

UNAIDS PROGRAMME COORDINATING BOARD

UNAIDS/PCB (33)/13.23
Issue date: 19 May 2014

THIRTY-FOURTH MEETING

Date: 1-3 July 2014

Venue: Executive Board room, WHO, Geneva

Agenda item 1.2

Report of the 33rd Meeting of the Programme Coordinating Board

Additional documents for this item: *none*

Action required at this meeting – the Programme Coordinating Board is invited to: *adopt*
the report of the 33rd Programme Coordinating Board meeting.

Cost implications for decisions: *none*

1.1 OPENING OF THE MEETING AND ADOPTION OF THE AGENDA

1. The 33rd meeting of the UNAIDS Programme Coordinating Board (PCB) took place at the Executive Board room of the World Health Organization (WHO) in Geneva, Switzerland on 17-19 December 2013. The agenda for the meeting is attached as Annex 1.
2. The PCB Chair, Mr Lov Verma, Secretary, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India, welcomed participants to the 33rd meeting. The Board observed a minute of silence in memory of all who had passed away from AIDS since the last meeting. The Board also paid tribute to the late Nelson Mandela, and a video was screened that highlighted his influential role in and commitment to the AIDS response.
3. The draft annotated agenda (UNAIDS/ Board (33)/13.14) was adopted with no amendments, as indicated by the Chair (Annex 1).

1.2 CONSIDERATION OF THE REPORT OF THE THIRTY SECOND MEETING

4. The Board adopted the report of the 32nd meeting (UNAIDS/ Board (32)/13.13).

1.3 REPORT OF THE EXECUTIVE DIRECTOR¹

5. The Executive Director of UNAIDS, Mr Michel Sidibé, began by thanking India for chairing the Board over the past year. The Executive Director acknowledged India's leadership in spearheading the 2013 ECOSOC Resolution on the Joint Programme jointly with the PCB Vice-chair, Australia, and, more broadly, engaging in the BRICS countries to enable greater access to low-cost, high-quality medicines, such as antiretroviral treatment, that has given hope to millions of people living with HIV around the world.
6. The Executive Director congratulated Ms Phumzile Mlambo-Ngcuka on her appointment as the new Executive Director of UN Women and said he is looking forward to strengthening the collaboration between the two organizations to address gender equality and violence against women in the context of the AIDS response in the post-2015 development agenda. The Executive Director gave a personal tribute to President Mandela—a man he described as an activist, a visionary and a pathfinder in the response.
7. The Executive Director highlighted the main activities to commemorate World AIDS Day 2013, including an event in Melbourne, Australia where he marked the day alongside Ms Daw Aung San Suu Kyi, the UNAIDS Global Advocate for Zero Discrimination. The Executive Director thanked the Government of Australia for hosting the World AIDS Day commemoration and welcomed Australia as incoming Chair of the Board, adding that Melbourne will host the 20th International AIDS Conference in July 2014.
8. Focusing on developments in the AIDS response, the Executive Director provided an overview of the latest UNAIDS data as featured in the *2013 UNAIDS Report on the global AIDS epidemic*. He drew the Board's attention to

¹ During this agenda item, the Board adjourned to allow participants to take part in a commemoration for Mr Mandela at the Palais des Nations, organized by the Government of South Africa.

a 33% decrease in new HIV infections globally since 2001, a 30% drop in mortality since 2005, and a 52% decline in new HIV infections among children since 2001. The Executive Director shared that more than 9.7 million people were accessing HIV treatment at the end of 2012.

9. In referencing the progress outlined in the 2013 Global Report, the Executive Director said that countries are updating national policies and programmatic approaches to sustain and accelerate gains in the AIDS response, citing a number of countries, such as Ghana and Ukraine that have been able to turn major HIV epidemics around.
10. The Executive Director emphasized continued headway in the Shared Responsibility and Global Solidarity agenda. In 2012 he said domestic spending on HIV accounted for more than half of global HIV resources, with more than 80 countries increasing their domestic investments for the AIDS response by more than 50% between 2006 and 2011. He cited the replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) as an example of donors' on-going commitment to the response. With the support of UNAIDS, the Executive Director highlighted that countries are developing investment cases to ensure maximum return on investments.
11. The Executive Director referenced the importance of leadership and political commitment as crucial components of the response. He named several world leaders who recently expressed their support and commitment to AIDS, from the Prime Minister of the United Kingdom, David Cameron, to the President of Uganda, HEM Yoweri Museveni. At the national level, he said countries are launching plans that are tailored to addressing the realities on the ground, such as Belgium, where the Government recognized that complacency cannot set in, and Nigeria, with the world's second largest HIV epidemic. Against this backdrop, the Executive Director expressed confidence that the goal of having 15 million people accessing HIV treatment by 2015 would be met. He said achieving this would result in avoiding 1.4 million deaths, preventing 500,000 new infections among children, and stopping 7 million children from becoming orphans.
12. Nevertheless, despite recent gains and a renewed sense of hope, the Executive Director cautioned that many significant challenges lie ahead: only one out of every three children has access to the HIV treatment; just 24% of people living with HIV in sub-Saharan Africa have an undetectable viral load; and every hour, 50 young women are newly infected with HIV. In addition, he said new infections are on the rise in several regions and countries.
13. The Executive Director said complacency is the greatest threat to the response, stating that efforts must be sustained to finish the unfinished business of the epidemic. He said that although the AIDS community no longer has to address the dichotomy of treatment versus prevention, he cautioned the importance of not neglecting primary HIV prevention. He shared with the PCB that the UNAIDS Secretariat would focus on documenting evidence of how scaling-up Pre-Exposure Prophylaxis (PrEP), voluntary male circumcision, the use of male and female condoms, and other primary prevention methods can contribute to breaking the trajectory of the epidemic.

14. The Executive Director underscored that efforts must continue to promote sexual and reproductive health and rights and comprehensive sexuality education, not only to prevent HIV infections but also early and unwanted pregnancies and unsafe abortions. In this regard, the Executive Director commended the Ministers of Health and Education from 21 countries of Eastern and Southern Africa for adopting, in partnership with young people, a Ministerial Commitment on Comprehensive Sexuality Education (CSE) and sexual and reproductive health services for youth.
15. Speaking to the growing discourse on ending AIDS, the Executive Director reiterated that reaching the three zeros will only be possible by ensuring that 'no one is left behind'. He said the AIDS response should continue to serve as an entry point to address social injustice and to eliminate the social, legal and political barriers that block access to services for the groups who are most at risk, such as people living with HIV, sex workers, people who inject drugs, men who have sex with men, transgender people, migrants and young girls. The Executive Director shared his concern over reports of several attacks targeted at civil society organizations and called for increased efforts to overcome inequality and exclusion.
16. The Executive Director congratulated Uzbekistan for lifting HIV-related restrictions on entry, stay and residence, and commended Thailand for pledging that all migrant populations can access universal health care services, including HIV treatment. The Executive Director underscored that human rights principles help ensure overall positive health outcomes.
17. Looking to the future of the AIDS response, the Executive Director underscored the importance of ensuring clear commitment and measurable goals with regard to positioning AIDS in the post-2015 development agenda, and he stressed the centrality of ending AIDS in the next development framework post-2015 agenda. He added that keeping focused on ending the epidemic will hold the international community accountable to build on progress on reaching zero HIV infections, zero discrimination and zero AIDS-related deaths.
18. The Executive Director said UNAIDS remains focused on leveraging the Joint Programme to make a difference. He cited the United Kingdom's Multilateral Aid Review (MAR) that showed out of 37 organizations UNAIDS was the only one to have moved to a higher value for money category. He said the UNAIDS strategic realignment gave donors confidence in the work of the Joint Programme, and he referenced financial commitments by Belgium, China, Denmark, Norway, Spain, Switzerland and the United Kingdom. In addition, he highlighted the partnership with the MAC AIDS Fund and its new grant for HIV treatment. The Executive Director also expressed his gratitude to the Netherlands for its readiness to go beyond the traditional donor relationship to collaborate on key populations in selected countries, based on Dutch experience.
19. Further on resource mobilization efforts, the Executive Director was pleased to announce that after Senegal and Congo, the Ivory Coast has become UNAIDS' newest African donor, providing US\$ 1 million to the core budget. He said UNAIDS is entering the new biennium in a strong financial position, thanks to the continued support of donors to UNAIDS and timely contributions to the Unified Budget, Results and Accountability Framework (UBRAF).

