

REPORT OF THE 41ST MEETING OF THE PROGRAMME COORDINATING BOARD

Additional documents for this item: *none*

Action required at this meeting—the Programme Coordinating Board is invited to:

Adopt the report of the 41st 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 41st meeting on 12–14 December 2017 in the Executive Board Room of the World Health Organization (WHO) in Geneva.
2. The PCB Chair, Kwaku Agyeman-Manu, Minister of Health, Ghana, welcomed participants to the meeting. Following a moment of silence in memory of all people who have died of AIDS, the PCB adopted the annotated agenda.
3. The Chair noted the high-level representation from several countries, including ministerial level. He then briefly updated the meeting on the state of the HIV response in Ghana.

1.2 Consideration of the report of the 40th meeting

4. The Board adopted the report of the 40th Programme Coordinating Board meeting.

1.3 Report of the Executive Director

5. Michel Sidibé, Executive Director of UNAIDS, began his remarks by noting that the PCB meeting coincided with Universal Health Coverage Day. He told the Board that it was meeting at a time of dramatic change, with economic challenges, humanitarian crises, climate change, migration and other factors fueling volatility and instability. But there are also many reasons for hope, he noted. Activism, community action, government commitment and scientific innovations are bringing hope to millions.
6. Mr Sidibé reminded the meeting that 40 years earlier people living with HIV had said “no to dying, to silence and to inaction”. They organized and pushed governments to act. When treatment became available, they worked hard to make sure no one was left behind. That spirit continues to drive the HIV response.
7. For the first time, more people were receiving HIV treatment than waiting for it. In South Africa, 90 people were on treatment in 2000, compared with 4.2 million people in 2017. Globally, nearly 21 million people were accessing treatment and 82% of people on treatment were virally suppressed. The world has to reach the remaining 16 million people with treatment as soon as possible, Mr Sidibé urged.
8. New HIV infections in sub-Saharan Africa have declined by nearly 50% since 2000, the result of shared responsibility and global solidarity. More countries (including six in the Caribbean) have validated the elimination of mother-to-child transmission of HIV and congenital syphilis. Hundreds of cities are accelerating their HIV responses.
9. But this does not mean that the AIDS epidemic is over, Mr Sidibé stressed. Several key challenges have to be addressed to achieve the goal of ending the epidemic by 2030, he said.

10. Services have to reach everyone in need of treatment. This calls for several improvements, among them the greater use of innovative testing approaches. There is also clear evidence that men are not using HIV prevention, testing or treatment services to the same extent as women.
11. Some regions are lagging behind, with new HIV infections increasing in eastern Europe and central Asia, especially in the general population. New infections in that region have risen by 60% since 2010 and AIDS-related deaths have increased by 27%. Mr Sidibé announced the appointment of Michel Kazatchkine as UNAIDS special advisor on HIV, STIs and HCV for the region. He also expressed concern about a “two-speed response” in Africa, where HIV responses in western and central African countries are lagging behind.
12. He called for a renewed focus on young people to boost the impact of HIV prevention. Girls and young women must receive greater protection, he urged, especially in sub-Saharan Africa, where 67% of new HIV infections among young people (15–24 years old) are among women and girls. Access to comprehensive sexuality education.
13. Mr Sidibé told the meeting that UNAIDS and partners had launched a new “roadmap for prevention” in October 2017, with a focus on community-based responses. Several countries were already finalizing their new HIV prevention strategies.
14. The United Nations (UN) would not achieve its vision for health nor realize the Sustainable Development Goals (SDGs) without confronting and eliminating stigma and discrimination, Mr Sidibé warned. One in five people living with HIV reports experiencing discrimination in health-care settings, and discrimination denies people who are most at risk for HIV infection access to life-saving services. Mr Sidibé announced that UNAIDS, responding to a proposal from the PCB nongovernmental organization (NGO) delegates, would convene a Global Compact on Eliminating Stigma and Discrimination.
15. The SDGs demand fresh approaches to global health and development, and UNAIDS continues to be a trendsetter on that front, Mr Sidibé told the meeting, adding that the HIV response overall has been transforming the health sector for decades. He urged other UN bodies to follow UNAIDS’ example by including civil society representation in their governing bodies.
16. He also stressed that it was crucial to “take AIDS out of isolation”. UNAIDS and its partners have to identify and build on synergies with other major health issues (such as tuberculosis, other sexually transmitted diseases, cervical cancer) and with broader development challenges.
17. He assured the Board that the Joint Programme and Secretariat were delivering on the UNAIDS 2016–2021 Strategy and the Fast-Track Targets to ensure the world can end the AIDS epidemic by 2030. He reported on several important UNAIDS initiatives, including the development of a Joint Programme Action Plan for a fully funded UBRAF and the successful restructuring of the Joint Programme (as reported at the 40th PCB in June 2017), which was delivering results.

18. Implementation of the Joint Programme Action Plan and the Strategic Resource Mobilization Plan for 2018–2021 was underway. The plans were already shifting responses in countries towards more integrated approaches. The rollout of the country envelope model in particular would allow UNAIDS to reinvigorate country-level joint work and deploy human and financial resources where they are needed the most.
19. Mr Sidibé reported several promising developments regarding funding. Some countries had increased their financial contributions, while Argentina, Côte d'Ivoire and Ghana were among the most recent contributors of funding to the Joint Programme.
20. Looking ahead, he said there would be a greater focus on adolescents; achieving universal access to sexual and reproductive health rights; empowering women and girls to protect their own health and that of their communities; reaching pregnant women, mothers and newborns that are being left behind; and safeguarding access to services in fragile settings and places facing humanitarian crises. UNAIDS was also developing a new gender action plan for 2018. It would continue tackling environmental issues and would address harassment on all fronts.
21. Board members congratulated Mr Sidibé on a comprehensive report and commended the work of the Joint Programme. Referring to UNAIDS as a successful example of multisectoral action within the UN, they said it holds lessons for jointly tackling the development challenges outlined in the 2030 SDG agenda. The collaborative approaches being used to tackle the remaining challenges in countries were demonstrating the value of the Joint Programme model.
22. They reminded that UN reforms are not merely a technocratic exercise—they have to advance the protection of human, social and economic rights, which are also vital for ending the AIDS epidemic. Members reiterated their ongoing commitment to end the AIDS epidemic by 2030, stressing the links between that goal and realizing the universal right to health.
23. Speakers commended the Joint Programme for delivering on its promises to the international community and for the steps taken to stabilize its funding situation and adjust its business model. They applauded the rapid progress made in implementing the UNAIDS Joint Programme Action Plan, describing it as an example of UNAIDS' determination to adapt to new circumstances and rise to its challenges.
24. Members welcomed the UNAIDS Joint Programme Action Plan's details, including the allocation of resources to countries and settings where they are most needed. They expressed support for efforts to ensure that funds reach countries quickly and are aligned with national health priorities.
25. They emphasized that a fully funded UBRAF was crucial, while noting that the financing of HIV and health programmes was a challenge in most regions. Encouraging countries to continue investing in the Joint Programme, they also highlighted UNAIDS' need for un-earmarked funding so it could rapidly respond to new developments and needs. Sweden announced a contribution for 2017 of over US\$ 32 million, which could rise to a potential US\$ 37 million pending approval by the country's Parliament. Côte d'Ivoire announced a contribution of US\$ 450 000 to UNAIDS.

