

REPORT OF THE 43RD PROGRAMME COORDINATING BOARD MEETING

Additional documents for this item: *none*

Action required at this meeting—the Programme Coordinating Board is invited to:
adopt the report of the 43rd Programme Coordinating Board meeting.

Cost implications for decisions: *none*

1. OPENING

1.1. Opening of the meeting and adoption of the agenda

1. The UNAIDS Programme Coordinating Board (PCB) convened for its 43rd meeting on 11–13 December 2018 in the Executive Board Room of the World Health Organization (WHO) in Geneva.
2. The PCB Chair, Anna Wechsberg, Policy Director for the United Kingdom's Department for International Development, welcomed participants. The meeting observed a moment of silence in memory of all people who had died of AIDS. The Chair noted that progress in the AIDS response was too slow to reach the 2020 targets.
3. Ms Wechsberg emphasized UNAIDS' importance in the global AIDS response. Referring to the release of the *Report on the work of the Independent Expert Panel on prevention of and response to harassment, including sexual harassment, bullying and abuse of power at UNAIDS Secretariat*, she asked the meeting to provide UNAIDS with clarity for moving forward.
4. The meeting adopted the agenda subject to review to consider the progress of work.

1.2. Consideration of the report of the 42nd meeting

5. The Board adopted the report of the 42nd Programme Coordinating Board meeting

1.3. Report of the Executive Director

6. Michel Sidibé, Executive Director of UNAIDS, updated the meeting on the commemoration of World AIDS Day at the White House with United States (US) Vice-President Mike Pence, US Global AIDS Coordinator Deborah Birx and leaders of faith- and community-based organizations. Earlier, in Beijing, leaders at the Forum on China–Africa Cooperation meeting had committed to end the AIDS epidemic as part of China–Africa health cooperation. The Russian Government had also approved a new three-year grant to UNAIDS for US\$ 17.8 million.
7. Mr Sidibé paid tribute to former United Nations (UN) Secretary-General, Kofi Annan. The world had lost a major champion of the global AIDS movement, he said. The Executive Director reminded the meeting that the world had embraced the ambitious goal of ending the AIDS epidemic as a public health threat by 2030 because it was unacceptable that new infections were still rising in more than 40 countries 40 years into the epidemic.
8. Globally, a majority of people living with HIV were on antiretroviral therapy (ART). It was beyond dispute that prevention programmes work when they are implemented well and at scale. Importantly, the Global Prevention Coalition was helping to put primary prevention back on the agenda. Ending AIDS came down to policy choices, Mr Sidibé told the meeting.
9. He welcomed the 2018 UN Political Declaration on the Fight against Tuberculosis (TB) and the 2022 targets. He informed participants of the launch, on 10 December (Human Rights Day), of a Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination. The partnership had been co-convened by UNAIDS, the

United Nations Development Programme (UNDP), UN Women and the Global Network of People Living with HIV.

10. The Fast-Track approach was driving strong results: 75% of all people living with HIV globally knew their status, 79% of them were accessing treatment, and 81% of people accessing treatment had suppressed viral loads. Analysis from the US President's Emergency Plan for AIDS Relief (PEPFAR) showed that 13 high-burden countries could reach epidemic control within the next two years.
11. Mr Sidibé cautioned, however, that the pace of progress in the AIDS response still did not match global ambitions. Ending the AIDS epidemic was not a foregone conclusion. He reminded the meeting that the global data hid a lack of progress in many countries: huge disparities remained in access to HIV and related services, and important geographic hot spots were being ignored.
12. The decline in the number of AIDS-related deaths was too slow to meet the target of less than 500 000 deaths by 2020. In addition, the number of new infections among adolescent girls and young women remained unacceptably high—due to widespread gender inequalities and harmful masculinities. Key populations, which accounted for about 47% of all new HIV infections, were not being reached with services.
13. Mr Sidibé pointed out that criminalization of drug use remained an obstacle in many countries. He called for a people-centred health and rights approach that restores dignity to people who use drugs. The launch of a model drug law for western Africa to guide policy-makers in the region on how to better frame their drug laws was a positive move, he said. UNAIDS had also endorsed a common UN position ahead of the Commission on Narcotic Drugs ministerial-level meeting in Vienna in March 2019.
14. Mr Sidibé reminded the meeting that the 2016 Political Declaration on Ending AIDS called for investing 25% for prevention and 6% for social enabling activities, and that 30% of all service delivery is community-led. Funding gaps had to be identified and addressed. He called for stepped-up, collective action in priority areas. For example, prevention programmes had to be strengthened, he said, including by widening access to pre-exposure prophylaxis (PrEP). Thirteen countries in the Asia and Pacific region had been supported to develop clear plans for the scale up of PrEP.
15. There had been important progress towards eliminating HIV infections in children and protecting their mothers. Globally, 1.4 million new HIV infections had been averted among children since 2010, and 80% of pregnant women living with HIV were accessing services for preventing mother-to-child transmission of HIV in 2017, up from 51% in 2010. Gains were especially impressive in eastern and southern Africa, where about 93% of women living with HIV started on ART in 2017.
16. More needed to be done, Mr Sidibé said: 180 000 children had acquired HIV in 2017 and only half of children under 15 years living with HIV were being treated in that year. Children living with HIV had to be diagnosed and started on ART as soon as possible.
17. Referring to the World AIDS Day report, Knowledge is power, he called for greater efforts to reach the estimated 9.4 million people who do not know they are living with HIV and

who are not on treatment. Countries also need to do a better job of reaching men with HIV testing services. Studies showed that men were less likely to take an HIV test, less likely to access treatment, and more likely to die of AIDS-related illnesses, compared with women.

18. Mr Sidibé stressed that the AIDS response had to meet the needs of people caught in crises, along with migrants and other people on the move. He welcomed the Global Compact for Safe, Orderly and Regular Migration, and commended Ecuador as one of the countries guaranteeing health care for refugees and migrants living with HIV. Strong cooperation and urgent action were needed to eliminate the threat of sexual and other violence against these populations, he said. UNAIDS was strengthening its work in this area. Actions including signing a memorandum of understanding in the Central African Republic to help translate UN Security Council Resolution 1983 into concrete actions.
19. A fully-funded Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) was essential, Mr Sidibé told the Board. Each country should have a sustainable transition plan so it could adapt to changes in the funding environment. Warning that even seemingly small cuts in donor funding could have major consequences, he said that a 20% cut in donor funds would be catastrophic for the 44 countries that relied on foreign funding for at least 75% of their HIV programmes.
20. Not fully funding the AIDS response will have drastic consequences, he said. An additional 2.1 million people would acquire HIV and 1 million more people would die of AIDS-related illnesses if the world misses the 2020 targets by more than five years.
21. Quicker action was needed in the countries lagging behind. Despite some recent improvements, countries in western and central Africa were not catching up quickly enough, he said. This had prompted UNAIDS to extend and transform the regional "catch-up plan" into an overall acceleration plan. In that region and elsewhere, user fees continued to prevent people from using health services. Mr Sidibé thanked Luxembourg for allocating an additional one million euros to the AIDS response in that region.
22. Turning to the issue of sexual harassment and bullying, Mr Sidibé expressed his commitment to ensuring that the UNADS Secretariat provided a healthy, safe, inclusive and equitable workplace for all staff. He was aware that not all staff had experienced an inclusive work culture. Reminding participants that he had called for the establishment of an independent expert panel in February 2018, Mr Sidibé said he looked forward to discussions on the panel's recommendations and on the UNAIDS management response.
23. In closing, Mr Sidibé announced that the next PCB meeting in June 2019 would be his last as Executive Director. He called on the PCB to put in place the necessary processes to ensure a smooth transition for UNAIDS.
24. Before contributions from the floor began, Portugal's Secretary of State of Health, Raquel Duarte Bessa De Melo, presented a short overview of the country's AIDS response, which has focused on ensuring that key populations are protected against HIV.
25. In late 1980s and early 1990s, HIV incidence in Portugal had been among the highest in Europe. At the epidemic's peak in the 1990s, infections were mainly associated with people who inject drugs. A needle exchange programme began in the late 1990s and an

enabling legal and service environment was created, including by decriminalizing drug use. The approach shifted from penalization to public health.

26. This brought the epidemic under control among people who inject drugs; it is estimated that fewer than 2% of new infections were currently associated with injecting drug use. Most new HIV infections were occurring during sexual intercourse, including sex between men. Since 2017, PrEP has been used as an additional prevention choice for people at high risk for HIV infection.
27. Portugal has achieved two of the 90–90–90 targets (testing and viral suppression, while 86% of people who tested HIV-positive were on ART). Testing was provided free of charge and self-testing was used as a complimentary approach. Adoption of the "treat all" strategy in 2015 meant that ART was also available free of charge, including for undocumented migrants. Testing and treatment for TB and viral hepatitis were also available.
28. Members welcomed the Executive Director's report and its realistic yet optimistic tone. They thanked him for his committed leadership and commended UNAIDS for leading and coordinating the global AIDS response. They emphasized that the epidemic was far from over and that a strong UNAIDS was vital for reaching the 2030 goal of ending the epidemic. Reaching that goal required an effective UNAIDS and a fully funded Global Fund, they said, reiterating their support for a strong UNAIDS.
29. Members highlighted the Joint Programme's central role in helping ensure that countries have quality data and can track, analyze and adapt their HIV programmes. They also noted recent positive developments, including UNAIDS' strategy (which supported an improved strategic focus at country level).
30. While praising the progress towards the 90–90–90 targets, the meeting was concerned about the unevenness of the progress and the recent rise in new HIV infections in almost 50 countries. Referring to UNAIDS' *Miles to go* report, members noted that a range of barriers continued to hold back quicker and more equitable progress. Strong political will was often the decisive factor in ensuring progress, they said.
31. UNAIDS' reports showed two contrasting realities: strong progress in some countries and communities, and faltering efforts in others. The latter was due mainly to a lack of sufficient political will, it was suggested. It was worrying that key populations did not appear to be sharing in the recent achievements. Countries had to focus on structural factors and develop robust catch-up plans for communities that were being left behind.
32. Cautioning against a narrow focus on biomedical interventions, members called for a balanced, human rights-based approach that fits countries' respective contexts. Sustained efforts were needed to reduce service access barriers, especially for adolescents, girls and young women and key populations. Countries were urged to recommit to the elimination of all forms of HIV-related stigma and discrimination, including in health-care settings.
33. A suitable balance was needed between testing, treatment and prevention, speakers said. They called for increased emphasis on prevention and urged that primary prevention be a priority for the Joint Programme. This had to include the promotion of gender equality and of sexual and reproductive health rights.

34. Noting the report submitted by the Independent Expert Panel on Prevention of and response to harassment, including sexual harassment, bullying and abuse of power at UNAIDS Secretariat (IEP), members insisted that UNAIDS had to ensure a functional, safe and inclusive work environment. They called on the PCB to help ensure this was achieved. Recent steps taken at UNAIDS to improve the working conditions for staff were noted.
35. Speakers expressed concern that HIV funding (and global health funding generally) was levelling off. Resources did not yet match political ambitions, including for community-based responses. They emphasized the need for a fully funded Unified Budget, Results and Accountability Framework (UBRAF) and highlighted the importance of achieving sustainable funding streams.
36. More had to be done to take HIV out of isolation, including the integration of HIV services into essential health benefit packages. Speakers warned, however, against abandoning HIV service platforms and reminded of the ongoing need to strengthen and sustain civil society systems and to link them with health systems.
37. Several members updated the meeting on recent progress in their countries, including increased domestic funding for key population services (Republic of Moldova), expanded prevention (Ecuador) and the wider use of HIV self-testing (Portugal). Malawi told the meeting that it had reached two of the 90–90–90 targets and was stepping up actions to eliminate HIV-related stigma and discrimination. Algeria, Belarus, Brazil, Chile, China, Côte d'Ivoire and Sri Lanka also reported on recent achievements and initiatives.
38. Cosponsors told the meeting that the AIDS response was at a dangerous juncture. It was off-track to meet the 2020 targets and progress on prevention was too slow. They called for greater integration of HIV in the context of Universal Health Coverage (UHC) and cited the Global Plan of Action on Health as a good example of UN organizations working together to pursue a shared agenda and goals.
39. The meeting welcomed the Political Declaration on the Fight against Tuberculosis (TB), which the UN High-Level Meeting on TB had endorsed in September 2018 and highlighted its ambitious 2022 targets. Speakers emphasized that the Political Declaration on TB highlighted the importance of intersectoral cooperation and civil society involvement.
40. One Member State and one Observer State told the meeting that sanctions imposed against them were undermining the AIDS response by compromising timely access to essential health commodities and preventing them from acquiring vital medical products, including antiretroviral (ARV) drugs and medications for TB. They urged UNAIDS to address this issue in an urgent manner.
41. Responding to questions from the floor, Mr Sidibé noted that self-testing was proving highly effective. Studies showed that it was both acceptable and accurate and that it could facilitate voluntary assisted notification. A challenge, though, was to link people who tested HIV-negative to prevention services, and to link those who tested HIV-positive to treatment services. The artificial divide between prevention and treatment had to be removed, he said. Studies on PrEP were showing very good results, especially in cities in Europe and North America. PrEP was also being rolled out in Latin America and in Africa.

