Agenda item 1.2

UNAIDS/PCB (55)/24.36

REPORT OF THE 55TH PROGRAMME COORDINATING BOARD MEETING

24–26 June 2025 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
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Additional documents for this item: N/A

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

- *Adopt* the report of the 55th Programme Coordinating Board meeting.

Cost implications for the implementation of the decisions: none

1. Opening

1.1 Opening of the meeting and adoption of the agenda

1. The UNAIDS Programme Coordinating Board (the Board or PCB) convened in Nairobi, Kenya and online in accordance with the approved modalities for its 55th meeting on 10 December 2024.

2. The PCB Chair, His Excellency Harry Kimtai, Principal Secretary of the State Department for Medical Services, Kenya, welcomed participants to the meeting. After the singing of the Kenyan national anthem, a moment of silence was observed in memory of everyone who had died of AIDS.

3. The Chair briefed the meeting on logistical arrangements and the conduct of the meeting, and recalled the intersessional decisions adopted by the PCB on the modalities and procedures for 2024 PCB meetings.

4. The meeting adopted the agenda.

1.2 Consideration of the report of the 54th meeting of the PCB

5. The Chair said the revised report of the 54th meeting of the PCB had been posted on the UNAIDS website in October 2024 following the clearance of the PCB Bureau and Chair. The meeting adopted the report.

1.3 Report of the Executive Director

6. Winnie Byanyima, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), welcomed delegates and thanked Kenya for hosting the PCB meeting in Nairobi. She praised the country for its HIV programming which was achieving major reductions in AIDS deaths and new HIV infections. She also welcomed incoming PCB members and NGO delegates.

7. Ms Byanyima called on governments everywhere to “take the rights path”, referring to the title of the 2024 World AIDS Day report. She said the mid-term review, presented in July 2024, showed positive progress but also identified the challenges ahead. She acknowledged that achieving the 95–95–95 targets by 2025 would not be easy but insisted that it was possible with serious investment and commitment from Member States.

8. It was necessary, however, to reckon with some “hard truths”, the Executive Director told the PCB. The global HIV response was facing a growing gap, amounting to about US$ 9.5 billion, she explained, even though 60% of HIV funding was coming from domestic resources. The biggest funding gaps were in the Middle East and North Africa and in eastern Europe and central Asia, regions that were also making the slowest progress against AIDS. Ms Byanyima called on governments to close the funding gap, including by contributing to the Global Fund replenishment and by fully supporting the United States President’s Emergency Plan for AIDS Relief (PEPFAR).

9. The mid-term review of the Global AIDS Strategy 2021-2026 also highlighted opportunities, she continued, including the “game-changing” potential of long-acting HIV medicines. If governments took the political and financial decisions needed to end inequalities, drive down new infections, and harness new technologies, the world would reach its shared goals, she said.

10. UNAIDS was working on several fronts to support countries to reach the 2030 goal

and sustain progress beyond that point, Ms Byanyima said. The Global Task Team on Targets for 2030 had completed its work, UNAIDS was supporting countries to develop sustainability roadmaps (more than 30 countries had completed their roadmaps thus far), and it had commenced the work of the independent High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme, she said. The proposed 2030 targets would focus on reducing new infections and AIDS-related deaths by 2030 and on integrated responses that will secure sustainable HIV services and systems after 2030. UNAIDS was working closely with PEPFAR, the Global Fund, governments and communities in developing a sustainability framework.

11. The overriding focus of the next Global AIDS Strategy would be a concerted push for HIV prevention and for securing the sustainability of HIV responses to 2030 and beyond. The next Global AIDS Strategy would build on the inequalities framing of the current Global AIDS Strategy and strengthen accountability, including on human rights issues, as well as emphasize the role of communities in leading HIV responses. It would also focus on the cost of inaction in the context of climate shocks and humanitarian crises.

12. The next Strategy would be developed through a phased and consultative process and would include regular briefings to the PCB, Ms Byanyima explained. The PCB would receive an outline of the Strategy in June 2025 and was expected to adopt the final Strategy at its December 2025 PCB meeting.

13. The High-Level Panel, consisting of diverse stakeholders which includes people living with and affected by HIV and the countries most affected by the epidemic, was developing its thinking on a revised operating model for the Joint Programme to make UNAIDS fit for the challenges of the future, she told the meeting. The Panel was considering key questions, including how the Joint Programme's work should evolve; how it could become more streamlined and flexible; and how it could adopt a more integrated approach to its budgeting, she said.

14. The panel had convened twice, and three sub-groups (on programming, partnerships and resourcing) had met several times. The Panel was working in a consultative manner with the support of external facilitation. The recommendations of the Panel would be received by the Executive Director and the CCO. Based on those recommendations, the Executive Director and the CCO would report back to the 56th meeting of the PCB in June 2025 on the revisiting of the operating model for consideration by the Board. Further information was available on the UNAIDS website.

15. The financial outlook for 2025 was worrying, the Executive Director said, and the Joint Programme was acting to adapt to the changing circumstances. The projected core contribution for 2024 remained at US$ 140 million, which was US $20 million less than the agreed core operating budget of US$ 160 million. In 2025, core contributions were expected to amount to approximately US$ 125 million, US$ 5 million lower than expected.

16. Ms Byanyima thanked all donors who continued to support UNAIDS and had provided or pledged amounts in 2024 despite the challenging global economic context. She said the Joint Programme relied on their ongoing support in 2025 and beyond, and she urged donors who had not yet made pledges for 2025 to do so and to pay their contributions for 2025 in full as soon as possible. This would enable UNAIDS to carry out its vital work in 2025.

17. The Executive Director acknowledged that some long-standing partners had had to make difficult decisions regarding their level of support to UNAIDS. She thanked them for remaining active and committed to the mission of the Joint Programme and asked them to facilitate non-core resources in cases where annual core contributions had

been reduced.

18. Ms Byanyima told the PCB that UNAIDS remained committed to accelerating resource mobilization by demonstrating its unique added value and to achieve further savings where possible. Expenditures for 2025 were being revised downwards to US$ 150 million and the Secretariat aimed to save US$ 6 million by freezing all vacancies and tightening travel and other expenses. The freeze on vacancies puts greater stress on staff, and managers were carefully monitoring staff wellbeing. Cosponsors were also being asked to find savings of US$ 4 million for 2025.

19. Turning to prospects for accelerating the HIV response, Ms Byanyima said more than 3500 people were newly infected and 1700 people died of AIDS-related illnesses each day. However, new long-acting prevention and treatment innovations had the potential to usher in a new era. The latest innovation, Lenacapavir, had shown that just two injections per year could prevent transmission of HIV with an efficacy of up to 100%. Other game-changing new technologies included injectable Cabotegravir, a three-month Dapivirine vaginal ring, and longer-acting (monthly) oral pre-exposure prophylaxis (PrEP), which was moving into phase 3 trials in 2025.

20. Ms Byanyima said the world had a rare opportunity to usher in a new era for the HIV response and move to the brink of finally controlling the pandemic. She reminded the meeting that it had taken almost a decade for lifesaving antiretrovirals (ARVs) to reach high-burden countries in Africa and that the roll-out of oral PrEP in Africa had taken many years to gain momentum. Delays and inequalities in access to vital technologies prolonged the pandemic, she warned and assured the PCB that UNAIDS and its partners were working hard to ensure that new technologies are available everywhere where they are needed.

21. Ms Byanyima urged countries to use science and innovations for the good of all humanity. Long-acting ARVs innovations could be crucial in driving down HIV infections and making the HIV response sustainable for governments, she said. However, along current trends, long-acting PrEP would reach only a few thousand people in 2025, even though the global PrEP target was 10 million.

22. High ambition was needed so countries could deploy long-acting ARVs at scale, she said. Manufacturing capacity for these and other crucial innovations should exist across all regions, including in Africa. Ms Byanyima applauded Brazil for steering the G20 consensus for a new global Coalition for Local and Regional Production, Innovation and Equitable Access and she thanked the governments of the G20 for including HIV as part of this initiative for local and regional production.

23. The Executive Director said every low- and middle-income country should be able to access affordable generics, including through the use of TRIPS flexibilities, where needed. It was also important to support new clinical trials for new combinations of HIV treatment that include long-acting ARVs, so the regimens can be available in all countries.

24. This urgent, lifesaving work could not continue without funding, Ms Byanyima stressed. Successful replenishment of the Global Fund and the reauthorization of PEPFAR for the next five years, which was due in March 2025, was vital to save lives across the world.

25. A difficult path lay ahead in a world experiencing multiple crises, she told the PCB. There were no “silver bullets”. New medicines were essential, but they would not solve the health system challenges or end stigma and discrimination. The Executive Director called on governments, donors and communities to seize the opportunities at hand for ending the pandemic.

26. The PCB Chair opened the floor for comments. Members and observers thanked the Executive Director for her timely, comprehensive and sobering report. They said they were encouraged by the progress documented in the mid-term review of the Global AIDS Strategy 2021-2026 but warned that substantial programming and fiscal challenges stood in the way. While there was much to celebrate, a great deal of work lay ahead. The world was not on-track to reach the 2030 targets, and the HIV response was at a critical juncture, they said.

27. Underinvestment in prevention was slowing progress and HIV infection rates were not declining fast enough, speakers told the PCB. In addition, HIV treatment programmes were missing more than nine million people living with HIV, with children significantly affected. Tight financial support and the push-back against human rights hindered the progress needed to control and end the pandemic.

28. The central focus had to be on decisively reducing HIV incidence, morbidity and mortality, speakers stressed. Scarce funds had to be directed towards the most effective interventions and astute political leadership was needed to manage available resources optimally. Complacency was not an option. Speakers reminded the meeting that the field visits ahead of the meeting had shown clearly how the HIV epidemic reflects and is fueled by inequalities and injustices.

29. Speakers also pointed out that the Joint Programme had enabled the world to make great accomplishments, but its job was not done yet. UNAIDS and PCB members had to face the collective realities together and adjust their approaches in light of the geopolitical challenges and constraints.

30. Speakers noted with great concern that resources for HIV were at their lowest level in a decade and said the funding gap badly hindered the global HIV response. Most funding was coming from domestic sources, but many low- and middle-income countries were struggling with limited fiscal space and high debt repayment obligations. Speakers called on all countries to ensure that the necessary resources are available for the HIV response, while recognizing that, in the short-term at least, development assistance for HIV would remain crucial.

31. Speakers commended UNAIDS's work, especially in managing and publicizing strategic information, advocating on vital issues, and mobilizing and coordinating action. They said they were proud of their longstanding relationship with the Joint Programme and focus on HIV-related human rights issues, including for women and girls. A strong UNAIDS was vital for ending the pandemic, they said. Backing off from the global HIV response would carry huge costs in lives lost and communities damaged. Speakers urged Member States to fully fund the Joint Programme. Denmark announced that it planned to contribute US$ 5.7 million in core contribution to UNAIDS annually to 2029, pending parliamentary approval.

32. Speakers acknowledged that the funding situation for UNAIDS reflected trends in the broader funding landscape. They urged UNAIDS to do contingency planning for different funding scenarios and to seek further ways to use available funding as effectively as possible. Cosponsors reminded the PCB that they had been advocating for scenario planning since 2021. The Joint Programme had to do more with less by prioritizing and avoiding duplication in the UN System, speakers said, though they also expressed concern about the decreasing presence of UNAIDS in some regions, including in the Middle East and Asia and the Pacific, where new HIV infections were increasing.

33. The need for a fit-for-purpose Joint Programme that can position itself effectively in a volatile context was emphasized throughout. Speakers welcomed the convening of the High-Level Panel and said they hoped it would help redefine the role of the Joint

Programme within the global health infrastructure. The Panel had to clearly guide this process of revisiting and pointedly lay out the key elements of an effective operating model, while considering the vital functions and changing roles of the UNAIDS Secretariat and Cosponsors.

34. It should also recognize that not all countries faced the same challenges and that not all Cosponsors had the same roles and resources for HIV, speakers said. They suggested it might be appropriate to consider a differentiated approach to resource allocation among Cosponsors and at country level. This could help the Joint Programme deliver more targeted and tailored support. The Panel should not shy away from bold decisions, speakers insisted, stressing that the time for minor decisions was gone.

35. Members and observers emphasized that the Panel had to be transparent and independent. The recommendations should be objective, and conflict of interest should be managed when finalizing the recommendations, the PCB was told. There was a suggestion that the Panel's recommendations be postponed to end-March 2025 to ensure that it had sufficient time to properly fulfil its mandate. Members said they looked forward to reviewing the findings and recommendations.

36. The PCB was told that Cosponsors had experienced a two-thirds cut in their funding from UNAIDS, with allocations reduced to 14% of the total UNAIDS budget. Cosponsors said they were working hard to mitigate the effects by leveraging other funds and pushing ahead with integration. This had enabled them to raise about US$ 7 for every dollar received from UNAIDS. However, their capacities were stretched and the work of the UNAIDS Joint Teams was under threat. Cosponsors explained that the non-core funding they used to complement the core UNAIDS support included in-kind and other funding and could not realistically replace the UNAIDS funding.

37. Cosponsors said they recognized a need to "right-size" the Joint Programme, which requires a mapping of capacities against needs and mandate, including an objective account of staffing numbers and seniority across the Secretariat and 11 Cosponsors. In seeking a fit-for-purpose Joint Programme, Cosponsors said they recognized the value of vertical approaches to HIV, while also implementing integrated HIV programmes. However, they cautioned that integration should be pursued responsibly, with differentiated approaches to meet the different needs of people and fit different contexts.

