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*Cover image: © UNICEF/NYHQ2011-2151/Patricia Esteve. A woman living with HIV embraces her daughter at a hospital in Chad’s Logone Occidental Region. The woman participated in a UNICEF-supported programme to prevent mother-to-child transmission of HIV (PMTCT). Her daughter is HIV-negative.*
Executive Summary

An AIDS-free generation is finally within reach. More pregnant women than ever before are having HIV tests. More pregnant women living with the virus are receiving medicines and support to protect their babies and keep themselves healthy. More women and children are getting the consistent, high-quality care needed to safeguard their health. And more young people are accessing the resources required to prevent infection, such as HIV prevention education, condoms, and HIV testing and counseling.

To date, the investments in an AIDS-free generation on the part of governments, bilateral and multilateral partners and UNICEF have helped turn the trajectory of the epidemic towards decline and mitigate the impact of AIDS on children and their families. The *Unite for Children, Unite against AIDS* campaign has influenced global, national and local discourse to prevent children from “falling through the cracks” in the HIV response. The campaign carries out this work with numerous partners, including UNAIDS and its co-sponsors, the Global Fund for AIDS, Tuberculosis and Malaria (The Global Fund), the United States President’s Emergency Plan for AIDS Relief (PEPFAR), the International Drug Purchase Facility (UNITAID), and by engaging networks of people living with HIV and AIDS and other partners. Central to UNICEF’s HIV mandate has been a drive to achieve the goals of the Political Declaration on HIV and AIDS (2011), Millennium Development Goals 4, 5 and 6, and contribute to Goals 1, 2 and 3 – and to realize the goals of both the High Level Meeting on HIV/AIDS (2011) and the UNAIDS 2011-2015 Getting to Zero Strategy, which was launched in 2011.

UNICEF is providing leadership at global, regional and country levels to implement the United Nations Secretary-General’s Global Strategy for Women and Children’s Health and the *Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive* (eMTCT), in line with the new UNAIDS Division of Labour. As co-convener (with the World Health Organization) of the Interagency Task Team on the Prevention and Treatment of HIV in Pregnant Women, Mothers and their Children, UNICEF provided technical support to 22 PMTCT priority countries to draft 10 national eMTCT plans; the remaining 12 priority countries are expected to finalize their costed plans in 2012. In low-prevalence countries and in those with concentrated epidemics, UNICEF is working to certify eMTCT data and to assure that national governments have a strong focus on reducing the risks and vulnerabilities of marginalized women and girls. In Latin America and the Caribbean, over 80 per cent of countries have costed national PMTCT strategies in place that put PMTCT in the context of the broader sexual and reproductive health needs of women and girls.

In 2011, UNICEF maintained its prominent role in HIV procurement and supply. Procurement of HIV commodities totalled $145 million for commodities reaching more than 54 countries, around a 45 per cent increase over 2010 procurement volumes. Collaboration with UNITAID in 17 countries accelerated the availability of more efficacious multi-drug combinations. UNICEF and the Clinton Health Access Initiative (CHAI) worked together to help eight countries improve the planning and implementation of procurement and supply management. UNICEF also provides support on quantification, forecasting and monitoring of HIV and AIDS commodities to countries with grants from the Global Fund; and the organization supports such UN partners as UNDP and UNOPS.
UNICEF hosted the Fifth Global Partners Forum on Children affected by HIV and AIDS in New York from 3-4 June 2011, in collaboration with PEPFAR and UNAIDS. The meeting brought together technical and policy leaders to galvanize support around evidence that was published by UNICEF, in collaboration with partners of the Inter-Agency Task Team on Children Affected by AIDS, in the report *Taking Evidence to Impact: Making a difference for vulnerable children living in a world with HIV and AIDS*.

UNICEF’s work with regional networks has been critical in advocating for national systems to support children affected by AIDS and reduce the stigma and discrimination they and their families face. UNICEF support for the East Europe & Central Asia Union of PLWH helped strengthen information exchange in seven Russian-speaking countries, which in turn contributed to increased uptake of prevention and treatment services for children.

UNICEF’s efforts to prevent HIV among adolescents have focused on helping governments obtain the evidence they need to make wise prevention investments. UNICEF led an analysis of global data to prepare the second edition of a global report on HIV and young people, *Opportunity in Crisis: Preventing HIV from early adolescence to early adulthood*. This report published for the first time country-specific estimates of the number of adolescents (male and female) living with HIV and the number of new HIV infections in young people aged 15-24.

Efforts to improve data collection also accelerated in 2011. The East Asia and the Pacific Data Hub collated, synthesized and analysed data for 1,400 indicators and disseminated that information to nearly 3,000 contacts within the region through data alerts, E Newsflash, social networks and RSS feeds. UNICEF also stepped up its efforts globally to support operational research to determine adolescent vulnerability to HIV in Bangladesh, Bhutan, Bosnia and Herzegovina, Burkina Faso, the Democratic Republic of the Congo, Moldova, Nepal, Serbia and Ukraine.

Adolescents living with HIV were more front and centre in the AIDS response in 2011. A Global Technical Advisory Group was established in 2011 to draw on expertise from UN agencies, bilaterals and research institutions. This collaboration resulted in the launch of a training initiative on adolescents living with HIV in eight countries. In West and Central Africa and in Latin America regional dialogues were held for young people living with HIV, with these meetings contributing to the development of national HIV care and support guidelines in a number of countries.

UNICEF’s efforts to support governments and communities have proven that we collectively can make a difference in ushering in an AIDS-free generation. We believe it will take sustained financial support and political leadership around four strategies that can guide the scale-up of high-impact interventions: *Synergy, Innovation, Equity* and *Partnership*.

Ironically, though, just as the tools to achieve an AIDS-free generation are at hand, funding for the children and AIDS response is waning. UNICEF’s thematic funding for HIV is no exception. In 2011, UNICEF received $7 million in thematic contributions for HIV/AIDS and children, amounting to 2 per cent of all thematic contributions received in 2011 ($373 million) for the five focus areas and humanitarian response. The 2010 thematic funding received for HIV/AIDS and children is 30 per cent less than the $10 million received in 2010, and government thematic contributions were less than 9 per cent of all HIV thematic contributions, with over 90 per cent of all HIV thematic contributions coming from UNICEF National Committees. Despite the 2011 decrease in thematic contributions for HIV this source of funding is essential in many ways. It provides UNICEF with the flexibility to support efficient and effective country initiatives leading to
sustainable results. Thematic funds in 2011 have in part laid the groundwork for innovative programmes such as the mobile health (mHealth) initiative Project Mwana in Zambia and ARV co-packaging to scale up PMTCT programmes for women with limited access to health facilities. UNICEF committed to an "innovations for elimination of mother to child transmission of HIV" agenda. Consequently we are supporting countries to pilot, evaluate and scale up innovative technologies and approaches to meet the ambitious targets of the Global Plan to Eliminate New HIV Infections in Children by 2015 and Keep Their Mothers Alive (eMTCT). In 2012, thematic funding will be crucial to the success of this agenda. HIV thematic funds for pediatric treatment; prevention, treatment and care for adolescents will equally be critical to meet our accountabilities in achieving universal access to treatment for mothers, children and families by 2015.

**Strategic Context**

AIDS remains one of the great challenges of our times, but one that we are finally starting to overcome. As of December 2010, an estimated 34 million people were living with HIV globally. Sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 68 per cent of all people living with the virus and 70 per cent of all people newly infected in 2010 – despite being home to only 12 per cent of the world’s population. Women make up 50 per cent of those living with HIV globally, but account for a larger share of infections than men in sub-Saharan Africa (59 per cent) and the Caribbean (53 per cent). As of 2009, an estimated 16.6 million children (nearly 15 million of them living in sub-Saharan Africa) had lost one or both parents to AIDS.

The continued growth in the number of people living with HIV primarily reflects improved treatment access. In low- and middle-income countries, antiretroviral treatment has averted 2.5 million deaths since 1995. Annual AIDS-related deaths (1.8 million in 2010) have fallen by 18 per cent since the mid-2000s, and the number of children dying from AIDS-related causes (250,000 in 2010) has declined by 20 per cent since 2005.

However, for each individual who started antiretroviral therapy (ART) in 2009, two were newly infected with HIV. At the same time, financial commitments provided by donor governments declined by 10 per cent over the 2009-2010 period, marking the first time annual support has fallen in more than a decade of tracking efforts. The Global Fund for AIDS, Tuberculosis and Malaria (the Global Fund) postponed the 2011 grant round. What’s more, existing government pledges to the Global Fund have been restricted by unpredictable budget allocations by donor governments – a significant challenge for recipient countries that are financing millions of people on HIV treatment through Global Fund grants.
These financial challenges have also had an impact on how governments and other programme implementers invest limited resources. Providing ART to the 6.6 million who are currently on treatment, never mind the millions more people who require it, is not economically sustainable without dramatic reductions in new infections.

One result of these constraints is that in addition to emphasizing the funding of simplified, low-cost treatment regimens, donors are also focusing resources on scaling up high-impact prevention investments. The article 'Towards an Improved Investment Approach for an effective response to HIV/AIDS', published in *The Lancet* (June 2011), outlined a global HIV investment framework that reduces the number of programmatic areas from over twenty to six. The framework also highlights context-specific critical enablers of programmatic success such as political commitment and advocacy, as well as synergies with other development sectors including social protection, education and gender-based violence. The motto, “doing more and better with less” resonated loudly during 2011 and, with the help of the investment framework laid out in the article in *The Lancet*, will undoubtedly guide HIV investments through the 2015 review of the MDGs.

