



## UNAIDS PROGRAMME COORDINATING BOARD

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### **THIRTY-FIFTH MEETING**

**Date:** 9-11 December 2014

**Venue:** Executive Board room, WHO, Geneva

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### **Agenda item 1.2**

**Report of the 34th Meeting of the Programme Coordinating Board**

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**Additional documents for this item:** *none*

**Action required at this meeting – the Programme Coordinating Board is invited to:**  
*adopt* the report of the 34<sup>th</sup> Programme Coordinating Board meeting.

**Cost implications for decisions:** *none*

## **1.1 OPENING OF THE MEETING AND ADOPTION OF THE AGENDA**

1. The UNAIDS Programme Coordinating Board (the Board) convened for its 34<sup>th</sup> meeting on 1-3 July 2014 in the Executive Board Room of the World Health Organization in Geneva.
2. The PCB Chair, H.E. Mr Peter Woolcott Ambassador and Permanent Representative, Permanent Mission of Australia in Geneva welcomed participants to the 34th meeting. The Board observed a minute of silence in memory of all who had passed away from AIDS since the last meeting.

## **1.2 CONSIDERATION OF THE REPORT OF THE 33<sup>rd</sup> MEETING**

3. The Board adopted the report of the 33rd meeting of the Board.
4. The Board elected El Salvador as rapporteur for 2014.

## **1.3 REPORT OF THE EXECUTIVE DIRECTOR**

5. After welcoming Australia and Zimbabwe as the Board's new Chair and Vice-chair, Michel Sidibé, UNAIDS Executive Director summarized key achievements in the global AIDS response and focused on the way forward towards ending AIDS. Recent progress includes the commitment by African Union leaders and by leaders in the Caribbean to ending the epidemic, adoption of the first AIDS strategy by the League of Arab States, the declaration by the Organisation of American States of the year 2014 as the inter-American year to promote the human rights of people living with HIV, and submission by a record 181 countries of national progress reports to UNAIDS in 2014.
6. The Executive Director highlighted that from 2003 to 2013, the number of new HIV infections among children declined by 57%. Marked gains have been made in bringing HIV treatment to scale; 26 countries in Latin America and the Caribbean have adopted ambitious regional post-2015 treatment targets, all countries in Eastern and Southern Africa are taking steps to implement the 2013 WHO consolidated antiretroviral treatment guidelines, and several countries in West and Central Africa are moving towards initiation of HIV treatment for all people living with HIV, regardless of CD4 cell count. The HIV prevention revolution is also advancing, with important leadership on prevention issues apparent in diverse countries.
7. Mr Sidibé thanked the Board, Member States and other partners for their continued support of UNAIDS. In particular, he acknowledged dedicated contributions for the Treatment Situation Room which was presented later in the meeting by Mr Badara Samb, Chief, Global Outreach and Special Initiatives for UNAIDS. The Treatment Situation Room provides up-to-the-minute estimates of HIV treatment uptake and has the capacity to provide granular information on progress and gaps at sub-national level.
8. Although notable gains have been made towards the vision of *zero new HIV infections, zero AIDS-related deaths and zero discrimination*, Mr Sidibé noted that key challenges remain. The implementation gaps must be closed, he stressed,

highlighting the urgent need to transform data collection and analysis to maximize impact and the return on investment. With the global aim of ensuring that 90% of all people living with HIV know their HIV status, HIV testing needs to be made routinely available to everyone everywhere.

9. Mr Sidibé said urgent attention is required to address the needs of those at risk of being left behind. HIV is now the second leading cause of death globally for adolescents (ages 10-19), and the risk of acquiring HIV among young people is especially pronounced for young women and girls. The crisis in paediatric HIV treatment also requires immediate attention.
10. The Executive Director underscored that the AIDS response needs to effectively address the social, political and economic drivers of HIV. Steps also need to be taken to manage the AIDS response in complex crises, such as conflicts in the Central African Republic, Crimea and South Sudan.
11. Mr Sidibé said a recent trip to Vancouver, Canada – where HIV treatment has been strategically used to make AIDS-related deaths rare and bring HIV almost completely under control – illustrates what ending AIDS looks like. In the USA, New York Governor Andrew Cuomo recently announced a plan to end the HIV epidemic in the state by 2020. He added these and other signs of growing commitment to end AIDS raise hopes that we will be able to control the epidemic, provide solutions to structural development problems and achieve the global objectives for sustainable development. Ending AIDS will require redoubled efforts with respect to innovation and scientific research, integration and de-medicalization of services, zero discrimination and new financial resources.
12. Mr Sidibé shared with the Board that in 2016, the global community will gather for a High Level meeting on HIV at the United Nations General Assembly. UNAIDS has already moved to implement the Board's request at its 33<sup>rd</sup> meeting that the Joint Programme assist country- and region-led efforts to develop HIV targets for the post-2015 era. As part of this effort, UNAIDS is assisting 66 countries in developing new financing approaches to ensure the sustainability of the response.
13. The Executive Director recalled that ending AIDS in the post-2015 era will require new approaches and new thinking, challenging conventional wisdom. A commitment to leave no one behind, principles of shared responsibility and global solidarity, and improving the quality and utilization of strategic information will be pivotal to success.
14. The Board took note of the report of the Executive Director and thanked him for the vision he outlined. Several Board members emphasized that ending AIDS will be impossible without addressing the HIV-related needs of key populations and minimizing stigma, discrimination and punitive legal frameworks that impede effective responses for these groups. While substantial gains have been made globally, the Board observed that new infections had either failed to decline or were increasing in some countries, including in Eastern Europe and Central Asia. Board members called for concerted efforts to strengthen HIV prevention, with a particular focus on young people, women and girls, key populations and other vulnerable groups; in this regard, it was reported that only 4% of HIV expenditure globally focuses on programmes for key populations. The Board encouraged strengthened

efforts to address gender inequities, including but not limited to gender-based violence.

15. Support was expressed for continued efforts to 'take AIDS out of isolation' and integrate HIV with broader health and development systems but Board members also urged that efforts should be made to ensure that AIDS is not obscured or de-prioritized in the post-2015 development agenda. Leveraging the push to achieve universal health coverage to strengthen and sustain the AIDS response was cited as an important priority. A number of Board members echoed the ECOSOC Resolution (E/RES/2013/11), emphasizing how lessons learned from the global HIV and AIDS response including the lessons learned from the unique approach of the Joint Programme can help inform the post-2015 development agenda and that the Joint Programme offers the United Nations a useful example to be considered, as appropriate, as a way to enhance strategic coherence, coordination, results-based focus and country-level impact, based on national contexts and priorities.
16. The Board emphasized the continuing advocacy and technical support roles of UNAIDS, especially in settings where the political and human rights climate is not conducive to an evidence-informed and rights-based response. During the discussion, Board members specifically urged heightened efforts to close the HIV treatment gap for children. It was noted that social protection strategies have the proven potential to reduce HIV risk and vulnerability among young girls.
17. Board members noted the importance of treatment scale-up in ending AIDS. A number of Board members reported that their countries had expressly committed to ensuring that by 2020: 90% of all People Living with HIV know their HIV status, 90% of people with diagnosed HIV infection receive sustained antiretroviral treatment, and 90% of people receiving HIV treatment have durable viral suppression. It was suggested that further reductions in the prices of HIV drugs will be needed to accelerate and sustain treatment scale-up, especially for second- and third-line drugs.
18. The challenge of mobilizing sustainable financing for the response was the focus of a number of Board interventions. It was observed that continued leadership by international donors will be needed to finance the AIDS response, and low- and middle-income countries highlighted plans for country-level dialogues on mobilizing increased domestic funding for HIV-related programmes and activities. A partnership approach – not only in financing, but across the breadth of the response – was cited as essential for ending AIDS. The critical role of civil society in the AIDS response was particularly noted.

#### **1.4 REPORT OF THE CHAIR OF THE COMMITTEE OF COSPONSORING ORGANIZATIONS**

19. The report of the Chair of the Committee of Cosponsoring Organizations (CCO) was presented by Mr Yury Fedotov, the Executive Director of UNODC. The report emphasized the importance of continued commitment and vigilance in the response. In particular, strengthened efforts are needed to improve the response for key populations, who remain largely without access to HIV services. Stigma, discrimination and punitive approaches continue to undermine progress, including but not limited to people who inject drugs.

