Agenda item 1.2

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REPORT OF THE 58TH PROGRAMME COORDINATING BOARD MEETING

UNAIDS

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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 58th Programme Coordinating Board meeting.

Cost implications for the implementation of the decisions: none

TUESDAY 30 JUNE 2026

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-person and virtually on 30 June 2026 for its 58th meeting.

2. The PCB Chair, Erika Schouten, Ambassador, Netherlands, welcomed participants to the meeting. She said the Board was meeting at a time of multiple, profound shifts. A moment of silence was observed in memory of everyone who had died of AIDS.

3. The Chair introduced the Dutch Vice-minister for International Cooperation, Pascalle Grotenhuis, who reminded the PCB that UNAIDS's transition was fundamentally about people, especially those who are most at risk. She said the Joint Programme was working in challenging times, with the international solidarity that once underpinned public health and human rights work under pressure. Conflict and polarization were on the rise. Despite differences of opinion, strong common commitment remained, as shown in the recent Political Declaration to end AIDS by 2030, she said.

4. Assuring the Board that the Netherlands remained a strong supporter of the Joint Programme, Ms Grotenhuis said the interim report of the Working Group showed what must be preserved, not least the power of multisectoral collaboration. While acknowledging concerns that come with change and the importance of preserving what works, she said UNAIDS had to keep up with a changing world, and it was well-placed to seize the moment and lead by example.

5. Scientific breakthroughs of great promise were being made, but their success required awareness and access, Ms Grotenhuis said. Looking ahead, a future-proof, impact-driven model that builds on the strengths of effective and efficient UN cooperation was needed. The model must be financially viable, anchored in human rights and community leadership, aligned with UN reform, and meaningful to people UNAIDS serves, she emphasized. A multitude of experiences and ideas were available to guide the necessary changes, including those of communities and their leaders. The necessary data, experience, political commitment and moral obligation were available, but had to be used well, Ms Grotenhuis said.

6. The Chair briefed the meeting on logistical arrangements and the conduct of proceedings, and recalled the intersessional decisions adopted by the PCB.

7. The meeting adopted the agenda.

1.2 Consideration of the report of the 57th meeting of the PCB

8. The meeting adopted the report.

1.3 Report of the Executive Director

9. Winnie Byanyima, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), welcomed delegates to the 58th meeting of the PCB and presented her report. Reminding the meeting that 149 Member States had voted to adopt the new Political Declaration on HIV/AIDS, she said it was a mandate for delivering on the promise of ending AIDS by 2030. Even in a complex context, UNAIDS retained the power to unite the world around ambitious targets, including a

new commitment to reach 40 million people with antiretroviral (ARV) treatment and 20 million with ARV-based prevention, she told the meeting.

10. Ms Byanyima then summarized key sections of the Political Declaration, noting that the most valuable elements had been protected and adapted to changing conditions in pursuit of strategic objectives. She said the document featured progressive language that had not been agreed in any other multilateral forum, for example on ensuring affordable, timely access to HIV medicines and diagnostics and related health technologies. She insisted that the global response had emerged stronger with the new Political Declaration.

11. The Executive Director told the meeting that the global HIV response was built on solidarity and international cooperation and had saved millions of lives. Of the 40 million people living with HIV, she said, 32.1 million were now on ARV treatment, living long and healthy lives. But that model was under strain. Multilateralism had weakened and the world was in a protracted “inequality-pandemic cycle”, marked by HIV, COVID-19, Mpox, Ebola and other major threats, including a collapse in development financing, and the roll-back of human rights, gender equality and civic space.

12. According to the Organisation of Economic Co-operation and Development, official development assistance fell by 23% in 2025, the sharpest annual drop on record, Ms Byanyima told the Board. UNAIDS data showed serious fragility in country programmes: HIV testing had fallen by 22% in high-burden settings, leaving more people unaware of their HIV status; funding for condoms had been cut by up to 90% in some places; and HIV prevention was being dismantled when it should be scaled up.

13. Protecting human rights was vital, yet key populations were under increased attack, she said, with criminalization again on the rise, undermining HIV services and allowing HIV to spread. Civic space was shrinking and community-led organizations were being forced to shut down. One study across 47 countries had found that community services to the people most in need had been cut by 50–85%, she reported. The effects were being seen in countries, she continued. Most drop-in centres for key populations in Kenya had shut their doors while almost half of those in Uganda had partially or entirely closed. In Zimbabwe, HIV services for female sex workers had collapsed and harm reduction programmes for people who use drugs had been badly disrupted.

14. In the face of these major threats to the HIV response, the Joint Programme continued to support government and communities, Ms Byanyima assured the Board, so they can ensure that everyone in need has access to life-saving services. Despite the challenges, she said she saw “windows of opportunity”, including new tools, new financing routes, revived regional commitment, a new Global AIDS Strategy and the newly adopted Political Declaration on HIV/AIDS, and a United Nations (UN) that was reforming itself through UN80 to become more focused, united and accountable to the people who depend on it. She stressed that countries were stepping forward with renewed leadership and increased domestic investment, but could not succeed alone and continue to require international solidarity and support.

15. The enormous potential of long-acting ARVs was a major opportunity, she said, and UNAIDS was doing everything possible to close the access gap. A further opportunity was a reimagining of HIV financing, including use of the Global Fund Grant Cycle 8 and the new United States (US) Government agreements to sustain gains and rebuild national responses for the long term.

16. Regional initiatives presented another opportunity, she said. The Accra Reset, led by President Mahama of Ghana, the African Union Roadmap, and the Alliance for the Elimination of HIV in the Americas were strengthening health sovereignty. UNAIDS

was closely involved in those initiatives and continued to work with partners, including Africa CDC, the Global Fund and the World Health Organization, she told the PCB.

17. A fourth opportunity, she said, was human rights. At a time of organized pushback, the UN's role in promoting and defending people's rights was indispensable, Ms Byanyima emphasized. At the global level, UNAIDS continued to provide coordinated UN leadership on human rights, gender equality and community leadership for the HIV response to/and ensure that people living with and affected by HIV were not left behind or rendered invisible.

18. A final opportunity was data, which allows countries to programme smartly, target resources where they matter most, and hold actors accountable for results. However, the abrupt funding cuts had disrupted HIV and related data systems. Ms Byanyima said UNAIDS was working closely with governments and communities to track the impact of the disruptions and ensure that gaps in services, financing and coverage are accurately recorded and understood so they can be addressed. She added that UNAIDS played a critical multisectoral role ensuring availability of epidemiological data to know the epidemic; programmatic data to know what works, and who was being left behind; data on policies and laws, to show where rights were upheld and where they were being denied; and financing data showing which investments were needed and where they were needed.

19. UNAIDS was on a transition path, Ms Byanyima assured the PCB, with Phase 1 having started following the report of the High-Level Panel, and before the Secretary-General announced his UN80 reform proposals. With the support of the PCB and the ongoing work of the Working Group, UNAIDS had aligned its transformation with the vision of UN80. She noted that UN80 had moved on from the "sunsetting" language to speak of "transitioning UNAIDS and mainstreaming capacity to protect the HIV response". At its best, UNAIDS represented the best of multilateral cooperation, she told the meeting, and she expressed confidence that the transformation would ultimately strengthen support for people living with and affected by HIV.

20. The first phase of its transition was moving rapidly towards its completion, she said. Of the 15 areas of work that had previously been delivered jointly by the Secretariat and Cosponsors, 11 technical, normative and implementation areas of work were transitioning fully to Cosponsor responsibility. The Secretariat was working closely with Cosponsors to ensure a responsible transition, support continuity of delivery and help sustain those functions during a period of disruption and constrained financing.

21. She told the Board that the Deputy Secretary-General of the UN had recently described the interim report of the Working Group as "excellent" and had indicated support for the emerging consensus that a central entity would continue to be needed to lead and coordinate the HIV response. The Deputy Secretary-General had also noted that UNAIDS's relationship with communities was unique and could not simply be shifted over to others.

22. Cosponsors had also reaffirmed their commitment to the UN's role in the global response and to assuming responsibility for areas where the Secretariat was withdrawing from joint delivery. Ms Byanyima briefly discussed the elimination of vertical transmission of HIV as an example and said other examples included closing positions in certain technical and normative areas, while consolidating the Secretariat's core functions. At the UN General Assembly, Member States had committed to "reinforce and expand" the Joint Programme's "unique multisectoral, multi-stakeholder, development and rights-based collaborative approach to end AIDS by 2030."

23. Ms Byanyima then discussed the four cross-cutting functions—multi-sectoral coordination; leadership and advocacy; accountability, including data and targets; and

community engagement. The functions are interlinked and represent the UN's unique contribution to the HIV response. She noted, however, they would have to be performed differently in the years ahead. She told the Board that the Secretariat was working to double down on its strengths while also consolidating. It had reduced its staff from 671 in early 2025 to 296 and its country footprint from 86 to 54 countries. UNAIDS was not just becoming smaller, it was becoming different. But this had involved very difficult decisions, including for example, the closure of 34 positions linked to data collection and use. She appealed for extra-budgetary support to fill gaps so that UNAIDS could adequately respond to country needs.

24. The transformation was being done in a responsible, transparent and accountable fashion, she assured the Board. Decisions were guided by clear criteria which were applied consistently and documented. The process complied fully with staff regulations and rules, with due process and access to appeal.

25. She then discussed Phase 2, which the Working Group was busy defining. The discussion had moved in a positive direction—from "sunsetting" to preserving the role of the UN in the global HIV response in a transformed manner, she said. This aligned with guidance from the Secretary-General's UN80 initiative and was aimed at joint delivery that was reshaped for the future and more affordable, without abandoning the UN's responsibility.

26. After thanking the co-facilitators of the Working Group, Ms Byanyima discussed its interim report which, she said, emphasized important areas of agreement. It affirmed that the UN mandate on HIV had to continue and that the quest to end AIDS as a public health threat was unfinished. It also identified several directions which it would develop further in the coming months.

27. There was broad convergence on the need for a central hub for leadership and multisectoral coordination of UN action on HIV and on preserving the core functions of the Secretariat and Cosponsors. The report also acknowledged that programme countries have underscored the value of having a single point of entry for support from UN partners and for communicating with them. It recognized the critical role of communities and civil society in national HIV responses and the important work of the Joint Programme in supporting that role. The Working Group has also recognized the unique and indispensable role of communities, civil society in the governance of the Joint Programme. That role, she reminded, was grounded in the ECOSOC mandate, which provides civil society with a formal place alongside Member States and the UN. She urged that ways be found to preserve that unique governance arrangement.

28. Ms Byanyima said the Working Group would also explore a new financing model for delivering the HIV mandate. The model would have to facilitate sufficient financing for a central leadership and coordinating role, as well as for the complementary roles of Cosponsors. The focus was on a realistic and costed transition. She said she looked forward to receiving the final report in October for consideration by the PCB. In closing, Ms Byanyima said the world would not end AIDS through institutions alone. It required people: communities, Joint Programme staff, partners and Member States—exerting leadership in the face of uncertainty.

29. Speaking from the floor, members and observers thanked the Executive Director for her report and congratulated UNAIDS on the successful adoption of the new Political Declaration on HIV/AIDS. They thanked UNAIDS staff for their dedication and diligence. They said the Political Declaration showed that Member States can still come together around shared commitments like HIV. The Declaration reflected the core principles of the HIV response, they said, and those principles should remain at the heart of the response. However, several speakers said they had been

disheartened by the challenging negotiating environment around the Political Declaration and by repeated attempts to introduce language that compromised the human rights focus of the HIV response. They reminded that some countries had sought to remove communities from the response, opposed references to adolescent girls, and resisted naming key populations. HIV responses would not succeed if those views were allowed to prevail, they warned.

30. The PCB was told that 2026 was a pivotal year for the struggle to end AIDS and that stability was needed to overcome the profound challenges ahead. The world had not met the 2025 targets, and it was off-track for achieving the 2030 targets. Major changes in global public health were underway, marked by pressures on countries to transition to greater domestic financing and ownership, speakers said, an abrupt funding cuts were compromising the HIV response, especially in low-income countries.

31. Several speakers described the difficult conditions for HIV responses in their countries and regions, including in eastern Europe, where some countries were also entering the final periods of Global Fund support. They warned that key population services, harm reduction activities, peer outreach and other work of community-led organizations were at risk if external funding declined further and legal and civic space continued to be restricted.

32. Declining funding, shrinking civic space, attacks on people's rights, and increased criminalization and repression, including against LGBTQI people, were pushing communities to the margins again, the Board was told. Speakers described communities being left behind, community organizations being forced to shut down or go underground, leaders being forced into hiding or exile, and prevention activities being suspended because it had become too dangerous to provide them. Communities were increasingly living with fear and facing growing barriers to accessing services.

33. The closures of services for key populations highlighted the need for a strong Joint Programme to counter attempts to erase certain communities, the meeting was told. This crisis called for renewed commitment to evidence-based interventions, for ensuring that vulnerable populations can access health services, and for involving communities as integral parts of primary healthcare systems. Speakers warned that HIV responses would falter if people had to choose between their own safety and access to life-saving services. Community-led interventions were essential, they said, not an add-on. Communities must be meaningfully involved in designing policies, allocating funding and providing services, and many speakers stressed that communities should be partners in shaping and co-creating future HIV responses and institutional arrangements.

34. Members and observers welcomed the shift from "sunsetting" UNAIDS to moving towards a reformed but preserved UN role on HIV. The "sunset" proposal, with a 2026 timeline, had been premature, they said. Hailing the achievements of the past 40 years, they reiterated their commitment to the global HIV response. The HIV movement was unlike any other and had helped achieve gains far beyond HIV, including for sexual and reproductive health and rights, sexuality education, and human rights, they said.

35. Important opportunities were available to accelerate the HIV response, the Board was told, but those innovations should be accessible to all who need them. Speakers insisted that innovation without access was injustice: the HIV response required equitable access to modern ARVs, including generic versions, and the balanced regulation of intellectual property. They also called rebuilding disaggregated data systems and strengthening implementation science that is rooted in community-led

approaches. The global research ecosystem should become more evenly distributed and inclusive, they said.

36. Speakers recognized the difficulty of the first phase of the Joint Programme's transition, which was marked by heavy losses of staff and the closure of Country Offices. They insisted that the transition must preserve what matters most, including the unique strengths of the Joint Programme, its relationship with communities, its multisectoral approach and its support to countries. It must be financially sustainable, and enable continued progress towards ending AIDS as a public health threat.

37. Speakers welcomed the interim report of Working Group and the progress made to date in identifying key areas of agreement and possible directions for future work. Change was not easy, they said, but it was necessary. They urged all parties to support the Working Group so it could carry out its mandate independently and effectively, informed by evidence, analysis and broad consultation. Several speakers emphasized the importance of providing the Working Group with adequate technical support and resources, and sufficient space to complete its task. There was also a request that interpretation and multilingual access be preserved throughout the transition.

38. Speakers lay emphasis on preserving the Joint Programme's convening, governance and coordination functions; its data and accountability role; and its role in ensuring the meaningful involvement and leadership of communities and civil society at the heart of the response. They also stressed the importance of preserving the unique governance role of communities and civil society established through the ECOSOC mandate.

39. A strong HIV response required meaningful partnerships between community networks, governments and international partners, the Board was told. Several speakers emphasized the importance of preserving trusted and accessible spaces through which communities could safely engage with institutions, services and decision-making processes. Meaningful engagement of civil society was essential to keep the response inclusive, rights-based and effective, and the future model had to be rights-based and grounded in the leadership of communities. They emphasized the importance of UNAIDS' role as a platform for communities to engage with governments. Cosponsors said they were committed to work closely for communities to keep civic space open and advance the HIV response.

40. Speakers highlighted the importance of UNAIDS' many data-related functions and its stewardship of global HIV targets, which they said are crucial for accountability in the global response. Accountability must be maintained throughout the transition, they stressed, especially on how resources are allocated and prioritized, how country-level support will be maintained in high-burden and fragile settings, and how risks will be mitigated in cases where critical functions are affected.

41. Speakers said they were confident that a responsible solution could be reached that retains the necessary Secretariat functions within a lean structure, along with a strong focus on national leadership and ownership. They noted that strengthened country ownership and strengthened community leadership are mutually reinforcing and both essential to sustainable HIV responses. They said the transition process must be transparent and accountable and must involve close engagement with communities and civil society. It must also facilitate better spending around clear priorities and must strengthen country ownership of their HIV responses.

