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Report of the Chair of the Committee of Cosponsoring Organizations

I. Context: the current status of the epidemic

After more than two decades, the expansion of the AIDS pandemic shows little sign of slowing: in 2004 nearly 5 million people were newly infected with HIV and more than 3 million died of AIDS, increasing the total number of deaths since the beginning of the epidemic to 20 million people. The number of people living with HIV and AIDS increased to almost 40 million, the highest level ever. And women now make up about half of all people living with HIV and AIDS worldwide. The trend of the feminization of the epidemic has continued and impact on adolescents and young adults, who account for one half of the new infections, remains disproportionate. Some 2.2 million of new infections were children; more than 14 million children lost one or both parents due to AIDS.

While more than 60% of people living with HIV live in sub-Saharan Africa, the fastest expansion of the epidemic is currently seen in Eastern Europe and Central Asia. This is mainly due to the use of contaminated injecting equipment among injecting drug users. In addition, South and South-East Asia are currently experiencing serious and expanding epidemics. There are some encouraging signs that the epidemic is beginning to be contained in a small but growing number of countries, but, according to the findings put forth in the 2005 Report of the Secretary-General, much of the world is at risk of falling short of the targets set forth in the 2001UNGASS *Declaration of Commitment on HIV/AIDS*.

International commitment to address HIV and AIDS has increased significantly over the past years, as have the financial resources made available for HIV and AIDS: in 2004, overall US$ 6.1 billion were available to address AIDS, including national budget allocations as well as international assistance such as from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank Multi-Country AIDS Programme, various foundations, and bilateral funding.

II. The response of the UNAIDS family in a changing environment

Over the past twelve months, the UNAIDS family—the ten cosponsors and the Secretariat—has continued to address the pandemic in an environment of increasing complexity, which has required urgent joint and strategic action. Under the guidance of the heads of agencies of the Cosponsors and the Secretariat, the global coordinators of the Cosponsors and specific focal points from the Secretariat developed the strategic direction for such joint action. Further to actions and achievements highlighted in the report of the UNAIDS Executive Director, this report seeks to highlight some joint and synergistic action on selected current priority issues.

The "Three Ones"

The number of major players and the funds available for the response to HIV and AIDS have dramatically increased in the last few years. While this is a positive development, it has resulted in a lack of coordination and points out a critical need for harmonization at the country level. The traditional ways of doing business at country level have resulted in fragmentation, duplication, waste and inefficient use of resources and inadequate strategic focus. Improving implementation at the country-level and ensuring better coordination and harmonization among all players are critical to accelerating and sustaining the global response to HIV and AIDS.

United in the determination to enhance coordination and strategic impact of national AIDS programmes, a broad range of stakeholders has reached consensus on the approach known as the "Three Ones": one national strategic plan, one national coordinating authority, and one national monitoring and evaluation system in each country. The UNAIDS family has played a leading role over the last two years in forging this global consensus. Leaders from donor and low- and middle-income country governments, civil society, UN agencies and other multilateral and international institutions met on 9 March 2005 and agreed to form a Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors that will make recommendations for improving the performance of the international architecture supporting country-led national programmes to scale up the AIDS response. The Global Task Team and its three working groups are composed of various stakeholders including representatives of national AIDS programmes, civil society, UN agencies and donors.

The UNAIDS family is represented in the Global Task Team by the UNAIDS Secretariat, UNDP, UNICEF, WHO and the World Bank; and is also represented in each of the three working groups. The Working Group on Harmonization of Programming and Financing is co-chaired by the World Bank with the World Food Programme representing all Cosponsors; the Working Group on Harmonization of Technical Support is co-chaired by WHO, with UNDP representing Cosponsors. The UNAIDS Secretariat, WHO and the World Bank represent the Cosponsors in the Working Group on Harmonization of Monitoring and Evaluation. The UNAIDS Cosponsors and the Secretariat are working closely together to translate the "Three Ones" into action, but it requires a sustained commitment by the major donors to put these principles into practice.