26. A strengthened funding relationship between UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) was mooted, and some members said they would welcome a report on options for greater cooperation between it and the Global Fund.
27. Noting the major progress made in the global HIV response in 2017, members stressed the need for the sustainable scale-up of HIV treatment, in parallel with strengthening of overall health systems. They reminded that health systems in developing countries face major financing, technology and staffing obstacles. Strong political will, coordinated actions and greater integration of service delivery are needed to reach the Fast-Track Targets, and efforts should fit with the framework of Universal Health Coverage. The integration of HIV into national health financing strategies was advised.
28. There was concern about continuing gaps along the treatment cascade, including failures to reach men and boys with the services they need. Persistent gender inequalities were also highlighted. Members called for actions that advance gender rights and improve access to quality sexuality education and to sexual and reproductive health, along with increased efforts to achieve equitable access to health, including reaching out to men and boys.
29. Members reiterated people's right to health and the need for an enabling environment that is free from stigma and discrimination. Ending discrimination, including in health-care facilities, should be at the core of the collective response to HIV. They highlighted the experiences of key populations, which continue to be victims of discrimination and criminalization.
30. The slow decline in new HIV infections was also a concern, with members agreeing on the need for a greater emphasis on prevention. Weaknesses in the HIV responses in western and central Africa and in eastern Europe and central Asia were highlighted. The disproportionate concentration of new HIV infections in key populations was noted, as was the need to make greater use of successful models and approaches for reducing new HIV infections among people who inject drugs.
31. Members also highlighted the value of "catch-up" campaigns to reboot HIV responses, especially at community level, and called for a more strategic approach to tackle HIV epidemics in settings of crisis and conflict. They welcomed the cooperation agreement signed by UNAIDS with the International Organization on Migration.
32. In response, Mr Sidibé thanked speakers for their constructive contributions and insights. Noting the importance of the partnership with the Global Fund, he welcomed the appointment of Peter Sands as new Executive Director of the Global Fund and thanked Australia for supporting a joint Global Fund/UNAIDS analysis of future funding flows.
33. Noting the many efforts that were converging around the goal of "health of all", Mr Sidibé said that countries should build strong health systems that are integrated and cost-effective, in the context of Universal Health Coverage. He underscored the need to address stigma and discrimination, as well as sexual and reproductive health rights.

1.4 Report by the NGO representative

34. The NGO representative, Lumumba Musah El-nasoor of the Uganda Youth Coalition on Adolescent Sexual and Reproductive Health Rights and HIV, introduced the report, *The UNAIDS We Need Must Leave No One Behind: Getting to Zero Includes All of Us (the 10–10–10)*.
35. Based on consultations with more than 300 people around the world, mostly from communities that are being left behind, the report highlights the inequity and neglect faced by individuals and communities who are disproportionately affected by HIV. It shows that certain key populations continue to be ignored or neglected in HIV responses and warns that the Fast-Track strategy will not reach them and address their changing needs unless rights-based, equitable approaches become genuine priorities.
36. Even as countries advance towards the 90-90-90 targets, significant proportions of people living with HIV are not being diagnosed and do not receive treatment. Key populations in particular face extreme neglect. In addition to sex workers, gay and other men who have sex with men, transgender persons and people who inject drugs, the people who are being left behind include socially excluded migrants, people in poverty, the elderly, street and other vulnerable children, people in prisons and other forms of incarceration, ethnic members of key populations and indigenous peoples who use drugs. Most of them experience multiple forms of marginalization and exclusion simultaneously.
37. The report referred to these communities as the “10–10–10” (in reference to the 90–90–90 Targets). Mr El-nasoor shared examples of their experiences, as documented in the report, and said they are being left behind not merely because they are “hard to reach”, but because they are easy to ignore. As a result, their human rights are routinely violated, while the shrinking space for civil society activities in many countries makes it difficult to provide them with the support they need.
38. The reasons for the neglect of these communities include a lack of data and other pertinent information about them; various social, cultural, economic, legal and political barriers; criminalization; prejudice, stigma and discrimination; and the weak capacity of NGOs working with the communities.
39. The report urges stronger political will to implement evidence-based strategies; legal and policy reforms; continued support for the participation of civil society organizations and affected communities in HIV responses; and improved collection of data so actions can be tailored to the different contexts and needs.
40. Noting the unique role of UNAIDS in working with and supporting civil society, the report requests the Joint Programme to redouble its efforts to ensure that no one is left behind. It asks UNAIDS to broker or convene stronger partnerships and cooperation between civil society groups and the state, while supporting communities so they can participate more effectively in the design and implementation of programmes that are meant to benefit them. Programmes should address the fact that these marginalized communities experience intersecting forms of vulnerability and risk. Disaggregated data collection has to improve and language barriers should be addressed.

41. In discussion, members applauded the important advocacy work of the NGO Delegation and thanked it for a timely and high-quality report. They commended the report's summary of proven approaches and its emphasis on challenging "business-as-usual" complacency and on reaching out neglected to communities. They called on countries to step up actions that can ensure universal access to health.
42. Speakers said that Member States, the UN, civil society and other partners bear a shared responsibility to address the inequalities and vulnerabilities described in the report. Recalling that UNAIDS was the first UN body to formally incorporate civil society in its governance system and other core procedures, they encouraged other UN agencies to follow that example.
43. Several members said that the principle of equity should be at the heart of HIV responses and that a stronger focus on key populations was a human rights obligation. However, some countries were not showing sufficient political support for programmes that can reach key populations with life-saving services. Members urged all governments to expand HIV service coverage for key populations and asked that donors support those efforts with funding. They pointed to UNAIDS' unique role in helping strengthen political will and facilitating collaboration between civil society and government.
44. Members said that an adequate response would need to go beyond HIV and should address the various layers of deprivation and marginalization that communities experience. They reminded the meeting that low levels of funding and shrinking space for civil society activities pose major barriers.
45. Members agreed on the need to identify, monitor and report on service access for key populations. Data systems should be strengthened, and data collection and disaggregation should be done in ways that do not stigmatize populations and that form part of broader improvements to health data systems. Such innovations should not duplicate existing systems. The disaggregation of data, for example, could be achieved by adapting existing methods of data collection and analysis.
46. In reply, the NGO Delegation highlighted the need for improved, disaggregated data; the removal of legal barriers; and effective steps to mitigate violence against marginalized communities. Welcoming the recognition of civil society's importance, the Delegation called for a formal framework for cooperation between governments and civil society groups. It suggested that the Joint Programme and Member States could use their convening powers to promote and facilitate such cooperation.

2. LEADERSHIP IN THE HIV RESPONSE

47. Ruth Dreifuss, chair of the Global Commission on Drug Policy and former President of Switzerland, addressed the meeting on the issue of people who inject drugs and responses to the HIV, tuberculosis and viral hepatitis epidemics.
48. Ms Dreifuss said that all people have a fundamental right to the highest attainable standard of health. She recalled how attitudes and approaches in Switzerland towards people who inject drugs changed as policymakers came to grips with the country's HIV epidemic. It showed that people who inject drugs are not vulnerable *per se*; they are made vulnerable when their rights are violated and when they are criminalized and denied the means to protect themselves.

49. It is the state's responsibility, she said, to provide people—including those in prisons—with the means to protect themselves. People who inject drugs need information and services that can help them avoid or postpone drug use and that can protect them when they do use drugs. Opioid substitution therapy and other substitution treatments are among the services countries are obliged to provide to citizens. Workable approaches exist and they succeed when information and prevention tools are made available in ways that respect people's rights, and with compassion and solidarity. Yet around the world people who inject drugs continue to lack access to services that can help them stop or control their drug use and protect them against infectious diseases such as HIV and viral hepatitis.
50. Ms Dreifuss reminded the meeting that the 2011 United Nations Political Declaration on HIV and AIDS had set the target of halving new HIV infections in people who inject drugs by 2018. Instead new infections in this population have risen by 30%. Countries continue to reject or ignore scientifically proven health measures. As a result, people who inject drugs experience HIV infection rates 24 times higher than those in the general population.
51. The focus has to be on reducing harm, she stressed. Even if drug use is illegal, countries have an obligation to protect people against the harm associated with it. Switzerland in the mid-1990s began providing substance testing at music festivals, it opened needle exchanges and it provided free condoms. None of those measures was found to encourage drug use, but they did reduce the health and social impact of drug use.
52. Today only 90 countries have needle and syringe programmes in place and only nine countries (all "developed" countries) provide supervised injection facilities, even though no deaths have been recorded in those facilities. Out on the streets, on the other hand, deadly overdoses remain commonplace.
53. Ms Dreifuss called on the G77 countries to launch a debate on the effectiveness of harm reduction measures. Approximately US\$ 100 billion is spent globally each year on drug interdiction; a mere 10% of that amount would be sufficient to provide adequate harm reduction programmes on a global scale.
54. Ending HIV transmission through drug use also requires the decriminalization of drugs use. Decriminalization means ending all civil and criminal penalties against drug use. It allows for the prevention of infection and for treatment and care. The evidence shows that countries that have adopted public health strategies and decriminalized drug use have brought their epidemics under control.
55. In closing, Ms Dreifuss reminded the meeting that the SDGs apply to everyone, including people who inject drugs. She warned that the world would not reach the SDGs if it clung to the fantasy of eliminating the use of drugs. She urged everyone who acts on behalf of States or civil society to use their powers and resources in ways that reduce risk and harm, and appealed for an end to the criminalization of drug use.
56. In discussion, members noted that HIV infections were increasing among people who inject drugs. They agreed that harm reduction is a proven prevention tool. Pointing to the experience of Portugal, where the decriminalization of drug use has had a positive health impact, they called for stronger political commitment to end the criminalization of drugs.