20. The Executive Director informed the Board that UNAIDS Secretariat would not intend to accept funds from the Global Fund for technical support. He said the strategic relationship enjoyed by Secretariat in its role as providing technical support to countries, as well as advocating and producing strategic information could potentially be jeopardized by conflicts of interest. The Executive Director encouraged donors to provide their full support to UNAIDS, which, in turn, would allow the Joint Programme to play an even greater catalytic role in ensuring that the Global Fund's New Funding Model delivers the greatest possible results for countries.
21. The Executive Director ended by acknowledging the contributions of outgoing US Ambassador Eric Goosby for his passion and leadership of PEPFAR and Ms Mabel Bianco from the PCB NGO Delegation who was participating in her last Programme Coordinating Board meeting. The Executive Director expressed his gratitude to UN Secretary-General Ban Ki-Moon for having extended him into a second term as Executive Director of UNAIDS.
22. The Chair of the Board, Mr Verma, applauded the Executive Director for his leadership, and he heralded UNAIDS as a model of partnership with diverse stakeholders working together to generate evidence-driven strategies, as well as to support key populations in claiming their human rights.
23. The Chair took the opportunity to share with the Board recent experiences from India, highlighting how an effective cross-sectoral collaboration on HIV, involving a range of ministries, has been possible. With regard to innovative financing, he highlighted the adoption of recent legislation, the Companies Act (2013), which mandates 2% of corporate profits to be transferred back into society. In addition, the Indian government has stepped up its own funding to the national HIV response, aiming to cover 70% over the next five years.
24. The Chair encouraged greater strengthening of mechanisms and platforms to promote the exchange of experience and best practices so that countries can learn from each other. Overall, the Chair said that the global health architecture should be remodelled to better support country-led responses, with specific attention devoted to TRIPS flexibilities to secure affordable, high-quality ARVs and Least Developed Countries (LDCs) in the area of technology transfer.
25. The Chair thanked the Board for supporting India in its role as Chair of the PCB in 2013 and for acknowledging India's contribution to the 2013 ECOSOC Resolution on the Joint Programme.
26. The Board expressed its thanks to the Executive Director for his leadership of UNAIDS and welcomed his appointment for a second term. The Board welcomed the Executive Director's report that provided a balanced view of results and challenges in the response. Several members recalled the uneven progress across regions captured in the report as a cause for concern that requires immediate attention and action. The rise in new HIV infections among adolescents was equally noted, with Board members calling for greater collaboration between and among different sectors and across ministries, such as health and education, to scale up and promote sexual and reproductive health and rights programmes.
27. In relation to antiretroviral treatment scale-up, while welcoming the opportunities presented by the new WHO Treatment Guidelines, some members of the Board

cautioned that treatment should not be viewed as a 'silver bullet' and that proven prevention efforts could be at risk of being side-lined. Overall, the Board recognized the need for a multi-faceted approach to guide the AIDS response with prevention efforts integral to treatment, care and support and a priority focus on key populations most at risk across all programmes.

28. The Board expressed broad support for the inclusion of HIV in the post-2015 development agenda, with several members emphasizing that concerted efforts are needed to position AIDS strategically in the post-2015 framework. The response was highlighted as a catalyst for social justice, innovative service delivery, and human rights-based programming, including the principle of GIPA (Greater Involvement of People Living with HIV/AIDS), civil society engagement, equity in access, and epidemiology for customized local responses. Several members said the post-2015 development agenda must be broadened to address stigma and discrimination, punitive laws and other challenges in relation to key populations and marginalized groups, such as transgender people, injecting drug users and youth.
29. In referencing the passing of Mr Mandela, the Board recognized the former president of South Africa as a human rights defender and for giving a voice to the voiceless. While encouraging the Board to scale-up action to eliminate stigma and discrimination in all its forms, including homophobia, transphobia and gender-based violence, one delegation quoted Mr Mandela as follows, "Democracy demands that political rights and those of minorities are protected." In this regard, several members recognized UNAIDS as a key actor in addressing the structural barriers to eliminate stigma and discrimination, and the launch of the Zero Discrimination campaign on World AIDS Day 2013 was referenced as an example of UNAIDS' contribution to this area. The role of civil society in the response was acknowledged by Board with members underscoring that the AIDS response would not be where it is today if not for the vibrant civil society movement.
30. Several Board members expressed the need to strengthen and enhance south-south cooperation and national capacity, as well as regional and inter-regional knowledge sharing. The importance of encouraging the pharmaceutical industry and other stakeholders to invest more in research and development, including in improving antiretroviral treatment regimens, was underscored. Delegations also expressed concern over several longstanding issues in the global AIDS response, notably the HIV treatment gap for children, gender-based violence as an entrenched and pressing obstacle to progress, the importance of focusing on key populations in national strategic plans, including ensuring their voices are consistently heard, and the integration of HIV with health programmes, including but also beyond tuberculosis (TB) programmes.
31. Additional challenges cited by the Board that require specific attention to address included the shortage of health workers in sub-Saharan Africa, the lack of fiscal space in many countries to scale up the response, inadequate supply and access to ARVs on a sustainable basis, and drug resistance, which several Board members urged countries to pay close attention to. The PCB NGO Delegation voiced its worry over the erosion of enabling environments for key populations to access HIV services in many countries and an overall decrease in funding for civil society organizations.

32. The situation of women and girls was pointed out by several members as requiring particular attention given that women and girls are disproportionately affected by HIV, and many members urged that renewed efforts be made to address the plight of women and girls, including tackling gender-based violence, ensuring social protection, addressing maternal mortality, strengthening health systems and delivering integrated services so that HIV services are provided along with sexual health and family planning.
33. The discussion on the many challenges in the AIDS response also saw members exchange best practices, innovations and experiences, such as China's health cooperation with countries in sub-Saharan Africa to the HIV Care continuum initiative in the United States and the on-going leadership of the President's Emergency Plan for AIDS Relief (PEPFAR). Sierra Leone shared that despite fiscal limitations the country has been able to reach 93% PMTCT coverage, which it attributed to having integrated HIV into a package of free maternal and child health care services.
34. Egypt, as an outgoing Board member, thanked the Board for promoting constructive dialogue and maintaining a spirit of consensus building. The delegate from Egypt confirmed that the country's new constitution commits to the right to health for all so everyone can benefit from a state insurance system without discrimination. Kenya was applauded for reducing HIV prevalence from 7.2% in 2007 to 5.6 % in 2012 through three key interventions: male circumcision, treatment for prevention, and targeted interventions that focused on key populations and specific geographical locations. Bangladesh announced that the country will host the 12th International Congress on AIDS in Asia and the Pacific (ICAAP) in 2015 and stated that the conference would serve as an important milestone for the region in the push towards the three zeros. The declaration of the Abuja+12 Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria was commended as a roadmap for accelerated action to achieve the three zeros in the African continent.
35. Members expressed appreciation to the UNAIDS Secretariat for organizing the Programme Coordinating Board Field Visit to Zambia, held 4 to 6 November 2013, as well as to the Government of Zambia for hosting the visit and facilitating an engaging programme that enabled participants to see first-hand the role of the Joint Programme in supporting the country's national AIDS response.
36. The Executive Director thanked the Board for its on-going support and for continuing to raise difficult and challenging issues. He said that despite members having at times diverging views, there is unity across the PCB to save lives and protect people's dignity.
37. The Executive Director shared an update on UNAIDS' partnership initiatives and related developments since the 32nd PCB, including with La Francophonie, parliaments, the world of sport and faith-based organizations. With regard to the latter, the Executive Director shared that he had the opportunity to address the 10th Assembly of the World Council of Churches in Busan, South Korea, which provided a platform to engage in a constructive dialogue with church leaders on human sexuality.
38. In relation to developments with the sporting community, the Executive Director welcomed Brazil's partnering with the Fédération Internationale de Football

Association (FIFA) to generate greater awareness around HIV in the context of the upcoming 2014 FIFA World Cup in Brazil. He shared that preparations are on track to kick-off the UNAIDS Protect the Goal HIV awareness campaign ahead of the World Cup.

