HIV positive.

- A high level meeting at the GreenTree Estate to help accelerate progress on reproductive and neonatal health. Participants included UN partners (UNAIDS, UNICEF, WHO, UN Women, World Bank) Health Ministers and senior health officials from six countries with large numbers of maternal and child deaths; leaders of UN agencies, the health cluster co-facilitator of the UNSG’s MDG Advocacy Group; and representatives from civil society. The meeting served two purposes: (a) to gain high level affirmation by countries and the UN of the central importance of expanding community-level access to midwifery resources; and (b) to prioritize some of the key training, management, and community mobilization actions needed.

- The H4+/H5 Taskteam addressing PMTCT: CIDA recently signed a $50 million, 5-year Agreement with UNFPA to accelerate progress in maternal and newborn health including PMTCT in all 49+ priority countries and to specifically support five African countries (Burkina Faso, DRC, Sierra Leone, Zambia, Zimbabwe) in accelerating the implementation of the commitments made to the Global Strategy. Though the implementation focus will be in the five countries, lessons learned and evidence-based interventions will be used to scale up actions and commitments in the 49+ priority countries. Zimbabwe is addressing equitable access to quality and comprehensive services along the ‘continuum of care’ including improved integrated management of Maternal Newborn and Child Health / Reproductive and Adolescent Sexual and Reproductive Health and Nutrition including a comprehensive PMTCT package of services at all levels.

- Documentation and dissemination of good practices and lessons learned in integrated SRH/Maternal Health/HIV prevention, including PMTCT scale-up and institutionalization of Maternal Death Reviews to improve care, especially in EmOC and HIV prevention proceeded in the ten focus countries of 2009 (Benin, Burkina Faso, Ethiopia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone, Uganda, Zambia) and South Africa.

**Lessons learned**

- There is still resistance to linking SRH and HIV, including through the MNCH/FP platform for eMTCT, exacerbated by ‘ turf’ issues, funding, political sensitivities and accountability. Progress requires continuing to provide the rationale for why and how eMTCT and SRH are related (MDGs 3, 4, 5, 6), providing models of good practices, and fostering collaboration between the IATT, G5, and H4+.

- Overcoming the stigmatizing attitudes and discriminatory behaviours that continue to be held towards key populations and PLHIV, in including health care settings, is essential and facilitated by supporting their direct engagement in planning and monitoring activities, and disseminating evidence (e.g., PLHIV Stigma Index findings).

- Eliminating GBV and engaging men are both necessary for effective eMTCT and SRH programmes, and yet, more efforts are required to make this happen within the community and health services.

- It is essential to link with the major maternal, newborn and child health initiatives, especially as HIV is a leading cause of mortality for women of reproductive age and of maternal mortality.

- Utilizing (social) media greatly facilitates the delivery of our mandate to wider audiences, such as the Dominican Republic delivering key PMTCT messages through Facebook reaching 3.156 people (of which 69% did not know initially about the importance of HIV testing for pregnant women within the first three months).
Evaluation

- In Kenya the barriers of access to family planning by PLWH were evaluated, as their unmet need stands at more than double (59%) the national rate (24%). A joint review showed the weakness of family planning within PMTCT. The PMTCT program was well received as it supported healthy born children, treatment and general wellness and health education.


- Argentina completed a seroprevalence study of HIV and congenital syphilis in 24 maternity hospitals.

Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$712,618</td>
<td>$162,272</td>
<td>$1,219,616</td>
<td>$2,094,506</td>
</tr>
</tbody>
</table>

Broad Activity 8: Advocacy and support for inter-linkages/integration of VCT in maternal health and other related services.

Achievements

Capacity Building and Training

- Kenya, Rwanda, Zambia, Uganda, Namibia, Seychelles, Swaziland, Zimbabwe, Comoros, DRC, and South Africa received support for VCT integration in MNH including equipment and IEC materials (Namibia), mobile and fixed VCT centers (Swaziland, South Africa, Rwanda, Uganda and Comoros); community-based and/or home based promotion of VCT (Swaziland and Zimbabwe), integration of RH into HIV prevention services (Kenya), PMTCT integration into ANC and encouragement for couple-visits (Zambia) and service sites for sex workers (Uganda, Zimbabwe).

- NGOs and Ministry of Health staff trained for counseling, service delivery and HIV testing to groups in conditions of vulnerability, pregnant women and public at large (El Salvador). Indonesia, Mongolia, Pakistan, Thailand and Timor-Leste received support for testing and counseling scale up.

- An assessment and situation analysis of the integration of ANC services with STIs screening testing and treatment, including HIV conducted in Indonesia resulted in revision of the national guideline on STIs and VCT services at primary health centers.

- UNFPA Mongolia supported developing guidelines, coordination and capacity building of VCT centers; results include increasing access and improved knowledge, skills and attitudes of doctors and counselors. Monitoring and evaluation of VCT centers (established with the support of UNFPA) resulted in recommendations to strengthen VCT services.

- UNFPA Pakistan shared IEC materials on HIV Prevention in MCH services and supported strengthening of HIV testing as part of emergency responses and in Timor-Leste UNFPA supported integration of HIV prevention in PMTCT. In Bangladesh, UNFPA provided technical inputs to the WHO-led VCT services need assessment and follow-up validation workshop.

- In Colombia, health services were strengthened for scaling up access to voluntary HIV testing, through technical assistance to 30 institutions providing health services, training of 300 professional health care workers, training of trainers for 12 Universities (representing broad national coverage) on VCT based on the new document “Pautas para la realización de la asesoría y prueba voluntaria en VIH con enfoque diferencial y de vulnerabilidad” (Guidelines for the implementation of HIV Voluntary Counselling and Testing with a differential and vulnerability approach).

- Capacities built of health professionals and providers on new HCT approach and rapid health tests (Mozambique); HIV surveillance and epidemiology in a maternal health hospital (Paraguay); HIV prevention, counseling, treatment and care (Uruguay); linking MH/SRH and HIV/AIDS (Guyana where civil society organizations were also trained); Ob/Gyn training to include HIV counseling within “efficient perinatal care” (Armenia) and a cadre of highly skilled trainers established within Ministry of Public Health (Egypt) where strengthening of the network of VCT centers resulted in an increased number of people tested.

- Staff capacities were built in governmental health departments and NGOs in VCT for pregnant women and vulnerable populations in El Salvador; and, the quality of VCT services on HIV counseling improved in five regions in the Dominican Republic.

- UNFPA collaborated with the Pacific Counseling and Social Services in Fiji to implement a comprehensive VCCT programme in ANC, and provided technical assistance for development of a rapid testing algorithm for HIV diagnosis in PICs which resulted in less time for receipt of test results.

Guidelines

- “Pautas para la realización de la asesoría y prueba voluntaria en VIH con enfoque diferencial y de vulnerabilidad” (Guidelines for the implementation of HIV Voluntary Counselling and Testing with a differential and vulnerability approach) developed, published and distributed to Health Secretaries and civil society (Columbia).
- Rwanda, Mozambique, Uganda were supported on HCT strategies and guidelines; in Uganda an operational plan was developed.

**Advocacy**
- Advocacy and VCT, IEC/BCC or social mobilization campaigns were supported in Namibia, Malawi, Burundi, Kenya, Zambia, Rwanda, Mozambique, Benin and Brazil.
- UNFPA Brazil contributed to the analysis of databases of 2009 and 2010 to improve management and planning to offer the tests. The National AIDS Program offered rapid testing during the 7 days of the Rock in Rio festival that brought together about one million people.
- UNFPA El Salvador supported 15 civil society organizations of the NGOs HIV Forum to carry out HIV prevention actions during the commemoration of the national HIV testing day (June 25) and the World AIDS Day.
- UNFPA Uruguay supported the launch of a communicational campaign on the importance of HIV testing.
- Moldova conducted a WAD community campaign to encourage uptake of HTC and reduce discriminatory attitudes to PLHIV to enable further testing.
- UNFPA supported the Safe Motherhood Alliance, set up by the parliamentarians for Population and Development Group in PNG, and advocated for linking VCT in maternal care.