57. In her reply, Ms Dreifuss said that even though States do not necessarily follow the same models they should share basic principles such as respect for the right to health and to life—and those principles should guide their actions.
58. Mr Sidibé said that tackling issues such as these were difficult but necessary. Everyone has a responsibility to ensure that people have access to health care and can protect their health. He cited China as an example of how public health approaches can be introduced on the basis of scientific evidence, and appealed to African Member States to avoid HIV epidemics related to drug use from becoming a major crisis on that continent.
59. The Chair noted the concerns raised by Ms Dreifuss, and added that the various representatives of governments present at the meeting should bring those concerns to the attention of their respective governments.

3. FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 40TH PROGRAMME COORDINATING BOARD MEETING: HIV PREVENTION 2020—A GLOBAL PARTNERSHIP FOR DELIVERY

60. Tim Martineau, Director of the Fast-Track Implementation Department at UNAIDS, recapped the discussions on HIV prevention at the 40th PCB meeting in June 2017. The emphasis had been on bringing HIV prevention to the center of the HIV response, moving beyond the false dichotomy of prevention/treatment, and taking a human rights-based approach that ensures quality services reach everyone in need.
61. There had been calls for countries to show stronger leadership in addressing structural barriers, providing comprehensive sexuality education and tackling harmful norms, policies and laws. Success in HIV prevention would depend ultimately on whether young people have adequate knowledge and access to services to manage their sexual and reproductive lives.
62. Discussions had also emphasized the importance of partnerships between governments and civil society, and of providing funding and other forms of support to communities so they can participate in the design, implementation and monitoring of interventions.
63. Strong political leadership is essential, Mr Martineau said, along with open debate on sensitive issues. Also important are clear, measurable prevention targets and national-level, high-quality monitoring and evaluation, so that results can be assessed, compared and improved. There also has to be adequate funding, including for neglected areas such as HIV prevention among key populations (which currently relies heavily on donor support).
64. Mr Martineau referred to several good practice examples of reaching people who are at high risk of HIV infection, including in Belarus (harm reduction), India (sex work programmes), South Africa (condom and voluntary medical male circumcision programmes) and the United States of America (pre-exposure prophylaxis). These experiences show that rapid scale up of effective HIV prevention is possible when strong leadership exists, adequate funding is provided and programmes address the structural aspects of the epidemic and do not rely only on biomedical interventions.

65. A global prevention coalition would need a Road Map drawn around those core elements, as well as clear targets, well-defined prevention packages, rights-based approaches and technical assistance. The targets should prioritize human rights, equality for women and the elimination of stigma and discrimination. Since faith-based entities are major health providers in some regions, they would need to be part of a new prevention strategy.
66. Mr Martineau told the meeting that a steering group had been set up and had met in October 2017 in Geneva, with 12 Ministers of Health attending. The meeting endorsed a draft Road Map, which includes clear targets and milestones, including a 100-day plan. A ten-point plan was developed for accelerating HIV prevention at the country level.
67. A Secretariat is now being set up in Geneva with support from the Bill & Melinda Gates Foundation, The Children's Investment Fund Foundation and the Government of Germany, and more than 20 countries are developing 100-day Plans. Dashboard/country scorecards for accountability are being validated.
68. In discussion, members expressed support for the Prevention Coalition, the Road Map and the 100-day Plan, and foresaw a vital role for the Joint Programme in strengthening multisectoral HIV prevention, including through UN country teams.
69. Members welcomed the renewed emphasis on primary prevention and on women and girls. They highlighted the need for evidence- and human rights-based approaches and called for an end to the dichotomy between behavioural and structural interventions. They also emphasized the importance of sexuality education and of sexual and reproductive health rights.
70. Some members, however, were concerned that the Coalition did not include all Member States. More information was requested regarding the capacity and technical resources the Secretariat was providing to support the work of the Prevention Coalition. It was also suggested that, rather than create new coordinating structures, existing health architecture should be leveraged.
71. In reply, Mr Martineau thanked the meeting for the expressed support and noted the important points raised regarding bringing additional actors aboard, avoiding duplication of architecture, adopting a public health approach and using "catch-up" campaigns.
72. Elizabeth Benomar, Global Coordinator for HIV/AIDS at the UN Population Fund (UNFPA), remarked on the need to strengthen the data and metrics that would inform the renewed prevention drive. She said that technical assistance rosters were being considered for guiding the provision of technical support. There was no objection to welcoming all countries into the Prevention Coalition, she added.

4. REPORT ON PROGRESS IN THE IMPLEMENTATION OF THE UNAIDS JOINT PROGRAMME ACTION PLAN

73. Joel Rehnstrom, Acting Deputy Executive Director for Management and Governance at UNAIDS, told the meeting that implementation of the UNAIDS Joint Programme Action Plan is guided by four central themes in the Quadrennial Comprehensive Policy Review (QCPR):

- i. Results-based planning, monitoring and reporting;
 - ii. Data, evidence, gender and rights-based approaches;
 - iii. Multisectorality and multistakeholder partnerships; and
 - v. Effectiveness, efficiency, accountability and impact.
74. The Joint Programme remains a unique model in the UN and already embodies many of the changes called for in the QCPR, including: strategic coherence and results-based focus, inclusive governance and civil society engagement, and joint work to enhance country-level impact. Twelve UN organizations are working together to address a complex issue—the global HIV epidemic—in an integrated manner, from multiple perspectives and by engaging multiple sectors and partners.
75. The Global Review Panel arrived at a number of recommendations that provided the basis for the Joint Programme Action Plan. Key among these were the following recommendations:
- i. Reinvigorate country-level collaborative action within and beyond the UN system to Fast-Track the response;
 - ii. Put money where it is most needed through dynamic resource mobilization and allocation; and
 - iii. Reinforce accountability and results for people.
76. Actions to intensify collaboration between UNAIDS Cosponsors and the Secretariat include engaging Heads of Agencies on key policy issues in the context of broader UN reform and refining the Division of Labour and aligning it with the UNAIDS 2016-2021 Strategy and the Unified Budget, Results and Accountability Framework (UBRAF). In addition, country envelopes, as part of a new resource allocation model, have been finalized and are ready for implementation based on capacity assessments and joint planning at country level, while resource mobilization is being strengthened.
77. Stronger joint work at country level is expected to enhance country focus and support the deployment of resources where they are needed most, accelerate the Fast-Track efforts, promote accountability and results for people and spearhead UN reform.
78. Mr Rehnstrom said that 97 country capacity assessments have been conducted, 97 UN joint UN plans on HIV have been developed or updated and 71 country envelopes have been established. This shows that UNAIDS can act quickly and act horizontally.
79. The inclusive and rapid joint planning process were designed to engage key country stakeholders, including national authorities, civil society and community-based organizations, the Global Fund, the United States President's Emergency Plan for AIDS Relief (PEPFAR) and other development partners.
80. Although time constraints made extensive consultation difficult, civil society priorities are reflected in the joint plans and programmes that have been developed based on national targets, which in turn form the basis for the country envelopes. Mr Rehnstrom said UNAIDS would ensure and document civil society engagement in the implementation of the 2018 country envelopes and in the allocation of envelope funding for 2019.
81. Pradeep Kakkattil, Director for the Programme Partnerships and Fundraising Department at UNAIDS, introduced the new Joint Resource Mobilization Plan for 2018–2021. A PCB

Working Group comprising representation from Member States, Cosponsors and civil society had guided the process, which was completed within three months.