39. The Executive Director, in response to a question from the floor, clarified that UNAIDS supports protective and not punitive legal and social environments. He elaborated that protective and enabling environments ensure equality and freedom from discrimination, access to justice and, ultimately, support an effective response to AIDS. He stressed that while UNAIDS respects the principles of state sovereignty, it actively supports and works with countries to ensure national laws are fair and just.
40. The Executive Director concluded by reminding the Board that AIDS is an unfinished agenda and countries will need to work collectively and optimize resources at their disposal. Mr Sidibé repeated the Secretary-General's call for a future free of AIDS and noted that a movement is needed to ensure the AIDS response is carried forward in the post-2015 development agenda.

1.3 REPORT OF THE NGO REPRESENTATIVE

41. The Board took note of the report of the NGO Representative, entitled *The Equity Deficit: Unequal and Unfair Access to HIV Treatment, Care and Support for Key Affected Communities*, and recognized the important contribution of civil society to the Board and in the global AIDS response.
42. Ms Dasha Ocheret, representing the Eurasian Harm Reduction Network and speaking on behalf of the NGO PCB Delegation, introduced the report. She started by cautioning the Board that while a record number of people living with HIV are accessing HIV treatment, the 'success story' presented does not reveal the fact that key populations – like sex workers, men who have sex with men, transgender people and people inject drugs – have been left far behind in treatment coverage. Ms Ocheret requested the international community to urgently address the 'equity deficit' with regard to access to HIV treatment, care and support across regions and among communities.
43. Ms Ocheret stated that treatment scale-up must first and foremost benefit people living with HIV, punitive laws must be abolished and abuse and coercion in healthcare settings must end. She continued by stating that intellectual property regimes can act as a barrier to affordable and accessible treatment. She added that treatment as prevention must be part of a broader package that includes primary prevention methods, such as condoms, lubricants and harm reduction, and recalled that the primary purpose and goal of treatment is for someone living with HIV to benefit their own health. Finally, she underscored that implementation of treatment as prevention in all contexts must be imbedded within a human-rights based approach.
44. Drawing from a review of available evidence, interviews, focus group discussions and case studies, the report detailed inequities in treatment access as a result of multiple underpinning barriers experienced by key populations. Currently, data demonstrates a disproportionate percentage of new infections, and a lack of treatment coverage, among key populations across regions. For example, the report highlighted that overall treatment coverage in Swaziland is 88% but only 33% among gay men and other men who have sex with men.

Among people who inject drugs in Europe, only 21% of those living with HIV are accessing treatment compared with 59% of all people living with HIV.

45. The report presented five factors that will 'make or break' the 'equity deficit' in the future:
- 1) *Human rights and ethics*: Scaling up treatment coverage must occur alongside concerted action to address existing barriers to equitable treatment, care and support for key populations, in particular stigma, discrimination and human rights violations;
 - 2) *Data and 'what works'*: Disaggregated data collection and analysis is required to ensure that key populations benefit from expanded treatment coverage, as well as data that helps identify and recognize 'what works' for these populations, especially comprehensive programmes and community-based services and support;
 - 3) *Financial investment*: Ending the 'equity deficit' requires a significant increase in investment in treatment, care and support for sex workers, men who have sex with men, transgender people and people living with HIV—groups that, to date, have been grossly under-funded;
 - 4) *Meaningful involvement*: To address the 'equity deficit', key populations must have a 'place at the table' of all relevant decision-making and resource-allocation fora related to the treatment landscape; and
 - 5) *Technical capacity*: To enable key populations to contribute fully, their critical and significant role must be recognized, respected and resourced, including by supporting community organizations and networks in providing technical support.
46. Ms Ocheret concluded by calling on the Board to adopt a number of recommendations, including convening a high-level meeting on HIV by the end of 2016 to reaffirm and renew political commitments, and to ensure accountability towards the achievement of universal access to HIV prevention, treatment, care and support in the post-2015 era.
47. Several members commended the NGO report's focus on the need to address the 'equity deficit' in the context of the future trajectory of treatment, recognizing how this relates to structural and systemic barriers like stigma and discrimination. Many acknowledged that UNAIDS, including the Programme Coordinating Board, can drive action forward in overcoming this deficit.
48. UNICEF, on behalf of the 11 UNAIDS Cosponsors, commended the report and the methodology applied. However, some delegations questioned some of the points raised in the NGO report, such as whether the barriers identified in the report can be generalized across countries, as well as the use of some terminology. Another concern raised by delegations concerned the overall Board procedure and the involvement of the NGO PCB Delegation in the decision-making process.
49. In responding to the concerns expressed, the Board Chair convened a drafting group that, upon returning to plenary, reached consensus around the proposed recommendations and adopted most of the recommendations as decision points under this and other agenda items.

2. LEADERSHIP IN THE AIDS RESPONSE

50. This agenda item was cancelled as the invited guest speaker, Sir Andrew Witty, Chief Executive Officer of GlaxoSmithKline (GSK), was unable to attend due to unforeseen circumstances relating to his travel.

3. UPDATE ON THE AIDS RESPONSE IN THE POST-2015 DEVELOPMENT AGENDA

51. Mr Kent Buse, Chief, Political Affairs and Strategy, UNAIDS Secretariat, presented the Board with an overview of key developments on the positioning of the AIDS response in the post-2015 development agenda since the 32nd PCB meeting in June 2013. He started by stating that, to date, there remains no clear consensus as to whether the new set of development goals will focus only on outcomes or also on so-called 'enablers' and 'instruments'. He noted that the overall impetus, in the view of the Co-Chairs of the Open Working Group on Sustainable Development Goals, is for a package to emerge that inspires the world to make inclusive and sustainable development a reality, which the Co-Chairs have articulated as an opportunity and a challenge.
52. Mr Buse provided an overview of some of the emerging possibilities for securing AIDS in the post-2015 development agenda, asserting that "ending AIDS" arguably provides both concrete outcomes and enablers for development. He reflected on the fact that there is broadspread support for the unfinished MDG agenda and that AIDS is far from over. He noted another opportunity is provided by the current high-level leadership for a future free of AIDS, citing the Secretary-General's call for a vision of a 'future free of AIDS', US President Barack Obama on World AIDS Day 2013 underscoring the need for a new set of AIDS goals, and the African Union's draft common position on the post-2015 framework that called for the end of AIDS by 2030.
53. Mr Buse explained that ending AIDS is not a static point but a dynamic process towards reaching the UNAIDS Vision of three zeros. In essence, the end of AIDS means reaching a point when AIDS no longer represents a public health threat, and, he added, the Executive Director of UNAIDS is calling for a global movement and an agreement for ending AIDS by 2030.
54. The update continued with a focus on the challenges ahead to position AIDS in a complex universal framework that is not only applicable to all countries but one that addresses a wide range of issues, from climate change to trade. To prominently position AIDS in the post-2015 development agenda, Mr Buse underlined the importance of building a case for AIDS in the post-2015 era that is anchored within the following framework in which the AIDS response:
- a. catalyzes and accelerates progress across a range of issues, as such making it relevant to many post-2015 development issues;
 - b. helps advance a socially-just sustainable development agenda, through championing human rights, dignity and equity;
 - c. acts as a guide in the generation and dissemination of global public goods, innovations and best practices on the path to ending extreme poverty and ensuring social inclusion; and
 - d. is in the interest of all countries—as a public health priority in many countries, and as a pathfinder for inclusive and rights-based development action everywhere.