The UNAIDS Cosponsors and the Secretariat are committed under national leadership to promote and support the "Three Ones" principles. This is clearly demonstrated in the 2006-2007 Unified Budget and Workplan. The Workplan recognizes the imperative of promoting and supporting adherence to the "Three Ones" principles to enhance the strategic coordination and effectiveness of diverse stakeholders at country-level, which is crucial to "making the money work".

Unified Budget and Workplan

The proposed Unified Budget and Workplan for 2006-2007 is the result of a series of consultations between members of the UNAIDS family as well as internally, within Cosponsors. The overarching goal was to identify priority areas where UNAIDS can make a difference and to clarify roles and responsibilities. The result is a strategic framework for the work of both Cosponsors and the Secretariat, capitalizing on the value added of each. The Workplan has been streamlined, reducing the number of key results—which fall under the responsibility of specific Cosponsors or the Secretariat—from 487 to 49. The results-based structure has also been strengthened. For the first time, the Unified Workplan contains a set of 16 results at the level of the Joint Programme as a whole, each with specific achievement indicators, providing the basis for better reporting and management, and a much more transparent level of accountability. The Workplan contains also a significant interagency component, which provides further opportunities for joint programming at global and regional levels, such as capacity building and meeting specific regional needs.

Scaling up treatment: the "3 by 5" Initiative

At the end of 2003, less than 10% of people in need of antiretroviral therapy for HIV and AIDS had access to it, despite tremendous scientific progress and rapidly falling prices for HIV and AIDS medicines. In response, WHO and UNAIDS initiated a global effort to treat at least half of those in need in low- and middle-income countries—3 million people—by the end of 2005. This "3 by 5" target is an interim step towards the ultimate goal of universal access to antiretroviral therapy.

During 2004, strong foundations were laid for a sustainable increase in HIV and AIDS treatment and care and the simultaneous acceleration of prevention efforts:

- new funding for HIV and AIDS responses, including antiretroviral treatment, has been made available through a wide range of donors and financing instruments;
- more than 40 countries have committed to scaling up treatment and have appealed to WHO and UNAIDS for assistance;
- country capacity is being built to procure and deliver essential HIV and AIDS medicines and other commodities as part of a comprehensive response to HIV and AIDS, and;
- innovative new partnerships have been developed to provide opportunities for communities, including people living with HIV, to join with governments and the private sector in bringing comprehensive national programmes to scale.

Significant progress has been made toward achieving the "3 by 5" target in the past year. By the end of 2004, 35 countries had developed national treatment scale-up plans and more than 3000 service outlets were providing antiretroviral therapy. The number of people on antiretroviral therapy in low- and middle-income countries increased from 400 000 in July 2004 to 700 000 by the end of 2004, in line with the milestone established for the end of 2005. This growth has continued during the first several months of 2005, and it is expected that there will be substantial further progress in the next semi-annual progress report, due shortly. While much has been accomplished, even more remains to be done. Reaching the "3 by 5" target will require an exponential growth in the capacity to procure and deliver antiretroviral medicines to those most in need.

Scaling up prevention

The trends in increasing numbers of people being infected with HIV year on year are of major concern, posing a critical threat to the entire AIDS response. While proven prevention strategies exist and are vital for young people, drug users and other vulnerable and key populations, such as displaced populations, information and services reach only a fraction of those who need them. And, while vulnerability issues continue to help drive infection rates, most countries have yet to exert the level of effort required to address the factors that increase vulnerability to infection. In 2002, it was estimated that implementation of a comprehensive prevention package could avert 29 million (63%) of the 45 million new infections expected to occur between 2002 and 2010.