42. The changing financing landscape required a rethink of how HIV responses are funded and sustained, speakers said. They appealed for financing that is diverse and predictable and that strikes an appropriate balance between domestic investment and international solidarity. While welcoming efforts to strengthen domestic ownership and

resourcing, they said international solidarity remained essential, particularly for countries with high HIV burdens and limited fiscal space. Germany pledged to remain a reliable partner through technical support and financial contributions and announced a further 6.75-million-Euro contribution to UNAIDS, along with providing JPO staff.

43. Speakers expressed strong concerns about rising persecution and the denial of rights of transgender and other key populations in several countries. In addition, needle and syringe programmes were closing or being cut back, stigma and discrimination remained intense and criminalization was increasing, they told the Board. They appealed to Member States and donors to sustain and expand funding for community-led organizations and harm reduction programmes, and to accelerate drug policy reforms, including decriminalization as a vital structural intervention. One member said that support to community-led organizations must occur in accordance with the national laws, culture, and religious norms of Member States.

44. Several members and observers shared updates on their HIV responses, some of which faced highly challenging conditions. They described actions taken to manage challenges, including earmarking certain tax revenues for HIV, “ring-fencing” some programmes, “frontloading” domestic investments in HIV, increasing community-led activities as part of health sector delivery, and embedding community networks in national health systems through social contracting. They also highlighted the importance of hosting robust UNAIDS Country Offices, including for technical support, advocacy and data stewardship.

45. In reply, Ms Byanyima thanked speakers for their support and comments. She commended the achievements made in many countries but noted that civil society, especially key populations, were being left behind in many places. Criminalization and discrimination were driving communities underground, community organizations were closing, and communities were increasingly living with fear. She stressed that efforts which rendered people living with and affected by HIV invisible would undermine the goal of ending AIDS as a public health threat.

46. While acknowledging the challenges in negotiating the Political Declaration, she insisted that it provided a guiding star for moving the response forward. She assured the meeting that the UN response to HIV would continue and that UNAIDS was committed to make it stronger and more effective. She highlighted the roles of UN entities, especially the 11 Cosponsors, and said all of them, including affiliate Cosponsors, continued to be engaged in the response.

47. She agreed that UNAIDS had to deliver on the transition targets and milestones and noted the commitments to preserve the leadership of civil society, as well as the strong calls for continued UNAIDS support at country level. It was clear that the future construction of UNAIDS must preserve what works and must deliver on the commitments made in the Political Declaration, she said. Ultimately, however, it was up to the Working Group to develop the recommendations that would shape the transition. In closing, she thanked donors for their financial support, especially those making multiyear commitments, and called on other donors to follow suit. She thanked the USA for its commitment to continue investing in UNAIDS.

48. The decision point was adopted.

1.4 Report of the Chair of the Committee of Cosponsoring Organizations

49. Mandeep Dhaliwal, Director of the Prosperity and Well-being Hub, UNDP, said the report covered the current context of the response and the further integration of the Joint Programme into the UN System and beyond, as well as the roles of Cosponsors in working with countries and communities. Cosponsors, she said, saw the transition

and integration as opportunities to strengthen the HIV response, improve coherence and impact, and clarify roles and responsibilities. They believed that the transition should continue to strengthen people-centred approaches, community engagement and multisectoral action, including through greater integration with primary healthcare systems where appropriate.

50. Ms Dhaliwal said Cosponsors wanted to “future proof: the UN's contribution and were already adapting their ways of working accordingly. However, there was a need to clarify roles, responsibilities and operations in a phased, practical way for responsible transition. She said Cosponsors were delivering on their existing divisions of labour and now had an opportunity to drive integration further through their in-country presence, multisectoral mandates, and various partnerships. The six “lead” Cosponsors were active in at least 130 countries, she told the meeting. She reminded that the transition options for the Joint Programme had to be flexible, reflect country needs and capacity, and address inequalities. One-size-fits-all approaches had to be avoided.

51. Regarding community engagement, she emphasized that communities were central to service delivery, accountability, advocacy and rights. In the current financial and political context, community-led responses were critical for reaching the most-affected populations and overcoming structural barriers. Communities should be structurally embedded in governance and decision-making across all aspects of the response. Cosponsors remained committed to partner with community-led organizations, she assured the Board.

52. Ms Dhaliwal said Cosponsors played critical roles across the areas of data, strategy and accountability, including data collection and validation. The intention was to streamline data collection; improve the comparability of estimates; strengthen national surveillance and population data systems; and increase data interoperability across disease programmes and national health information systems.

53. Cosponsors were also committed to scaling the use of prevention and treatment tools, including long-acting ARVs, and to sustaining investment in combination prevention, including through increased domestic financing. They supported the evidence-based use of AI and digital tools, with the proviso that equity, privacy and human rights must be safeguarded.

54. Health sovereignty, she said, must be accompanied by solidarity. Also necessary was a clear division of labour based on Cosponsors’ mandates and strengths. Cosponsors were committed to further analysis on financing and implementation to ensure feasibility, cost-effectiveness and sustainability.

55. Cosponsors were engaging with the Working Group to further develop the transition, which, she said, must strengthen coherence and impact; support country ownership and the roles of communities; protect accountability, data and monitoring functions; prioritize financial sustainability and engagement with communities and civil society.

56. Members and observers thanked the CCO for the report, appreciated Cosponsors’ reaffirmation of their commitment to the HIV response, and agreed with many of the points made. They said UN80 underscored the need for a coherent and efficient UN system in a context of increasing need and constrained resources, with Cosponsors expected to take on UNAIDS’ core functions.

57. Questions were raised about how UNAIDS functions would be carried forward in a future model, and how Cosponsors could take on further responsibilities in relation to the HIV response, particularly in light of ongoing reforms across the UN system. Speakers sought greater clarity about how integration would occur in practice,

including how coherence, accountability, community engagement and support to countries would be maintained across entities with different mandates and responsibilities. Roles, responsibilities and accountability functions would have to be clearly defined, speakers insisted.

58. Speakers also requested further information on how Cosponsors would contribute to future arrangements, including their operational capacities, comparative advantages and ability to assume additional HIV-related responsibilities. Clarification was also sought regarding the continued engagement of “affiliate” Cosponsors how it would be ensured.

59. Speakers called on the CCO to engage actively with the Working Group and contribute practical ideas, analysis and evidence to support its work. They emphasized the importance of working collectively with the Secretariat and communities to develop realistic and actionable ideas for future arrangements.

60. Overall, they said, the future model must preserve the achievements of the HIV response, strengthen accountability and ensure continued and coherent support from the UN system for country responses, especially those with high HIV burdens. Country realities must remain at the centre of all operational decisions, and future arrangements must be responsive to national capacities and needs.

61. Speakers emphasized that country ownership and national leadership were essential, while also stressing the importance of maintaining accountability and protecting human rights. Communities must continue to have meaningful voices in shaping decisions that affect their lives. They welcomed the report’s recognition of the critical role of communities and insisted that their engagement be strengthened across the transition process.

62. Civil society representatives said the Joint Programme’s transition was an opportunity to achieve genuine “co-creation” and institutionalize community-led responses. The transition should not merely involve redistributing functions but should create a stronger role for communities in designing, governing, delivering and holding the HIV response accountable. However, they were concerned that communities might be marginalized in decision-making under future arrangements.

63. There were concerns that communities might be marginalized in decision-making in Cosponsors. Speakers appealed for the inclusion of communities at the highest levels of Cosponsor governing bodies and asked for more clarity on how community engagement would be embedded in those structures. A request was made for analysis of the participation mechanisms that were currently available for civil society in each Cosponsor. Cosponsors were also encouraged to transfer lessons from the HIV response into other areas of work, especially rights-based programming, multisectoral coordination, and community-led activities.

64. In reply, Ms Dhaliwal noted the comments and questions and assured the PCB that Cosponsors’ commitment to end AIDS by 2030 and strengthen the roles of communities remained high. She shared an example of how UNDP was working with national statistical commissions, LGBTQI communities and the World Bank to capture nationally owned LGBTQI-related data. She assured the meeting that Cosponsors had significant capacities that could be more systematically leveraged in support of the HIV response.

65. Angeli Achrekar, Deputy Executive Director of UNAIDS, thanked the CCO for the report and said Cosponsors were also undergoing enormous changes, which made their commitment to the HIV response especially commendable. The HIV response had always been multisectoral and the ECOSOC mandate required the Joint

Programme to coordinate that work. This was not a moment to pit one entity against the other, she said.

66. The meeting adopted the decision point.

2. Leadership in the AIDS response

67. Ms Achrekar introduced the panelists for this agenda item, on human rights barriers, inequalities and sustainability of the HIV response. She referred to the recent adoption of the Political Declaration on HIV/AIDS and its emphasis on human rights, ending stigma and discrimination and inequalities.

68. Adisa Musah from Ghana, speaking from personal experience, told the PCB that stigma, discrimination and fear stopped many people from accessing HIV services. A rise of anti-rights movements was underway in many countries, making it more important than ever to protect human rights and communities.

69. Javier Padilla Bernáldez, Secretary of State for Health, Spain, said the HIV response was being shaken by funding cuts, shrinking civic space and attacks on human rights. Eliminating stigma and discrimination was essential to end AIDS, but in the current context there was a big risk that this would lose priority. He said UNAIDS stood at the intersection of human rights and health, and he emphasized the centrality of community leadership for taking the response forward. The current crisis went beyond HIV and affected priorities like gender equality, migrant rights, human rights and more, he told the meeting. Spain, he said, had recommitted to universal healthcare being a core principle of its HIV response, had included long-acting pre-exposure prophylaxis (PrEP) in its national HIV strategy and was fully committed to the protection of human rights. He shared several examples of specific actions taken in line with those principles. However, he warned that the financing crisis could lead to the HIV response and the struggle for human rights losing momentum and becoming ever-more difficult to maintain.

70. Senator Catherine Mumma, Kenya, congratulated UNAIDS on the adoption of the new Political Declaration and said that a human rights-based approach was essential for success. UNAIDS' coordination role was one of the UN's biggest innovations and had had a positive impact across societies, she told the Board. The HIV response had shown that operating separately, in silos, was not effective. She then described how Kenya's HIV response had evolved along rights-based lines and become anchored in the law, enabling communities to successfully challenge certain practices and policies. This rights-based approach was key to Kenya's HIV achievements, she told the PCB.

71. At the same time, better understandings were needed about why HIV incidence continued to be high among young women and adolescent girls. One reason, she suggested, were high levels of sexual and gender-based violence, which underlined the need for policies and legal changes that can protect young women and adolescent girls, along with changes to the ways in which health and other services are provided to them. Ms Mumma briefly discussed a range of related improvements across a variety of sectors that were needed to take Kenya's HIV response forward. She said the struggle against HIV must not be allowed to become a footnote in UN operations.

72. Dorthe Raben, Director of Public Health and Operations at the Copenhagen HIV Programme, shared information about a European Commission-funded project called "SHIELD", or "Strategies for Health Interventions to Eliminate Infection-Related Cancers". Started in late-2025 with 69 partners across 25 European countries, the project focuses on vaccine-preventable cancers, while also addressing HIV, tuberculosis and viral hepatitis. Ms Raben explained that the project emphasizes early diagnosis and linkage to treatment and care, which requires addressing stigma and

discrimination. At the policy level, that has involved working with the Global Partnership for action to eliminate HIV related stigma and discrimination. The project's aim is to have an integrated approach across various diseases, she explained, with the human rights focus of HIV responses linking into a larger policy agenda that encompasses eliminating stigma and discrimination around other infectious diseases.

73. Marcella Favretto, Chief of Development, Economic, Social and Cultural Rights at the UN Office of the High Commissioner for Human Rights, said HIV was fundamentally a human rights issue, so HIV programmes must comprehensively address the issues driving the epidemic and the many barriers holding back effective responses. The right to health also requires ensuring that health goods and services are available, accessible and affordable for everyone. While those commitments had progressed, a broad pushback against human rights and its universality was now a major threat. She highlighted the backlash against gender equality, a roll-back of sexual and reproductive health and rights, and persistent gender-based violence. Ending AIDS required confronting gender inequalities, she stressed. Also underway was continuing discrimination and increasing hostility against LGBTQI persons, which was driving people away from services and support. Shrinking civic space, both online and offline, was having a chilling effect and causing people to disengage from services due to fear. Reduced financial resources were compounding those difficulties, with sub-Saharan African countries experiencing the steepest funding cuts. She told the Board that it was crucial to defend the universality of human rights, protect civic space, remove punitive laws, tackle stigma and discrimination, confront gender inequality, and protect key populations, including LGBTQI persons.

74. Ms Achrekar thanked the panelists and said they had clearly described how sustaining progress against AIDS required protecting the rights and freedoms that make essential public health responses possible.

75. Members and observers thanked the panelists for an inspiring discussion. They said many countries, notably in Africa, had progressed towards ending AIDS, thanks to collaboration between and support from governments, communities and international partners. However, funding cuts were now affecting services and activities, while ongoing inequities remained a challenge, including for accessing long-acting ARVs. Innovation without access was injustice.

76. Speakers noted that people's basic rights were being violated, community-led organizations were having to close their doors, community workers were increasingly intimidated, and members of key populations were avoiding public health clinics out of fear. They described efforts to improve transgender rights and access, but said progress was fragile. While important, legal recognition of transgender people did not guarantee access to services or protect against discrimination, they warned. HIV programmes could sserve as an entry point for comprehensive gender-affirming healthcare that is delivered without discrimination.

77. Speakers agreed that communities were leading the HIV response but said their leadership required sufficient resources, including through domestic financing. They called for strategic collaboration between communities, country leaderships, and global partners to advance community-led, nationally owned actions on stigma, discrimination, and various structural barriers. They said the future of the HIV response depends on multilateral action that reinforces country leadership, empowers communities, engages civil society, and delivers coordinated support where it is needed most.

78. Four priorities were emphasized: country leadership, well-resourced community leadership, the reduction of inequalities, and defense of the universality of human

rights. Countries must move away from approaching the reduction of stigma and discrimination as a standalone intervention, speakers urged. More preferable was a systems-based approach that upholds human rights, community engagement, and accountability within national health systems and other settings.

79. Some members and observers described steps they had taken to establish enabling laws and policies, support community organizations and achieve effective multisectoral coordination.

3. Follow-up to the thematic segment from the 57th PCB meeting on Beyond 2025—Long-acting antiretrovirals: potential to close HIV prevention and treatment gaps

80. Ms Achrekar recapped the topic of the previous thematic segment and the key messages emerging from that discussion. Andy Seale, HIV Adviser, WHO, summarized the discussion, which had emphasized the potential of long-acting ARVs to bring both individual and population-wide benefits, as well as the key roles of community engagement and leadership for achieving those results.

81. Several recommendations had been made for PCB decision-making, among them the need to ensure equitable access to long-acting ARVs, he said. That could be achieved with ambitious targets, supportive national policies and regulatory processes, robust partnerships with affected communities, and attention to laws and structural barriers. Also important was the public health-oriented management of intellectual property rights, including full utilization of World Trade Organization TRIPS flexibilities to secure access to global public goods for HIV and other diseases, and to protect public health.

82. Mr Seale said the discussion had highlighted the use of pooled procurement mechanisms for accurate demand forecasting, market shaping, negotiation of lower prices, and continued accelerated national regulatory approvals. In addition, it had emphasized the development of local and regional manufacturing capacities, and the use of technology transfer mechanisms, for long-acting products.

83. Speaking from the floor, members and observers thanked Mr Seale for the informative update and commended the recommendations that had emerged from the thematic segment. They hailed the potential of long-acting ARVs for prevention, but said innovation without access was not progress: realizing the full potential of long-acting PrEP required that it be accessible and affordable to all who need it. While welcoming the Global Fund and PEPFAR efforts to expand access, speakers expressed concern that high prices, limited manufacturing capacity, regulatory bottlenecks, constrained health system capacity and declining resources threatened wide and equitable access. Public health approaches were needed to support timely and affordable access, they said.