38. New medical advances brought great opportunities to accelerate the HIV response, speakers said: for example, treatment had been improved and simplified and highly effective PrEP had been developed. New, long-acting ARVs could revolutionize prevention and treatment and move the world even closer to the goal of ending AIDS, they said. For that to happen, innovations had to reach the people who needed them the most, including through fast-tracking regulatory approval, lowering prices, facilitating diversified manufacturing and providing technical guidance for their use.

39. It was also acknowledged that drugs alone were not sufficient and that other, underlying requirements for controlling HIV also had to be addressed, including resolving health system weaknesses, reducing stigma and discrimination, upholding human rights, and building enabling policy and legislative environments. Noting the evidence that HIV prevalence tended to be higher in countries with punitive laws, speakers said it was imperative to reduce stigma and discrimination, improve access to justice and remove criminalizing laws. The next Global AIDS Strategy had to advance those changes, they added. It would require bold thinking and tough decisions. Members said they looked forward to hearing more about the consultative process for the new Strategy.

40. In order to succeed, the global response had to address HIV as a social justice issue and tackle the systemic inequalities and discrimination that drive the pandemic, speakers said. They stressed the vital and unique roles of affected communities and praised UNAIDS for supporting and creating space for their voices and activities.

41. Several members briefed the meeting on progress made in their HIV responses, strategies they were using, and support received from UNAIDS. They noted the value of frameworks for UN-wide action and referred to renewed commitments for the HIV response made by leaders of the Association of Southeast Asian Nations (ASEAN).

42. Strong health systems, enabling environments and human rights protections were crucial, speakers told the PCB. Countries making strong progress highlighted that they now had to focus on reaching hard-to-reach populations, people in remote areas and those facing severe stigma and discrimination, which was challenging. Even in ostensibly successful responses, some populations were being missed, and some countries were actively refusing treatment to people with HIV who use drugs, the PCB was told.

43. Speakers also noted that conflicts and the effects of climate changes were presenting new challenges for their health services. Referring to the war in Ukraine, a country from Eastern Europe said refugees from Ukraine were being provided with access to free HIV testing and treatment on the same terms as their citizens and that 3200 Ukrainian refugees were receiving antiretroviral therapy (ART).

44. Countries were urged to refocus their HIV efforts for children who still lagged behind in access to testing, treatment and care. Every child with HIV, from whatever population, had to be able to receive comprehensive HIV care. The PCB was also reminded that young people faced many obstacles in making informed HIV prevention decisions, including social and structural inequalities, stigma and discrimination.

45. The World Health Organization (WHO) briefed the meeting on its preparatory work related to new technological breakthroughs, including the convening of a group to draft guidance on long-acting ARVs.

46. Speakers paid tribute to Cornelius Baker, the long-time AIDS and public health advocate, who had recently passed away.

47. In reply, Ms Byanyima thanked the speakers for their remarks and support. She said she appreciated the recognition of the Joint Programme’s hard work and found the reports on country progress heartening. For now, she said, the emphasis had to be on strengthening HIV prevention and closing the treatment gap for children. She said she felt encouraged by the commitment of PCB members to rapidly get long-acting ARVs to everyone who needs them. A concrete plan for that roll out was needed, she said.

48. The pushback against human rights was a major concern, the Executive Director said, not least because medicines alone would not end the pandemic: stigma and discrimination had to be tackled, and people’s human rights had to be upheld. Seeing the lived realities of the people most affected by the pandemic during the site visits ahead of the meeting was a reminder that HIV was ultimately a social justice issue, she said.

49. Thanking the meeting for supporting the High-Level Panel, Ms Byanyima assured the PCB that the panel was independent, with UNAIDS playing a supportive role, and that UNAIDS would give the panel more space as it took forward and completed its work.

50. The next Global AIDS Strategy would be developed in a consultative and inclusive process, she assured the PCB. It would be ambitious, drawing on new alliances and collaborations while building on the best of existing approaches and resources.

51. Regarding the financial outlook, Ms Byanyima said the High-Level Panel recommendations and the new Global AIDS Strategy would help sharpen the Joint Programme's activities over the coming years and would shape the next Unified Budget, Results and Accountability Framework (UBRAF).

52. Adjustments were already being made based on financial realities, but the Joint Programme was operating at "mission critical" capacity, the Executive Director warned. She again thanked donors who had recommitted and/or increased their contributions, including Denmark, France, Germany, Netherlands, Spain, the United Kingdom and the United States of America. She appealed to all Member States to consider investing in the Joint Programme, whether through in-kind or small contributions.

53. In closing, Ms Byanyima thanked Kenya for its decades-long action against the epidemic, its strong support for UNAIDS, and for striving for global solidarity against the pandemic.

54. Welcoming participants to the PCB, Debra Barasa, Cabinet Secretary for the Ministry of Health, Kenya, said the meeting came at a time of progress against the HIV epidemic. Despite that, the world was not on-track to reach the 2025 targets due to faltering investments and ongoing inequalities. Africa and the world dearly needed UNAIDS to continue its work, she said. UNAIDS played a key role coordinating the global multisectoral response, but reduced funding was putting this work at risk.

1.4 Report by the NGO Representative

55. Cecilia Chung presented a summary of the report of the NGO Delegation and urged participants to read the full report. She explained that the report had been developed on the basis of an online community survey, eight regional dialogues, key informant reviews and a literature and peer review process.

56. After referring to various definitions of "community leadership" and "community-led organizations", she said community leadership went beyond representing communities on decision-making bodies. She briefly reviewed historical milestones and principles of community leadership in the HIV response. The roles of communities in HIV responses were highlighted in the 30–60–80 community leadership targets and the 10–10–10 societal enabler targets in the Global AIDS Strategy, she explained, but none of those targets were on-track for achievement. Stronger accountability systems and monitoring and evaluation frameworks were needed, along with solid data collection systems and financial commitment.

57. Ms Chung stressed that strong and systemic community leadership was needed to end the HIV pandemic, but its full potential was being held back by shrinking civic space, attacks by the anti-gender and anti-rights movement, and inadequate funding. Citing a CIVICUS report, she said almost one third of the world's population lived in countries with "closed civic space". Some countries were using "foreign agents" laws to limit civil society activities and were passing laws against LGBTQI+ communities.

58. A well-coordinated and -funded anti-gender and anti-rights movement was seeking to roll back human rights protections and was advancing for harmful policies and laws, Ms Chung told the PCB. She detailed some of the ways in which these actions were undermining community leadership, including the use of punitive anti-LTBQI+ legislation, especially in Africa, the tightening of drug laws and growing attacks on sex worker rights.

59. Meanwhile, funding for community-led organizations was decreasing. Most of it was projected-based and tied to specific results, with very little support for core work and capacity building. This exacerbated the volunteerism that had characterized the HIV

response for decades. The effects were especially severe for women-, youth- and key population-led organizations, she explained.

60. Ms Chung called for a paradigm shift in the HIV response. Funding should be more flexible, responsive and context specific. Domestic financing was essential but some earmarked external funding for communities had to be maintained, she said, especially for key population-led organizations. The Robert Carr Fund was an exemplary case study, she noted.

61. According to her, civic space, solidarity and coordinated action—and a counter-narrative ground in science and evidence—was needed to confront the anti-gender and anti-rights movement. Ms Chung said UNAIDS Cosponsors and the Global Fund could do more to support alliances between communities and governments and to normalize the meaningful involvement of community-led organizations in decision-making, while challenging policies and practices that undermine an effective HIV response.

62. Stronger accountability was also needed to ensure that the commitments in the Global AIDS Strategy and related strategies are met. Community leaders had to be meaningfully involved in national, regional and global decision-making. The NGO report provided a set of actionable recommendations for sustainable and equitable financing, centering community leadership in the HIV response and building resilience to counter the shrinking of civic space, she said in conclusion.

63. The Chair opened the floor for discussion. Speakers thanked the NGO Delegation for a timely, important and results-focused report, and for the thorough evidence and research presented in it. They welcomed its overall proposals.

64. Reminding the PCB that communities had rescued HIV responses in many countries during the COVID-19 pandemics, speakers said communities played irreplaceable roles, but this essential work was under attack. They reaffirmed their commitment to advance community leadership and human rights as priorities in the global HIV response and called for an increase in the proportion of community-led services, as set out in the 30–80–60 targets. They urged PCB members to “follow the science”, support decriminalization efforts, invest in equity and empower communities.

65. Speakers pointed to the “paradox” that, in places where community leadership was most needed, it faced the greatest obstacles. They underscored the concerns about shrinking civic space, especially for grassroots organizations, and said they supported the efforts to build the resilience of community-led organizations to counter anti-gender and anti-rights movements. Those movements threatened to dismantle the gains made against HIV and to engulf organizations and networks that had achieved progress. Community organizations were being suffocated, the meeting was told; they could not sustain the HIV response while under constant attack. If these organizations—and civic space—were not defended it would lead to more HIV infections and higher treatment costs, speakers warned.

66. Also emphasized was the need for sufficient financing and other enabling support. Governments, donors and UN agencies were urged to do more to empower communities, for example by assisting them in accessing sustainable resources, including from the private sector. Communities’ reliance on a few remaining donors had to be reduced. Speakers pointed to the Robert Carr Fund as an instructive example of how the funding question could be addressed. They also echoed calls for shifting funding strategies towards more direct, flexible and long-term models. New strategies and approaches were needed to defend and facilitate the work of community-led organizations. Difficult times called for thinking “outside the box”, the PCB was told.

67. Some members described the ways in which community leadership—at national and subnational levels—featured in their HIV responses. Examples included the “Healthy Brazil” programme, which prioritizes intersectional action and strong alliances with community and social movements.

68. The PCB was reminded that faith-based organizations acted as service providers as well as being vital partners and bridges to communities. It was important to build dialogues and collaborations with them to drive the HIV response forward.

69. In reply, Ms Chung thanked the speakers for their comments and said it was clear that some of the gains made over the past 40 years were at risk of being lost. Urgent, concerted action was needed to avoid such an outcome.

70. Invoking the right of reply, one member contested statements made about the war in Ukraine and said they were misleading. The representative said that the Russian Federation was taking in more refugees from Ukraine than any other country, and that access to HIV services in Ukraine had increased since 2022. The representative asked speakers not to politicize the meeting.

71. Referring to the decision points for agenda item 1.4, the Russian Federation said it disassociated itself from decision point 4.3 because of terminology that it does not agree with.

72. In response, a speaker expressed concern about the difficulty in reaching consensus over some terminology in decision points. The Joint Programme, with partners and civil society, was asked to undertake further consultations to arrive at clearer, shared definitions of that terminology.

2. Leadership in the AIDS response

73. Introducing the panelists for this agenda item, Ms Byanyima said new biomedical breakthroughs were crucial, but they did not remove other challenges, such as health system weaknesses, stigma and discrimination, and laws that undermine HIV efforts.

74. Angeli Achrekar, Deputy Executive Director for Programmes, UNAIDS, reminded the PCB that, although there was no vaccine or cure for HIV, the tremendous achievement of having almost 31 million people on HIV treatment had changed the epidemic by driving down both AIDS-related deaths and new HIV infections. This accomplishment was the product of bold ambitions, strong investments, community-driven advocacy and rapid action to improve health policies and systems, she said.

75. However, the 1.3 million new HIV infections occurring each year were not sustainable, Ms Achrekar continued. Long-acting ARVs were a massive opportunity to reduce HIV incidence more rapidly—not as stand-alone interventions, but as additional, highly-effective options and choices. They represented the world’s “1996 moment”, referring to when highly effective HIV treatment first became available. She urged the world to seize this moment with ambitious, multilateral actions that bring the private and public sectors together and prioritize the health of people.

76. Ethel Maciel, Secretary of Health and Environment Surveillance, Ministry of Health, Brazil, said the new long-acting ARVs presented both a big opportunity and a challenge, due to the current, high cost of the medications. Ways had to be found to make the new technologies accessible for all, she said.

77. Ms Byanyima said the only way to end the HIV pandemic was by drastically reducing new HIV infections—and wide access to ARVs was the most powerful tool available for doing so. She told the PCB that new efforts were underway to diversify the production

of ARVs and other essential medicines, including the creation of the G20 Global Coalition for Local and Regional Production, Innovation and Equitable Access, which was working with Africa CDC to explore the expanded production of new HIV medicines.

78. Jerop Limo, Executive Director of the Ambassador for Youth and Adolescent Reproductive Health Program, Kenya, said she had been living with HIV since childhood and took ARVs every day. However, the pills still invited stigma. Long-acting ARVs would help lift that burden and help people, especially young people, who were struggling to adhere to treatment. The ARVs would also broaden prevention choices, especially for adolescent girls and young women. These products had to reach the people who needed them, Ms Limo urged.

79. Cissy Kityo, from the Joint Clinical Research Centre, Uganda, said new HIV infections and deaths due to AIDS had to be reduced more rapidly. After reminding the PCB that people with an undetectable viral load could not transmit HIV to others, she recapped the evolution of PrEP. While oral PrEP was a potentially important prevention tool, she said, it required taking a daily pill, which was not easy. Injectable long-acting ARVs promised a new era, she said. The first had been Cabotegravir, a bimonthly injection, which reduced the risk of acquiring HIV by 66–88%, according to two studies. Access was slow, though. More recently, she continued, studies had shown that a six-monthly injection of Lenacapavir reduced that risk to almost zero.