**Lessons learned**
- Integrating efforts for primary HIV prevention and to prevent unintended pregnancy in PMTCT is a challenge at both policy and implementation level. The comprehensive approach with practical standardized procedures supplemented with evidence on the benefits of integrating are critical in convincing stakeholders to scale up programmes.
- In Gambia, the number and quality of service providers is still a challenge. Colombia cites paucity of health provider training on VCT where guidance is currently being promoted on knowledge and approaches to improve the capacities of the health institutions and the civil society organizations. [http://www.unfpa.org.co/menuSupIzqui.php?id=4](http://www.unfpa.org.co/menuSupIzqui.php?id=4). Civil society training and staff involvement on VCT service delivery has expanded Ministry of Health efforts to prevent and detect HIV infections in El Salvador. Inclusion of HIV prevention and ASRH in pre service trainings for midwives is a good entry point to ensure adequate knowledge and updated information.
- Guidelines need to be updated regularly and shared widely among health care workers as well as trained counselors. In an emergency situation such as floods in Pakistan with population movement, VCT is a critical element of BCC promotion for safer behaviours including male and female condom use.
- Illuminating the need for stronger integration of SRH and HIV services, while VCT and ARV are free routine services in health centers in Madagascar, high levels of stigma are impacting access (HIV/AIDS services are located in special units within hospitals). Similarly for young people in Brazil, having rapid testing alternatives to health sector is an important strategy to promote access.
- In Malawi, even with national support of integrated services, success in service centers is impacted by various shortages.
- In Mozambique ANC-based HCT is mainly reaching women with community based awareness and peer education envisaged for reaching young men. Limited infrastructure may also limit male involvement as noted in Zambia. In DRC the military and police services are equipped for VCT and FP thus reaching this cadre of men.

Targeted messages improved HCT demand in Uganda where demand is now outpacing supply of test and rights-protection kits. Conversely, there is low uptake of testing by sero-discordant couples because of stigma.

- In Zimbabwe community-based promotion of VCT worked effectively, and there is an expression of interest to explore possibilities of promoting PMTCT and MC in the same manner.
- Strong coordination between the departments of MoH and ‘buy-in’ of the NAC was needed in South Africa to support the government campaign Lovelife
- Despite the precariousness and lack of economic resources or inputs at appropriate times in the Dominican Republic, forums conducted with service providers SSR, GBV and HIV show good practice around service delivery, especially in the services installed in the communities with higher levels of poverty.
- The need of parental consent guided by the medical council is one of the key barriers to young people seeking VCT of HIV in Thailand
- Multi-sectoral collaboration is essential for mainstreaming VCT services. Demand creation for VCT services is crucial, but needs to be done cautiously to avoid panic in low prevalence countries such as Bangladesh.
- Need to involve authorities of local health centers in VCT management and discuss other complementary services in cross border areas with related partners.
Evaluation

- In Comoros, a situational analysis of integration of SRH and HIV/AIDS-prevention services was conducted, report is attached. In addition, an Evaluation of SRH and HIV linkages showed decisive benefits which generated broad support but the MoH does not have the necessary funds to take action
- In Rwanda, data from TRACPlus was used. http://www.tracrwanda.org.rw/index1.htm
- In Mongolia, 2011 evaluation of VCT centers established with support of UNFPA have been undertaken and recommendations on strengthening centers provided.

Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$599,411</td>
<td>$18,226</td>
<td>$41,819</td>
<td>$659,456</td>
</tr>
</tbody>
</table>

Broad Activity 9: Development, documentation and up-scaling of models to strengthen the evidence base to support programming in the context of HIV and sex work.

Achievements

The WHO/UNFPA/Network of Sex Work Projects (NSWP) guidance on HIV and STI interventions for sex workers and their clients progressed with systematic reviews being undertaken on violence against sex workers, community empowerment, periodic presumptive treatment and syndromic management of STI and a values and preferences study undertaken by NSWP. A consultative review meeting of experts including sex workers, researchers, WHO, UNFPA, UNDP and the UNAIDS Secretariat, examined the validity of the systematic reviews. It is expected the guidelines will be approved and released by mid year 2012 for utilisation at the country level.

UNFPA partnered with the World Bank and the Johns Hopkins Bloomberg School of Public Health and Center for Human Rights and the Network of Sex Work Projects to produce state of the art policy guidance for national implementation on: the epidemics among sex workers in different regions and the cost effectiveness of interventions for/with sex workers. UNFPA funded and Co-Chaired the community consultation with the researchers as part of the validation process. The report will be released mid 2012 and is expected to influence investments on HIV and sex work.

The report of the 1st Asia Pacific Regional Consultation on HIV and Sex Work, held in Pattaya, Thailand in October 2010, was widely distributed. Actions arising from the recommendations of the Pattaya Consultation include: an analysis of the needs and opportunities to promote sex work as work and safer sex work environments (ILO led), guidance on priority interventions to strengthen health sector responses to sex work (WHO led), draft report on enabling legal policy and human rights environments (UNDP and UNFPA), and regional research on violence against sex workers (UNFPA and UNDP).

UNFPA contributed technical input to the research on the specific HIV care and support needs of sex workers, men who have sex with men and transgender people. Regional research on key populations was conducted and evidence generated in six countries in the Caribbean (Barbados, Grenada, Guyana, Jamaica, St. Lucia, and Trinidad and Tobago).

Legal mapping of sex work methodology was developed in partnership between UNDP, UNFPA and the Michael Kirby Centre for Public Health and Human Rights to support actions removing punitive laws, policies and practices relating to HIV and sex work.

UNFPA funded the development of the Paolo Longo Research Initiative newsletter (PLRI) addressing sex work, men who have sex with men and transgender people facilitated the immediate transfer of information, research, reports, good practice sharing across Country Offices and regions. The PLRI newsletter provided a monthly update on sex work research and was used by civil society organizations, sex work organizations.

IPPF, UNFPA, UNODC Network Sex Work Projects, the Global Forum on MSM, and several UNAIDS COs collaborated to produce a series of Report Cards on key populations. Pakistan: sex workers; India and Cambodia on men who have sex with men; Macedonia on people who use drugs. The Report Cards on Key Populations provide a quick analysis of the epidemiology on key populations in the country, details on access to services, legal environments, and key data on the relevant key population to guide country level responses to reducing the HIV risk and vulnerability of those populations.

In 2010 and 2011 data generation, mapping, assessments and size estimations of sex workers (predominantly) and men who have sex with men were undertaken in 26 countries (Algeria, Azerbaijan, Bolivia, DRC, Ecuador, Ethiopia, Fiji, Gabon, Kenya, Kiribati, Malawi, Namibia, Peru, Rwanda, South Africa, Sri Lanka, Sudan, Swaziland, Tanzania, Thailand, Turkey, Turkmenistan, Uganda, Vanuatu, Yemen, Zambia, Zimbabwe). Most have led to better informed national strategies, plans and programmes and the generation of good practice. In Rwanda, for instance, this has led to the National AIDS Control Commission developing a minimum package for sex workers. In Brazil, a strategic assessment of the social, cultural, and political context of programmatic actions with sex workers in four cities was developed with UNFPA technical support. The assessment has a specific focus on the relationship between stigma, rights, social mobilization, health, and cultural activism. The assessment provides an analysis of current programming and directs future work and covers the need to systematically monitor and evaluate human rights based programming. The assessment team includes researchers, the government and sex work organisations.

Research on sex work, men who have sex with men and transgender people was undertaken in 14 countries including: Tanzania on the risks of HIV and STI transmission for women through heterosexual anal sex;
mapping child commercial sexual exploitation; on vulnerability to HIV and lack of access to health care for men who have sex with men, transgender people and bisexual people in Argentina; and on condom use by sex workers with non-paying partners in India; in the DRC BCC on sex work was conducted and 3225 sex workers were treated for STIs and provided with condoms. UNFPA Colombia produced reports on: “Sexual behaviour and HIV prevalence among men who have sex with men, in seven cities of the country”; “Characterization of HIV vulnerability of population living on the streets, in the cities of Bucaramanga and Barranquilla” and “HIV/AIDS vulnerability contexts in groups of high risk drug users in the cities of Armenia and Medellin.

Pakistan held a National Consultation on HIV and Sex Work in 2008. Further, Pakistan participated in the 1st Asia Pacific Regional Consultation on HIV and Sex Work, Pattaya. The culmination of both has resulted in increased collaboration between the government, bilateral agencies, the sex worker community, and NGOs has resulted in the scaling up of services for sex workers based on the agreed minimum service package, providing greater geographical coverage, reaching a greater number of sex workers with an enhanced range of services. Indonesia also participated in the Pattaya. Subsequent to this, the National AIDS Commission, with support from UNFPA, developed a draft of government regulation on HIV prevention through sexual transmission including access to condoms and STIs service for sex workers.