84. Speakers complained about the continued exclusion of many middle-income countries from voluntary licensing agreements for long-acting ARVs. They highlighted the need for access in regions such as eastern Europe and central Asia and Latin America, where high numbers of new HIV infections were occurring. Unsustainable prices, limited generic competition and insufficient local production would keep these life-saving technologies out of reach for millions of people, particularly those belonging to key and vulnerable populations, they warned.

85. Speakers reiterated that a range of lawful mechanisms existed to expand equitable access. They stressed that measures such as the use of TRIPS flexibilities, voluntary licensing, technology transfers on mutually agreed terms, and strengthened local and regional pharmaceutical manufacturing capacity (especially in Africa) were entirely consistent with international trade rules. Long-acting tools would be marginalized if

commercial interests were allowed to override public health imperatives, the PCB was told. The importance of incentives for new products and sustained resource mobilization was also discussed. While acknowledging the role of the pharmaceutical industry in innovations, speakers encouraged corporations to ensure that breakthroughs are affordable and widely accessible.

86. The PCB was told that voluntary licensing through the Medicines Patent Pool had enabled access to quality-assured generic HIV medicines across 148 low- and middle-income countries. In 2025, this had benefited more than 26 million people in 129 countries. The Medicines Patent Pool model was being used to deliver long-acting options through a voluntary license with a pharmaceutical corporation, which meant that 133 countries would be able to access quality-assured generics of long-acting cabotegravir for both prevention and treatment.

87. Calling for the integration of long-acting products into national health systems, speakers reminded that expanded access required regulatory readiness (including through collaboration with the African Medicine Agency), accurate forecasting, resilient procurement and supply chains, and responsive service delivery. Some speakers (e.g. Cambodia, China, Kenya, South Africa and Spain) described steps countries had taken to increase access to long-acting ARVs while striking a balance between effectiveness and equity.

88. The Board was reminded that long-acting technologies were not a “silver bullet”. They must expand choice, not replace existing prevention and treatment options, speakers said, and they must be delivered as part of comprehensive combination prevention. The stressed the importance of integrating biomedical, behavioural and structural interventions that respond to the diverse needs of individuals and communities. National HIV programmes should adopt differentiated, people-centered approaches that support informed choice rather than a single model of service delivery, the meeting was told. Achieving that requires carefully designed pilot programmes that generate evidence on feasibility, acceptability, cost effectiveness, and suitable service delivery models *before* wider scale up.

89. Speakers emphasized the critical roles of community organizations in bringing innovations to people, as well as in shaping the research and development agenda, programme design and implementation, and demand generation. Also noted was the importance of sustained investment in health systems, including workforce capacity, and the removal of legal, social, and stigma-related barriers. Speakers warned that the social conditions and human infrastructure to deliver long-acting ARVs to key populations, including trans communities, were being eroded. Community health workers were being defunded, community-led clinics were shutting down under pressure from anti-gender movements, and key populations were being subjected to renewed harassment and repression.

90. In response, Ms Achrekar thanked speakers for their comments and emphasized that innovations do not really matter unless people can access them equitably. She highlighted the new 40+20 target in that context. Mr Seale reminded that long-acting PrEP was one of several prevention options and said that the roll-out was proceeding steadily, with African countries having introduced lenacapavir for PrEP since December 2025.

91. Ms Byanyima urged the companies that own the technologies to move faster to enable production across the world so that long-acting ARVs can reach everyone who needs them. While commending the roll-outs that were beginning in some African countries, she said they were too slow: a strategy was needed to allow accelerate access.

4. Update on strategic human resources management issues

92. Stephan Grieb, Director of People Management at UNAIDS, presented the update, which focused on Phase 1 of the transition of UNAIDS. He told the PCB there had been a 57% reduction in staff (from 671 to 292), with 85% of remaining staff shifted away from Geneva (its complement had been reduced to 20 staff) to Bonn, Johannesburg and Nairobi, and the affiliate workforce increasing by about 15%. UNAIDS had reduced its staff by two thirds in the past 15 years. UNAIDS staff comprised 89 nationalities and were predominantly (58%) female. Senior leadership was mainly female, with women outnumbering men at every grade expect the P5 and junior general service levels.

93. Mr Grieb said staff reductions were based on organizational reviews and guided by strategic relevance, cost and operational necessity. He assured the Board that there had been constant communication with staff via verbal notifications and formal letters. Planned separations were being completed in mid-2026. Fourteen staff had lodged appeals during the process. Longer-term teleworking was allowed for 24 staff outside their designated duty stations, at lower salaries. The Secretariat's country presence had been reduced from 75 Country Offices in December 2024 to 17 Country Offices, 11 Multicountry Offices, and 6 UNAIDS offices that are headed by a national officer.

94. He then detailed the ratio of professional staff (41%), general service staff (25%) and directors and above (10%). About 77 long-term consultants supported overall delivery capacity, along with 11 UN Volunteers, 6 junior professional officers, and 5 UNDP PSA personnel. Mr Grieb summarized other process steps in what he described as a dignified, phased transition, as well as the support offered to staff to ease their departures and support future career path development.

95. Speaking from the floor, members and observers thanked the Secretariat for the update and said they were deeply aware of the human impact. They offered their gratitude to all UNAIDS staff, past and present, praised them for their contributions and resilience, and reminded the meeting that staff were UNAIDS' most valuable asset. Speakers expressed concern about the reduction in capacity to provide country-level support. Workforce reduction was not only an human resource issue but posed a programme delivery risk, they warned.

96. While noting that the changes had been implemented through transparent and policy-compliant processes, speakers emphasized that a leaner organization must not result in unmanageable workloads, fatigue and burnout for the staff left behind, particularly those operating in high-burden countries. They urged the Secretariat to prioritize the duty of care to staff and ensure that human resources match the organizational priorities and workload requirements. They also urged Member States to stabilize funding for UNAIDS.

97. While welcoming efforts to align the workforce with available resources, speakers asked that future human resource strategies preserve the specialized talent that is needed to deliver strategic information and technical support for evidence-based programming, including the data and analytical capacities that countries rely upon to guide and monitor their HIV responses.

98. They urged UNAIDS management to continuously monitor the impact of the cuts on programmatic delivery and to safeguard human capital. Some speakers also advised against an over-reliance on temporary modalities to perform core, long-term functions. While the use of consultants and other flexible contractual arrangements provided necessary flexibility, this should complement and not replace institutional expertise and continuity, they stressed.

99. Speakers recognized the financial realities driving the reforms, but said they remained concerned about the potential impact on organizations' ability to provide timely, high-

quality technical support to countries, including for their engagement with communities and implementation of the Global AIDS Strategy. UNAIDS' greatest value, they said, lay in its ability to provide strategic leadership, technical expertise, policy guidance, strategic information and coordinated support to countries and communities on the frontlines of the HIV response.

100. Members from Africa expressed concern about the impact of the restructuring on their citizens, and on capacities in regions with the highest HIV burden. While welcoming the decentralization of functions away from Geneva, they asked that the relocated offices be resourced adequately to handle their HIV mandates.

101. Ms Byanyima said Phase 1 of the transition was guided by the withdrawal of staff from areas where the Secretariat was working alongside Cosponsors. She displayed a slide showing 15 areas of work, 11 of which involved joint delivery with Cosponsors, while four were core areas of the Secretariat's work. She explained that Phase 1 involved closing positions and ceding 11 areas of work to Cosponsors. "Consolidation" had also occurred, with the Secretariat reducing its country presence to focus on 54 countries, including through multicountry offices. The Secretariat recognized the importance of retaining capacity around data, she said, and it would seek extra-budgetary resources to retain or restore that capacity.

102. Ms Stegling, Director of Management and Partnerships, UNAIDS, admitted that the report and discussions presented a very sobering picture, and highlighted the challenges of managing and planning during a period of significant uncertainty. She emphasized the importance of achieving greater financial predictability and stability as the organization continued its transition.

103. The decision point was adopted.

5. Statement by the representative of the UNAIDS Secretariat Staff Association (USSA)

104. Alankar Malviya, Chair of the USSA, thanked the PCB for its appreciation and solidarity and said it was a very difficult time to present the report. He began by briefly summarized the USSA's background and constitution before telling the PCB that the Association had 227 dues-paying members, down from 659, while its executive committee had been reduced from 15 members to 7. A new committee had been elected earlier in June 2026. He said the USSA was one of the few UN staff associations operating a legal support mechanism, which had assisted some 50 staff in the previous two years.

105. Mr Malviya said the report reflected the views of staff, which had been collected through various channels, including surveys and "town hall" gatherings. Regarding progress on the previous recommendations, he said eight recommendations had been tabled at the 57th meeting of the PCB.

106. He welcomed the interim report of the PCB Working Group and its recognition of the need to ring-fence three decades of gains against AIDS. The Staff Association had been represented on the restructuring consultation group, he said, though the pace of restructuring had not allowed enough time for meaningful consultation with all staff. Management's regular updates and engagement with the USSA were acknowledged and appreciated.

107. During 2025, said Mr Malviya, the USSA had provided legal support to 49 of its members, one-on-one legal counsel to 36 staff, and legal insurance coverage to 13 members. It had also supported staff on work and residence permit issues, in addition to other assistance. However, the Staff Association still faced resource constraints.

108. Issues raised by staff related mainly to workload concerns, staff health and work-life balance. Also highlighted were concerns about transparency on staffing and restructuring decisions (including waivers and exceptional approvals); equal treatment for separated staff; and management of expectations from partners, governments and civil society organizations.

109. Mr Malviya said that considering one of the UN's most successful programmes for “sunsetting”, a term which the Staff Association rejected, overlooked the extensive restructuring that had occurred already. Staff were urgently seeking stability and could not cope with one restructuring process after another. A key request was transparency and fairness in the transformation process, including the rehiring of separated staff if resources become available. Greater clarity was also needed around how single-person Country Offices would perform political, technical and operational duties with far fewer resources.

110. Other priorities, he said, included the timely release of entitlements and simpler separation procedures. Those issues were compounded by the introduction of new tools and the migration to the new Business Management System, which was resulting in delays. Lessons should be drawn from those experiences, he said, so that future separation entitlements are released in a timely manner.

111. Mr Malviya thanked the PCB Working Group for developing a pragmatic way forward. He appealed to the Board to avoid a rushed process and said the USSA asked to be meaningfully engaged in all decisions affecting the future of UNAIDS, including participation in the PCB Working Group and the implementation of its recommendations.

112. Entitlements of separating staff must be released in a timely manner in the spirit of dignified exit, he told the PCB. If and when resources become available to UNAIDS, separated staff should be considered for reinstatement with full transparency on extensions, rehiring and exceptional waivers, and regular updating of the organogram.

113. The Chair said all staff deserved the Board’s gratitude, empathy and respect. Speaking from the floor, members and observers thanked Mr Malviya for the important updates and commended the USSA and all UNAIDS staff for their commitment and dedication during a very difficult period. They noted the unsustainable workloads and anxiety stemming from ongoing uncertainty and emphasized the need for full transparency, clear accountability, adequate responsibility, consistent fairness, and meaningful participation of staff throughout the entirety of the transition.

114. Speakers also noted that demand for the USSA's legal support had surged even as membership shrank and financial support was reduced. The sustainability of the Staff Association was being called into question at a time when staff most needed a credible voice, they said. The Board was asked to reflect on this matter.

115. Management’s efforts to offer career and transition support, were noted, along with some improvements in relationships with management. However, speakers highlighted several issues of ongoing concern. Staff Association reports in recent years had chronicled continuous restructuring, driven mainly by financial constraints. Speakers noted concerns about the cumulative effects of repeated restructuring on staff morale, wellbeing and workloads. They asked the Board to take decisive action to minimize uncertainty and protect staff well-being.

116. While acknowledging the need for restructuring, speakers said budget reductions had not reduced the workload, just shifted it onto fewer people. The global response could not be sustained on goodwill alone, they warned. Speakers expressed concern that reductions in staffing and organizational capacity at the country and regional levels

could affect the ability of UNAIDS to sustain engagement with governments, civil society and communities and to continue providing high-quality technical support. There must be stronger alignment between expectations, resources and capacities, speakers insisted.

117. UNAIDS management was asked to sufficiently consult the Staff Association as the transition proceeds; be transparent in decision-making; ensure that organizational changes are shaped by realistic expectations; and keep staff informed in a timely manner of proposed changes and the reasoning behind them.

118. In reply, Mr Malviya thanked the speakers for their remarks and support. He said he hoped the report drafted by the PCB Working Group would reflect appreciation of the pains of staff and the need for stability. Ms Stegling, thanked the USSA and staff for their dedication, acknowledged calls for transparency around decisions, and committed to do better. Responding to comments regarding administrative and other problems, she said those were due to technical problems, including moving to a new Business Management System (at WHO). She paid tribute to all staff, past and present.

119. Ms Byanyima, thanked the Staff Association for its report and acknowledged the concerns raised. She said management would increase transparency and she assured the meeting that waivers had been properly documented, though not published. She added that there was already a policy to rehire staff who had left the organization, once sufficient resources are available. Regarding staff burnout, she said this was the first agenda item in weekly meetings with senior management. Ms Byanyima acknowledged that administrative processes for staff separation had been slow, but said the processes were not under UNAIDS' control: the introduction of a new Business Management System at WHO was causing delays.

120. Addressing the feedback received, Ms Byanyima strongly reaffirmed the work of UNAIDS secretariat staff. She emphasized that, even while undergoing major restructuring, the organization had continued to deliver key global processes, including the Global AIDS Strategy, the High-Level Meeting and the Political Declaration. She also highlighted the continued support being provided to countries, including assistance with Global Fund processes and proposals, HIV estimates and monitoring, the introduction of new long-acting prevention technologies, and support to countries navigating new agreements and memoranda of understanding with the United States Government. She noted that greater recognition of those efforts would have been appreciated.

121. The decision point was adopted.

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6. Unified Budget, Results and Accountability Framework (UBRAF) 2022–2026

122. A moment of silence was observed to mark the death of Gustavo Gallón, Colombian ambassador to the UN.

6.1 Performance monitoring report

123. Angeli Achrekar, Deputy Executive Director at UNAIDS, introduced the performance monitoring report (PMR), which set out the collective results across 11 Cosponsors and the Secretariat at all levels and the Joint Programme's contribution to advancing the HIV response in 2025.

124. She began by reviewing the state of the HIV epidemic and response. She told the PCB

that the global HIV response had saved almost 27 million lives since the inception of the Joint Programme in 1996. In 2025, the Joint Programme was supporting 79 countries to expand combination prevention and 72 countries to expand HIV treatment services as part of their overall health systems.

125. New HIV infections had fallen by 43% since 2010, though this was short of the 2025 target. Progress was inconsistent across regions, she said, with most of the decline occurring in sub-Saharan Africa. Outside that region, the annual number of new infections had barely changed since 2010 as treatment coverage in many countries is not sufficient and prevention options are not reaching the population most in need.

126. Treatment gaps persisted. Among the estimated 40.9 million people living with HIV, 32.1 million were on ARV treatment, a small increase since 2024 but below earlier average annual increases. There were also discrepancies in service coverage, with men less likely than women to access treatment in sub-Saharan Africa. Ongoing stigma and discrimination were hampering treatment and prevention services and had to be dealt with more effectively, she said.

127. As requested by the PCB, the 2025 PMR had been simplified, Ms Achrekar explained, but still captured the results of the Joint Programme across the UBRAF three outcomes, 10 interconnected result areas, and the strategic functions of the Secretariat. A major accomplishment in 2025 had been the development of the new 2026-2031 Global AIDS Strategy that includes the new set of 2030 global AIDS targets. The Joint Programme had also supported countries across dramatic shifts in funding to ensure continuity of services. The PMR also reflected the Joint Programme's work and results in mitigating the impact of the funding shifts.

128. She explained that the PMR measured progress against 45 indicators, of which 28 reached their 2025 milestones, 13 showed slow progress or partially reached their milestones, while two did not reach their milestones. Indicators across 2022–2025 showed that the promising progress of previous years was stalled in 2025, reflecting the reduced scale and depth in Joint Programme capacity.