However, while we must do more and better with less, this in no way means we should scale down the HIV response. Scaling back investments in AIDS would have a devastating impact on children and their families. AIDS is a leading cause of death among women of reproductive age, accounting for an estimated 19.2 per cent of all deaths in 2009. In some countries in southern Africa, HIV is associated with almost half of all pregnancy-related maternal and child deaths. In some African countries, HIV has led to a tenfold increase in tuberculosis incidence. HIV-related illness and death undermines household resilience and threatens hard-won development gains in relation to poverty reduction, access to education, gender equality and health-systems strengthening.

In 2005, only 14 per cent of HIV-positive pregnant women in low- and middle-income countries received antiretroviral drugs for PMTCT, while in 2010 that figure rose to 48 per cent. UNICEF, along with national partners, is playing a critical role in helping countries develop national eMTCT scale-up plans and leveraged funding from PEPFAR, GFATM and other donors to support this effort.

The number of new HIV infections among children peaked in the early 2000s before decreasing steeply in the past few years as access to PMTCT services increased. An estimated 390,000 children were newly infected with HIV in 2010, 30 per cent fewer than the peak of 560,000 children newly infected annually in 2001. The number of children under age 15 living with HIV globally has levelled off in the past few years and totalled 3.4 million in 2010; more than 90 per cent of these children were living in sub-Saharan Africa. Deaths among children under age 15 from AIDS-related illness are declining, falling 20 per cent between 2005 and 2010, from 320,000 to 250,000. This trend is primarily due to the expansion of services to prevent HIV from being transmitted to infants and, to a lesser degree, the expansion of access to treatment for children.

Treatment availability for children increased from 21 per cent in 2009 to 23 per cent in 2010 – an unacceptably low rate of progress. UNICEF is a strong advocate for getting infants tested for HIV early and promoting access for infants living with HIV to appropriate paediatric antiretroviral drug formulations. In collaboration with UNITAID, the Clinton Health Access Initiative (CHAI) and other partners, UNICEF is promoting the development of low-cost paediatric formulations and making them available to children who need it.
In 2010, an estimated 35 per cent of pregnant women in low-and middle-income countries (approximately 123 million) received an HIV test, up from 7 per cent in 2005. Increases were observed in almost all regions, with the percentage of pregnant women testing for HIV growing by around 10 per cent or more between 2009 and 2010 in three regions. During 2010, in 65 low- and middle-income countries, 28 per cent of infants were reported to have been tested for HIV within the first two months of birth, versus the 6 per cent who were tested in 2009.

Young people aged 15-24 accounted for 42 per cent of new infections in 2009, yet there are some encouraging trends among young people in several countries with a high burden of HIV. Data from antenatal clinics from 2000 to 2010 showed that HIV prevalence declined among women aged 15–24 in 22 of the 24 countries with national HIV prevalence of 1 per cent or higher and with data available. In 11 of 19 African countries, the percentage of young men with multiple partners in the last 12 months fell significantly. However, young women continue to become infected at higher rates than their male counterparts in many areas due to their heightened physiological susceptibility to HIV and because of socioeconomic vulnerabilities.

Results from three recent studies have enabled scientists to definitively conclude that antiretroviral medicines can prevent sexual transmission of HIV. The HIV Prevention Trials Network (HPTN) 052 trial demonstrated in 2011 that early ART taken by the HIV-positive partner in a serodiscordant relationship provided 96 per cent protection against HIV acquisition by the HIV-negative partner. Once-daily oral Truvada (tenofovir plus emtricitabine) taken by at-risk, HIV-negative men who have sex with men and transgender persons in six countries participating in the I-PrEX trial resulted in a 44 per cent reduction in incidence. In the CAPRISA trial, 1 per cent tenofovir vaginal gel, when used before and after sex, demonstrated a 39 per cent reduction in HIV incidence in women (2010), although efficacy was not shown in a subsequent trial where the gel was used once daily (VOICE - 2011).

Medical male circumcision has been shown to lower HIV incidence in men by up to 76 per cent. UNICEF has been working with WHO and UNAIDS to apply this research to generalized epidemic settings, specifically by providing information to young men and by participating in guidance development for neonatal circumcision. Swaziland is leading the way in integrating neonatal circumcision into its neonatal care services, with support from UNICEF.

Globally, an estimated 5 million young people aged 15-24 were living with HIV in 2009, a 12 per cent reduction compared to 2001. In collaboration with the Global Network of People Living with HIV (GNP+) and WHO, UNICEF has intensified its efforts in recent years to increase access and coverage of adolescents on antiretroviral treatment and to develop treatment, care and support guidelines.

Most countries in sub-Saharan Africa have made significant progress towards parity in rates of school attendance for orphans and non-orphans aged 10-14. In 27 out of 31 countries in sub-Saharan Africa that report data, school attendance among children who have lost both parents (including those who died from AIDS-related illness) has increased.

AIDS and child-sensitive social protection efforts led and supported by UNICEF have been catalysts for broader initiatives that have affected health and development outcomes. Kenya, Malawi, Namibia, South Africa and Zambia, motivated in part by the severity of the AIDS epidemic in their countries, have several large national cash-transfer programmes that benefit AIDS-affected individuals and households without explicitly targeting them (thereby avoiding stigma). There has been a demonstrable impact on nutrition, education and health-seeking behaviours for children affected by AIDS.
Remaining challenges – addressing inequities in the AIDS response

Inequities in the AIDS epidemic are rooted in age, gender, geography, and socioeconomic status. Inequities are also well documented among socially marginalized populations, in particular men who have sex with men, sex workers and people who inject drugs.29 Globally, in 2009, young people aged 15-24 accounted for 41 per cent of new infections among adults aged 15 and older. An estimated 890,000 young people aged 15-24 were newly infected with HIV in 2009, with 79 per cent of these new infections occurring in sub-Saharan Africa. In nine countries in southern Africa, at least 1 in 20 young people are living with HIV. Some 4.9 million of the 5 million young people aged 15-24 living with HIV in 2009 were in low- and middle-income countries and 3.2 million were female. Globally, young women make up more than 60 per cent of all young people living with HIV; in sub-Saharan Africa, their share jumps to 72 per cent, and young women face their greatest burden of infection before the age of 25.

Levels of HIV knowledge and skills among adolescents and young people remain insufficient. In most high-burden countries in sub-Saharan Africa, disparities in knowledge about HIV are reported by wealth quintile, residence and gender. Accurate HIV knowledge among young people in sub-Saharan Africa is lowest among the poorest households and in rural areas, and young women are less likely than young men to have accurate knowledge about HIV and AIDS. Only 47 per cent of young men (aged 15-24) and 32 per cent of young women (aged 15-24) who reported having sex with multiple partners during the previous 12 months indicated they had used condoms at their last intercourse.30 Adding to the complexity of HIV prevention in sub-Saharan Africa is intimate-partner violence, an indirect and disturbing cause of HIV transmission. An estimated 11-45 per cent of girls aged 15 or younger report their first sexual experience as forced.31

In most countries with low-level or concentrated epidemics, infection is spread primarily by people who inject drugs or men who have sex with men – many of them adolescents and young people. In Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), HIV prevalence is on the rise, largely because of soaring levels of unsafe injecting drug use. Four out of five people living with HIV in the region are under age 30, and one out of every three new HIV infections occurs among young people aged 15-24.32 Young men who have sex with other men also often have higher rates of infection. A young man in the suburbs of Cape Town, South Africa, or Lilongwe, Malawi, who has sex with other men has about a 20 per cent risk of becoming infected with HIV by the age of 24, whereas the risk in the general population in either country is much lower: 4.5 per cent in South Africa and 3.1 per cent in Malawi.33

These disparities in rates of infection mirror disparities in access to HIV testing, treatment, care and support. Only 40 per cent of people globally know their HIV status, and that figure is even lower for young people.34 In developing countries, only 8 per cent of young people aged 15-24 have taken HIV tests and received their results; among young people in sub-Saharan Africa, only 10 per cent of young men and 15 per cent of young women in this age group know their HIV status.35

While women have more entry points into testing via maternal, newborn and child health (MNCH) services, including antenatal care (ANC), in 2010 only 35 per cent of pregnant women in low- and middle-income countries were tested for HIV, and only 28 per cent of children born to HIV-positive mothers received an HIV test within the first two months of life.36 Globally, 22 countries account for nearly 90 per cent of pregnant women living with HIV. The same countries are also home to approximately 90 per cent of children under age 15 with HIV who are in need of antiretroviral therapy.37
In 2010, treatment coverage, at 23 per cent, was notably lower for children under age 15 than for adults aged 15-49 years, for whom coverage was 51 per cent. Global treatment statistics for adolescents and young people are not available. Adults and children with HIV require 20 to 30 per cent more nutrition (energy intake) than the general population; and coverage of cotrimoxazole prophylaxis, an inexpensive drug regimen that prevents common infections in infants and children who are living with or exposed to HIV, remains low, at 23 per cent.

For children and families affected by AIDS, there is still a great deal to do to keep parents alive and protect children from the negative impacts of HIV. At the end of 2010, despite the millions of dollars invested in programmes for orphans and vulnerable children, many people remain underserved. In 25 countries where household surveys were conducted between 2005 and 2009, a median of only 11 per cent of households were receiving external support. Many HIV-affected children, especially girls, are taken out of school. This puts them at risk of early sexual debut, abuse and diminished access to health services – which in turn makes them more susceptible to HIV infection. Many studies indicate that children affected by AIDS, especially older adolescents, may be more frequently absent from or drop out of school due to increased economic pressures and caregiving responsibilities. Women and girls account for at least two-thirds of all caregivers for people living with HIV in Africa, with similar trends across the developing world.