Guidance Notes and five training modules were developed in Sri Lanka for targeted intervention programmes for sex workers and MSM and countries have progressed implementation of the UNAIDS Guidance Note on HIV and Sex Work, including Uganda and Zambia

UNFPA Mozambique provided technical support to address the circumstances of men having sex with men currently in prisons. Six supervisory visits and technical updates for peer educators in prisons were implemented in Maputo; 72 peer educators for prisons were trained at the municipal level; and two libraries were opened in two jails.

Over 6000 sex workers were reached through 16 outreach sites and 2 static clinics operated and/or supported by UNFPA in Zimbabwe with SRH/HIV services. HIV prevalence was found to be 60% among the sex workers hence the need for scale up is urgent. Mozambique successfully advocated for the integration of nurses at the night clinics into national payment schemes, which resulted in improved sustainability. In Burundi 11% of adult population used condoms during their last intercourse. The condom use has registered a marked increase among the sex workers group.

Female sex workers from Indigenous people trained in HIV prevention and sexual and reproductive health in Argentina.

In Bolivia, UNFPA, UNDP and UNAIDS CO supported the empowerment of 18 transgender leaders in a 96 hour training programme and UNFPA supported the national forum of sex workers to develop their 2012 work plan.

Lessons learned

The 1st Asia and Pacific Regional Consultation on HIV and Sex Work was ground breaking in its commitment to meaningful participation with sex work networks and organisations. Its other hallmark feature was bringing together government officials from a range of ministries (police, health, justice) with sex workers to jointly discuss country plans of action. The Regional Technical Working Group was formed to monitor country level implementation and to undertake regional level work to maintain the momentum. It has succeeded in several areas including commissioning research papers, technical guidance, and providing funding support to the Asia Pacific Network of Sex Workers. It has also provided a mechanism to facilitate alignment between country priorities and the types of technical support required from regional agencies. However, the Regional Thematic Working Group also illustrates the importance of meaningful participation in all aspects of planning, implementing, monitoring and evaluation and the need to continually build a relationship of trust and respect among all members. Achieving cohesion, harmonisation, quality and consensus is an ongoing process and one that requires appropriate levels of resourcing – human and financial – to ensure gains are sustainable.

The importance of occupational and health safety standards needs to be included in responses to HIV and sex work. Air quality, work-related drug and alcohol consumption, access to condoms and lubricants, access to voluntary HIV and STI testing and management, violence, access to toilets and bathing facilities, clean linen, are just some of the working condition issues that need to be addressed. Very little programmatic work is being undertaken by the Joint Cosponsored Programme to cover these aspects of reducing HIV risk and vulnerability for sex workers and clients. Implementation of ILO Recommendation 200 in the context of sex work should become a priority in UBRAF 2012-2015.

Municipal level responses need to be strengthened. Sex workers and their clients clearly lack access to services in many municipalities and in the rural areas surrounding those urban centres. The availability and quality of STI screening and syndromic and asymptomatic management is poor in most settings outside major cities (and even within those cities). The lens of labour mobility needs to be applied to HIV and sex work. Both sex workers and their clients are frequently highly mobile, and many are undocumented migrants. Service provision in most countries does not meet the needs of these mobile populations and rarely take account of language and cultural differences. Very few countries are programming and implementing services along transport corridors and in border areas where sex work is common; the HIV risk and vulnerability in these settings is significant.

- In Sri Lanka it is suggested there be concerted outreach to the media as adverse media coverage resulted in the premature stoppage of a pilot programme with male sex workers.
- Thailand has learnt that understanding the lived experiences of sex workers is critical to finding a common ground for government, sex workers and other partners to work together
- Timor Leste is struggling to deliver cohesive planning and implementation in an environment of significant fragmentation among government institutions.
- Punitive laws, policies and practices continue to hamper HIV prevention and treatment efforts for sex workers around the world. Every region reports this as a major structural impediment to provide the level and types of services required to halt and reverse the HIV epidemic in the context of sex work.
- Working with clients is insufficiently addressed. While scarce resources should not be drawn away from service provision for sex workers efforts to increase the health seeking behaviour of clients and that reinforce the need for clients to take responsibility for their own sexual behaviour are important.
- The stigma, discrimination and violence that men who have sex with men, transgender people and sex workers face is common in every region and in most countries. Latin and Central America are coming up with innovative approaches to redress these human rights violations, especially for transgender people (95% of whom sell sex) and men who have sex with men.
Evaluation

- In China, a Thematic Evaluation for CP6 (2006-2010) HIV Component was conducted in China by an independent national evaluator in 2010. Key deliverables include:
  - HIV knowledge rate (UNGASS indicator) among the sex workers increased from 35.9% in 2006, 40.8% in 2008, 47.4% in 2009, to 39.4% in 2010.
  - Condom use among sex workers during their last sexual encounter increased from 84.3% in 2006, 85.4% in 2008, 91.1% in 2009, to 89.3% in 2010.
  - Condom use rate among sex workers in the last month has increased from 53.8% in 2006, 64.1% in 2008, 75.3% in 2009, to 71.9% in 2010.
- Also in China, UNFPA’s 2010 thematic HIV evaluation report highlighted that correct HIV knowledge and condom use in last sex course among sex workers increased from 2006 to 2010. The cross border project baseline (2008) and end line (2011) data of China side showed an increase in correct HIV knowledge among sex workers, mobile traders and truck drivers.
- In South Africa, a gap analysis on key populations at risk was completed. See attached research report and policy briefs: [http://www.d4d.co.za/blog/?p=4032]
- Good practice approaches were documented on HIV and sex work in Indonesia, Malawi, Russia, and implemented in Jamaica. UNFPA was actively engaged in supporting the Ministry of Labour, Invalids and Social Affairs (MOLISA) in introducing the concept of harm reduction for HIV prevention in sex work to replace detention centers in Viet Nam. 14 good practice case studies from 7 countries addressing comprehensive responses to HIV and Sex Work were documented in Asia and Pacific as one of the products from the Regional Thematic Working Group on HIV and Sex Work (RTWG) in Asia and the Pacific formed in 2011. UNDP, UNODC, the UNAIDS RST in Asia and the Pacific collaborated with the Nossal Institute to produce Good Practice on effective law enforcement as part of the HIV response among key populations.

Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,142,291</td>
<td>$40,000</td>
<td>$616,500</td>
<td>$1,798,791</td>
</tr>
</tbody>
</table>

Broad Activity 10: Advocacy and technical support on evidence-informed policies and programmes to governments and civil society to scale up HIV prevention, treatment, care and support services for those engaging in sex work and their clients.

Achievements

- 79 countries were supported by UNFPA to develop and/or implement programmes on HIV prevention services for female, male and transgender sex workers
- 12 UNFPA Country Offices engaged specifically with men who have sex with men and a smaller number on transgender people. 1000 men who have sex with men had increased access to HIV prevention in Sudan. In Bolivia, Colombia, Costa Rica, and Uruguay, UNFPA supported in HIV prevention efforts for transgender people, participating as a member of the Universal Access Committee for GBT and Transgender persons [Bolivia], trained health professionals [Colombia], trained transgender people on research methodology [Costa Rica]. Much of this work was also extended to men who have sex with men with active participation by UNFPA in anti homophobia campaigns
- Globally, UNFPA contributed to sex workers and men who have sex with men being specifically referred in the High Level Meeting Political Declaration 2011 and was involved in the strong representation of sex workers in the regional dialogues of the Global Commission on AIDS and the Law
- UNFPA provided catalytic support strengthen the capacity of sex worker led networks and organisations in HIV prevention, treatment care and support; in particular to increase sex worker participation across Namibia, to harmonise donor support and better focus national priorities on sex work; support for a mobile HIV and SRH service for sex workers in the border town of Maputsoe, Lesotho; and, activities to promote economic empowerment of sex workers in Gabon. Similar support addressing sexual and reproductive health and HIV prevention, advocacy, has been provided to the Network of Sex Work Projects, the Africa Sex Workers Alliance, the Asia Pacific Network of Sex Workers, REDTRASEX, SWEAT and Sisonke in South Africa, 14 provincial organisations of sex workers in Ecuador, El Salvador, Costa Rica, Panama, Sudan, Occupied Palestine Territory, Egypt, China, Nepal, Pakistan, Russia, resulting in stronger sex work organisations and greater inclusion in national and municipal level HIV prevention measures. Countries like El Salvador have been supported by UNFPA to increase the provision of sexual reproductive health services for sex workers and their adolescent children. The All India Network of Sex Workers (AINSWW) was supported to provide inputs to NACO for the formulation of NACP IV. In Thailand, UNFPA supported the Service Workers in Group Foundation improving coverage and quality of SRH /HIV services targeting 6,000 male and female sex workers in Pattaya and supported two Provincial Health Offices to expand service coverage to 5,000 sex workers. Russia produced a guide to sexual and reproductive health services for sex workers and expanded work in 7 regions. In Swaziland UNFPA and WHO scaled up interventions and resources for key populations.
- The issue of sex work and migration [including undocumented migrants] and mobility was addressed in Costa Rica and UNFPA contributed to the Ministry of Labour Relations defining the legal and procedural
basis to define sex work as work. The Mongolia-China border project reached 41,118 mobile people and 1023 female sex workers through various activities such as community-based trainings, outreach work, public campaigns and VCT services.