129. Mandeep Dhaliwal, Director of the Prosperity and Well-being Hub at UNDP, continued the presentation. She said Outcome 1 showed continued improvement in HIV services delivery, with expanded differentiated service delivery models, enhanced resilience of health systems, and expanded community-based care. In 2025, 88% of people living with HIV knew their HIV status, 89% of those who knew their status were on treatment, and 95% of those on treatment had viral suppression. Forty countries had updated their national recommendations on testing, treatment and service delivery, and the WHO-recommended dolutegravir-based treatment regimens were being used in 125 countries, more than double the 60 that had done so in 2020.

130. Community-led approaches and trusted access platforms were increasing access to prevention, Ms Dhaliwal said. Some 1.2 billion condoms had been procured by UNFPA globally, contributing to the prevention of an estimated 118 000 new infections. She said 121 countries reported having national plans for eliminating vertical transmission of HIV, and the Maldives had become the first country to achieve triple elimination of vertical transmission of HIV, syphilis and hepatitis B.

131. Long-acting prevention options, including lenacapavir, was accelerating, with Eswatini and Zambia already starting programmatic delivery and a total of 12 regulatory agencies approving it for HIV prevention. As of May 2026, 9 countries have launched lenacapavir, with an additional three expected to launch by end 2026. The goal is to reach 24 low- and middle-income countries by 2027. Ms Dhaliwal said donors had committed to reaching three million people having access to lenacapavir for HIV prevention by 2028 and to a price of approximately US$ 40 per person per year. The

Joint Programme had played a major role in that achievement, she told the Board, including through technical and implementation support, guidelines, donor engagement, sustainability planning, advocacy for local production, and community mobilization. Communities of practice were being built for long-acting pre-exposure prophylaxis, in concert with a range of partners. Focused advocacy for local production was also ongoing.

132. Ms Dhaliwal reminded the meeting that Outcome 2 focused on social, legal structural barriers to accessing HIV services and achieving better HIV outcomes. She said the Joint Programme continued to place communities at the centre of the response and supported countries to strengthen and integrate community systems into national HIV responses, with 79 countries having received support to expand community-led responses. Sixty-six countries were supported to remove/reform punitive or discriminatory laws and policies and helping to create more enabling environments for prevention, treatment and care. Angola had recently passed a law to end discrimination against people living with HIV. During 2016–2024, 15 countries had decriminalized same-sex sexual acts. However, three countries had introduced punitive laws indicating that more needs to be done. The Joint Programme had also supported 66 LGBTQI-led organizations across 32 countries, gender assessments and gender-transformative programmes, and the expansion of youth-friendly HIV services and youth leadership.

133. Turning to Outcome 3, which focuses on sustainability and integration, Ms Dhaliwal said the Joint Programme had supported countries to strengthen financing, transition planning, service integration and resilience, all in a very challenging funding context. Sustainability was a major priority. Support included the development of new guidance, financing frameworks, costing tools, and resource tracking systems. An example was the Rapid AIDS Response Financing Tool, which was deployed in 32 countries and across two regional programmes to help governments identify financing gaps, determine resource needs, and decide where the greatest impact could be achieved. By end-2025, 25 countries had either developed or were finalizing transition and sustainability plans for increased domestic financing and ownership of their HIV responses. She said about 60% of HIV funding was already domestically sourced in 2024.

134. HIV was also integrated further into health and social systems, work that helped address the social and structural factors that shape HIV outcomes. Ms Dhaliwal emphasized the importance of ensuring that HIV services remain available in humanitarian and crisis settings. In 2025, 41 countries had implemented HIV interventions for key populations in humanitarian settings, she said, while 50 countries had incorporated priority HIV services into national pandemic preparedness and response plans.

135. Fodé Simaga, Director of Country Programmes, Coordination and Partnerships at UNAIDS, reported on the five Secretariat core functions to reach the three overarching outcomes. He said the Secretariat had continued its vital high-level political engagement activities. It had influenced 17 global policy forums, supported 74 countries to strengthen national strategies, supported the development of HIV estimates in 172 countries, managed Global AIDS Monitoring data submissions from 158 countries, and aided community-led monitoring work in 34 countries. Analysis of those data had been presented in the annual global AIDS update and World AIDS Day reports.

136. Mr Simaga reminded the PCB that major reductions in external assistance from major donors had not yet been matched by increases in domestic resources, with major effect on HIV response. The Joint Programme had reacted quickly, he said, by

monitoring disruptions and developing impact projections for advocacy and mitigating actions. It had also supported governments and partners to introduce mitigating actions and had advocated for greater global solidarity and increased domestic investments. Technical support for national AIDS spending assessments had been provided in 17 countries, and 25 countries were developing strategies to transition their HIV responses. A big increase in domestic HIV funding was underway, Mr Simaga said, with 10 of 54 reporting countries having increased domestic funding by at least 10% in 2025.

137. Ms Stegling continued the presentation with a report on finances. She told the Board that overall budget implementation was 106% against allocated core funds for the Joint Programme. Total core allocated funds were US$ 150.9 million, which included a carry-forward balance of US$ 11.5 million from 2024 and prior years, while core overall expenditures and encumbrances came to US$ 159.3 million. She said the estimated noncore funds stood at US$ 280 million in 2025, and the actual non-core expenditure and encumbrances came to almost US$ 170 million. Total allocated funds were US$ 430.7 million and total implementation equalled US$ 329.2 million.

138. Expenditures and encumbrances came to US$ 60.9 million for Outcome 1, US$ 58.5 million for Outcome 2, and US$ 27.5 million for Outcome 3, while US$ 182.2 million went towards the Secretariat functions. She explained that utilization above the approved budget was made possible by the Board's approval for using part of the Operating Reserve Fund to finance the transition to a new operating model. US$ 13.1 million had been transferred from the Fund to cover indemnity payments for core-funded staff separating from the Secretariat during 2026 as part of the transition process.

139. Ms Stegling then summarized core and noncore expenditures and encumbrances for the 10 results areas (total utilization came to US$ 146.9 million) and disaggregated core and noncore expenditures and encumbrances by region. Eastern and southern Africa had the highest level of investment, at US$ 81.3 million.

140. Looking ahead, Ms Achrekar said the Joint Programme would strive to ensure that the Political Declaration commitments are translated into action at country and community levels. Sustainability, domestic financing, sovereignty and country ownership were the core priorities in the years ahead, she said. Community-led services would have a central place; integrated, people-centred approaches would be advanced within national systems; and community-led responses would be supported to close the remaining gaps. The Joint Programme would continue strengthening national data systems and capacities to ensure that countries have the data they need for effective responses and accountability.

141. Speaking from the floor, members and observers thanked the Joint Programme for the sobering PMR and financial reports and commended it for its leadership and resilience under difficult conditions, including a 60% drop in financial contributions. They praised its work to break down barriers, uphold human rights, support communities and reduce inequalities. Even in the face of profound financial, political and operational challenges, a coordinated and evidence-driven multilateral response continued to deliver results, they said.

142. UNAIDS was congratulated for achieving the milestones for 70% of the 45 UBRAF indicators. The results validated the multisectoral approach, speakers said, but also showed the fragility of current gains. Noting that 30% of the indicators showed a lack of sufficient progress, they asked whether it was realistic to expect positive results to be achieved under continued financial pressure.

143. Speakers celebrated the roll-out of lenacapavir and triple elimination of vertical

transmission achieved in the Maldives. They noted that discriminatory and punitive laws had been removed or amended in dozens of countries, that almost 60% of HIV funding came from domestic sources, and that UN Sustainable Development Frameworks in 75 countries include HIV among their national priorities. This was important for strengthening country ownership, they told the Board.

144. They also acknowledged the development of the 2026-2031 Global AIDS Strategy and the approval of the new Political Declaration on HIV/AIDS. All this, speakers said, had been done with limited financial capacity and testified to the resilience, commitment and agility of the Joint Programme. They thanked all staff of the Joint Programme for their dedication and hard work.

145. Nevertheless, huge demands were being placed on the Joint Programme, speakers added, and there was a large gap between its mandate and country needs, on the one hand, and its capacity to deliver, on the other. They said the report showed the organization operating with a much smaller budget and reduced footprint, which raised questions about its ability to continue to deliver. They reminded the PCB that the Joint Programme's value lay in providing technical leadership, strategic guidance, convening partners, and supporting countries to implement effective, rights-based HIV responses. Some members (e.g. Cambodia, Haiti, Philippines and Senegal) shared updates on recent developments in their national HIV programmes but also expressed concerns about declining UNAIDS' country-level capacity. Speakers highlighted the need for continued technical support to countries and community-led responses and said the Joint Programme's ability to provide that support would help determine whether it remained fit for purpose.

146. Civil society representatives said the PMR report showed two realities: impressive progress but a growing crisis for communities, with punitive, criminalizing laws increasing and civic space diminishing. This had been clear in the voting on the Political Declaration, they said, where an increasing number of countries had opposed references to key populations and harm reduction, for example. Several speakers stressed the Joint Programme's crucial role in helping secure space for civil society organizations and advancing evidence-based HIV responses. The role of the UNAIDS Country Office supporting the HIV response in Ukraine under war conditions and enabling country partners to sustain HIV services was highlighted.

147. While agreeing on the need to secure national sovereignty, some speakers warned that it was very difficult to mobilize resources at country level for key population activities without political support. They reminded that the number countries criminalizing key populations had increased; meanwhile, key populations accounted for most (almost three quarters) of new HIV infections outside sub-Saharan Africa. The Board was warned that handing responsibility for key population-focused services strictly to national governments could put criminalized populations at risk.

148. Speakers appreciated the adjustments made in challenging funding conditions and said that having a net fund balance of US$ 39 million was an achievement. The positive asset and liability balance with US$ 193.7 million in total assets against total liabilities of $65 million was also commended. However, the overall decline in donor financing posed a serious threat to UNAIDS and to the sustainability of the HIV response, the PCB was warned. Total revenue had fallen by 59% and core revenue had fallen from US$ 149 million in 2024 to only US$ 66 million in 2025, leaving a US$ 84 million funding gap against the revised workplan and budget. That should not be allowed to become the "new normal", speakers insisted. For Africa especially, which continued to have the highest HIV burden, the reductions put hard-won gains at risk.

149. Funding shifts meant that people were losing access to lifesaving services. Even

though communities were mobilizing to fill the gaps, they could not mount entire HIV responses on their own. They needed resources, political will and sustainable financing, speakers insisted and urged partners to fully fund the UBRAF and protect the minimum capacity needed to support countries.

150. Speakers stressed the need for more domestic funding but warned that the Joint Programme risked becoming fragmented at a point when countries needed coherent coordination, accountability and support for transitioning their own HIV responses. They noted the Joint Programme's key role in supporting country transitions to nationally funded HIV services and welcomed its support to countries to identify how best to allocate domestic HIV resources, including through the Rapid AIDS Response Financing Tool.

151. However, speakers also said that many countries could not afford to allocate much more domestic funding to HIV. Hybrid resource provision—domestic alongside international support—was needed. While national leadership and domestic resource mobilization was essential, this could not replace international solidarity and shared responsibility: predictable, sustainable, and equitable financing remained indispensable.

152. The PCB was reminded that core UBRAF contributions to Cosponsors had declined steeply, with reductions of up to 95% for "lead" Cosponsors and 100% for "affiliate" Cosponsors. No country envelopes had been dispensed to Cosponsors yet in 2026. Those reductions also affected Cosponsors' abilities to source noncore funding for HIV work. Nonetheless, Cosponsors assured the Board that they continued to work with countries, communities and partners to prioritize interventions for the greatest impact and protect essential services.

153. Speakers welcomed those commitments and called on Cosponsors to continue leading within their respective mandates, given the importance of their technical expertise and operational reach for the sustainability of the HIV response. It was suggested that the distribution of core funding, with most going to the Secretariat, would need to be revisited to reflect an increasing reliance in the future on Cosponsors. However, there were also calls for greater transparency regarding the financial and staffing contributions from Cosponsors to the HIV response.

154. Speakers insisted that the Joint Programme's transition must reinforce its unique convening power and core HIV functions and must follow an orderly process. However, noting the extent of funding losses, they asked about the implications for country-level support, how priorities were being decided to protect those most at risk, and which functions might cease if funding continued to decline. Strong emphasis was placed on the need to safeguard country presence, technical support and community responses during the organizational restructuring. UNAIDS was encouraged to continue strengthening accountability, efficiency and transparency, while maintaining its unique coordinating role.

155. Speakers reiterated the need for clear, realistic financial planning to navigate the difficult funding conditions. They insisted that the transition must be anchored on a credible, fully costed, and affordable plan that aligns ambitions with available resources and instills confidence that essential functions can be sustained throughout the transition. The new operational model for the Joint Programme would have to be appropriate for limited financing, while enabling the UN response to be relevant, prioritized, and accountable. The transition, the PCB was told, was not merely a downsizing exercise, but a fundamental structural change that required a predictable financing modality to underpin the new model. Cosponsors reported that they were working on a costed model which would be shared with the PCB Working Group in the

coming weeks.

156. In reply, Ms Achrekar thanked speakers for their comments and suggestions, for recognizing the resilience of the Joint Programme in very difficult times, and for stressing the continued importance of global solidarity. She noted the comments on prioritization and said UNAIDS looked forward to the recommendations from the Working Group.

157. Ms Dhaliwal said that enabling legal and policy environments in countries allowed for better use of funding: the removal of punitive laws reduces stigma and discrimination, making it easier for people to access services. Ms Stegling said issues raised by Canada and the United Kingdom would be addressed in the agenda item on financial reports but acknowledged that the Board had enabled UNAIDS to draw on the Operating Reserve Fun to honour commitments to departing staff.

6.2 Financial reporting

158. Samson Kambarami, Director of Finance and Accountability at UNAIDS, presented a summary of the financial reports and audited annual financial statements. He told the PCB that the Joint Programme had again received an unmodified or clean audit opinion from the External Auditor.

159. Due to a significant reduction in contributions, he reported, the net fund balance stood at US$ 39 million at the end of 2025 (compared with US$ 107 million at end-2024). However, this was still US$ 11.3 million above the minimum level of US$ 27.7 million. That level, he explained, had been established several years earlier at 22% of the biennium budget. For 2026, it was 22% of US$ 126 million (US$ 63 million x 2), which came to US$ 27.7 million. He added that the US$ 39 million figure incorporated the US$ 15 million transferred from the Operating Reserve Fund, as approved by decision point 6.9 at the 56th meeting of the PCB.

160. In 2025, said Mr Kambarami, UNAIDS had raised US$ 66 million (down from US$ 149 million in 2024), of which US$ 60 million came from government donors. Total core expenditures and encumbrances came to US$ 151 million (compared to US$ 160 million in 2024). The top donors were Netherlands, Germany, Denmark, Belgium, United Kingdom, Australia, Ireland, Luxembourg, Norway and Spain.

161. Noncore income in 2025 was US$ 28.3 million, which included US$ 2.2 million in in-service and in-kind contributions. The top donors were the United States (through the Centres for Disease Control and Prevention), Australia, Germany, France and China.

162. Comparing contributions in 2024 with those in 2025, Mr Kambarami said US$ 28.3 million had been raised in 2025, which was US$ 53.6 million less than the US$ 81.9 million in 2024. Expenses, meanwhile, totaled US$ 181.2 million in 2025, a US$ 45.4 million drop from 2024. Staff and personal costs had increased due to extensive separations of staff but had fallen in all other categories (e.g. transfers and grants to counterparts, contractual services, general operating expenses, travel, equipment etc.).

163. Continuing, he told the PCB that US$ 43.8 million in core income had been recorded by the end of May 2026, compared with US$ 41.6 million at the same point in 2025. Projected core income for 2026 was US$ 63 million, without US Government contribution. The core budget for 2026 was US$ 63 million (of which 6 “lead” Cosponsors would receive US$ 3 million and the Secretariat US$ 60 million). By end-May 2026, each “lead” Cosponsors had received US$ 250 000, half of the allocation for 2026. US$ 22.7 million in noncore contributions had been recorded by end-May, of which US$ 21.4 million was available for immediate use.

164. Mr Kambarami said the net fund balance and Operating Reserve Fund had stood at US$ 142 million in 2024. At the end of 2025, it was US$ 39 million, which was US$ 11.3 million above the required minimum level of US$ 27.7 million. He reminded the Board that it had endorsed a revised level of US$ 35 million for the Operating Reserve Fund, and that US$ 15 million had been transferred from the Fund to the fund balance. This left the Operating Reserve Fund at US$ 20 million.