A main driver of inequity is stigma and discrimination. About 3 in 10 countries worldwide do not have laws prohibiting HIV-related discrimination. In 6 of 24 countries surveyed by the United Nations Development Programme Commission on HIV and the Law, the evolving capacity of children to seek health services and exercise their right to health go unrecognized until they reach the legal age of adulthood and therefore the age of consent to medical treatment.

Finally, while there are many programmatic challenges to address, the need for political leadership in times of economic austerity and waning public interest for a 30-year-old epidemic cannot be underestimated. While resources for HIV are dwindling, scientific advancements coupled with solid implementation experience are more than ever poised to give children the opportunity to grow up as part of an AIDS-free generation.

Wise investment based on science and local knowledge of the epidemic is the way forward.

**Resources**

In 2011, the overall expenditure for Focus Area 3 from UNICEF’s core budget (Regular Resources) and Other Resources (Regular and Emergency) amounted to US$ 151.4 million (see table below).

<table>
<thead>
<tr>
<th>Funding type</th>
<th>Expenditure (in US$ millions)</th>
<th>Expenditure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular resources</td>
<td>44.6</td>
<td>29.5</td>
</tr>
<tr>
<td>Other resources – regular</td>
<td>99.9</td>
<td>66</td>
</tr>
<tr>
<td>Other resources – emergency</td>
<td>6.8</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>151.4</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
What is thematic funding?
Thematic funding was created after the adoption of UNICEF’s MTSP (2001-2005) as an opportunity for donors to support the goals and objectives of the MTSP and to allow for longer-term planning and sustainability of programmes. While regular resources continue to be UNICEF’s preferred type of funding, thematic contributions are the next best option, as they have fewer restrictions on their use than traditional other resources. Donors can allocate thematic funds to the five MTSP focus areas and humanitarian response as follows:

Focus Area 1: Young child survival and development
Focus Area 2: Basic education and gender equality
Focus Area 3: HIV/AIDS and children
Focus Area 4: Child protection from violence, exploitation and abuse
Focus Area 5: Policy advocacy and partnerships for children’s rights
Humanitarian response

Contributions can be provided at the global, regional or country level. Thematic contributions from all donors to the same focus area are combined into one pooled fund account with the same duration, which simplifies financial management and reporting for UNICEF offices. As funds are pooled, UNICEF cannot track individual donors’ contributions. Thematic donors also agree to accept one annual consolidated narrative and financial report that is the same for all donors. Due to reduced administrative costs, thematic contributions are subject to a lower cost recovery rate of 5 per cent (compared with the standard 7 per cent).

Within other resources, some donors give flexible funding to thematic pooled funds for the five focus areas of UNICEF’s Medium-Term Strategic Plan (MTSP) or for humanitarian response. In 2011, UNICEF received US$7 million in thematic contributions for HIV/AIDS and children, amounting to 2 per cent of all thematic contributions received in 2011 ($373 million) for the five Focus Areas and humanitarian response.

**Thematic contributions to MTSP focus areas and humanitarian response, 2011:**
$373 million

- Humanitarian Response $187m (50%)
- Basic Education and Gender Equality $128m (34%)
- HIV/AIDS and Children $7m (2%)
- Young Child Survival and Development $28m (8%)
- Child Protection from Violence, Exploitation and Abuse $19m (5%)
- Policy Advocacy and Partnerships for Children’s Rights $4m (1%)
Due to the extraordinary response to the funding appeals for the Horn of Africa, 50 per cent of thematic funding in 2011 went to humanitarian response. Total thematic funding for the five MTSP focus areas and humanitarian response in 2011 was US$373 million, 35 per cent less than in 2010. This drop is partly the result of decreased contributions from a major donor following the economic downturn. The narrow funding base of thematic funding continues to pose a challenge.

The thematic funding received for Focus Area 3 in 2011 was 30 per cent less than the US$ 10 million received in 2010. In 2011, 91 per cent of the contributions were from UNICEF National Committees; government donors accounted for 8 per cent, and inter-organizational arrangements provided the remaining 1 per cent. In 2011, the largest donor to thematic funding for Focus Area 3 was the Korean Committee for UNICEF, followed by the Netherlands Committee for UNICEF, the Finnish Committee for UNICEF, the United States Fund for UNICEF, and the United Kingdom Committee for UNICEF.

Sweden, the Netherlands Committee for UNICEF and United States Fund for UNICEF increased their contributions significantly to Focus Area 3 compared to 2010. Continuing the previous years’ trend, the Korean Committee for UNICEF and Finnish Committee for UNICEF continued their commitment to HIV/AIDS and children.

### Thematic contributions to HIV/AIDS and children, by donor, 2011

<table>
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<tr>
<th>Donor Type</th>
<th>Donor</th>
<th>Amount (in US$)</th>
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</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
<td>Sweden</td>
<td>329,889</td>
</tr>
<tr>
<td></td>
<td>Liechtenstein</td>
<td>180,072</td>
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<tr>
<td></td>
<td>Canada</td>
<td>76,672</td>
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<tr>
<td><strong>Inter-Organizational Arrangement</strong></td>
<td>UNAIDS - Geneva</td>
<td>83,128</td>
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<td><strong>National Committee</strong></td>
<td>Korean Committee for UNICEF</td>
<td>2,557,477</td>
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<td></td>
<td>Netherlands Committee for UNICEF</td>
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<td>Finnish Committee for UNICEF</td>
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<td></td>
<td>United States Fund for UNICEF</td>
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<td>United Kingdom Committee for UNICEF</td>
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<td></td>
<td>Danish Committee for UNICEF</td>
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<td>Norwegian Committee for UNICEF</td>
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<td>Canadian Committee for UNICEF</td>
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<td>Irish Committee for UNICEF</td>
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<td>Spanish Committee for UNICEF</td>
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<td>Japan Committee for UNICEF</td>
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<td>New Zealand Committee for UNICEF</td>
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<td>Slovenia Committee for UNICEF</td>
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<td><strong>Total</strong></td>
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Top 15 donors to thematic focus area 3: HIV/AIDS and children, 2006 – 2011

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<td></td>
<td>in US$ thousands</td>
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<tr>
<td>Netherlands</td>
<td>6,024</td>
<td>6,024</td>
<td>6,641</td>
<td>4,000</td>
<td>22,689</td>
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<tr>
<td>United Kingdom NC</td>
<td>2,034</td>
<td>2,226</td>
<td>1,872</td>
<td>1,869</td>
<td>746</td>
<td>458</td>
<td>9,205</td>
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<tr>
<td>Korea NC</td>
<td>200</td>
<td>502</td>
<td>293</td>
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<td>6,420</td>
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<td>Sweden</td>
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<td>Norway</td>
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<td>Finland NC</td>
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Top donors to thematic focus area 3: HIV/AIDS and children, 2006 – 2011

![Graph showing contributions of top donors](image)
Results

Key Result Area 1: Reduce the number of paediatric HIV infections; increase the proportion of HIV-positive women receiving antiretroviral drugs; increase the proportion of children receiving treatment for HIV/AIDS

UNICEF is providing leadership at the global, regional and country levels for the implementation of the United Nations Secretary-General’s Global Strategy for Women and Children’s Health and the Global Plan to Eliminate New HIV Infections in Children by 2015 and Keep Their Mothers Alive (eMTCT). This is in line with the new UNAIDS ‘Division of Labour’. In 2011, UNICEF and partners helped countries develop national, costed, eMTCT scale-up plans that promote equity at their core. UNICEF has been championing the integration of PMTCT and MNCH services and the promotion of decentralized, facility-level planning. Integral to this effort is UNICEF’s work with community-based health workers to alleviate health-system bottlenecks to women’s and infants’ access to MTCT services. UNICEF, along with WHO and other partners, has also made progress in utilizing innovations (e.g., point-of-care CD4 machines) to improve access to HIV testing for the partners of pregnant women, improve access to treatment to prevent AIDS-related deaths in children, and help mothers with HIV to exclusively breastfeed where appropriate.

Figure 1. Estimated number of children newly infected with HIV in low- and middle-income countries, 2000–2015


22 PMTCT priority countries: Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Low- and concentrated-epidemic countries will have the support of UNICEF and partners to support integration of eMTCT services and also certify claims of eliminating new paediatric HIV infections.
Advocacy for the elimination of new infections in children by 2015 and keeping their mothers alive (eMTCT)

Strengthening global, national and regional commitments to eliminate MTCT was a UNICEF priority in 2011. This issue was given the spotlight at the high-level meeting on HIV/AIDS in June 2011, when United Nations Secretary-General Ban Ki-moon launched The Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive (hereafter referred to as the Global Plan). The specific goal of the Global Plan is to reduce new HIV infections among children by 90 per cent and HIV-related deaths among pregnant women by 50 per cent. UNICEF is working with the newly established Global Steering Group (GSG), led by UNAIDS and the United States Government, to support the implementation of the Global Plan.

UNICEF also developed the UNICEF Action Plan for the Elimination of New Paediatric HIV Infections in High Burden MTCT Countries, which outlines priority actions for the organization. UNICEF’s role in supporting global elimination draws upon its comparative advantage of strong relationships with the government ministries accountable for maternal and child health, international and national staff with exceptional technical competencies, and a long history of leadership and coordination on the issue.

As co-convener (with WHO) of the Interagency Task Team (IATT) on the Prevention and Treatment of HIV in Pregnant Women, Mothers and their Children, UNICEF is responsible for coordinating technical assistance to the 22 PMTCT priority countries where 90 per cent of new child infections occur. The organization is also responsible for developing and implementing normative guidance and monitoring country progress towards the targets in the Global Plan. Ten countries had costed national plans in place at the end of 2011 and are now beginning to implement the Global Plan. The remaining 12 priority countries are expected to finalize their costed plans in 2012.