20. Mr Fedotov noted that civil society has a key role to play in addressing human rights barriers, reaching key populations and tailoring local responses. He stated addressing the social drivers of the epidemic will require recognition that HIV infection does not occur in isolation but that risk and vulnerability are heavily influenced by the social, legal, political, economic and cultural context. The report underscored cosponsors' commitment to ending AIDS, highlighting the need to leverage all available resources to expedite and sustain gains.
21. The Board took note of the Report of the Chair of the CCO. Particular appreciation was expressed for the emphasis on responding to HIV among people who inject drugs in Eastern Europe, Central Asia and other regions. It was observed that valuable strides have been made in strengthening UNODC partnerships with civil society. Similar appreciation was expressed to the CCO's emphasis on partnerships with civil society. It was recommended that the Joint Programme enhance coordination in responding to crisis situations.

## **2. LEADERSHIP IN THE AIDS RESPONSE**

22. Sir Andrew Witty, Chief Executive Officer of GlaxoSmithKline (GSK), and Mr Subhanu Saxena, Managing Director and Global Chief Executive Officer of Cipla, addressed the Board in a discussion on innovation and research and development in the AIDS response. As the chair observed, the two keynote speakers and the companies they represent have important perspectives to share with respect to the quest to ensure accessible, affordable and reliable supplies of antiretroviral medicines.
23. Sir Andrew noted the remarkable scientific progress made on AIDS, which in a single generation has transitioned from being a disease that was out of control to one that is now considered chronic and manageable. HIV-related scientific advances have occurred in the midst of a time of extraordinary technological progress. He said prospects for continued advances in HIV treatment are excellent, including the real possibility that long-acting antiretroviral medicines will be developed. He shared with the Board that continued gains are being made towards a preventive vaccine for HIV, although the road ahead is likely to be long, difficult and uncertain.
24. Sir Andrew highlighted that partnership and collaboration will remain key to realization of HIV-related scientific progress. In particular, treatment access is an important area for collaboration. He said while it has historically taken 10 to 15 years for a therapeutic innovation to achieve global availability, this pattern has been broken over the last decade, in part due to the emergence of voluntary licensing for new medicines.
25. Sir Andrew addressed the relationship between patents and pricing, suggesting that no single solution will apply to every new medicine in every setting. He described GSK as a pioneer of tiered pricing, but he said additional strategies would be needed, such as effective leveraging of existing health networks and innovative financing mechanisms.

26. Mr Saxena of Cipla observed that the vast majority of the more than 12 million people receiving antiretroviral therapy are taking inexpensive drugs manufactured by generic companies in India. While ready access to affordable drugs will remain essential, he noted that focused efforts are needed to support patients in adhering to treatment. In some countries, he said half of patients who initiate HIV treatment are no longer in care three years later.
27. Mr Saxena shared with the Board that Cipla was the first company to manufacture a fixed dose combination for HIV treatment, and it is now working with the Drugs for Neglected Diseases Initiative to develop a sprinkle formulation for paediatric HIV treatment. He said the relationship between generic companies and multi-national companies has improved over the years, highlighting the value of partnership in improving treatment access for people in resource-limited settings. However, he emphasized that Cipla will continue to challenge patent applications it perceives to be weak, and he stressed the importance of compulsory licensing where patent monopolies serve to reduce access to priority medicines.
28. While lower prices for many HIV drugs are needed, Mr Saxena said it is also important to avoid lowering prices to such a degree that companies opt to leave the market. In Africa, Cipla has established manufacturing facilities as one way to bring manufacturing to the region most affected by the epidemic. He suggested that regulatory systems should be strengthened to avoid delays in access to new therapies.
29. In the discussion following the keynote addresses, Board members thanked the speakers for their remarks, welcomed the focused discussion on the role of the pharmaceutical industry in the global AIDS response, and agreed that partnership approaches would be needed to further expand treatment access. Access to quality generic medicines was cited as critical to an effective, sustainable AIDS response, with a particular call made for the pharmaceutical industry to prioritize development of appropriate paediatric antiretroviral formulations. Board members also called for continued efforts to strengthen procurement and supply management systems and for further price reductions for second- and third-line regimens. A call was also made for urgent efforts to increase access to viral load technologies, including in middle-income countries. Several Board members highlighted the importance of local and regional manufacturing in expanding access to priority medicines.

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

30. Mr Kent Buse, Chief, Strategic Policy Directions, UNAIDS Secretariat, updated the Board on progress towards the post-2015 development agenda and on prospects for including ending AIDS as an important outcome in the post-2015 framework. He acknowledged the many interactions between UNAIDS, Board members and other stakeholders on the post-2015 agenda.
31. Mr Buse described the consultative processes that have been undertaken to inform the development of the post-2015 development agenda. In particular, he highlighted key developments, such as the timeframe for the submission of the final report of the Intergovernmental Committee of Experts on Sustainable Development Financing to the General Assembly in September 2014. He added that the

Sustainable Development Solutions Network has proposed “HIV prevalence, treatment rates, and mortality” as one of seven indicators for the proposed health target of ending preventable deaths.

32. Mr Buse shared that as of 30 June 2014, the Open Working Group on Sustainable Development Goals was reviewing 17 proposed Sustainable Development Goals. He outlined that 10 of these goals would depend on effective multisectoral action for AIDS, and the Working Group’s proposed health goal – ‘attain healthy life for all’ – includes ending AIDS and other priority communicable diseases as one of nine targets. Meanwhile, he said the United Nations Development Group’s consultations on means of implementation of the Sustainable Development Goals has found that the AIDS response has championed new approaches to development. This has also been explicitly noted in decisions from the 32<sup>nd</sup> PCB meeting and the 2013 ECOSOC resolution on the Joint Programme.
33. Mr Buse noted how scientific advances are contributing to the optimism around the feasibility of ending the AIDS epidemic in the post-2015 era, with an array of prevention tools validated in recent years, including HIV treatment as prevention, voluntary medical male circumcision, and pre-exposure antiretroviral prophylaxis. South Africa demonstrates the impact of enhanced commitment, with the number of people receiving antiretroviral therapy increasing from 25 000 in 2003 to more than 2.1 million in 2012.
34. Mr Buse clarified that by ending the AIDS epidemic, UNAIDS means ending AIDS as a public health threat by 2030. This is defined as 90% reductions (from 2010 levels) in new HIV infections, stigma and discrimination experienced by people living with HIV and key populations, and AIDS-related deaths, such that AIDS no longer represents a major threat to any population or country. He added Working Group 1 of the *UNAIDS and Lancet Commission: Defeating AIDS – Advancing global health* endorsed the feasibility of ending AIDS.
35. Bold approaches will be required to end the AIDS epidemic, Mr Buse stated, with outcome-oriented goals agreed to drive progress and promote accountability. To end the epidemic, he noted several key requirements, including scaling up HIV prevention and treatment; addressing underlying social, economic and legal barriers; political commitment and resource mobilization; social mobilization and community involvement; reducing stigma and social inequities; and strengthening health systems. Progress towards ending AIDS can serve as a pathfinder for tuberculosis and malaria, and generate broader health and social transformation.
36. Mr Buse added that the Board is uniquely positioned to advocate for ending AIDS. Citing the successful response of Thailand from an emerging epidemic in the 1990s, Mr Buse noted that the country has recently released a national AIDS strategy to end AIDS by 2030 as defined as 90% reductions in new infections and AIDS-related deaths. He noted that similar resolute leadership would be required worldwide to end AIDS.
37. The Board welcomed the update on work towards the post-2015 development agenda and thanked UNAIDS for its leadership on this issue. It reiterated its finding from its 32<sup>nd</sup> meeting that HIV and AIDS are central to the post-2015 development agenda and that specific targets are needed towards UNAIDS vision of the three



Zeros. Continuing the momentum from the last 10 years was cited as a global priority for the coming years. In particular, Board members called for intensified efforts to capture the prevention potential of antiretroviral therapy. It was recommended that UNAIDS continue to prioritize the goal of universal access to HIV prevention, treatment, care and support. Calls were made to intensify focus on populations who are being left behind – including children, adolescents and key populations – and it was recommended that enhanced priority be given to community mobilization.

38. Specifically recognizing the value of lessons learned from the global AIDS response, the Board agreed that these lessons can help address other complex health and development challenges in the post-2015 era. The Board called on members states and UNAIDS to pursue a clear commitment to ending AIDS in the post-2015 era, and Board members expressed support for the 90% reduction targets included in the definition of ending AIDS. The Board encouraged UNAIDS and member states to pursue HIV-sensitive indicators in several areas, including but not limited to health, gender, education, partnership and youth, and to address the social, political, economic and environmental determinants of HIV, poor health, poverty and inequality (at community, national and global levels). Noting that the AIDS response demonstrates the importance of community involvement in health and development efforts, the Board called for strengthened inclusive accountability mechanisms to enable broad participation and ownership in implementing and monitoring the post-2015 agenda.
39. The Board said that in ending the AIDS epidemic, many challenges need to be to be confronted, including understanding AIDS as more than a health problem, eradicating poverty and inequality, and respecting human rights, including moving away from criminalization approaches meeting the needs of adolescents, and strengthening health systems through continuing and strengthening collective focus and effort.
40. The Chair committed to convey, to the President of the General Assembly and the United Nations Secretary General, the decision of the UNAIDS Programme Coordinating Board on the positioning of the AIDS response in the post-2015 development agenda.