165. Speaking from the floor, members and observers thanked the Secretariat for the comprehensive information, the improved clarity of the report and the explanations provided. They welcomed the updates on key financial risks and said UNAIDS was undergoing a very painful process. They acknowledged the steps taken to increase stability.

166. Speakers told the meeting that despite the great difficulties encountered in 2025, the Joint Programme had delivered on each results area. They praised it for keeping key populations and vulnerable communities at the centre of the response and commended its role in sustaining multisectoral HIV responses across the world. They also applauded the monitoring of disruptions to country responses due to budget cuts and appealed to countries to reprioritize their HIV programmes accordingly.

167. However, speakers added that the financial situation remained troubling, with an operating budget that was well below the reduced approved budget. With only US$ 66 million in core revenue mobilized, this left a deficit of US$ 86 million. A major decline in receivables linked to multiyear donor agreements was further cause for concern, they said, since it pointed to ongoing uncertainty about future revenue streams. Management was asked to share information on strategies to mobilize noncore resources from a more diverse range of donors.

168. Speakers expressed concern about the sharp drop in the net fund balance, which had decreased by more than 70% since end-2024, which they said raised serious questions about the Joint Programme's financial resilience. They asked for clarification on how the gap between revenues and expenditures would be financed in 2026 and about the timeline and scale of savings which the restructuring was expected to generate. UNAIDS was also asked for information about how it intended to mobilize funds from programme countries' Global Fund grants.

169. Regarding the use of reserves to finance the transition, speakers asked what the strategy was for rebuilding those financial buffers so that the Joint Programme could emerge from the transition in a financially resilient state. Some asked about the US$ 13 million which had been taken from the Operating Reserve Fund for various areas of delivery. UNAIDS clarified that this was in line with the PCB's decision to use up to US$ 15 million of the Operating Reserve Fund to cover liabilities for departing staffas part of the transition to the revised operating model. Continued use of the Operating Reserve Fund and the reduction of net assets were not sustainable, the PCB was told. The Secretariat was urged to continue to adapt to a new funding landscape and was asked to report to the PCB on the evolving funding situation, including the results of outreach efforts to traditional and new donors. Speakers hailed Germany's contribution of 6.5 million euros and encouraged other countries to follow that example.

170. Speakers also asked for more information about the increase in staff-related liabilities and about concrete measures that were being taken to address operational challenges related to the introduction of the new Business Management System. The Secretariat was asked to consider including the After-Service Health Insurance in the balance sheet in the future financial reporting to better reflect assets and liabilities of the Joint Programme.

171. Ms Stegling, in reply, thanked speakers for their remarks. Replying to questions, she

reminded that the reporting was for 2025 and assured the Board that, for 2026, the Joint Programme would still be able to honour new requirements with current available funds. Regarding comments about the After-Service Health Insurance, she agreed on the need to ensure that all staff liabilities can be covered but added that there was a degree of overfunding. She said the Joint Programme was engaged in discussions with WHO on this matter and would appreciate advice from the Oversight Committee.

172. Turning to the financial outlook, Ms Stegling said the financial report did not reflect the Euro 6.75 million contribution from Germany and the A$ 5 million contribution from Australia. She thanked other donors who had made multiyear contributions (including Belgium, Denmark and the Netherlands) and the increasing number of programme countries that were providing support, including core specified contributions (including Algeria, Brazil, Cambodia, Côte d'Ivoire and the Philippines). She assured the meeting that the Secretariat was engaging both traditional and new donors and said there were some opportunities on the horizon. However, it was very difficult to engage donors when the recommendations of the Working Group were not yet known. She reiterated that there continued to be a UN mandate on HIV and that this mandate needed "a landing place"—greater clarity on that would help efforts to raise funds for the UN mandate.

173. Mr Kambarami replied to questions about how the Joint Programme continued to operate with only US$ 66 million in revenue and US$ 151 million in expenditures. He said this was possible through the use of the net fund balance, which had stood at US$ 107 million in 2024 and had been reduced to US$ 39 million. Most expenditures were staff-related (about 75%) and were legal obligations, but a substantially reduced workforce would greatly reduce staff expenses from July to December 2026, amounting to a big reduction in payroll costs, which would make it possible to operate within current means.

174. Some speakers noted that staff health insurance (SHI) fund assets of US$ 180.3 million amounted to 318% of defined benefit obligations, leading to questions about whether the level of reserves remained proportionate to the assessed obligations in the current financial context. There was support for the outreach to WHO on the handling of SHI surplus assets, as well as for presenting SHI assets and liabilities in the statement of financial position.

175. Regarding use of the Operating Reserve Fund to support UNAIDS' transition, some speakers noted that the Fund balance was projected to decline further to about US$ 19 million by end-2026. That projected fund balance would be 15% of a US$ 126 million biennial budget, which was below the PCB-mandated minimum threshold of 22%. Some speakers suggested this was reasonable, given that the costs of transitioning to the new operating model were front-loaded, with savings accruing from mid-2026 onwards, making a lower annual budget in 2027 achievable. However, others asked the Secretariat to clarify whether this would leave sufficient resources in the Fund to manage future transition and restructuring costs.

176. Referring to questions about the After-Service Health Insurance, he confirmed that discussions were underway with WHO but noted that international public accounting standards would have to be considered. A decision would be taken on whether to show the ASHI surplus as a note to the financial statements or as an asset in the Statement of the Financial position.

177. The decision points were adopted.

7. Organizational oversight reports

7.1 Internal Auditor's report

178. Elena Sobre Flotats representing the Office of Internal Oversight Services (IOS), presented the report of the Internal Auditor. She explained that the IOS provided investigation and audit services to UNAIDS in accordance with terms outlined in a revised 2022 memorandum of understanding. She said the IOS had performed three audits in 2025: one was rated satisfactory and two partially satisfactory with some improvement required. No audit was rated as unsatisfactory. The IOS had noted improvements in the effectiveness of controls test, up to 80% compared with 73% in 2024. Controls with a high level of residual risk had decreased from 4% in 2024 to 1% in 2025.

179. As of May 2026, the IOS had closed two audits (of multicountry offices) as well as an audit of the UNAIDS Country Office in the Central African Republic. Ms Sobre Flotats said the number of outstanding recommendations were down from 49 in May 2025 to 37 in May 2026. However, most of those recommendations were overdue.

180. Turning to investigations, she said the Office had handled 27 cases in 2025, including 14 that had been carried over from prior years and 13 new cases. It had closed nine cases, of which seven had been finalized at intake and two had required investigation. Of the seven finalized cases, two had been referred to management for action.

181. Thirteen cases had been opened in 2025, a slight increase over the 10 cases in 2024, but significantly lower than the 28 cases in 2023. Of those 13 cases, six related to financial misconduct, six to abusive conduct, and one to sexual misconduct. Two of the 13 cases related to the UNAIDS restructuring process; both were closed at intake. Of the 18 cases carried over to 2026, 16 were at investigation stage.

7.2 External Auditor's report

182. Ritika Bhatia presented the report of the External Auditor. She briefly summarized the audit objectives and told the meeting that an unqualified opinion on the financial statements had been issued. Regarding the compliance audit, she said the main issues related to the delayed disposal of assets, incomplete documentation, and outdated asset register records. The recommendation was to ensure implementation of the planned IT asset-tracking platform to improve monitoring of the complete disposal cycle.

183. Regarding procurement compliance, she told the Board that over 2,000 service purchase orders had been reviewed, valued at about US$ 35 million, as well as 576 good purchase orders, valued at almost US$ 1.2 million. Two recurring issues had been identified: retroactive purchase orders and overdue open purchase orders. The recommendation was to strengthen internal controls so that purchase orders are raised before services commence and completed contracts are formally closed.

184. A sample of PFA-related purchase orders had also been reviewed. The main gaps were incomplete documentation, non-adherence to payment terms, and missing reports. The recommendation was to strengthen monitoring of programme funding agreements.

185. On the status of implementation of previous external audit recommendations, she reported that there had been seven outstanding recommendations at the end of 2025, of which four remained outstanding. The recommendations presented in the report had all been accepted by UNAIDS management.

7.3 Ethics Office report

186. Lord Dartey, Head of the Ethics Office at UNAIDS, told the PCB that 2025 had been a

challenging year, with significant organizational changes, including major loss of staff and a substantially reduced country footprint. The operating environment was also affected by uncertainty regarding UNAIDS' future.

187. Mr Dartey reported that an anticipated increase in requests for advice and assistance from the Ethics Office had not materialized. On the contrary, requests declined from 203 in 2024 to 147 in 2025. Most requests concerned conflict of interests, standards of conduct, and human resource matters. Harassment-related requests were mostly for advice and guidance, not formal complaints. Ethics training completion rates had also fallen from their peak in 2023. In response, new versions of mandatory training modules had been developed and were being rolled out, he said.

188. No new allegations of sexual misconduct were received in 2025, Mr Dartey told the Board. A new, online prevention-of-sexual-misconduct training was being rolled out, and other embedded preventive measures were being taken, including background checks using UN ClearCheck verification and social media reviews. Results from the UNAIDS staff awareness survey showed consistently high levels of awareness of sexual exploitation and abuse issues but also pointed to a need to strengthen safe reporting and awareness raising beyond training alone, he said.

189. Turning to the implications of a new operating model, Mr Dartey said that the expanded use of multi-country offices, one-person country presence, greater reliance on implementing partners, and remote oversight carried a heightened risk of fragmented responsibilities and delayed actions. The Ethics Office therefore recommended that UNAIDS management set up an organization-wide safeguarding accountability and coordination framework, with clear roles and responsibilities that are aligned to the new operating model.

190. Regarding the independence of the Ethics Office, he noted the Joint Inspection Unit (JIU) standards require the head of the Office to be appointed for full term, which in UNAIDS is four years. However, the current UNAIDS human resources framework limits appointments to two-year terms, and Management had indicated that the current framework does not permit exceptions. He further noted that the requirement to consult the Independent External Oversight Advisory Committee (IEOAC) on appointment and dismissal of the head of the Office provides an important safeguard. It was recommended that the IEOAC be notified if the non-renewal of the head of Office is considered.

191. Mr Dartey informed the Board that, to strengthen operational capacity, a P3 ethics officer post had been established in 2024 but was abolished in 2025 due to the downsizing process. Management had, however, agreed to engage a UN Volunteer as an interim measure. In closing, he noted that future priorities included reinforcing protection against retaliation, safeguarding accountability frameworks, improving training uptake and providing proactive guidance on high-risk matters. He told the PCB that sustaining the ethics function would require strong accountability systems, sustained preventive efforts, and visible leadership commitment to ethical conduct and safe reporting.

7.4 Report of the UNAIDS Independent External Oversight Advisory Committee

192. Ana-Mita Betancourt, Chair of the Independent External Oversight Advisory Committee (IEOAC), described the mission and background of the Committee, which had held three sessions in the previous 12 months, covering all items on the PCB-approved terms of reference. It had also considered other relevant matters, including finalization

of the new Global AIDS Strategy, implementation of the Business Management System enterprise resource planning system, and human resources. The Committee had been briefed on the work of the PCB Working Group. She said the Committee believed that the transformation of UNAIDS must follow clear strategic direction and preserve robust civil society engagement.

193. Turning to specific recommendations, she said the IEOAC had reviewed the report of the External Auditor and the Statement of Internal Control. It had noted that the financial statements addressed issues regarding After-Service Health Insurance in a note, whereas earlier statements had disclosed those assets on the balance sheet. The Committee advised that the latter approach was preferable.

194. The Committee had reviewed the draft annual report of the IOS and recommended regular engagement between UNAIDS management and the IOS. It also recommended that management, as a priority, address overdue recommendations that carried high levels of residual risk. It advised that the IOS adjust the funding and resource requirements for audit and investigations functions so they could align better with the current status and scope of UNAIDS. That could be captured in a revised memorandum of understanding. The Committee also recommended that management work with the IOS to provide information across entire investigations.

195. Regarding oversight and ethics, the IEOAC noted the robust tracking system to monitor responses to oversight recommendations. It reiterated a previous recommendation that UNAIDS continue to implement a risk-based approach to determine which JIU recommendations are most relevant to UNAIDS. It also reiterated a recommendation that UNAIDS reach out to comparable UN organizations to understand how they respond to recommendations issued by the JIU. She confirmed that all formal 2019 JIU recommendations directed at UNAIDS had been addressed.

196. Ms Betancourt, said the Committee had considered the Ethics Office report and recommended that it institute backup measures for when the ethics officer was absent. It encouraged management to formalize an arrangement in which the UNAIDS Cabinet would serve as a Risk Management Committee and said it looked forward to the finalization and implementation of a risk appetite statement. Ms Betancourt said the Committee had been monitoring implementation of the WHO Business Management System and was concerned about delays and other difficulties. It encouraged UNAIDS management to develop contingency measures to mitigate associated risks. On cybersecurity, the Committee had been informed that risks were increasing and that countermeasures were being introduced.

197. Finally, Ms Betancourt informed the Board that all five remaining Committee members would complete their terms at the end of 2027 and that the terms of reference stipulated the processes for recruiting and appointing new Committee members. She said the IEOAC would conduct a self-assessment exercise and engage with key stakeholders by November 2026.

7.5 Management response to the organizational oversight reports

198. Ms Stegling said UNAIDS management welcomed the recommendations of the oversight bodies. Regarding the external audit recommendations, she said that of the seven prior recommendations, three had been implemented and four were being implemented. Management accepted the new recommendations, and action plans were underway to address them. She then briefly discussed each of the recommendations.

199. Ms Stegling said the IOS had closed 26 recommendations, six of which had high residual risk. That left 37 recommendations open, a 90% drop since 2020, and the

lowest level in at least a decade. High residual risk recommendations had also been reduced from 13 to eight. The internal audit showed improvements in the effectiveness of controls and a drop in the number of open internal audit reports.

200. Continuing, she said the IOS had received 13 new reports of concern, a slight increase over 2024 but much fewer than the 28 received in 2023. She told the Board that management continued to bolster safeguarding measures against misconduct. She thanked the Ethics Office for strengthening policy coherence and providing confidential advice and reaffirmed a commitment to fully staff the Ethics Office and work with it as it supports staff during restructuring.

201. Management also welcomed the IEOAC recommendations regarding the ethics function, resource mobilization, Business Management System implementation, cybersecurity, human resources, enterprise risk management, and the treatment of surplus in the After-Service Health Insurance fund.

202. Regarding the JIU, Ms Stegling said UNAIDS had recorded a 70% acceptance and 72% implementation rate in 2025. However, the reviews imposed a disproportionate burden on small teams that were already operating with reduced capacity. Management would adopt a risk-based approach to prioritize the recommendations most relevant for UNAIDS, she said.

203. In discussion, members and observers thanked the presenters for their reports and the recommendations made by oversight bodies. They said the reports showed that UNAIDS remained committed to transparency, risk management, accountability and sound stewardship of resources, despite operating in very difficult conditions. Strong oversight and accountability processes, including strong internal controls and risk management, were especially important during a period of transition, speakers emphasized.

204. Governance, risk management, and internal controls must evolve in step with the organization's transformation, speakers said. They called for safeguarding the independence and adequate resourcing of oversight functions, strengthening risk management, including regular reviews of top risks, and aligning workloads with available capacity and support. They also asked for further information on measures taken to manage the risks associated with UNAIDS' increasing reliance on noncore funding.

205. It was noted that some regional risk registers had not been updated to reflect the new realities, and that the external auditor had identified weaknesses in procurement processes, programme funding agreements, and asset management. Speakers asked management to prioritize implementation of overdue, particularly high-risk, audit recommendations, including those relating to enterprise risk management, cybersecurity, procurement, ethics and business continuity.

206. For some speakers, the reports raised questions about the risk of losing institutional knowledge and programme information during the transition. They asked what UNAIDS was doing to ensure that operational gaps do not affect the quality of programme data, accountability to donors and confidence in the strategic information that guide HIV response. They also asked whether UNAIDS was considering the use of AI for oversight purposes (e.g. continuous risk monitoring, real-time audit support, procurement oversight, financial anomaly detection, and tracking implementation of audit recommendations).