55. Turning to the overall post-2015 process, Mr Buse shared updates on the activities of the Open Working Group, the UN-facilitated global thematic consultations, as well as AIDS-specific outcomes like the July ECOSOC resolution on the Joint Programme and the PACT2015! youth initiative. Mr Buse concluded by recalling the work of *The UNAIDS and Lancet Commission: Defeating AIDS – Advancing global health*. He referenced the Commission's three Working Group papers and drew attention to the questions raised in the papers, inviting the Board to share its input and views. In closing, highlights were shared from a series of regional and thematic consultations and dialogues that were held to gather wide-ranging views and preparations for the final meeting of the Commission in February 2014.
56. The Board took note of the progress report and expressed its appreciation to the UNAIDS Secretariat for providing an update on the overall post-2015 process and efforts undertaken to position AIDS in the post-2015 development agenda. There was broad support among members to ensure that the 'unfinished business' of AIDS is positioned firmly and prominently in the post-2015 framework with many stating that any new goals and targets must sustain progress on existing AIDS goals, including MDG 6 and the global AIDS targets. It was widely recognized that AIDS must be addressed as more than a health issue and used as a transformative force for multi-sectoral action grounded in a human-rights based approach.
57. Some Board members encouraged a more coherent and collaborative approach among Cosponsors in view of multiple efforts across the UN system to support Member States to establish a post-2015 framework. Members articulated the importance of making linkages with several key issues that are directly related to HIV, such as sexual and reproductive health and rights, including the International Conference on Population and Development (ICPD) programme of action, the proposed universal health coverage goal, the right to health, social protection and more broadly, stigma and discrimination and gender equality. The Board noted how HIV has helped spearhead the notion of shared responsibility, which is now reflected in a number of countries, in particular in sub-Saharan Africa that are increasing domestic investments and moving from aid recipients to partners and even donors.
58. Mr Buse thanked the Board for its support of the UNAIDS-Lancet Commission, underscoring that it is one of many instruments to inform the overall post-2015 debate.
59. The Executive Director welcomed what he described as the beginning of an important discussion with the Board aimed at ensuring that AIDS is not lost in the push towards the post-2015 development agenda. Mr Sidibé recalled that AIDS is an entry point to link and strengthen other health and development issues, emphasizing that the zero on AIDS-related deaths is closely linked with the proposed goal of universal health coverage. He described how innovations generated by the AIDS response need to be transferred to reinforce broader health systems to increase accessibility, particularly people most marginalized and excluded from society.
60. Mr Sidibé said zero discrimination must remain central to the AIDS response, and he cautioned that if ending stigma and discrimination loses traction in the post-2015 framework, the international community would have failed, not only

on AIDS but in securing a broader social justice agenda. He underscored the importance of ensuring better integration and convergence with other health-related issues, such as Hepatitis C, TB and sexual and reproductive health.

61. The Executive Director concluded the agenda item by encouraging the Board to convey and amplify the messaging around positioning AIDS firmly and prominently in the post-2015 development agenda among counterparts in capitals and representatives in New York and elsewhere.

4. STRATEGIC USE OF ANTIRETROVIRAL MEDICINES FOR TREATMENT AND PREVENTION OF HIV

62. The agenda item opened with a video message from Mr Francois Hollande, President of France, who expressed France's commitment to universal access to HIV prevention, treatment and care and shared his conviction that AIDS can be defeated.
63. Mr Luiz Loures, Deputy Executive Director of Programme, UNAIDS Secretariat, presented the agenda item and started by highlighting the instrumental role of HIV treatment in reducing the number of AIDS-related deaths. He stated that without treatment, an estimated 50 million people would have died of AIDS by 2020, versus some 35 million deaths from the disease to date. He added that the AIDS community is presented with an historic opportunity to redefine the approach to HIV testing and treatment uptake, which, he noted, could transform both HIV prevention and treatment.
64. Mr Loures outlined key moments in the timeline of HIV treatment, noting important milestones such as the 2001 General Assembly Special Session on HIV/AIDS, the launch of the Global Fund and PEPFAR, the 2011 High level Meeting on AIDS, and the 2013 WHO Treatment Guidelines. He added that people living with HIV today have at their disposal smarter and better HIV treatment options, such as triple therapy that requires only one pill a day. As a result of the scientific and political developments linked to treatment, he noted that a record number of people living with HIV have access to treatment in low- and middle-income countries.
65. With regard to the *Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive*, Mr Loures shared that the plan has provided a foundation for country-led movement towards the goal, and as a result new HIV infections among children have declined by 35% over the last few years. He expressed confidence that the 2011 UN Political Declaration target of 15 million people on HIV treatment by 2015 would be met.
66. To achieve the 2015 target on treatment and advance the overall treatment agenda, Mr Loures said a spotlight would need to be placed on many of the deep-rooted problems that continue to impede the AIDS response, referring in particular to gender-based violence and the sobering fact that many women report their first sexual experience was forced, adding that access to post exposure prophylaxis (PEP) is crucial.
67. Mr Loures encouraged the Board to set new global targets for HIV treatment, noting that in view of the new WHO Treatment Guidelines, many countries were moving forward with implementing the guidelines and in some instances going

beyond the recommendations. He cautioned that without uniform and global targets on treatment coverage, inequities may widen between countries, adding that having a common set of treatment goals could enhance efficiency and effectiveness across the response through the provision of clear directives, targets and roadmaps. Another reason for new and more ambitious targets, he said, is the changing HIV landscape thanks in large part to treatment as prevention. To illustrate this, Mr Loures presented the findings of a 2013 study on treatment coverage in KwaZulu-Natal, South Africa that showed how HIV incidence levels fell by 1.1% [0.8%-1.4%] for each 1% increase in HIV treatment coverage.

68. In moving forward the treatment agenda, Mr Loures outlined five principles that he called as 'access to treatment non-negotiables' consisting of:

- a. treatment is an integral part of the right to health;
- b. treatment, first and foremost, safeguards the health of people living with HIV;
- c. HIV testing and treatment initiation must always be voluntary and non-coercive;
- d. ensuring the best interests of people living with HIV always prevail; and
- e. the highest quality of medicines and care should be assured.

69. The Deputy Executive Director continued by presenting to the Board seven key directives, building on lessons learned, to guide the treatment agenda:

- 1) *Mind the country context*: responses need to be more nuanced and focused on where needs are greatest;
- 2) *Ensure no one left behind*: the treatment gap is stark for key populations, from children to people who inject drugs. Treatment access must be equitable and reach all people who need it;
- 3) *"Pro-test"*: treatment cannot be expanded without the scale up of HIV testing, and it is also timely to converge and pool screening for different diseases by enabling HIV testing for patients on a routine basis, beyond TB patients where significant progress has been made;
- 4) *Scaling up*: importance of demonstrating efficiency gains and the results of the investment approach, as well as renewing TRIPS flexibilities as a vehicle to reduce prices for treatment, including for second- and third-line regimens;
- 5) *Communities at the centre*: evidence shows that community health workers and health centres lead to better health outcomes and increase treatment adherence;
- 6) *Global solidarity, shared responsibility*: the rapid expansion of treatment access in low- and middle-income countries has been possible thanks to global solidarity and shared responsibility. While most treatment is financed by domestic funds, international contributions remain essential; and
- 7) *Getting the balance right*: efforts at country level need to address the overall AIDS response in a balanced manner and avoid compartmentalizing prevention primary and treatment.