#### **4. FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 33<sup>RD</sup> PROGRAMME COORDINATING BOARD MEETING: HIV, ADOLESCENTS AND YOUTH**

41. Ms Mariângela Simão, Director Rights, Gender, Prevention and Community Mobilization Department, UNAIDS Secretariat, reported on outcomes from the thematic segment of the 33<sup>rd</sup> Board meeting, which focused on HIV, adolescents and youth. She recalled that AIDS is the leading cause of death among adolescents in Sub-Saharan Africa, highlighting the value of a youth-centred format such as the one used in the thematic session of the 33<sup>rd</sup> Board meeting. The session consisted of four key components: (1) perspectives from four young people living with HIV; (2) successful HIV prevention for young people; (3) scaling up HIV testing among young people; and (4) improving young people's access and adherence to HIV treatment.

42. The session emphasized the importance of scaling up proven, evidence-informed HIV programmes for young people, as well as the need to make existing programmes more sensitive to the needs of young people. The earlier thematic sessions also found that parental consent laws and policies impede young people's access to HIV testing and counselling, harm reduction, treatment and other services. As the thematic session found, participation of young people across the full programme development cycle can lead to more effective programmes. In particular, attention is needed as young people transition to adult services to ensure continuity and appropriateness of care.
43. Noting the limited data available on adolescents (ages 10-19), the session also focused on ensuring routine data disaggregation by age and sex, investments in research for adolescents and young key populations, and the need to clarify research protocol guidelines to involving people under age 18. Among 29 core indicators used to monitor progress in implementing agreed global AIDS targets and commitments, only 10 specifically request information on young people.
44. During the subsequent discussion, Board members reiterated the importance of lowering the age of consent for HIV testing, asking the Joint Programme to support countries, upon request, in reviewing their HIV testing, counselling and treatment policies and address age- and gender-related legal, regulatory and social barriers to service access experienced by young people. Concern was also expressed about the fact that globally young women aged 15-24 are twice as likely to be infected as young men and that gaps persist in treatment access between adults versus adolescents and children. The Board encouraged member states to urgently scale up evidence-informed, gender-responsive and youth-friendly HIV prevention, increase access to paediatric HIV treatment, scale up care and support programmes and empower youth-led associations to ensure their participation in programme design, implementation and monitoring and evaluation. Specific action was requested by member states to ensure comprehensive programming for adolescents and youth who inject drugs. The Board also requested UNAIDS to support countries to improve systematic and coordinated collection, dissemination and analysis of sex- and age-disaggregated data at the national and sub-national levels. UNAIDS was also asked to develop indicators to monitor youth participation in the AIDS response.

## **5. UNAIDS 2012-2015 UNIFIED BUDGET, RESULTS AND ACCOUNTABILITY FRAMEWORK**

45. In introducing the agenda item, Ms Jan Beagle, Deputy Executive Director, Management and Governance, UNAIDS Secretariat, noted that the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) is a unique instrument in the United Nations system, combining the efforts of the Cosponsors and Secretariat in a single framework.
46. Ms Beagle stressed that the UBRAF was approved by the PCB three years ago at its 28th meeting, and that last year the PCB requested a mid-term review of the UBRAF. She indicated that, leading up to this PCB, a number of assessments and consultations took place to consider progress in implementing the UBRAF, lessons learned so far, and efforts needed to sustain and intensify the response to AIDS. This process included multi-stakeholder consultations in Geneva in October last

year and March this year, as well as regional consultations and country level reviews, and several meetings involving UNAIDS Secretariat and the Cosponsors, including a meeting of the Committee of Cosponsoring Organizations (CCO) in May.

47. Ms Beagle outlined that the mid-term review drew on data and evidence from a range of different sources, external assessments of UNAIDS, in-depth reviews, analyses and information generated through the Joint Programme Monitoring System (JPMS), the web-based tool developed to monitor implementation. To assist the Board in assessing the Joint Programme's performance under the UBRAF, Ms Beagle noted that the Secretariat submitted a variety of materials and analyses. These included overall findings of the mid-term review of the UBRAF, a performance monitoring report, a summary of external evaluations and six country case studies. In addition, the Board received a conference paper on UNAIDS' collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR). Additional materials including an expenditure and indicator matrix and thematic reports from the JPMS were made available online. Ms Beagle recalled the challenge UNAIDS faces to balance the comprehensiveness of the information presented to the Board on a complex multi-sectoral issue involving 11 Cosponsors and the Secretariat, with the desire to be strategic and clear. She also pointed out that it is important to note that the mid-term review is conducted two years into a four year framework.
48. Ms Beagle emphasized and outlined the three central themes which emerged from the mid-term review: the significant contributions by UNAIDS to the response; challenges to overcome to reach goal of ending AIDS, and; the predictability and continuity needed going forward.
49. To support Board members in understanding the country-level impact of the Joint Programme's efforts and to bring the field perspective to the Programme Coordinating Board, two panel discussions explored UNAIDS' contributions to national responses. The first panel focused on the role of UNAIDS in support of AIDS responses in Asia. Dr Kemal N. Siregar, Secretary of the National AIDS Commission, Indonesia, noted that UNAIDS had assisted Indonesia in adopting treatment as prevention, using a joint UNAIDS/WHO assessment to make strategic use of antiretrovirals a national policy. The strategy is being rolled out in 10 districts, with plans to expand to 75 by the end of 2014. Dr Siregar said Indonesia will need continued UNAIDS support to help close gaps in the treatment cascade and to ensure inclusion of HIV in the country's universal health coverage programme.
50. Mr Douglas Broderick, United Nations Resident Coordinator for Indonesia, described challenges in managing programmes across an archipelago of islands. Mr Broderick noted the close collaboration between the national government and the United Nations system. Indonesia has shown leadership in addressing HIV in prisons and is leading the regional cities initiative. It was noted that Indonesia has an important role in supporting the development of the post-2015 development framework, with the President of Indonesia serving as a co-chair of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda.

51. Mr Steve Kraus, Director of the UNAIDS Regional Support Team for Asia and the Pacific, said the UBRAF had improved how the Joint Programme communicates and coordinates at the regional level. UNAIDS has collaborated with partners to make information specific to the Asia-Pacific region widely available, receiving more than 25 000 hits per month on the dedicated web portal. He added that the regional UNAIDS family in Asia and the Pacific meets on a monthly basis to review progress and ensure accountability, and engages regularly with government and civil society partners. As an example of collaboration, Mr Kraus shared that UNAIDS Regional Support Team has worked with UNFPA, UNDP, the Global Network of Sex Worker Projects and national governments to commission studies in four countries to examine violence against sex workers. UNAIDS Regional Support Team also worked to strengthen strategic information pertinent to HIV and transgender communities in the region. Through the regional Technical Support Facility, 18 countries in the Asia-Pacific region are submitting proposals to the Global Fund.
52. The second panel focused on the role of UNAIDS in supporting AIDS responses in Latin America. Dr Ernesto Ponce, chief of the national AIDS programme of Guatemala, described UNAIDS' support to national efforts to monitor and address cases of domestic violence. Guatemala has established a special commission in the national human rights office to promote inclusion, equal opportunity, non-discrimination and full respect for the diversity of sexual orientation and gender identity. Concerted efforts are focusing on reducing stigma, with particular efforts to sensitize health care workers with respect to the diverse populations affected by HIV.
53. Ms Alma de León, Regional Director for the International Treatment Preparedness Coalition, reported that UNAIDS had played an important role in facilitating the involvement of civil society in regional HIV decision-making. Ms de León also noted the negative effects of stigma and discrimination, stressing the importance of enforcing laws that ostensibly protect against discrimination. She shared that treatment efforts in the region face considerable challenges, including stock-outs, inadequate access to viral load tests, and financial barriers, especially among the 50% of clinic patients who are unemployed. She noted the importance of tailoring HIV services for the specific needs of men who have sex with men and transgender people, who are often ill-treated in mainstream health care settings.
54. Mr César Núñez, Director of the UNAIDS Regional Support Team in Latin America, said UNAIDS had a coordinated, harmonized and well-functioning relationship with the Global Fund, PEPFAR, national governments and other partners. He highlighted some of the recent gains that have been made in Central America, where a sub-regional strategic plan and strong political leadership guide and strengthen regional efforts.

## **5.1 MID-TERM REVIEW**

55. Ms Beagle noted that UNAIDS has made a substantial contribution towards realization of the three zeros, adding that performance results confirm the usefulness of a strategic focus on a limited number of high impact countries and on addressing the particular needs of key populations, as well as the continuing value of a multisectoral approach.