207. There was strong concern that staff workloads had not decreased in line with the downsizing and that this affected performance, staff well-being and institutional sustainability, as well as posing a high risk of burnout. Speakers reiterated the need to

find a balance between staffing capacities and workloads and advised that the impact of further staffing losses on the capacity to deliver on the Joint Programme's core functions be assessed.

208. Speakers also supported a recommendation for introducing a safeguarding accountability and coordination framework across UNAIDS, with clearly assigned roles and responsibilities under the new operating model. Given the shift to multi-country presence and greater reliance on partners, this should be treated as a priority, they said.

209. Speakers welcomed the External Auditor's unqualified opinion and management's response regarding those recommendations. Referring to the internal audit, they recognized the dedication of UNAIDS staff and said the improvements in the effectiveness of internal controls were major achievements in very difficult conditions. They appreciated the reduction in total outstanding recommendations, the closure of multi-country office audits, and efforts to strengthen monitoring systems for assets.

210. There was concern about implementation of the new Business Management System, which had been rated partially satisfactory with major improvement required. Speakers pointed to significant budget overruns, delays and potential stability risks and said recommendations for addressing identified weaknesses should be acted upon with urgency. They also stressed the importance of addressing information security and cybersecurity weaknesses and asked management for more information on specific measures to address such gaps.

211. Noting that funding for investigative services had not been provided for the 2024–2025 biennium, and that discussions on sustainable funding had been deferred, speakers stressed that strong oversight cannot exist without adequate resources. They urged management to prioritize the updating of the memorandum of understanding to secure sustainable funding for investigation services.

212. There were concerns about ongoing indications of fear of retaliation among staff and gaps in confidence in safe reporting mechanisms. Speakers emphasized that trust required clear communication, confidentiality, protection, and visible follow-through by management. Declining completion rates for mandatory ethic training were also noted. Management was asked how it would mitigate the related risks.

213. Speakers welcomed the IEOAC's clear recommendations and underscored their support for the Committee's recommendation for a regular review of key organizational risks, including through formalized quarterly risk oversight. They agreed with recommendations for a finalized risk appetite statement and clearer information on the full life cycle of investigations from complaint to management action. They also supported a recommendation for the future inclusion of After-Service Health Insurance assets and liabilities on UNAIDS' balance sheet. This was necessary, they explained, so the Board could fully understand UNAIDS' overall asset and liability situation.

214. Speakers endorsed the Committee's view that UNAIDS' transformation must preserve strong governance, effective risk management, and meaningful community and civil society engagement. They asked for the Committee's ideas on how its role should evolve during UNAIDS' transition.

215. Replying to a question about the evolution of the IEOAC, Ms Betancourt said the Committee had already evolved and would continue to do so in line with UNAIDS' transformation and as prescribed in the Committee's terms of reference. Addressing comments on the ethics function, Mr Dartey said a draft document addressing several of the issues raised had already been submitted to management. Commenting on a question regarding training, he said new modules had been launched.

216. Ms Stegling assured the meeting that management was prioritizing the outstanding audit recommendations. She explained that the oldest recommendations had been addressed first and the others would now be prioritized. Issues raised regarding the Ethics Office were a major concern, she said: further ways had to be found to safeguard staff. She agreed that cybersecurity risks were a major priority and said activities were underway to combat such risks, including phishing regulations, mandatory training and vulnerability scanning and third-party penetration scanning. She said the issue of backdated purchase orders was being addressed, but she warned that there might be an increase in next year's reporting due to problems experienced with the introduction of the Business Management System.

217. Ms Elena Sobre Flotats, the Internal Auditor, said she welcomed the ongoing discussions on a memorandum of understanding to fund investigations. Regarding the investigation case load, she said a risk and prioritization approach was being used to streamline investigation activities. She noted the concerns about an increase in abusive conduct and said this would be examined to see whether it reflected a systemic trend. The External Auditor said implementation of recommendations were always a concern and that management was being engaged on this issue.

8. Interim report of the PCB Working Group on the further transition and integration of UNAIDS into the UN system and beyond

218. Introducing this agenda item, the Chair emphasized the importance of the discussion and described the format that would be followed.

219. The co-facilitators of the PCB Working Group, Bob Rae, Fionnuala Murphy and Joe Phaahla, presented its interim report. They briefly recounted the background to the establishment of the PCB Working Group, its four deliverables, and its modalities, processes and activities (which includes 12 meetings and a range of consultations).

220. They emphasized that this was an interim report outlining possible directions for further transition and noted that further work was required before final conclusions and recommendations could be made. They asked the meeting to focus their feedback on the strengths, weaknesses and non-negotiable "red lines" regarding the four possible routes forward that they had identified in their report. The PCB Working Group had made the most progress on Deliverable 1 regarding possible futures for transition and integration, the co-facilitators said.

221. The Board was told that stakeholders had been emphatic that UNAIDS should not be "sunsetted", while recognizing that transformation was necessary. There was a strong feeling among stakeholders that the Joint Programme's core functions were inter-related and had to be preserved. Many stakeholders cautioned against a hurried transition that could weaken core functions, country support, community engagement or accountability mechanisms that currently underpin the HIV response. Of special note was UNAIDS' unique involvement of civil society in the HIV response and its role in facilitating community access to decision-making forums in countries. There was appreciation, as well, that some Cosponsors have elements of community involvement.

222. The PCB was informed that four directions had emerged from the PCB Working Group's consultations. One entailed a further transformation and downsizing of the Secretariat, building on changes already under way; stakeholders generally agreed that further change would be required beyond current arrangements. A second direction could involve transitioning the Secretariat to a smaller, streamlined hub or partnership that could be hosted within the UN system, while a third direction would involve the wholesale mapping and transfer of the core functions to the different

Cosponsors. The fourth direction was for the Joint Programme to merge or integrate with other relevant, existing health partnerships. The directions were not discrete but could inform a hybrid or phased model, the Board was told. There was also a strong feeling that the model selected would have to be stronger and more cost-effective than the current one. Each of the options was then discussed in greater detail.

Direction 1

223. Direction 1 entailed downsizing and transformation, the co-facilitators explained. It would retain an independent UN Programme and protect the core functions of the Joint Programme. However, discussions had also indicated concerns that this could amount to retaining a Secretariat in a leaner form. The co-facilitators said the Working Group saw Direction 1 transforming the model in ways that can maximize the leadership of Cosponsors across key results areas. It could be an avenue towards institutionalizing the involvement of civil society and people living with HIV, and it could accommodate other stakeholders in the delivery model. It was important, they said, to note that Direction 1 did not imply a continuation of the status quo. It was viewed as a practical way to preserve core functions while enabling further transformation.

Direction 2

224. Direction 2 involved a UN hub that would constitute the new “brains and heart” of the UN HIV mandate, with core functions and strengthened synergies retained within the UN system. This direction offered the advantage of a “fresh start”, but it also carried a risk of losing key Secretariat capacities and a focal point for global leadership on HIV. The direction therefore presented a possible risk to the “UNAIDS brand”, it was explained. At the same time, it also presented the opportunity to renew the brand.

225. At the same time, Direction 2 could provide a centralized reservoir for donor contributions to the UN HIV response, perhaps under a new funding model. There were concerns, however, regarding the administrative, financial and governance implications of such a model, along with questions about where a hub would be housed.

Direction 3

226. Direction 3 involved the transfer of existing core functions across the UN to Cosponsors under agreed roles and a clear division of labour. During consultations, some participants associated this direction with earlier “sunsetting” discussions, while others emphasized that any such approach would still need to preserve the UN HIV mandate and core functions. Although Cosponsors had firm mandates regarding some functions, there were questions about transferring others, such as leadership and advocacy around HIV, given the wider overall mandates of Cosponsors. The direction could also fragment different functions, spreading them ineffectively across different entities.

227. The Board was told that there were also opportunities for a hybrid approach, including for a multisectoral data function. That could expand opportunities for using community-led data and community-led monitoring to track progress and drive accountability. Discussions highlighted several threats, especially for financing, since donors might choose not to transfer funds currently invested in UNAIDS to individual Cosponsors.

Direction 4

228. Direction 4 involved an integrated approach. One strength would be that a merger with other health partnerships could support broader alignment with the Global AIDS Strategy and provide for closer coordination between the HIV response and other health movements. However, this direction was not explored in-depth by the Working

Group.

229. Some questions raised during consultations involved timing and sequencing. One mooted possibility was to preserve the Joint Programme until 2030 and use that time to evolve or create a more integrated, HIV-mandated body. But there were concerns that a merger could dilute the visibility and urgency of the HIV response. It was noted that the proposed health partnerships do not have a UN mandate (in the manner of the Joint Programme). The Working Group felt that further exploration of the governance implications was also needed.

230. The co-facilitators shared some analysis of the direction. They noted that approximately US$18 billion was available for the AIDS response in 2025. The PCB-approved core budget of the Joint Programme for 2026 represents only around 1/300th of this amount.

231. They acknowledged that the conversation about transforming UNAIDS had been underway for some time, including under the auspices of the High-Level Panel. Implementing countries, communities and civil society had been clear about the enormous achievements of the Joint Programme at country level, they said. The Secretariat, in particular, played a key role in building political commitment and leadership and establishing accountability, which were crucial for the HIV response. While it was important to have flexibility in how responses are designed and delivered, it was equally important to have an entity that can track those responses and engage with governments, the co-facilitators told the Board. One suggestion for sustaining those functions was to locate HIV advisors in Resident Coordinator Offices. They also emphasized the need to preserve the meaningful engagement of key and priority populations in HIV responses.

232. The co-facilitators stressed the need for a clear, coherent plan that can earn the confidence and trust of stakeholders and attract the requisite funding. They highlighted some key risks, including having a fragmented UN response and reducing the political priority of AIDS. The selected transformation direction had to maintain the trust of affected communities, governments and donors, they said.

233. Looking ahead towards a final report, the co-facilitators said, four potential strategic directions had been identified. Some non-negotiable issues had also been identified. They said the governance model must reflect the meaningful participation and leadership of people living with HIV, communities and civil society; and governance must maintain coordination, leadership and accountability of the HIV response. The selected model must be realistic, must maintain international solidarity and must mobilize sufficient resources to sustain and strengthen the UN's work on HIV. The transition must be phased, realistic and guided by clear milestones.

234. The co-facilitators told the meeting that the Working Group would examine the directions, consult further, and push for compromise among stakeholders so that an agreement can be achieved.

235. Following the presentation, the Chair suspended the formal session. Participants then divided into informal breakout sessions to discuss in greater detail three questions related to the directions identified by the Working Group.

236. The first question was: "What are the critical elements that should inform the transition of the current Secretariat core functions to enhance accountability, capacity, meaningful engagement and collaboration of the Secretariat, Cosponsors and civil society?"

237. The second question was: "How can we best align the UNAIDS transition with the key

objectives of the UN80 initiative to improve efficiency and impact, while ensuring an integrated and multisectoral HIV response at global, regional, and country levels?"

238. The third question was: "In a shrinking funding environment, what level of financing is required to sustain an effective Joint Programme and support the global HIV response, without jeopardizing long-term goals or creating risks from chronic underfunding?"

239. The PCB reconvened in plenary and an informal summary of the breakout discussions was presented. The Chair then resumed the formal session on agenda item 8.

240. Discussion from the floor then continued in plenary. Speakers recognized the urgency and complexity of the Working Group's tasks and commended it for the interim report. They reiterated that although "sunsetting" was no longer recommended, this did not entail a rejection of change.

241. There was broad agreement that the UN must continue providing leadership in the global HIV response, while heeding the need for reforms in a fast-evolving context. Many speakers also emphasized that leadership, accountability and coordination functions for the HIV response require a clearly identifiable focal point within the UN system. Speakers said that the UNGA High Level Meeting on HIV/AIDS reiterated the need for a central entity to provide leadership to mobilize the global community. It was highlighted that this leadership has always been a core competency of the UNAIDS Secretariat, while Cosponsors contribute with sectoral expertise. The transition was an opportunity to modernize the UN HIV response in line with new realities, while preserving the core value and innovative features of the Joint Programme. The situation was delicate, but it offered an opportunity to transform and strengthen the global HIV response, the Board was told.

242. Speakers emphasized that the starting point for deciding a new model should be functionality, not institutional architecture. They insisted that a well-managed transition was imperative: it must be orderly, grounded in realism (not least regarding funding trends), based on evidence, in line with wider UN-reform efforts, and must strengthen, not dilute the response. Premature reduction or retirement of UNAIDS could create a vacuum at country level, they warned. A clear transition roadmap, with clear milestones, was needed, along with a sustainable and equitable financing model.

243. They also stressed that the transition must be grounded in accountability, equity, and meaningful community leadership, and it must strengthen, not dilute people-centered, rights-based, multisectoral responses. That implied determining clear roles for stakeholders, with measurable responsibilities, regular reporting, and continued accountability at country level. A lighter governance structure was proposed, but with a mandated role for civil society and communities. Practical guidance for achieving that was needed.

244. Crucially, speakers said, the chosen arrangement must preserve what works and avoid creating or introducing new weaknesses and further fragmentation. For many, that meant safeguarding coherence across the Joint Programme's four core functions that underpin the global response, which might involve transitioning specific Secretariat functions to individual Cosponsors.

245. They emphasized that a new model must preserve the convening role performed by UNAIDS and its country-level presence; enable and strengthen coherent, rights-based, community-driven responses; and advance country ownership.

246. Several priorities were highlighted. At the multilateral level, the new model must support ongoing advocacy; multisectoral action; strong coordination capacity; accountability across the UN system; meaningful participation of civil society and

communities, including in governance and decision making; and the embedding of human rights standards and framing in decision-making. Also highlighted was sustained multisectoral data generation, and time-bound target-setting for evidence-based decision-making.

247. The meeting was reminded that Cosponsors bring decades of experience and action as the implementation arms of the Joint Programme. Speakers said the model should fully leverage the comparative advantages of Cosponsors and their operational presence and technical expertise across the UN system. One member suggested to transfer the health functions of the Joint Programme to WHO, while other functions could go to other Cosponsors, without the need for a Secretariat. However, speakers cautioned that it was important to identify gaps and determine which core functions they can be realistically assume.

248. There was wide insistence that meaningful participation of communities and civil society must be a cornerstone of the transition. Several speakers highlighted the importance of preserving safe and trusted spaces for community engagement and leadership. Communities were the backbone of implementation, speakers stressed, and the transition should strengthen their capacities and involvement. Some speakers highlighted a preference for Direction one of a further downsized Secretariat as it would achieve a transition of the Joint Programme with less institutional disruption and at a lower cost.

249. The new model, some speakers said, was an opportunity to make participation of communities and their networks a permanent, institutionalized part of the HIV response, especially at country level. Some speakers emphasized that co-creation and community leadership should become more deeply embedded across future arrangements and observed that approaches to community engagement and partnership continue to vary across contexts. They reminded that country ownership must be understood broadly, as governments, communities and other partners working jointly to ensure results.

250. There were also reminders that community engagement was not standard across the UN. The trust and relationships which UNAIDS had built with communities could not simply be transferred to a new entity, the Board was told. The PCB was reminded that different UN agencies operate under different legal frameworks for engaging civil society, including within their governing bodies. Cosponsors were urged to broaden and deepen civil society roles and governance within their agencies.

251. Governance considerations were also highlighted. Questions regarding the future of the ECOSOC mandate, the protection of civil society engagement mechanisms, and the implications of different hosting or merger arrangements require much deeper analysis, speakers said.

252. Speakers repeatedly emphasized the importance of preserving the ECOSOC mandate for the HIV response and the governance arrangements that enable the participation of communities and civil society in deliberations and decision-making processes. They said that any direction that requires reopening that mandate should be approached with great caution. Central to preserving that mandate was keeping the PCB as an independent, autonomous governing body, they said.

253. It was important, speakers added, to safeguard the immediate post-transition period through standardized real-time monitoring with clear objectives to quickly detect any retreats in national responses.

254. Some speakers asked that the Working Group present a more systematic assessment of actionable directions, including their benefits and disadvantages, with supporting

evidence.

255. Clarity on functions and directions was needed, the PCB was told, which implied a clear analytical framework for assessing functions, and more details regarding the essential elements of each function and which of those elements should be prioritized. It was also important to indicate where, for each of the directions, core functions would be located, what their costed implications would be, and what accountability mechanisms would be used to track their performance. Several speakers emphasized that decisions on future structures should be guided by an assessment of the functions that must be preserved and the arrangements required to deliver them effectively. It was noted that such assessments could draw upon earlier discussions, including during the High-Level Panel process.