A crucial component of national eMTCT plans is understanding where the gaps, disparities and inequities are occurring. In collaboration with partners, UNICEF developed a PMTCT bottleneck analysis tool and trained focal points from governments and from UNICEF country offices to undertake country-level analyses. In West and Central Africa, for example, the bottleneck tool was used in seven countries and results formed the basis for developing and costing eMTCT plans. Findings from bottleneck analyses were also used to draft the PMTCT component of new National AIDS Strategic Plans (2012-2015) in Cameroon and the Democratic Republic of the Congo.

Geographic and socio-economic disparities were observed in all countries where bottleneck analyses were conducted. In Cameroon, nomadic populations, pygmies and poor women were found to have higher unmet need for PMTCT than the average woman in Cameroon. Similarly, in Chad analysis found that nomadic populations, fishing communities around Lake Chad and poor women have lower access to PMTCT services than women in the general population. These findings make the case for careful decentralized planning that takes this evidence of inequity into consideration in order to accelerate progress toward eMTCT.
Countries that have conducted equity-based bottleneck analyses consider this exercise to be critical because it unearths disparities in access to and utilization of services. Such analysis can also reveal key factors that block progress – thus providing essential information for evidence-based programming and for prioritizing work. Regions with low and concentrated epidemics are also working to incorporate these kinds of analyses. In Latin America and the Caribbean, for example, nearly all countries (80 per cent) completed National Strategic Plans to reduce MTCT with UNICEF support in 2011. Global efforts are already starting to yield results, as demonstrated by UNICEF-supported impact evaluations of PMTCT efforts in Kenya, Rwanda and South Africa.

Many regions have challenges gathering reliable information on eMTCT because countries use differing indicators or have different interpretations of indicators. In many countries, for example, data systems do not currently collect longitudinal data, which is a priority in tracking the implementation of the new PMTCT regimens and paediatric treatment. Yet strong data collection systems are crucial for tracking and monitoring progress towards eMTCT goals. To address data collection problems, UNICEF is working with countries to strengthen data collection systems for PMTCT by verifying data and identifying areas of weakness through Level 3 Monitoring and Universal Access reporting.

Regions with low and concentrated epidemics are exploring ways to strengthen data collection systems for marginalized populations. For example, in CEE/CIS, there is a lack of data on the prevalence of drug use and drug dependence among pregnant women, and an absence of clear policy and programming guidance on appropriate approaches to PMTCT among drug-dependent pregnant women. In 2011, UNICEF’s regional office in CEE/CIS assessed the technical assistance and policy support needed to address issues related to drug use policies, gender-sensitive harm reduction and support strategies, and PMTCT programming.

Integration to improve efficiency and effectiveness of PMTCT and MNCH services
UNICEF and partners continue to champion the integration of PMTCT and maternal, newborn and child health (MNCH) services, and to promote decentralized facility-level planning for both types of services. Mothers, their partners and children all benefit from improved HIV and MNCH outcomes when effective models of integration are used. UNICEF ROSA looked at how decentralized HIV services in India affect children and how HIV and AIDS services have been integrated into primary health care. The review concluded that decentralized services increased geographic coverage, increased demand for services, made better use of existing resources and fostered new ways of thinking about HIV and MNCH service delivery.

There are currently efforts in many countries to link HIV and MNCH services at the policy and programming levels. In CEE/CIS, for example, UNICEF advocated with national governments for a stronger focus in national PMTCT strategies and programming on reducing risks and vulnerabilities of marginalized women and girls, in particular women who inject drugs. In Eastern and Southern Africa, HIV testing and counselling has become integral to antenatal care and delivery services in all 14 priority countries. In the Central African Republic, UNICEF conducted integrated trainings on emergency obstetrical and neonatal care and PMTCT in three health districts. In Latin America, countries are working to integrate PMTCT and prevention, diagnosis and treatment of congenital syphilis into MNCH.
UNICEF works with countries experiencing emergency or humanitarian situations to ensure that issues related to children and HIV are addressed. The organization provides training, technical support, and prevention, care and support services. UNICEF also works to ensure that these issues are integrated into regular work planning – a crucial yet often overlooked step. This is particularly important for reaching pregnant women living with HIV in pursuit of the MTCT elimination goal. In 2010, an estimated 1.1 million women aged 15-49 living with HIV were affected by emergencies worldwide – with an estimated 810,000 living in Eastern and Southern Africa and another 117,000 in West and Central Africa.

**Paediatric treatment**
UNICEF continues to advocate for infants to get tested for HIV early, and for those living with HIV to have access to appropriate paediatric drug formulations. For example, UNICEF is working with UNITAID, the Clinton Health Access Initiative (CHAI) and other partners to produce low-cost, easy-to-use paediatric formulations.

UNICEF is partnering with the private sector and with academic institutions to implement new HIV testing equipment (also commonly referred to as ‘point of care diagnostics’) that makes it easier for mothers and their infants to access testing and receive more timely results. UNICEF and CHAI have formed a partnership to accelerate access to innovative point of care diagnostics and are establishing the groundwork for rolling out new early infant diagnosis technologies that are expected to become available in 2013.
UNICEF is also working with partners to capitalize on cell-phone technology and other innovative communications efforts to retain mothers and their infants in HIV services and secure their access to AIDS treatment, care and support. In Zambia, for example, the innovative mobile health initiative ‘Project Mwana’ is helping make infant HIV test results available more quickly and reducing delays that pose a significant barrier to early initiation of infants on antiretroviral therapy, especially in rural settings. With the help of RapidSMS, a free and open-source software, Project Mwana has relayed more than 3,000 infant HIV test results since the pilot launched in 31 clinics in six provinces in June 2010. The results have reduced turnaround times by around 50 per cent.

UNICEF facilitated a study tour for 17 individuals from Benin, Gambia, Senegal and Sierra Leone to learn from the experiences of early infant diagnosis in “Point of Care” (CD4) systems in Zimbabwe. Each participant country defined key priority actions to be implemented for turning lessons learnt on the study trip into concrete actions in their own countries.

Capacity to provide treatment, care and support to children living with HIV has been strengthened in several countries in Eastern Europe and Central Asia through the Russian language training course, “Integrated Management of Childhood Illnesses – Complementary course on HIV/AIDS.” This course provides guidance on treating children with HIV in primary health care settings in countries with low and concentrated epidemics. After field testing in three countries, the course was rolled out to seven countries in the region, including Belarus, Ukraine and five Central Asian countries.

In ROSA, the absence of early infant diagnosis programmes means that many HIV-exposed children are lost to follow-up and risk being excluded from paediatric treatment and care. In Pakistan, the National PMTCT programme, with support from UNICEF, began piloting a comprehensive district model approach in 2010, where trained lay health workers identified women at risk of HIV. As part of this programme, children were tested for HIV if considered at risk and offered paediatric AIDS care if they tested positive for HIV. To date, several hundred men, women and children at risk have been screened. This district model will be scaled up to eight high-risk districts in 2012.

Research, technology and innovation
UNICEF, in collaboration with WHO and PEPFAR, helped countries implement the revised WHO guidelines on PMTCT, infant feeding and antiretroviral therapy that were issued in 2010. This work is being coordinated by UNICEF and WHO with over 27 partners of the Interagency Task Team (IATT) on the Prevention and Treatment of HIV in Pregnant Women, Mothers and their Children in the 22 countries with the highest burden of mother-to-child transmission of HIV.45 UNICEF and WHO are also providing advocacy, financial and technical support at the regional and country levels to facilitate the transition from single-dose nevirapine, which is no longer recommended by WHO, to more efficacious drug regimens for PMTCT.
Co-packaging of ARVs is an innovation being explored as a way to scale up PMTCT programmes for women with limited access to health facilities. In the second half of 2011, UNICEF put on hold plans for widespread implementation of the Mother Baby Pack (MBP) – a copackaging innovation – in order to address concerns regarding the concept, protocol and guidelines for implementation. Lesotho adapted the MBP concept, building upon experience that began in 2007 with a pre-cursor package to the MBP. Recommendations from an external advisory group on the MBP are now being applied to support countries wishing to pilot and evaluate the MBP. A formal, external evaluation of the Lesotho experience of the MBP is being conducted in 2012.

In CEE/CIS, UNICEF developed new and innovative tools to improve uptake of HIV testing and other PMTCT services among pregnant women and to help them better understand HIV. Tools included a flip-chart for use by health providers in antenatal clinics, information materials for women, and a Russian-language website that makes the information widely accessible.

Operations research is underway in Malawi, Mozambique and Zimbabwe to develop innovative approaches to integrate nutrition and HIV programmes for infants and young children. India is also strengthening support for PMTCT operational research, and developed two proposals in 2011, with implementation expected to begin in 2012.

UNICEF supported operational reviews of PMTCT programmes in Armenia, Kyrgyzstan and Ukraine. The Ukraine evaluation assessed costs of PMTCT programming and was used to help decision makers find ways to optimize programme expenditures. The Armenia and Kyrgyzstan assessments resulted in the revision of national PMTCT strategies in both countries; they also served to reemphasize the need to provide universal coverage of antenatal HIV testing and re-focus prevention interventions to prioritize services for most-at-risk pregnant women, including women using drugs, women who have partners who inject drugs, women selling sex, illegal migrants, homeless women and women in prisons.

Operations research on the impact of stigma on women’s access to PMTCT programmes was conducted in Accham District in Far Western Nepal in 2011. The study revealed significant evidence of the links between HIV and inequities related to geography and wealth, and will be used to develop equity-based programming and human resources development for PMTCT in communities.