- DRC established an STI and HIV care centre for sex workers, and country offices in Algeria, Belize, Burundi, Comoros, Congo, Côte d'Ivoire, Egypt, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Guyana, Kenya, Lesotho, Liberia, Madagascar, Mozambique, Namibia, Nicaragua, Nigeria, Peru, Rwanda, Seychelles, Sierra Leone, South Africa, South Sudan, Suriname, Tanzania, Turkmenistan, Uganda and Zimbabwe focused on capacity building of sex workers on SRH, GBV, condom use, media usage, economic empowerment, drop in centres and outreach services, and care for sex workers living with HIV. In South Sudan for instance, 77 sex workers were trained in HIV prevention and reached 3,000 sex workers distributing 50,000 condoms and addressing issues of stigma. Rwanda scaled up the provision of the minimum package to sex workers in 5 districts in partnership with civil society organisations and reached 250 sex workers. Malawi provided integrated SRH/HIV services including Family Planning, STI management, HTC and PMTCT utilising an outreach model to reach sex workers. This resulted in early detection of STIs among sex workers, referral to other services such as PMTCT and an increase in contraception uptake. Serbia conducted 3 provincial HIV prevention workshops to reduce HIV exposures and risks in key populations. In Guinea-Bissau, government partnerships with NGOs and social marketing organizations strengthened condom programming targeting sex workers.

- Mauritius expanded its programme to address young people in prisons and people living with HIV. Russia and Albania used trained adolescent peer educators in prison settings using drama and counselling to reduce HIV and drug use. Mozambique expanded programmes with transgender people and men who have sex with men and Belize scaled up programming for people living with HIV with an emphasis on men who have sex with men. In Turkey, the “Monitoring and Supporting Safe Sex Behaviour of Men who have Sex with Men Population” project provided services on STI/HIV counselling; VCT referrals; information on safe sex and condom use.

- UNFPA contributed to support to countries to include sex workers, men who have sex with men, transgender people and people who use drugs in applications for GFATM grants.

- UNFPA has significantly expanded its coverage of sex work programing with 18 countries in Eastern and Southern Africa and 13 countries in Asia and the Pacific included sex work and other key populations in key national documents, strategies and HIV programmes. In Zimbabwe a national sex work programme was developed and rolled out with UNFPA support based on the Zimbabwe National Strategic Plan 2011-2015. Indonesia developed a national action plan for HIV programme among young people including most at risk young population following the regional training on HIV programme for most at risk young population. Bangladesh moved ahead in establishing local partnership forums in two municipalities following the 2009 National Partnership Forum on HIV and Sex Work Issues, in Viet Nam, harm reduction for sex workers using drugs was included in the Programme of Action on Sex Work 2011-2015 with the support of UNFPA and other partners, in DRC, Ethiopia, Kenya, and Uganda advocated for and supported the National Strategies on HIV prevention in sex work settings, and in Rwanda the minimum package was ‘validated at national level’. In Côte d’Ivoire, specific actions targeting Young People, Sex Workers and Uniformed Services were included in the NSP 2011-2015

- The Caribbean undertook a mapping of technical expertise and organizations working in sex work, men who have sex with men and transgender people in four countries (Trinidad and Tobago, Jamaica, Antigua and Belize). In Nicaragua, 18 workshops on Sexual and Reproductive Health and Rights, Violence Prevention and HIV were held and 6,900 new materials were produced for sex worker organisations on Sexual and Reproductive Health and Rights, Violence Prevention and HIV. Further, the first health’s manual for transgender people was developed and printed as a result of the First National Meeting for transgender people.

- Armenia distributed 100,800 male condoms under the Joint UN Programme of Support on HIV/AIDS (2010 –2011) including via 10 NGOs working with sex workers, people who use drugs, men who have sex with men, young people and military recruits. Armenia also strengthened peer education programmes for most at-risk young people and Kosovo expanded programmes for men who have sex with men.

**Lessons learned**

- Funding/resource mobilization continues to be a challenge to improving quality and coverage of service delivery to sex workers, men who have sex with men, and transgender people, and is frequently not a priority within national budgets.

- Capacity development to community organisations is a long term investment that needs to be made. Often community organisation members have low levels of education, common in sex work organisations, and every assistance is required to enable them to function at a high level. Often the NGP service providers are reluctant to transfer power and ownership of interventions to the communities themselves.

- Religious norms, punitive legislation, and lack of government support are major obstacles to the scale-up of HIV prevention services for sex workers, men who have sex with men, people who use drugs and transgender people.

- Although sex workers face significant discrimination and human rights violations, HIV prevention and SRH services can be expanded through linkages to non-controversial, existing programmes (Kenya, Uganda, and Mozambique are examples). Programming strategies should include an upstream advocacy component spearheaded by not only by sex worker associations, but also by SRH and human rights organizations.

- As UNFPA Thailand is approaching the final two years of the current country programme, and Thailand becomes a middle income country with rapid changes and improved capacity, the valuable experiences of Thailand’s response to HIV prevention with sex workers and transgender people over the past few years are important to share widely. It is important that these examples of good practice and lessons learned be documented, synthesized, and assessed.

- Rwanda provides the example of a GBV – One Stop Centre: In working closely with hospital staff, the police and the judiciary and providing the necessary training and institutional support, UN agencies and its partners are helping ensure the kind of “accessible, compassionate, respectful and confidential services” which can be documented and systematized, thus becoming an appropriate model for scale up. In conjunction with close attention to prevention and policy, creating such a scalable model is the essence of good gender-mainstreaming approach. Programmes like this need to be expanded to include sex workers,
men who have sex with men and transgender people all of whom experience gender based violence

- There is significant disparity in the quality and availability of services for key populations. Municipal level approaches need to be urgently scaled up
- The evidence base remains weak in many countries hampering service provision and the willingness for governments and other partners to invest.
- There needs to be a significant expansion of SRH/HIV linkages for key populations
- Save the Children undertook a study on HIV prevalence in Port Moresby, Papua New Guinea, and found a prevalence rate of 18%. The current national response is inadequate to reduce HIV risk and vulnerability in the context of sex work.
- A study in Comoros found that 59% of sex workers were having protected sex with clients.

Evaluation

In Zimbabwe HIV prevalence among sex workers attending UNFPA supported sites is 60%. An evaluation of the pilot program of national referral centres coupled with outreach sites in Zimbabwe was conducted and suggested that the approach should be scaled up.

Related Case Studies: Summary of experiences around providing care and treatment to sex workers in Zimbabwe

Expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,550,075</td>
<td>$0</td>
<td>$608,637</td>
<td>$2,158,711</td>
</tr>
</tbody>
</table>

Broad Activity 11: Coordination, advocacy, resource mobilization and capacity development including technical assistance for Joint UN Teams on AIDS, governments and civil society partners to increase access to comprehensive SRH/HIV information and education, skills and services for especially vulnerable and at risk young people including those out of school with emphasis on meaningful youth participation in policy, design and implementation of programmes and services.