256. The Working Group was urged to present a concrete, actionable recommendation, including clear milestones and a phased timeline so the transition can be implemented gradually without disruption to national responses. The plan must capture the respective roles of Cosponsors, governments, communities and civil society, and it must offer guidance for current and future donors, including a realistic funding model, the PCB was told.

257. There was a request for detailed financial analysis of the transition, including one-off transition costs, recurring operation costs, underlying financial assumptions and implications of more distributed funding arrangements. Speakers appealed for financial support to ensure that the Working Group can complete its work.

258. Speakers said the chosen model must be capable of convening, mobilizing and advocating for a coherent, strategic HIV response—all of which pointed to the need for a central entity. A large number of speakers agreed with the Working Group that a central entity within the UN that delivers political leadership, coordinates activities, drives advocacy, and tracks accountability will continue to be required. Speakers said national responses must be convened, coordinated and supported by a structure that can preserve institutional memory, actively facilitate expertise and technical support, and drive HIV responses.

259. The timeline for the transition must follow, not precede, agreement on the transition itself, they said. The transition must proceed on the basis of a clear understanding of how core functions will be preserved, where they will be located, and how they will be financed—not the other way around.

260. Many speakers expressed interest in a lean, clearly mandated multilateral entity within the UN System that could preserve leadership, coordination and accountability functions while operating within a more sustainable model. Questions were raised about merger or integration arrangements involving other health partnerships and implications for governance, accountability, mandate and visibility of the HIV response. Speakers noted that these other partnerships have very different objectives and architectures.

261. There was some support for transitioning the HIV leadership and coordination role at national level into Resident Coordinator structures. However, the resourcing and accountability implications would need to be carefully considered, speakers advised. Without dedicated resources and clear accountability, the HIV focus and community engagement were at risk of being diluted.

262. There were concerns that reliance on the Resident Coordinator model could lead to country-level UN support for the HIV response depending on individuals rather than institutions. Advocacy and technical support at country level could then suffer. Also mentioned was a possibility of having strong regional hubs that can support groups of

countries.

263. In reply, the co-facilitators thanked speakers for their rich comments and suggestions. They said there was a clear commitment to a responsible and well-planned transition that will provide a platform for an accelerated HIV response. The discussion had provided sufficient guidance for the Working Group's further work, they said.

264. The co-facilitators told the meeting that clear questions had been posed: What were the essential functions of the Joint Programme; what structure would best serve that function; what model of governance was needed to ensure co-creation and active participation by people living with HIV and community organizations; and could the transition to such a model be funded?

265. They appealed for sufficient resources to be made available so the Working Group can complete its consultations and draft a final report for presentation in October 2026.

266. The co-facilitators said it was clear from the discussion that function should have precedence over structure: the selected direction had to ensure impact and results in countries and communities. Regarding community engagement, a priority was to protect and create safe and trusted spaces for communities and to enable them to co-create the response. The transition or transformation had to uphold human rights.

267. It was also clear, they added, that ways had to be found to support country leadership in the HIV response, national ownership and strong integrated national programmes. Interesting ideas had been shared regarding having regional hubs rather than a single global hub. Also highlighted during discussions was the need to avoid fragmentation and to be alert to the impact of the new model at country level: ultimately, the transformation must advance country-level impact.

268. Ms Byanyima thanked delegates for sharing their views. It was clear from the discussion, she said, that the transformation process must be guided by the needs of the people most affected by the AIDS epidemic. It had also become clear through successive discussions that the future response would need to build on what works today while continuing to evolve to meet new realities. UNAIDS was on a journey, the course of which would be shaped by the recommendations of the Working Group report, she said, noting that there had been a clear rejection of the language of "sunsetting".

269. Ms Byanyima said it was clear that UNAIDS must accompany countries along the paths they have chosen. At the same time, UNAIDS must be able to continue to open doors for communities, who insist that they must co-create the HIV response. It was clear that the ECOSOC mandate and the role it provides for communities in governance were red lines for many community representatives; UNAIDS supported that position, she said.

270. Funding was a major challenge, the Executive Director acknowledged. While some donors had remained strongly committed to UNAIDS, there was a need to demonstrate continued value to both current and future supporters. She noted that greater clarity regarding the future UN HIV mandate would also support resource mobilization efforts. In closing, she reaffirmed her full support for the Working Group as it completed its remaining work and prepared recommendations for October.

271. The PCB agreed that the consolidated summary of the informal breakout sessions would be annexed to the report of the meeting (Annex 3).

272. The decision points were adopted.

THURSDAY 2 JULY 2026

9. Thematic segment: Beyond 2025: Addressing health inequities through sustained HIV response, human rights, and harm reduction for people who use drugs

Opening dialogue and keynote addresses

273. After a minute of silence honouring the people who had lost their lives to the AIDS epidemic, Daria Ocheret, Adviser, Community Led Responses, UNAIDS, told the meeting that new HIV infections were increasing in many places among people who inject drugs, a trend driven by stigma and discrimination, inequalities and limited access to harm reduction services. Funding constraints and fragile service delivery systems were putting these populations at even greater risk.

274. Presenting the opening remarks, Winnie Byanyima, Executive Director, UNAIDS, said fewer people were acquiring HIV and dying of AIDS-related causes, but the progress was not spread equally. People who inject drugs had a 34 times higher risk of acquiring HIV than the general adult population; in 2024, about 85 000 of them had acquired HIV. Highly effective preventive measures existed, she said, and 112 countries made explicit reference to harm reduction in national policy documents. Yet less than half of the people who inject drugs reported having access to HIV prevention services. Ms Byanyima reminded the meeting that the Political Declaration on HIV/AIDS called for 90% of people in need having access to and using effective prevention options, including PrEP, condoms and harm reduction services. However, in 2025 only Malaysia and Seychelles reported reaching the targets for opioid agonist maintenance therapy (OAMT) and only Bangladesh and Myanmar reported distributing the requisite numbers of clean syringes. People who needed HIV services were still being pushed to the margins by stigma and discrimination, criminalization and neglect, she said.

275. However, there were also exciting examples of countries and communities acting to fill the gaps by addressing the inequalities and structural barriers that drive HIV risk; advancing human rights; working with affected communities; and shifting towards sustainable domestic funding for harm reduction. Ms Byanyima cited examples of progress in Kenya, Nigeria, Cambodia and cities in Poland, where community-led efforts were underway to shift from punishment to upholding people's rights, health and well-being.

276. Mathume Joseph Phaahla, Deputy Minister of Health, South Africa, thanked UNAIDS for its leadership in advancing a global HIV response guided by equity, human rights and sustainable development. He said inequalities continued to undermine collective progress, especially for key populations, with stigma and discrimination presenting major barriers. He said there were indications of very high incidence among people who inject drugs in South Africa, with HIV treatment interruption also a major challenge, due to migration, forced relocation by police, imprisonment, and other factors.

277. Although South Africa did not yet have a national harm reduction strategy, targeted interventions were being carried out with civil society, with linkages to primary healthcare, he told the meeting. Achievements included having two thirds of people living with HIV who inject drugs knowing their HIV status, 80% of whom were on treatment, with 46% of those on treatment having viral suppression. An opioid agonist therapy pilot project was operating in two provinces, methadone had been included in the National Essential Medicines List, and some cities were providing harm reduction services. Expanding such projects was challenging, however. Surveillance data for

people who inject drugs were limited, making planning and tracking difficult. Mr Phaahla emphasized the important roles of communities in designing and implementing the necessary interventions and said primary healthcare was an important basis for harm reduction services.

278. Monica Juma, Executive Director of the United Nations Office on Drugs and Crime (UNODC), addressed the meeting via video. She said that about 14 million people injected drugs globally, and an estimated 1.7 million of them were living with HIV and almost 7 million were living with hepatitis C, which showed that were many gaps in bringing HIV services to this population. Yet the evidence showed clearly that when health services are accessible and respond to people's needs, infections decline and health outcomes improve. It was vital to remove barriers, including criminalization, and to support harm reduction, prevention and treatment as a continuum of care, she said. It was also necessary to expand partnerships across sectors, establish meaningful engagements with communities, and invest in evidence-based approaches.

279. Anton Basenko, Executive Director, International Network of People Who Use Drugs (INPUD), shared his own experiences as a person with lived experience of injecting drugs and said that community-led harm reduction services had saved his life. Needle and syringe projects were often the first contact with healthcare for people who inject drugs, he said. He cautioned that the appropriate policies and services could never be guaranteed: they had to be defended constantly. A recent INPUD survey showed that in the context of recent policy and funding shifts harm reduction projects were being closed, outreach services were ending, and community organizations and networks were in crisis, he said. Funding cuts were occurring alongside increased use of punitive policies, which were pushing people who use drugs further underground. Yet the evidence showed that needle and syringe programmes connect people to healthcare services and can drastically reduce HIV and hepatitis C transmission. When those programmes disappear, he warned, people do not stop using drugs, but their health is undermined. Community-led projects build trust, increase uptake of HIV services, improve health outcomes and save lives, he said, and they urgently need flexible and predictable financing. He appealed to Member States to realize their HIV commitments by funding harm reduction services and supporting community-led organizations. Every person who uses drugs should have the same chance he had been given, he said—not by luck, but by design.

Setting the scene; presentation of background paper highlights (data)

280. Mary Mahy, Director, Data and Evidence, at UNAIDS, presented an update on the epidemiology of HIV. She said new HIV infections outside sub-Saharan Africa had stayed almost unchanged for the past 15 years and were increasing in some regions. About 13% new infections outside sub-Saharan Africa were among people who inject drugs, 31% among gay men and other men who have sex with men, 6% among sex workers, 5% among clients of sex workers, and 5% among transgender women, she told the meeting. Although the HIV epidemic was having a disproportionate impact on people who inject drugs, less than 1% of total HIV spending went to programmes focused on them. Moreover, young people (aged 15–24 years) who inject drugs were 50% more likely to acquire HIV and hepatitis C than their older counterparts and HIV prevalence was also higher among women who inject drugs than among their male peers (15% vs 9%). Geographically, HIV prevalence among people who inject drugs was highest in eastern Europe and central Asia (11%) and in Asia-Pacific (8%). Ms Mahy said there was a lack of reliable population size estimates and other relevant data on these populations.

281. The evidence showed that access to needle and syringe and OAMT programmes did not increase drug use but reduced HIV transmission and improved antiretroviral (ARV) treatment adherence among people who inject drugs. As an example, Ms Mahy cited Portugal's decision in the early 2000s to decriminalize drug possession for personal use and provide harm reduction services to people who use drugs. The number of people using heroin fell from 100 000 to 25 000 by 2017 and HIV transmission among people who use drugs declined sharply. In Fiji, by contrast, a major HIV outbreak occurred in 2024, with a substantial proportion of newly diagnosed people reporting injecting drug use as a primary risk. This occurred in a context of widespread stigma and discrimination, high-risk injecting practices, and limited availability of harm reduction service.

282. Globally in 2024, only about 39% of people who inject drugs had access to HIV prevention services, while treatment coverage was higher but far from the levels needed, she said. Only five countries were meeting the global needle and syringe programme and OAMT targets, most of them high-income countries, while only 11 countries had harm reduction programmes in at least one prison. PrEP was mostly inaccessible: only 27 countries (15 of them high-income countries) were offering PrEP to people who use drugs in 2023. Mahy stressed the need to collect, provide and use relevant data, including community-led monitoring data, so HIV responses for people who use drugs can be grounded more firmly in public health principles.

283. Umunyana Rugege, Team Lead, Communities & Human Rights ai, UNAIDS, discussed the legal, policy and social environments in which people seek healthcare. In 2025, she said, 152 countries criminalized possession of small amounts of drugs for personal use (only 29 countries did not), while 112 countries recognized harm reduction in national policy documents. However, the challenge was putting those policies into practice. She said new guidance from UNAIDS, UNDP and INPUD showed that the criminalization of drug use and of possession of needles was associated with higher HIV incidence and prevalence and with lower engagement in health services.

284. Punitive legal and policy environments reinforced violence, discrimination and exclusion, and should be removed, she said. GAM data showed that a median of 35% of people who inject drugs reported experiencing stigma and discrimination in the previous six months (16 reporting countries); 23% said they had experienced physical or sexual violence in the past year; (18 reporting countries) and 17% said they had avoided seeking healthcare due to stigma and for fear of being reported to the police or being forced into treatment (23 reporting countries)). Ms Rugege explained that women who inject drugs are especially at risk, while young persons who use drugs are often excluded from harm reduction services and targeted with abstinence approaches.

285. Many people who inject drugs lack trust in formal institutions, she said, but organizations led by their peers can reach them in trusted and nonjudgemental ways that are more likely to meet their needs. She shared examples of such projects from India, Indonesia, Ukraine and Latin America and the Caribbean.

286. Turning to financing, Ms Rugege said less than 1% of HIV spending went to interventions for people who inject drugs, with donor funding for harm reduction having halved in real value in 2007–2022. In 2023, approximately US$151 million was available, compared with a projected need of US$1.5 billion by 2030. She highlighted examples of approaches to strengthening domestic financing and integration, including South Africa, where municipal financing supports community-linked harm reduction delivery, and Albania, where OAMT was integrated into the public health system and transitioned towards domestic financing from 2023.

287. Speaking from the floor, participants thanked the presenters for an informative session. They agreed that people who inject drugs bear disproportionate burdens of HIV, hepatitis C and other preventable harms, while stigma and discrimination, criminalization and other barriers prevent them from accessing health services. They highlighted the compounded discrimination and inequalities experienced by women who use drugs. Harm reduction was an essential part of a people-centred, rights-based HIV response and was backed by strong evidence, they said, yet availability and access were far below need.

288. Speakers called on countries to remove structural and other barriers so people can safely access HIV and other health services. They said community organizations were best placed to reach affected populations, provide trusted services, identify barriers, and achieve accountability. They called for stronger data on people who use drugs and said increased use of community-generated data could help close some of the current data gaps. Some country representatives (e.g. India, Iran and Mexico) described policy changes and programmes they had introduced or were considering introducing, including the provision of harm reduction services in some prisons. Long-acting ARVs were an important option for people who inject drugs, speakers noted. Speakers were deeply concerned by the financing picture. Services for key populations, including community-led harm reduction services, were highly vulnerable to disruption. They appealed for greater domestic investment and further integration of HIV programmes into national health and social protection systems.

Panel 1: Addressing inequalities that prevent progress in the HIV response for people who use drugs

289. This session examined the impact of structural and social inequalities and discussed how harm reduction services were adapting to the evolving needs of people who use drugs.

290. Kaumba Akuffo, human rights advocate and co-founder of Tithandizane Comfort Homes, Zambia, described changing drug use patterns in her country which she said were increasing the risk of HIV infection and other harms, with women especially vulnerable. She thanked the Zambian Government and other partners for supporting the roll-out of the long-acting ARV lenacapavir and told the meeting that community-led organizations were more than service providers: they understood people's realities, earned their trust, and connected them to healthcare. She called for increased investments in community-led organizations, expanded gender-responsive services, strengthened HIV/TB treatment and support, and greater involvement of people who use drugs in decisions that affect their lives.

291. Alexei Lakhov, policy advisor at the European Network of People who Use Drugs, said he had been imprisoned 22 years earlier for drug-related offences but was now advising prison authorities on the introduction of harm reduction services. Shame and self-stigma did not protect people against drug overdoses, he said. Against the backdrop of his own experiences with overdosing, he informed that his own country used to have more than 100 harm reduction organizations, which in the course of the last years had been reduced to 10. In some places where OAMT had been outlawed, people were turning to home-cooked methadone. Drug use occurred on a continuum––and the response must operate accordingly as a comprehensive set of services and tools, he said. Harm reduction is a human right and should not be reserved for people who can prove they are trying to quit dugs. Naloxone (opioid overdose treatment) must also be easier to access, without a prescription. Even though the Global AIDS Strategy emphasized harm reduction as a key part of the HIV response, no country in the world was meeting all the harm reduction targets, he said.