As a catalyst to narrowing the prevention gap, and in response to PCB recommendation from its 15th meeting in June 2004, the Cosponsors and the Secretariat—in extensive consultation with numerous stakeholders, including national governments, civil-society organizations, young people, organizations of key populations and donors—have developed a policy position paper on intensifying HIV prevention that outlines ten essential policies and ten essential programmatic actions for HIV prevention framed by six overarching principles upon which national level actions are to be built. This paper is being presented at this PCB meeting. The next steps will include dynamic operationalization of the UNAIDS prevention action plan which is being finalized to be implemented in concert with and in complement to the implementation of the recommendations of the Global Task Team noted above and in line with the recommendations emanating from the UNGASS on HIV/AIDS review and the upcoming Millennium Summit.

The UNAIDS family has also taken opportunities over the past year for actions and initiatives towards strengthening prevention with each leading in its area of comparative advantage working in collaboration with partners. Some examples include the following.

- In line with the recommendations in the Policy Position Paper; Intensifying HIV Prevention, the WHO-led “3 by 5” initiative—as noted above—provided unprecedented opportunities for an acceleration of prevention efforts by reducing infection, strengthening health systems, including diagnosis and treatment of sexually transmitted infections, improving access to confidential voluntary counselling and testing, increasing community awareness, and increasing the number of people who know their HIV status.

- UNFPA has spearheaded efforts towards strengthening linkages between sexual and reproductive health and HIV/AIDS which has led to the Glion Call to Action (with WHO) linking family planning and prevention of mother-to-child transmission and the New York Call to Commitment, which articulates a comprehensive framework to maximize the use of sexual and reproductive health services to strengthen the global AIDS response.
- UNFPA and partners have expanded youth-adult partnerships focused on access to information, education and services, launched a 20-country initiative on the female condom, and put in place a reproductive health commodities security trust fund to help alleviate shortfalls including for preventive commodities.
- Cosponsors have also come together in support of the Global Coalition on Women and AIDS, whose work focuses on seven action areas which contribute directly to prevention, prevention-treatment-care synergies, or vulnerability reduction.
- The World Bank is one of the largest financiers of prevention efforts worldwide.

Near-term future action and focus are outlined within the Unified Budget and Workplan 2006-2007 and the Policy Paper; Intensifying Prevention and echoed in the UN System Strategic Framework on HIV/AIDS 2006-2010, which broadens strategic guidance further across the UN system. Overall, with the need for greater coverage of effective prevention efforts, the UNAIDS family will continue to work towards harmonization and coordination of efforts, strengthened support to global and national HIV-prevention efforts and provision of clearer accountability for results.

The development of the Policy Position Paper; HIV Prevention coincided with the development of the Global Initiative on HIV/AIDS and Education, launched by the Cosponsors and the Secretariat in March 2004. This initiative, led by UNESCO, seeks to enhance national responses against the epidemic by helping governments and other key stakeholders to implement comprehensive, nation-wide and collaborative education programmes for young people, especially those who are at highest risk of exposure to HIV.

As part of an overall UNAIDS prevention strategy, and in concert with all relevant development partners, the Global Initiative contributes to existing international goals, notably the Millennium Development Goals, goals set by the United Nations General Assembly Special Session on HIV/AIDS, and Education For All. The emphasis is on working closely with national authorities and other stakeholders at the country level in accordance with the “Three Ones” principles.

Within the framework of the Global Initiative, UNESCO has led the prioritization of efforts in the area of prevention education in the context of its five established core tasks within its HIV/AIDS and prevention education strategy:

- advocacy, expansion of knowledge and enhancement of capacity;
- customizing the message and finding the right messenger;
- reducing risk and vulnerability;
- ensuring rights and care for the infected and affected, and;

- coping with the institutional impact.

Guiding the efforts of the Cosponsors and UNESCO's work will be strong consideration of widely recognized essential characteristics of effective prevention, including a special focus to ensure that approaches are gender responsive, culturally appropriate, age-specific, and seek to involve people living with HIV in appropriate and meaningful ways.