70. Mr Loures concluded by encouraging the Board to consider new treatment targets that reflect new realities in countries.

71. Ms Meg Doherty, Coordinator of Treatment and Care, HIV Department, WHO, presented an overview of two recently-issued documents that provide the normative guidance for treatment scale-up: the use of antiretroviral drugs for treating and preventing HIV infection and HIV testing and counselling and care for adolescents living with HIV. Ms Doherty outlined that the rationale behind the new guidance was to have consolidated guidance across age groups and populations, as well as across the continuum of care, from testing to retention. Importantly, she noted, the new guidance responds to new scientific and technological developments and encompasses a new vision of treatment as prevention, supported by a simplified and less toxic new first-line regimens.
72. Ms Doherty shared that WHO is currently working to support the operationalization of the new treatment guidance, from going to one pill to task-shifting and treatment delivery at the community level. Since the launch of the guidelines, WHO has convened regional meetings to establish baselines and a roadmap that encourages countries to address issues such as decentralization and community care models. With regard to the latter, she gave an example of a recent case study from Mozambique focused on community-level treatment delivery. The study, which focused on more than 8000 patients being treated through community care, showed an adherence rate of 95% after 20 months compared to 75% in standard care.
73. Ms Doherty concluded by stating that WHO hoped the new WHO Treatment Guidance would contribute to reducing AIDS-related deaths by 52% and new HIV infections by 42%. Looking ahead, she added that WHO is in the process of preparing guidance for the post-2015 period that will involve making linkages with other co-morbidities, such as hepatitis and the broader non-communicable diseases (NCDs) agenda.
74. Representing the community perspective, Ms Carol Nyirenda, speaking on behalf the Community Initiative for Tuberculosis, HIV/AIDS and Malaria (CITAM+), challenged the Board to address key bottlenecks in the context of treatment scale up. She underlined that the treatment gap is fuelled by many barriers, such as treatment illiteracy, criminalization of key populations and HIV transmission and exposure, gender inequality, poverty, lack of affordable and accessible services, stigma and negative attitudes towards key populations, including homophobia and transphobia, discrimination against sex workers and people who use drugs, abusive health workers and an overall shortage of accessible and available diagnostics. She stressed that achieving universal access will require going the 'last mile' in order to reach key populations, and recommended a 'one-stop shop' approach where HIV is addressed and integrated with other health challenges, adding that HIV can help tackle other diseases such as TB and NCDs.
75. Focusing on the role of communities in treatment scale up, Ms Nyirenda expressed concern over what she viewed as a lack of understanding on the part of governments as to how communities complement and add value to the health system, noting that affected communities often understand the landscape better. She called on countries to increase the involvement of communities in both decision making and service delivery, and in this regard, she asserted that to ensure quality service delivery, workers must be remunerated, noting that financing must reach the community level. In closing, Ms Nyirenda urged the Board to focus on address inequalities in future discussions on considering new treatment targets.

76. The Board took note of the report prepared for this agenda item and expressed its appreciation to the presenters for providing a comprehensive overview of the strategic use of ARVs for HIV treatment and prevention. Members offered strong support for scaling up treatment and the new WHO Treatment Guidelines. Many voiced concern that only 34% of people eligible for treatment under the new guidelines in low- and middle-income countries were receiving it.
77. Several members drew attention to the importance of monitoring HIV drug resistance, strengthening communities and ensuring the sustainability of national AIDS responses, including the supply of affordable and quality medicines, along with the need for further integration and revised national targets. It was noted that while progress in preventing mother-to-child transmission was recognized as a significant advancement, several members said it remains unacceptable that an estimate 700 children are born with HIV every day and AIDS-related deaths are increasing among 10 to 19 year olds.
78. In recognizing that two out of three children do not have access to treatment, the Board requested UNAIDS to prepare an analysis on paediatric HIV treatment, care and support with specific, time-bound targets for getting all children living with HIV on treatment and a strategy on how this would be achieved to be presented at the 35th meeting of the PCB in December 2014.
79. Several questions were raised in response to the information presented, including understanding the role of the private sector in supporting treatment scale up; ensuring continuity of care for people on treatment, especially as many countries have reached or are reaching a tipping point in terms of scale up; responding to the barriers faced by people who use drugs, as well as the specific challenges encountered by sex workers, including female, male and transgender.
80. A number of Board members underscored the need for country-led processes among relevant stakeholders, including the Global Fund and PEPFAR, to generate a common understanding of the most effective interventions. Linked to this was a question on the Division of Labour with regard to the new WHO Treatment Guidelines among various stakeholders. It was also noted that the UNAIDS investment approach had not been addressed in the report to the Board under this agenda item.
81. The Africa Group identified many challenges to meet the 2015 treatment targets in sub-Saharan Africa, including high prices of ARVs, stock outs, lack of knowledge of HIV status and an absence of diagnostics. Several members called for greater technology transfer to ensure access, sustainability of medicines and improved diagnostics.
82. On the issue of sustainability, a long-term financing strategy was raised as an important element in the overall discourse on treatment, as transitioning to long-term and sustainable funding will require supporting countries to engage with ministries of finance and to demonstrate smart investments using the investment approach. Concern was expressed over the low levels of treatment coverage in Europe, which stands at 26% compared to 47% globally. A key bottleneck identified was the high price of treatment. Another member also spoke to the issue of pricing and alerted the Board that fixed-dose combination

may cost more than individual doses and encouraged UNAIDS to monitor this through its country offices.

83. Several Board members underscored that in order to expand treatment, HIV testing levels must increase, with many highlighting that only half of people living with HIV worldwide know their status.
84. In response to the questions and comments raised by the Board, Ms Doherty addressed the main points and concerns expressed. On the issue of the treatment gap for children, she informed the Board that WHO is working with partners to implement the new treatment guidelines and that this involves integrating paediatric HIV treatment as part of the Integrated Management of Childhood Illness (IMCI) approach. In terms of concrete measures to respond to concerns over drug resistance, Ms Doherty informed the Board that WHO is working to ensure that drug resistance monitoring is embedded in country-based and country-owned surveys, including early warning indicators. She reassured members that the pharmaceutical industry has been informed about the evidence with regard to drug combinations and drew the Board's attention to an upcoming conference on drug optimization, as well as a global price reporting mechanism.
85. With regard to HIV testing, Mr Loures suggested to the Board that new technologies be urgently explored to make testing more accessible and to also use viral load as a measure of success. Mr Loures also stated that people with a HIV-positive diagnosis should be informed about the prevention benefits of treatment so that they can make informed decisions. On pricing, he underlined the need for innovative mechanisms, such as the UNITAID patent pool. He closed the agenda item by describing the current period in the AIDS response as one of transition, and encouraged the Board to already set ambitious targets to scale up treatment with a view towards the end of AIDS.