56. Ms Beagle underlined that the review confirmed that a multi-sectoral approach and the model of a joint and cosponsored programme remain relevant and appropriate to support the goal of ending AIDS by 2030. She noted that coordination on AIDS has become more systematic and duplication has been reduced, and that the Joint Programme has matured considerably through the development and implementation of the UBRAF.
57. Ms Beagle said the mid-term review confirmed that the UBRAF is much more than its predecessor, the Unified Budget and Workplan (UBW), that it reflects a new way for the Joint Programme to work together to demonstrate coherence and accountability, and that the UBRAF provides a clearer representation of UNAIDS' contributions to the AIDS response. She noted that the UBRAF more clearly specifies country-level results, with direct reporting from country and regional level on the contributions of the Joint Programme to specific results. The improved results framework in the UBRAF has also aided in development of better workplans and improved reporting, which, in turn, has resulted in better support to countries and engagement with partners.
58. Ms Beagle said a number of performance monitoring issues require further attention, including joint planning, monitoring and reporting; programming across different sectors; and collaborating with major funders of the response, civil society, the private sector and other partners. Moving forward, she added UNAIDS will focus on continued implementation of the UNAIDS Strategy beyond 2015; support the establishment of ambitious, yet practical, global and country-specific targets; improve quality and utilization of data, evidence and analysis; support interventions underpinned by evidence to ensure no one is left behind; invest in adolescents, particularly young girls, and other vulnerable groups; and take the principles of shared responsibility and global solidarity to the next level by ensuring sustainable financing of the response.
59. The Board took note of the report on the mid-term review and expressed appreciation for the Joint Programme's role in the AIDS response. The Board asked UNAIDS to accelerate efforts to support countries to achieve the global AIDS targets adopted by the United Nations General Assembly in 2011. The need to focus programming on key populations was specifically highlighted during the Board's discussion, as was the importance of addressing the needs of women and adolescents.
60. The Board extended the duration of the existing UNAIDS strategy by two years, through 2017, and asked UNAIDS to update the goals in the current strategy and to present on that basis an updated UBRAF for 2016-2017 at the 36<sup>th</sup> meeting of the Board, taking into account lessons learned from the mid-term review of the UBRAF, including the need for a clear results-chain linking outputs to outcomes and impact intended for the Joint Programme.. The Board requested that UNAIDS develop the next phase strategy (beginning in 2018), results framework and budget for the Board's consideration at its 40<sup>th</sup> meeting, building on the current strategy and the vision of the three zeros. It was agreed that the next strategy will align with the resolution on the Quadrennial Comprehensive Policy Review (QCPR) of operational activities for development and will take into account lessons learned from implementation of the QCPR and the UBRAF.

## 5.2 PERFORMANCE REPORTING

61. The Board took note of the Performance Monitoring Report (PMR) and asked UNAIDS to provide a consolidated PMR at the 36<sup>th</sup> Board meeting. The requested PMR should capture progress against core indicators and expenditures, and demonstrate the link to outcomes, goals and targets. The PMR should distinguish Cosponsor, Secretariat and joint results and should leverage the UBRAF structure to showcase country performance. Some Board members expressed a desire for greater clarity regarding specific contributions by the Joint Programme and its individual members towards achievement of specific results. Other Board members applauded the shortening and streamlining of the PMR, and were pleased to be able to see results in each region.
62. Board members welcomed refinements made to the JPMS, with particular appreciation expressed for enhanced reporting from country offices. Appreciation was also expressed for the information provided by UNAIDS regarding its strategic work with key global partners. Board members noted that UNAIDS had played an important role in programmatic and policy gains in different parts of the world. Specific appreciation was expressed for the country examples provided during the session. It was suggested that more explanation of challenges encountered by the Joint Programme would be helpful, and Board members also recommended additional information on how coordination among Cosponsors has improved. Board members welcomed the alignment of UNAIDS overall resource planning with the planning cycles of other United Nations agencies.
63. Zimbabwe, on behalf of the Africa group, expressed appreciation for improvements in performance reporting and also asked for revisions to certain indicators. Specifically, it was requested that reporting on the integration of HIV into the broader health system be strengthened, that the indicator on comprehensive sexuality education be revised to focus on good quality sex education in line with agreed language in the 2011 Political Declaration on HIV and AIDS, and that indicators on specific populations should refer to vulnerable groups and key populations according to national epidemiological context. The Africa Group indicated that it would not be in a position to adopt the indicator set in its current form and recommended that it should be revised in line with comments presented. Zimbabwe, on behalf of the Africa group, also proposed that efforts to strengthen engagement with civil society organizations should encourage accountability, be inclusive and align with the burden of disease at regional and national level.
64. Board members welcomed the information provided on the Joint Programme's work with civil society. The Board asked the Secretariat to prepare a conference room paper for the 35<sup>th</sup> meeting of the Board on concrete actions taken to address and implement previous Programme Coordinating Board decision points pertaining to civil society. The need for an assessment of the resources that should be channelled through civil society of the total funding required for the AIDS response was cited by Board members. Board members encouraged UNAIDS to intensify its work to address human rights violations and their impact on the AIDS response. In response to Board interventions, it was acknowledged by UNAIDS that performance reporting on the Joint Programme's work with civil society continues to evolve and that further refinements and improvements can be anticipated.

### 5.3 FINANCIAL REPORTING

65. Mr Joel Rehnstrom, Director, Planning, Finance and Accountability, UNAIDS Secretariat, noted that the 2013 financial statements for UNAIDS were the second set of financial statements prepared in accordance with the International Public Sector Accountability Standards (IPSAS), and that UNAIDS financial situation remains stable with 98% of the core budget mobilized in 2013.
66. Core income mobilized in 2013 (US\$ 237.4 million) exceeded amounts mobilized in 2012 (US\$ 220.2 million), with total expenditure in 2012-2013 amounting to US\$ 476.4 million, roughly US\$ 8 million less than the approved budget. The gap of US\$ 27 million between revenue and expenses was covered from the fund balance. Non-core funding equalled US\$ 77 million in 2012-2013, compared to US\$ 58 million in 2010-2011. The fund balance of US\$ 140.2 million is within the approved maximum level of 35% (or US\$ 170 million).
67. Mr Rehnstrom highlighted cost savings and efficiency gains achieved by the UNAIDS Secretariat: total expenditure in 2012-2013 was 8% lower than in 2010-2011. The Secretariat achieved a 20% reduction in general operating costs, 30% reduction in travel costs and 35% reduction in contractual and consultancy costs.
68. In 2014, Mr Rehnstrom noted that the UNAIDS Secretariat has mobilized US\$ 140.5 million to date, or 58% of the core UBRAF of US\$ 242.4 million. Cosponsors have received 100% of their respective allocations for 2014, amounting in total to US\$ 87.3 million. Forty percent, or US\$ 195 million, has been expended and encumbered against the 2014-2015 UBRAF. Mr Rehnstrom said donors are requested to sustain, or where possible increase, their funding to UNAIDS, and member states that have not yet made their contribution were invited to do so.
69. Mr Rehnstrom shared with the Board that UNAIDS Secretariat received an unqualified ("clean") audit opinion for 2013. The external auditors recommended that steps be taken to improve guidance and procedures on transfers and grants to counterparts, and to strengthen internal mechanisms for monitoring and closure of grants. The external auditors also recommended the formulation of an overall procurement strategy and finalization of a procurement manual. It was also recommended that UNAIDS evaluate the use of Long Term Agreements (LTAs) and identify appropriate risk and mitigation measures for LTAs.
70. Mr Rehnstrom highlighted that UNAIDS Secretariat is in the process of developing a strategy for enterprise risk management (ERM), a systematic and organization-wide approach that supports achievement of strategic objectives by proactively identifying, assessing, evaluating, prioritizing and controlling the probability or impact of adverse events to an organization. Mr Rehnstrom stated that a roadmap has been developed and an ERM policy along with a governance model and a risk management committee have been put in place to support this process. Moving forward, he added UNAIDS will develop an organization-wide register of top risks; develop a guide and supporting training materials, and conduct an organization wide risk assessment. During the Board discussion, it was suggested that UNAIDS should develop a coordinated strategy to address risks to the lives of People Living

With HIV, as reflected in recent passage of anti-LGBT laws, loss of access to harm reduction services, and the backlash against people living with HIV in many regions.