Joint action for children affected by HIV and AIDS

During the past 12 months, the UNAIDS family under the leadership of UNICEF has continued to urge national authorities and international partners to be more responsive to the needs of children affected by HIV and AIDS.

In 2004, 16 sub-Saharan countries completed rapid assessments and action plans for national responses to this growing problem, with support from UNAIDS, WFP, UNICEF and USAID. However, the challenge in many countries is for the government to implement nation-wide responses. In addition, Burkina Faso, Cameroon, the Central African Republic, Gabon, Ghana and Senegal have also completed draft national strategies or policies for children affected by HIV and AIDS.

As a measure of improved support to national efforts, the revitalized and expanded Inter-Agency Task Team on Children and AIDS has been focusing on action and impact at country level and has developed a work-plan to support the implementation of the recommendations of the second Global Partners' Forum, convened jointly by UNICEF and the World Bank in December 2004. Participants from a wide range of stakeholder organizations agreed to focus on key joint actions, including abolishing school fees, tracking resources and programmes for and with children affected by HIV and AIDS, and setting treatment targets for children.

In East and Southern Africa, the UNAIDS family is learning from the use and potential of social protection mechanisms for AIDS-affected households and children, including use of cash transfers in Kenya.

WHO, the William J. Clinton Foundation and UNICEF also contributed to drawing international attention to paediatric care, support and treatment. This included a series of consultative meetings with partners to review programming experience, promote the development of appropriate paediatric drug formulations and model the burden of disease in children.

USAID, UNAIDS and UNICEF published *Children on the Brink 2004*, which was launched at the XV International AIDS Conference held in Bangkok. The UNAIDS family also worked on cost estimates for a comprehensive global response to the needs of orphans and vulnerable children and established a set of indicators of progress in this area.

To help address the growing crisis around children affected by HIV and AIDS, and in collaboration with a wide range of partners, UNICEF is spearheading a global action, advocacy and fund-raising campaign for children affected by HIV and AIDS. Included

will be those infected, orphaned, or made vulnerable by the disease. The Global Campaign on Children and AIDS will be launched at the end of 2005.

The triple threat of HIV and AIDS, food insecurity and governance

The triple threat of HIV and AIDS, weakened governance and food insecurity has demanded an accelerated and intensified response to the epidemic in Southern Africa. The UN Regional Inter-Agency Coordination Support Office for the Special Envoy for Humanitarian Needs in Southern Africa is helping to ensure the full coordination of regional activities. The partnership includes UNICEF, WFP, UNDP, UNFPA, WHO, UNAIDS Secretariat, FAO and OCHA, and, working in collaboration with UNHCR, national governments, key stakeholders and the South African Development Community (SADC), will strengthen responses to the triple threat and mobilize donor support.

The Regional Directors Team, comprising WFP, UNICEF, UNAIDS Secretariat, UNDP, UNFPA, WHO, FAO and OCHA, was established to support country teams in Southern Africa in addressing the triple threat and working towards the Millennium Development Goals. A number of UNAIDS cosponsors are implementing joint activities to address the impacts of HIV and AIDS, weakened governance and food insecurity. For example, activities include the following.

- UNICEF and WFP are working with FAO and other partners to establish Junior Farmer Field and Life Schools to teach agricultural techniques to children and young people affected by AIDS. The schools aim to share agricultural knowledge, and business and life skills with orphans and vulnerable children between the ages of 12 and 18.
- WHO, UNAIDS Secretariat, WFP, UNICEF, UNDP, UNFPA and FAO have participated in joint programming missions to Swaziland and Malawi to redefine strategies for scaling-up HIV and AIDS responses.
- UNFPA and WFP are addressing links between HIV and AIDS, gender-based violence and vulnerability relating to food shortages; and WFP, WHO, UNICEF and the UNAIDS Secretariat have worked to assess evidence, lessons learned and recommendations for action on malnutrition, food insecurity and HIV and AIDS.
- UNHCR, WFP and UNICEF have developed practical guidance on implementing programme strategies that incorporate both HIV and AIDS and food security/nutrition activities in refugee settings.
- An interagency HIV and AIDS in the workplace initiative is being established by FAO, WFP, UNDP, UNAIDS Secretariat, OCHA and WHO. The regional initiative will involve workshops for spouses and children, life skills training sessions, and regular forums for staff members.