82. Reviewing UNAIDS' financial situation, he said that US\$ 180 million had been raised against the core budget in 2016, while US\$ 172 million was raised in 2017 (slightly less than the projected US\$ 180 million). Cost savings measures were implemented in 2017. For 2018, UNAIDS expected to raise US\$ 184 million against a target of US\$ 184 million. This is in a context where total donor government disbursements globally for HIV had declined to US\$ 7 billion in 2016, from a peak of US\$ 8.5–8.6 billion in 2013–2014. Core funding for Cosponsors in 2017 was transferred in full, while 2018 allocations are to be transferred in the first quarter of 2018.
83. Noting that a fully funded UBRAF requires US\$ 242 million, Mr Kakkattil said that the shortfall was affecting the Joint Programme's ability to deliver in key areas and was having an impact on programming and on the ability to support civil society activities.
84. The new Resource Mobilization Plan is aimed at improving the funding situation and has three main pillars:
 - i. Sustain, strengthen and engage government donor funding (UNAIDS currently relies on 14 donors who provide about 95% of its funding), including identify donors that are invested in health and HIV but have not engaged sufficiently in supporting the UBRAF, and engage smaller, emerging donors;
 - ii. Expand private sector funding, including foundations, corporations and individual giving; and
 - iii. Leverage other partnerships (especially with the Global Fund) and innovative financing.
85. He emphasized that the Plan called for the Joint Programme as a whole raising funds, and not solely the Secretariat. In addition, the partnership with the Global Fund would be strengthened, with a Memorandum of Understanding expected to focus on clear result areas and on the value added by the Joint Programme. UNAIDS sits on 79% of the Global Fund's Country Coordinating Mechanisms and 69% of its Oversight Committees, and it adds great value to the scope and quality of the Fund's activities. It plays a major role in the replenishment of the Global Fund, and in managing grants in-country.
86. Next steps include implementation of the Plan, along with monitoring and reporting on progress, further engaging the PCB leadership and civil society, and pursuing innovations in fundraising. In closing, Mr. Kakkattil said that UNAIDS was operating in a crowded fundraising landscape and that it was important that resource mobilization efforts do not compete internally with other UN agency efforts.
87. Presenting the reflections of the Committee of Cosponsoring Organizations (CCO), Nazneem Damji, Policy Advisor on Gender Equality, Health and HIV/AIDS at UN Women, said that the CCO noted the collaborative spirit in which the Joint Programme had developed the Resource Mobilization Plan. It was another example showing that UNAIDS was on the frontline of UN reform.
88. The rapid progress made around the Action Plan also held lessons with respect to governance (e.g. a need for healthy cross-Board coherence), joint working (e.g. sharpening implementation principles for the refined UNAIDS Division of Labour and

reinvigorating joint planning), and the joint Resource Mobilization Strategy (e.g. shared responsibility for resource mobilization and a need to finance civil society activities).

89. At the level of the Heads of Agencies, the CCO committed Cosponsors to the effective implementation of the Action Plan, and renewed its commitment to achieve the Global Prevention Coalition targets. National partners have to be engaged fully and it is especially important to increase the space for civil society activities and enhance their sustainability. The CCO also noted the moves towards stronger accountability and monitoring, ongoing mainstreaming of HIV and taking AIDS out of isolation, and the need to combine biomedical interventions with social and structural ones.
90. The CCO felt that the financial situation, although not optimal, had stabilized. However, for the Joint Programme to be fit for purpose, all its components have to be financed adequately. A fully funded UBRAF therefore remains a priority. The new Resource Mobilization Strategy was seen as a joint strategy that leverages all the Cosponsors.
91. Recent experience confirmed that the Joint Programme remained resilient, adaptable and creative. Among many examples are WHO, which has shifted its approach to include viral hepatitis, and UNESCO, which is mainstreaming HIV into other areas of work.
92. Regarding joint work, the CCO recognized the need to respond quickly to shifting country needs and priorities. Country Divisions of Labour may have to be updated to achieve such flexibility. There were concerns about weakened capacity at the country level and about the fact that allocations did not always match epidemic priorities.
93. In discussion, members expressed their thanks for a comprehensive report. They commended the inclusive process in which the Action Plan and Resource Mobilization Plan had been developed and the speed with which UNAIDS had completed such major reform and planning exercises.
94. Members congratulated the Joint Programme for the results-oriented plans and urged that the PCB's endorsement of the Resource Mobilization Plan be matched with increased funding support. They also welcomed intentions to broaden the donor base and mobilize funds from diverse sources and said they looked forward to more detailed accounts of resource mobilization efforts and results. They reiterated, however, that new fundraising efforts should not lead to counter-productive competition with partners.
95. Speakers supported the creation of an Investment Book and said they looked forward to updates on that process. Vital next steps included building investment cases that clearly show the results achieved by the Joint Programme and the "value add" of the Secretariat's work. Members also requested updated reports on the UNAIDS budget showing available funding, allocation and gaps across core and non-core aspects of the Joint Programme.
96. The strong partnership between the Global Fund and the Joint Programme was highlighted as a pivotal part of the global response, with members noting the importance and wide range of the support UNAIDS provides to the Global Fund at country level. An appeal was made to donor countries to keep small percentages of donor funding aside for UNAIDS in order to protect and optimize the support countries are receiving from the Global Fund.

97. Members expressed satisfaction with efforts to implement the Action Plan and welcomed the decision to distribute resources under the envelopes also to countries other than the Fast-Track countries. They endorsed the collaborative approach used for the country envelopes and emphasized the need for rapid allocation of the envelopes and for broad consultation when drafting Country Plans.
98. It was noted that the revised operating model had helped energize joint teams in several countries, but that the transaction costs for raising additional funding were high and that country responses could not solely rely on country envelope funds.
99. There were concerns that some of the current envelope proposals did not clearly enough reflect the involvement of and benefits to civil society. Given the importance of civil society, UNAIDS was urged to consult more broadly on country envelopes and more information was requested on resource flows to civil society in countries. A clear division of labour between international partners at country level was proposed.
100. In her reply, Ms Damji assured the meeting that the proposed Division of Labour took into account the state of HIV responses in countries, their gaps and the context of the SDGs. The Division of Labour was also aligned with the strategic results areas. Acknowledging that the process had been quick, she said the deliverables were now being analyzed. The peer review process had been useful and would likely continue.
101. In his reply, Mr Rehnstrom said UNAIDS continued to gather relevant information on the implementation of the Action Plan and would share further details, including allocations by strategic results areas and for civil society, at the June 2018 PCB meeting. He added that a core principle of the UBRAF was the strengthening of monitoring and evaluation, external validation and accountability under the new Resource Allocation Model.
102. Regarding the process at country level, information provided by country offices showed that, in some countries, civil society partners indeed were at the table during the development of the country envelopes. The capacity and staffing of the Joint Programme at country level were being reviewed, with a view to improve the tailoring of human and financial resources to country needs. UNAIDS would also report on the “rightsizing” and repositioning of the Secretariat and on the impact of those changes. Fund transfers to Cosponsors would be based on Letters of Agreement (one per Cosponsor), which would expedite the transfer of funds to countries and implementation. The release of additional funds for countries would be performance-based.
103. Mr Kakkattil summarized the main messages that emerged during the discussion. One was the sense of urgency and the need to accelerate resource mobilization. To that end, UNAIDS in early 2018 would start rolling out strong advocacy plans for donors, perhaps drawing on support provided by the PCB Working Group. These would clearly capture and convey the added value that UNAIDS brings. The Investment Book, for example, would also reflect where the money goes and the impact it is having. He noted that there were opportunities to collaborate closely with civil society on that front. UNAIDS was keen to work with civil society to address funding gaps around civil society advocacy, he added.
104. Another message was the need to build on approaches and relationships that are reliable, and to look at using blended financing as a way forward. He assured the meeting that UNAIDS takes the civil society suggestions very seriously. A strengthened

partnership with the Global Fund was also emphasized. Board-to-Board engagement would be crucial; thus far those dialogues had been excellent, he said.