In CEE/CIS, an innovative e-learning version of the “Integrated Management of Childhood Illnesses – Complementary course on HIV/AIDS” allows for interactive, more individualized and quicker approaches to training of staff. It also reduces the costs of training when compared to traditional training workshops. In Kazakhstan and Turkmenistan, UNICEF also supported the adaptation and implementation of the IMCI e-learning course in the national languages as part of the post-graduate curriculum for health care professionals.

Information Communication Technology (ICT) assessments undertaken in 11 countries in East Asia and the Pacific examined the current and potential use of ICT to strengthen monitoring of PMTCT services to address loss to follow-up. The assessments found that immediate attention is needed to improve data and information management in line with an overall health information system strengthening strategy to leverage ICT effectively for PMTCT.
Improving adherence to HIV treatment among children in Kazakhstan and Ukraine

To improve adherence to HIV treatment among children, UNICEF developed ‘Vitaminka’, an HIV treatment adherence package that includes a children’s fairy tale book, an animated cartoon on DVD and an adherence calendar. The package helps children understand treatment and develop a habit of taking treatment regularly; it also supports parents and caregivers in ensuring adherence to medications. The Vitaminka package was developed in partnership with the Ukrainian and Kazakh Association of People Living with HIV. One innovation of 2011 was the development of an interactive website featuring the Vitaminka, complemented by additional information and interactive games for children aged 3–12. Web-based access has made the Vitaminka package available to a larger audience (www.vitaminka.kz). Considering continued demand for such support tools, two Global Fund-supported grant recipients in these countries are planning to re-print Vitaminka and translate it into local languages.

In response to the continued need for materials to support ARV treatment adherence, UNICEF is supporting the development of three more storybooks for children aged 3-6. An important objective is to help parents talk to children about HIV in an age-appropriate manner that can help alleviate the stress of status disclosure. These tools are being developed in cooperation with local associations of families who have children living with HIV.


In Papua New Guinea the ‘Mingende practice model’ for PMTCT, implemented in the Mingende Rural Hospital and evaluated with the support of UNICEF, showed that the hospital was able to effectively follow up with pregnant women and their partners throughout the continuum of care. Loss to follow-up was reduced, ART was provided in a timely fashion and adherence was improved.

Procurement and supply chain management of HIV drugs and diagnostics

In 2011, UNICEF maintained its prominent role in HIV procurement and supply. Procurement of HIV commodities totalled $145 million for over 54 countries, an approximate increase of 45 per cent over procurement volumes in 2010.46

In 2011, 80 per cent of the total procurement money was spent on ARVs, a 50 per cent increase compared to 2010; 13 per cent was for rapid HIV and STI tests (a 30 per cent increase compared to 2010); and 7 per cent was for HIV diagnostics. Malawi, Zambia and Zimbabwe received 70 per cent of total HIV procurement expenditures. UNICEF coordinated procurement and supply management assessments in Cameroon, Kenya, Nepal and Zambia, in collaboration with WHO and others. These assessments led to the development of new strategies to prevent stock-outs and overcome barriers to the scale-up of PMTCT, including reconceptualizing the Mother Baby Pack – which bundles commodities needed for PMTCT and maternal and child health services – to better tailor it to the local context.
Collaboration with UNITAID accelerated the provision of more efficacious multi-drug combinations in 17 countries to replace single-dose nevirapine, which is often used for PMTCT but is no longer recommended by WHO. UNITAID, UNICEF and CHAI actively supported eight countries to improve planning and implementation of procurement and supply management. Another goal in these countries was to ensure effective coordination to reduce duplication, wastage and stockouts of PMTCT-related drugs and commodities. In collaboration with UNITAID and UNICEF/HQ, UNICEF’s West and Central Africa regional office helped mobilize and make use of over US$ 18 million in commodities for an accelerated scale-up of PMTCT and paediatric AIDS services in Cameroon, the Central African Republic, Côte d’Ivoire and Nigeria.

UNICEF’s Supply Division in Copenhagen also provides in-country technical support to quantify, forecast and monitor HIV- and AIDS-related commodities. In 2011, 65 per cent of UNICEF’s ARV procurement was underwritten by the Global Fund. Such funding was used in: Somalia and Egypt, on behalf of UN partners such as UNDP and UNOPS in Belarus, Haiti, Myanmar and Zambia; and for ministries of health in Cambodia and Malawi.

**Key Result Area 2: Support national capacity to increase the proportion of children orphaned or made vulnerable by HIV and AIDS receiving quality family, community and government support**

UNICEF continued to improve strategic approaches to meet the needs and rights of children who have lost one or both parents due to AIDS. In 2011, UNICEF accelerated its work providing international guidance. It also maintained an emphasis on strengthening government capacity to provide external support to households caring for orphans and vulnerable children, work increasingly concentrated on supporting systems that foster, either directly or indirectly, sustained demand creation for basic services.

**Advocacy and leadership for children affected by AIDS**

UNICEF hosted the Fifth Global Partners Forum on Children affected by HIV and AIDS in New York from 3-4 June 2011. Joint sponsors of the event included UNAIDS and PEPFAR. Under the heading of ‘Taking Evidence to Impact,’ the Forum brought together 115 practitioners, policymakers, academics and donors to discuss evidence-based approaches for responding to the most vulnerable children affected by HIV and AIDS.

At the meeting, UNICEF, in collaboration with partners of the Inter-agency Task Team on Children Affected by AIDS, released the guidance document *Taking Evidence to Impact: Making a difference for vulnerable children living in a world with HIV and AIDS*. The purpose of this report was to inform the development of appropriate responses for children affected by HIV and AIDS. It builds on the principles and approaches from the 2004 *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, bringing in new evidence from academic analyses and programmatic experience. It translates evidence into guidance for policymakers and programmers. UNICEF also led development of a guidance note on social protection and HIV with the social protection, care and support working group. This guidance document highlights key principles and areas of good practice, and was launched at the 2011 International Conference on AIDS and STIs in Africa (ICASA).

The new UNAIDS division of labour sets UNICEF as the co-convener of the IATT on Social Protection along with the World Bank. UNICEF has used this role to galvanize support for the above-mentioned guidance.
Using advocacy, UNICEF worked to strengthen policy and leverage resources on behalf of children affected by AIDS in South Asia. Among the most significant policy results was consideration of children affected by AIDS in the draft Children’s Act in Bangladesh, a result of direct technical assistance and high-level advocacy by UNICEF’s regional office. One of the most noteworthy results in terms of resource leveraging was the inclusion of areas important for children affected by AIDS in the Global Fund Round 10 proposal in Nepal, which was awarded US$ 57.3 million. To date, this is the most substantial funding UNICEF has been able to leverage for children affected by AIDS in South Asia.

UNICEF led support for Thailand’s successful GFATM Round 10 application for “Comprehensive HIV/AIDS Care, Support and Social Protection for Affected and Vulnerable Children Living in High Prevalence Areas to Achieve Full Potential in Health and Development”. The grant was approved to strengthen and integrate policies and systems, improve access to health and social services, increase social acceptance, and improve strategic information systems.

UNICEF launched a Challenge Fund in four countries – Mozambique, Namibia, Sierra Leone and Uganda – to catalyse responses to children affected by AIDS based on recommendations outlined in Taking Evidence to Impact. The funds have supported formative research, operational research, impact assessments and technical assistance. The goal is to generate evidence and improve programming around social protection, alternative care and children affected by AIDS, linking communities to health systems and supporting integrated community approaches to vulnerable children.

**HIV-sensitive social protection scale up and system strengthening**

In 2011 UNICEF provided technical support to 13 countries in Eastern and Southern Africa to help them develop evidence-informed national strategic plans for the protection, care and support of vulnerable children. These plans began with mapping the current systems in each country. Through it, UNICEF helped leverage USAID funding to scale up national responses for children affected by AIDS. Work begun in 2011 includes situation analyses, action plans and monitoring and evaluation frameworks.

UNICEF has successfully advocated with government partners in Moldova, Serbia and Ukraine to change the way health and social welfare systems are structured in order to provide more comprehensive services. In Moldova, UNICEF worked with government and civil society partners to link health and social services by developing a referral system that meets the needs of vulnerable children and adolescents and their families. The system employs social assistants as case managers to monitor and evaluate the progress of intervention plans intended to facilitate the access of children and their families to social assistance, health, education, the criminal justice system and civil society organizations. In four Central Asian countries, UNICEF’s advocacy for social protection and family support measures resulted in the introduction of or increase in cash transfers to assist families caring for children living with HIV.

UNICEF continued to help India’s National AIDS Control Organization implement its programme for the care, support and protection of children affected by AIDS, begun in May 2010. 2011 saw situation assessments and implementation in additional districts, as well as the establishment of District Coordination Committees to map vulnerable children’s unmet needs and orient all providers and stakeholders at the district level to the needs of children affected by AIDS.
Research and evaluation to generate evidence that support policy and programming

In 2011 UNICEF undertook a statistical analysis of DHS and MICS household data to identify key factors affecting child vulnerability in the context of HIV and AIDS. Global analysis showed that being a single or double orphan is not consistently a useful predictor of child vulnerability and that poverty intensifies the impact of HIV and AIDS on children's lives. Identifying vulnerable children requires assessing multiple variables, including household wealth, orphan status and residency patterns. The results of this process will help redefine AIDS-related vulnerability and guide the development of a standard measure of child vulnerability that is AIDS-sensitive and can be used globally in different contexts. The analysis will also be used to facilitate monitoring of programme coverage and to inform estimates of vulnerable children at the global level.