To sustain and develop the human and institutional capacities needed to deliver basic social services, UNDP is implementing the Southern Africa Capacity Initiative (SACI) in partnership with cosponsors and national and regional stakeholders. The initiative focuses on alleviating capacity shortages due to AIDS across government, civil society and the private sector. SACI is helping to strengthen national responses to the triple threat by creating innovative partnerships to deliver essential services, and providing support for

filling critical shortfalls on an emergency basis through national, regional and international UN Volunteers.

In 2004, more than 130 trained UN volunteers were placed in ministries and local governments in Lesotho, Malawi, Mozambique, Namibia, Swaziland and Zambia. System-wide capacity assessment, data collection and empirically-based analysis has been undertaken in Botswana and Zambia to determine how HIV is affecting the supply and demand for services; assessment plans and workshops have been carried out in Botswana, Malawi, Namibia and Swaziland to reorganize public service delivery for maximum outreach. In partnership with WHO and UNV, UNDP's Community Capacity Enhancement Initiative has trained over 500 facilitators to build capacity in communities for addressing issues relating HIV and AIDS and treatment literacy and access, to support SADC countries in meeting their committed targets under the WHO-led "3 by 5" initiative.

HIV and AIDS among injecting drug users and prison inmates

Except for sub-Saharan Africa, the use of contaminated injection equipment among injecting drug users remains in many countries the most important or at least a very significant route of HIV transmission. There are approximately 13.2 million injecting drug users worldwide, and in many countries of Europe, Asia, the Middle East and the Southern Cone of Latin America, the use of non-sterile injection equipment by injecting drug users is accounting for between 30% and 80% of all reported infections. Epidemics related to injecting drug use spread more rapidly than sexually transmitted HIV epidemics: Soon after HIV is introduced into a community of injecting drug users infection levels among them can rise from 0% to 50% or 60% within one or two years, sometimes even in shorter periods of time. From injecting drug users, the virus moves through sexual transmission to their partners, and, as there is considerable overlap between sex working and drug injecting populations, via so-called bridging populations to the general public. In many countries, HIV epidemics started among injecting drug users before they became generalized epidemics.

In addition, HIV infection rates in prisons are generally higher than in the community. There are worldwide at any given time approximately 10 million prisoners with an annual turnover of 30 million. While some prison inmates are being infected outside prison, a significant percentage of them are being infected inside the institution. Frequent sharing of contaminated drug injection equipment is the predominant mode of HIV transmission among prisoners. HIV is also transmitted in prisons through unsafe sexual behaviour, sometimes associated with sexual violence. Prison overcrowding, gang violence, lack of protection for the youngest inmates, corruption and poor prison management increase significantly the vulnerability to HIV transmission among inmates.

To highlight the spread of HIV across the countries of the Commonwealth of Independent States (CIS), where the use of contaminated injection equipment among injecting drug users and HIV transmission in prisons play major roles, and to launch a broad-based response to the growing epidemics, cosponsors and the Secretariat, with UNODC in the lead, collectively organized a Ministerial Meeting in Moscow, on 31 March to 1 April 2005. CIS Ministers of

Health, Justice, Interior and their representatives, and representatives of civil-society organizations attended the meeting, hosted by the Russian Federation.