105. Mr Sidibé thanked the PCB for its guidance during a difficult process and for enabling UNAIDS to arrive at innovative solutions. He said that UNAIDS' strength lay in its Member State-driven and multisectoral character, and in the strong role played by the Board in guiding and funding the Joint Programme's work. Without those features there was a risk that the Programme could be reduced to a subcontractor. UNAIDS' structure and governance had to reflect the primacy of countries in its work.
106. He said a symbiotic relationship existed between UNAIDS and the Global Fund, and he was pleased to discuss even closer cooperation. He added that UNAIDS' added value was evident and well known, and that the same applied to the Global Fund. He urged countries investing in the Global Fund to reserve a small percentage of that funding for the Joint Programme to help ensure that the Global Fund operates as effectively as possible. In closing, Mr Sidibé thanked the United Kingdom for its recent positive and encouraging review of the Joint Programme's work.

5. UPDATE ON ACTIONS TO REDUCE STIGMA AND DISCRIMINATION IN ALL ITS FORMS

107. Luisa Cabal, Special Adviser in the Human Rights and Gender Division at UNAIDS, summarized the report prepared on efforts to reduce stigma and discrimination during 2015–2017. The report covered two main areas: strengthening global commitment to reduce stigma and discrimination, and specific actions to put those commitments into practice at the national level. It drew on information gathered from consultations with country offices, civil society, government partners and other sources.
108. Ms Cabal referred to key commitments for eliminating stigma and discrimination, including the UNAIDS 2016–2021 Strategy (which includes specific results areas that pertain to stigma and discrimination); the 2016 Political Declaration on Ending AIDS; and the Commission on the Status of Women Resolution 60/2 on women, the girl child and HIV (which has a strong emphasis on gender equality and women's empowerment).
109. Those commitments provided impetus for initiatives at the Human Rights Council (including several resolutions), the Global Commission on HIV and the Law meeting on "Opportunities for the Future", among others. Efforts to advance the Global Commission's recommendations are underway in more than 88 countries and many countries are reforming or reviewing relevant laws. UN agencies have also issued joint statements declaring their commitment to act against stigma and discrimination.
110. At the national level HIV-related stigma and discrimination is increasingly being monitored and measured, and policies and programmes are addressing stigma and discrimination in practical ways. The Joint Programme is providing valuable support to those efforts, including guidance for stigma and discrimination reduction (including gender discrimination and violence); technical support for reforming laws, regulations and policies and for increasing access to justice; sensitization of legislators, judges and law enforcement officials; and the development of an agenda to end discrimination in health-care settings. Cosponsors are active in many areas and the support has led to concrete actions in dozens of countries.

111. Ms Cabal added, however, that actions to translate policy commitments into practice are outstripped by the demand for support. Many challenges therefore remain. Importantly, experiences are highlighting the centrality of community-led efforts and of engaging multiple stakeholders, and the importance of ensuring that interventions and policies address discrimination against the people who are most vulnerable.
112. Laurel Sprague, Executive Director of the Global Network of People Living with HIV (GNP+), addressed the meeting on the current state of actions to reduce stigma and discrimination. While there has been encouraging progress in some areas, much has to be done in others, she said. The actions needed to eliminate stigma and discrimination in health-care settings are clear and the necessary legal changes are often obvious. Important steps are being taken in those areas. But progress has been slow in reducing stigma and discrimination against key populations.
113. Ms Prague provided a brief update on findings from the People Living with HIV Stigma Index, which uses a questionnaire-based methodology. Since 2008, more than 100 000 people have been interviewed for the Index, which was recently reviewed to improve its assessment of barriers hindering testing and treatment access.
114. Initial findings from the revised survey show that more than 60% of respondents said they hide their HIV status, 23–41% hesitated to take an HIV test, and 14–36% reported being physically harassed. A large percentage of gay and other men who have sex with men said they were afraid to seek health care. Other health surveys are reporting similar findings, including violence against women in health-care settings.
115. Ms Prague told the meeting that 69 countries continue to criminalize HIV transmission, despite the absence of evidence that this has any public health benefit. There were 228 reported prosecutions in the past year (most of them in the United States of America, Russian Federation, Canada, Zimbabwe and Belarus)).
116. She urged countries to maintain the focus on stigma and discrimination, conduct more research into the prevalence and impact of stigma and discrimination, and add stigma and discrimination indicators to monitoring and evaluation systems. More has to be done to improve social and economic equality, including equal access to education, employment, housing and justice. Political leaders and decision makers have to act courageously.
117. In discussion, members commended the comprehensive report, welcomed the increased efforts to end stigma and discrimination, and endorsed the Stigma Index. They applauded the Joint Programme's efforts to advance human rights principles (including the many guidance documents it has produced on the issue) and encouraged it to leverage its partnerships and further increase the focus on stigma and discrimination in its data collection work.
118. UNAIDS was asked to implement the decision points from the 39th PCB meeting regarding children and stigma and discrimination. There was a request for updates on the use of the 2017 *Confronting discrimination* report to combat stigma and discrimination in countries with a high prevalence of HIV infection.
119. Members reiterated that stigma and discrimination remain major barriers in the global HIV response, and stressed that the principle of leaving no one behind applies to all

populations and should be realized without exception. Key populations (especially prisoners, migrants, gay and other men who have sex with men, and people who inject drugs) are denied basic rights, remain marginalized and struggle for social inclusion and access to health care services, including HIV services. The highest attainable standard of health is the universal right of every human being and health-care personnel and services must uphold that right for everyone. Several members reported on actions they had taken to reduce stigma and discrimination.

120. Members called for a collective push to eliminate stigma and discrimination. They requested that UNAIDS facilitate the creation of a global compact to end stigma in all its forms, including measurable targets, improve data availability.
121. Members emphasized that civil society organizations have a central role in eliminating stigma and discrimination, but need funding and other support to fulfill that role. Evidence shows that community-based organizations are vital for combatting stigma and discrimination against key populations and for improving their access to HIV and other health services.
122. Nondiscriminatory legal environments are also essential: analysis done by the Global Commission on HIV and the Law shows that the removal of discriminatory laws could prevent 1.2 million new HIV infections. A call was made for explicit targets and indicators related to the protection of key populations' human rights.
123. In reply, Ms Cabal welcomed the support for continued data collection, including through the Stigma Index, and the ongoing development of policy guidance for governments and other stakeholders. She also welcomed the specific suggestions for accelerating effective actions against stigma and discrimination.
124. Ms Sprague referred to some of the efforts to resist increased stigma and discrimination in some countries, including the rejection by lawmakers in Malawi of a proposed set of punitive HIV-related measures.
125. Mr Sidibé noted the proposal for a global compact on stigma and discrimination, and assured the meeting that UNAIDS would work on creating a mechanism to facilitate such an initiative.

6. UPDATE ON HIV IN PRISONS AND OTHER CLOSED SETTINGS

126. Sabine Böhlke-Möller, Ambassador for the Permanent Mission of the Republic of Namibia to the UN in Geneva, introduced a video message from Bernard Haufiku, Minister of Health and Social Services for Namibia.
127. In the video, Mr Haufiku said that HIV prevalence appeared to be much higher in prisons and closed settings than in the general population. He assured the meeting that Namibia was committed to guarantee the right to the highest attainable standard of health for all people, including prisoners and detainees. Good prison health ultimately translates into good community health, he said. Namibia's Correctional Services Department was acting to increase access to health services by formulating a policy for detainees and prisoners. Nurses and medical officers from prison clinics were also being trained in the provision of HIV treatment and care.