71. The Board accepted the financial report and audited financial statements for the year ending 31 December 2013, and took note of the interim financial management update for the 2014-2015 biennium, including the partial funding of staff-related liabilities and the replenishment of the Building Renovation Fund. Board members expressed some concern regarding the gap between revenue and expenditure, and encouraged UNAIDS to take steps to close this gap. The Board encouraged donor governments to release their contributions towards the 2012-2015 UBRAF as soon as possible.
72. The Board asked UNAIDS Secretariat to conduct an analysis to determine the appropriate lower-limit threshold for the net fund balance and report back to the Board at its 36<sup>th</sup> meeting. The Board also asked UNAIDS to hold a Financing Dialogue before the end of 2014 to ensure predictable and sustained funding, the efficient management of funds and transparency for effective UBRAF implementation within the broader AIDS response.
73. In response to the Board's questions, suggestions and comments, Mr Sidibé noted as a very encouraging sign that several African countries are currently in discussions to contribute to the core budget of UNAIDS.

## **6. UPDATE ON STRATEGIC HUMAN RESOURCES MANAGEMENT ISSUES**

74. Mr Roger Salla Ntounga, Director, Human Resources Management at UNAIDS Secretariat, updated the Board on strategic human resources management issues – in particular, consolidation of the organizational realignment, and implementation of the UNAIDS Secretariat Human Resources Strategy.
75. The organizational realignment aimed to align resources – human and financial – with the UNAIDS vision and corporate priorities, strengthen staff deployment and skills for an increased country focus, demonstrate value for money and achieve cost effectiveness. Mr Salla Ntounga said the Secretariat has achieved its staffing target of 820 staff and a 30:70 headquarters to field ratio; two objectives that were set at the start of the realignment in July 2011. As of April 2014, the Secretariat has 817 staff, 236 staff in Headquarters and 581 staff in the Regional Support Teams (RST), Country Offices (UCO) and Liaison Offices.
76. Mr Salla Ntounga noted that headquarters structure had been streamlined – with a decrease of 85 staff (26%) between July 2011 and April 2014 – and that staff were refocused around the global AIDS targets and the Secretariat's core functions. Steps were taken to retain the Secretariat's capacity for normative work in all key areas such as strategic information, investment and efficiency, technical support, and human rights and gender equality.
77. Mr Salla Ntounga also noted that a strengthened field presence and structure was in place in particular in high-impact countries, through additional personnel and re-profiling of functions.. As reflected in the new title of UNAIDS Country Director, the role of the UNAIDS head of office at country level has also been repositioned to



place a stronger focus on leadership, advocacy, and delivery of results. The Secretariat's mobility policy and annual exercise continued to be a key workforce planning and development tool, with 153 staff moved to new positions (19% of the Secretariat workforce) in the two most recent rounds. Mobility was also strategically used to increase the number of qualified women in management positions.

78. Mr Salla Ntounga emphasized that the Secretariat has now entered a consolidation phase, with enhanced focus on strengthening of staff competences, and talent management, in alignment with the high-level targets and commitments. In this framework, the launch of a new performance management system (PALM) and a performance management policy marked important milestones in the implementation of the Secretariat's human resources strategy. An innovative system integrating management of staff performance and learning, PALM guides staff in aligning their work with the expected results of the Secretariat and will be an important accountability tool. Moreover, increased focus is being placed on staff development, including through a new induction programme for UNAIDS Country Directors incorporating distance learning sessions, a face-to-face workshop at headquarters, and a community of practice to ensure ongoing support.
79. Mr Salla Ntounga explained that the Secretariat Gender Action Plan, launched in March 2013, is intended to benefit all staff by nurturing a supportive culture of respect and diversity, with specific targets in seven strategic areas. Progress since the launch of the Gender Action Plan included increasing the number of women UNAIDS Country Directors - from the 27% in February 2013 to 35% in April 2014 - and increasing the number of women at P5 level – from 36% to 42%. A pilot mentoring programme for women was launched in April 2014 to contribute to career development of women staff, involving 15 mentees and 15 mentors and representing a variety of grade levels, functions and office locations. Mr Salla Ntounga stressed that UNAIDS received a positive review for the development of the Action Plan in the first round of reporting on the UN System-wide Action Plan on Gender Equality and the Empowerment of Women (UN-SWAP). UNAIDS' overall performance was rated better than the performance of Funds and Programmes as a whole, with UNAIDS having met or exceeded in 73% of the performance indicator ratings. At the beginning of 2014, the Secretariat submitted its 2013 report in relation to UN-SWAP, highlighting UNAIDS' progress against the 15 UN-SWAP Performance Indicators. The initial scoring from UN Women indicated that the Secretariat has advanced in two areas, gender responsive auditing, and organizational culture.
80. Mr Salla Ntounga described the actions taken to ensure staff well-being, including a new policy on flexible working arrangements, which aims to balance professional and private commitments while maximizing efficiency and effectiveness. The excellent collaboration with the UNAIDS Staff Association was underscored. Staff security remained a paramount concern. A Security Awareness Training programme for women was developed. The Secretariat also assessed compliance with the UN Minimum Operating Security Standards (MOSS) by all offices, and took stock of the occupational health and safety situation.
81. The role of the Secretariat in leading two innovative UN system-wide initiatives to support staff members and families, UN Plus and UN Cares, was also highlighted. Mr Salla Ntounga shared that within the UN, the Secretariat was ranked as the top

agency on standards for HIV in the workplace. Programmes delivered through UN Cares go well beyond HIV to foster communication and respectful and productive workplaces.

82. Mr Salla Ntounga's presentation ended with an overview of key UNAIDS staff data. As of 1 April 2014, 49% of staff were in the International Professional category, 13% were National Officers and 38% were General Service. While the Secretariat workforce has a presence across seven regions, almost 50% of field staff work at the epicenter of the epidemic in Eastern and Southern Africa (30%) and West and Central Africa (22%). International Professional staff come from a total of 99 countries across all geographic regions. With regard to the age distribution of the UNAIDS workforce, the average age is 46. As a knowledge organization, the Secretariat requires experienced, high-level professionals who can independently deliver technical and management results and draw upon well-developed professional networks. At the same time, the Secretariat increased the representation of younger people in its workforce. Currently, staff aged between 20 and 39 constitute 27% of the overall workforce.
83. The Board took note of the update on strategic human resources management issues and several members expressed their appreciation for its comprehensiveness and quality. Several delegations noted the progress made across many of the strategic issues identified, including in streamlining headquarters, increasing the relative number of staff in field offices, and implementing the Gender Action Plan. It was noted that staff deployment should be congruent with the burden of the epidemic.

## **7. STATEMENT BY THE REPRESENTATIVE OF THE UNAIDS STAFF ASSOCIATION**

84. Mr Jason Sigurdson, chair of the UNAIDS Secretariat Staff Association (USSA), reported on the results of the latest annual staff survey, which achieved a 60% response rate. The survey highlighted the importance of health insurance reform for staff members, as staff often experienced lack of recognition of health insurance at the point of service (often resulting in substantial out-of-pocket costs), long delays in reimbursement and outdated paper-based reimbursement claim procedures. On this key issue, Mr Sigurdson said a joint staff-management task force was convened in 2013, with strong support from the Mr Sidibé and Ms Beagle. Although the problems with regard to staff health insurance have not been resolved, he said staff have been encouraged by signs that WHO is undertaking a serious study to address staff concerns. Other issues raised by the chair of the USSA included the impact of currency fluctuations and high inflation in some settings, as well as ongoing issues relating to work-life balance.
85. The Board noted the statement by the representative of the UNAIDS Staff Association.