The East and Southern African Children and AIDS Regional Initiative (CARI), under the leadership of UNICEF, was evaluated in 2011 and was found to add momentum and evidence to national debates on social protection and the development of national structures and systems. UNICEF has actively used CARI funding, as well as other funding mechanisms, to remain at the centre of on-going policy debates and to respond promptly to external changes in the environment in several fields. In 2005/6, many countries had weak policy environments for vulnerable children. By 2011, all countries had begun evaluations of their national plans for vulnerable children or strengthened their national plans to make them more sustainable.

In Uruguay, in collaboration with the country’s State Health Services Administration, the HIV/STI Program, and the Ministry of Health, UNICEF supported a study on the situation of children orphaned by AIDS. Findings showed the need to improve access to comprehensive care services for people living with HIV and to address the needs of the children in AIDS-affected households. Study results are now informing policies and programmes that respond to children’s needs.

Two initiatives to improve research and M&E capacity were launched in 2011. Each required substantive input by national-level partners on research and evaluation protocols. In one, with UNICEF support the South Africa-based NGO the Economic Policy and Research Institute will examine how social protection can act as a critical enabler to promote HIV prevention, treatment, care and support. Five countries in sub-Saharan Africa have outlined their research questions.

In the second initiative, UNICEF is providing technical support to the ministries in Botswana, Cameroon and Uganda responsible for the response for orphans and vulnerable children and to National AIDS Councils to help them assess and strengthen their national M&E systems related to orphans and vulnerable children. This work has already provided the line ministries in those three countries with useful tools to carry out regular assessments of their national M&E systems for orphans and vulnerable children. The initiative also mapped out key actions for strengthening these systems and outlined roles and responsibilities of stakeholders in addressing barriers and emerging issues.

More broadly, in 2011 UNICEF, in collaboration with Médecins Sans Frontières and other partners, published evidence in a peer-reviewed journal on how best to integrate implementation and operational research into programme offices. UNICEF work in Zimbabwe with the CORE initiative provides an example of how researchers and programmers can work together to design research questions and feed research findings directly into programmes for improved efficiency and effectiveness.
Stigma and discrimination
Supporting children affected by AIDS is integral to reducing the stigma and discrimination that is associated with HIV. In Kyrgyzstan, UNICEF supported a communication strategy designed to reduce stigma and discrimination towards children and families affected by HIV in the Osh Region. The strategy became the basis of an anti-discrimination decree by the region’s governor. UNICEF also helped the East Europe and Central Asian Union of People living with HIV establish the first regional network of parents and guardians of HIV-positive children. The network is active in seven Russian-speaking countries and has resulted in specific initiatives to improve parents’ access to relevant information, advocacy to ensure availability of paediatric treatment formulations, actions to counter stigma and discrimination in educational settings, and support for treatment adherence, disclosure, and other areas. It has also resulted in stronger exchanges of information and resources among parents and families affected by HIV.

Stigma is also a barrier to accessing PMTCT services. UNICEF supported operational research on the impact of stigma on women’s access to PMTCT programmes in Accham District in Far Western Nepal in 2011. The study, entitled HIV and Child Protection: a rapid assessment on stigma and PMTCT uptake in Achham district in the Far Western part of Nepal, is now informing the development of equity-based PMTCT programming at the community level. In Lesotho, UNICEF-supported research on co-packaging innovations revealed that stigma was a key consideration when a woman was deciding whether to accept a mother-baby pack from the health facilities. The findings of this research prompted a decision to provide all pregnant women with a mother-baby pack containing safe pregnancy commodities, with PMTCT medicines included for HIV-positive women.

Key Result Area 3: Support reduction of adolescent risk and vulnerability to HIV and AIDS by increasing access to and use of gender-sensitive prevention information, skills and services

In 2011, UNICEF focused its adolescent HIV prevention efforts on building the evidence base for a more equitable, efficient and effective response. UNICEF supports a combination of simultaneous HIV prevention interventions throughout the lifecycle of adolescents and young people. These interventions include access to comprehensive HIV knowledge, condoms, HIV testing and counselling; treatment; harm reduction for young people who use drugs in concentrated epidemics; and male circumcision in generalized epidemic settings.

UNICEF has worked with young people in many regions to determine how best to increase HIV-related knowledge and skills to promote healthy behaviour, while working with leaders to create policies that reflect science and experience. UNICEF has led efforts to compile state-of-the-art science on which interventions are most applicable in different epidemic settings. The organization also works with young people themselves to advocate for the implementation of effective prevention efforts. 2012 is expected to see an intensification of the focus on prevention efforts for adolescents.

Advocacy, leadership and policy development
UNICEF led an analysis of global data to prepare the second edition of Opportunity in Crisis: Preventing HIV from early adolescence to early adulthood, a global report on HIV and young people that was issued in June 2011. The report highlighted challenges and current knowledge around adolescents living with HIV. It presented comprehensive age- and sex-disaggregated data on a number of epidemiological, behavioural and service-related indicators for each
country. *Opportunity in Crisis* presented the first-ever country-specific estimates of the number of adolescents (male and female) living with HIV and the number of new HIV infections in young people aged 15–24. It also consolidated key information on knowledge and behaviour and on access to high-impact interventions among young key affected populations.

UNICEF and its partners have taken this new information and used it in advocacy and upstream policy efforts to ensure that the needs of young key affected populations are adequately met. The regional office in Latin America and the Caribbean hosted a regional training course for national decision makers in five countries (Barbados, Guyana, Jamaica, St. Kitts & Nevis and Suriname) to improve their capacity to meet the specific needs and rights of adolescents from key affected populations across the Caribbean. The course was based on one previously developed by UNICEF, UNFPA and the University of Melbourne for the Asia-Pacific region. It has helped UNICEF country offices better target their workplans to address the needs of young key affected populations: for example, as an outcome of the workshop the UNICEF Guyana country office has identified key priorities related to HIV, such as developing programmes for youth with HIV and other vulnerable youth populations, targeting those in the urban and hinterland areas.

UNICEF participated in and provided input into the European Action Plan for HIV/AIDS 2012-2015, which was developed in collaboration with governments, civil society and UNAIDS co-sponsors under the leadership of the WHO Regional Office for Europe. The action plan was subsequently approved and adopted by the Ministries of Health of all 53 countries in the WHO European region. Efforts around the Action Plan helped seven countries in CEE/CIS include key affected adolescent populations in their National AIDS Strategies or operational plans.

In West and Central Africa, considerable strides were made in 2011 to incorporate into national strategies the needs of adolescents who use drugs or sell sex, adolescent men who have sex with men, and other marginalized populations. Nigeria, for example, revised its national prevention plan to promote combination prevention and articulate a standard minimum prevention package for these populations; the Central African Republic finalized its HIV Sectoral Plan for youth based on the findings from the youth vulnerability study. In Guinea-Bissau, data from a UNICEF-supported analysis indicated that literacy was strongly associated with later sexual debut and that marital status (not household economic status) is the strongest factor associated with both early sexual debut and cross-generational sex. This information is informing national policy and programming on HIV prevention.

Technical reviews of national strategic plans in Lesotho, South Africa and Uganda were conducted to determine the underlying causes of the epidemic and the direction of the national response, by disaggregating data by age and sex. A focus was on ensuring that adolescent girls were prioritized in these plans.

**Monitoring, evaluation and programming for key affected youth populations**

During 2010-2011, UNICEF strengthened national AIDS strategies, work plans and surveillance systems in several countries in CEE/CIS to include a focus on HIV prevention among adolescents engaged in risky behaviours, including those injecting drugs, selling sex, living on the streets or adolescent men who have sex with men. UNICEF built the capacity of over 2,300 programme managers and service providers in these seven countries to deliver gender-sensitive health and social services focusing on these key populations.

In Eastern and Southern Africa, UNICEF helped 17 countries generate data on their national targets on HIV prevention for youth and assess this data for age and sex disaggregation. Eight
had disaggregated comprehensive knowledge targets, seven had disaggregated condom use targets and four had disaggregated HIV testing targets.

The East Asia and the Pacific Data Hub collated, synthesized and analysed data for 1,400 indicators and sub-indicators from over 700 unique national and sub-national sources covering around 4,300 geographic points. Updated data on the Data Hub portal is disseminated on a timely basis to 2,772 contacts within the region through data alerts, E Newsflash, Social networks and RSS feeds.

UNICEF supported a Johns Hopkins University-led evaluation of ‘Tribes’ in 2010-2011. ‘Tribes’ is an episodic drama produced by MTV and shot on location and aired in Trinidad and Tobago. Findings showed that the majority of those surveyed knew the main messages of the programme, and that the programme had an impact on their views on HIV testing, concurrent relationships and stigma. Despite these positive results, however, viewership of Tribes was limited. UNICEF and key partners are looking at ways to improve young people’s exposure to the show.

In several countries in Eastern Europe and Central Asia UNICEF supported evaluations of the effectiveness of youth-friendly services in reaching and providing HIV prevention and care for adolescents, particularly those at highest risk of HIV. Results indicate that there is high demand among adolescents engaged in risky behaviour for friendly, tailored, low-threshold services that use multi-disciplinary approaches, along with case management to meet the wide range of needs of these target groups. A UNICEF-supported study in Tajikistan looked at the cost-effectiveness of these services and concluded that they represented an effective investment.

In Burkina Faso, UNICEF supported an analysis of the contribution of 900 youth to the Millennium Development Goals. Findings revealed that 40 per cent of young people were engaged in HIV-related interventions. A key outcome of this analysis was the identification of specific groups of young people at risk who could benefit from specific interventions (young and ‘undeclared’ female sex workers, adolescent girls and boys in the mining sector, mobile vendors, and young people in bars, kiosques and clubs). Meeting the needs of these groups can help facilitate progress towards the MDGs.