42. The Board took note of the report of the Executive Director, including the need for smooth succession planning, and called for the immediate initiation of the selection process for the next UNAIDS Executive Director.

1.4 Report by the NGO representative

43. Ms Valeriia Rachynska, Head of the Regional Policy Team at the All-Ukrainian Network of People Living with HIV, presented the report by the NGO representative, which focused on people on the move. After describing her childhood experiences as an undocumented migrant, she told the meeting that mobile populations were overrepresented among people living with HIV.
44. Ms Rachynska reviewed key recent trends in mobility. They included the increasing diversity and complexity of human mobility; the "feminization" of migration (about 11 million people on the move globally were female domestic workers) and the unique vulnerabilities migrant women face (including sexual abuse and violence); and the ongoing lack of shared definitions of mobility, which hampered effective actions.
45. She called for new approaches to thinking about mobility. Drawing attention to the terminology used in the report, she pointed to a need for a broader and more inclusive definition of people on the move. Referring to data featured in the report, she said globalization was a key driver of increased migration and she highlighted the rise in politicized opposition to migration. Importantly, population mobility featured more centrally in the Sustainable Development Goals (SDGs).
46. Numerous factors were preventing mobile populations from accessing HIV and other health services. They included language and cultural barriers; reluctance to access services for fear of being reported to the police or deported; a lack of targeted services for people on the move; poor understanding of how to access services and a general lack of information. Nine countries still denied entry to people living with HIV and 51 countries imposed some restrictions on entry for people living with HIV.
47. Ms Rachynska listed several improvements which countries could introduce. Policies should explicitly involve people on the move, including those who belong to key populations. Legal and regulatory reforms were needed, and stigma and discrimination had to be eliminated. National health systems and UHC had to be inclusive of people on the move. Capacity building for organizations serving people on the move was needed.
48. Also important was the explicit inclusion in the AIDS response of people on the move who belong to key populations. The development of a policy brief on the meaningful involvement of migrants and mobile populations, in accordance with the Greater Involvement of People living with AIDS (GIPA) principle, would be useful.
49. Ms Rachynska recommended the development and promotion of a basic package of primary healthcare services for mobile populations. The PCB was urged to help ensure that no migrant or mobile person is left behind. UNHCR was requested to prepare a report on the state of respect for the human and health rights of mobile populations.
50. Members thanked the NGO delegate for a timely and comprehensive report and for outlining good practices that could guide efforts to reach and serve people on the move. They stated their support for the Global Compact for Migration and the Global Compact on Refugees and warned that migrant populations were in danger of being left behind in

the AIDS response. Intersectoral policies and systems, migrant-sensitive national programmes and interagency cooperation were needed to avoid such an outcome. Improved data related to HIV and people on the move could also help health-care systems ensure that HIV services are available to everyone who needs them.

51. Members stated their support for UNAIDS' efforts to promote access to services for all vulnerable populations, including migrants, refugees and people affected by complex emergencies. They commended the Joint Programme for collaborating with the International Organization for Migration (IOM) and other partners to support people on the move and requested it to update the PCB on its work with the IOM. Some speakers suggested that UNAIDS should first develop a solid strategy before entering the international discourse on this complex issue.
52. Several members shared information about recent initiatives to address the issue, including the High-Level Panel on Migration in Africa (which was set up to harmonize country policies), the establishment of health clinics at border crossings (southern Africa), and the development of multilingual health booklets (France and Germany).
53. There was discussion about the lack of clear shared definitions of some of the terminology used in the report (e.g. "people on the move" or "mobile populations"). Speakers emphasized the importance of using inclusive terminology to avoid people being left behind. It was suggested that the term "people on the move" was useful since it refers to human mobility in all its varieties.
54. The meeting was reminded of the specific needs and challenges of adolescents on the move, including mental health issues. Not enough was being done to provide adolescents on the move with the services and counseling they needed. Also highlighted was the criminalization of people on the move, including those living with HIV. It was noted that in many countries, including some with previously liberal policies, new laws and policies were excluding people on the move from accessing health and other essential services.

3. PREVENTION OF AND RESPONSE TO HARASSMENT, INCLUDING SEXUAL HARASSMENT; BULLYING AND ABUSE OF POWER AT THE UNAIDS SECRETARIAT

55. Daniel Graymore, Chair of the PCB Bureau, introduced the session by recalling the process that led to the report of the Independent Expert Panel (IEP) on prevention of and response to harassment, including sexual harassment, bullying and abuse of power at the UNAIDS Secretariat.
56. He said the process had been thorough and had involved wide consultation and engagement, including with staff, civil society and other stakeholders. The Panel was independent of both UNAIDS and the PCB, and it reported to the PCB via the PCB Bureau. He reminded that some of the issues that had led to the creation of the Panel had been brought to the PCB's attention by the UNAIDS Staff Association in previous years. Along with the Panel's report, a management response and a statement from the Staff Association would also be presented to the PCB at this meeting.

3.1 Report on the work of the Independent Expert Panel on prevention of and response to harassment, including sexual harassment; bullying and abuse of power at UNAIDS Secretariat

57. Gillian Triggs, Chair of the Independent Expert Panel, summarized the backgrounds of the IEP members and noted that the Panel's terms of reference had been very broad. She thanked the Bureau for respecting the independence of the Panel.
58. Ms Triggs said the Panel had been respectful of the important work of UNAIDS, the inspirational role of the Executive Director and the dedication of its staff. It took account of the unique nature of the Joint Programme and the many challenges of the AIDS response. She stressed that UNAIDS had to exemplify the principles and rights it was tasked with protecting and advancing.
59. She reminded the meeting that the Panel did not have a mandate to determine the truth of allegations. However, the Panel believed that the evidence presented to it merited the direct and forceful language of the report, which she said was based on compelling data and testimony received from a variety of sources.
60. Ms Triggs said there had been a 60% response rate to the Panel's survey, with 44% of the respondents agreeing that the prevailing culture and procedures at UNAIDS did not serve to prevent abuse and harassment. 86% of that subgroup of respondents stated they were not satisfied with responses when complaints had been lodged and that often no action had been taken. The UNAIDS Staff Association survey on the Panel's findings had a 78% response rate—with 47% of respondents agreeing that the findings accurately described their experiences. The IEP had conducted 70 interviews and had received 33 written submissions.
61. Ms Triggs acknowledged that the data compiled in the report possibly could be replicated in many other organizations. However, the spotlight in this case was on UNAIDS and it had to respond to the findings. Summarizing the core findings, she said the Panel had advisedly used a dramatic phrase when it stated that UNAIDS was "in crisis". The policies at UNAIDS were close to best practice, but there had been a failure to implement them in the day-to-day working lives of staff.
62. She divided the findings along four themes: leadership, governance, management and the complaints process. The leadership style appeared to be patriarchal, with UNAIDS frequently likened to a family. However, she said, this did not excuse the failure to ensure that processes were respected; regarding governance, core UN policies had not been followed. She told the meeting that management had allowed an unsafe working culture to exist, a situation that was magnified in some Country Offices. Finally, the complaints process failed to support staff who had lodged complaints. Often the matters were not dealt with and staff were vulnerable or felt vulnerable to retaliation.
63. The report's recommendations spoke to the Panel's findings, Ms Triggs said. To strengthen governance, the PCB should perform more regular oversight of UNAIDS work, including through a new human resources committee which should be set up within the PCB. Improved training of Country Directors would help strengthen management. An external complaints conciliation process was needed to rebuild trust in the organization and restore confidentiality.

64. The IEP was pleased to see the positive response from the UNAIDS management, which appeared to accept the findings and showed commitment to act on them. The Board had an opportunity promote a world best practice on these issues.
65. Panelist Fulata Moyo described the methodology used by the IEP, which, she said, followed social scientific norms. The panel conducted 70 interviews with current and former UNAIDS staff and with representatives of civil society organizations. It used a human rights lens to analyse the data, which it compared with the data reported in UNAIDS staff surveys. She emphasized that the Panel did not investigate individual cases.
66. Panelist Robert Francis paid tribute to the immense commitment of UNAIDS staff to their work and to the individuals who had stepped forward to share their experiences. He told the meeting that the IEP had studied many policies, regulations and systems for preventing and dealing with abuse and harassment. It had interviewed officials responsible for oversight in those areas, in the UN and elsewhere. It had also asked staff about their experiences of the processes in UNAIDS.
67. He said the Panel had found a widespread perception that the system was not working for staff on the whole. Although policies largely reflected UN-wide values, staff experiences did not always meet their expectations, and this led to a lack of trust.
68. There appeared to have been pressure to pursue informal processes that were inappropriate, particularly when power imbalances existed. Informal processes can be useful in minor disputes, but they are not appropriate for serious matters, Sir Robert said. The Panel also found that some staff feared retaliation. He emphasized that it was the responsibility of the organization, not staff, to ensure that complaints were addressed.
69. The Panel saw a need to externalize systems of investigation and redress. Introducing those systems would take time. While that was being done, UNAIDS would have to increase the transparency of its existing systems and procedures. The IEP also believed that the current, high standard of proof for complaints was anachronistic. It was very important to continually review progress towards implementing the Panel's recommendations, he said.
70. Panelist Vrinda Grover said that both UNAIDS management and the staff association agreed on the need for substantial action. The IEP called for a fundamental shift to processes and systems that would protect staff. It was the duty of UNAIDS management to introduce and enforce an effective system of redress. Due process and rights had to be protected, and policies and processes had to be gender-just. It was important for UNAIDS to lead the field in these important areas.

3.2. Management Response

71. Mr Sidibé presented the management response of the UNAIDS Secretariat to the recommendations of the IEP. He began by thanking the Panel for its work and UNAIDS staff for showing the courage to raise such difficult issues in pursuit of a stronger UNAIDS. They had helped him understand the organization through the eyes of others, he said.
72. Mr Sidibé agreed that many elements of the workplace culture had to change, and he apologized that some staff did not feel protected at work. UNAIDS had to work hard to

create a workplace where every staff member felt safe and valued. Sufficient collective will could shift behaviours, he said. Inclusiveness was the foundation for the important changes that had already begun at UNAIDS, especially through the Dignity-at-Work task force, and it underpinned UNAIDS' agenda going forward. In requesting the establishment of the IEP, Mr Sidibé said he had seen a unique opportunity to pave a path of change at UNAIDS and in the UN system generally. The challenge, he said, was to ensure that the Panel's work be used to improve UNAIDS and the world beyond it.

73. Mr Sidibé told the PCB that the responsibility for changing UNAIDS' work culture started with him. Management systems had to be strengthened and decision-making had to occur at the appropriate levels and with full transparency. UNAIDS would introduce a series of concrete reforms and changes to its management systems, along with other improvements. He described UNAIDS' Agenda for Change, including a series of concrete reforms, as well as changes to management systems and policies. These measures, he said, put staff at the centre; strengthened compliance and standards; galvanized inclusive leadership, governance and oversight; invested in management systems and activities, and enhanced the capacity of UNAIDS' staff.
74. He acknowledged that some Board members had doubts whether the required changes could be achieved under his leadership. The answer, he suggested, should be based on what is best for the staff of UNAIDS and for the communities it serves.
75. In closing, the Executive Director expressed his regret that the strategies and systems for preventing and dealing with harassment had not been enough. Declaring his eagerness to work with staff and the PCB to overhaul those systems, he proposed that a PCB working group be set up to study key gaps in management response, implementation and monitoring. He also proposed creating a UNAIDS evaluation function which would report directly to the Board. He pledged to develop—in concert with the proposed working group and with staff—a precise management action plan that would include review mechanisms, timelines and success metrics.

3.3. Statement by the representative of the UNAIDS Staff Association

76. Lina Nykänen-Rettaroli, Chair of the UNAIDS Staff Association, noted that it had been a difficult year for UNAIDS but added that the issues raised had not been new. The Staff Association hoped that the discussion of the issues would lead to strengthened awareness, accountability, security, fairness and inclusiveness in the UNAIDS workplace.
77. She told the PCB that the Staff Association had surveyed staff reactions to the IEP report. Despite very little time to respond, 550 staff around the world had completed the survey (a response rate of 78%).
78. She reported that the survey had asked whether the Panel's findings and recommendations accurately described the UNAIDS workplace; 47% of respondents agreed and 38% disagreed. A larger share of headquarters staff felt that the Panel's findings accurately described their workplace compared to staff in the field.
79. She reported that the survey asked whether staff were hopeful that the Panel recommendations would help strengthen the UNAIDS work culture; 56% of respondents agreed while 25% disagreed.