128. Despite many challenges, Namibia was committed to ensure that prisoners have easy access to HIV services, including pre- and post-exposure prophylaxis, free condoms, voluntary medical male circumcision, and full testing and treatment services. He noted that the country still had to abolish apartheid-era anti-sodomy laws.
129. Monica Beg, Chief of HIV/AIDS Section and Global Coordinator for HIV/AIDS at the United Nations Office on Drugs and Crimes (UNODC), told the meeting that on any given day about 10.3 million people are incarcerated, a 20% increase since 2000. Overall about 144 out of every 100 000 people in the world are in prison or detention, typically in overcrowded conditions.
130. Many factors increase the risk of HIV transmission for incarcerated persons, she said. Key populations tend to be over-represented in those facilities, conditions are poor, prison management is often weak and detainees are isolated from the public health system. In addition, stigma, neglect and violence are rife.
131. As a result, the prevalence of HIV, tuberculosis and viral hepatitis is typically higher among incarcerated persons than in the general population. Women comprise about 5–10% of the global prison population and HIV prevalence among imprisoned women is almost always higher than for men. The global female prison population has increased by 50% since 2000.
132. Condoms and lubricants are available to prisoners and detainees in only about 40 countries (mostly in only a few facilities and mainly in conjugal visiting rooms). About 60–90% of people who inject drugs are incarcerated at some point in their lives. Yet very few countries provide needle and syringe programmes and/or opioid substitution therapy in prisons. The health needs of pre-trial detainees are seldom met and treatment interruption is common.
133. Ms Beg told the meeting that major global commitments on HIV and health have been made in recent years, notably the Nelson Mandela Rules. The UNAIDS Strategy also stipulates the need for HIV services for people in prisons and detention centres. The Joint Programme has developed technical guidance and tools and is providing support to countries for drafting policies and strategies on HIV services in places of detention (in sub-Saharan Africa, and in Afghanistan, Myanmar and Ukraine, for example). It is supporting the collection of strategic information in Zimbabwe, providing capacity-building support in Afghanistan, Egypt, Ukraine and Viet Nam, and assisting in the training of prison staff in the Republic of Moldova. Other forms of support are being provided in Egypt, Pakistan and the United Republic of Tanzania.
134. Ms Beg said strategic information on health in places of incarceration should be improved to promote and inform supportive laws, policies and practices. She acknowledged that changes in practices were complicated by the fact that the responsibility for health services in prisons usually rests with the Ministry responsible for Correctional Services rather than with the Ministry of Health.

135. She called for a set of actions to reduce the impact of HIV and other infectious diseases on incarcerated persons. Alternatives to incarceration should be considered for key populations and people convicted for petty, non-violent offences. Prison reform initiatives should be developed and implemented, and comprehensive HIV services should be funded and scaled up as part of improvements to health services in prisons. Finally, coordination among the public health, criminal justice and other relevant government sectors should be improved.
136. A short video was shown by UNODC. It described the epidemiology of HIV in prisons and included personal testimonies on gaps in service provision in different geographical regions.
137. In discussion, members thanked the Joint Programme for a comprehensive report that highlighted the need to provide evidence-based services in prisons, including life-saving treatment services. They welcomed the work of UNAIDS to update or develop technical guidance for improving access to HIV services in prisons and reiterated that HIV and other epidemics in prisons had to be controlled for the sake of both prisoners and the broader community.
138. Members called for more effective coordination between the judicial and health authorities, and for improved data collection on HIV and health service access in prisons. They requested the PCB to support actions by governments, civil society and technical partners to improve the availability of and access to HIV services in prisons. Countries were urged to consider the review of criminal laws to address the over-representation of key populations in prisons.
139. PEPFAR's support for HIV treatment provision in prisons in several countries was noted. Also mentioned was the provision of HIV treatment services for prisoners in Poland, Belarus' plan to provide treatment in prisons in 2018, efforts in the Islamic Republic of Iran to expand HIV services for incarcerated persons, the promotion in Brazil since 2014 of a national policy for health care for all incarcerated persons, and emerging policies in India for improving access to health services for prisoners and detainees.
140. Some members noted that the report did not discuss the prevalence of rape and violence against key populations in prisons, while others reminded the meeting that, in many countries, indigenous people were massively over-represented in prison populations. The plight of teenagers in detention and prisons was highlighted, and the meeting was told that conditions in prisons in southern Africa, for example, were appalling. Comprehensive reforms of juvenile justice systems (along the lines seen recently in Malawi, for example) are needed, along with possible amnesty systems.
141. Acknowledging the difficulties in bringing about improvements, members applauded the Joint Programme's support for changes to laws and policies, while noting that such processes can take time. Specialized dialogues with relevant ministries—in particular among the Ministries of Health, Justice and Correctional Services—would help speed up progress.
142. In her reply, Ms Beg thanked members for the valuable discussion. She said prisoners were probably the most neglected key population in the HIV response. It is important for countries and agencies to support harmonized approaches that can improve access to HIV services, including harm reduction services, in prisons and detention facilities.

7. NEXT PROGRAMME COORDINATING BOARD MEETINGS

143. The Chair summarized the proposals received for the thematic segments for the 42nd and 43rd meetings of the PCB and proposed dates for the meetings. The Board decided that the 46th PCB meeting would be held on 23–25 June 2020 and the 47th PCB meeting would be held on 15–17 December 2020. It also approved themes for the 42nd and 43rd meetings and mandated the PCB Bureau to prepare the thematic discussions. The approved themes are: *Ending tuberculosis and AIDS—a joint response in the era of the Sustainable Development Goals* (42nd PCB meeting), and *Mental Health and HIV/AIDS—promoting human rights, an integrated and person-centred approach to improving ART adherence, well-being and quality of life* (43rd PCB meeting).

8. ELECTION OF OFFICERS

144. The Chair announced the Election of Officers and introduced two new NGO representatives to the PCB. The Board elected the United Kingdom, current Vice-Chair of the Board, to assume the function of Chair for one calendar year, beginning 1 January 2018, and elected China as Vice-Chair and Algeria as Rapporteur. The composition of the PCB NGO Delegation was also approved.

9. ANY OTHER BUSINESS

145. No other business was brought before the Board.

10. THEMATIC SEGMENT: ZERO DISCRIMINATION IN HEALTH-CARE SETTINGS

146. The thematic segment was devoted to ending discrimination in health-care settings. Presentations and discussions included empirical evidence and personal accounts of ongoing discrimination, accounts of successful interventions, and proposed actions for ending discrimination in health-care settings and beyond.

147. The Chair introduced the thematic segment. The moderator, Mahesh Mahalingam, Director of Communications and Global Advocacy at UNAIDS, outlined the segment's three main objectives: review evidence of the impact of discrimination in health-care settings; identify and showcase good practices; and galvanize action to eliminate such discrimination.

148. Mr Sidibé reiterated UNAIDS' commitment to set up a global compact on eliminating stigma and discrimination. He said the HIV response had always been about transforming the way public health is understood and practiced. The progress made thus far stemmed from people's refusal to accept "things as they are". However, the fear and reality of stigma and discrimination in health-care facilities continues to prevent many people, especially those in key populations, from accessing lifesaving services.

149. Lillian Kyomuhangi Mworeko, Regional Coordinator of the International Community of Women Living with HIV in Eastern Africa, outlined the many ways in which women experience stigma and discrimination related to their health. Migrant women are especially likely to be denied HIV and other health services, she said. For pregnant women it is mandatory to be tested for HIV, yet many women avoid taking an HIV test for fear of violence or rejection from their partners. Important guidance documents have

been developed and countries can use them to tackle and address these violations. But women also need to have access to information that enables them to take the best decisions for themselves and their families.

150. Camille Anoma, Director of the Clinique Confiance in Abidjan, Côte d' Ivoire, said that key populations experience intense self-stigmatization in addition to the stigma they face from others. Many are afraid to use health-care facilities. She described the services of Clinique Confiance, which offers free and confidential health services, works with peer groups who provide primary prevention services, and engages other health service providers around the difficulties key populations experience.
151. Abhina Aher, Associate Director for Sexuality, Gender and Rights at the India HIV/AIDS Alliance, said health-care systems and staff are still not equipped to deal with transgender realities. Punitive laws remain a major problem. In Asia-Pacific, for example, 49 of 75 countries have laws that allow for the punishment of certain key population behaviours.
152. Winfield Tannis-Abbott, Chair of Caribbean Regional Network of People Living with HIV and AIDS, highlighted the effect of stigma and discrimination on young people's willingness and ability to seek medical care, especially those living with HIV. Mental health issues are a challenge for many young people living with HIV, and stigma and discrimination is often a contributing factor.
153. Jim Campbell, Director of the Health Workforce Department at WHO, focused on the need to ensure that health-care workers' rights are also respected so that they can uphold people's human rights. The discussion about stigma and discrimination in health care settings should not lose sight of the fact that health-care workers have roles and responsibilities, but also have rights, he told the meeting.
154. Ms Aher suggested that the focus should be on improving attitudes and preserving people's dignity. Policies and laws could only lay the groundwork for changes in attitude. Ms Mworeko pointed to the importance of "healthy" health-care systems. Health workers could not reasonably be expected to safeguard patients' rights when their own rights are being violated. Good practices should be shared more widely. Ms Mworeko referred to "centres of excellence" that had been identified in her region and described how exchange visits are being used to share their experiences with other health-care providers.
155. Luiz Loures, UNAIDS Deputy Executive Director, introduced the next discussion with a reminder that stigma and discrimination has been a problem since the earliest days of the HIV epidemic and that it helped catalyze the social movement that has brought treatment to more than half of the 36.7 million people living with HIV. But that achievement also highlights the challenge that remains, he noted. About 80% of new HIV infections outside sub-Saharan Africa are in key populations who are already vulnerable and who are discriminated against in numerous ways. In that region, a large percentage of new HIV infections are in women—and women generally are subject to violence and inequality. The current patterns of the HIV epidemic highlight the importance of stigma and discrimination, and the violence it often fuels.