In West and Central Africa and in Asia, efforts to link adolescents and young people to HIV services are ongoing. In the Democratic Republic of the Congo, nearly half a million out-of-school children were reached with HIV prevention interventions, and many of them received HIV testing. In Côte d’Ivoire, over 30,000 vulnerable young people (including victims of gender-based violence) accessed youth-friendly services including HIV testing, STI prevention and treatment and reproductive health services. In China, UNICEF helped Guangdong Province develop and introduce community-based rapid testing; HIV/STI counselling; and referral services that focus on youth including young key affected populations in the two demonstration sites, which have seen a dramatic increase in HIV cases among young people engaged in risky behaviours.

In 2011, a situation assessment of adolescents engaged in risky behaviours in six provinces of Afghanistan was conducted by the NGO Youth-Health and Development Organisation, supported by UNICEF and the country’s National AIDS Control Programme. The study looked at the knowledge, attitude, behaviour, living situations and access to services of these adolescents. Findings, expected in 2012, will help guide advocacy and decision-making around HIV prevention efforts for adolescents in Afghanistan.
Evidence presented by the PAHO-UNICEF joint publication *Girls and Female Adolescents Health Blueprint* highlights the HIV and sexual and reproductive health needs of women and girls in Latin America and the Caribbean. This work informed a UNICEF project in Trinidad and Tobago, Breaking the Silence, which documented links between child sexual abuse, incest and the spread of HIV. Findings are being used for programming and advocacy and to inform UN joint initiatives on children, HIV and violence.

UNICEF also supported advocacy and provided technical assistance for including data on risk profiles of adolescents in national HIV-related monitoring and evaluation systems and protocols in a number of countries. In Ukraine, this work resulted in recognition of the need to provide services to younger cohorts of key affected populations. The National AIDS authorities set clear targets for coverage with prevention services among groups at high risk for HIV infection, which included a specific target for prevention among key affected adolescent populations of 60 per cent coverage.

In South Asia, UNICEF has made significant contributions to the scientific literature on adolescents engaged in risky behaviours and has integrated findings from operational research into programmes for these adolescents.

Operational research was also undertaken to better understand the situation of young people who inject drugs in Bosnia and Herzegovina, Moldova, Serbia and Ukraine. One result was a better understanding of the age and circumstances surrounding initiation into drug injection, which tends to occur during adolescence. Programmes were subsequently designed to reduce initiation into injection and risky injection practices. Data from this work has contributed to the international scientific literature.

**Adolescents living with HIV**

A Global Technical Advisory Group was established in 2011 to draw on expertise from UN agencies, bilateral institutions and research institutions to guide those providing services to adolescents living with HIV. Efforts of this group informed a training initiative around adolescents living with HIV in 2011 involving eight governments and national teams. Government-designated teams of trainers and service providers are documenting facility practices in relation to diagnosis, disclosure, ART, adherence, primary health and prevention – the six critical areas of care.

National consultations on adolescents living with HIV were held in Namibia and Zimbabwe. Conclusions from these meetings noted that there were many chronically ill children who turned out to be long-term HIV survivors, and that efforts to diagnose children between the ages of 6-14 should be promoted and become a standard of care.

Youth representing Côte d’Ivoire, the Democratic Republic of the Congo, Nigeria and Senegal participated in a regional conference for Positive Health, Dignity and Prevention in West and Central Africa, and the group drafted a framework outlining the needs of adolescents living with HIV.

In Brazil, UNICEF supported the 5th National Young People Living with HIV Network meeting. The three-day meeting was held in Amazonas, Brazil, and it brought together approximately 120 adolescents and young people living with HIV, along with service providers and policymakers. Youth participants discussed issues of health care, education, human rights and political
advocacy. UNICEF also supported the government of Brazil to create two family health teams to work with children and adolescents living with HIV.

Colombia, Jamaica and Paraguay have all made progress in assistance to adolescents living with HIV, with UNICEF support. In Colombia, UNICEF supported the launch of a webpage developed by adolescents living with HIV for their peers, and to address stigma and discrimination more broadly (http://www.alejalaignorancia.org/). In Jamaica, a multi-day meeting Lessons from the Field – documenting experiences in the provision of services for adolescents living with HIV (ALHIV) reviewed existing activities in Jamaica directed to the provision of services for adolescents living with HIV, strengthened the collaboration among key partners, and developed concrete actions for strengthening service provision for these adolescents.

Paraguay developed a nutrition handbook for children and adolescents living with HIV and a guide to help teachers, parents and health workers support this population. The team also produced a guide on diagnostic disclosure and counselling for children and adolescents.

UNICEF established a partnership with FHI to review and field-test the forthcoming tool Positive Connections that is being developed to aid adolescents living with HIV. In Guyana, UNICEF supported a local NGO’s work to field-test Positive Connections and helped finance the administration of a national assessment of young people living with HIV and the development of guidance for providing them with services. UNICEF also conducted a service assessment study in the country to develop a referral network system for adolescents living with HIV.

**Future Workplan**

With the advent of new evidence and powerful new prevention and treatment tools, global leaders have begun to speak of the beginning of the end of AIDS. UNICEF expects to make a crucial contribution to this by organizing its work around four key strategies: **Synergy**, **Innovation**, **Equity** and **Partnership** for an AIDS-free generation. Central to UNICEF’s contributions to achieving and AIDS-free generation will be investments in **high-impact HIV interventions** to eliminate new HIV paediatric infections, keep mothers alive, prevent and treat HIV among adolescents and support families affected by HIV leading to diminished morbidity and mortality.

The synergies between the UNICEF AIDS response and other health and development priorities offer a great opportunity for better results in a number of areas. Integration of HIV into the maternal, newborn and child health platform, along with efforts to prevent HIV infection among adolescents and mitigate the effects of HIV on families and children, are all crucial for achieving Millennium Development Goals 1 through 6.

UNICEF will accelerate action aimed at halting the spread of HIV among adolescents, especially key affected adolescent populations. This will be furthered by decentralized planning of health and HIV prevention services so that programmes are closer to those who need them. UNICEF’s HIV programme will increase investments in this area, including enhanced field-level monitoring and documentation so that lessons can be shared among South-South partners.
To date, our collective successes have made children central to the global AIDS response. Yet there is insufficient innovation to bridge the gap between research and the ‘real life’ problems faced by implementers in applying new science to local-level programmes. Recent groundbreaking research is providing new evidence that promises to reduce new HIV infections significantly – witness the ‘treatment as prevention’ and ‘male circumcision in generalized epidemic setting’ breakthroughs. But the challenge is in applying this new knowledge equitably, because the most marginalized often lose out on the benefits of new knowledge and science because they have diminished access to information and services.

If we are to apply the new science and years of implementation experience to achieving an AIDS-free generation, we will need to address the inequities that underpin the epidemic: inequities between adults and children; boys and girls; urban and rural residents; and richest and poorest families. If not addressed, the inequities in how these different groups access and make use of HIV-related services and knowledge will increase the long-term economic and social consequences of AIDS.

Finally, but not least important, it is critical that UNICEF strengthen and foster effective partnerships, especially in times of economic austerity. Our partnership goals will be to: (a) accelerate – with equity – the scale-up of high-impact HIV investments and the social and programmatic enablers; (b) diversify international and domestic funding for the children and AIDS response; and (c) advocate for AIDS- and child-sensitive responses in health, protection, education, gender and human rights.

UNICEF, the international community and national stakeholders must invest in the following high-impact HIV interventions for the underserved to diminish inequities in HIV outcomes. Only by addressing the inequities in the HIV response will we be able to accelerate the end of AIDS. UNICEF will focus on six basic programme areas that are detailed in *The Lancet* as essential components of an AIDS programme, in addition to social protection, which can ensure the most effective utilization of services and diminished stigma and discrimination: 58

a) Prevention of mother-to-child transmission of HIV;
b) HIV testing for infants, adolescents and pregnant women as a gateway to treatment and prevention;
c) Treatment;
d) Voluntary male medical circumcision in generalized epidemics;
e) Condoms;
f) Harm reduction for people who use drugs; and
g) Support to households affected by HIV.
Financial Implementation

In 2011, the overall expenditure for Focus Area 3 from UNICEF’s core budget (Regular Resources) and Other Resources (Regular and Emergency) amounted to US$ 151.4 million, representing 4.4 per cent of UNICEF’s total programme expenditure (see table below).

**Total expenditure by MTSP Focus Area, 2011 (all funding sources)**

<table>
<thead>
<tr>
<th>MTSP Focus Area</th>
<th>Total Expenditure (in USD million)</th>
<th>% of Total MTSP Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Child Survival and Development</td>
<td>1,821.9</td>
<td>52.4%</td>
</tr>
<tr>
<td>Basic Education and Gender Equality</td>
<td>711.7</td>
<td>20.5%</td>
</tr>
<tr>
<td>HIV/AIDS and Children</td>
<td>151.4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Child Protection: Preventing and Responding to Violence, Exploitation and Abuse</td>
<td>339.6</td>
<td>9.8%</td>
</tr>
<tr>
<td>Policy Advocacy and Partnerships for Children's Rights</td>
<td>358.9</td>
<td>10.3%</td>
</tr>
<tr>
<td>Other</td>
<td>91.6</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,475.0</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Total Expenditure by MTSP Focus Area, 2011 (in USD, million)**

- Basic Education and Gender Equality: $711.7 (21%)
- HIV/AIDS and Children: $151.4 (4%)
- Child Protection from Violence, Exploitation and Abuse: $339.6 (10%)
- Policy Advocacy and Partnerships for Children's Rights: $358.9 (10%)
- Other: $91.6 (2.6%)

**Total Expenditure: $3,475**
In 2011, UNICEF’s largest expenditure for HIV/AIDS and children was in the Eastern and Southern Africa region, followed by the West and Central Africa region. Together they accounted for 66.6 per cent of total expenditure for HIV/AIDS and children.