80. Ms Kityo noted, though, that studies of long-acting ART had been being done mostly in high-income countries among populations with specific sub-types of HIV and less background drug resistance than in some of the high-burden countries. Studies to provide evidence from low- and middle-income countries regarding long-acting ARVs were now happening, including the CARE study at eight sites in eastern and southern Africa which was showing very good results. These kinds of evidence had to be used to guide policy and practice and to facilitate access. It took 13 years to get ARVs to low- and middle-income countries; they should not have to wait that long again, she urged.

81. Sylvia Vito, Africa Head of EVA Pharma, said her company had received approval via a voluntary license to manufacture Lenacapavir in Africa. She explained that the critical steps involved obtaining the active pharmaceutical ingredient (API) and getting the product registered. Her company had started the process to receive the API from the supplier and it planned to also produce its own API.

82. The company, which is based in Egypt, would seek approval from the Egyptian Drug Authority and would then compile a “drug master file” for provision to other regulators. Approval from the Egyptian authority was expected in the fourth quarter of 2025, after which formal approval could be sought from other regulatory bodies. Ms Vito said a price estimate was not yet available, but the company was committed to make the drug more affordable than the current price.

83. The Executive Director noted that Lenacapavir cost about US$ 44 000 per year in the United States market, although some estimates suggested that the price could be brought down to as low as US$ 40 per year.

84. Javier Padilla Bernáldez, Secretary of State for Health, Spain, said HIV programmes found themselves in an exceptional situation. Long-acting ARVs could change the HIV landscape entirely but only if the world avoided repeating the mistakes that had delayed access to ARVs in the late 1990s and early 2000s. He emphasized the need for constant dialogue with the populations who would benefit the most from long-acting treatment and prevention. A “game-changer” that was not available to all who needed would be a “nothing changer”, he said.

85. Spain had approved a national multistakeholder strategy for the pharmaceutical industry, which brings together government, the private sector and the public as an effort to ensure full access to drugs in situations of public health concern, he told the PCB. Similar approaches can be taken at the global level. He emphasized that a universal perspective was needed for the roll-out, focusing on the populations in need wherever they are. People in middle-income countries should not lose out. It was important to ensure that there were no reprisals or threats against countries that seek to make use of the TRIPS exceptions, Mr Padilla said.

86. Ms Byanyima reminded the meeting that the current licensing agreements for Lenacapavir excluded many middle-income countries, including several with a high burden of HIV. Asia Russell, Executive Director of Health Gap, concurred and said the current access strategy for Lenacapavir was flawed because it excluded many communities in middle-income countries. A new coalition had been launched to press for greater access, she told the PCB. It was calling on the manufacturer to remove current exclusions, extend the licensing agreement to all countries, and set an affordable, single access price for all countries in the vicinity of US$ 40 per patient per year. The coalition was also demanding that no action be taken against countries that seek to achieve equitable access by, for example, issuing compulsory licenses. Ms Russell also urged country leaders to make greater use of non-voluntary tools when needed.

87. Carmen Perez Casas, Senior Technical Manager at Unitaid, said long-acting innovations had transformed other health areas (e.g. long-acting contraception) because they were efficacious and easy to use. She highlighted three priorities for long-acting ARVs: scale and volume (demand) should be built quickly; regulatory, manufacturing and other steps had to be completed rapidly so the innovations can have a quick, real-life impact; and equity should be centre-stage, so the tools can reach all who need them, wherever they are. Pricing should be competitive with oral PrEP if the necessary scale was going to be reached. She said generic manufacturers were ready to step in, but it was important to stimulate demand—people had to be aware that these options existed. The counter-factual to wide access was clear, she told the PCB: 1.3 million new HIV infections each year amount to more than US$ 2 billion in treatment costs every year for life. That was not sustainable, she pointed out.

88. Ms Barasa said equity and sustainability of access were clearly crucial, along with ensuring that the necessary resources are available and proceeding with integrating HIV responses with other health programmes.

89. The Chair opened the floor for discussion. Members and observers thanked the panelists and supported the calls for equitable access to prevention and treatment tools. The end of AIDS as a public health threat was in sight, they said, but it could not be taken for granted: progress did not equal success. Each year, 1.3 million became newly infected by HIV and over 9 million people living with HIV were not getting HIV treatment, while a range of social and legal barriers, including persistent stigma and discrimination, stood in the way. Yet the tools for accelerating progress existed, especially with the advent of long-acting ARVs which could herald a “prevention revolution”.

90. Speakers applauded the focus on making long-acting drugs available to all who need them and said they looked forward to WHO issuing guidance for these prevention and treatment tools in the coming months. Long-acting technologies could transform the HIV response—but only if they reached everyone who could benefit. High costs were a barrier. Speakers said they were pleased that Unitaid was involved in this important work, as stronger collaboration between it and UNAIDS could help make long-acting ARVs available to all who need them.

91. One speaker noted that his country had participated in the studies which had demonstrated the very high efficacy of Lenacapavir, yet it was excluded from the licensing agreement that broadened access for some countries. He urged countries and stakeholders to commit to universal treatment and ensure that scientific advances reach everyone who need them, not just a fortunate few.

92. Speakers agreed with the panelists that no single tool was enough: countries also had to reduce inequalities, provide information and education about HIV, and protect the human rights of marginalized people. Biomedical tools had to be integrated with social progress. The meeting was reminded of Brazil's experience in jointly mobilizing government and social movements for rolling out of HIV treatment.

93. Speakers from Africa appealed to donors to support UNAIDS, which was an indispensable partner in their national efforts to end the HIV epidemic. They recalled how UNAIDS's actions had been crucial for expanding equitable access to treatment, strengthening the fight against stigma and discrimination, and promoting comprehensive health care.

94. Several members shared updates on the progress made in their national HIV responses.

95. In reply, Ms Achrekar said there was enthusiasm to seize this historic opportunity. Panelists agreed that a special opportunity had arrived and said the cost of squandering it would be measured in the lives of millions. They called for ambitious actions and urged governments and UN agencies to work with communities and manufacturers to seize this opportunity.

96. Ms Kityo said the research showed high levels of satisfaction with this long-acting prevention option, along with extremely high levels of efficacy. She told the PCB that another study was looking at combining, as long-acting HIV treatment, a dose of Cabotegravir every two months with Lenacapavir every six months. In addition, research would be carried out to identify and remove implementation barriers.

97. Ms Byanyima agreed and said that long-acting HIV prevention was the closest the HIV response had come to having a vaccine. It would also enable people to avoid the stigma attached to most other HIV prevention tools. Governments could incentivize price reductions, build demand and speed up the regulatory processes, while the Joint Programme would play its crucial role supporting and driving the process.

3. Follow-up to the thematic segment from the 54th PCB meeting

98. Jame Atienza Azcona, Director, Equitable Financing Practice, UNAIDS, presented the follow-up to the thematic segment from the 54th PCB meeting and said UNAIDS was proposing a new approach to secure the sustainability of the HIV response.

99. After briefly recapping the background to the thematic segment, Mr Azcona said speakers had stressed the relevance of the recommendations included in the background note, which had informed the proposed decision points for this agenda item.

100. Several key messages had emerged from the segment, he said. Confidence that the world could end AIDS by 2030 was tempered by concern that the HIV response was moving too slowly and unevenly. Since sustainability of the HIV response depended on meeting the 2025 and 2030 targets, accelerated action was urgently needed.

101. HIV responses had to match country epidemics and express a commitment to efficiency and prioritization that was based on value for money and impact, he told the

PCB. Amid a financing decline for health and HIV, a mix of domestic, international and other funding sources was required. Long-term, country-owned pathways for a sustainable HIV response had to be grounded by 2025, Mr Azcona said.

102. HIV was not only a health crisis, but a development and security threat, he told the meeting before briefly describing future scenarios. Modeling showed that the number of people living with HIV would rise to over 42 million in 2030 and to 46 million in 2050 on current trends, he warned. Reaching the 2025 targets would reduce that number to under 29 million in 2050. Regarding funding, Mr Azcona said HIV financing in low- and middle-income countries had declined after a 2017 peak, even though domestic resources had grown significantly (60%). The share of HIV financing international donors other than PEPFAR and the Global Fund had decreased by 61% since 2010.

103. The HIV response faced several other challenges, as well, he continued. People living with HIV required lifelong care; prevention was under-resourced and making slow progress in many countries; stigma and discrimination and criminalization remained rife; and civil society and communities were being involved fully. Innovative technologies were available, but they were not yet affordable everywhere. HIV responses also had to leverage opportunities for convergence, including shifts towards primary health care, universal health coverage and people-centred responses.

104. Mr Azcona said countries had to focus on three pillars of sustainability: political, programmatic and financial. Political sustainability required top-level political commitment; partnerships with communities and people affected by HIV; shared responsibility; enabling laws and policies; and equitable responses that assure affordability and wide access to key HIV innovations, he said.

105. According to him, programmatic sustainability involved multidisciplinary research that draws together social and biomedical evidence; multisectoral strategies; the meaningful involvement of people and communities affected by HIV; and strong and well-resourced systems for health. Finally, financial sustainability required increased domestic and adequate external funding for HIV; the use of country-tailored financing solutions alongside necessary global solidarity; and seeking further cost-efficiencies.

106. Sustainability roadmaps were intended to guide those actions, he explained. Initial dialogues and preparations had started in 2024, and part B of the process would occur in 2025. Roadmap development was already underway in 30 countries, he informed.

107. Speaking from the floor, participants thanked the Secretariat for the high-quality report. They acknowledged the achievements of the HIV response but cautioned that the pandemic was not over and that setbacks would lead to a resurgence.

108. Children, adolescents and young people remained among the most vulnerable populations in the HIV pandemic, they said, and the disproportionate percentages of new infections among adolescent girls and young women in Africa remained a concern. An ageing population of people living with HIV also required deeper integration of HIV and other health services. The long-standing effectiveness of the HIV response required reducing inequalities, speakers said. The meeting was reminded of the disproportionately high rates of HIV among Indigenous people in North America and their lack of access to HIV and many other essential services.

109. Speakers welcomed the progress made in developing country Sustainability roadmaps. The process required financing support; leadership from local communities upwards; strong grassroots involvement and full respect for human rights; and universal access to prevention, diagnostic and treatment tools and services. Diversified manufacturing of ARVS and other essential HIV products could help achieve universal access, they said.

110. There were calls for a strategic and targeted approach to HIV financing. While recognizing the need to advance towards country-owned financing, speakers noted that fiscal space for HIV and health was highly constrained. Most countries in Africa were spending more on debt servicing than on health in a context of slow economic growth, they told the meeting. Donor funding therefore would remain important as countries shifted towards greater domestic funding. Donors were urged to keep including HIV in their health financing support, while low- and middle-income countries were urged to seek ways to expand their fiscal space for health expenditures.

111. Successful integration was reliant on strong health systems, which highlighted the importance of linkages to the primary health care and universal health coverage agendas, speakers told the PCB. But it was crucial to do so while securing the coverage and quality of HIV services and retaining their rights-based features. Rights-based people-centred programming services for key affected populations and equity had to be a focus of sustainability efforts, which in turn required enabling social and legal environments, speakers stressed.

112. Some speakers cautioned that integrating HIV responses into ailing health systems marked by stigma and discrimination carried risks for the HIV response. Services should be devoid of stigma and discrimination, they insisted and called on governments to do more to reach the 10–10–10 targets. A multifaceted approach was needed. Further integration should be blended with differentiated approaches that are tailored to the needs of different populations and uphold their rights, they said.

113. According to some speakers, it was important to recognize and facilitate the important roles of community-led organizations. Their expertise and contributions transcended HIV and were evident also in relation to COVID-19 and other health challenges. Financing arrangements should support community-led responses, including through social contracting models. Referring to a field visit prior to the PCB meeting, speakers said that peer educators worked tirelessly and fearlessly but were paid extremely poorly, which was neither just nor sustainable.

114. It was observed, for example, that harm reduction interventions had become over-medicalized and that their social and community dimensions were being neglected. Community empowerment had to be kept in the picture, which in turn required funding support and regulatory space for community-led organizations. Speakers underscored UNAIDS's role in advocating for programmes and interventions that meet the needs of all populations and catalyze cooperation.

115. Some members and observers shared details of steps they were taking to foster the sustainability of their HIV responses, including top-level endorsement of the main messages highlighted in the thematic segment. Cambodia's representative said the country's sixth national AIDS plan was being developed based on those recommendations. The national AIDS authority was committed to build the capacity of stakeholders for long-term sustainability planning, deepen integration of the main elements of the response, and achieve greater synergy with other sectors that affected HIV outcomes, he said. Ultimate accountability would rest with the country's Council of Ministers.

116. In reply, Mr Azcona thanked speakers for their valuable inputs. He highlighted the remarks affirming the need for community-led work; reducing stigma and discrimination and upholding human rights; deploying tailored responses; and reducing new infections by reaching populations that were being left behind, including adolescent girls and young women in Africa. Sustainable financing was especially important in light of the debt and other constraints faced by many countries, he said and also underscored the value of diversified production of essential medicines. He

acknowledged the need for nationally-owned and -led Sustainability roadmap processes that include strong involvement of affected communities and donors.

117. Ms Byanyima told the meeting that UNAIDS worked hard to enable countries and communities to own their national HIV responses and to support strong national leadership that progressively assumes greater responsibility for the HIV response. This was part of the unique value of the Joint Programme, she said.

118. However, low- and middle-income countries were operating in a dire economic context and were being constrained by unsustainable debt burdens. Comprehensive debt restructuring was needed for these countries to fully take over their national HIV responses, she told the PCB. UNAIDS was working to help lower those barriers, in line with the UN Secretary-General's commitment to achieve debt relief for highly indebted countries.