80. Fifty-four percent of respondents agreed that the UNAIDS management response provided a clear way forward, while 21% disagreed, she told the meeting. Respondents working at headquarters were more likely to report that the panel findings accurately reflected their experiences, and they were less likely to believe that the management response offered a clear way forward, she said
81. Ms Nykänen-Rettaroli told the Board that the Panel report described allegations that should never occur in any workplace, let alone a UN organization. She said that although the Panel's report may not reflect the everyday reality of working in UNAIDS for many staff members, people should respect the experiences of colleagues documented by the panel.
82. Staff, she said, saw their work at UNAIDS not as a "job" but as a conviction. Their passion, dedication and effort drove the organization's results. Despite being in the middle of a very public discussion about their workplace, staff had continued to work hard to deliver on the UNAIDS mandate. She also stated that the Staff Association was proud of its strong dialogue with management.
83. Ms Nykänen-Rettaroli told the meeting that the Panel had presented a tough report, different from the kinds of reports that were customary in the UN. The report painted a picture of deep frustration, lack of trust, injustice, impunity and disfunction. The Staff Association was deeply concerned by the views and experiences of staff captured in the Panel's findings.
84. She reminded the Board that the Staff Association had repeatedly brought the issues raised by the Panel to the attention of UNAIDS' leadership and the PCB. Yet too little had been done. The IEP report showed that change was needed on many fronts—at UNAIDS and beyond it in the wider world.
85. She said the Staff Association was confident that, although painful, the findings and recommendations of the Panel could provide the necessary impetus to achieve positive change. To move forward, staff needed an honest and open acknowledgment from senior management about what had gone wrong and senior leaders needed to be role models. Ms Nykänen-Rettaroli called for the Board's full commitment to bring about the required changes. She also reminded the Board that investing in staff wellbeing was critically important to maximize the staff's contributions to the AIDS response.
86. Before discussion from the floor, Morten Ussing, Director of Governance and Multilateral Affairs at UNAIDS, told the meeting that a web link had been created so UNAIDS staff around the world could follow proceedings at the PCB. However, someone had circulated the web link to the public via social media. Mr Ussing reminded that the PCB meeting was open to staff and accredited members, but not to the public at large. The web link therefore had to be taken down.
87. Members thanked the Panel for the report, saying it presented serious findings which demanded strong action. They insisted on zero tolerance for all forms of harassment and bullying. Some speakers noted that even though a culture of sexual and other harassment prevailed beyond UNAIDS as well, this could not detract from the Panel's findings.
88. Members commended the dedication and important work of UNAIDS staff and the Executive Director and reaffirmed their commitment to support the Joint Programme. They emphasized that the world needed a strong UNAIDS to drive the AIDS response.

Although the report acknowledged the outstanding contributions of UNAIDS and the Executive Director to the global AIDS response, this important work could not be used to excuse senior management of responsibility for the issues highlighted in the report.

89. Some members acknowledged that the Panel's findings painted a picture of distrust, impunity and frustration. They said the report justifiably also critiqued the PCB and they reminded the meeting that the Staff Association had been raising many of the issues over the years.
90. Several speakers insisted that widespread experiences of harassment at UNAIDS and a lack of adequate action called into question its leadership, governance and management systems. Senior leadership, they said, had to accept full responsibility and accountability for the situation. They called for strong action on the recommendations of the IEP and on the issues highlighted by the Staff Association.
91. Several members felt that the Panel had overstepped its mandate, for example by questioning the leadership of the Executive Director, and expressed reservations about the tone and methodology of the report. Some members said the Panel report posed important questions regarding the Executive Director, senior management and the work of UNAIDS' governing structures, including the PCB.
92. The meeting thanked the Staff Association for its thoughtful statement, which reflected the commitment and quality of UNAIDS staff. They supported calls from the Staff Association for full acknowledgment from senior management of the problems.
93. Members welcomed the management response, saying it reflected a strong intention to act on the issue of harassment. However, several members felt that the response did not go far enough in addressing the issues at hand and that it would benefit from greater focus and detail.
94. The Board was asked to carefully consider the Panel's recommendations in order to decide on the best way forward for dealing with the identified issues. It was urged to proceed on the basis of consensus.
95. Members and observers stated that the issues highlighted in the report could not be addressed adequately without far-reaching changes, including solid mechanisms and policies for complaint, investigation and redress. They added that it would take more than training and policies to change the work culture and environment.
96. A safe working environment required coherent and transparent systems that effectively protect against all forms of harassment and abuse. Members called for prompt action from UNAIDS to address the identified issues and introduce appropriate measures.
97. The Executive Director was urged to actively promote a culture of prevention with regard to harassment, strengthen relevant processes and ensure their confidentiality, and to establish an independent process of complaint and inquiry.
98. Among the changes proposed from the floor was a strong management plan with a clear review process and timelines; increased accountability of the Executive Director; and a strengthened UNAIDS human resource management system. An independent oversight mechanism should be considered. The creation of a PCB sub-committee to strengthen the Board's oversight (including the filling of outstanding leadership positions) was also

suggested, along with the creation of a standing body to carry forward the necessary changes.

99. Members acknowledged the leadership of the Executive Director in the global AIDS response and his role in establishing UNAIDS as a leading advocate and defender of human rights and empowerment. However, some speakers felt that such boldness did not appear to be as evident when it came to taking responsibility for internal management failures.
100. Some members expressed doubts whether the existing leadership could take the required actions and argued that a change of leadership was needed for UNAIDS to restore trust and unity. They said they would welcome an early leadership recruitment process for a new Executive Director.
101. Other speakers commended the Executive Director for the actions taken to prevent and deal with harassment and declared their confidence in his leadership.
102. Noting that the IEP report had implications for the wider UN system, some members urged that it be shared with top UN management. They called on the UN Secretary-General to take the necessary measures to ensure that all UN employees enjoy a safe working environment. Other members noted that the call to do so was premature, since the report had not yet been appropriately reviewed by the members.
103. In response, Ms Nykänen-Rettaroli reiterated the need for new approaches and actions, adding that the same accountability and action demanded from UNAIDS should also be achieved across the UN system.
104. Mr Sidibé urged UNAIDS and Board to remain united.
105. Ms Triggs said there was clear agreement on at least two matters: sexual harassment, abuse of power and bullying was completely unacceptable; and divisions would not take the Joint Programme forward.
106. Regarding criticisms of the Panel's recommendations, she repeated that the terms of reference had been very wide. She read the terms of reference to the meeting and said it could not be claimed that the Panel had no mandate to consider issues of management, leadership and abuse of power.
107. Ms Triggs rejected claims that the Panel's methodology had not been rigorous. She told the PCB that the Panel had received a total of 412 responses and that findings based on those responses were similar to data in the UNAIDS Staff Association surveys.
108. The PCB Chair agreed that there was clear consensus regarding zero tolerance for harassment, bullying and abuse of power, and on the need for effective action. It was not clear, however, what exactly should be done. There were many specific issues on which the meeting was not in agreement.
109. Referring to a suggestion that a working group be set up to study the implications of the report, the Chair acknowledged that members had had limited time to study the report. However, it was vital that for the current meeting of the PCB to agree on a clear way forward. Informal discussions would therefore continue during the evening.

110. Mr Graymore told the meeting that the PCB_Bureau had met during the previous week to discuss proposed decision points. Further discussion had yielded a new text, which was then discussed afresh. This led to the draft decision points presented to the meeting during this session.
111. The meeting discussed the draft decision points. Questions were raised about holding a proposed special PCB session in March 2019, since this would offer the Secretariat little time to assess the outcomes of actions taken. Other members felt that the special meeting was necessary to demonstrate that both the PCB and UNAIDS were taking extraordinary action. Delaying the report-backs and discussions until the June PCB did not reflect the seriousness of the situation.
112. Regarding the decision points overall, members thanked the meeting for the willingness to compromise and take UNAIDS forward in a constructive manner. They stressed the need to address the identified issues in urgent and coherent ways. Some members reiterated that a smooth leadership transition at UNAIDS should begin immediately.
113. Mr Sidibé said he was grateful that the meeting had chosen unity over division. Important work lay ahead to ensure a culture of respect at UNAIDS and a smooth transition to the next Executive Director. He emphasized the importance of transparency and told the meeting he would do all in his power to make UNAIDS a safe workplace. It was for that reason that he had called for the creation of the IEP. He reiterated his hope that the Panel's findings would benefit both UNAIDS and the entire UN.

2. LEADERSHIP IN THE AIDS RESPONSE

114. Peter Sands, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), emphasized the vital importance of the Global Fund's partnership with UNAIDS. The Global Fund depended on the Joint Programme for advocacy, reliable data and analysis and technical assistance across all aspects of the AIDS response, he said. That relationship was guided by the 2014–2017 Memorandum of Understanding, which was being renegotiated currently. Mr Sands said he envisaged an even stronger partnership in the future.
115. During a brief review of some of the major challenges ahead, Mr Sands underlined the very high HIV infection rates among adolescent girls and young women in eastern and southern Africa. This indicated that not enough was being done to address the deep structural causes of risk and vulnerability. There was a risk of social disaster if those realities were not addressed, he added. He also stressed the need to ensure that HIV and other health services reached men, especially men in their 20s and 30s.
116. Significant human rights barriers still hindered key populations from accessing services which, even when available, tended to be too small in scale. User fees continued to be a major barrier and often constituted false economies since even small user fees could undermine large HIV programmes.
117. Mr Sands reminded the meeting that about half of all children with HIV were not receiving treatment. A range of operational difficulties in identifying and linking those children to treatment had to be overcome. A swift transition to the use of dolutegravir was also needed and the identified safety issues had to be addressed urgently.

118. Turning to another recurring concern, Mr Sands acknowledged that funding transitions were difficult and uncomfortable. They had to be planned well, but they were seldom easy, he said. A related concern was the creeping sense of complacency about HIV among decision makers, which was compromising HIV prevention especially. He warned that a relaxed approach towards the epidemic could cause the AIDS response to regress rapidly, with dire consequences. While recognizing the perceived need to increase spending on health systems and commodities generally, he emphasized that these were not binary choices.
119. Mr Sands underscored the importance of the Global Fund's upcoming replenishment conference. The world had to avoid the misperception that it was on a smooth glide path towards the elimination of AIDS. The epidemic was a formidable adversary and a lot of work lay ahead to prevent a disastrously rebounding epidemic, he told the PCB. Beyond the world of public health, however, most decision makers did not understand how quickly the HIV epidemic evolves and adapts, and how the high HIV incidence among certain populations (including adolescent girls and young women) was driven by structural factors and by failures to protect people's human rights.
120. In closing, Mr Sands reminded that the Global Fund was a financing entity. Robust technical advice from UNAIDS and WHO informed its investments, and UNAIDS' advocacy was vital for boosting the impact of the funded programmes. The Global Fund's partnership with UNAIDS was fundamentally important for ensuring that the investments led to the intended benefits.
121. In discussion, members commended the Global Fund for its central role in the AIDS response and for supporting progress towards the SDGs. The Fund's facilitating support for civil society was highlighted. UNAIDS and the Global Fund were applauded for joining the Healthy Lives for All initiative, which showed their commitment to advance the SDGs.
122. Several members described their healthy relations with the Global Fund and noted that funding eligibility rules had been relaxed in some cases to facilitate continued support for certain programmes.
123. Members hailed UNAIDS' work in guiding investments from the Global Fund and other funding sources. A fully-funded Global Fund and a capable UNAIDS were essential for the global AIDS response, members said. They called on both private and public partners to commit sufficient funds.
124. The meeting was reminded that few countries were on-track to reach the 2020 targets and that the structural causes of HIV risk and vulnerability were not being tackled effectively enough. Additional resources for programmes serving adolescents and young women were especially needed. They praised the Global Fund for introducing a matching funds approach, which was a valuable incentive, especially for programmes focusing on adolescent girls and young women and on key populations.
125. Some members stated that Global Fund support tended to focus on the purchasing of commodities, at the expense of prevention and community-based programmes. Noting that Global Fund allocations for primary prevention had declined, members noted that HIV prevention tended to be a minor element in most country grant proposals. They urged that country proposals be aligned and prioritised with national prevention road maps.

126. The Global Fund was asked to include specific binding language in allocation letters for the 2020–2022 funding cycle, ensure that adequate funding was available for HIV prevention, and track and publish HIV spending in countries (especially regarding prevention).
127. The meeting heard that some countries still faced problems in accessing Global Fund support. Accurate costing of programmes was sometimes difficult and a limited evidence base for effective programmes (especially for adolescent girls and young women) was a hindrance.
128. Members and donors were encouraged to provide technical assistance and help strengthen long-term capacity for advocacy and communications, as well as ensure sustainable funding for key population programmes and for police and criminal justice reform programmes. Countries were urged to remove legal barriers preventing the scale up of services for key populations.
129. In reply, Mr Sands said the renegotiation of the Memorandum of Understanding with UNAIDS was an important opportunity to achieve some of the desired improvements. He agreed on the importance of more effective primary prevention and told the meeting that the Fund was increasing investments in prevention through country allocations and catalytic funding. However, it was also important for countries lead the way by focusing and investing adequately in prevention.
130. Regarding sustainability and funding transitions, he acknowledged the difficulty of the processes but added that good lessons were being learnt. He assured the meeting that the Global Fund was committed to review key aspects of its sustainability and transition policy in order to make it more effective and appropriate.
131. Mr Sands concluded by highlighting the importance of programmes that focus on adolescent girls and young women and other key populations. The fact that such programmes were most effective when they involved affected communities was one of the reasons for the launching of "HER Voice" in early 2018, a fund which helps ensure young women's and girls' voices are heard at key decision-making forums.

4. FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 42ND PROGRAMME COORDINATING BOARD MEETING

132. Alasdair Reid, Senior Adviser on Testing, Treatment and Tuberculosis at UNAIDS, presented a summary report on the outcome of the thematic segment on "Ending Tuberculosis and AIDS—a joint response in the era of the Sustainable Development Goals" from the 42nd PCB meeting. He said key recommendations from the segment had been shared with the New York Ambassadors of Antigua and Barbuda and Japan, cofacilitators of the UN High-Level Meeting on TB in September 2018 in New York City. He summarized the main outcomes of that meeting, including the milestones and targets set out in the Political Declaration on the Fight against TB.
133. After describing the process for developing the background note and agenda, Mr Reid recalled the two main questions that had been posed in the thematic session: what was to be done to achieve the Political Declaration targets (centrally, a 75% reduction in TB deaths among people living with HIV by 2020) and how could the HIV and TB communities strengthen collaboration in order to reach the 2030 goals?

134. The meeting heard that TB remained the leading cause of death among people living with HIV, despite being preventable and treatable. The latest WHO global TB report showed that TB had been responsible for 300 000 deaths among people living with HIV since 2010. Effective, affordable tools to prevent TB deaths existed but were not being used at the scale needed to achieve the Political Declaration target. HIV and TB programmes had to work more closely with health and other government programmes to reach the millions who were missing out on life-saving interventions.
135. Mr Reid said the latest WHO, Global Fund and PEPFAR guidelines for addressing TB among people living with HIV should help drive quicker change. However, there remained a need for increased investment in researching and developing more effective TB drugs.
136. Referring to presentations made during the thematic segment at the 42nd PCB meeting, he reminded the meeting that the most effective long-term strategies to address TB epidemics were poverty reduction and associated improvements in nutrition, living and working conditions. Countries had to address the social and structural determinants of TB and other diseases. Gender inequality and stigma and discrimination continued to prevent millions of people from accessing the TB and HIV prevention, diagnostic and treatment services they needed.
137. Members praised the report and commended UNAIDS for having arranged the thematic segment. The meeting was told that the segment had prompted PEPFAR to rewrite its Country Operational Plan (COP) guidance.
138. Speakers called on countries and donors to ensure that the actions and approaches outlined in the Political Declaration on TB were implemented. This included integrating TB and HIV programmes into strong health systems and improving the coordination between TB and HIV programmes and between those programmes and other health and social development programmes.
139. The WHO representative updated the meeting on the latest TB-related data, including the epidemic's impact on women and key populations. This data showed low coverage of preventive treatment and of treatment for people living with TB. A lot of work lies ahead if the Political Declaration on TB targets were to be met, he said. Integrated, rights-based and people-centred programmes were essential, along with stepped-up actions that address the underlying causes of vulnerability and risk.
140. Members also highlighted the need to combat antimicrobial resistance, called for more applied and technical research, and urged greater action to reduce the inequalities that facilitate the spread of HIV and TB. Strengthened community mobilization and advocacy was key to ending TB, they said. There were calls for increased funding to eliminate TB-related stigma and discrimination.
141. Several members (including Algeria, China, Islamic Republic of Iran and the Russian Federation) described actions they were taking to address the TB epidemic among people living with HIV, including scaling up mobile community-outreach programmes.
142. In reply, Mr Reid thanked the meeting for the constructive comments and thanked PEPFAR for its commitment to address HIV and TB.

5. WAY FORWARD TO ACHIEVING SUSTAINABLE AIDS RESULTS

143. Tim Martineau, Deputy Executive Director a.i, Programme Branch, at UNAIDS, introduced the session, which focused on the work of the Joint Programme to ensure the sustainability of HIV response results in the SDG era. He noted that the session linked to many of the other issues discussed at the meeting, including the importance of key populations, affordable access to health commodities, data challenges and organizational capacities to move their AIDS responses forward.
144. Iris Semini, Senior Adviser in the Fast-Track Department at UNAIDS, presented the discussion paper and described the inputs and consultation reflected in it. She began by highlighting the developmental benefits of AIDS investments, including the strengthening of human capital. In some sub-Saharan African countries, AIDS investments had increased average life expectancies by more than five years over the past decade. The benefits of the AIDS response went beyond people's health and supported the rights of key populations, adolescents and girls, she added.
145. Ms Semini told the meeting that evidence suggested a false dichotomy between investing in HIV programmes and in health systems: AIDS responses had facilitated huge investments in building cadres of community health workers, for example. PEPFAR had built the capacities of 270 000 new health-care workers to deliver HIV and other health services (by September 2018), while the Global Fund had invested approximately US\$ 1 billion in strengthening health systems. The symbiotic relationship between the AIDS response and health systems underpinned the discussion on sustainability, she said.
146. Reminding the meeting of the funding commitments in the 2016 Political Declaration on Ending AIDS, Ms Semini said domestic funding for HIV had increased but a funding gap remained and it had to be closed. It was also crucial to ensure that the money went to the right programmes, places and populations. She described some of the discrepancies in AIDS response funding in various regions.
147. Ms Semini told the meeting that countries had mixed experiences of funding transitions. Neither the Global Fund nor PEPAR determined countries' eligibility strictly on the basis of per capita gross domestic product; they also factored in countries' burden of disease. But this potentially left countries with low HIV prevalence exposed. Middle-income countries with low HIV prevalence represented a "risky middle", she said. Their epidemics are often associated with key populations that tend not to be priorities for public health spending.
148. Achieving sustainability in countries experiencing epidemic, funding and/or programmatic transitions required meeting several challenges until country sustainability strategies could take effect. It was generally assumed that all countries had to increase domestic funding for HIV. More granular information regarding programme costs and spending would support efforts to advocate for and guide increased domestic funding.
149. However, countries' actual abilities to make those increases in a sustainable manner were also determined by macroeconomic factors and by their ability to prevent new infections and successfully treat people living with HIV. The first objective had to be to reverse and control the epidemic, otherwise fiscal control in the medium- to longer-term would be impossible, she told the meeting.
150. This meant that changes were needed in how sustainability was gauged and measured: was the money going to the right people and places, and were the funded services

reaching key populations, for example? Sustainability strategies also had to fit with shifts towards UHC.

151. Emphasizing the centrality of political commitment, Ms Semini reminded that governments often were reluctant to fund programmes for key populations and community-led activities. Poorly planned and executed transitions disproportionately affected interventions for key populations, adolescent girls and young women, which typically depend on donor funding. Donor coordination was needed to avoid service disruption during transitions.
152. Countries had not yet exhausted the programme and system efficiencies that could lead to greater savings, she added, pointing to South Africa's shifting towards dolutegravir for first-line ART regimens as an example. Appropriate delivery models could also contribute to sustainability: e.g. community health workers trained as part of HIV programmes were delivering integrated health services in many countries (bringing sector-wide savings). It was important to invest in communities, with social contracting as one of several ways for doing so. Ms Semini noted that the UNDP, World Bank, Global Fund, US Government and other partners were prioritizing support for social contracting.
153. Regardless of their economic status, disease burden and health system capacity, countries had to develop mechanisms for sustainable AIDS results by integrating government and community systems. This included increasing domestic investments in HIV and health; ensuring that the investments are used as efficiently and effectively as possible; investing in community engagements; delivering HIV services as part of UHC essential benefits packages; integrating donor financing within government-led fiduciary systems; and developing appropriate metrics to track progress towards sustaining AIDS response results.
154. In summary, a coherent approach to sustainability was needed, Ms Semini told the meeting. Countries and donors had to take a step back and assess how the various components of a successful AIDS response, donor priorities and sustainability efforts could best fit together. The Joint Programme was committed to strengthen its efforts to support those processes, including by providing technical support for the development of integrated sustainability plans.

6. ANNUAL PROGRESS REPORT ON HIV PREVENTION 2020

155. Tim Martineau, Deputy Executive Director a.i, Programme at UNAIDS, presented a report on progress on HIV prevention 2020. He told the meeting that slow reductions in new HIV infections meant the world was significantly off-track for reaching the 2020 prevention targets. Good results in some countries were offset by slow progress in preventing new infections in others, especially among adolescent girls and young women and key populations.
156. Thanks in part to the work of the Global Prevention Coalition, 28 of the most affected countries were aligning their prevention work around a common agenda, with agreed priority pillars of primary prevention, he told the meeting. More consistent diagnosis of gaps, barriers and uptake of services was occurring, and this was being done against an agreed set of global and country targets. In addition, an increased number of high-impact countries were developing dedicated prevention programmes for and with key populations and young women. However, there were still "miles to go" when it came to actual implementation of improved, scaled-up programmes.

157. Mr. Martineau provided a brief overview of recent prevention progress. There had been good progress in expanding uptake of voluntary medical male circumcision in 2017 in the 14 priority countries: uptake had increased from 57% of the annual global target in 2016 to 81% in 2017. Domestic investment in this intervention needed to increase, however. Condom programmes were in crisis in several countries, he said, partly due to weakened demand generation and social marketing efforts. It was a concern that condom programming seemed to be falling off the family planning agenda, as well. Coverage of key population programmes was still too low, despite the existence of successful programme models and clear guidance. He highlighted the need for well-prioritized, national prevention programmes for adolescent girls and young women, and called for stronger efforts to ensure access to PrEP for priority populations.
158. Alvaro Bermejo, Global Prevention Coalition Co-chair and Director General of the International Planned Parenthood Federation, spoke on behalf of the Global Prevention Coalition, convened by UNAIDS and UNFPA. At first comprising primarily countries with the highest numbers of new HIV infections, the Coalition recently added new members (Botswana, Islamic Republic of Iran, Myanmar and Norway).
159. According to Mr Bermejo, reasons for the slow progress on HIV prevention included limited political commitment and leadership for prevention (though there were positive changes), policy and legal barriers, gaps in HIV prevention financing, and a lack of systematic implementation of prevention programmes at the required scale.
160. Stronger commitment was becoming visible, he said. Nearly all countries in the Coalition had assessed their prevention responses, re-established working groups, redesigned their prevention strategies and were preparing road maps. Most countries in the Coalition had identified their main policy and legal barriers, but progress was slow in removing them. A majority of the participating countries had at least some service packages and standard operating procedures in place for prevention programmes.
161. Communities were increasingly involved in planning and implementing prevention programmes and nearly all the Coalition members had adopted a scorecard approach to track progress. Actual scale up of services was just beginning however. Major gaps still existed, especially around condom and key population programmes.
162. Some initial steps were being taken to tackle the financial gaps around prevention (e.g. financing dialogues and the development of social contracting mechanisms). Those gaps, however, remained large, Mr Bermejo said.
163. The Coalition's secretariat had been strengthened with technical, training and communications support, and stronger civil society engagement was occurring. Next steps included closer collaboration with the Global Fund and individual countries to remove the identified barriers more swiftly and supporting countries to introduce their road map activities.
164. Elizabeth Benomar, Global Coordinator, HIV/AIDS, UNFPA, said that although the 2020 Road Map called for capacity building programmes, few countries had stepped up that work. Most still reported capacity gaps. There was a need to adapt and refocus assistance, for example by using South-South training etc. The Secretariat was working with Cosponsors and UN regional teams to provide countries with support across the 10 steps outlined in the 2020 Road Map, including programme-specific technical assistance.

165. Ms Benomar highlighted some of the opportunities for improving specific interventions for adolescent girls and young women and key populations, and to increase access to and uptake of PrEP and voluntary medical male circumcision. In closing, she said that integrated approaches were needed to reboot HIV prevention in the context of UHC.
166. Christopher Castle, Chief of Section of Health and Education Division for Inclusion, Peace and Sustainable Development, Education Sector and Global Coordinator for HIV, UNESCO, said that, despite some improvements, HIV prevention was off-track in many countries. Major concerns included the absence of an enabling environment in many places, that adolescent girls and young women were still left behind, and key populations were not receiving the services they needed.
167. Priority actions included strengthening gender equality (e.g. through greater access to comprehensive sexual and reproductive health services, sex education, social protection and access to contraception and other commodities). Further integration of HIV and sexual and reproductive health services was needed. Programmes also had to take account of the specific challenges at play in fragile states and humanitarian emergencies.
168. Agenda items 5 and 6 were discussed jointly. Members welcomed the reports and thanked the UNAIDS Secretariat for its important work on sustainability and prevention. They expressed deep concern about the slow declines in new HIV infections, stagnating financing for health and for HIV programmes, and the fact that key populations were still left behind in the AIDS response. Speakers called for strong accountability measures to galvanize improved prevention results.
169. Each of the almost 50 countries where new HIV infections had increased had an epidemic that was focused around key populations, the meeting was told. This showed a lack of responsiveness to those types of epidemics. Very small proportions of HIV funding, including prevention funding, were being allocated to key populations. The meeting also heard that some countries still imposed substantial restrictions on funding for rights-based key population programmes and services.
170. There was clear evidence on which interventions worked and in which conditions they worked best. Countries had to use this knowledge. However, legal and policy barriers continued to be the biggest factors blocking effective prevention for key populations. Modelling from Africa, for example, showed that decriminalization could be the single most effective intervention for reducing HIV infections among sex workers and their clients.
171. Countries continued to target general populations even when their epidemics were concentrated in specific vulnerable populations. Members said this was due less to a lack of resources (many of the key population-associated epidemics were in middle-income countries, it was noted) than a lack of political will. Discrimination against key populations was a major handicap for AIDS response. There were suggestions that the Prevention Road Map should more clearly reflect the differences between "generalized" epidemics and epidemics concentrated on key populations.
172. The meeting was told that current evidence showed no clear correlation between the strength of health systems and decreases in new HIV infections. In fact, countries achieving the steepest declines in new infections tend to have weaker health systems.