5. COORDINATION OF HIV TECHNICAL SUPPORT IN A RAPIDLY CHANGING ENVIRONMENT

86. Before the agenda item started, the Chair of the Board, Mr Verma, invited the Executive Director of the Global Fund, Mr Mark Dybul, UNAIDS Executive Director, Mr Michel Sidibé, and the Minister of Health of Cote d'Ivoire, Her Excellency Ms Raymonde Goudou Coffie, to take part in a signing ceremony for a new partnership agreement aimed at expanding HIV treatment access in the country.
87. The agenda item was introduced by Mr Loures, Deputy Executive Director, UNAIDS, who stated the global AIDS community needs to operate differently in view of changes in the context and scope of the AIDS epidemic. Importantly, he said it is paramount to keep abreast of how local epidemics are evolving, and he used various maps to illustrate how epidemics differ across geographical regions in different countries. He said the maps underscore the importance of ensuring that essential services are provided where HIV transmission occurs. Additionally, the Deputy Executive Director said funding for technical support needs to target the populations and geographical areas with the greatest need.
88. Mr Loures recalled the substantial increase in resources for the AIDS response in recent years and reminded the Board of the AIDS spending target of between US\$ 22 billion to \$24 billion annually needed by 2015 to meet the global AIDS

targets. He stated that the recent replenishment of the Global Fund of \$12 billion was a welcomed development, as well as the increasing number of countries able to finance their own response. The challenge, he added, is ensuring investments are used strategically to have the greatest impact. Notwithstanding, the Deputy Executive Director gave an example from Asia where less than 6% of resources are used to address the epidemic among men who have sex with men, yet over 30% of new HIV infections in this region are among men who have sex with men.

89. Ms Loures shared the results of a survey conducted by UNAIDS to identify the technical support priorities of 55 countries planning to submit proposals under the Global Fund's New Funding Model (NFM) concept notes in 2014. In summary, he stated that countries outlined a need for support in the areas of: 1) programme review, analysis and design; 2) key populations and critical enablers; 3) HIV investment cases and national strategies; 4) Concept Note development and country dialogue; and 5) epidemiological data review.
90. In response to these identified needs, Mr Loures said UNAIDS is in the process of designing a new typology on how best to support countries, while recognizing that countries are in the driver's seat and must take the lead. Consequently, he added that UNAIDS is adapting its level and type of technical support in response to the needs and the capacity of individual countries, ranging from Haiti, where capacity is fragile and progress gradual, to Nigeria, which has an exceptional need for support in light of the scale of its epidemic, to countries like Thailand, where national capacity is high and substantial progress has already been made.
91. Mr Loures reminded the Board of the organizational realignment of the UNAIDS Secretariat and its objective of better aligning the organization with country needs and deploying more staff to countries. He said the exercise has already produced results, and he proceeded to give an example of support provided to Myanmar as an early application under the Global Fund's New Funding Model, highlighting that assistance was provided to members of networks of key populations to participate in the drafting team of the Concept Note, which allowed for their needs to be presented and incorporated.
92. The Deputy Executive Director stated that the UN system is doing better overall in working collectively to support countries. He shared the example of the Inter-Agency Task Team (IATT) for Prevention and Treatment of HIV Infection in Pregnant Women, Mother and Children that has provided strong support to countries in recent years with tangible results. Another example he noted is the International Labour Organization's VCT@WORK initiative that aims to reach 5 million women with voluntary and confidential HIV counselling and testing by 2015.
93. Mr Dybul, Executive Director of the Global Fund, stressed the paradigm shift that the New Funding Model represents, moving away from assisting countries to building countries' capacity to take charge and meet their own responsibilities and needs. He stated the shift also means changing the mindset around technical support, and transitioning from top-down approaches to bottom-up capacity building, including in relation to responding to difficult issues such as key populations.

94. Mr Dybul underscored the critical importance of UNAIDS Country Offices in the deployment of the New Funding Model, which is expected to involve an exceptionally high number of countries, some 65, over the next year. He expressed that it was a privilege for the Global Fund to have a 21st-century model of partnership with UNAIDS. The Executive Director of the Global Fund thanked Mr Sidibé for his leadership not only in the area of technical assistance but more broadly in laying out the vision for the end of AIDS.
95. Mr Paul Chimedza, Deputy Minister, Ministry of Health and Child Care, Zimbabwe, presented Zimbabwe's recent successful experience as an early applicant to the New Funding Model. The process, steered by the Country Coordinating Mechanism (CCM), was characterized as highly participatory, grounded in a strong national strategic plan, and underpinned by commitment from, and leadership of, national health authorities and backed by robust technical support from UNAIDS and other partners.
96. Mr Chimedza outlined to the Board the various steps taken by the Technical Review Panel to review the country context, starting with HIV prevalence and AIDS-related deaths, which had declined thanks to prevention strategies and treatment scale up. He said Zimbabwe's response to AIDS has been one of broad, multi-sectoral engagement, which was essential in the creation of its five-year strategy (2011-2015) around the three zeros. The Deputy Minister added that the Zimbabwe CCM extended the principles of country dialogue into the development of the Concept Note, ensuring all stakeholders were consulted and engaged.
97. The Deputy Minister highlighted some of the challenges experienced as an early applicant to the New Funding Model, including the tight timeline and disconnect in the level of detail in the concept note and the requirements in the grant application. He continued by sharing Zimbabwe's lessons learned from the CCM, including a suggestion that the CCM secretariat should be given authority to drive the process, the importance of timely decision-making, and the need for multi-stakeholder processes to be mainstreamed across health service delivery. In addition, Mr Chimedza noted that leadership should remain within the Ministry of Health, funding partners should be sensitized in advance, and sufficient time should be allocated for the grant making process. He explained that success factors for Zimbabwe included working from the basis of a strong National Strategic Plan, rapid mobilization of participatory and inclusive consultative processes and planning, strong commitment from the national health authorities, a technically-skilled and highly-committed writing team, and effective support from UNDP as principle recipient.
98. The Board welcomed the paper on coordination of technical support provided as background for the agenda item, and requested UNAIDS, in view of the New Funding Model, to step up its work in coordinating technical support and retain its focus on the 30+ priority countries. UNAIDS was asked to report on the UNAIDS-Global Fund Partnership Agreement at the 34th meeting.
99. The Board noted the important changes in the overall AIDS landscape that has resulted in increased demand for technical support to countries. As part of a strategic investment approach, members stated that countries need to be supported in selecting the interventions that will have greatest impact, including for key populations. In this context, one representative stated that key populations represent "the Master Key" for a more effective global response,

and several representatives of networks of key populations urged the Board to ensure their greater involvement as partners in guiding the AIDS response.

100. The Board expressed support for the New Funding Model, noting that the ultimate objective of technical assistance is to build the capacity of countries to design and mandate their own strategies and plans to respond to their own specific epidemics. Members agreed that technical support be built around supporting countries in achieving their own goals in the AIDS response, which, it noted, is in line with international consensus on development and aid effectiveness approaches. While expressing support for the UNAIDS Executive Director's decision to not accept funds from the Global Fund, some Board members requested more information on the partnership agreement between the two organizations.
101. Several questions and comments were raised by members in response to the presentations and subsequent discussion, including UNAIDS' role in supporting greater south-south cooperation, how countries such as Brazil, China and Mexico can engage in offering technical support to others, and the different modalities of technical support available, such as building capacity for research and information systems to ensure the collection of disaggregated data.
102. In response to a query on the need for more effective UN coordination to support the New Funding Model, UNDP shared that a letter from Ms Helen Clark, Administrator of UNDP, and Mr Dybul of the Global Fund had been sent to UN Country Teams asking them to coordinate with a view to ensuring government engagement and, more broadly, a country-led process. In addition, a Global Fund capacity toolkit has been developed by UNDP. WHO expressed its commitment to the New Funding Model and stated it will support countries in a range of areas, such as epidemiological analysis, population size estimates, national strategy plans, and peer reviews of the health sector. On the issue of the UNAIDS and Global Fund partnership agreement, Mr Loures explained that, at the core of the relationship, is an on-going and intensive dialogue with the Global Fund on how to scale up technical support in light of the capacity of individual countries.
103. In relation to the decision points under this agenda item, some members reiterated that technical cooperation is a vast field, encompassing a wide range of perspectives, actors and modalities for implementation in light of different country contexts. While the decision point related to the agenda item specifically addressed the New Funding Model, it was recommended that future sessions of the Board explore technical cooperation more broadly to address the collaboration of UNAIDS in countries and contexts not eligible for Global Fund resources. In addition, the NGO Delegation emphasized the importance of civil society in delivering technical support.