119. Ms Byanyima linked the sustainability challenge to the opportunities presented by long-acting ARVs for prevention and treatment: if the HIV epidemic could be controlled by making those tools available to all who need them, sustainability would become much more likely, she predicted.

120. Referring to the decision points for agenda item 3, the Islamic Republic of Iran disassociated itself from decision point 5.2b. It asked that this be reflected in the report and in the decision points.

4. Findings of the mid-term review of the Global AIDS Strategy 2021–2026

121. Angeli Achrekar and Christine Stegling, Deputy Executive Directors, UNAIDS, presented this agenda item. Ms Achrekar told the meeting that the HIV response was at a crossroads. Great progress was being made, but the pandemic was not yet at the disease control stage: intensive actions were needed to drive down HIV incidence to reach that point.

122. New infections were declining but 1.3 million people newly acquired HIV in 2023, far more than 370 000 target for 2025. There had been great progress in reducing AIDS-related deaths to 630 000 in 2023, but the 2025 the targets were not yet being reached. HIV treatment was a huge public health success story, and the world was getting closer to the 95–95–95 targets, but it was not reaching them yet.

123. In addition, progress was not equal across populations: inequalities still shaped the epidemic and response. For example, viral suppression levels globally were 48% for children but 78% for adult women and 67% for adult men.

124. Whereas Africa was achieving strong declines in new infections, there was very little change in the rest of the world and new infections were increasing in eastern Europe and central Asia, South America and the Middle East and North Africa. Prevention options should be tailored to different populations, Ms Achrekar advised. In sub-Saharan Africa, adolescent girls and young women were still disproportionately at risk of acquiring HIV. Outside that region, new infections were mostly among male populations and 80% of new infections were among members of key populations and their sex partners.

125. Stigma and discrimination remained a big barrier, with surveys showing that 13% of people living with HIV had experienced stigma and discrimination when seeking HIV care and 25% have had similar experiences when seeking other health care. One third of the people who had experienced stigma and discrimination had stopped or interrupted their HIV treatment and care.

126. Integration of HIV care with other services offered important opportunities, but not all opportunities were being used to the full yet (even for managing ART and tuberculosis treatment), Ms Achrekar said. She cautioned that integration should be pursued carefully and should not compromise the quality and accessibility of services. The hallmark of the HIV response—to address the needs of diverse populations—should be safeguarded.

127. Ms Achrekar highlighted the critical funding shortage for the HIV response in low- and middle-income countries. About US$ 19.8 billion was available in 2023, almost US$ 9.5 billion short of the amount needed in 2025. Development assistance for HIV would continue to be essential, with PEPFAR and the Global Fund playing crucial roles.

128. She shared a snapshot of progress made towards the 2025 targets, which showed that most progress was occurring around HIV testing and treatment, while responses were off-track for the HIV prevention targets and for targets related to gender equality and empowerment, human rights and discrimination, and pediatric treatment. She called for urgent action on the areas and issues where progress was too slow or absent. Societal enablers were critical for making an impact, she said, referring to modeled projections which showed that both new HIV infections and AIDS-related deaths would rise if societal enablers were not operating.

129. Concluding, Ms Achrekar said failure to reach the 2025 targets would see the number of people living with HIV globally rise to about 46 million in 2050, compared with about 29 million if targets were met. Reductions in HIV incidence had to be accelerated and gaps in the treatment cascade had to be closed. This could be achieved with a major push for HIV prevention, using new technologies.

130. In 2030, between 30 and 40 million people would need HIV care and treatment and would need to be able to stay on treatment and have suppressed viral loads. That required addressing structural and societal barriers as well, which called for a multisectoral response that links the health, finance, justice, education and social welfare sectors. In addition, integration of services required a careful effort to ensure quality, stigma-free services were available to all in need.

131. Continuing the presentation, Ms Stegling said the next Global AIDS Strategy would seek to strengthen political “buy-in” and build on the current “inequalities lens” approach. A powerful narrative was needed if the Strategy was to have traction in a world facing numerous interlocking crises (including debt burdens, security issues and conflict, climate change shocks, human rights violations and shrinking civic space). Country Sustainability roadmaps would inform the Strategy, along with the 2030 targets and examples of country successes.

132. The Strategy would be developed in six phases. The first phase involved a scoping exercise and wide stakeholder consultations, followed by identification of the main problems and solutions, prioritization and criteria setting, and multistakeholder consultation, she said. Adoption of the final Global AIDS Strategy was scheduled for the December 2025 meeting of the PCB.

133. Ms Achrekar continued the presentation with a roundup of the work done by a Global Task Team to develop a set of evidence-informed targets for 2030. The targets constituted the “what” for the HIV response, while the Strategy presented “how” the targets could be achieved. Consultations had shown there was support for continuity with the existing Global AIDS Strategy 2021-2026 but that the targets could be streamlined further, she explained. The focus would be on reducing new infections and deaths, along with addressing inequalities and achieving an integrated response that secures sustainable HIV services and systems after 2030.

134. She presented the core draft targets. The main outcomes would be: 90% fewer new HIV infections in 2030 compared with 2010 and a continued decline of 5% per year after 2030; 90% fewer AIDS-related deaths in 2030 compared with 2010; and securing sustainability of HIV response after 2030.

135. Ms Stegling then discussed the work being done on sustainability and said the new Strategy had to position the world to sustain the achievements of the HIV response beyond 2030. The Sustainability roadmaps would build on regional and global partnerships; provide frameworks for stakeholders to align their action plans with country-owned visions; sketch pathways to leverage multisectoral collaboration and resources with special role for communities; and seek to ensure human rights protections.

136. The Joint Programme's next Unified Budget Results and Accountability Framework (UBRAF or equivalent) would cover the 2027–2031 period and would be adopted in 2026. It will be informed by the new Global AIDS Strategy, along with the High-Level Panel recommendations on the new operating model and related PCB decisions while as planned, a "bridging" Joint Programme Workplan and Budget for 2026 under the current UBRAF 2021-2026 would be approved in 2025.

137. Ms Stegling concluded with a timeline for the work of the High-Level Panel, which was expected to present a report with recommendations in March 2025. Based on those recommendations, the Executive Director and the CCO will report back to the 56th meeting of the PCB in June 2025 on the revisiting of the operating model for consideration by the Board.

138. In discussion from the floor, members and observers thanked the Secretariat for the robust analysis presented in the mid-term review and said it was a sobering reminder of the challenges and opportunities awaiting the HIV response. They strongly supported the findings of the review and said they had to guide the path forward, including for the High-Level Panel process and the development of the next Global AIDS Strategy 2026-2031 and UBRAF.

139. They welcomed the substantial progress shown in the mid-term review—especially around treatment and care, much of it provided free of charge—but noted that persistent gaps and obstacles left the world off-track against the 2025 targets. New HIV infections were rising in at least 28 countries amid deep inequalities, uneven access to services and support, and persistent stigma and discrimination. Many countries with high HIV burdens also had large debt repayment burdens.

140. Speakers reiterated that the world had the tools and knowledge to end AIDS by 2030. Yet, the mid-term review showed clearly how the HIV response was being hampered by the ongoing problems of stigma and discrimination, inequalities, human rights violations and violence, and disruptions caused by conflict and the climate change crisis. Field visits had shown clearly the need to remove policies and laws that limit people's access to services and medicines, including harm reduction services. Quicker and more equitable progress against the pandemic would not be possible without tackling such issues and working closely with community organizations, they said.

141. Highlighted for attention and action were the reduced political commitment in some countries; funding shortfalls and the narrow HIV funding base; inequitable access to medicines; insufficient emphasis and resources for HIV prevention; weak and inadequately financed health systems; ongoing HIV-related stigma and discrimination; and the global rollback on human rights.

142. Scientific innovations offered hope, but they had to be accessible and affordable, and they had to reach the populations who needed them, the meeting was told. Speakers

emphasized the potential for stronger cooperation with Unitaid to achieve the rapid rollout of long-acting PrEP and treatment.

143. They agreed with the review's emphasis on the critical roles of civil society across the HIV response and called on countries and donors to support organizations that can reach the most affected and disadvantaged populations. Also noted was the value of compelling epidemiological analysis and strong investment cases.

144. The PCB was told that the challenges required a transformational effort rather than staying the course and that the Sustainability roadmaps were an opportunity to rally around the most crucial actions. Speakers congratulated UNAIDS for supporting and facilitating the development of the roadmaps.

145. Noting the need to rethink the way forward, speakers welcomed the High-Level Panel process and said they looked forward to its recommendations for adapting the Joint Programme so it could drive a stronger response to the challenges identified in the mid-term review.

146. Emphasizing that the Joint Programme had to be fit for purpose and able to work within its budget, they encouraged it to ensure coherence across its various work streams.

147. They insisted that the High-Level Panel process had to be transparent, consultative and meaningful, and suggested that regional consultations might be useful for capturing specific shifts and realities.

148. Speakers said the next Global AIDS Strategy would be crucial for addressing the many challenges identified in the mid-term review. The next set of targets and the Global AIDS Strategy had to strike a balance between realism and ambition amid multiple challenges, they noted. A lean and reimagined new Strategy was needed to galvanize political support and both the new Strategy and UBRAF had to respond to the implications of the ongoing funding gaps. Speakers said they hoped the next Strategy would clearly show how countries' HIV efforts and funding can be deployed most effectively to achieve the goals by 2030 and beyond.

149. Regarding the next Global AIDS Strategy's content, they highlighted the importance of an accelerated prevention push; equitable access to ARVs, including long-acting versions; and investments in health and community systems to achieve timely access to HIV services and technologies, especially for marginalized populations. The Strategy also had to reflect the fact that long-term sustainability required strong political will and robust community mobilization to overcome the equity barriers, protect human rights and advance gender equality. A strong focus on integration of HIV interventions with sexual and reproductive health, tuberculosis, primary health care and the broader universal health coverage agenda was also advised.

150. The next Global AIDS Strategy, speakers said, had to maintain a focus on sustaining the priorities that had brought progress, while devising new ways to address both ongoing and fresh challenges. There was a suggestion to highlight the most impactful strategies and to convey clearly which interventions had to remain on-track and which needed to be boosted. It was also suggested that the Strategy be framed in ways that allow countries to implement it in accordance with their national stakeholders' priorities.

151. Speakers insisted that the next Global AIDS Strategy be developed in a transparent and inclusive manner and asked the Secretariat to explain how stakeholders were being involved in its development. The Secretariat was asked whether the next Global AIDS Strategy would include mechanisms of accountability for implementation.

152. Speakers said they were impressed by the many processes that were underway but stressed the need for complementarity. Ultimately, they said, the PCB had to emerge from its December 2025 meeting with a clear vision of how the world would go about reaching the AIDS targets and goals.

153. Some members briefed the meeting on progress made in their HIV responses, including rising ART coverage and viral suppression levels, increased access to PrEP, and deeper integration of HIV into the broader health system. They noted, however, that the provision of long-acting ARVs was being limited by high costs; most middle-income countries were not benefiting from the price reductions offered for lenacapavir. The Netherlands announced that it planned to contribute 23 million euros to UNAIDS in 2025.

154. Concerns were raised about the closure of UNAIDS's regional office in the Middle East and North Africa, a region where the HIV response was lagging behind. They asked whether UNAIDS was paying sufficient attention to the region and said that HIV programmes that were experiencing the major problems and limitations should receive more attention.

155. In reply, Ms Achrekar thanked speakers for their remarks and suggestions. She said the purpose of the mid-term review was to describe the status of the global HIV response and guide improvements. It was a foundational input for the next Global AIDS Strategy, the next UBRAF and related and complementary processes. Throughout these activities, UNAIDS was committed to ensure inclusive processes, including for young people.

156. Ms Stegling thanked speakers for their inputs, guidance and continued support. Responding to remarks about regional responses, she said UNAIDS would consider whether a more regionalized approach might be needed, including in the Global AIDS Strategy. She assured the meeting that engagement with the Middle East and North Africa region was continuing via three other UNAIDS regional and some remaining country offices but acknowledged the concern about the trajectory of the HIV epidemic in that region. However, UNAIDS had to contend with the reality of having fewer resources at its disposal. While agreeing that a risk analysis of the costs of not being able to sustain certain forms of support was important, she noted that prioritization and refocusing had consequences—everything could not remain the same.

157. In closing, Ms Stegling said that, while the discussions had focused on longstanding problems, it was important to focus also on the new opportunities for dealing with those challenges and for accelerating progress.

158. The decision point was adopted.

5. HIV in prisons and other closed settings

159. Fariba Soltani, Global Coordinator for HIV at the UN Office on Drugs and Crime (UNODC) began her presentation by recapping earlier PCB decision points and sharing the latest epidemiological data on HIV in prisons and other closed settings.

160. She told the PCB that the global prison population was increasing, with 11.5 million people detained at some point in the year, 5.5% more than a decade earlier. Men comprised 94% of incarcerated people. Prisons were overcrowded in at least 60% of countries, due largely to overuse of pretrial detention and the incarceration of nonviolent offenders. In 2022, 7 million people had been in formal contact with police for drug user-related matters, for example. She said overcrowding exacerbated health problems and risks, violated people rights, and led to increased prison violence, including rape–-all of which stand in the way of protecting people against HIV and

other health threats.

161. The median prevalence of HIV in places of incarceration globally was 1.3% in 2023, approximately twice the prevalence of adults 15–49 years in the general population, she continued. Prisoners also have higher rates of tuberculosis and hepatitis C. The prevalence of sexually transmitted infections is 2–10 times higher in prisons than in the general population and mental health complications are much more common in prison populations.