After reviewing the context and the impact of the epidemics in the region, the meeting addressed specifically HIV- and AIDS-issues related to young people, injecting drug users and inmates in prisons. The meeting participants concluded, inter alia, that:

- A series of factors make the region highly vulnerable to HIV including injecting drug use, rapid social change, population mobility, instability, conflict and displacement, lack of knowledge in the general population and the presence of other vulnerable groups.
- The epidemic in CIS countries is now at a critical point—moving from vulnerable groups to the general population. The proportion of new infections through heterosexual contact is steadily increasing.
- Leadership—especially political leadership—is required both to raise the profile of HIV and AIDS in general and of vulnerable populations specifically, and undercut fear, stigma and discrimination.
- Better coordination and cooperation among organizations and entities in addressing HIV and AIDS, both at national and international levels, is essential.
- Civil Society is an essential partner particularly as a channel to reaching vulnerable groups.
- Young people must be engaged as a proactive part in the response to HIV and AIDS.
- Intensified HIV-related action in prisons is needed. Prison populations are highly vulnerable to HIV, and, given the large number of people entering and leaving prison systems, HIV in prisons cannot be separated from HIV in society.

Governments represented at the meeting adopted a Joint Declaration[1], which identified a series of actions to accelerate the implementation of the UNGASS *Declaration of Commitment on HIV/AIDS*. UNAIDS was called upon to reinforce joint actions in support of country-led responses to HIV/AIDS in the Member States of the CIS, through the strengthening of policy and legislative dialogue, capacity building and technical assistance as well as resource mobilization and partnership building. In a subsequent meeting, the CCO discussed possible ways of intensifying support to countries of the CIS and reiterated its common positions for interventions addressing the vulnerability to HIV of injecting drug users.

III. Challenges for 2005-2006

For 2005-2006, the UNAIDS family will face numerous challenges inherent to the AIDS pandemic. These include (to mention only a few):

- scaling up of the response to HIV and AIDS;
- taking steps to ensure effective use of resources and provide more, better and better coordinated and harmonized technical assistance at the country level;

[1]Available at http://www.unodc.org/unodc/en/event_2005-03-31_1.html

- intensifying prevention, treatment and care, by, among other things, developing and implementing an operational plan of the Policy Position Paper; Intensifying HIV Prevention;
- intensifying collective action to prevent major epidemics in so-called new wave countries;
- implementing the recommendations emanating from the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors, and;
- supporting countries towards the achievement of the targets of the UNGASS *Declaration of Commitment on HIV/AIDS* and the Millennium Goals.

The UNAIDS family will also continue to address more internal and urgent challenges, including working better and more efficiently together, and addressing HIV and AIDS in the UN workplace in a more collective manner.

Working better and more efficiently together

The recent five-year evaluation of UNAIDS highlighted the limited impact the CCO has had in "ensuring the coherence of the overall UNAIDS programme and individual agency contributions". Various factors are mentioned as causes, including interagency competition, ambiguity and different expectations as to the CCO's role, and lack of clarity on the relationship between the Secretariat and actions of individual agencies under the auspices of the Joint Programme.

Moreover, additional recent developments, such as the increase in the number of Cosponsors to ten, the expansion of the Programme's activities, the evolution of the Secretariat's role as well as the changes in the course of the epidemic itself, have modified the dynamics of interaction within UNAIDS, calling for a critical re-examination of the functioning of the CCO.

The UNAIDS family has hired the Boston Consulting Group to carry out a review to identify how to improve the Committee's performance, maximize the strengths of each Cosponsor and promote shared ownership and accountability as well as effective cooperation among partners in the Joint Programme. Current UN reform efforts will represent the backdrop against which the analysis will be conducted.

The Consulting Group’s involvement will provide UNAIDS with an independent, objective and fact-based assessment of the situation and a clear set of recommendations for improvements aimed at enhancing the CCO's effectiveness and accountability.
It is hoped that the Consulting Group will recommend necessary improvements to be made to the CCO and its organizational structure, roles, resources, processes and mechanisms at global and country level. These recommendations will be presented to the CCO in October 2005 and all PCB members will be advised of these recommendations and follow-up action. The PCB Chair and a representative of a civil-society group will be on the review's reference group.