Achievements

Media

- Millions of youth were reached with multi media campaigns for and by youth supported in many countries covering HCT, condom use, sexual and reproductive health and rights, risk reduction and health seeking behaviours including South Africa, Gabon, Cameroon, Democratic Republic of Congo, Nigeria, Ghana, Benin, Mozambique, Cote d'Ivoire, Bolivia, Nicaragua, and Mongolia. Youth journalists were trained in Uzbekistan and Kazakhstan. Selected examples include:
  - LoveLife-Siyabangena Campaign on HCT for young people which disseminated 300,000 youth-friendly pamphlets and aired radio spots and a PSA for youth on 10 public stations with a reach of 5,343,000 and 13 community radio stations, with a reach of 8,445,000.
  - SoulCity by co-funding a 26 episode radio programme "Wize-UP, Your Decision, Your Future" with Swedish SIDA. Research analysis allowed participants from 7 countries to develop common themes and creative briefs for radio shows followed by a branding exercise by young people and further development of the 26 episodes to air through April 2012.
  - In Cote d'Ivoire DJs were trained in delivery of eleven (11) prevention messages geared toward youth were adapted to the DJ rapping languages under 4 themes: the use of condoms for every sexual activity, using VCT services, risks taking behavior and use of health structures.
  - In Angola, IEC/BCC materials were distributed and 10 radio programs on SRH and prevention of STIs, including HIV/AIDS were set up.
  - In Mozambique, national level communication campaign addressing key drivers of the epidemic was supported with youth specific messages on radio and television addressing multiple concurrent partnerships, condom use, age disparate relationships and GBV.
  - In Bolivia 20 interactive television programmes on sexual and reproductive health and rights addressed to adolescents were developed and broadcast.
  - In Mongolia a website on RH was developed and TV programmes supported for sustained achievements gained from the cross border HIV prevention project and integration of STI/HIV prevention intervention for youth.
  - In Belize technical and financial support was provided for group sensitization activities on men’s health issues (HIV/STIs, infertility, etc), masculinity and gender roles with twenty disc jockeys, Media Personalities and local Artists

Advocacy

- Capacity building and empowerment of young people including through networks and coalitions such as Youth LEAD, AfriYAN, and pre-conference Youth Forums enabled youth to voice their opinions towards
National HIV/AIDS Strategies, youth friendly services, comprehensive sexuality education, youth involvement in the implementation of national HIV/AIDS responses and SRH programming and engagement in discussion and advocacy with their respective national and regional leaders. Results include incorporation of YKAP issues in several of the meeting resolutions, YP inclusion in funding applications, youth declarations (e.g., 4th national AIDS Summit and the 6th Asia Pacific Conference Sexual and Reproductive Health and Rights) and implementation of charters as well as development of national youth strategies or incorporation on youth issues in national and regional HIV strategies.

- Provision of critical data through support to key inter-agency publications: Opportunity in Crisis: Preventing HIV from Early Adolescence to Early Adulthood; and Securing the Future Today: Synthesis of Strategic Information on HIV and Young People.
- 12 countries (Lesotho, Uganda, Mauritius, Mozambique, Kenya, Botswana, South Africa, Comoros, Zambia, Namibia, Ethiopia and Zimbabwe) engaged in national policy dialogue in support of vulnerable groups including young people. In 7 countries (Rwanda, Burundi, Uganda, Comoros, Zimbabwe, South Africa and Ethiopia) multi-sectoral interventions for young people were undertaken including those most at risk with actions such as Burundi’s promotion of a strategy for mobile VCT. In Angola community awareness campaigns on RH and HIV focused on youth were conducted.
- The capacity of national partners from government and non-government agencies in social and behavior change communication for HIV prevention was enhanced leading to development of draft BCC guidelines for HIV prevention for young people (Tanzania)
- In 18 EECA countries youth were trained in use of drama techniques to support community education. In Mozambique, Lesotho, Eritrea, Botswana and other countries, community campaigns have engaged local chiefs, faith-based leaders, youth associations, rural libraries, and even barbers and beauticians to open dialogues and to ensure correct and comprehensive information on SRH, family planning, HIV and gender is communicated.
- Development of leadership skills in young people has resulted in noticeable growing confidence among the girls to take up leading positions in development activities in Malawi.
- Campaigns targeting adolescent boys and young men aged 15-24 in Zambia focused on reducing HIV risk associated with multiple concurrent partnerships (MCP), prevention of mother-to-child transmission of HIV, unprotected sex, alcohol abuse and gender based violence (GBV).

Comprehensive Sexuality Education (CSE)/Family Life Education (FLE)

- In 70 countries national implementing partners were supported in the design, implementation and evaluation of comprehensive sexuality education programs. In EECA support resulted in a charter on comprehensive education and national level prioritized action on SRH and education for youth. In Togo, 22% of high schools have integrated HIV in the curriculum.

Capacity was built for
- teachers in Albania, Armenia, Belarus, BIH, Georgia, Macedonia, Moldova, Turkey, Turkmenistan, Ukraine, Uzbekistan to raise awareness, reduce risk behavior, encourage health seeking behavior and promote tolerant attitudes to PLHIV;
- development of youth strategies and incorporating youth elements within HIV strategies (Albania, B&H): training of youth leaders and institutions in advocacy, information management and resource mobilisation (Bulgaria, B&H, Kazakhstan, Uzbekistan);
- peer education for in- and out-of-school youth - including vulnerable, disabled, orphaned - on SRH, HIV, STI and drug issues (Albania, Azerbaijan, B&H, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Turkey, Turkmenistan, Uzbekistan);
- 70 Curriculum Development Specialists from the Ministries of Education from Ten SADC Countries (Botswana, Kenya, Namibia, Lesotho, South Africa, Uganda, Zambia, Zimbabwe, Swaziland and Malawi: Lesotho, Swaziland, South Africa, Uganda and Zambia have already incorporated lessons learned into their curriculum reviews and a ToT toolkit has been developed; and
- use of sexuality education guidelines and tools as well as current best practices in 18 countries of Asia Pacific.

- In Latin America and the Caribbean strategies employed include promotion of guidelines, youth and teacher training in sexuality education and SRH, post graduate and masters courses, lead teachers as trainers (TOT toolkit), and creative educational materials extending reach to thousands of schools in the region. In Peru, 100 lead teachers trained an additional 605 teachers ultimately reaching over 14,000 students with CSE. Support to Gurises Unidos NGO has resulted in strengthened local capacities and coordination between health and education sectors to promote sexual and reproductive rights in the framework of the SRH law.
- Tens of thousands of young people (both in and out of school) took part in life skill, peer education and youth dialogue interventions. Engagement of youth centers and councils, health professionals and communities, continued support and partnership with Y-PEER, and innovative approaches such as training herd boys as peer educators in Lesotho, through dance in Argentina and institutionalization of Theater Based Peer Education for HIV prevention in Lebanon expanded reach to out of school youth. In Gambia, a strengthened Youth AIDS Network reached 43,895 young people age 10-24 with life skill based HIV education. A Joint Programme on Adolescents (UNFPA, UNICEF, WHO, UNESCO) is showing results of girls remaining in school and motivated to pursue careers.
- In several countries, partnership and support to Ministries of Education, Youth and Sports including through use of Youth Aides have improved the development and delivery of SRH and HIV information and education within the formal school system.

Youth Friendly Services (YFS)
- 87 countries were supported to strengthen youth friendly SRH/HIV services within and outside the health sector including for information, counseling and testing, and promotion and negotiation of male and female condom use through programme reviews, training of health care providers and national institutions, and establishment or strengthening youth friendly centers (fixed site/mobile/outreach/hotline/website) and youth
outreach including peer educators. For young PLHIV, national capacity building in Eastern and Southern Africa, in partnership with UNICEF and WHO, targeted provision of high quality treatment services that also addressed issues of adherence, disclosure and reduction of stigma at home, in the school, and community

- About 10,000 young people were mobilized to access SRH/HIV services from the various facilities in focus districts in Uganda. Kenya is supporting the construction of 4 youth-friendly centers. In Comoros, a youth-friendly center was opened on each island. In Ethiopia, the number of prevention service centers reaching youth was increased. In DRC, four health facilities have been rehabilitated and strengthened in the provision of Youth-friendly RH services and more than 8000 young people and teenagers were reached with HIV prevention messaging. National Guidelines on Youth Friendly Spaces (YFS) were finalized in Trinidad and Tobago. In Nicaragua and Online Course on Human Rights, Sexuality and Gender-responsive HIV/AIDS Prevention was supported and implemented through Voz Joven Programme and in the Dominican Republic a process for strengthening the alliance between SRH and Youth Networks VCM and the border was developed reaching 8,190 adolescents and youth with BCC strategies on SRH, HIV, VAW and promotion of the health care services.

- Training was also provided in some countries for service providers on attending survivors of sexual violence (Ethiopia) and to nurses and midwives (Cote d’Ivoire, Namibia) on comprehensive ASRH (including HIV prevention, counseling and testing) as an integrated part of their curriculum.