162. Ms Soltani noted that there was insufficient data to track progress for HIV for people in prisons. Improved and more targeted HIV-related data collection among prisoners was needed, including for ART coverage and viral suppression rates.

163. Continuing the presentation, Ehab Salah, Advisor on Prisons and HIV, UNODC, said the available data showed HIV service coverage was very limited in prisons. Among 37 countries reporting these data, ARV coverage exceeded 95% in 18 countries and was under 50% in five countries, while harm reduction services were rare, with only 11 countries providing needle and syringe programmes in some prisons (whereas 92 countries reported having such programmes in the wider community). Naloxone was reportedly available in prison settings in 11 countries; most of the countries providing harm reduction services in prisons are in western Europe and North America, he informed.

164. According to him, condom provision had increased, with condoms available in at least some prison facilities in 55 countries in 2024, up from 45 in 2021. But HIV services generally were not being tailored for specific sub-populations, such as women, gay men and other men who have sex with men or transgender persons. Stigma and discrimination against incarcerated people, people living with HIV or LGBTQI+ people were major challenges.

165. Other challenges included limited data and monitoring; legal and structural barriers (including overuse of incarceration and pretrial detention, and imprisonment for nonviolent offences); lack of political will and lack of funding and resistance to legal reforms; insufficient continuity of care; and limited civil society engagement, he said.

166. Joint Programme activities had led to or supported several achievements, the PCB was told, including: normative guidance for service delivery, stronger advocacy, the review and improvement of policies; increased technical assistance; and capacity building for partners, including civil society organizations. UNAIDS Cosponsors had also developed technical and other guideline publications and tools, including for HIV, viral hepatitis and STI prevention, testing, treatment and care, and for prevention of vertical transmission of HIV, among others.

167. Doreen Namyalo Kyazze, from Penal Reform International, told the meeting that addressing the rights and health of imprisoned people was a moral imperative and public health necessity and that their health and rights were integral to the broader HIV response agenda. Highlighting the potential contributions of civil society organizations, she said the newly created informal penal health working group would seek to ensure that the needs of people in prisons are heard and addressed in global forums. This was an opportunity to place prison health more firmly on the health and HIV agenda and to ensure that the global HIV response is truly inclusive, she said.

168. Recommendations from the report included: the development of standard tools and indicators for routine tracking and measuring progress; stepped up Joint Programme advocacy for prison health and criminal justice reform, including around pretrial incarceration; and the removal of discriminatory laws.

169. In discussion from the floor, members and observers thanked UNODC for the excellent report.

170. Speakers shared country evidence of the high rates of viral hepatitis infection in prisons, along with high levels of stigma, discrimination and violence. A chronic lack of access to clean syringes and condoms in prisons, and the exposure of both men and women to sexual and other forms of violence were highlighted. Prison health had to be placed more firmly on the public health and HIV agenda, speakers said. They called on governments to align their prison health systems with international human rights standards.

171. Also highlighted was the value of improving the collection and sharing of health data for prisons and of introducing policy and legal changes to improve the health of prisoners. Speakers recognized, however, that this work was difficult, not least because it required stronger political and collaboration across government sectors.

172. Governments were urged to apply the principle of compassionate justice and reduce the use of imprisonment for petty and nonviolent offences by considering alternatives to imprisonment. People who use drugs were especially overrepresented in prisons, with hundreds of thousands of people incarcerated for the possession of small amounts drugs, speakers told the PCB. They urged governments to consider decriminalizing drug use, sex work and consensual same-sex relations. The scientific evidence showed the benefits of decriminalization, they said.

173. Governments and other donors were asked to ensure that the prison-related HIV work of UNODC and partners continues to be funded. Speakers noted that the new guidelines and tools provided by the Joint Programme could be used to reshape prison health policies.

174. Some members shared details of steps taken to improve access to HIV and related health services, including PrEP, in prisons. They noted, though, that many challenges remained, especially for violence prevention and the provision of harm reduction services.

175. A European country reported that it included improved ARV access and the introduction of Hepatitis C Virus treatment and opioid agonist therapy treatment in prisons. A representative from an European country described its success in providing harm reduction services in all state prisons, and peer education done with nongovernmental organizations. HIV prevalence in prisons had fallen steeply afterwards. A country in Central Asia was working with prison authorities regarding HIV services in and outside prisons, including information and education, testing and harm reduction services for HIV and hepatitis C. These and other changes had helped reduce HIV prevalence in prisons from over 2% to under 0.8%, the PCB was told.

176. The representative from a Latin American country described actions taken to strengthen cooperation between the Ministries of Health and Justice to improve services for HIV, viral hepatitis and other STIs, and tuberculosis. Special training for prison officials had also been introduced, including for reducing stigma and discrimination.

177. In reply, Ms Soltani thanked speakers for their important observations. She noted that prison data were incomplete and not sufficiently disaggregated yet. She also acknowledged that the coverage of HIV services was still too low to be making an impact on the HIV epidemic overall.

178. Mr Salah reminded the meeting that the systematic neglect of the health of people in prison had become especially obvious during COVID-19. The integration of prison

health data in the health information systems was important, including for mobilizing more resources, he noted, adding that services had to be accessible, acceptable and of good quality if they were to achieve the required impact.

179. He also stressed the importance of multisectoral work and of integrating the work of different sections of the health system. Since prison health was the responsibility of health providers on both sides of the prison wall, integration between prison health services and the overall public health system was vital, he said.

180. Replying to a question, Mr Salah explained that the HIV prevalence cited in the current report appeared to be lower than the figure reported in 2021 because the latest estimates were for median prevalence, whereas the previous estimates had been for mean (or average) prevalence. In addition, a different statistical model had been used to calculate the latest estimates.

6. Evaluation Office annual report and UNAIDS management response

181. Adam Ruiz Villalba, Director of Independent Evaluation, UNAIDS, introduced the item by briefly recapping the background to the creation of the evaluation function and its current functions within UNAIDS. Jyothi Raja Nilambur Kovilakam, Senior Advisor, Independent Evaluation, UNAIDS, then presented the annual report and said that 2024 had been a transition year for the Evaluation Office, with two evaluations and one review carried out in 2024, and one evaluation moved to 2025.

182. The completed evaluations were the joint evaluation of the Global Action Plan for healthy lives and well-being for all (SDG3 GAP), which had been led by WHO with 13 SDG3 GAP signatory agencies. It had recommended two pathways: either close-out the GAP or develop a new framework. Most of the agencies had opted for the first option. Ms Kovilakam summarized the other findings and told the meeting that the full report was available at UNAIDS Website.

183. The second completed evaluation was a mid-term Secretariat evaluation of the Cooperative Agreement (2021–2026) between UNAIDS and the United States Centers for Disease Control and Prevention. It found that the agreement was proceeding well but that implementation varied between countries and strategic areas. Further improvement of community-led monitoring was among the five recommendations in the report.

184. In addition, a report on the review of the Joint Programme evaluations and assessments (2020–2024) had been done as the first step of the evaluation on the role of the Joint Programme in sustaining the response to HIV planned for 2025. It showed that UNAIDS excelled in global leadership on HIV, strategic information and advocacy. However, internal coordination challenges (between the Secretariat and Cosponsors), resource constraints and external factors hindered progress toward achieving several programmatic objectives.

185. The Joint Programme's operating model was found to have strengths (multisectoral collaboration) and weaknesses (coordination gaps, data inconsistencies and resource allocation inefficiencies), with UN reforms and an evolving global health landscape adding complexity. The current operating model required significant adjustments to enhance efficiency, accountability and long-term sustainability, Ms Kovilakam reported.

186. Ms Kovilakam said that the findings of the review of the UNAIDS Joint Programme evaluations and assessments, undertaken by the Evaluation Office, would feed into the work of the High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response, as would the management response. The High-Level Panel had started its work in October 2024

and was expected to provide a set of recommendations on the operating model of the Joint Programme by April 2025, which will be received by the Executive Director and the CCO. Based on those recommendations, the Executive Director and the CCO would report back to the 56th meeting of the PCB in June 2025 on the revisiting of the operating model for consideration by the Board.

187. Noting that some PCB members had pointed to overlap between the work of the High-Level Panel and the Joint Programme evaluation, she said the Panel's work did not substitute that of the evaluation. The latter would proceed as per the PCB-approved work plan. She asked the PCB to help ensure the utility of the evaluation and its findings for the Joint Programme and to not regard it as merely another exercise. Regarding expenditures, she said that 85% of budgeted allocations had been expended.

188. Continuing, Mr Villalba provided an update on the Evaluation Expert Advisory Committee. Two of the committee members' appointments were coming to an end and another member was withdrawing for six months, he said. Nomination for the PCB NGO delegation had been submitted for the approval from the PCB. The Evaluation Office and PCB Bureau had agreed that the Committee would remain fully functional with five members. He also reminded the PCB that the Evaluation Office had been moved to Bonn, Germany, and a new Director had been appointed in August 2024. Looking ahead, he said the review of the UNAIDS Evaluation Policy (to be done every four years) was falling due again; a peer review of the evaluation function was required so the policy can be reviewed in 2025.

189. Mr Villalba said the Evaluation Office would continue to strengthen the evaluation culture across the Joint Programme, as well as seek to decentralize and strengthen the use of evaluations by partners. It hoped to introduce new ways of working, including through using an "evidence gap map" to increase the value and utility of evaluations. It also hoped to introduce new work methods and approaches.

190. Mahesh Mahalingham, Chief of Staff at UNAIDS, said 2024 had been a year of transition for the Evaluation Office and that UNAIDS was happy to welcome Mr Villalba to his post as Director of Independent Evaluation. The management responses to the specific evaluations were being developed in consultation with the partners involved, he said, and that the Secretariat was fully supportive of the proposed professional peer review of the evaluation function.

191. The Chair opened the floor for discussion. Speakers commended UNAIDS for its commitment to the evaluation function, thanked the Evaluation Office for its report and congratulated it on implementing its planned activities despite being in transition. They praised the Evaluation Office staff for their excellent work and asked the Executive Director to ensure that the Office is sufficiently funded. They also asked UNAIDS management to speed up the development of its responses to the various evaluation reports it had received.

192. Stressing the importance of good governance and strong accountability frameworks, speakers said they were encouraged by the commitment to strengthen evaluation tools. They also appreciated the clear findings of the completed evaluations, including those regarding the added value of the Joint Programme.

193. Speakers commended the Joint Programme for the achievements highlighted in the evaluation, including its considerable success in advocacy, mobilizing global leadership for the HIV response, managing and disseminating vital strategic information, and supporting social mobilization. However, there were concerns about findings regarding weaknesses in coordination and resource allocation.

194. Speakers suggested that the findings showed a need for significant adjustment to the current operating model in order to strengthen efficiency and accountability and build long-term institutional and financial sustainability. Referring to apparent coordination difficulties, they asked whether the current division of labour was clear enough to avoid duplication. Financing shortfalls also remained a significant problem and were hindering the full realization of programmatic goals, they said.

195. Speakers commented that the full evaluation on the role of the Joint Programme in sustaining the response to HIV in 2025 would be able to explore those issues in greater depth and provide important inputs into PCB decision-making on how to make the Joint Programme more sustainable, resilient and fit for purpose. They agreed that this evaluation was different from the work of the High-Level Panel and would complement the latter's recommendations.

196. Speakers said they were pleased to see the encouraging results from the review of the cooperative agreement between the Joint Programme and the CDC, which confirmed that PEPFAR investments were yielding positive outcomes and results. Referring to the SDG 3 GAP evaluation, they said they looked forward to hearing the Secretariat's perspectives on the findings and how it intended to address the shortcomings noted in the evaluation.

197. They also welcomed the acknowledgement of the vital contributions of community organizations on monitoring but noted that the findings also showed urgent need for further action. Community-led monitoring was important, including for reducing stigma and discrimination and for highlighting persistent gaps in capacity and funding. They said communities were ready to be held accountable but warned that shrinking civic space was preventing community-led organizations from operating effectively.

198. Speakers said they supported maintaining accountability lines through the planned peer review of the evaluation function, and other planned actions. They recalled the positive findings of the MOPAN regarding the establishment and operations of the Independent Evaluation Office and evaluations that had been conducted. The Secretariat was asked to make every effort to ensure that the peer review was done in 2025.

199. The Evaluation Office was asked for clarification about the total budget allocated to the various evaluations, as well as the role of the Evaluation Expert Advisory Committee in relation to the Independent External Oversight Advisory Committee.

200. In reply, Mr Villalba thanked speakers for their comments and addressed the issues raised. He said the management responses to the evaluations completed in 2024 might take some time and that the role of community-led monitoring could be examined more closely in one of the planned evaluations. The Evaluation Office would clarify the expenditures and provide additional tables for review, and it would continue its strong relationship with Cosponsors, he told the PCB. The peer review in 2025 would be a key exercise for the evaluation function and required full participation in the process, he said. Ms Kovilakam added that the Office had been approached by some countries regarding placing greater emphasis on community engagement and community-led monitoring in the evaluations.

201. Mr Mahalingham said the Secretariat shared the PCB's appreciation for the work of the Evaluation Office and assured the meeting that it took the evaluations very seriously. He said the Secretariat and Cosponsors also invested a great deal of work in supporting the evaluations, processing the findings and incorporating them in their respective work areas. Referring to the GAP report, he said a meeting of all 13 principal signatories had been called to discuss the evaluation report and agree on a way forward.