6. NEXT BOARD MEETINGS

104. The Board agreed that themes of the 34th and 35th Board meetings be respectively "Addressing social and economic drivers of HIV through social protection" and "Halving HIV transmission among People Who Inject Drugs".
105. The Board also agreed to change the dates of the 34th Board meeting to 24-26 June 2014 and the 36th Board meeting to 30 June - 2 July 2015.

7. ELECTION OF OFFICERS

106. The Board confirmed Australia as Chair and elected Zimbabwe as Vice Chair for the period 1 January to 31 December 2014.
107. The Board requested the incoming Chair to continue consultations to propose a Rapporteur at the next Board meeting.

8. ANY OTHER BUSINESS

108. No new business was presented.

9. THEMATIC SEGMENT: HIV, ADOLESCENTS AND YOUTH

109. The thematic segment was devoted to HIV, Adolescents and Youth, with the day planned and implemented by young people. The preparations of the thematic segment were undertaken in collaboration with the thematic working group including member states, cosponsors and PCB NGO delegation representatives. For this segment, the set-up of the Board room was modified to enable the youth participants to engage alongside members and speak from their official seating position. Under the theme "Walk in my shoes", a diverse group of participants came together to discuss the HIV prevention, testing and treatment issues from a youth perspective.
110. This set-up facilitated a frank, open and lively dialogue that enabled the participants to interact with the Board on exploring ideas, sharing experiences and proposing solutions to improve young people's access to high-quality HIV programmes and the right information and services to protect themselves and lead healthy lives.
111. The segment's theme responds to a major concern in the global AIDS response which is ensuring that that young people are not simply passive recipients of programmes but play an integral role in their design, implementation and evaluation to ensure services are better calibrated to meet the needs of young people, including comprehensive sexuality education.
112. Although there has been a 32% reduction in the estimated number of new HIV infections among people aged 15-24, young people are facing an emerging crisis. While the number of AIDS-related deaths overall fell by an estimated 30% between 2005 and 2012, estimates suggest that the number of deaths among young people increased by 50%. In addition, 15 to 24 year olds still account for 39% of all new adult infections in 2012.
113. The UNAIDS Executive Director opened by highlighting the importance of the theme, stressing that young people are "the now and the future". Mr Sidibé stressed that unless young people's needs are addressed, an AIDS-free generation will be not reached and the gains made towards eliminating new HIV infections among children will be lost, adding that their HIV risk would be merely deferred to the second decade of life.
114. In a session on what successful HIV prevention looks like for young people, their unique prevention needs were highlighted, including those among young key populations. Young leaders shared good practices at country level including successful harm reduction services for young women who inject drugs were

shared. Such services provide access to information and support on a range of issues in safe spaces, free of prejudice and judgment.

115. A common element of success across all programmes highlighted was the involvement of young people in service design. The participants highlighted that only by working with young people will services be developed which are 'right for them, delivered in the right way, by the right providers and in the right places'. As one participant explained, "We know the market because we are the market".
116. In a discussion on HIV testing, many of the youth participants underlined the need to change the social and legal environments that often act as barriers to young people accessing HIV testing and being linked into treatment and care, as well as HIV prevention information and services. A barrier raised repeatedly by participants was laws and policies which mean adolescents need their parent's or guardian's consent to accessing HIV testing. An animated dialogue also took place on challenges and solutions in relation to access to treatment and how this access can be integrated into youth-friendly services that also offer sexual and reproductive health programmes and support adherence to treatment, as well as support for adolescents and young people to disclose of HIV status when and to whom they want.
117. On the post-2015 development agenda, young people were seen as powerful agents to drive the process forward, as many participants noted that youth organizations are more organized than ever, citing the recently-established PACT collaboration across 25 youth-led and youth-serving organizations in the AIDS response. ACT 2015—a youth-led initiative that aims to ensure sexual and reproductive health and rights are recognized and HIV remains a priority in the post-2015 agenda—was shared as a prime example of effective youth engagement in the process supporting young people to get organized at national level to influence governments positions.
118. At the end of the day, youth delegates and Board members were galvanized into redoubling their efforts to ensure that young people have the tools and the space to put themselves front and centre of the AIDS response and play an active role towards achieving the goal to end AIDS.

10. CLOSING OF THE MEETING

119. The Chair closed the 33rd UNAIDS Programme Coordinating Board meeting.
120. The 33rd meeting of the UNAIDS Board made a number of decisions, recommendations and conclusions (Annex 2).

[Annexes follow]

Annex 1



PROGRAMME COORDINATING BOARD

UNAIDS/PCB (33)/13.14

Issue date: 6 December 2013

THIRTY-THIRD MEETING

DATE: 17-19 December 2013

VENUE: Executive Board Room, WHO, Geneva

TIME: 09h00 - 12h30 | 14h00 - 18h00

Draft Annotated Agenda

TUESDAY, 17 December

1. Opening

1.1 Opening of the meeting and adoption of the agenda

The Chair will provide the opening remarks to the 33rd PCB meeting.

1.2 Consideration of the report of the thirty-second meeting

The report of the thirty-second Programme Coordinating Board meeting will be presented to the Board for adoption.

Document: UNAIDS/PCB (32)/13.13

1.3 Report of the Executive Director

The Board will receive a written outline of the report by the Executive Director.

Document: UNAIDS/PCB (33)/13.15

1.4 Report by the NGO representative

The report of the NGO representative will highlight civil society perspectives on the global response to AIDS.

Document: UNAIDS/PCB (33)/13.16

2. Leadership in the AIDS response

A keynote speaker(s) will address the Board on an issue of current and strategic interest.

3. Update on the AIDS response in the post-2015 development agenda

The Board will receive an update on progress to date on how AIDS is being positioned in the post-2015 development agenda, including through the work of The UNAIDS and Lancet Commission: Defeating AIDS - Advancing global health.

Document: UNAIDS/PCB (33)/13.17;

UNAIDS/PCB (33)/13.CRP1; UNAIDS/PCB (33)/13.CRP2;

UNAIDS/PCB (33)/13.CRP3; UNAIDS/PCB (33)/13.CRP4

WEDNESDAY, 18 December

4. Strategic use of antiretroviral medicines for treatment and prevention of HIV

The Board will receive a report on the strategic use of ARVs for treating and preventing HIV infection.

Document: UNAIDS/PCB (33)/13.18

5. Coordination of HIV technical support in a rapidly changing environment

The Board will receive a report describing the progress in the coordination of technical support as requested by the Board at its 30th meeting.

Document: UNAIDS/PCB (33)/13.19

6. Next Programme Coordinating Board meetings

The Board will be asked to agree the topics of the Thematic Segments for its 34th and 35th BOARD meetings in June and December 2014.

Document: UNAIDS/PCB (33)/13.20

7. Election of Officers

In accordance with Programme Coordinating Board procedures, the Board shall elect the officers of the Board for 2014 and is invited to approve the nominations for NGO delegates.