Most at Risk Young People (MARYP)

- UNFPA supported the capacity of programmers and policy makers through a joint publication of a technical report on Young People Most-at-Risk of HIV (MARYP). The report calls attention to young people ages 10-24 within populations considered most at risk of HIV infection: men who have sex with men, those who sell sex, and those who inject drugs. The report discusses the unique vulnerabilities of these young people, provides some successful program examples from the field and makes some recommendations to programmers and policy makers to empower community-based youth led organisations to implement HIV prevent programmes, UNFPA provided a grant to the HIV Youth Leadership Fund (HYLF) to support 23 grantees in 18 countries and one global program, with projects working in a wide range of areas.

- In the Asia Pacific have received capacity building for programming for most at risk young people in low and concentrated epidemics including through a short e-course on MARYP to build capacity of policy makers and programmers;122 have taken the course to date. 8 countries have developed and implemented programmes for most at risk young people (Indonesia, Iran, Mongolia, Nepal, Sri Lanka, Thailand, Timor-Leste and Vietnam). An EECA regional training resource for provision of services to MARYP/MARA was developed and delivered an initial training session to participants from 6 countries (Albania, Bulgaria, Georgia, Macedonia, and Turkey). Armenia extended and tailored youth peer-education efforts to focus on MARYP including YP using drugs, orphans and children with absent (migrating) parents.

- In partnership with the Red Cross Societies of Mongolia and China, a 'Cross border HIV prevention project' for young female sex workers aged 18-25 and their potential clients - mobile traders and truck drivers who regularly cross the border since 2009-2011 has reached 41,118 members of mobile populations and 538 female sex workers on the Mongolia side and approximately 20,000 members of mobile populations in China including female sex workers, truck drivers, mobile traders, miners and local residents in the border area through community-based trainings, outreach, public campaigns and VCT services, including using innovative approaches such as the internet and mobile phones, and involvement of entertainment establishment owners. Results include increased correct knowledge, attitudes and healthy behaviours to prevent HIV/STI among the target groups. The capacity of local Red Cross societies to deliver and sustain scaled-up HIV prevention Knowledge has also increased.

Uniformed services

- Supported efforts to reach young men including through prevention programmes for uniformed services including anti-stigma campaigns, media messaging, condom procurement, SRH and HIV prevention training, and training military and police personnel as peer educators. Cross reference BA 13

Lessons learned

- To incorporate key results into a national plan, an assessment of the national response including gaps, challenges, partners and resources is required to establish baselines and inform evidence-based programming. The overall process takes time and requires a significant amount of both financial and expert technical support which is often not readily available.

- Evaluations of the Framework for Action workshops showed they successfully led to the development of country action plans that have been implemented.

- Sufficient time must be allocated for training of trainers in life-skills and SRH to fully equip the trainers with the necessary skills. Adaptation and cultural sensitivity, including in training of teachers in CSE and its incorporation into each specific school curriculum and in peer education, are also critical elements to ensure that the process leaves a core critical mass of people with skills to ensure quality delivery of information and services and realize potential cost savings.

- High level national and local government and NGO partners (health, education, sports and youth affairs) are important for success of healthy lifestyles programmes, with national ownership and commitment of implementing partners supporting successful programme implementation. It also enhances ASRH knowledge and awareness among the young people, stakeholders and policy makers. As an example, linking Voz Joven Programme (Nicaragua) with other government agencies and NGOs fostered increased coverage of, promotion, prevention and advocacy for human rights to cope with HIV/AIDS. Full engagement of key affected youth populations also provides a better understanding of the needed HIV support.

- “One-stop shops” with well trained personnel are the most effective youth friendly services (YFS). Linking ASRH services with youth community centres, with a central youth resource centre helps to coordinate a network of youth community/ASRH services, is one good way deliver these services discreetly in a youth friendly manner. As an example, family planning services provided by general practitioners are generally ineffective for young people and need to be augmented with youth friendly counseling centers, community outreach, youth advocacy/peer education and free condoms - especially in rural areas.

- The involvement of parents and educators, training providers linked with the peer education constitute an inseparable trio for a successful program for young people in addition to planning interventions at times...
Adolescents and youth empowerment, caretakers creating a supportive environment, and YFS should be considered integral to a comprehensive ARSH program.

There is a need for continuous, updated and correct information on SRH including HIV/AIDS and services for young people nationwide especially those not accessing youth friendly spaces and those living in hinterland communities.

Community level interventions and campaigns are also needed together with improved capacity of primary health care providers in health promotion activities.

The lack of ASRH policy continues to pose a challenge for health workers in providing SRH services including contraceptives and dual protection to youth accessing services.

Teachers require adequate time, support and capacity building with training materials adapted to the reality and cultural context to accomplish their role as facilitators in the implementation of comprehensive sexuality education. Ongoing evaluation and skill enhancement of teachers in CSE better ensures high quality implementation.

The implementation process of the comprehensive sexual education requires different amounts of time in each school according to its own characteristics and should be factored into action planning within the Ministry of Education. Intimate interfacing and mobilization of school officials and executives enhance uptake of controversial ideas and concepts.

Peer education facilitates message transmission and delivery of educational materials to promote SRH and prevent HIV and STI in adolescent and young populations and remains a cornerstone for delivering programmes for young people especially in out of school settings particularly for girls.

Peer educator techniques need to be contextualized and localized. In Cote d’Ivoire, DJs were used as vehicle to identify appropriate messages to youth and to their peers effectively reaching two different groups through complementary means. Social media networks are also increasingly used to impart knowledge, build networks and strengthen programmes (eg www.ypeer.by, www.ypeer.ba, www.foryouth.ge use of Facebook).

Drama is increasingly seen as a powerful tool for social change with sensitization and participation of young people.

Training of religious leaders can result in realization that HIV sensitization and ASRH did not promote promiscuity, but rather helped them to adopt healthy life style helping FBOs to be more effective in reducing HIV risk in young people via evidence based and informed approaches.

In a predominantly catholic country (e.g., Philippines) establishing a strong collaboration with the church and involving them in most endeavors has given results with the delineation of spirituality/morality specific for the church and FP/RH including RHCS for the government.

Evaluation

In Peru, two tools for monitoring and evaluation of the implementation of the comprehensive sexual education in public schools have been designed and will be implemented in 2012.

In Cote d’Ivoire Madagascar states that the revitalization of health centers to be more youth friendly, the involvement of parents and educators, training providers linked with the peer education constitute an inseparable trio for a successful program for young people. UNFPA also trained religious leaders: After the training of the religious leaders on HIV prevention communication and ARH there is a change in the perception with respect to HIV sensitization and sexuality education. Before the training most leaders believed that talking about ARH and HIV promote promiscuity. After the training they realize that HIV sensitization and ASRH did not promote promiscuity, but rather helped them to adopt healthy life style helping FBOs to be more effective in reducing HIV risk in young people via evidence based and informed approaches.

Training of religious leaders can result in realization that HIV sensitization and ASRH did not promote promiscuity, but rather helped them to adopt healthy life style helping FBOs to be more effective in reducing HIV risk in young people via evidence based and informed approaches.

An analysis of vulnerability of young people (jointly with UNICEF, UNFPA, UNAIDS and the World Bank-sponsored Pumls) was conducted over the period October 2010 to November 2011. (see report attached)

In Botswana, UNFPA provided technical assistance for the evaluation of the ASRH Implementation Strategy. Results show that various government departments and NGOs used the Strategy to guide their strategies and programs for young people. However, the dissemination of the Strategy was weak, which limited its use especially by NGOs/CBOs

In Swaziland, an ASRH needs assessment indicated that youth is faced with a number of challenges such as early sex, pregnancy and parenthood. There is also high unemployment and substance abuse as well as low access to ASRH services.

In Uganda, a situational analysis was conducted on school health programs including existing clubs in 9 districts on teenage pregnancy, HIV/AIDS education and GBV. An assessment of the Local governments’ development planning processes was done to define the extent to which youth issues were incorporated and actually allocated resources. A revision of the 2001 National Youth Policy has been initiated and will be completed mid-2012, as well as being used to inform development the policy action plan

Macedonia conducted a mid-term evaluation of ASRH services/youth information project

Kyrgyzstan conducted a formal situational analysis for guiding national implementation of the UNFPA Framework for action on HIV and young people. This evidence based approach enabled focus on MARYP,
and facilitated multi-stakeholder collaboration and consensus building on a comprehensive response to prioritized issues.