7. Next PCB meetings

202. Morten Ussing, Director of Governance UNAIDS, presented the themes for the thematic segments of the PCB meetings in 2025, as well as the dates for the 60th and 61st PCB meetings. He described the process by which the themes of the thematic segments are decided. Five proposals had been received in 2024 and the PCB Bureau had agreed on the two topics for 2025, based on four criteria (broad relevance, responsiveness, focus, and scope for action):

- Beyond 2025: Addressing health inequities through sustained HIV response, human rights and harm reduction for people who use drugs— for the 56th PCB meeting in June 2025; and
- Beyond 2025: long-acting antiretrovirals: potential to close HIV prevention and treatment gaps—for the 57th PCB meeting in December 2025.

203. The next PCB meeting dates had also been selected: 29 June – 1 July 2027 (60th PCB meeting) and 14–16 December 2027 (61st PCB meeting).

204. Speakers supported the dates set for the forthcoming PCB meetings. They thanked Kenya for hosting an excellent meeting and thanked the Secretariat for its capable organizing of the meeting.

205. Referring to the decision points for this agenda item, the Russian Federation said it dissociated itself from decision point 9.1a. It asked that this be reflected in the report and in the decision points.

8. Election of Officers

206. Mr Ussing, Director Governance, UNAIDS, informed the meeting that 21 Member States were eligible for election as officers of the Board. After explaining the process for selecting officers of the Board, he said expressions of interest had been received from the Netherlands to serve as vice-chair and Kenya to serve as Rapporteur, while Brazil would assume the role of chair in 2025.

207. Five new delegates for the NGO delegation for 2025 to 2026 had been confirmed. For Africa: Humanity First Cameroon; for Asia and the Pacific: Youth LEAD; for Europe: Trans Europe and Central Asia; for Latin America and the Caribbean: Organizacion Llanto, Valor y Esfuerzo; and for North America: National Native America HIV Prevention Center.

208. He thanked the outgoing PCB NGO delegates for their excellent services.

209. In discussion from the floor, speakers thanked the outgoing NGO delegates for their crucial contributions and Kenya for its excellent chairing of the PCB meetings and its warm hosting of the 55th PCB meeting. They also paid tribute to the important work of civil society and the support of the Joint Programme, WHO and the Global Fund.

210. Referring to the decision points under this agenda item, the Russian Federation said it dissociated itself from the decision points. It asked that this be reflected in the report and in the decision points. The Chair thanked the PCB for supporting Kenya in its role as Chair and wished the incoming Chair the best.

Thursday 12 DECEMBER 2024

10. Thematic segment: Addressing inequalities in children and adolescents to end AIDS by 2030

211. The thematic segment discussed the inequities and other factors that are barriers to progress in ending AIDS in children and adolescents by 2030.

Introduction and keynote addresses

212. The moderators for the session were: Shaffiq Essajee, Senior Adviser on HIV and specialist on child health at UNICEF, and Ikpeazu Akudo, Team Lead for HIV, Tuberculosis, Hepatitis & STIs at the WHO African Region Office.

213. Angeli Achrekar, Deputy Executive Director for Programmes, UNAIDS, said there had been major progress, with vertical transmission programmes averting about four million new infections in children since 2000. Yet the HIV response was not performing well enough for adolescents and children. Every HIV infection in a child was preventable, she said, yet 120 000 children acquired HIV in 2023, more than 80% of them in sub-Saharan Africa. Almost half the children living with HIV were not yet on treatment. As a result, children accounted for 3% of people living with HIV, but 12% of AIDS-related deaths, she added.

214. This amounted to more than a biomedical challenge, Ms Achrekar said. Children's and adolescents' rights had to be upheld and the inequities, gender-based violence and HIV-related stigma affecting them had to be addressed. According to her, there are behavioural and structural barriers that must also be addressed. Funding gaps were also holding back vertical transmission programmes. Spending on HIV programmes for children and adolescents in low- and middle-income countries was US$ 1 billion below the level needed.

215. A video was screened with a contribution from South Africa's Minister of Health, Aaron Motsoaledi. He said the ambition to end AIDS by 2030 was under threat if countries did not overcome the inequalities that lead to inadequate services, care and support for the young. He said South Africa had made major gains against the epidemic. Its programme for preventing the vertical transmission of HIV was the largest in the world and had reduced the vertical transmission rate from 31% in 2000 to a little over 2% in 2024. However, treatment and care services were not reaching all the children and adolescent in need. In 2023, the treatment cascade was 96–79–95 for adults but 87–80–70 for children and adolescents. More than 150 000 children were living with HIV in 2023 and more than 6500 children acquired HIV in that year.

216. Referring to the Global Alliance to End AIDS in Children by 2030, he said the collaboration had led to the launch of South Africa's national plan to accelerate and refocus its HIV response for children and adolescents.
About 80% of children receiving HIV treatment had been transitioned to new Dolutegravir regimens, treatment regimens had been simplified, and treatment adherence support was being strengthened. Stigma and discrimination remained pervasive barriers, however. Mr Motsoaledi described the multisectoral approach taken and the tools and programmes that were being used to reduce HIV-related stigma.

217. He added that adolescents living with HIV faced numerous intersecting challenges, with girls especially affected, but said that empowerment through education, skills and economic opportunities, could help break the cycle of poverty and inequality. He described the steps taken to protect adolescent girls in schools, as well as an extensive social protection system which includes large school feeding schemes. Comprehensive sexuality education was being implemented in schools in all nine provinces so adolescents could have the age-appropriate knowledge and skills for making informed decisions.

218. Sitsope Adjovi Husunukpe, Executive Director of the Positive Children, Adolescents

and Youth Network, Togo, said ART coverage was only 35% among children living with HIV in western and central Africa. A lack of suitable policies, programmes and interventions was killing children and adolescents, she said. After paying tribute to Patrick-Alain Fouda, an AIDS activist who had died recently, Ms Husunukpe said people living with HIV were determined to change the laws, structures and policies that discriminated against them and denied them their rights and dignity. She described discovering, as a child, that she was HIV-positive and that her parents had died of AIDS-related causes. The solidarity and support of her peers had enabled her to survive and build her resolve, she told the PCB. A new generation of young people was committed to ending inequalities and oppression, she said and called for more investment in effective approaches for preventing new infections, bridging treatment gaps and educating adolescent girls and young women. She insisted that affected populations had to be actively involved in the decisions affecting them. Adolescents were not “beneficiaries”, they were actively trying to improve their lives, she said.

Session overview

219. This session provided the highlights from the thematic segment background note. It included an analysis of the needs, gaps and challenges of an accelerated response to AIDS in children and adolescents, as well as an update on the epidemiological status of HIV among pregnant and breastfeeding women, children, and adolescent girls and boys.

220. Mary Mahy, Director of the Data for Impact Department at the UNAIDS Secretariat, insisted that it was possible to end AIDS in children. The biomedical interventions existed for achieving that goal, but the societal and structural gaps had to be closed. She highlighted four elements: reducing HIV incidence in women; preventing vertical transmission of HIV; testing HIV-exposed children; and closing the gaps for children who are living with HIV but are not yet on treatment.

221. Much of the burden of paediatric AIDS was in sub-Saharan Africa, Ms Mahy said. In 2023, there had been an estimated 50 000 new paediatric HIV infections in eastern and southern Africa, 48 000 in western and central Africa, and 19 000 children in the rest of the world. As HIV incidence drops, she explained, fewer women living with HIV are bearing children—and fewer children are exposed to HIV. A strong decline in new HIV infections in women was underway in eastern and southern Africa, but progress was slower in western and central Africa. Vertical transmission can also be prevented by ensuring that women living with HIV are on treatment, she said, but ART coverage was much lower in western and central Africa (54%) than in eastern and southern Africa (94%). Consequently, the reduction in vertical transmission differed widely in those two regions.

222. Most new infections in children in southern and eastern Africa were related to mothers acquiring HIV during pregnancy or breastfeeding or not getting ART, she continued. That could be prevented with PrEP, with counseling and testing, and with referral to treatment. In western and central Africa, most new infections were due to pregnant women living with HIV not getting ART. That could be addressed by expanding access to antenatal care and ensuring women can access HIV testing and receive treatment. However, antenatal care and HIV testing access in western and central Africa remained low.

223. Ms Mahy said there were huge gaps in testing HIV-exposed children within their first two months of life. Globally, about 600 000 children living with HIV were not receiving ART; almost two thirds of them were aged 5–14 years. Treatment coverage among children with HIV was 42% for 0–4-year-olds, 60% for 5–9-year-olds, 67% in 10–14-year-olds, and 64% for 15–19-year-olds.

224. It was crucial to address the continued risk of HIV infection, including among adolescent girls and young women. The HIV-related disadvantages affecting adolescent girls and young women were evident already among 15–19-year-olds. Globally, they were twice more likely to acquire HIV compared with their male counterparts and in sub-Saharan Africa they were five times more likely to do so. Adolescent girls and young women were also heavily affected by intimate partner violence, which increased the risk of HIV acquisition, she said. Condom use among non-regular partners was low for women, with a lack of HIV education and comprehensive sexuality education and poor access to services among the main reasons.

225. Priorities included reducing inequalities and providing stigma-free HIV and health services, along with combining HIV testing services with antenatal care, and improving maternal care for breastfeeding women living with HIV. Children exposed to HIV should be tested early and often, Ms Mahy said, and the cost of testing had to be reduced for pregnant women and children. More support was also needed to help with the difficult transition from childhood to adolescence and adulthood for children on treatment.

226. Meg Doherty, Director, Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes at WHO, highlighted five areas that should be stepped up: diagnosis and treatment for children and adolescents; integrated services; support for communities to lead; more targeted investments; and knowledge about the evolving epidemic among children, adolescents and pregnant women. Among the main gaps and barriers, she cited limited training for paediatric care; services that are too centralized and not tailored for the needs of adolescents; consent issues for testing and sexual and reproductive health services; limited services for young key populations; and data gaps. Structural issues included gender inequalities; intimate partner violence; and barriers blocking access to sexual and reproductive health services for adolescents and young adults. Funding gaps and insufficient commitment from leaders added to the difficulties, she said. Programmes in low- and middle-income countries were being underfunded by about US$ 1 billion annually.

227. Ms Doherty highlighted several proven ways to close the gaps. First was testing infants and children who have been exposed to HIV and linking them to care and treatment, if needed. Innovations were available, she said, including early infant diagnosis and improved paediatric case-finding through index testing and provider-initiated testing in settings where sick children present for care. For children who test HIV-positive, highly effective Dolutegravir regimens were the standard-of-care and triple fixed-dose combinations were available.

228. Secondly, services should be decentralized and integrated more thoroughly with primary health care. The triple elimination initiative was an opportunity to take this work forward, she said. For key populations, HIV care would be more effective when integrated with community-led care via one-stop-shop services. Thirdly, communities needed support to lead activities. Fourthly, targeted investments had to increase, including from domestic sources. More funding was needed for PrEP for adolescent girls and young women, for key population programmes and for economic support. Fifthly, countries had to track their evolving epidemics, disaggregate the data, follow mother-infant pairs over time, and link health data across health services.

229. Members and observers thanked the presenters and said it was unacceptable that 120 000 children were acquiring HIV each year and that so many children living with HIV were not receiving treatment. HIV programmes still seemed to be oriented primarily towards adults, they said. The situation in western and central Africa was highlighted, as were the challenges faced by adolescent girls, especially those with children, and

their need for supportive and tailored services. Speakers referred to the special challenges faced in countries with low HIV prevalence and where health-care providers have less experience with HIV in children. Speakers noted the need for comprehensive sexuality education and for removing structural barriers but asked how this could be done in the current political climate.

230. Some speakers (including China, Dominican Republic and the Islamic Republic of Iran) shared information about their efforts to end AIDS in children, including improving access to new paediatric diagnostics and treatment, as well as social protection support.

231. In reply, Ms Doherty said stigma (including self-stigma) remained a vexing problem and was proving difficult to reduce in the health-care workforce, though there were some examples of success.

Round table 1: Addressing remaining barriers to eliminating vertical transmission of HIV

232. This session discussed solutions for specific challenges to eliminating vertical transmission of HIV, including triple elimination, with a focus on data use, improved outreach to marginalized women, improving outcomes in adolescent girls and young women, and tackling incident HIV infection in pregnant and breastfeeding mothers.

233. Mariana Iacono, International Community of Women Living with HIV Latina, Argentina, recalled the evolving policies for eliminating vertical transmission and said more holistic approaches were needed. Violence against women had to be tackled and mental health support—including for women dealing with post-partum depression and for children and adolescents with depression—was key but remained scarce. Pregnant women's and mothers' right to health information had to be met, she said.

234. Dvora Joseph Davey, from the Desmond Tutu HIV Foundation & University of Cape Town, South Africa, said pregnant and breastfeeding women's heightened risks of acquiring HIV were due to a range of factors, including violence, stigma and gender inequalities. She called for a stronger focus on primary prevention, including access to long-acting PrEP. Modeling showed that provision of long-acting Cabotegravir during pregnancy could reduce HIV incidence in pregnant and breastfeeding mothers by 40%, she said, while two doses of Lenacapavir could prevent HIV acquisition in both mother and infant during pregnancy. Primary prevention was also vital for the hepatitis B and STI epidemics. She reminded the meeting that syphilis was associated with adverse pregnancy outcomes, including stillbirths and neonatal deaths, and increased risk of HIV acquisition and vertical transmission. Syphilis screening during pregnancy and timely treatment were critically important and had to be integrated with antenatal care, she said.