156. Mr Loures emphasized the need for accurate, disaggregated data that capture the availability and equity of services and that can reveal more clearly the costs of stigma and discrimination, including the economic costs. Strengthened training and capacity-building on stigma and discrimination are needed for health-care providers, and affected communities should be involved centrally in such training. Health-care workers' rights must also be protected. More appropriate laws and policies will make a difference, including changes to laws that require young people to obtain the consent of their parents before they can use health-care services. Achieving the target of zero discrimination will require reaching deeper into society, into faith-based organizations and communities, he added.
157. Members congratulated the UNAIDS Secretariat for arranging this thematic segment and welcomed the proposed global compact on stigma and discrimination. They described some of their efforts to reduce stigma and discrimination, including through decentralizing health services and greater use of community-based services. They urged countries to take practical steps, such as enhanced education and training for health-care workers, using peer support methods, creating mechanisms for reporting rights violations and achieving redress, and introducing procedures that are gender-responsive.
158. Important legal challenges were being mounted against stigma and discrimination in some countries. Decriminalization was also singled out as an important tool for reducing discrimination against key populations. Other desirable changes include improving women's knowledge of their rights and enabling them to exercise those rights. The ethics of confidentiality and informed consent must be respected. Speakers stressed that a rights-based approach has to underpin the HIV response and reminded that human rights extend also to social and economic life. Realizing people's right to health requires safeguarding a broad range of human rights. UNAIDS Cosponsors reiterated their commitment to reach the target of zero discrimination in health care.
159. Taweessap Siraprapasiri, Acting Senior Advisor for Preventive Medicine in Thailand's Ministry of Health, said a system for monitoring stigma and discrimination has been introduced in Thailand at national and subnational levels after being piloted in two provinces in 2013. Based on initial findings, special participatory training programmes for health workers were introduced in 2015. The results were positive. The approach shows that stigma and discrimination can be monitored and measured, that monitoring can inform effective actions and that interventions can be scaled up if they are incorporated into existing systems.
160. Charafa Boudries, Medical Examiner at Algiers Central University Hospital in Algeria, described some of the steps Algeria has taken to counter stigma and discrimination in health-care settings, including the use of existing legal codes to enforce the counter-measures. In her presentation, Frederike Boeke of the International Federation of Medical Students' Associations emphasized the importance of a people-centred, rather than disease-centred, perspective. This requires recognizing that people's health is intertwined with their social, legal and economic standing in society. She called for fundamental changes in health systems, including more inclusive and rights-sensitive curricula for medical education.

161. Richard Elliott, Executive Director of the Canadian HIV/AIDS Legal Network, distinguished between three levels of discrimination: direct discrimination, denying or impeding access to health care, and criminalization. He stressed the need for “know your rights” programmes, along with greater access to legal services and support and to mechanisms for redress. While litigation and law reforms are important, they would not be necessary if certain behaviours were not criminalized, he noted.
162. Members shared country-level experiences of countering stigma and discrimination, including changes to the health code in France and actions in Germany to reduce stigma and discrimination against people living with HIV who seek dental care.
163. Doina-Ioana Straisteanu, a human rights lawyer in the Republic of Moldova, discussed the country’s National Equality Council, an ombudsman mechanism set up to deal with rights violations. Although the Council lacks enforcement powers, its decisions are publicized and serve to promote public debate and corrective actions, she said. José Zuniga, President of the International Association of Providers of AIDS Care, said professional associations have important roles in promoting the right to health.
164. Julian Kerbogossian, a member of the board of the Global Network of People Living with HIV, described the experiences of young people living with HIV in Lebanon when trying to use health-care services. Some young people were opting against HIV treatment for fear that they would lose their jobs or that their families would discover their status and ostracize them. Simón Kawa, Deputy Director-General of the Commission of National Institutes of Health in Mexico, reminded that the most vulnerable groups in society tend to experience the most severe stigma and discrimination. He said guidelines for protocols and methodologies had been developed and distributed to health-care providers, and back-up training was being provided.
165. Kate Thomson, Head of the Community, Rights and Gender and Civil Society Hub of the Global Fund, said that the Fund was undertaking a five-year programme to address human rights-related barriers related to HIV, tuberculosis and malaria services in 20 selected countries, 13 of them in Africa. Countries were being supported to document cases of human rights violations and calculate the costs of programmes for systematically tackling those violations. Five-year action plans will be developed on the basis of the findings, with mid- and end-point monitoring. Initial assessments showed that, despite non-discriminatory policies, people living with HIV and/or tuberculosis routinely experienced stigma and discrimination from health-care providers and have a poor understanding of their own rights. While some countries are trying to address such violations, actions tend to be isolated.
166. Introducing the closing session, Ms Booke urged countries to pursue “100–100–100” targets. This could be done if representatives from key populations participate actively in policymaking and if health facilities provide stigma- and discrimination-free services.
167. Mr Loures said that achievements in the realm of health care could have a much broader impact across society. He confirmed that UNAIDS would move towards establishing a global compact on stigma and discrimination.

11. CLOSING OF THE MEETING

168. The 41st meeting of the Board was adjourned.

[Annexes follow]

Annex 1

PROGRAMME COORDINATING BOARD

UNAIDS/PCB (41)/17.16

Issue date: May 2018

FORTIETH MEETING

DATE: 12–14 December 2017

VENUE: Executive Board Room, WHO, Geneva

TIME: 09h00–12h30 | 14h00–18h00

Annotated Agenda

TUESDAY, 12 DECEMBER

1. Opening

1.1 Opening of the meeting and adoption of the agenda

The Chair will provide the opening remarks to the 41st PCB meeting.

Document: UNAIDS/PCB (41)/17.16

1.2 Consideration of the report of the fortieth meeting

The report of the fortieth Programme Coordinating Board meeting will be presented to the Board for adoption.

Document: UNAIDS/PCB (40)/17.15

1.3 Report of the Executive Director

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

Document: UNAIDS/PCB (41)/17.17

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 (41)/17.18

2. Leadership in the HIV response

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

3. Follow-up to the thematic segment from the 40th Programme Coordinating Board meeting

The Board will receive a summary report on the outcome of the thematic segment on HIV Prevention 2020: a global partnership for delivery.

Document: UNAIDS/PCB (41)/17.19

WEDNESDAY, 13 DECEMBER

4. Report on progress in the implementation of the UNAIDS Joint Programme Action Plan

The Board will receive a report on progress in the implementation of the UNAIDS Joint Programme Action Plan, as requested at the 40th PCB meeting.

Documents: UNAIDS/PCB (41)/17.20, UNAIDS/PCB (41)/17.21

5. Update on actions to reduce stigma and discrimination in all its forms

The Board will receive a report on actions to reduce stigma and discrimination in all its forms, as requested at the 35th PCB meeting.

Documents: UNAIDS/PCB (41)/17.22

6. Update on HIV in prisons and other closed settings

The Board will receive an update on HIV in prisons and other closed settings, as requested at the 37th PCB meeting.

Document: UNAIDS/PCB (41)/17.23

7. Next PCB meetings

The Board will agree the topics of the thematic segments for its 42nd and 43rd PCB meetings in June and December 2018, as well as the dates for the 46th and 47th meetings of the PCB.