Document: UNAIDS/PCB (33)/13.21

8. Any other business

THURSDAY, 19 December

9. Thematic Segment: HIV, adolescents and youth

Document: UNAIDS/PCB (33)/13.22; UNAIDS/PCB (33)/13.CRP5

10. Closing of the meeting



Annex 2

33rd Meeting of the UNAIDS Programme Coordinating Board Geneva, Switzerland 17-19 December 2013

Decisions, Recommendations and Conclusions

UNAIDS Programme Coordinating Board,

Recalling that all aspects of UNAIDS work are directed by the following guiding principles:

- Aligned to national stakeholders' priorities;
- Based on the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection;
- Based on human rights and gender equality;
- Based on the best available scientific evidence and technical knowledge;
- Promoting comprehensive responses to AIDS that integrate prevention, treatment, care and support; and
- Based on the principle of non-discrimination;

Agenda item 1.1: Opening of the meeting and adoption of the agenda

1. *Adopts* the agenda;

Agenda item 1.2: Consideration of the report of the thirty second meeting

2. *Adopts* the report of the 32nd meeting of the UNAIDS Programme Coordinating Board;

Agenda item 1.3: Report of the Executive Director

3. *Takes note* of the report of the Executive Director;

Agenda item 1.4: Report by the NGO representative

4. *Requests* UNAIDS in collaboration with Member States and partners to:
 - a. *ensure* that any implementation/guidance on new biomedical preventative technologies proceeds with the full and meaningful engagement of key populations², promoting informed and voluntary adherence to ART;

² As defined in the UNAIDS 2011-2015 Strategy *Getting to Zero*: "Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people

- b. *further ensure* the potential impacts of treatment as prevention – as indicated by an increasing body of evidence and support of the earliest initiation of ART for people living with HIV – will be aligned to the principle of treatment being first and foremost to benefit those living with HIV;
- c. *intensify* coordinated technical support to governments, civil society, and key populations³, and UNAIDS to periodically report to the Programme Coordinating Board on progress in the effectiveness of technical support interventions at the country level;
- d. *report* to the 35th PCB on concrete actions taken to reduce stigma and discrimination in all its forms consistent with the UN High Level Political Declarations of 2006 and 2011, the UNAIDS Strategy 2011-2015 and all the Programme Coordinating Board decisions related to the reduction of stigma and discrimination;

Agenda item 3: Update on the AIDS response in the post-2015 development agenda

- 5.1. *Welcomes* the update report on the AIDS response in the post-2015 development agenda and *looks forward* to discussing the findings and recommendations of the UNAIDS and Lancet Commission at its next meeting in June 2014;
- 5.2. *Recalls* the decisions from the 32nd PCB on the AIDS response on the post-2015 development agenda and *invites* the United Nations General Assembly to consider convening a High Level Meeting on HIV at an appropriate time after 2015 as part of a broader strategic effort to reaffirm and renew political commitments, and to ensure accountability towards the achievement of universal access to HIV prevention, treatment, care and support in the post-2015 era;

Agenda item 4: Strategic use of antiretroviral medicines for treatment and prevention of HIV

- 6.1. *Welcomes* the paper;
- 6.2. *Calls* upon Member States to:
 - a. *ensure* that acceleration of access to HIV treatment, particularly for key populations⁴ as well as women, children and adolescents living with HIV, including addressing the barriers to treatment access, are factored into all stages of HIV and health planning, implementation, monitoring and evaluation, and resource mobilization, particularly with regards to development of investment thinking approach, and support for the roll-out

living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.”

³ *Ibid.*

⁴ *Ibid.*

of the New Funding Model of the Global Fund to Fight AIDS, TB and Malaria (Global Fund) and other funding sources;

- b. *implement* the 2013 WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection with the active engagement of People Living with HIV and key populations⁵;
- c. *monitor* HIV drug resistance according to the WHO Global Strategy for the Surveillance and Monitoring of HIV Drug Resistance 2012;
- d. *continue work* towards further scale-up of access to HIV services including by strengthening communities and their role in the health system for promoting and supporting informed and voluntary uptake of HIV testing and counselling, treatment, care and support, and promoting treatment adherence;
- e. *work* to ensure the sustainability of national AIDS responses recognizing the principles of country leadership and ownership through strengthening of shared responsibility, innovative sustainable financing to meet increased demand, building of strategic partnerships, strengthening health systems, including through the integration of HIV services, and multi-sectoral approaches;
- f. *ensure* that programmes to expand access to HIV treatment are fully integrated in national health strategies and offer quality HIV services, improve treatment literacy, are voluntary, non-coercive and respect the human rights of people living with HIV;
- g. *ensure* that national programmes effectively address the barriers to HIV testing and treatment faced by children and adolescents;

6.3. *Requests* the Joint Programme to:

- a. *support* on-going national and international processes led by countries and regional institutions to convene national and regional consultations for the definition of revised national targets for universal access to HIV treatment keeping in mind the need for defining new milestones and targets for the AIDS response beyond 2015, and to provide a report at a future meeting of the Programme Coordinating Board;
- b. *further support* implementation of the 2013 WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection ensuring the active engagement of People Living with HIV and key populations⁶;
- c. *further support* countries to monitor HIV drug resistance according to the WHO Global Strategy for the Surveillance and Monitoring of HIV Drug Resistance 2012;

⁵ *Ibid.*

⁶ *Ibid.*

- d. *support* capacity development of communities in their role in the health system for promoting and supporting informed and voluntary uptake of HIV testing and counselling, treatment, care and support, and promoting treatment adherence;
 - e. *continue* to support the availability of affordable, quality, safe and effective antiretroviral medicines and harmonizing medicines regulatory systems, as well as the provision of technical support for countries to maximize utilization of the flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration;
 - f. *support* countries to effectively address and remove the barriers to HIV testing and treatment faced by children and adolescents;
 - g. *further support* countries to effectively address and remove barriers to HIV testing and treatment for key populations⁷, women and girls;
- 6.4. *Recognizing* that two out of three children do not have access to treatment:
- a. *requests* UNAIDS to prepare a discussion paper and a gap analysis on paediatric HIV treatment, care and support with specific, time-bound targets for getting all children living with HIV on treatment and a strategy on how this would be achieved to be presented at the 35th meeting of the Programme Coordinating Board.

Agenda item 5: Coordination of HIV technical support in a rapidly changing environment

- 7.1. *Welcomes* the paper on coordination of Technical Support in a rapidly changing environment;
- 7.2. *Recalls* the UNAIDS technical support coordination role for all countries and regions;
- 7.3. *Requests* UNAIDS, in light of the importance of the roll-out of the Global Fund New Funding Model, to take necessary steps to strengthen the coherence and coordination among bilateral and multilateral technical support agents based on country contexts and requirements, in particular for the implementation of this Model. In doing so, UNAIDS should continue to address other technical support as needed, retaining its focus on the 30+ priority countries and cooperate closely, within its mandate, with technical support agents for TB and Malaria as well as for health system strengthening retaining the principle of national ownership and leadership;
- 7.4. *Requests* UNAIDS to report on the UNAIDS-Global Fund Partnership Agreement and its financial implications, including for UNAIDS' Technical Support Facilities, at the 34th meeting of the Programme Coordinating Board;

Agenda item 6: Next Programme Coordinating Board meetings

⁷ *Ibid.*

- 8.1. *Agrees* that the themes for the 34th and 35th Programme Coordinating Board meetings be respectively: “Addressing social and economic drivers of HIV through social protection” and “Halving HIV transmission among People Who Inject Drugs”;
- 8.2. *Further agrees* to request the Programme Coordinating Board Bureau to take appropriate and timely steps to ensure that due process is followed in the call for themes for the 37th Programme Coordinating Board meeting, as necessary;
- 8.3. *Agrees* the change in the date of the 34th PCB meeting to 24-26 June 2014 and of the 36th PCB meeting to 30 June-2 July 2015;

[End of document]