## **8. ANY OTHER BUSINESS**

86. No new business was presented.

## **9. THEMATIC SEGMENT: ADDRESSING SOCIAL AND ECONOMIC DRIVERS OF HIV THROUGH SOCIAL PROTECTION**

87. A full-day thematic segment was devoted to the role of social protection in addressing the social and economic drivers of HIV. In his opening remarks, Mr Sidibé recognised the foresight of the Board in dedicating the thematic session to social protection, citing social protection as the next frontier of the AIDS response. He stated that addressing social and economic drivers were critical to the achievement of the UNAIDS vision, stressing the importance of acting beyond the health sector and of co-financing from other sectors, and he called on social protection to be a priority issue in the High Level Meeting of the United Nations General Assembly on HIV/AIDS. Mr Sidibé stated that research commissioned by the ILO indicate that among people living with HIV who receive social protection in Rwanda, 95% were able to keep their jobs, 99% of their children remained in school, and 95% accessed antiretroviral therapy. Evidence from Malawi and South Africa on the role of social protection in HIV prevention was also cited.
88. Mr Guy Ryder, ILO Director General, highlighted ILO's commitment to addressing social economic drivers of HIV, as evidenced by ILO passage of the recommendation 200 and 202 Social Protection Floors. He emphasized the importance of the workplace in addressing HIV, as People Living With HIV who are in decent employment are 39% more likely to persist on antiretroviral therapy. He called for inclusion of social protection in the post-2015 agenda, cited research in four countries demonstrating that social protection reduces vulnerability and improves lives. Mr Ryder cited numerous continuing obstacles to a more effective response, including lack of awareness regarding social protection schemes, social protection coverage gaps (including eligibility criteria that exclude many people living with HIV particularly those in the informal economy), red tape and bureaucratic obstacles, high levels of stigma and discrimination towards key and vulnerable populations, and a common perception among decision-makers that social protection is unaffordable. He indicated that the more social protection interventions are done, the more it is proven that social protection is affordable, citing recent experience in Mozambique.
89. Providing the perspective of a Person Living with HIV, Ms Morolake Aderinoye Odetoyinbo, of Nigeria, indicated the need for social protection to be available to everyone regardless of the HIV status or nationality. She bemoaned the lack of gainful opportunities for employment for People Living with HIV and observed that people who participate in jobs as volunteers are often side-lined when opportunities for gainful employment arise. She noted that health insurance plans in many countries exclude People Living with HIV and that too many people in need of antiretroviral therapy are insufficiently educated regarding its importance. Having moved to the USA to pursue her education, she has encountered obstacles to obtaining essential services due to restrictions experienced by people who are not US citizens. She advocated for action to address the needs of migrants living with HIV, nutritional needs of living with HIV, homophobic laws, health and educational needs of orphans and vulnerable children, and social stigma.
90. Ms Catherine Sozi, UNAIDS Country Director, China, moderated the thematic session. Her introductory remarks framed the session as a culmination of

preparatory work done by UNAIDS and partners in countries, regions and the headquarters. She indicated that a working group encompassing Member States, Cosponsors, and civil society led the preparation of the session including the drafting of the background paper which is posted on the UNAIDS website. Among 52 proposals received in response to 'UNAIDS call for submissions of programmes and/or initiatives that make a case for addressing social and economic drivers of HIV through social protection towards goals of ending AIDS, extreme poverty, inequality and marginalization, a number were selected to present key findings to the Board. These presentations were organized in a series of panel discussions.

*Social protection and HIV: Do financial incentives work for the HIV response?*

91. Mr David Wilson, head of the World Bank's Global AIDS Programme, reported that a quarter of the world's people live on less than US\$ 1.25 per day. However, there has been an important increase in social protection programmes, which currently reach more than 1 billion people worldwide, with fastest growth occurring in Africa. Despite these gains, two-thirds of people who live on US\$ 1.25 per day are not currently reached by social protection programmes.
92. Mr Wilson noted that the World Bank is the largest global funder of social protection. In addition to evidence demonstrating the effectiveness of school feeding and cash transfer programmes in reducing poverty and promoting non-HIV health outcomes, three randomized controlled trials that used biological endpoints have found that cash transfers reduce HIV transmission. He stated that in Tanzania, people offered up to US\$60 each annually to stay free of sexually transmitted infections (STI) had a 25% lower STI prevalence; and in Malawi, a US\$ 15 monthly cash transfer to poor families to ensure young people remained in school reduced by 64% new HIV infections regardless whether the young women remained in school or not. In Lesotho adults offered a chance to participate in a lottery to win US\$50 or US\$100 every four months conditional on remaining HIV negative had 25% lower HIV incidence which increased to 33% among young women. Although questions regarding durability of benefits and scalability of cash transfers remain unanswered, Mr Wilson concluded that sufficient evidence exists to expand these programmes, and the World Bank is convening a series of meetings to explore how best to move forward.
93. Dr Lucie Cluver of the University of Oxford focused on whether government cash transfers programs reduce HIV risk, whether cash and care produce better HIV prevention outcomes and the pathways by which social protection may reduce HIV risk and vulnerability. In three studies, Dr Lucie Cluver and her colleagues conducted in South Africa, it was found that a teenage girl who is not experiencing physical or emotional abuse and who is not hungry has a 0.9% chance of having transactional sex, compared to a 57% chance for a girl who experiences all of these problems. While cash transfers do not prevent young people from engaging in risk sexual risk behaviours, recipients of cash transfers appear to make safer decisions regarding the type and age of sexual partners. Cash transfers alone significantly reduce the odds of sexual risk behaviours by 40% for adolescent girls but not for adolescent boys. However, when cash transfers are combined with psychosocial care and support, boys experience a 50% reduction in risk behaviours. In addition to their effect on HIV risk behaviours, social protection programmes also increase treatment adherence, with the combination of cash and

care resulting in 80% improvement in adolescents' adherence rates. She concluded that cash transfers work for HIV prevention in the real world.

94. Ms Noxolo Leo Myeketsi, of Cape Town, South Africa, provided a real-world example of the role of social protection. She described for the Board how a child cash grant to her grandmother helped her cover school-related expenses, including application fees, as well as food, helping her avoid intergenerational sexual relationships to support her basic needs. She is now pursuing her studies at university, an option that would not have been feasible without the grant provided to her grandmother.
95. Ambassador at large and US Global AIDS Coordinator, Dr Deborah Birx, focused on the role of savings groups for economic strengthening. Savings groups are a community-based intervention that helps people better manage their money, gain access to basic financial services where affordable lending is unavailable, and strengthen social safety nets. These savings build on traditional practices common in almost every country where PEPFAR works, making savings groups easy to understand, accept and operate. Dr Birx noted that savings groups are proving to be a low-cost, scalable, and self-sustaining intervention that accelerate and sustain programmatic outcomes for AIDS. In more than 15 countries where more than 13 000 savings groups with more than a quarter million beneficiaries have been established, members have managed to save over US\$6.5 million from their own resources, with savings used for a variety of purposes, chief among these investing in the care and wellbeing of about 1 million children in their families.
96. Dr Birx highlighted tangible results from PEPFAR's support for savings groups. In Rwanda 97% of orphans and vulnerable children continue to be enrolled in school even after discontinuing the program, 88% have health insurance which is paid by the family and 85% continue indicating high levels of psychosocial wellbeing. In Ethiopia, savings groups among people living with HIV supported by WFP and PEPFAR were associated with 97% adherence to antiretroviral therapy relative to 84% of a comparison group. In Cote d'Ivoire savings were associated with a reduction in intimate partner violence. PEPFAR is now ramping up support for cash transfers for orphans and vulnerable children and is watching with interest the discussion on social protection including cash transfers for the AIDS response.
97. The panel's presentations resulted in extensive discussion, with Board members expressing appreciation for the discussions. Board members said that social protection interventions work, are affordable and need to be delivered in combination with broader programs to reduce inequality, promote human rights, reduce poverty and enhance food security. It was noted that 16 million people in South Africa currently receive social grants. Countries (such as Rwanda and Tanzania) are investing significant domestic resources towards social protection, and that PEPFAR, UNICEF, World Bank, DFID, Switzerland and other donors provide financial support for various social protection initiatives. Switzerland highlighted the social protection program it supports in Tanzania targeting older people who are often marginalised and not targeted with HIV mitigation services. Board members advised that social protection is a critical component of the global AIDS response. As one example, it was noted that food security and nutrition have an important role to play in promoting treatment adherence. In response to queries from Board members, PEPFAR stated that the reauthorization legislation for the

programme did not diminish resources for social protection interventions but instead underscored the need to ensure HIV treatment access for orphans and vulnerable children. Board members observed that middle-income countries are often unable to obtain assistance for social protection, notwithstanding acute poverty and vulnerability in many of these countries. Board members encouraged countries to scale up social protection and cash transfer programmes, including through inclusion of these programmes in concept notes to the Global Fund and in Country Operational Plans for PEPFAR.

*Access in action: lived experience on social protection and HIV*

98. Dr Mehdi Karkouri, of the Association de Lutte contre le SIDA in Morocco, described Morocco's concentrated epidemic, including the substantial burdens and access barriers experienced by key populations. For example, he outlined how it is often difficult for people living with HIV to obtain timely appointments for diagnostic tests because of long distances to HIV services, poverty and stigma associated with HIV. Dr Karkouri outlined a programme supported by the Global Fund recruits social workers to assist people living with HIV in navigating health and social service systems in order to obtain needed treatment and diagnostic services. These included basic support for transportation, basic needs including food, clothing and temporary shelter for people living with HIV who live long distances from health facilities.
99. Dr Pornpet Panjapiyakul, of the Thailand Ministry of Health, described how Thailand had taken steps to ensure migrant workers access social security and health care. He indicated that Thailand has 3 million migrants of which 1.8 million are undocumented. Migrants account for 2 700 of the country's 460 000 People Living with HIV. Through a new process that enables migrants to obtain national identification, migrants and their families are now able to access essential health care including HIV prevention, treatment, care and support services. He indicated that 140,000 migrants have so far been covered by the scheme and that the scheme would become self-sustaining when the number of enrollees reaches 200,000.
100. Mr Charles King, Executive Director of Housing Works, a non-governmental organization in New York City, described how his organization had worked to overcome the effects of homelessness and substance addiction on the health and well-being of People Living with HIV. Among people who live in Housing Works' congregate housing programme, over 65% are virally suppressed and about two-thirds either discontinue or reduce their drug use. The organization's housing programme also facilitates access to voluntary harm reduction, mental health services, vocational training and work opportunities. Mr King urged greater financial support for housing and access to broader employment opportunities for homeless people as a key intervention to address the social and economic drivers of HIV.
101. As Mr Krishan Ballabh Agarwal of India explained, HIV often drives individuals and families into despair. India has extended social protection programmes to cover People Living with HIV. Among the notable achievements, he indicated that 35 state and central schemes were amended to include people living with HIV. As of December 2013, more than 600 000 people living with HIV are accessing these schemes, including transport refunds, subsidies, compensation for missed wages,

employment opportunities, widow pensions, subsidized housing and medical insurance. The programme appears to be sustainable, as it is protected by statute.