HIV and AIDS in the UN workplace

One of the challenges faced by the UN system is the implementation of HIV and AIDS policy and programmes in the context of its own workplace. Since 2002, the Heads of Agencies have committed themselves to scale up the implementation of the UN HIV/AIDS Personnel Policy based on the ILO *Code of Practice on HIV/AIDS and the World of Work*. Relentless advocacy has resulted in more countries and more agencies on board but a number of challenges still exist in terms of promoting compliance with the ILO *Code of Practice* and a more comprehensive and collective UN workplace response to HIV and AIDS. These include the following.

1. Protection of the rights of those infected and/or affected by HIV and AIDS

- *Moving towards a single UN policy and programme on HIV and AIDS in the workplace*: the UN system still does not have a common system-wide approach that takes account of the organizational impact of HIV and AIDS on its human resources and operations. While some agencies have managed to develop their own workplace programmes and budget, others with limited staff and financial resources are not in a position to do so at this point or do not consider it necessary.
- *Accountability framework:* there is a need to agree upon a global accountability framework for HIV- and AIDS-related workplace programmes based on monitoring and evaluation indicators in consultation with the relevant workplace stakeholders. A draft accountability framework and areas for common services and assistance are currently under discussion within the Human Resources Task Force with an aim to present to the CCO and HLCM in October of this year.
- *Stigma and discrimination:* the challenge is how to integrate HIV and AIDS workplace issues into general staff policies, to ensure protection of rights such as confidentiality while encouraging a more open environment for the Greater Involvement of People living with AIDS (GIPA principle), and to provide appropriate remedies where rights are violated.
- *Gender-sensitive programmes:* there is a need to recognise the links between gender equality and HIV and AIDS in the UN workplace and the differential impact of HIV and AIDS on men and women.
- *Commitment and action:* the identification and appointment of full time focal points in all agencies with adequate working budgets is not yet achieved, in order to move forward, improve coordination and strengthen the UN response.

2. Prevention through education and training

- *Moving from learning and awareness to action*—building on *Know Your Status* and implementation of the learning strategy to achieve sustainable behaviour change practices.
- *Building the capacity and competence of professional staff* to address HIV and AIDS in the UN workplace and in their programmatic work, including mainstreaming HIV and AIDS modules in other appropriate learning activities. Special emphasis is to be placed on the needs of humanitarian staff in emergency *contexts.*

3. Access to care and treatment for staff and dependants

- *Improving access to medical care*: as treatment becomes more affordable and accessible, there is an urgent need to revise the health insurance to include better coverage for short-term staff and to ensure that all workers on the UN premises have access to adequate means of protection.
- *Extending coverage of HIV and AIDS policies* through inserting 'HIV/AIDS conditionality' clauses in licensing contracts requiring compliance with the ILO *Code of Practice* and respect for basic conditions of work as a prerequisite for UN partners and implementing agencies. For example, ILO and UNHCR are collaborating on work place policy development for nongovernmental organization partners in the South African region to ensure that supportive, non-discriminatory work place environments exists for nongovernmental organizations and their families.

IV. Concluding remarks

Guided by the Committee of Cosponsoring Organizations, the UNAIDS family—the ten cosponsors and the Secretariat—continued to strengthen collective action in 2004-2005 to address the pandemic of AIDS in a changing and increasingly complex environment. Some examples of these joint activities and collective initiatives are provided in this report. The Committee remained an important forum for strategic planning and policy development, and a driving force for an increased UN response in support of countries to address HIV and AIDS. While each of the Cosponsors has its comparative advantage and area of expertise in the field of HIV and AIDS, the CCO mechanisms continued to be a forum of support and frank peer review in the UNAIDS family.