235. Artur Olhovetchi Kalichman, from the National Department of HIV/AIDS, Tuberculosis, Viral Hepatitis, and Sexually Transmitted Infections in Brazil, said the country's HIV treatment programme spanned 27 federal units and over 500 municipalities. He described the HIV services and commodities provided by the health system, including for eliminating vertical transmission of HIV (and syphilis), and said about 60% of pregnant women with HIV knew their HIV status ahead of attending antenatal care. A subnational process for the elimination of vertical transmission, starting at municipal levels, was underway. To date, seven federal units and 151 municipalities had been certified either for the elimination of HIV and/or syphilis and hepatitis B.

236. Soeurette Policar, of the Civil Society Forum Observatory in Haiti, told the PCB that Haiti was experiencing very difficult political and security conditions and that many

health centres and hospitals had been closed. Over 800 000 people had been displaced and many of them were struggling to get medication and services in extremely unsafe conditions, with health workers being attacked, killed, raped and kidnapped. The Ministry of Public Health, with international partners, had set up a crisis unit to find people who were missing from HIV treatment programmes. Centres had also been set up to assist displaced people in camps. His organization was providing both PrEP and ARVs for women. Ms Policar appealed for international support to assist the health services and provide protection for health workers and citizens.

237. Members and observers thanked the presenters for their contributions. Several members (including Cambodia and Kenya) described their progress in reducing vertical transmission of HIV and/or syphilis and affirmed their determination to end AIDS in children. The elimination of vertical transmission requires that women can make informed decisions about their body without fear of coercion or force, speakers said; however, health systems were failing to uphold the dignity and rights of women and girls and too often prioritized control over care. They insisted that sexual and reproductive health was a fundamental right and had to be integrated with services for HIV. Integration promoted open dialogue about sexual health, helped reduce the stigma surrounding HIV and sexual health, boosted service use, and improved health outcomes, they said. The value of integrating mental health in HIV service delivery was also noted, along with the importance of using a person-centred approach to service delivery and meaningfully engaging adolescent girls and young women, including as mentors.

238. In reply to a question regarding the availability of tools and guidance on children's and adolescents' health, the WHO representative said extensive, evidence-based normative guidance and other publications for children and adolescents were available and were updated regularly. Replying to a question, Ms Kalicham said the treatment cascade for children and adolescents in Brazil performed more poorly than for adults. However, once children living with HIV had been identified, diagnosed and linked to treatment, coverage was very high.

Round table 2: Addressing inequalities in access to treatment and care services for children and adolescents

239. The session discussed solutions to challenges in identifying and effectively treating children and adolescent girls and boys living with HIV.

240. Umahi Godwin, Paediatric and Adolescent HIV Services, Nigeria National Programme Implementing Partner, Nigeria, said that, in 2020, only 35% of pregnant women in Nigeria had accessed antenatal care at health facilities which also provided services for preventing vertical transmission. The vertical transmission rate was 23% and only 35% of children living with HIV had been diagnosed. He described how a data-driven process was being used to improve testing for HIV-exposed infants at health-care facilities that were experiencing major service gaps. This included improvements in the district health information system to enhance data capture and link the data to training when issues were identified.

241. Gibstar Makangila, Circle of Hope, Zambia, told the meeting that faith-based organizations, had great reach, trust and local knowledge—and were the biggest "low-hanging fruit" available to the HIV response. She urged HIV programmes to foster partnerships with churches and mosques to build awareness and demand for the kinds of HIV services.

242. Tumie Komanyane, Frontline AIDS, Botswana, said the lives and circumstances of

adolescents and young people were constantly changing and emphasized the value of meaningfully engaging them. Programmes should draw on indigenous systems of knowledge when deciding what types of services and approaches to use. She also highlighted the value of improved data collection and advocacy for adolescents and young people, and of linking them to livelihood and income-generating activities. She suggested that UNAIDS consider moving the thematic segment to Day One of future PCB meeting to ensure better attendance.

243. Ayu Oktariani, Indonesia Positive Women Network, Indonesia, said that stigma was pervasive and had a huge impact on children living with HIV. It forced some children to leave school, while caregivers often lacked the knowledge to support children due to their own fears and self-stigma, leaving children stranded. A lack of palatable ARVs for children also undermined treatment adherence, she said, while mothers were often blamed for transmitting HIV to their children, which isolated them and their children. Education systems and curricula should help ensure that children living with HIV are safe from stigma and victimization, she urged.

244. In discussion, speakers commended the presentations and personal testimonies and insisted that every child and adolescent living with HIV must get the treatment and care they need. Levels of ART coverage and viral suppression among children were much too low. The necessary resources had to be allocated to the most effective programmes to end AIDS among children, they urged. A speaker described the work of the Gap-f network, which sought to accelerate the treatment roll-out for children, including by facilitating timely transitions to the best available ARV regimens. An important recent development (given the supply problems for optimal paediatric ARV regimens) was the approval granted to a generic manufacturer to produce paediatric Abacavir/Lamivudine/Dolutegravir (ALD), which brought to four the number of pre-qualified licensed generic manufacturers for this breakthrough ARV. Speakers also referred to the value of stronger coordination between providers of paediatric and adult HIV services to prevent treatment interruptions; the ways in which stigma and legal and policy barriers limited access to testing, treatment and prevention services; and the importance of systematically addressing coinfections of HIV, hepatitis B and C, and syphilis.

245. In reply to a remark that not all faith leaders supported the use of HIV prevention tools, Mr Makangila called for stronger collaboration between different faiths around common values such as empathy, love and compassion. Each faith system could then seek to advance those values in the ways that fit it best, she suggested. Responding to a question regarding which interventions and approaches were dispensable, panelists said short-term funding cycles should be abandoned, along with working in isolation and competition. If programmes were integrated more effectively at community and facility levels, resources could be managed and used better, they said. They emphasized the importance of improving access to HIV testing and diagnosis for children and making supply chains more resilient and efficient. Investments in the lives and wellbeing of children, adolescents and mothers were investments in their communities and societies, the panelists said. They urged donors and governments to earmark and ring-fence funding for children and adolescents.

Round table 3: Financing the response to AIDS in children and adolescents

246. This panel discussed financial investments in ending AIDS in children, the funding gaps and opportunities.

247. Thembisile Xulu, National AIDS Council, South Africa, said her country was making strong progress towards ending AIDS among children but faced a dilemma of how to

ensure ethical financing in the face of budget constraints and competing priorities. South Africa had reduced perinatal transmission to under 2.5%, Ms Xulu said, and had expanded early infant diagnosis and access to child- and youth-friendly clinics and services. The national government funded 75% of the HIV response, which included providing ART to over 5.6 million people for free and funding HIV prevention. However, when piloting new technologies and methods, it relied significantly on PEPFAR and Global Fund support, she explained. But donor-driven programmes were not always affordable once they transitioned into nationally funded ones. National programmes tended to prioritize adult-focused services due to the size of the adult epidemic, which often left paediatrics and adolescent services underfunded and deprioritized.

248. Several steps could be taken, Ms Xulu said, starting with generating evidence on cost-effective interventions and packaging it as investment cases that can be "sold" to the national treasury. Other steps include doing costing and integration studies to determine the cost of delivering priority interventions (currently funded by donors) through existing government delivery platforms; and advocating for public financial management reforms, such as creating discrete budget lines and conditional grants that are tied to improved health outcomes so child- and youth-focused spending can be earmarked. It is also possible to prioritize districts for HIV funding, based on indices that include HIV epidemiological, poverty and population welfare data, she said.

249. Annah Page Sango, GNP+ and a member of the Coalition for Children Affected by AIDS, Zimbabwe, said the inequities in HIV testing and treatment for children were due largely to structural barriers. Finding the "missing" children should not be difficult: they were in local communities, in schools and their parents attended churches or mosques; however, stigma and discrimination remained huge problems. Children and adolescents did not fall out of care, she said, they were bullied out of care. Gender-based violence and intimate partner violence were a further challenge; they heightened the risk of HIV acquisition for women and exposure to HIV for children, compromised their care, and traumatized them. Legal barriers were a further difficulty, especially for reaching the children of key populations, she said.

250. Hilary Wolf, PEPFAR, said PEPFAR funded about 47% of the HIV response for children and adolescents in low- and middle-income countries. The support included US$ 210 million for prevention, care and treatment for adolescents; the Lift-up initiative for activities in 12 high-burden western and central African countries; US$ 150 million for the elimination of vertical transmission; and a 10% allocation annually for orphans and vulnerable children care and support. Highly committed partnerships like the Global Alliance were a big priority for PEPFAR, she said. In order to improve the impact and efficiency of existing funding, PEPFAR aimed to emphasize interventions such as case finding and use innovative and evidence-based strategies, including for monitoring and evaluation and for social and economic support. It also intended to promote partnerships, including with government ministries, the faith-based sector and the private sector to have a more coordinated and effective response. According to her, other focus areas include identifying policy and legal barriers and advocating and planning for their removal; and improving the collection and analysis of paediatric-specific data to identify and resolve gaps.

251. Yogan Pillay, from the Bill and Melinda Gates Foundation, said the Foundation provided catalytic support, especially for innovations and approaches that can be taken to scale and that are practical and affordable. New initiatives supported by the Foundation included exploring models for mother-infant care post-delivery; the launch of HIVE, which involves supporting six countries to share lessons and take elimination initiatives to scale; and support for the roll-out of dual HIV-syphilis testing at programme level, including through addressing supply chain issues. Other activities included supporting the South African government's push to have a further 1.1 million

people living with HIV (including children) on ART; working with the Global Fund and Gilead on the procurement of Lenacapavir and making generic versions available at the most affordable price; and working with specific countries to place greater emphasis on children and adolescents in their Sustainability Roadmaps.

252. Speaking from the floor, participants lamented the shortage in funding for ending paediatric AIDS. Every dollar invested in children and adolescents made a difference for them, their communities and the future, they said. Speakers said age-of-consent restrictions were limiting access to health services and putting adolescents at risk. They called for the greater involvement of children and adolescents in HIV programmes and said social media could be used more effectively to reach them with information.

253. In reply, the panelists agreed on the need to ensure that necessary commodities are available for children. They appealed to donors to coordinate their efforts and target the biggest HIV funding gaps for children. They also urged greater efforts to remove the structural and societal hindrances that put children and adolescents at risk. Replying to a question about earmarked funding, speakers stressed the need to protect and prioritize funding for paediatric and adolescent HIV services.

Conclusion and ways forward

254. Lucy Wanjiku Njenga, Executive Director, Positive Young Women Voices, Kenya, said programmes had to reach adolescents before they acquired HIV, intimate partner violence had to be reduced, stronger awareness about the epidemic was needed, and U=U had to be promoted more widely. She called for increased investment, including for peer support systems and community-led organizations. Let communities lead, she said.

255. Christine Stegling, Deputy Executive Director for Policy, Advocacy and Knowledge at the UNAIDS Secretariat, thanked the panelists and participants. She said the global HIV response had come far but progress was stalling for children and adolescents, with sub-Saharan Africa still bearing a disproportionate burden of vertical transmission. She noted the advice about which interventions funders should prioritize and agreed that ending paediatric AIDS must be a bigger priority. She also noted the emphasis on a multisectoral approach and on multilayered, long-term interventions, as well as the reminders that services and programmes had to reflect the fact that children and adolescents are constantly changing as they grow older. Recalling the remark that people do not leave HIV care, but are bullied out of it, she said it was sad that stigma remained such a huge hindrance.

256. It was important to translate the discussions into concrete action, she urged. That could be done by strengthening existing partnerships and forging new collaborations (especially with the faith sector); mobilizing new resources for children and adolescents (and protect the existing funding); and doing more to remove the underlying inequalities. Speakers had also vividly shown the power of community-led work, including peer support activities. Ms Stegling thanked the moderators and organizers and called for renewed urgency and commitment to ending AIDS in children.

11. Any other business

257. There was no other business.

12. Closing of the meeting

258. The Chair noted that 12 December also marked the 60th anniversary of Kenya's independence. He said the world could end paediatric AIDS if it removed societal and structural barriers, ended stigma, put young people and communities in the lead, and invested sufficiently in evidence-based interventions.

259. Members thanked Kenya for hosting the meeting in Nairobi, Bureau members for their work, the Secretariat and the governance team for managing the meeting, and outgoing NGO delegates for their services. They also thanked Member States who had contributed financially to the Joint Programme and paid tribute to Elizabeth Benomar, UNFPA, on the eve of her retirement.

260. The incoming Chair, Brazil, thanked Kenya for its effective chairing of the PCB and thanked the PCB for electing it as chair for 2025.

261. The Chair provided an update on the finalization of outstanding decision points and stressed the importance of striving for consensus, in line with the commitment to inclusiveness in the HIV response.

262. The decision points were adopted.

263. Presenting the closing remarks, Ms Achrekar and Ms Stegling, Deputy Executive Directors for UNAIDS, thanked Kenya for its excellent chairing of the PCB in 2024 and welcomed the incoming Chair, Vice-chair and Rapporteur; the incoming NGO delegates and Member States; the outgoing members of the Board; the incoming chair of the Committee of Cosponsoring Organizations; and the Cosponsors for their support.

264. They paid tribute to Elizabeth Benomar of UNFPA and recognized her extensive contributions during her 29-year relationship with the Joint Programme; thanked Efraim Gómez, Director, External Relations, and former Chief of Staff at UNAIDS, for his service; and recognized the work of the staff of the Kenya Country Office, the communities who had hosted field visits, and the UNAIDS governance team, the IT team and interpreters.