Expenditure by region and funding source for HIV/AIDS and children, 2011

<table>
<thead>
<tr>
<th>Region</th>
<th>Regular resources (in USD, million)</th>
<th>Other resources - regular (in USD, million)</th>
<th>Other resources - emergency (in USD, million)</th>
<th>Total expenditure (in USD, million)</th>
<th>Total expenditure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESARO</td>
<td>14.8</td>
<td>58.0</td>
<td>3.8</td>
<td>76.6</td>
<td>50.6%</td>
</tr>
<tr>
<td>WCARO</td>
<td>12.8</td>
<td>10.3</td>
<td>1.2</td>
<td>24.2</td>
<td>16.0%</td>
</tr>
<tr>
<td>EAPRO</td>
<td>4.8</td>
<td>8.7</td>
<td>0.4</td>
<td>13.9</td>
<td>9.2%</td>
</tr>
<tr>
<td>ROSA</td>
<td>7.0</td>
<td>4.1</td>
<td>0.3</td>
<td>11.4</td>
<td>7.5%</td>
</tr>
<tr>
<td>HQ</td>
<td>1.9</td>
<td>5.9</td>
<td>0.0</td>
<td>7.8</td>
<td>5.2%</td>
</tr>
<tr>
<td>TACRO</td>
<td>1.1</td>
<td>5.2</td>
<td>0.4</td>
<td>6.7</td>
<td>4.4%</td>
</tr>
<tr>
<td>MENA</td>
<td>1.0</td>
<td>3.8</td>
<td>0.6</td>
<td>5.5</td>
<td>3.6%</td>
</tr>
<tr>
<td>CEE/CIS</td>
<td>1.1</td>
<td>4.1</td>
<td>0.1</td>
<td>5.3</td>
<td>3.5%</td>
</tr>
<tr>
<td><strong>All Regions</strong></td>
<td><strong>44.6</strong></td>
<td><strong>99.9</strong></td>
<td><strong>6.8</strong></td>
<td><strong>151.4</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Within Focus Area 3, key result area (KRA) 1 and KRA2 received a large and nearly equal share of expenditures, followed by KRA2.

### Expenditure by key results area for HIV/AIDS and children, 2011

<table>
<thead>
<tr>
<th>Key results area</th>
<th>Total Expenditure (in USD, million)</th>
<th>Total Expenditures %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KRA1</strong> - Reduce the number of pediatric HIV infections; increase the proportion of HIV-positive women receiving antiretroviral drugs (ARVs); increase the proportion of children receiving treatment for HIV/AIDS</td>
<td>56.6</td>
<td>37.4%</td>
</tr>
<tr>
<td><strong>KRA2</strong> - Support national capacity to increase the proportion of children orphaned or made vulnerable by HIV/AIDS receiving quality family, community and government support</td>
<td>28.2</td>
<td>18.6%</td>
</tr>
<tr>
<td><strong>KRA3</strong> - Support reduction of adolescent risk and vulnerability to HIV/AIDS by increasing access to and use of gender-sensitive prevention information, skills and services</td>
<td>57.1</td>
<td>37.8%</td>
</tr>
<tr>
<td>Cross-cutting*</td>
<td>9.6</td>
<td>6.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>151.4</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

* The cross-cutting category includes cost recovery and other cross-cutting expenditures.

### Expression of Thanks

UNICEF expresses its sincere appreciation to all the donors that have supported our work in the thematic area of HIV/AIDS and children and have made possible the results described in this report. In particular, we are grateful to the governments of Sweden, Liechtenstein and Canada. Special thanks also go to the UNICEF National Committees of Korea, Netherlands, Finland, United States and the United Kingdom, which have contributed generously. Thematic funding is important because it provides greater flexibility and longer-term planning and sustainability of programmes in order to achieve our MTSP results.
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral</td>
</tr>
<tr>
<td>CARI</td>
<td>children and AIDS regional initiative</td>
</tr>
<tr>
<td>CEE/CIS</td>
<td>Central and Eastern Europe and the Commonwealth of Independent States</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton health access initiative (CHAI)</td>
</tr>
<tr>
<td>EAPRO</td>
<td>East Asia and Pacific Regional Office</td>
</tr>
<tr>
<td>eMTCT</td>
<td>global plan to eliminate new HIV infections in children by 2015</td>
</tr>
<tr>
<td>ESARO</td>
<td>Eastern and Southern Africa Regional Office</td>
</tr>
<tr>
<td>GFATM</td>
<td>global fund to fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GNP+</td>
<td>global network of people living with HIV</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HPTN</td>
<td>HIV prevention trials network</td>
</tr>
<tr>
<td>IATT</td>
<td>interagency task team</td>
</tr>
<tr>
<td>ICT</td>
<td>information communication technology</td>
</tr>
<tr>
<td>MBP</td>
<td>mother baby pack</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MENA</td>
<td>Middle East and North Africa</td>
</tr>
<tr>
<td>MNCH</td>
<td>maternal, newborn and child health</td>
</tr>
<tr>
<td>MTCT</td>
<td>mother-to-child transmission</td>
</tr>
<tr>
<td>MTSP</td>
<td>Medium-Term Strategic Plan</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS</td>
</tr>
<tr>
<td>PLWH</td>
<td>people living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>ROSA</td>
<td>Regional Office for South Asia</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>TACRO</td>
<td>Latin America and the Caribbean Regional Office</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
</tr>
<tr>
<td>UNITAID</td>
<td>international drug purchase facility</td>
</tr>
<tr>
<td>WCARO</td>
<td>West and Central Africa Regional Office</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
ENDNOTES

1 The relevant Millennium Development Goals are: Eradicate extreme poverty and hunger (Goal 1); Achieve universal primary education (Goal 2); Promote gender equality and empower women (Goal 3); Reduce child mortality (Goal 4); Improve maternal health (Goal 5); Combat HIV/AIDS, malaria and other diseases (Goal 6).
2 UNICEF. Taking Evidence to Impact: Making a difference for vulnerable children living in a world with HIV and AIDS. 2011.
10 Kaiser Family Foundation, 2011
13 WHO, Women and Health: Today’s evidence tomorrow’s agenda, 2009
14 WHO. Women and Health: Today’s evidence tomorrow’s agenda, 2009
15 Source needed
21 Eastern and Southern Africa (from 52 per cent to 61 per cent), Central Asia (from 73 per cent to 84 per cent) and East, South and South-East Asia (from 18 per cent to 30 per cent).
24 Angola, Bahamas, Burkina Faso, Botswana, Democratic Republic of the Congo, Chad, Ethiopia, Gabon, Ghana, Haiti, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Namibia, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.
25 Researchers use ‘serodiscordant’ to describe couples where one individual is HIV-positive and the other is HIV-negative.
28 UNICEF. Taking Evidence to Impact: Making a difference for vulnerable children living in a world with HIV and AIDS. 2011.
29 Socially marginalized populations vary by setting, but science has demonstrated increased risk for HIV infection among certain populations across cultural settings: injection drug users (IDU), men who have sex with men (MSM) and sex workers
30 Data on sub-Saharan Africa refer to the most recent year available for 2005-2010.
40 AIDS, DHS, MICS and other national household surveys, 2005-2009
41 UNAIDS. Making the law work for the HIV response, 2010.
42 2011 expenditure data is provisional.
43 2011 expenditure data is provisional.
Building on the UNAIDS Outcome Framework for 2009–2011, the Division of Labour consolidates UNAIDS support to countries on HIV in 15 areas. Each area has one or two convening agencies – each with relevant mandates and technical expertise – to both facilitate the contributions of broader UNAIDS family partners and ensure the quality of overall results in the respective area.

Angola, Botswana, Burundi, Cameroon, Chad, Côte d’Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

[$101m – figure reported in 2010 Thematic Report].

Lesotho, Malawi, Rwanda, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe

UNICEF as a Global Fund principal recipient

UNICEF as a Global Fund sub-recipient.

Angola, Burundi, Ethiopia, Kenya, Malawi, Namibia, Rwanda, Zambia, Botswana, Eritrea, Mozambique, Somalia, South Sudan, Swaziland and Zimbabwe


Generalized HIV Epidemic: The HIV prevalence rate is >1 per cent in the general population. Concentrated HIV Epidemic: The HIV prevalence rate is <1 per cent in the general population, but >5 per cent in at least one high-risk subpopulation, such as MSM, IDUs, commercial sex workers (CSWs), or the clients of CSWs

Albania, Bosnia and Herzegovina, Moldova, Montenegro, Romania, Serbia and Ukraine

Belarus, Moldova, the Russian Federation, Tajikistan and Ukraine

Albania, Bosnia and Herzegovina, Moldova, Montenegro, Romania, Serbia and Ukraine


Narrating the Social Relations of Initiating Drug Use: Transitions in Self and Society, Rhodes et. al, International Journal of Drug Policy 2011; and “Back then” and “Nowadays:” Social transition narratives in accounts of injecting drug use in an East European Setting, Rhodes T., Bivol S. Social Science and Medicine, 2011

Towards an Improved Investment Approach for and effective response to HIV/AIDS', The Lancet, V337, June 11, 2011, 2031-41

2011 expenditure data is provisional.