102. Ms Maureen Owino, of the Committee for Accessible Treatment in Toronto, Canada, described challenges that immigrants often experience in obtaining HIV treatment services. Prominent access barriers for immigrants include fear of deportation, difficulties in understanding the migration process, lack of culturally appropriate immigration counselling and multiple dimensions of vulnerability. The increasing number of black immigrants being charged with criminal transmission of HIV is another barrier to accessing HIV services for migrants. In response, service providers came together to create the organization where she works, which specifically focuses on enhancing access for immigrants. Since its creation in 1999, the organization has transitioned from one driven by service providers to one that is run and controlled by immigrants who are living with HIV.
103. In response to the presentations, Board members welcomed and expressed appreciation for the Joint Programme's efforts to place social protection at the centre of the response. Speakers called for efforts to provide psychosocial support to people living with HIV, and to ensure that no one is left behind in the coverage of social protection. UNAIDS was encouraged to lead efforts to increase the resilience of vulnerable groups (including the homeless), include social protection in the post-2015 agenda and make a persuasive economic case for investing in social protection to finance ministers.

*Ending AIDS: No one left behind*

104. The thematic session's final series of presentations focused on the experiences of key populations and the need for social transformation to reduce HIV vulnerability.
105. Mr Andrés Scagliola, of the Uruguay Ministry of Social Development, reported on his country's efforts to address the needs of transgender people, whose life expectancy is only about half of that for the country as a whole. HIV prevalence among transgender people in Uruguay is estimated to be 21%, and transgender people experience considerable barriers to service access, in part because of discrimination within the health care system. Uruguay has taken steps to align national identification schemes with each individual's gender identity. The TUS Transcard has been developed and is available throughout the country. This has enabled 1088 transgender people to obtain unconditional cash transfers. Organizations arising from the transgender community have emerged, and the country has embarked on a national campaign to combat stigma against transgender people.
106. Ms Penninah Mwangi, Director of the Bar Hostess Empowerment and Support Programme (BESP) in Nairobi, Kenya, described her organization's founding in 1997-1998, when many sex workers were dying as a result of HIV. The organization began training sex workers on HIV prevention and human rights. The organization distributes condoms, provides HIV testing and counselling and facilitates linkage to care. In response to violence against sex workers, the organization has advocated for greater security from law enforcement organizations. BHESP has helped form and strengthen 30 sex worker networks,

trained over 500 paralegals and over 600 peer educators, provided over 1 000 sex workers and 400 men who have sex with men with biomedical support (e.g., condoms, PEP, PrEP, HIV treatment), and sponsored 15 free legal aid clinics for sex workers. The organization also facilitates legal services for sex workers who experience harassment from law enforcement officers, winning 10 cases in which arrests were challenged.

107. Mr Derrick Malumo, of Zambia, reported on the experience of prisoners living with HIV. With support from UNAIDS, the Government of Zambia now provides services for prisoners living with HIV as well as ex-prisoners. However, ensuring continuity of care for prisoners who are released into the community remains a challenge. Many individuals released from prison experience homelessness and a lack of economic opportunities, often leading to re-arrest. He urged increased access to social services for prisoners, including housing support to facilitate socioeconomic integration of ex-prisoners.
108. Ms Maksym Demchenko, of Ukraine, called attention to the social protection needs of people who inject drugs. The Ukrainian Network of People living with AIDS has managed to secure various government benefits. However, a sustainable response requires attention to the social drivers and root causes of HIV risk and vulnerability. Law enforcement officers, in particular, need to be sensitized and stop harassing people who use drugs. Strengthened harm reduction programmes and an integrated approach that links HIV prevention and treatment are needed. In Ukraine, it was noted that recent political unrest had exacerbated the HIV challenge among people who use drugs by interrupting service access.
109. Following the presentation, Board members advocated for the active leadership of key populations with respect to programmes that focus on them. Challenges faced by indigenous people were highlighted, with Board members noting that the response is currently leaving them behind and calling for concerted action to address their HIV-related needs. Zambia's effort to address HIV in prisons was applauded, and it was observed that other countries from various regions have also taken steps to improve HIV programming and policy with respect to prisons settings.
110. Summarizing results of the thematic session, Ms Simão reiterated that strong evidence now exists that social protection programmes work to reduce vulnerability, enhance social justice and reduce HIV risk. Social protection is also affordable, as the cost of doing nothing is far greater than investments required for social protection programmes. She said governments have a major role to play in expanding access to social protection, although engagement of communities and civil society is essential for success. She added that the UN is a natural partner in efforts to expand access to social protection.

## **10. CLOSING OF THE MEETING**

111. On behalf of the Joint Programme, Ms Beagle thanked the chair and co-chair and expressed appreciation for the Board's support of the UNAIDS vision and for extending the UNAIDS Strategy.
112. The Chair closed the 34th UNAIDS Programme Coordinating Board meeting.



113. The 34th meeting of the UNAIDS Board made a number of decisions, recommendations and conclusions (Annex 2).

[Annexes follow]

Annex 1



## PROGRAMME COORDINATING BOARD

UNAIDS/PCB (34)/14.1

Issue date: 17 June 2014

### THIRTY-FOURTH MEETING

DATE: 1-3 July 2014

VENUE: Executive Board Room, WHO, Geneva

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

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## Draft Annotated Agenda

**TUESDAY, 1 July**

### 1. Opening

#### 1.1 Opening of the meeting and adoption of the agenda

*The Chair will provide the opening remarks to the 34th PCB meeting.*

#### 1.2 Consideration of the report of the thirty-third meeting

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

*Document: UNAIDS/PCB (33)/13.23*

#### 1.3 Report of the Executive Director

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

*Document: UNAIDS/PCB (34)/14.2*

#### 1.4 Report of the Chair of the Committee of Cosponsoring Organizations (CCO)

*The Chair of the Committee of Cosponsoring Organizations will present the report of the Committee.*

*Document: UNAIDS/PCB (34)/14.3*

### 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.*

Document: UNAIDS/PCB (34)/14.4;

UNAIDS/PCB (34)/14.CRP1; UNAIDS/PCB (34)/14.CRP2.

**4. Follow-up to the thematic segment from the 33<sup>rd</sup> Programme Coordinating Board meeting:**

*The Board will receive a summary report on the outcome of the thematic segment on "HIV, adolescents and youth"*

Document: UNAIDS/PCB (34)/14.5

**WEDNESDAY, 2 July**

**5. UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework**

**5.1 Mid-term review**

*The Board will receive a report on the Mid-Term Review of the 2012-2015 Unified Budget, Results and Accountability Framework. Key findings of external reviews of UNAIDS and country case studies are included as annexes. Snapshots of UNAIDS work in high impact countries will be presented to the Board as a conference room paper, illustrating the work of the Joint Programme at country level.*

Document: UNAIDS/PCB (34)/14.6; UNAIDS/PCB (34)/14.7; UNAIDS/PCB (34)/14.8;

UNAIDS/PCB (34)/14.CRP3.

**5.2 Performance reporting**

*The Board will receive a report on progress in implementing UNAIDS Unified Budget, Results and Accountability Framework in 2012-2013. A revised indicator framework for 2014-2015 is presented as an annex. The 2012-2013 Results, Accountability and Budget Matrix, a report on UNAIDS collaboration with the Global Fund to fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan For AIDS Relief (PEPFAR) as well as a report on the work of the Joint Programme with Civil Society will be presented as conference room papers.*

Document: UNAIDS/PCB (34)/14.9; UNAIDS/PCB (34)/14.10 ;

UNAIDS/PCB (34)/14.CRP4; UNAIDS/PCB (34)/14.CRP5.