265. The Deputy Executive Directors said the PCB had agreed on important decision points and had highlighted the need to seize the opportunities for ending AIDS, including making long-acting ARVs rapidly available to everyone who needs them. Referring to the High-Level Panel and the next Global AIDS Strategy, they said 2025 presented major opportunities for accelerating and sustaining the HIV response.

266. They thanked donors—including Côte d'Ivoire, Denmark, France, Germany, Netherlands, Spain, United Kingdom and the USA—for their commitment to the Joint Programme and the HIV response. The PCB had kept communities at the centre, including by bringing the experiences of young people, practitioners and activists to the meeting, they said.

267. The 55th meeting of the Board was adjourned.

[Annexes follow]

PROGRAMME COORDINATING BOARD

UNAIDS/PCB (55)/24.24

Issue date: 30 August 2024

FIFTY-FIFTH MEETING

DATE: 10–12 December 2024

TIME: 09:00–18:00 (EAT/UTC+3:00)

VENUE: Nairobi, Kenya, and virtual

Annotated agenda

TUESDAY, 10 DECEMBER

1. Opening

1.1 Opening of the meeting and adoption of the agenda
The Chair will provide the opening remarks to the 55th PCB meeting and will present to the Board the draft agenda for adoption.
Documents: UNAIDS/PCB (55)/24.24; UNAIDS/PCB (55)/24.24

1.2 Consideration of the report of the 54th PCB meeting
The report of the 54th Programme Coordinating Board meeting will be presented to the Board for adoption.
Document: UNAIDS/PCB (54)/24.23

1.3 Report of the Executive Director
The Executive Director will present her report to the Board.
Document: UNAIDS/PCB (55)/24.25

1.4 Report by the NGO representative
The report by the NGO representative will highlight civil society perspectives on the global response to AIDS.
Document: UNAIDS/PCB (55)/24.26

2. Leadership in the AIDS 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 54th PCB meeting

The Board will receive a summary report on the outcome of the thematic segment on Sustaining the gains of the global HIV response to 2030 and beyond.
Document: UNAIDS/PCB (55)/24.27

WEDNESDAY, 11 DECEMBER

4. **Findings of the mid-term review of the Global AIDS Strategy 2021–2026**
The Board will receive a report on the findings of the mid-term review of the Global AIDS Strategy 2021–2026 and an update on the preparations for the development of the next Global AIDS Strategy and UBRAF.
Document: UNAIDS/PCB (55)/24.28

5. **Update on HIV in prisons and other closed settings**
The Board will receive a report on the status of HIV in prisons and other closed settings.
Document: UNAIDS/PCB (55)/24.29

6. **Evaluation report and management response**
The Board will receive the annual reporting from the UNAIDS Evaluation Office and the management response to the annual report.
Documents: UNAIDS/PCB (55)24.30; UNAIDS/PCB (55)24.31

7. **Next PCB meetings**
The Board will agree on the topics of the thematic segments for its 56th and 57th PCB meetings in June and December 2025, as well as the dates for the 60th and 61st meetings of the PCB in 2027.
Document: UNAIDS/PCB (55)24.32

8. **Election of officers**
In accordance with PCB procedures and the UNAIDS Modus Operandi paragraph 22, the Board shall elect the officers of the Board for 2025 and is invited to approve the nominations for NGO delegates.
Document: UNAIDS/PCB (55)24.33

THURSDAY, 12 DECEMBER

10. Thematic segment: Addressing inequalities in children and adolescents to end AIDS by 2030
Documents: UNAIDS/PCB (55)/24.34; UNAIDS/PCB (55)/24.35; UNAIDS/PCB(55)/CRP1

11. Any other business

12. Closing of the meeting

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12 December 2024

55th Session of the UNAIDS Programme Coordinating Board, Geneva, Switzerland

10–12 December 2024

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;

Intersessional decisions:

Recalling that, it has decided through the intersessional procedure (see decisions in UNAIDS/PCB(54)/24.2:

- Agrees that, health situation permitting, the 2024 PCB meetings will be held in-person with optional online participation in accordance with the modalities and rules of procedure set out in the paper, "Modalities and Procedures for the 2024 PCB meetings";

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

1. *Adopts* the agenda;

Agenda item 1.2: Consideration of the report of the 54th PCB meeting

2. *Adopts* the report of the 54th meeting of the Programme Coordinating Board;

Agenda item 1.3: Report of the Executive Director

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

Agenda item 1.4: Report by the NGO representative

4.1 *Takes note* of the report by the NGO representative;

4.2 *Reaffirms* the essential role of communities in the HIV response and *requests* Member States, in close collaboration with community-led HIV organizations and other relevant civil society organizations and partners, with the support of the Joint

Programme, to fast-track targeted and measurable actions towards the 2025 targets;

4.3 Noting with concern that reaching the goal of ending AIDS as a public health threat by 2030 is negatively impacted by declining HIV funding to community-led HIV responses, restrictions on civic space and regression of gender equality and human rights as recognized by international human rights law, and persistent stigma and discrimination in the HIV response, calls upon Member States and the Joint Programme to:[1]

a. Increase and facilitate sustainable, long-term and core financing mechanisms for community-led organizations engaged in the HIV response, with transparent reporting on this financing;

b. Facilitate support, including emergency support, for communities facing human rights violations in the context of HIV;

c. Strengthen collaboration within the Joint Programme and with communities of people living with, affected by and most at risk of HIV to increase support for civic space and human rights, and advance gender equality, noting the importance of the Global Partnership for action to eliminate all forms of HIV-related stigma and discrimination;

d. Reiterate commitment to prioritizing the meaningful involvement of communities, people living with HIV, affected by, or most at risk of HIV, including key[2] populations, and adolescent girls and young women in high burden regions, in the development of the Global AIDS Strategy 2026–2031 and the preparations for the 2026 United Nations General Assembly High-Level Meeting on HIV and AIDS;

e. Reaffirm the importance of and accelerate progress towards the achievement of the 30–80–60 targets;

Agenda item 3: Follow-up to the thematic segment from the 54th PCB meeting

5.1 *Takes note* of the background note (UNAIDS/PCB (54)/24.22) and the summary report (UNAIDS/PCB (55)/24.27) of the Programme Coordinating Board thematic segment on “Sustaining the gains of the HIV response to 2030 and beyond”;

5.2. Noting the importance of sustainable, resilient, well-resourced, health systems and an equitable, multisectoral approach to reach and sustain the end of AIDS as a public health threat by 2030 and beyond, and also noting the difficult health financing context, including high debt-servicing costs, faced, in particular, by developing countries, *encourages* Member States to:

a. Advance, in collaboration with communities and partners, as appropriate, the development of country-owned HIV response sustainability roadmaps;

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[1] The Russian Federation disassociates itself from decision point 4.3.

[2] As defined in the Global AIDS Strategy 2021–2026. Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

b. Advance long-term HIV sustainability planning, especially through the integration of HIV responses into adequately resourced Primary Health Care that includes synergies with sexual and reproductive health and reproductive rights, tuberculosis and other relevant programmes, to meet the needs of all, including key populations;[3]

c. Scale up domestic and international funding for the response, and emphasize that action is needed to ensure political, programmatic and financial accountability and sustainability at all levels, while integrating social contracting models for community-led HIV responses and monitoring;

d. Ensure enabling policies and legal environments that support equitable, accessible, affordable and high-quality HIV services that leave no one behind, supported by community leadership and societal enablers to end HIV-related stigma, discrimination, and gender inequalities and health inequities;

e. Promote sustainable and equitable access to safe, effective and affordable interventions to prevent, diagnose and treat HIV and its co-infections and comorbidities, including to innovative health technologies, for all people, especially in developing countries, facilitating the advancement of local and regional production of HIV diagnostics and therapeutics;

f. *Reaffirms* the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) as amended, and also *reaffirms* the 2001 WTO Doha Declaration on the TRIPS Agreement and Public Health, which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to essential health tools for all, and notes the need for appropriate incentives in the development of new health products;

5.3 *Requests* the Joint Programme to:

a. Continue to support and facilitate countries' efforts to develop and implement holistic, country-owned long-term HIV response sustainability roadmaps;

b. Provide a progress update to the Programme Coordinating Board in December 2025 on the HIV response sustainability roadmaps;

c. Advance timely access to cost-effective, affordable, high-quality, and effective long-acting antiretrovirals worldwide;

Agenda item 4: Findings of the mid-term review of the Global AIDS Strategy 2021–2026

6.1 *Takes note* of the report on the findings of the mid-term review of the Global AIDS Strategy 2021–2026 (UNAIDS/PCB (55)/24.28);

6.2 On the basis of the findings of the mid-term review of the Global AIDS Strategy 2021–2026, the 2030 target-setting process, and the ongoing review of the Joint Programme operating model, and acknowledging the need for coherence and transparency between these parallel processes, *requests* the Executive Director to:

[3] The Islamic Republic of Iran disassociates itself from decision point 5.2b since it may imply recognition, protection or promotion of those behaviours that are unlawful or unethical under its legal system or sociocultural norms, or may contradict its moral and religious values.

a. Present the annotated outline of the Global AIDS Strategy 2026-2031, to be developed through an inclusive and transparent multistakeholder consultative process, for consideration by the Programme Coordinating Board at the 56th PCB meeting in June 2025;

b. Present the one-year transitional UBRAF Workplan and Budget for 2026, within the framework of the current UBRAF at the 56th PCB meeting;

c. Recalling decision 7.5 of the 50th PCB meeting, establish a working group for the development of the next UBRAF to be operational by September 2025;

6.3 Recalling decision 6.5 of the 53rd PCB meeting, *looks forward* to the report of the Executive Director and the Committee of Cosponsoring Organizations at the 56th PCB meeting on the recommendations from the review of the Joint Programme operating model supported by the High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response.

Agenda item 5: Update on HIV in prisons and other closed settings

7.1 *Takes note* of the report on HIV in prisons and other closed settings;

7.2 *Notes with concern* the lack of progress on HIV prevention, treatment and care and the remaining challenges related to HIV-related stigma and discrimination for people in prisons and other closed settings;

7.3 Recalling the decisions from the 49th PCB meeting in 2021, *urges* Member States to renew their commitments to fast-track the implementation of priority actions on HIV in prisons and other closed settings, where applicable, in order to meet the 2025 targets;

7.4 *Further* c*alls on* Member States, with the support of the Joint Programme and civil society organizations engaged and working in the context of HIV and/or prisons and other closed settings to:

a. Collect disaggregated data on epidemiological trends on HIV and related service provision and, as appropriate, report progress through the Global AIDS Monitoring system;

b. Further improve collaboration between prison and public health departments, community-led services and other relevant stakeholders to strengthen comprehensive and integrated HIV, tuberculosis, sexually transmitted infection and viral hepatitis prevention, including the use of pre-exposure prophylaxis, diagnostic and treatment services, and ensure protection of human rights and comprehensive care for people in prison;

c. Create a social, legal and policy framework that contributes to improving prison conditions, including through reducing overcrowding, to reduce HIV transmission and improve HIV and related health outcomes;

d. Increase efforts to eliminate stigma, discrimination, all forms of violence and other human rights violations experienced by key populations and people living with HIV, while expanding care for survivors of violence and promoting equitable access to HIV prevention, testing, treatment and other health care services in prison settings;

e. Adequately prioritize the allocation of resources for comprehensive HIV

prevention, testing, treatment and care in prisons and other closed settings as part of national Sustainability Roadmaps;

7.5 *Requests* the Joint Programme to:

a. Scale up technical support to Member States by building capacity, developing standardized data collection tools, where appropriate, in collaboration with national statistical agencies, and establishing monitoring frameworks to ensure the routine collection of disaggregated data in prisons. Promote collaboration between prison health services and national HIV programmes to assess progress towards the 2025 targets and address data gaps for consistent, data-driven interventions;

b. Provide technical support to Member States for improving the availability and quality of comprehensive, evidence-informed and gender-responsive interventions addressing HIV prevention, treatment and care in prisons;

c. Report to the Programme Coordinating Board, if appropriate, through the annual UBRAF performance reporting, on progress related to HIV among people in prisons and other closed settings;

Agenda item 6: Evaluation report and management response

8.1 *Recalls* decision 7.5 of the 53rd session of the Programme Coordinating Board approving the UNAIDS 2024–2025 Evaluation Plan, as well as decision point 7.10 of the 53rd session of the Programme Coordinating Board requesting the next annual report to be presented to the Programme Coordinating Board in 2024;

8.2 *Welcomes* continued progress in the implementation of the 2024–2025 Evaluation Plan (UNAIDS/PCB (53)/23.30) and the role of the Evaluation Office in generating evidence of the UNAIDS Joint Programme's contributions to results;

8.3 *Takes note* of the summary of the main findings of the evaluations conducted in 2024;

8.4 *Takes note* of the management response to the 2024 annual report on evaluation (UNAIDS/PCB (55)/24.31);

8.5 Recalling decision 7.7 of the 53rd PCB meeting, *appoints* the candidate nominated by the PCB NGO delegation and *agrees* to the full composition of the Expert Advisory Committee proposed by the PCB Bureau for 2025 as mentioned in Annex 1 of the annual report on evaluation (UNAIDS/PCB (55)24.30);

8.6 *Takes note*, with appreciation, in accordance with provision 73 of the evaluation policy, that the UN Evaluation Group peer review will be undertaken in 2025;

8.7 *Looks forward* to the annual report on evaluation to be presented to the Programme Coordinating Board in 2025;

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