This highlighted the importance of political will; many countries were in effect choosing not to invest in HIV prevention, it was suggested.

173. Members stressed that biomedical, behavioural and structural approaches to prevention had to be combined and promoted equally. They also highlighted the impact of cash transfers and actions that enable girls to stay in secondary schooling.
174. Several members described recent improvements in their prevention programmes—including China, the Islamic Republic of Iran (using social contracting to connect civil society and public health programmes, and incorporating harm reduction in UHC essential packages), Malawi (roll out of PrEP and provision of free secondary education), Mexico and Peru (reaching remote communities, including in the Amazon areas, with prevention services).
175. Members agreed that reaching the 2020 and the 2030 targets and sustaining those results required increased investments from both domestic and international sources and the integration of HIV services into UHC essential benefit packages.
176. The principle of shared responsibility had to shape the sustainability agenda, several speakers suggested. They highlighted the importance of sustaining effective service coverage, especially during transitions, and warned that poorly planned donor transitions threatened country programmes. It was noted that only about one quarter of countries had developed an HIV sustainability or transition plan. Countries were urged to develop investment cases and to integrate their investment and sustainability plans. UNAIDS was requested to continue supporting countries, including through technical assistance.
177. Speakers agreed with the concerns raised about the funding dilemmas experienced by countries in the so-called "risky middle". It was suggested that per capita gross domestic funding was an insufficient yardstick for funding eligibility, because it ignored inequalities in societies.
178. Members also reiterated the importance of people-centred and human rights-based programmes and called for communities to have more central roles in the sustainability agenda. Social contracting and dual financing approaches should be pursued. Speakers also cautioned that many countries would continue to avoid funding health programmes for criminalized populations. Donors intent on transitioning out of countries had to bear this in mind when devising exit strategies.
179. UNAIDS and PEPFAR were thanked for keeping the needs of adolescent girls and young women on the global AIDS agenda. UNAIDS was also thanked for highlighting the inadequate investment in harm reduction programmes. The meeting was reminded that clear guidance and best practices existed for preventing HIV among people who inject drugs, yet programme coverage remained very low globally. New data were shared, showing the major public health impact of HIV and viral hepatitis infections among people who inject drugs.
180. Funding for harm reduction programmes had flatlined in low- and middle-income countries (amounting to about 13% of what was needed annually to mount an effective HIV response for this key population). Many countries were reducing prevention services for people who inject drugs. In low- and middle-income countries, almost two thirds of programmes focused on this key population relied on international funding, which was declining. It was pointed out that a very small percentage of the funds spent annually on

the "war on drugs" would be sufficient to end the HIV and hepatitis C epidemics globally among people who inject drugs.

181. The meeting was reminded of the unmet health needs of people with disabilities, including those living with HIV. The estimated one billion people living with a disability globally were twice as likely not to access medical services and three times as likely not to receive proper care, compared with the rest of the population. Study data from countries in western and central Africa indicated HIV prevalence was higher among people with disabilities than in the rest of the adult population. The discrepancy was especially large among disabled women. UNAIDS was thanked for its support in putting this issue on the agenda.
182. In reply, Mr Martineau said that both the prevention and sustainability agendas required prioritizing resources and efforts where the need was greatest and using the most effective interventions. Many of the issues highlighted during the discussion required policy changes that were highly feasible. He cautioned against a trade-off between treatment and prevention; the two focus areas functioned symbiotically.
183. UNAIDS and Global Prevention Coalition were working with the Global Health Facility and the "Every Women Every Child Coalition" to ensure that gender and women's empowerment initiatives also applied an HIV lens.
184. Mr Bermejo reiterated that sufficient evidence existed on the kinds of prevention interventions that work and where they work best. The main factor missing was the courage and commitment to implement appropriate strategies at scale. The emboldened opposition to women's rights, sexual and reproductive health rights, and sexuality education had to be confronted if progress was to be made.

7. UPDATE ON THE ACCESS COMPONENTS OF THE UNAIDS 2016–2021 STRATEGY: REMOVING ACCESS BARRIERS TO HEALTH TECHNOLOGIES FOR HIV AND ITS COINFECTIONS AND COMORBIDITIES IN LOW- AND MIDDLE-INCOME COUNTRIES

185. This session focused on the findings of an exploratory study on how low- and middle-income countries can be supported to overcome access barriers, including intellectual property-related, and factors that affect the availability and affordability of health technologies for HIV and its coinfections and comorbidities.
186. Mr Martineau presented the study's main findings. About 20 million people had access to affordable and effective HIV medicines by the end of 2017, he said, with multiple agencies and governments working to build on that progress. He assured the meeting that the Joint Programme would intensify its efforts to promote access of affordable health technologies for HIV and its coinfections and comorbidities.
187. Major challenges lay ahead, however. Almost half the people living with HIV were not yet receiving ART, and treatment coverage for children was lower than for adults. Children-friendly ARV formulations were still needed. Most middle-income countries were not included in the voluntary licensing agreements that had facilitated more affordable pricing arrangements for HIV-related medicines and other health technologies. In many of those countries, the prices for those commodities was still high.

188. The flexibilities provided within the Trade-Related Aspects of Intellectual Property Rights agreement (TRIPS) were nominally available but countries often encounter significant difficulties when seeking to use them. Local production of medicines was expanding significantly outside India (which remained the largest source of generic ARV). However, many countries still struggled to access affordable versions of the drugs. The prices of new generations of ARVs still varied considerably from country to country, especially in upper-middle-income countries.
189. The prices of hepatitis C treatment—an important coinfection for people living with HIV—also differed very widely, Mr Martineau said. TB treatment prices, especially for multidrug-resistant medications, also varied significantly, although about 60 low-income countries were benefiting from expanded access programmes via the originator companies. Access to PrEP was increasing and high-income countries had employed mechanisms to overcome potential barriers related to market exclusivity of originator companies.
190. The need for new models of financing research and development of HIV medicines and commodities was mentioned. New HIV-related technologies that could improve patient outcomes were in the pipeline, but access challenges would affect their availability.
191. Mr Martineau said that expanded and affordable access to medicines was also important for tackling diseases besides HIV, TB and malaria, and was essential for UHC. UNAIDS had an important role in advancing the access agenda and helping remove obstacles—for example by supporting data collection of the prices of HIV-related drugs and commodities, of updated patent information and of relevant regulatory issues and developments.
192. He highlighted several points for discussion. How could access to affordable HIV treatment, including for children, be expanded further? What major investments should the Joint Programme make to help ensure that health technologies were widely affordable? How could governments better ensure access to affordable HIV and related medicines and how could UNAIDS best support those efforts?
193. In discussion, members welcomed the report and said it was unacceptable that people were dying due to the unaffordability or inaccessibility of essential medicines. They stressed that access to affordable quality medicines was crucial for sustainable health coverage and for the SDGs.
194. Speakers noted that many factors shaped access to medicines, including the development, registration and pricing of medicines. Speakers also emphasized the importance of reliable supply chains and urged UNAIDS to continue working with governments to prevent drug stock-outs. A comprehensive approach was needed to ensure access. One member expressed serious concern over the adverse effect unilateral coercive measures in the formal banking and financial sanctions were having on technical cooperation in the AIDS response, as well as on access to medicines and medical treatment by people with HIV. It urged UNAIDS to address this issue in an urgent manner.
195. Speakers praised the major progress made in expanding access to ART, which stemmed largely from substantial funding and price reductions. However, they were concerned that about 40% of people living with HIV were not receiving HIV treatment. High prices were still impeding access to WHO-recommended treatment options; intellectual property protections were among the factors standing in the way of securing more affordable

prices. Several members pointed to the use of intellectual property rights to keep the prices of 2nd- and 3rd-line ARVs for treatment of coinfections elevated. Speakers described some of the tactics that were used to create and extend market monopolies. They said many countries still faced strong pressures from pharmaceutical corporations and governments to align themselves with the interests of those corporations. They reaffirmed the right of Member States to make full use of the TRIPS flexibilities.

196. Some members, including Brazil, described how they had used the TRIPS flexibilities to improve access to ARVs. They noted that those efforts had to be repeated to ensure wider access to drugs for comorbidities, paediatric ARVs and new generation ARVs. They cited the roll-out of the ARV dolutegravir as an example of how quickly new ARVs could be made available at affordable prices.
197. However, new barriers of access were being created, including data exclusivity measures; these had to be tracked and publicized. Trade secret protection laws were being used to prevent the disclosure of data that could support new research in health products and facilitate price transparency. Originator and generic companies were also collaborating increasingly, a trend that carried the risk of reducing the capacity of generic companies to challenge patents and remain important sources of affordable generics of new drugs.
198. Also highlighted was the need for a larger variety of palatable paediatric treatment formulations. The meeting was reminded of ongoing initiatives, including the Rome Action Plan, to improve the quality and availability of paediatric drugs. Speakers said that new paediatric formulations were expected in 2019, which could lead to simplified regimens in some cases.
199. It was also likely that long-acting formulations would become important additions to treatment options in the years ahead. Members reminded that the affordability of prevention technologies and commodities also had to be assured.
200. There were calls for the increased development and production of medicines in developing countries to meet the global targets. It was noted that the African Union was promoting such production and UNAIDS was urged to work closely with African countries and other multilateral organizations around similar initiatives.
201. The need for real-time market data to track products and prices in different countries and settings was raised. Speakers reported that the Medicines Patent Pool had developed a database offering patent data transparency.
202. Members insisted that UNAIDS had a responsibility to protect the public interest with regard to affordable access to medicines. They called for strengthened policy coherence across the Joint Programme on the issue and asked that UNAIDS continue its efforts to address market failures and improve access to medicines, including by working with affected communities.
203. UNAIDS was asked to continue using its advocacy and convening mandate to widen access to affordable, quality-assured health commodities and to support related data collection. There was a request for UNAIDS to publish data on loss-to-follow-up among people receiving ART (as an important indicator of efficiency and effectiveness of treatment, especially in Fast-Track countries) in the next global AIDS update. UNAIDS was also asked to include in its annual performance report an analysis of the major barriers affecting access to HIV-related commodities in Fast-Track countries.

204. Some members were concerned that limited human resources hampered the Secretariat's ability to advance the access agenda. They suggested that cosponsors were perhaps better positioned to take some of the proposed actions forward.
205. The development of a road map for improved access to medicines was also due for discussion by the WHO Executive Board in early 2019. WHO reported on the ongoing collaboration with the World Intellectual Property Organization and the World Trade Organization on how the policies and rules established in those fora might enhance access to health commodities.
206. In reply, Mr Martineau agreed that intellectual property rights were not the only factor affecting access to affordable medicines, but he stressed that it was a fundamentally important one. He highlighted several emerging complications, including a blurring distinction between originator and generic companies.
207. Regarding the Secretariat's work in this area, he noted that although it was a fast-moving area of work, UNAIDS could make a valuable contribution in "joining the dots" of the various challenges, gaps and opportunities.
208. The decision points were referred to a drafting group.

8. BEST PRACTICES ON EFFECTIVE FUNDING OF COMMUNITY-LED HIV RESPONSES

209. Laurel Sprague, Special Adviser, Community Mobilization at UNAIDS, presented a report on the barriers to and best practices on effective funding of community-led responses. After describing the methodology and scope of the report, Ms Sprague told the meeting that despite strong evidence of the effectiveness of community-led AIDS responses, funding for such activities was declining. The effect was most notable among small NGOs; those focused on advocacy, human rights and key populations; and NGOs in middle-income countries undergoing funding transitions.
210. A range of barriers—including criminal penalties and restrictions on fundraising—still made it difficult to fund community and human rights NGOs. In addition, donor frameworks and the practices of larger NGOs meant that small NGOs were often in financial trouble. Ms Sprague added, however, that the report also documented several good funding practices. They tended to engage community-based organizations throughout funding processes; tracked and reported on expenditure flows to community-led and human rights responses; and used social contracting and innovative financing methods. The Robert Carr Foundation was mentioned as an example.
211. Ms Sprague reminded the meeting of the target to ensure that 30% of services are community-led and that 6% of HIV financing goes towards social enablers. The Global AIDS Monitoring system had been updated to track progress against that indicator. UNAIDS had also revised the National Commitments and Policy Index to include issues such as the political, legal and regulatory safeguards for community-led responses. As well, National AIDS Spending Assessment tools allowed for tracking spending work on social enablers. Niger was cited as an example demonstrating that it was feasible for countries to monitor and report on funding streams for community-led activities.