**5.3 Financial reporting**

*The Board will receive the financial report and audited financial statements for 2013 which includes the report of the external auditors for 2013. The Board will also receive a financial management update as at 31 March 2014.*

Document: UNAIDS/PCB (34)/14.11; UNAIDS/PCB (34)/14.12

**6. Update on strategic human resources management issues**

*The Board will receive an update on strategic human resources management issues.*

Document: UNAIDS/PCB (34)/14.13

**7. Statement by the representative of the UNAIDS Staff Association**

Document: UNAIDS/PCB (34)/14.14

**8. Any other business**

**THURSDAY, 3 July**

**9. Thematic Segment:** Addressing social and economic drivers of HIV through social protection.

Document: UNAIDS/PCB (34)/14.15;  
UNAIDS/PCB (34)/14.CRP6.

**10. Closing of the meeting**



## Annex 2

03 July 2014

### **34<sup>th</sup> Meeting of the UNAIDS Programme Coordinating Board Geneva, Switzerland 1-3 July 2014**

#### **Decisions**

The 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-third meeting**

- 2.1 *Adopts* the report of the 33rd meeting of the UNAIDS Programme Coordinating Board;
- 2.2 *Elects* El Salvador as Rapporteur for 2014;

#### **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 Chair of the Committee of Cosponsoring Organisations (CCO)**

4. *Takes note* of the report of the Chair of the Committee of Cosponsoring Organisations (CCO);

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

- 5.1 *Welcomes* the update on the AIDS response in the post-2015 development agenda and;
- 5.2 *Takes note* of the decision of the UNAIDS Programme Coordinating Board at its 32<sup>nd</sup> meeting on the post-2015 development agenda, in particular:
  - a. *Stresses* the importance of ensuring that HIV and AIDS are central to the post-2015 UN development agenda and of advocating for the inclusion of targets under relevant goals towards achieving zero new HIV infections, zero AIDS-related deaths and zero discrimination; and
  - b. *Builds* on the lessons learned from the HIV and AIDS response in addressing other complex health and development challenges in the post-2015 era;
- 5.3 *Takes note* of the ECOSOC Resolution E/RES/2013/11, in particular:
  - a. *Recognizes* the value of the lessons learned from the global HIV and AIDS response for the post-2015 development agenda, including the lessons learned from the unique approach of the Joint Programme and that the Joint Programme offers the United Nations a useful example to be considered, as appropriate, as a way to enhance strategic coherence, coordination, results-based focus and country-level impact, based on national contexts and priorities;
- 5.4 *Takes note* of the ongoing work of the Open Working Group on Sustainable Development Goals and its explicit inclusion of language on “ending the epidemics of AIDS, tuberculosis and malaria”;
- 5.5 *Calls* on member states and the UN Joint Programme to pursue, in line with our common vision of the three zeros, a clear commitment in the post-2015 development agenda to ending the AIDS epidemic as a public health threat and an obstacle for overall sustainable development by 2030, provisionally defined as the rapid reduction of new HIV infections, stigma and discrimination experienced by people living with HIV and vulnerable populations and key populations<sup>1</sup>, and AIDS-related deaths by 90% of 2010 levels, through evidence based interventions to include universal access to HIV prevention, treatment, care, and support, such that AIDS no longer represents a major threat to any population or country;

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<sup>1</sup> As defined in the UNAIDS 2011-2015 Strategy ‘Getting to Zero’, footnote n. 41: ‘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 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’.

- 5.6 *Encourages* the UN Joint Programme and member states to pursue HIV-sensitive indicators under several goal areas, including, but not limited to, health, gender, education, partnership, and youth, to ensure policy coherence and joined-up action to address the social, political, economic and environmental determinants of HIV, poor health, poverty and inequality (at community, national and global levels); and strengthened inclusive accountability mechanisms to enable broad participation and ownership in implementing and monitoring the post-2015 agenda;

**Agenda item 4: Follow-up to the thematic segment from the 33<sup>rd</sup> Programme Coordinating Board meeting: HIV, adolescents and youth**

- 6.1 *Takes note* with appreciation of the summary report of the Thematic Session on HIV, adolescents and youth;
- 6.2 *Recognizes* with great concern that globally young women aged 15-24 have HIV infection rates twice as high as young men, and that there is a persistent and significant gap between antiretroviral treatment coverage rates for adult vs. adolescents and children;
- 6.3 *Encourages* member states to urgently scale up evidence informed, gender-responsive, youth-friendly HIV prevention, increase access to paediatric HIV treatment, scale up care and support programmes and to empower youth-led associations in order to ensure their participation throughout the HIV programming cycle including design, implementation and monitoring and evaluation;
- 6.4 *Urges* member states to strengthen initiatives that would increase the capacities of young women and adolescent girls to protect themselves from HIV infection;
- 6.5 *Requests* the Joint Programme to support countries, upon request, in reviewing their HIV testing, counselling and treatment policies and address age- and gender related legal, regulatory and social barriers to HIV testing, prevention treatment, care and support faced by adolescents;
- 6.6 *Encourages* member states and the Joint Programme to follow up on decision points 8.5 and 8.9 from the 24th Programme Coordinating Board with respect to comprehensive programming for adolescents and youth who inject drugs;
- 6.7 *Further requests* the Joint Programme to support countries to improve systematic and coordinated collection, dissemination and analysis of sex- by age disaggregated data at the national and sub-national level;
- 6.8 Recognizing the contribution of young people through the full programme cycle and within decision-making processes, *requests* UNAIDS to develop indicators to monitor youth participation within the AIDS response;

## **Agenda item 5: UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework**

### **Agenda item 5.1: Mid-term review**

- 7.1 *Takes note* of the report; expresses appreciation for the role that the Joint Programme has played in the response to AIDS; and urges acceleration of UNAIDS efforts to support countries achieve the global AIDS targets adopted by the UN General Assembly in 2011;
- 7.2 *Decides* to extend the duration of the existing strategy for two years through 2017, requesting UNAIDS to update the goals in the current strategy and to present on that basis an updated UBRAF for 2016-2017 at the 36<sup>th</sup> meeting of the Programme Coordinating Board, taking into account the lessons learned from the Mid-term review of the UBRAF and the ongoing consultative process of improving the UBRAF, including the need for a clear results-chain linking outputs to outcomes and impact intended for the Joint Programme;
- 7.3 *Requests* UNAIDS to develop the next phase strategy (starting 2018), results framework and budget for consideration of the Programme Coordinating Board at its 40<sup>th</sup> meeting, building on the current strategy and our common three zero vision, aligned with the resolution on the Quadrennial Comprehensive Policy Review (QCPR) of operational activities for development and taking into account lessons learned from the implementation of the QCPR and the UBRAF;

### **Agenda item 5.2: Performance reporting**

- 7.4 *Takes note* of the report (Performance Monitoring Report) and *requests* UNAIDS to provide a consolidated Performance Monitoring Report to the 36<sup>th</sup> Programme Coordinating Board that captures progress against core indicators as well as expenditures; shows the link to outcomes, goals and targets; distinguishes cosponsor, Secretariat and joint results; and, using the UBRAF structure, showcase country performance;
- 7.5 *Requests* the Secretariat to prepare a conference room paper for the 35<sup>th</sup> Programme Coordinating Board meeting on concrete actions taken to address and implement the previous decision points approved by the Programme Coordinating Board that relate to civil society;

### **Agenda item 5.3: Financial reporting**

- 7.6 *Accepts* the financial report and audited financial statements for the year ended 31 December 2013;
- 7.7 *Takes note* of the interim financial management update for the 2014–2015 biennium for the period 1 January 2014 to 31 March 2014, including the partial funding of staff-related liabilities and the replenishment of the Building Renovation Fund;
- 7.8 *Encourages* donor governments to release their contributions towards the 2012–2015 Unified Budget, Results and Accountability Framework as soon as possible;



- 7.9 *Requests* UNAIDS to do an analysis to determine the appropriate lower-limit threshold for the net fund reserve and report back at the 36th Programme Coordinating Board meeting;
- 7.10 *Requests* UNAIDS to hold a Financing Dialogue aimed at ensuring predictable and sustained funding, the efficient management of funds and transparency for effective implementation of the UBRAF within the overall AIDS response. The Financing Dialogue should take place before the end of 2014 to discuss programmatic and financial accountability and reporting, to review the distribution of core and non-core funds and to provide monitoring information on trends in funding and expenditures in relation to strategic directions and functions;

**Agenda item 6: Update on strategic human resources management issues**

8. *Takes note* of the update on strategic human resources management issues;

**Agenda item 7: Statement by the representative of the UNAIDS Staff Association**

9. *Takes note* of the statement by the representative of the UNAIDS Secretariat Staff Association.

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