**Related Case Studies:** Positive Youth, Sex, & HIV

**Expenditure**

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$3,811,213</td>
<td>$1,017,525</td>
<td>$4,991,492</td>
<td>$9,820,230</td>
</tr>
</tbody>
</table>

**Achievements**

- In collaboration with UNAIDS IAWG on Women and Girls, and UN Women, UNFPA contributed to development of the Agenda for Accelerated Country Action for Women, Girls, Gender Equality, and HIV and is coordinating with UNDP, UNAIDS, and the IAWG, its implementation. The IAWG convened a Multi-Stakeholders Consuliation with civil society to strengthen partnerships for implementing the three pillars of the broad-scoped Agenda, resulting in collectively mapping activities to identify gaps and challenges, identifying successes, determining regional and global priorities, and planning for strengthened collaboration. The consultation agreed upon the importance of building ownership for the Agenda at country level; strengthening use of strategic information; and mobilizing resources for sustained action for women and girls. These results will contribute to the mid-term review of the Agenda for Women and Girls in 2012.

- A consultation in East and Southern Africa on the Agenda for Women and Girls contributed to the HLM and led to the establishment of a High level task force on Women, Girls, Gender equality and HIV launched at ICASA 2011, along with a paper on ‘Sexual Reproductive Health, Gender Equality, HIV

- Led by UN Women and other partners, UNFPA contributed to development of a Compendium of Indicators for Gender Equality and HIV which will help countries assess their progress.

- UNFPA supported development of national strategies/policies/laws: Benin, Lesotho, Namibia, Swaziland and Tanzania developed national action plans on women, girls, gender equality and HIV, and many have undertaken a gender review of their national response to HIV. In 9 Countries (Mozambique, Swaziland, Zimbabwe, Burundi, Seychelles, Uganda, Madagascar, DRC, and Zambia) national strategies or guidelines on GBV and gender (in relation to HIV) were launched or reviewed. Seychelles integrated RH protocols in GBV interventions. Rwanda has a law against GBV since 2009 and is now working towards guaranteed PEP for every woman reporting GBV in 2012. Solomon Islands developed a policy to eliminate violence against women. In Angola, advocacy efforts led to the approval of a law against domestic violence passed by Parliament on June 2011. PNG developed a National Gender and Health policy. Ecuador developed a National Plan to end GBV. Uzbekistan drafted legislation on gender equality and violence awaiting approval by government. Ukraine developed male SRH standards. Bi-national agreement between Bolivia and Argentina for promotion and protection of sexual and reproductive health and rights, including GBV, adolescent pregnancy, STIs, and HIV of Bolivian migrant populations in Argentina. Malawi developed and launched the Women Girls and HIV Action Framework. Mozambique developed a communication strategy around the law against domestic violence. In Uganda a law to prohibit FGM was issued in 2010 after seven years of joint advocacy. Mauritius conducted research on GBV and HIV related discrimination. Mozambique undertook an in-country mapping of HIV and gender activities to facilitate strategic development and planning for 2012.

- UNFPA supported capacity building/outreach: Cote d’Ivoire trained 150 female peer educators (18-24) on HIV/STI to promote behavior change among peers. Ethiopia conducted a large-scale girls-outreach programme which reached a total of 1,141,000 girls. In addition, more than 1621 vulnerable women including female sex workers were able to benefit from and took part in the income generating schemes that includes training them on life skills aiming at reducing their vulnerability, enhancing their negotiation power and prevention new infections. Training workshops/protocols on SRH/FP/GBV/VAW advocacy and services for women/girls living with HIV (Ukraine, Tajikistan and Kyrgyzstan). More than 200 teenage mothers reached with information on HIV prevention in Suriname and Guyana. Bangladesh sensitized 60 policy makers, media and civil society on HIV and linkages with gender, and empowerment of women and girls. Nicaragua broadcasted 8 radio programmes on ASRH and SRH of women living with HIV. UNFPA provided financial support to the Girls Scouts of the Philippines to implement the Adolescent Reproductive Health, HIV and STI peer education program in 6 regions which resulted in strengthened capacity with 60 core trainers and 1000 trainees. UNFPA also supported the roll-out of an interactive STI and HIV CD (70% games and 30 % ready lecture information) as a teaching aid tool used to train 230 persons.

- UNFPA supported strengthening of services: Roll out of one-stop-centers for GBV survivors supported in Lesotho, Malawi, Mongolia, Rwanda, Togo, Zimbabwe. In Zimbabwe, the centers attended to 500 clients in 2010. In Lesotho, the center receives over 10 clients per day for counseling. Swaziland provided an integrated manual on GBV handling for health clinics. Moldova piloted restorative justice (twelve-step) programme for survivors and perpetrators of domestic violence. Thailand incorporated rights based RH services for people living with HIV in the national health programme. Belize Joint UN Adolescent Girls Project supported a mapping exercise to determine what type of SRH services and programmes are being offered, where these programmes are located and who is accessing the services. Research on HIV, SRH, GBV was conducted and reports disseminated to stakeholders in Ethiopia, Zambia, Mozambique and Uganda (Female Condoms Study).
**Lessons learned**

- Access to resources remains a critical challenge for scaling up gender-responsive HIV programming.
- The Agenda has been instrumental in catalysing action at the country level, as an advocacy tool, and means of galvanizing partner support around a common action platform, addressing the needs of women and girls to achieve the MDGs, particularly 3 – 6, giving prominence to key concerns such as GBV, rights, and sexual and reproductive health.
- A gender-sensitive response must confront the broader social barriers to health and rights, with the meaningful participation of women and girls, including those living with HIV and key populations.
- Stigma and discrimination are still major challenges for women and girls, particularly for women living with HIV, sex workers, women who use drugs, and young women, and the PLHIV Stigma Index.
- National programme capacity is still insufficient to collect analyse, and use data for strategic planning.
- Gender mainstreaming of national policies does not necessarily translate into action at community level.

**Evaluation**

- In Zambia, the end-evaluation of the 6th Country Programme indicated that the activities of the Safe Motherhood Action Groups and other community groups were effective in promoting male participation and the mobilization of communities towards the reduction of GBV in the target areas.
- In Zimbabwe, the Interim BC evaluation survey suggested a reduction in women experiencing physical violence between 2007 and 2009.

**Expenditure**

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$646,626</td>
<td>$110,000</td>
<td>$1,808,665</td>
<td>$2,565,291</td>
</tr>
</tbody>
</table>

**Achievements**

- UNFPA developed internal Strategic Guidance for Engaging Men and Boys and ensured that HIV/AIDS is an important component especially in humanitarian contexts.
- UNFPA leveraged approximately $500,000 of EC funding for Gender, HIV initiatives for demobilized personnel and women associated with armed groups (e.g. Sudan, Cote d’Ivoire, Republic of Congo, Nepal), and approximately $100,000 from Denmark for HIV-emergencies related interventions in Africa (e.g. working with FBOs, integrating HIV issues in emergency preparedness).
- Two training courses on Gender and DDR were held training at least 50 UN and government counterparts received training, including detailed sessions on HIV/SRH/GBV. UNFPA was involved in design and facilitation of the course. Country office staff from Nepal, Cote d’Ivoire and Sudan were also trained and have been able to apply the skills learned in their local contexts.
- 15 UNFPA humanitarian focal points and 40 senior staff of national disaster management units in East and Southern Africa and humanitarian actors from Ghana and Nigeria were trained to catalyze integration and roll out of SRH/HIV interventions in humanitarian programmes at country level.
- A regional MISP (SPRINT) ToT course was conducted (Georgia, Moldova, Kyrgyzstan, Tajikistan, Turkey, Turkmenistan, Uzbekistan), assisting country offices to participate in national emergency preparedness/contingency planning exercises/processes. Several countries conducted in-service training of military personnel to raise HIV/GBV awareness (Armenia, Georgia, Azerbaijan, Turkmenistan, Uzbekistan). Georgia has mentored female recruits to uniformed services to support their role in re-shaping gender sensitive attitudes within these services.
- Latin America Faculty of Social Sciences documented experiences, accumulated knowledge and lessons learned of Armed Forces and National Police of Latin America and Caribbean and developed three virtual training modules on Gender, Human Rights and SRH; masculinity; and project design which were introduced in 33 projects at 23 army forces and 10 police stations in 13 Latin American countries. (Argentina,
Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Haiti, Honduras, Nicaragua, Panama, Peru and Venezuela). 1118 uniformed services educated were on HIV prevention in Paraguay. El Salvador established two mobile teams to address issues around GBV, STIs, FP and HIV in temporary shelters for people affected by tropical storm E-12. HIV prevention and care, SRH, GBV integrated into 4 regional contingency plans (Honduras). Guatemala distributed 200 rape kits to health services in flood areas. Dignity kits were provided to people affected by natural disasters in Honduras (1450 kits) and Panama (500 kits).