212. A civil society engagement marker was piloted in 2018, showing it was also feasible to track UNAIDS contributions to civil society at country level. In 2019, a refined "civil society marker" would be applied against all resources coming from the Joint Programme.
213. Ms Sprague discussed the broader challenge of building stronger understandings and commitment among political leaders and decision makers regarding the importance of community-led AIDS responses in order to reverse funding declines and remove barriers. She urged UN Member States to champion community-led AIDS responses and meet their commitments on funding for civil society.
214. Funders should develop pre-approval processes with community and human rights organizations and donors should align their application and reporting requirements, she suggested. Countries should report annually on coverage and expenditures using the GAM and NASA tools.
215. The Joint Programme can and does support countries to review laws and policies that might impede financing of both community-led AIDS responses and social enablers, she told the meeting. Countries are also recommended to review and amend relevant laws and policies so civil society organizations could operate free from hindrance.
216. Nicholas Niwagaba, Executive Director of the Uganda Network of Young People Living with HIV/AIDS, briefed the meeting on examples of community-led initiatives in Uganda. They include the Y+ Beauty Pageant, which advocates against HIV-related stigma and discrimination and which has reached 8.5 million people with information and awareness-raising activities since 2014. It has also trained 120 young "ambassadors" who support young people living with HIV to access health services in 16 districts in Uganda. The project won an award for its work at the 2018 International AIDS Conference.
217. Mr Niwagaba also described the work of Act!2030, a youth-led initiative that advocates for young people to support implementation of the SDG agenda, especially SDGs 3.3 and 5. Supported by Switzerland, Act!2030 is a collaboration between the International Planned Parenthood Federation, UNAIDS and a coalition of youth organizations working on HIV in 12 countries. Act!2030 has trained over 500 young people on advocacy, accountability and how to conduct research and data collection.
218. UNAIDS made it possible for the youth coalition to receive the funds for this initiative. UNAIDS and other partners were also providing technical assistance to these projects. The next challenge, he said, was to develop stronger working partnerships between these kinds of initiatives and national health and social welfare systems in order to take their activities to scale.
219. Members commended the excellent report and applauded the crucial work done by community-led organizations. They expressed alarm at the declining funding for community-led activities.
220. Several speakers provided specific, recent examples of law and policies (including laws criminalizing certain behaviours) that prevented or made it very difficult for community-led organizations to receive funding. They critiqued the failure to remove those barriers and called on countries to identify and review policies and laws that prevent community-led organizations from receiving government or donor funding.

221. The meeting heard that organizations working on sexual and reproductive health rights were facing increased dangers in many countries. Laws and policies creating such inhospitable climates had to be reviewed and removed, speakers urged.
222. Some members (e.g. China, Islamic Republic of Iran and Mexico) described steps they had taken, including setting up dedicated funds to finance community-led interventions. The Act!2030 project was cited an example of how effective community-led organizations could be when they received sufficient funding and capacity building support. Members were urged to share good practices and develop recommendations for financing community-led HIV services.
223. Speakers reminded the meeting of the importance of technical assistance to support community-led organizations to apply for and manage Global Fund grants. Also mentioned was a need for clearer, shared definitions of concepts such as "community-led" and "social enablers", which could make it easier to track and monitor support for community-led activities.
224. Speakers emphasized the need for innovative community-led programmes also in high-income countries with apparently successful AIDS responses but where specific vulnerable populations were not being reached. An example was a consortium of Dutch groups, which provided community-led services to migrants living with HIV but was struggling to operate due to a lack of funding.
225. In reply, Ms Sprague thanked the meeting for the excellent discussion. She agreed that many community-led NGOs faced dire situations despite the evidence that community-led responses were effective. She noted that Cosponsors and other partners had developed tools to facilitate support for community-based organizations. She urged donors to support those organizations and activities immediately and to look forward to, but not to wait until precise definitions of "social enablers" and "community-led services" were achieved.
226. Mr Sidibé thanked the outgoing NGO delegates for their commitment and service.

9. NEXT PCB MEETINGS

227. Gunilla Carlsson, Deputy Executive Director, Management and Governance, UNAIDS, outlined the consultation of theme proposals for the next thematic segments. The PCB Bureau had considered 10 proposals.
228. The meeting agreed on the themes for the 44th and 45th PCB meetings. The theme for the 44th meeting would be "Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage (UHC)". The theme for the 45th meeting would be "Reducing the impact of AIDS on children and youth".
229. The meeting also agreed that the 48th PCB meeting would be held on 29 June to 1 July 2021, and the 49th meeting would be held on 7–9 December 2021.

10. ELECTION OF OFFICERS

230. Ms Carlsson announced that the current Vice-Chair, China, had indicated its interest in assuming the duties of Chair. The USA had expressed interest in the position of Vice-Chair, while Belarus had expressed interest in the position of Rapporteur.
231. A member enquired about the process for electing the NGO delegates. The NGO Delegation described the recruitment and selection process.
232. The meeting was told that the positions were advertised on organizations' websites, through their networks and on social media. Applications and recommendations from NGOs as well as regional network recommendations were received, the validity of applications was checked, and candidates were then reviewed and ranked.
233. The top two candidates in each region were then interviewed by panels comprising a regional delegate, a non-regional delegate from the NGO delegation and a civil society representative from the relevant region. The interview panel then made recommendations to the NGO delegation which decided on the nomination. Delegates were selected for two-year terms with a possibility of an additional one-year term.
234. The enquiring member proposed that all future NGO nominations be submitted to the PCB and be accompanied by information detailing the nominated organizations and the selection process.
235. In response, several members stated their support for the independent selection and representation of NGOs at the PCB and declared their opposition to measures that could compromise the independence of the NGO delegation to the PCB.
236. In closing, Mr Sidibé urged the Board to arrive at a consensus that would transform and strengthen UNAIDS. He repeated that he would leave his post at the end of June 2019 and requested the PCB to put in place process to facilitate a proper transition.
237. Mr Sidibé reminded the meeting that he had asked for the IEP and that UNAIDS had acted transparently. He urged the Board to bear in mind the interests of UNAIDS staff and the people the Joint Programme sought to serve.

11. ANY OTHER BUSINESS

238. No other business was brought before the Board.

12. THEMATIC SEGMENT: MENTAL HEALTH AND HIV/AIDS—PROMOTING HUMAN RIGHTS, AN INTEGRATED AND PERSON-CENTERED APPROACH TO IMPROVING ART ADHERENCE, WELL-BEING AND QUALITY OF LIFE

239. The thematic segment focused on mental health and HIV, with panelists and contributions from the floor sharing personal experiences and discussing new evidence and good practices. Accompanying the discussion was a background paper and a conference room paper. The latter collated 33 good practices for integrating HIV and mental health in countries around the world.
240. Laurel Sprague, Special Adviser, Community Mobilization at UNAIDS, who moderated the thematic segment, informed the meeting that the sessions unfortunately had to be shortened in order to allow time to complete discussions and finalize decision points from earlier agenda items.
241. Statements, which the members and other participants had been unable to present to the meeting, but had been submitted in writing to the PCB, have been incorporated in this report of the proceedings.
242. The segment began with several members reading the personal testimonies of people affected by mental health issues.

Mental health and HIV: Understanding and addressing the intersections

243. Doris Peltier of the Canadian Aboriginal AIDS Network was the key speaker in the opening session. She told the meeting she had been diagnosed with HIV in 2000. Indigenous people, she said, had "been researched to death". It was vitally important for indigenous people to understand and be able to tell the stories of their lives. However, Western research traditions perpetuated harmful narratives about aboriginal people, which had huge implications for people's mental health.
244. Ms Peltier said that, after she had been diagnosed with HIV, she was immediately stigmatized for having a "dirty disease". People used words that were common in the traditional research discourse on indigenous people, which portrayed them as sickly and in need of help. That same narrative had been used to justify the forced assimilation of indigenous people, including the removal of children from their families, which inflicted long-lasting damage on indigenous communities. Many individuals were disconnected from their identity, culture and language—which affected their mental wellbeing.
245. Ms Peltier told the meeting that indigenous researchers were decolonizing research in Canada. She described one project, Visioning Health, a five-year study with HIV-positive indigenous women which differed from standard "rescue-mode" approaches of seeking and treating, and instead, - focused also on the underlying determinants of mental health, such as colonization, in-country migration, dispossession and discrimination. She proposed that a future PCB meeting devote a thematic segment to indigenous people.

246. The first session focused on mental health, substance use, quality of life, wellbeing and HIV. It included discussion of effective approaches for addressing the interlinked challenges of HIV and mental health.
247. Tedros Adhanom Ghebreyesus, Director-General of WHO, addressed the meeting via a screened video recording. He said that research showed that many people still struggled to cope with their HIV-positive diagnoses and that mental health difficulties were a common challenge. This underscored the need for integrated health services, including services for mental health, and for integrating those services into community-based primary health care, to achieve the ultimate goal of ensuring universal health coverage (UHC) for all.
248. Mark van Ommeren, Director a.i., Mental Health and Substance Abuse at WHO, told the meeting that one in six people globally experienced mental health or substance use problems. He highlighted the linkages among HIV, mental health and substance use and said that addressing those linked issues was a "win-win" approach. Referring to the recent creation of an international alliance on mental health and the first-ever global summit on the issue, he said there were signs that mental health was emerging from the shadows.
249. Mr van Ommeren said research showed significant associations between harmful alcohol and drug use, heightened risk of HIV infection, and mental health issues, with numerous pathways linking those risks. Studies showed that people with mental health conditions were less likely to access and adhere to HIV treatment.
250. They also showed that affordable depression treatment enhanced ART adherence. Yet development assistance for mental health was very low—equivalent to about 1% of the resources allocated to HIV programmes—despite evidence showing that care for depression, for example, brought a very good return on investment (US\$ 5 return for every US\$ 1 spent).
251. He emphasized the need to integrate effective HIV and mental health services, including within UHC. Integration could be achieved by providing the relevant services in single facilities or through referrals. WHO had developed guidelines for key interventions (including eMental health approaches, which were becoming more popular) and for integrating them effectively.

Why addressing mental health is crucial for HIV prevention, treatment and care

252. Panelists discussed prominent challenges and presented examples of good practices related to maintaining mental health and wellbeing in the context of living with HIV.
253. Etheldra Nakimuli-Mpungu, a psychiatrist at Makerere University in Uganda, reminded the meeting that treatment alone would not end the AIDS epidemic: prevention was also key. Effective prevention required tackling the determinants of HIV risk, including mental health conditions, she said.
254. HIV service providers seldom pay attention to people's mental health, Ms Nakimuli-Mpungu told the meeting. When mental health symptoms become severe, providers may refer people to mental health services. Generally, though, mental health care tends to be neglected, she said. UNAIDS could help change this by championing educational

campaigns on mental health and by advocating for the scale-up of culturally sensitive interventions (such as those developed in some African countries).

255. She described a group therapy approach she had developed for people living with HIV who were experiencing mental health difficulties. Unusually, the approach also attracted large numbers of men, partly because the therapy was being linked with poverty reduction support and skills. Evaluations showed that the interventions were associated with reduced post-traumatic stress symptoms, improved self esteem, and increased social support. When depression symptoms were reduced, adherence to HIV treatment improved and viral suppression rates rose. Ms Nakimuli-Mpungu said the benefits were equally evident among women and men.
256. Sílvia Ouakinin, a psychiatrist at the National Health Service in Portugal, reiterated the two-way relationship between HIV and mental health conditions. She told the meeting that depression rates among people living with HIV were more than twice higher than in the general population and that neurocognitive disorders affected almost 50% of HIV patients.
257. Ms Ouakinin stressed the importance of early, tailored interventions. Health-care providers should screen people living with HIV for potential mental health care needs, and procedures should exist to ensure that individuals receive the mental health services they need. Doing so also required tackling the stigma that was associated with both mental health conditions and with HIV infection.
258. Marco Castro-Bojorquez, a filmmaker from Mexico and the United States of America, presented emotional testimony of his recent experiences with HIV, stress and depression and the difficult dilemmas they created. He said people were not drawing on the support families could offer them; instead they were often stricken by a sense of abandonment. Family acceptance was difficult, but it was a source of great strength, he said.

Promoting rights and engaging communities to eliminate stigma and discrimination and improve quality of life

259. This session was devoted to approaches for addressing mental health and HIV issues from a human rights perspective, including through community engagement and people-centred approaches.
260. Michelle Funk, Coordinator of Mental Health Policy and Service Development at WHO, said that people experiencing mental health difficulties were frequently exposed to physical and/or sexual violence and various coercive practices, including in health-care settings. Those violations were disempowering and they fed self-stigma. People living with HIV endured many similar experiences, she added, and the harm was compounded for those with mental health conditions. Common approaches were needed in these linked areas, particularly rights-based approaches that overcame discriminatory practices.
261. Working on a limited, face-to-face level was not enough, Ms Funk said. WHO had developed a range of tools for addressing the issue on a large scale—including eTraining tools, which were showing impressive results. It was also important to build community-based support. This entailed shifting from a narrow, biomedical focus to a more holistic, person-centred recovery model that was meaningful to people's lives. People with lived experience of the issues had to be at the centre of the activities. She concluded with a call for strong, implementable policies that address discrimination and increase access to health, social protection, employment and other services.