Document: UNAIDS/PCB (41)/17.24

8. Election of Officers

In accordance with Programme Coordinating Board procedures, the Board shall elect the officers of the Board for 2018, and is invited to approve the nominations for NGO delegates.

Document: UNAIDS/PCB (41)/17.25

9. Any other business

THURSDAY, 14 DECEMBER

10. Thematic Segment: Zero discrimination in health-care settings

Documents: UNAIDS/PCB (41)/17.26; UNAIDS/PCB (41)/17.27

11. Closing of the meeting

[End of document]

**41st Meeting of the UNAIDS Programme Coordinating Board
Geneva, Switzerland**

12–14 December 2017

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: Opening of the meeting and adoption of the agenda

1. *Adopts* the agenda;

Agenda item 2: Consideration of the report of the fortieth meeting

2. *Adopts* the report of the 40th Programme Coordinating Board meeting;

Agenda item 3: Report of the Executive Director

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

Agenda item 4: Report by the NGO representative

- 4.1 Recalling decisions from previous Programme Coordinating Board meetings as referenced in the NGO Report (UNAIDS/PCB (41)/17.18) and welcoming the upcoming discussion at the 42nd Programme Coordinating Board meeting on ways to monitor the achievement of the finance-related targets of the 2016 Political Declaration on Ending AIDS, including the proportion of services delivered through expanding the community-led service delivery to cover at least 30% by 2030; and that investment in social enablers—including advocacy, political mobilization, law and reform, human rights, public communication and stigma reduction—should account for 6% of global AIDS investments;
- 4.2 *Takes note* of the report;
- 4.3 *Requests* UNAIDS' continued support to Member States, in collaboration with community-based organizations and civil society, in monitoring and reporting, including through the Global AIDS Monitoring system, on progress made on Fast-Track Targets, using disaggregated data, as feasible, so as to leave no one behind;

- 4.4 *Requests* UNAIDS and member states in partnership with civil society organizations and all other relevant stakeholders to:
- Develop and apply country-level, community-participatory evidence gathering methodologies to identify barriers and measure the level and quality of access to services for all at risk populations so as to leave no one behind;
 - Develop methods of assessment of community engagement in countries in line with the core principles of the Joint Programme and the UNAIDS Strategy 2016–2021;
- 4.5 *Requests* the Joint Programme to facilitate partnerships between Member States and community-based organizations to help ensure effective action to meet HIV prevention, early diagnosis and treatment needs so as to leave no one behind;
- 4.6 *Requests*, in light of these decisions, UNAIDS for an update of the 2014 *Gap report* in terms of the HIV response and to report back to the Programme Coordinating Board;

Agenda item 3: Follow-up to the thematic segment from the 40th Programme Coordinating Board meeting

- 5.1 *Notes* with appreciation the background note (UNAIDS/PCB (40)/17.14) and the summary report of the Programme Coordinating Board thematic segment on HIV prevention 2020: a global partnership for delivery;
- 5.2 *Takes note* of the HIV Prevention 2020 Road Map, as launched at the inaugural meeting of the Global HIV Prevention Coalition on 10–11 October 2017;
- 5.3 *Encourages* Member states, stakeholders and partners to:
- Take bold and decisive actions to scale up prevention programmes and meet the agreed targets and commitments in the 2016 Political Declaration on Ending AIDS;
 - Set national prevention programme, financing and impact targets for 2020, alongside already established 90–90–90 treatment targets, in line with the UNAIDS 2016–2021 Strategy and the 2016 Political Declaration on Ending AIDS to create enabling legal, social and policy frameworks and to rapidly scale up efforts to reach those targets;
- 5.4 *Requests* the Joint Programme to:
- Support Member States, civil society and key populations¹ in their efforts to strengthen and sustain, including through, as appropriate, the Global HIV Prevention Coalition, the global prevention agenda and make primary prevention a priority for the Joint Programme;
 - Accelerate efforts to develop strong synergies between primary prevention and relevant initiatives to achieve the Sustainable Development Goals;
 - Provide countries with technical support for HIV prevention and strengthen overall prevention programme monitoring, management and programme delivery for the five pillars, including the behavioural and structural components of those programmes;
 - Report back to the Programme Coordinating Board annually on progress made on prevention;

¹ As defined in the UNAIDS Strategy 2016–2021 (p.33).

- 5.5 *Requests* Member States and key donors to invest adequately in HIV prevention as part of a fully funded global response and to take concrete steps to ensure that, on average, no less than one quarter of HIV spending is invested in prevention programmes, as agreed to in the 2016 Political Declaration on Ending AIDS, to ensure adequate coverage of interventions to reach the stipulated targets;

Agenda item 4: Report on progress in the implementation of the UNAIDS Joint Programme Action Plan

- 6.1 *Takes note* of the report on progress in the implementation of the UNAIDS Joint Programme Action Plan and the Strategic Resource Mobilization Plan 2018–2021, and *looks forward* to a further update at the 42nd meeting of the Programme Coordinating Board in accordance with decision 5.3 of the 40th meeting of the Programme Coordinating Board;
- 6.2 *Encourages* Member States and other stakeholders to make contributions towards the full funding of the core UBRAF, in accordance with decisions 6.5 and 6.6 of the 40th Programme Coordinating Board meeting, and additional contributions in line with the UNAIDS Joint Programme Strategic Resource Mobilization Plan;

Agenda item 5: Update on actions to reduce stigma and discrimination in all its forms

- 7.1 *Takes note* of the report;
- 7.2 *Requests* the Joint Programme to support member states and civil society in scaling up programmes to eliminate stigma and discrimination towards people living with HIV and key populations in the context of Fast-Tracking the HIV response;
- 7.3 *Requests* the Joint Programme to support member states and civil society in accelerating efforts to create enabling legal and social environments that promote non-discriminatory access to health services, employment, justice, and education, including for key populations;
- 7.4 *Requests* the Joint Programme to provide a report on progress at a future meeting of the Programme Coordinating Board;

Agenda item 6: Update on HIV in prisons and other closed settings

- 8.1 *Takes note* of the report;
- 8.2 Recalling decision points 7.2 and 7.3 of the 37th Programme Coordinating Board meeting and, in line with the 2016 Political Declaration on Ending AIDS, promoting laws, policies and practices to enable access to services and end HIV-related stigma and discrimination:
- a. *Requests* the Joint Programme to support Member States to collect and analyse disaggregated data on health conditions and services in prisons, respecting confidentiality of medical information;
 - b. *Requests* the Joint Programme to support Member States, communities, including civil society, and relevant stakeholders to enhance coordinated rights-based, nondiscriminatory, and people-centred national responses which are tailored to

- address gender inequalities to improve the availability, accessibility, acceptability, continuity and quality of comprehensive prevention, treatment and care services for HIV and coinfections, for people in prisons and other closed settings, as defined in the *Update on HIV in prisons and other closed settings* (UNAIDS/PCB(41)/17.23), including key populations, during stay, all stages of transfer and after release;
- c. *Requests* the Joint Programme to continue to support Member States to review discriminatory laws, policies and practices that lead to the disproportionate incarceration of people living with and most affected by HIV;

- 8.3 *Requests* the Joint Programme to report on progress and concrete actions taken on this topic at a meeting of the Programme Coordinating Board in 2020;

Agenda item 7: Next Programme Coordinating Board meetings

- 9.1 *Agrees* that the themes for the 42nd and 43rd Programme Coordinating Board meetings be:
- a. Ending tuberculosis and AIDS—a joint response in the era of the Sustainable Development Goals (42nd);
 - b. Mental Health and HIV/AIDS—promoting human rights, an integrated and person-centred approach to improving ART adherence, well-being and quality of life (43rd);
- 9.2 *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 44th and 45th Programme Coordinating Board meetings;
- 9.3 *Agrees* on the dates for the 46th (23–25 June 2020) and the 47th (15–17 December 2020) meetings of the Programme Coordinating Board;

Agenda item 8: Election of Officers

10. *Elects* the United Kingdom as the Chair, China as the Vice-Chair and Algeria as the Rapporteur for the period 1 January to 31 December 2018 and *approves* the composition of the Programme Coordinating Board NGOs.

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