- UNFPA distributed safe sex kits containing male and female condoms, IEC and referral information in 11 Pacific Island Countries; and provided male and female condoms in Pakistan as part of RH services in response to the floods, introduced the female condom to the general population, and trained uniformed personnel on including HIV prevention services for MARPs affected by the floods. UNFPA provided over 100 hygiene kits, containing male and female condoms, to displaced populations including women and girls following a tropical storm in Jamaica which were distributed by the Jamaica Red Cross; and provided 20 RH Emergency kits for victims of GBV during the Kyrgyzstan conflict.
- UNFPA provided RH/HIV services to UNHCR-managed camp settings in 25 countries and ensured HIV interventions were integrated in the emergency response provided to Haiti and Pakistan
- In collaboration with Women's Refugee Commission and Governess Films, UNFPA developed the documentary on young people affected by emergencies, focusing on former child soldiers, and the impact of HIV and GBV on DDR in Northern Uganda.

Lessons learned
- Local government and community involvement in DDR activities is vital and their support is needed to ensure transparency of DDR process (particularly in selection of participants), acceptance of projects at grassroots level, and effective monitoring and evaluation activities.
- National ownership and strong coordination between different stakeholders (including civil society) supporting HIV/SRH/GBV in humanitarian settings are key to effective implementation of programmes and to avoid reliance on donors.
- Specific DDR context IEC materials and identification of peer educators as ‘champions’ to raise awareness are crucial to reach target population.
- DDR experiences, lessons learned and good practices should be documented and disseminated more.
- Utilizing existing programme structures in post-emergency communities for RH promotion, such as nutrition, proved very helpful.
- To ensure that SRH/HIV/Gender issues are being included systematically in humanitarian responses, training of national service providers on Minimum Initial Service Package should continue to scale up.

Evaluation
- Operational studies conducted in Cote d’Ivoire and Republic of Congo to inform integrated programming on HIV for male/female ex-combatants, their dependants, women/men formerly associated with armed forces and groups. Preliminary findings showed need for:
  - strengthened coordination among agencies and with national counterparts;
  - clear overview of various activities, geographical areas and implementing partners to identify joint implementation and avoid overlaps;
  - dedicated technical/human capacities to incorporate and implement HIV interventions within DDR programmes; HIV often sidelined and not seen as priority within DDR programmes or DDR is not seen as priority within broader HIV mechanisms (Global Fund monies etc.).
  - Out of 12 Sudanese communities where outreach was conducted, 120 male ex-combatants participated in focus group discussions on HIV/GBV. Evaluation showed improved awareness of 80% of participants on definition and type of GBV; and challenges in reporting GBV cases. Changes in men’s perceptions and attitude towards GBV were identified – domestic violence and rape were no longer seen as part of local customs.
- Technical gender/ HIV review in Côte d’Ivoire identified grave violations of human rights: 658 cases of GBV, including 326 cases of sexual violence recorded from January to May 2011 and 22% survival sex; awareness and preparedness of host communities remain inadequate. Recommendations: i) make available PEP kits, promote dual protection method male / female condoms among ex-combatants ii) Integrate interventions for HIV / AIDS and gender in policy documents at regional office level and in host communities.
- In Malawi, a Mid Term Review of Malawi Defence Force HIV/AIDS Strategy and Plan of Action was conducted.

Expenditure

<table>
<thead>
<tr>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$432,399</td>
<td>$600,000</td>
<td>$1,414,480</td>
<td>$2,446,880</td>
</tr>
</tbody>
</table>
Broad Activity 14: Advocacy and technical assistance for the incorporation of inter-linkages of population dynamics and gender equality, sexual and reproductive health, young people’s needs and HIV/AIDS in national and sectoral development plans, poverty reduction strategies and expenditure frameworks.

Achievements

- UNFPA supported the multi-partner development of “One Health Tool” to strengthen countries’ planning, costing and budgeting of their National Health Plans/Strategies. The tool also incorporates HIV components including costing for prevention, treatment, etc. and impacts related to AIM impact module.

- UNFPA support to inter-linkages of young people’s needs resulted in establishment of a multi-sectoral MDG partnership which is strategically positioned to lead development of a comprehensive Youth Policy in Georgia; and participation of young people in development of ASRH and HIV policies in Uzbekistan.

- UNFPA advocated for the update of the existing policy on HIV/AIDS in Bangladesh to incorporate linkages between HIV, GBV, SRH and adolescent issues.

- UNFPA supported the development of a costed National Strategic Plan on STI/HIV/AIDS in Mongolia, which was approved by the Government, and included condom promotion, empowering young people and HIV and sex work as priority areas.

- UNFPA provided technical assistance to Nepal to ensure HIV prevention, reproductive health, and gender issues were incorporated in the National Population Plan, the National Gender Policy, the National Health Strategy, and the National Youth Policy.

- UNFPA in collaboration with Global Youth Coalition trained AfriYAN Youth Network leaders from Zambia, Kenya, South Africa, Burundi and Malawi on how to ensure integration of youth issues into Global Fund proposals, NSPs, PRSPs and other development frameworks. In Lesotho and Namibia, Youth Networks were trained in advocating for integration of youth issues and HIV into PRSPs and other development frameworks.

- 50 young people from Zambia, Kenya and DRC trained on integration of ASRH/HIV Prevention and other youth development issues in poverty reduction strategies—using UNFPA’s PRSP analysis tool. These three countries are currently initiating mid-term review or revision of their PRSPs and the young people will be able to advocate for inclusion of their issues and potentially budgeting for youth programming.

- In Timor Leste, UNFPA engaged the government in policy dialogue to ensure that population dynamics, gender and RH are included in national priorities. UNFPA in collaboration with the Minister of Health and other partners developed the National Guidelines on Youth Friendly Health Services, currently piloted in the capital through a youth resource center and youth friendly health facility.

- Macedonia developed a results-based National Preventive Programme on HIV (2011), linked to the Preventive Programme on Maternal Health, Breast and Uterine Cancer, and Reduction of use of Drugs.

- Sudan addressed population dynamics, HIV, gender, maternal health and youth related issues in interim poverty reduction strategy paper (PRSP) 2011, National Strategic plan (2012-2016) and 2010-2014 HIV national strategy.

- UNFPA in Zambia supported the government to develop medium term frameworks specifically targeting the youth and adolescents. Key among these is the Adolescent Sexual and Reproductive Health & Rights (ASRHR) Policy and the Adolescent Health Strategic Plan, which seek to strengthen the governance, coordination and delivery of adolescent health services and to provide for a coordinated response to adolescent health needs in Zambia.

- With UNFPA’s support, El Salvador launched its National Policy on Youth, along with its Plan of Action 2010-2014, which includes seven areas of intervention: access to education; employment; health; prevention of violence; culture, sport and participation and construction of citizenship.

- In South Africa, UNFPA supported the revision of the Adolescent and Youth health Policy which allowed for the opportunity to include SRH and HIV prevention linkages and promote gender sensitive approaches within the policy.

- HIV is integrated in local development plans in the six targeted governorates of Yemen.

- UNFPA contributed to and supported the development of a European Union proposal mobilizing €7 million for Botswana, Lesotho, Namibia, Malawi, Swaziland, Zambia and Zimbabwe for the linkage of SRH and HIV at the policy, systems and service delivery levels.

Lessons learned

- UNFPA can contribute to the development of comprehensive youth policies via technical and financial support.

- Continuous advocacy and capacity building are needed to establish an enabling environment for promotion of young people’s rights.

- Belize noted that even with SRH/HIV included in poverty reduction strategies and national development plans, implementation of activities addressing these issues is not a given and requires more advocacy and support.
**Evaluation**

- The Dominican Republic conducted a baseline study on health services in the border states and HIV testing and ARVs. 50% of respondents had not received information about HIV testing, and 50% do not know how to administer ARVs.

- In Uganda, an assessment on the extent of integration of population dynamics in district development plans was conducted for UNFPA supported districts. An evaluation of the Health Sector HIV/AIDS Strategy around the WHO health systems building blocks was conducted. A review of the National Health Policy was conducted. A review of the education sector HIV/AIDS response was also finalized.

**Expenditure**

<table>
<thead>
<tr>
<th></th>
<th>Core</th>
<th>Supplemental</th>
<th>Global/Regional Resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$410,286</td>
<td>$70,345</td>
<td>$870,382</td>
<td>$1,351,013</td>
</tr>
</tbody>
</table>