262. Nyasha Sithole, Programmes Director at the My Age Zimbabwe Trust in Zimbabwe, told the PCB that limited social and professional support was available to young people with mental health difficulties and that medical staff often treated them with great disrespect. Countries in Africa had severe shortages of psychiatrists: Zimbabwe, for example, had about 70 psychiatrists for the entire country. She called for integrating mental health and HIV services, with mental health screening available along the entire continuum of HIV services. She added that young people had to be at the centre of these strategies.
263. Taweessap Siraprapasiri, Senior Adviser in the Department of Disease Control in Thailand's Ministry of Public Health, described some of the steps taken in his country. Although HIV testing and treatment was being integrated into UHC, stigma and discrimination remain major problems. Thailand was monitoring HIV-related stigma and discrimination nationally, including in health-care settings, he said. An online complaints mechanism for rights violations was available and the data was being used to guide corrective actions.
264. A package of tools had also been developed for reducing HIV-related stigma and discrimination. It included participatory training for health-care staff and procedures for improving services. Initially implemented in six hospitals, the package was being expanded to more than 100 hospitals across the country and it was being used also in China, Laos and Viet Nam, Mr Siraprapasiri said. The project showed that stigma and discrimination, although complex, can be measured and effectively tackled. Preliminary data showed large reductions in stigma and discrimination in settings where the package had been used. Tools for reducing self-stigma were also being piloted in the hospitals and would be evaluated during 2019.
265. Jules Kim, Chief Executive Officer of the Scarlet Alliance and Australian Sex Workers Association, described some of the conditions faced by sex workers and said it was very difficult for people to maintain their mental health and wellbeing in such circumstances. Importantly, interventions had been developed to support the mental health of key populations, many of them focusing on people's rights and responsibilities. She emphasized that supporting the mental health of people living with HIV created "win-win" situations by improving people's health in multiple, mutually reinforcing ways. UNAIDS was asked to provide greater support to communities to meet these interlinked challenges.

Substance use and HIV: what has been overlooked?

266. In this session, attention turned to issues surrounding HIV and the harmful use of drugs and alcohol.
267. Marcelo Ribeiro, psychiatrist and director of the Centro de Referência de Álcool, Tabaco e Outras Drogas (CRATOD) in Sao Paulo, Brazil, described the city's open-air drug scene, known as "Cracolândia", where up to 2,000 crack users congregated daily. Rates of syphilis and HIV in this community were high (up to 12%), especially among lesbian, gay, bisexual and transsexual individuals (up to 25%). CRATOD saw the need to go beyond merely containing the harm that was being done, he said. It tests and treats users for HIV and other infectious diseases, using a recently introduced fast-track system that screens as many as 80 people a day.

268. David Subeliani of the Eurasian Network of People Using Drugs and the NGO, White Noise, briefed the meeting on the trends of drug use in Georgia, where the use of stimulants and other noninjected drugs is on the rise. He said harm reduction projects had to adapt to this reality since the evidence showed that noninjecting drug use was also associated with an elevated risk of HIV infection.

Taking care of the mental health and wellbeing of activists and service providers

269. This interactive session focused on the challenges activists and service providers face in protecting their own mental health.
270. Daniil Stolbunov from the Teenergizer project in Ukraine shared his experiences as an adolescent HIV-positive activist in a conservative community. He told the meeting that mental health services were ill-equipped to serve young people, with doctors typically lacking the necessary communication skills and experience for treating young people, especially those living with HIV, with dignity and respect.
271. Iregi Mwenja of the Global Mental Health Peer Network in Kenya described similar experiences. Living with a mental health condition in low- and middle-income countries was very difficult due to poor access to services and pervasive stigma, he said. Yet effective low-cost solutions existed and they could have a big impact if they got enough support. For example, PDO (Psychiatric Disability Organization) Kenya, operating on a small budget, had provided therapy to over 5,400 people in the previous 2.5 years and trained 186 peer counselors in secondary schools in the previous year. In South Africa and Zambia, the SMH Foundation was running mobile phone support groups for HIV-positive adolescents, while the #FriendshipBench initiative in Zimbabwe showed that some of the gaps in mental health services could be bridged by using trained lay health workers.
272. Mr Mwenja highlighted a recent trend that was making it more difficult to provide rights-based, comprehensive services. He said HIV service providers were increasingly "chasing numbers" as they sought to reach quotas and targets, at the expense of providing quality care. Testing and treatment programmes could not be effective in the long term under such conditions, he warned. In addition, funding for social and psychosocial support for people living with HIV was declining as donors favoured technical treatment services and commodities. People's wellbeing was suffering as a result, Mr Mwenja said. He suggested that UNAIDS expand the 90–90-90 targets to the fourth 90 by requiring that 90% of people who test HIV-positive be enlisted in a psychosocial support programme.
273. Cecilia Chung, activist and founder of the annual Trans March in San Francisco, told the meeting that service providers faced great pressures and often endured trauma. This affected their decision-making at work and their personal lives. She emphasized that mental health had to be integrated into the entire platform of HIV-related services.
274. Due to time constraints, discussion from the floor had to be abbreviated. The statements summarized below include several written contributions which, due to limited time, could not be presented at the session itself.
275. Speakers commended UNAIDS for organizing first time the discussion at the PCB this important though often-forgotten topic and thanked the panellists for sharing their experiences and expertise. The speakers also commended UNAIDS for showing sensitivity to the terminology used around mental health. They welcomed the background

paper's use of more neutral expressions rather than language that could contribute to perpetuating stigma around mental health conditions.

276. It was noted that more than 1 billion people around the world were estimated to have experienced a mental health condition, a substance use disorder or an alcohol use disorder—an estimated 16% of the global population and that people living with HIV were at an increased risk of developing mental health conditions.
277. Emphasizing the "two-way" relationship between mental health and HIV, speakers pointed to strong evidence that mental health conditions affect HIV treatment access or adherence. Several contributions urged stepped-up actions and investment to integrate mental health and HIV services as part of a fully-funded global AIDS response. They emphasized the need for actions that target the social determinants of poor mental health and HIV.
278. Speakers insisted on a human rights-based approach to mental health. A shift was needed from a mainly biomedical focus to a more balanced and holistic model that integrates biosocial aspects. The meeting was reminded of the 2017 Human Rights Council Resolution on Mental Health and Human Rights and the 2018 Report of the UN High Commissioner for Human Rights on Mental Health and Human Rights, which urged action on the social determinants of mental health conditions. The Human Rights Council resolution also urged States to develop mental health services that avoid overmedicalization and inappropriate treatments and called for human rights education and training for health-care workers, police, law enforcement officers, prison staff and other relevant professions.
279. A human rights-based approach was also crucial for tackling the stigma and discrimination that still attached to HIV and to mental health conditions, the meeting heard. Contributions provided examples of efforts to end stigma and discrimination, including through PEPFAR-supported programmes as well as activities supported by the Disability Rights Fund and the Robert Carr Civil Society Networks Fund.
280. The meeting was reminded that mental health was a major issue also for people with disabilities, including people with intellectual or developmental disabilities. In a recent survey by the AIDS Committee of Toronto, for example, autistic and other persons with developmental disabilities reported widespread neglect and human rights violations, including in health-care settings. Countries were urged to ratify the Convention on the Rights of Persons with Disabilities.
281. Contributions from the floor also noted the links among drug use, mental health and HIV. The meeting was informed of technical guidance which the UN Office on Drugs and Crime (UNODC) had developed for addressing HIV and viral hepatitis among people who use stimulant drugs. The importance of changing patterns of drug use was noted and it was suggested that a thematic segment on the issue be considered.
282. Good practices from Kenya, Malawi, Poland and the United Republic of Tanzania were shared as evidence that mental health issues experienced by people living with HIV can be addressed in responsive and respectful ways. UNAIDS and donors were urged to support such initiatives. UNAIDS was requested to advocate for the integration of mental health and psychosocial support into HIV programmes and to share best practices. There were also requests for the development of clear guidance on integrating services for HIV and mental health, which UNAIDS and WHO were asked to explore.

283. Due the reduced time allotted to the thematic segment, it was proposed that the next PCB meeting should dedicate time to continue the discussion and arrive at decisions regarding the integration of mental health and HIV services.

284. The Chair thanked the speakers and organizers of the thematic segment and apologized for the abbreviated discussion.

13. CLOSING OF THE MEETING

285. The 43rd meeting of the Board was adjourned.

[Annexes follow]

Annex 1

PROGRAMME COORDINATING BOARD

UNAIDS/PCB (43)/18.18

Issue date: 26 September 2018

FORTY-THIRD MEETING

DATE: 11–13 December 2018

VENUE: Executive Board Room, WHO, Geneva

TIME: 09:00 – 12:30 | 14:00 – 18:00

Annotated Agenda

TUESDAY, 11 DECEMBER

1. Opening

1.1. Opening of the meeting and adoption of the agenda

*The Chair will provide the opening remarks to the 42nd PCB meeting.
Document: UNAIDS/PCB (43)/18.18*

1.2. Consideration of the report of the forty-second meeting

*The report of the forty-second Programme Coordinating Board meeting will be presented to the Board for adoption.
Document: UNAIDS/PCB (42)/18.17*

1.3. Report of the Executive Director

*The Board will receive a written outline of the report by the Executive Director.
Document: UNAIDS/PCB (43)/18.19*

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 (43)/18.20*

2. Leadership in the AIDS response

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

3. Prevention of and response to harassment, including sexual harassment, bullying and abuse of power at the UNAIDS Secretariat

3.1. Report on the work of the Independent Expert Panel on Prevention of and response to harassment, including sexual harassment; bullying and abuse of power at UNAIDS Secretariat

The Board will receive a report on the work of the Independent Expert Panel on preventing and addressing Harassment

Document: UNAIDS/PCB (43)/18.21

3.2. Management Response

The Board will receive a management response of UNAIDS Secretariat on the recommendations of the Independent Expert Panel

Document: UNAIDS/PCB (43)/18.22

3.3. Statement by the representative of the UNAIDS Staff Association

The representative of the UNAIDS Staff Association will present a statement to the Board

Document: UNAIDS/PCB (43)/18.23

4. Follow-up to the thematic segment from the 42nd Programme Coordinating Board meeting

The Board will receive a summary report on the outcome of the thematic segment on Ending tuberculosis and AIDS – a joint response in the era of the Sustainable Development Goals

Document: UNAIDS/PCB (43)/18.24

WEDNESDAY, 12 DECEMBER

5. Way forward to achieving sustainable AIDS results

The Board will receive a report on the work of the UNAIDS Joint Programme to ensure the sustainability of HIV response results in the SDG era.

Document: UNAIDS/PCB (43)/18.25

6. Annual progress report on HIV prevention 2020

The Board will receive the annual progress report on HIV prevention 2020.

Document: UNAIDS/PCB (43)/18.26

7. Update on the access components of the UNAIDS 2016–2021 Strategy: removing access barriers to diagnostics and treatment for HIV and co-infections in low- and middle-income countries

The Board will receive the findings of an exploratory study on existing data and data gaps, challenges and best practices to support countries in overcoming access barriers, including intellectual property (IP)-related and other factors that may impact the availability, affordability, and accessibility of treatment and diagnostics for HIV and co-infections in low- and middle-income countries.

Document: UNAIDS/PCB (43)/18.27

8. Best Practices on effective funding of community-led HIV responses

The Board will receive a report on the barriers to and best practices on, effective funding of community-led responses

Document: UNAIDS/PCB (43)/18.28

9. Next PCB meetings

The Board will agree the topics of the thematic segments for its 44th and 45th PCB meetings in June and December 2019, as well as the dates for the 48th and 49th meetings of the PCB

Document: UNAIDS/PCB (43)/18.29

10. Election of officers

In accordance with Programme Coordinating Board procedures, the Board shall elect the officers of the Board for 2019 and is invited to approve the nominations for NGO delegates.

Document: UNAIDS/PCB (43)/18.30

11. Any other business

THURSDAY, 13 DECEMBER

12. Thematic segment: *Mental health and HIV/AIDS—promoting human rights, an integrated and person-centred approach to improving ART adherence, well-being and quality of life*

Documents: UNAIDS/PCB (43) /18.31, UNAIDS/PCB (43)/18.32

13. Closing of the meeting

[End of document]

Annex 2

43rd Meeting of the UNAIDS Programme Coordinating Board Geneva, Switzerland

11–13 December 2018

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 subject to review to consider the progress of work;

Agenda item 1.2: Consideration of the report of the forty-second meeting

2. *Adopts* the report of the 42nd Programme Coordinating Board meeting;

Agenda item 1.3: Report of the Executive Director

- 3.1 *Takes note* of the report of the Executive Director, including the need for a smooth succession planning;
- 3.2 *Calls* for the immediate initiation of the selection process for the next UNAIDS Executive Director;

Agenda item 1.4: Report of the NGO representative

- 4.1 Recalling Article 25.1. of the Universal Declaration of Human Rights "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.";
- 4.2 Recalling from the 41st meeting of the UNAIDS Programme Coordinating Board, decision points 4.1 through 4.6, related to HIV and migrant and mobile populations, as well as refugees and crisis-affected populations as well as the 2014 UNAIDS Gap Report;

- 4.3 *Takes note* of the report;
- 4.4 *Calls* upon the Joint Programme to address the diverse needs, risks and vulnerabilities of migrant and mobile populations, as well as refugees and crisis-affected populations and design and implement HIV prevention and response programmes accordingly to promote access to HIV prevention, treatment, care and support services;
- 4.5 *Encourages* the Joint Programme to fully implement the General Cooperation Agreement between the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM) to strengthen the engagement of IOM in the AIDS response;
- 4.6 *Calls* on the Joint Programme to support Member States, in partnership with communities and civil society organizations and other relevant partners, in accordance with national law, context and priorities, to:
 - a. Support access to HIV prevention, treatment, care and support services, for migrant and mobile populations, as well as refugees and crisis-affected populations, including, as appropriate, through strengthening international cooperation;
 - b. Contribute to the generation and improved availability of national, regional and local data on HIV and migration to improve the evidence base relative to the needs of mobile populations;
 - c. Review and adapt laws, policies and practices that prevent migrant and mobile populations, as well as refugees and crisis-affected populations from accessing life-saving treatment, with a particular focus on key populations;
 - d. Strengthen technical capacity so that national health systems address HIV and co-morbidities among migrant and mobile populations, as well as refugees and crisis-affected populations;
 - e. Encourage an enabling environment for cooperation between national health systems and communities and civil society organizations including through availability of financial resources;
- 4.7 *Requests* the Joint Programme to report back on progress in the implementation of the AIDS response for migrant and mobile populations, as well as refugees and crisis-affected populations, as appropriate;

Agenda item 3: Prevention of and response to harassment, including sexual harassment, bullying and abuse of power at the UNAIDS Secretariat

- 5.1 *Recognizes* the important contribution and commitment of the UNAIDS Secretariat staff to implement the UNAIDS Strategy and support Member States to achieve the 2016 Political Declaration on Ending AIDS;
- 5.2 *Commits* to zero tolerance against harassment, including sexual harassment, bullying and abuse of power to ensure the highest standards in order to create an exemplary workplace in the UNAIDS Secretariat;
- 5.3 *Welcomes* the earlier request of the Executive Director to establish the Independent Expert Panel (IEP) on prevention of and response to harassment, including sexual harassment, bullying and abuse of power at the UNAIDS Secretariat;

- 5.4 *Recalls* that the PCB endorsed the steps taken by the PCB Bureau in response to this request and agreed that the priority should be for the IEP to be enabled and empowered to provide an authoritative review and a comprehensive set of recommendations pertaining to harassment, including sexual harassment, bullying and abuse of power at the UNAIDS Secretariat;
- 5.5 *Notes* that the IEP has presented its report and recommendations to the PCB;
- 5.6 *Notes* that the UNAIDS Secretariat has presented its Management Response to the PCB;
- 5.7 *Welcomes* the statement by the UNAIDS Secretariat Staff Association (USSA), and *recognizes* the critical role of the USSA in bringing the PCB's attention to this important issue;
- 5.8 *Highlights* both, the limited circulation time of these important reports and the divergent, varied and differing views expressed by the PCB members and observers;
- 5.9 *Emphasizes* that there is consensus on the need for action to address harassment, including sexual harassment, bullying and abuse of power;
- 5.10 *Recognizes* with remorse the negative impact of harassment, including sexual harassment, bullying and abuse of power on the staff of the UNAIDS Secretariat and their ability to deliver on the critical mandate of the Joint Programme;
- 5.11 *Notes* that some of the recommendations of the IEP and the Management Response have broader implications for the United Nations system;
- 5.12 *Notes* that, as part of the Joint Programme's commitment to transparency and accountability, the IEP report is in the public domain and has been transmitted to the UN Secretary-General by the UNAIDS Secretariat;
- 5.13 *Decides* that, at a special session of the PCB no later than March 2019, the PCB after complete consideration of the IEP report may elect or choose to bring specific recommendations to the attention of the UN Secretary-General;
- 5.14 *Decides* to establish a working group of the PCB to oversee the immediate implementation of the management response and to further review the conclusions and recommendations contained in the IEP report, and the management response, proposing options to the next PCB meeting, for strengthening the PCB's monitoring and evaluation role on the UNAIDS Secretariat with the view of ensuring zero tolerance against harassment, including sexual harassment, bullying and abuse of power at the UNAIDS Secretariat;
- 5.15 *Calls* on the UNAIDS Secretariat to:
 - a. Fully implement the actions set out in the Management Response, and develop a more detailed, fully costed Management Action plan, complete with review mechanisms and timeline, with regards to the IEP recommendations, which are under its responsibility, in a robust, measurable, timely and ambitious way for consideration by the PCB by intersessional decision making;
 - b. Operate to the highest standards to tackle harassment, including sexual harassment, bullying and abuse of power;

- c. Provide a Progress Report to the next regular session of the PCB on the implementation of the above actions;

Agenda item 4: Follow-up to the thematic segment from the 42nd Programme Coordinating Board meeting

- 6.1 *Takes note* of the background note (UNAIDS/PCB (42)/18.16), the summary report of the Programme Coordinating Board thematic segment on Ending tuberculosis and AIDS—a joint response in the era of the Sustainable Development Goals, the 2016 Political Declaration on Ending AIDS and the 2018 Political Declaration of the high-level meeting of the General Assembly on the fight against tuberculosis (A/RES/73/3);
- 6.2 *Calls* on Member States, through a multisectoral approach, to:
 - a. Establish ambitious national coverage and mortality reduction targets that are reflected in acceleration plans to achieve the 2020 target of a 75% reduction in TB deaths among people living with HIV;
 - b. Better coordinate efforts between TB and HIV and other health and social programmes, and with civil society, to find “the missing millions” living with HIV and TB;
 - c. Increase access to rapid TB and HIV diagnostics to reduce delays between symptom presentation, diagnosis and treatment and to ensure adequate treatment literacy, adherence support and retention in care;
 - d. Accelerate efforts to initiate all newly diagnosed adults and children living with HIV on antiretroviral treatment and ensure access to either TB treatment or TB preventive treatment;
 - e. Integrate TB prevention and treatment into HIV services (and vice versa) and broader health systems to ensure more efficient, effective and equitable service delivery for all who are in need;
 - f. Develop better coordinated plans to address the common social and structural determinants of HIV and TB, including poverty, inadequate living conditions, stigma and discrimination;
- 6.3 *Calls* on Member States and key donors to invest in TB research to develop health technologies, new funding models and new approaches for fast-tracking research, as well as innovative approaches and regulatory reforms to ensure access and affordability of TB diagnostics and treatment;
- 6.4 *Calls* on the UNAIDS Joint Programme to:
 - a. Provide clear guidance to national stakeholders on how to measure, monitor and reduce the impact of TB and HIV stigma and discrimination in health-care, workplace and community settings;
 - b. Better engage, empower and support communities of people living with, and affected by TB and HIV to be fully involved in the development, decision making, implementation, monitoring and evaluation of national HIV and TB responses;

Agenda item 5: Way forward to achieving sustainable AIDS results

- 7.1 *Recalling* the commitments in the 2016 Political Declaration on Ending AIDS, as well as the 2030 Agenda for Sustainable Development, and in order to ensure progress towards the goal of ending the AIDS epidemic as a public health threat by 2030;
- 7.2 *Recognizing* the emerging challenges, the potential high costs of complacency and the importance of ensuring that the goal of sustainability shapes the decisions of all partners, country stakeholders, communities and donors;
- 7.3 *Takes* note of the report;
- 7.4 *Encourages* countries to develop integrated AIDS Investment Cases as well as transition and sustainability plans that are linked with health and Sustainable Development Goal financing strategies, and to fulfill their commitments to close the HIV funding gaps;
- 7.5 *Encourages* UNAIDS to expand the existing Joint Programme working group on investment and efficiency to include civil society and communities and to develop and implement a Joint Programme Policy Framework on Investments and Sustainability and metrics to guide a coherent, people-centered approach that will be utilized to guide high-impact support to countries and communities; and to report back through the UBRAF reporting process on results achieved and lessons learned;

Agenda item 6: Annual progress report on HIV prevention 2020

- 8.1 *Recalls* the decisions from the 41st PCB meeting on the Follow-up to the thematic segment on HIV prevention 2020: a global partnership for delivery;
- 8.2 *Takes* note of the 2018 progress report on the Implementation of the HIV 2020 Prevention Road Map and invites States to consider joining the Global HIV Prevention Coalition;
- 8.3 *Calls on* Member States, in collaboration with community-based and civil society organizations and other partners to continue accelerating a scaled-up prevention response in line with the commitments in the 2016 Political Declaration on Ending AIDS;
- 8.4 *Stresses* the importance for Member States and key donors to continue to invest adequately in HIV prevention, with no less than one quarter of HIV spending to be invested in prevention programmes;
- 8.5 *Requests* the Joint Programme to support countries in developing and implementing robust prevention plans which include sustainable capacity development and resource mobilization strategies and report back in 2019 to the Programme Coordinating Board on progress made on prevention;

Agenda item 7: Update on the access components of the UNAIDS 2016–2021 Strategy: removing access barriers to health technologies for HIV and its coinfections and comorbidities in low- and middle-income countries

- 9.1 *Recalling* the commitments at previous Programme Coordinating Board meetings and relevant paragraphs from Resolution 70/266 of the UN General Assembly – Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV

and to Ending the AIDS Epidemic by 2030, June 2016, which recognized that access to safe, effective and affordable medicines and commodities for all, without discrimination, in the context of epidemics such as AIDS is fundamental to the full realization of the right of everyone to enjoy the highest attainable standard of physical and mental health;

- 9.2 *Takes* note of the findings in the report;
- 9.3 *Reaffirms* the objectives on increased access to medicines and health technologies included in the 2016-2021 UNAIDS Fast-Track Strategy and UNAIDS UBRAF 2016–2021 that include increased access to medicines and health technologies and their objectives;
- 9.4 *Requests* UNAIDS to allocate sufficient financial and human resources to achieve these objectives and to, among other things, include:
 - a. Convening on a regular basis, key actors and stakeholders across the HIV response to discuss and address critical challenges and opportunities related to ensuring innovation and access to medicines and other health technologies for HIV;
- 9.5 *Calls* on UNAIDS to regularly report on progress with regards to these objectives in the framework of the UBRAF performance report;

Agenda Item 8: Best Practices on effective funding of community-led HIV responses

- 10.1. *Recalling* the 2016 Political Declaration on Ending AIDS, paragraphs 60d and 64a
- 10.2. *Takes* note of the report;
- 10.3. *Encourages* Member States to:
 - a. Dedicate maximum available resources to fulfilling the right to the enjoyment of the highest attainable standard of health, including the 30% coverage by community-led HIV programmes and 6% of HIV financing towards social enablers, as agreed in the 2016 Political Declaration on Ending AIDS;
 - b. Review and amend relevant laws, policies, institutions and mechanisms to create and maintain a safe and enabling environment in which civil society can efficiently support the AIDS response and the achievement of the targets for, and the goal of, ending AIDS by 2030;
 - c. Report on coverage and expenditures using the Global AIDS Monitoring and National AIDS Spending Assessment tools on an annual basis;
- 10.4. *Requests* the Joint Programme to:
 - a. Support the process of reviewing laws and policies that may impede financing of both community-led AIDS responses and social enablers;
 - b. Convene a task team with diverse donors, implementing countries, and civil society representatives, including representatives of people living with HIV, women and adolescent girls and young women, youth and key populations, to standardize the use of definitions, including, “community-led AIDS response” and “social enablers” and to recommend good practices and improved modalities to ensure access to funding for community-based organizations and constituency-based networks;

Agenda Item 9: Next PCB meetings

- 11.1 *Agrees* that the themes for the 44th and 45th Programme Coordinating Board meetings be:
- a. Delivering on SDG3: Strengthening and integrating comprehensive HIV responses into sustainable health systems for Universal Health Coverage (UHC) (44th);
 - b. Reducing the impact of AIDS on children and youth (45th);
- 11.2 *Requests* 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 46th and 47th Programme Coordinating Board meetings;
- 11.3 *Agrees* on the dates for the 48th (29th, 30th June and 1st July 2021) and the 49th (7th, 8th and 9th December 2021) meetings of the Programme Coordinating Board;

Agenda Item 10: Election of officers

12. *Elects* China as the Chair, the United States of America as the Vice-Chair and Belarus as the Rapporteur for the period 1 January to 31 December 2019 and *approves* the composition of the PCB NGO delegation.

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