292. Álvaro Morales Aser, forensic psychologist specializing in psychopharmacology and substance abuse at the San Carlos Clinical Hospital, Spain, said that people who use drugs experience intersecting and layered forms of inequality, discrimination, violence and more, with criminalization, stigma and exclusion generating fear and vulnerability. This degraded individual and public health, by discouraging health-seeking, undermining treatment, damaging mental health and pushing people away from services into invisibility. Citing examples of the stigmatization and discrimination experienced by people who use drugs when trying to access healthcare services, he said trust was the most important element and it was best built through community leaderships that reaches people otherwise excluded from health systems, provides respectful support, creates safer spaces, and identifies gaps which routine systems fail to detect.

293. Tatyana Sleiman, former executive director of Skoun, in Lebanon, said criminalization led to overlapping forms of stigma, discrimination and fear. Stigma was also linked to poverty, displacement and other factors, including HIV status, gender identity, sexual orientation and mental health. Together, those intersecting vulnerabilities created substantial barriers to health and social protection. In addition, humanitarian responses typically neglected people who use drugs, further excluding them from support systems. This could be addressed by integrating harm reduction into health systems, which required also reducing high levels of stigma among first responders and healthcare workers, which is often due to a lack of knowledge about substance use and harm reduction. As long as drug use remains criminalized, equitable access to healthcare would stay out of reach for people who use drugs, she said.

294. Nara de Araujo, Director of Prevention and Social Reintegration in the National Secretariat for Drug Policy at Brazil's Ministry of Justice and Public Security, said drug policies in Brazil used to be highly punitive, an approach which intersected with racial, social and gender prejudices and discrimination. In 2024, a Supreme Court ruling had reclassified the possession of cannabis for personal use from a criminal to an administrative offense, she told the meeting. The Court had called on the executive branch to move beyond a strictly punitive framework towards a more comprehensive health-centred model. The ruling had also allowed for the implementation of Centres for Access to Rights and Social Inclusion, a community-based service that connects excluded communities to healthcare, social care, legal assistance and other support.

295. The moderator asked panelists about the roles of communities. Ms Akuffo said they were central to finding viable solutions because they understood people's realities and were trusted. Álvaro Morales Aser said communities could use their knowledge and compassion to improve access to services for people who use drugs, help institutions understand their realities, and introduce necessary interventions. Mr Lakhov agreed and said networks of people who use drugs kept harm reduction alive in criminalized communities, while Ms Sleiman emphasized that they were also bearers of expertise but cautioned that effective harm reduction could not operate in a context of criminalization. Ms de Araujo said governments must involve community-led organizations in harm reduction programmes, on national drug policy forums, in the development of national drug policy plans, and in data collection.

296. Speaking from the floor, participants stressed the over-arching importance of choosing a public health approach over solely punitive approaches, and of reducing stigma and discrimination against people who use drugs. They noted that women who use drugs were especially vulnerable to HIV and highlighted an overlooked aspect of harm

reduction: the needs of trans and gender-diverse people who use drugs. Anti-gender movements were affecting community-led harm reduction services in different countries, they warned.

297. Speakers drew attention to the many barriers that block harm reduction, including criminalization, intense stigma and discrimination, and restrictions placed on community-led organizations. They urged governments to base their drug policies not on fear but on evidence and public health priorities, and called for human rights protection, effective action against stigma and discrimination, and strengthened integration of people-centred approaches. Community leadership should be at the centre of those efforts, they said. Multiple channels of outreach were needed, the PCB was told, including social network strategies, and mobile and digitally assisted services. Speakers also highlighted the need to consider interactions between drug use and HIV sexual transmission, the value of age-differentiated harm reduction services, the importance of mental health support, and the overlooked challenge of drug use and harm reduction in humanitarian settings.

298. Speakers shared examples of how collaboration between the state and civil society can facilitate integrated harm reduction programmes (e.g. Ukraine) and described the introduction of relevant interventions in their countries, including the collection of community-led data and evidence; the integration of harm reduction in national drug policies (e.g. Islamic Republic of Iran); locating needle and syringe programmes and OAMT in public health clinics (e.g. Kenya); and linking OAMT recipients to ARV treatment (e.g. Ukraine). However, ongoing stigma and the effects of funding cuts were threatening harm reduction programmes, they warned and called for carefully managed transitions to domestic funding and for increased direct funding to community-led organizations. One country representative told the meeting that coercive measures applied against their country were undermining access to the commodities needed for harm reduction. Another country representative said their comprehensive approach comprised of free-of-charge, voluntary HIV and viral hepatitis testing and treatment, drug treatment and behaviour change communication had reduced HIV incidence among injecting drug users.

299. The Chair interrupted the thematic session to introduce the draft decision point under Agenda Item 3. One member, the USA, requested a vote after declining its right to disassociate from the decision point. A vote was conducted among members. The result was: 21 votes in favour of the decision point, 1 vote against, no abstentions. The decision point was approved.

300. The USA put on record its opposition to the language in the decision point pertaining to trade, to sexual and reproductive health, and to equitable access, and reiterated that PCB decision points were nonbinding documents that did not create legal obligations under law. The representative of the Islamic Republic of Iran acknowledged the adoption of the decision point in accordance with its national laws and regulations and in full respect of its social, cultural and religious values and national development priorities. It emphasized the importance of equitable, affordable and fair access to medicines, medical equipment, and other essential health products.

Panel 2: Protecting human rights through law and policy change

301. This session examined the importance of human rights- and public health based laws and policies for achieving the Global AIDS Strategy targets for people who use drugs and the need to remove criminal sanctions for drug use and possession for personal use. Panelists discussed the evidence regarding the effects on HIV outcomes of

decriminalization of drug use, alternatives to punishment, and the role the community of people who use drugs in advocacy and monitoring.

302. Jaime Urrego, Vice Minister of Health, of Colombia, via video, said that the evolution of legislation and case law in his country had facilitated an approach that prioritizes human rights over punitive responses to drugs. After describing specific examples of laws upholding public health principles, he said Colombia was using public policy tools that incorporate HIV harm reduction as a cross-cutting component of the health system. That includes the introduction of the CAMAD strategy, a drug addiction medical care centre that served more than 280 000 people with hygiene supplies, prevention tools, naloxone to respond to drug overdoses, screening for HIV and sexually transmitted infections, and referrals for OAMT.

303. Mandeep Dhaliwal, Director of the Prosperity and Well-being Hub at UNDP, said decriminalization helped reduce stigma and facilitated harm reduction and access to HIV prevention and other health services. She explained that decriminalization removes personal use of drugs from criminal law or criminal penalties; depenalization maintains the criminalization of drug use but removes or reduces custodial or sanctions; and legalization permits certain forms of drug use within a defined legal framework. She said many current drug conventions dated to the 1960s and allowed for health-centered, non-punitive responses. New guidance developed by UNAIDS, UNDP and INPUD on the decriminalization of drug use in the context of HIV sought to use those flexibilities to decriminalize the possession, purchase, or cultivation of certain drugs for personal consumption.

304. Ms Dhaliwal said the guidance note included a roadmap for achieving enabling legal and policy environments. Criminal penalties for personal drug use should be removed, she said, and the use of other laws for similar punitive purposes should be avoided. Services should be based on consent, be affordable and accessible, and be rooted in community perspectives and the reformed policy should be reviewed regularly to check whether public health and human rights outcomes are being met.

305. Elsa Maia, Senior Officer in the General-Directorate for Intervention on Addictive Behaviours and Dependencies in Portugal's Ministry of Health, told the meeting that Portugal had faced a major public health challenge linked to heroin use in the 1980s and 1990s, with HIV incidence rates among the highest in Europe. This had led to the development of a policy that emphasized public health, human rights and social inclusion. A key step had been the passing of a 2001 law which continued to prohibit drug use but downgraded it to an administrative offence. Other measures taken included a new intervention model and strong investment in prevention, treatment, harm reduction, social reintegration, and recovery services. A nationwide network of harm reduction interventions was introduced, including needle and syringe projects, OAMT programmes, outreach teams, drop-in centres, drug consumption rooms and other community-based services. This helped reduce barriers to healthcare and social support. Twenty-five years later, the benefits for the HIV response and public health were clear. Portugal had made strong progress against the global AIDS targets, including "95–95–95", and HIV infections associated with injecting drug use now comprised less than 2% of new HIV infections, compared with over 50% in the late 1980s.

306. Ms Maia said decriminalization—when combined with comprehensive harm reduction, social integration and recovery programmes—can create better conditions for prevention, treatment and care service, and contribute to a substantial decline to HIV

infections associated with injecting drug use. But success, she added, requires sustained investment in high-quality, person-centred services across the continuum of care, as well as reductions in stigma and discrimination and the involvement of people who use drugs in the design, implementation and development of programmes.

307. Aniedi Akpan, Chairperson of the Drug Harm Reduction Advocacy Network and Executive Director of the Drug Free and the Preventive Healthcare Organization in Nigeria, told the meeting that criminalization of drugs created a culture of fear, reinforced stigma and discrimination, and fueled mistrust—making it difficult for HIV and other services to reach people who use drugs. Arrests, detention, extortion and humiliating treatment by law enforcement personnel further discourage people who use drugs from seeking health services, he said. His organizations were advocating for de facto decriminalization by engaging with multiple stakeholders, including the national Human Rights Commission, to establish alternatives to the criminalization of drug possession and use.

308. Ardhany Suryadarma, National Policy Manager at Rumah Cemara in Indonesia, said Indonesia was amending its narcotics laws and nongovernmental organizations were working to ensure that the amendment leads to actual change. He said decriminalization was often misunderstood as the endorsement of drug use when in fact it was aimed at ensuring that no-one loses their right to health because they use drugs. Drug use patterns were changing dramatically across south-east Asia, leaving many national drug policies outdated, Mr Suryadarma told the PCB. Most policies were still punitive, even though the evidence showed that this approach did not halt drug use. New approaches, focused on mental health services, community support, and harm reduction, were needed. Reformed drug policies and decriminalization should be integral parts of public health policy and HIV responses, he said adding that it took time and the work of strong community organizations to change policies. Ultimately, he said, it was impossible to end AIDS as a public health threat if people are afraid to access HIV and other health services.

309. Verónica Russo, of the Latin American and Caribbean Network of People Who Use Drugs and the Argentine Network for the Rights and Assistance of People Living with HIV, told the PCB that a lack of systematically implemented harm reduction programmes in several countries in the region was due largely to legislative gaps. She said the evidence showed that fear of criminal penalties, and institutional stigma do not reduce drug use, but they do hinder early diagnosis and retention in health services. Criminalization nullified the effectiveness of prevention efforts, she said, whereas harm reduction was a cost-effective health intervention endorsed by WHO.

310. Asked about the role of communities in law and policy reform, Ms Russo said progress against HIV in her region had originated with communities, and people who use drugs were producing the evidence, devising solutions and building mechanisms for effective HIV responses. She said community-led monitoring was an indispensable tool for identifying market failures, shortages of harm reduction supplies, and human rights violations which official systems fail to record. She called for direct, flexible funding to organizations led by people who use drugs.

311. Responding to the same question, Mr Suryadarma said communities contribute unique insights to policy development, monitor legal and policy reforms, help reduce stigma, and ensure that drug policies achieve the desired objectives. Ms Maia said communities help define drug policies and are important sources of information about which measures work and which do not. She said Portugal has a formal mechanism for community engagement which holds regular public consultations on key national documents, where community representatives can participate and contribute to policy

development.

312. Speaking from the floor, participants said the evidence clearly showed the devastating consequences of punitive drug policies and restricted access to harm reduction. Yet, prohibition remained the standard system of drug control, despite having failed to reduce drug use, while producing massive, wasteful and deadly systems of incarceration and discrimination. They cited research showing that women who use drugs experience overlapping forms of criminalization, stigma and coercion that create fear, discourage engagement with health services, and increase their risk of harm. Those experiences erode women's trust in health systems and undermine their abilities to make informed decisions about their bodies. Young people who use drugs were also routinely exposed to the harms of unregulated drug markets, deprived of information on how to stay safer around drugs, and afraid of seeking help for fear of arrest and a lifelong criminal record.

313. Needed instead are moves towards health and human rights-centered frameworks of drug harm control, the PCB was told. Drug dependence must be treated as a health condition, not a punishable offence. Punitive approaches to drug use undermine individual and public health, they said, while human rights-based approaches bring people into care. The evidence supported making harm reduction and decriminalization key features of drug policies, speakers said. These were efficient and effective tools to save lives and reduce HIV and viral hepatitis infections. Yet policymakers in many countries continued to ignore the evidence. Harm reduction suffered from chronic underinvestment and was now under even greater threat following recent cuts to global health funding, which were having devastating effects on community-led activities.

314. The meeting was reminded that the UN had a common position on drug use, which was based on experiences such as in Portugal. That position empowered UN Resident Coordinators to work with communities and countries to improve drug policies and bring them in line with human rights. Guidance had been developed and the tools and evidence existed to push for decriminalization and wider availability of and access to harm reduction. Speakers added that policies must address the intersecting identities and experiences of people who use drugs. They urged that decriminalization guidance explicitly refer to trans and gender-diverse people among the marginalized communities disproportionately affected by punitive drug policies.

315. Speakers shared details about harm reduction efforts in their countries (e.g. Germany and Kenya), including in prisons, as well as lessons learned. Since the beginning of the AIDS epidemic, they said, affected communities had driven the HIV response, often in the face of hostility and criminalization. They cited numerous examples of community-led organizations defending harm reduction programmes against funding cuts and campaigning for the decriminalization of drug use, including in Mexico, South Africa and Ukraine.

Sustainable financing for harm reduction

316. The session reviewed funding gaps and other financing challenges and focused on the long-term sustainability of harm reduction services. Catherine Cook, Executive Director of Harm Reduction International, presented an overview of the funding situation. After summarizing the benefits of harm reduction, she said that 112 countries currently included it in national policies. In 2025, 95 countries had at least one OAMT programme and 60 were providing OAMT in a least one prison, while needle and syringe programmes were operating in 93 countries and were available in prisons in 11 countries. However, coverage of those services was far below the global targets.

317. Harm reduction funding in 2024 amounted to only 6% of the estimated global need. Two thirds of the funding came from donors, but many bilateral donors had withdrawn their support from harm reduction, leaving country programmes heavily reliant on the Global Fund, which currently provided about three quarters of all donor funding for harm reduction. However, recent funding cuts and Global Fund reprioritization were forcing many of those programmes to end or reduce their services, with peer outreach and community-led services hit hardest, along with advocacy for human rights-based interventions. Ms Cook told the meeting that modeling suggested that just one year of disrupted services could lead to almost 10 000 new HIV infections and more than 13 000 hepatitis C infections in just nine countries. She urged countries to not deprioritize harm reduction. Noting the ongoing roll-back of human rights, gender equality and civic space, she called for the protection of communities and civil society organizations that provide and advocate for harm reduction.

318. She said that sustainable financing required going beyond small grants and pilot projects and embedding harm reduction in public health budgets and in insurance and benefit packages, and having social contracting mechanisms so civil society providers can access funding. The benefits were well-documented, she told the meeting, citing evidence that, for every US$ 1 spent on a needle and syringe programme, over US$ 7 was saved on healthcare costs.

319. Ms Cook emphasized the importance of financial and programmatic data on harm reduction, which were becoming patchier, making it more difficult to identify and address gaps. Integration was an opportunity, she said, but it also brought risks since people who use drugs face stigma, discrimination and criminalization, and often feel unsafe in standard healthcare settings. This underscores the need to preserve community-led services and peer workers as core elements of integrated harm reduction programmes.

320. Governments had an opportunity to critically assess the vast amounts of money spent on drug law enforcement that did not achieve the stated aims, caused human rights violations and impeded HIV responses, said Ms Cook. Decriminalization could free up resources for health and harm reduction, she told the PCB. She highlighted several points: domestic investment was key, but donor support remained crucial during that transition; integration must expand access without diluting the quality of harm reduction services; and decriminalization, community leadership, and disaggregated financial and programmatic data were crucial for building effective and accountable programmes.

321. Sha'ari Bin Ngadiman, vice-chair of the Global Fund Country Coordinating Mechanism in Malaysia, said that social contracting had been used since the 1990s via grants to the country's National AIDS Council, which channeled resources to community organizations. The introduction of a harm reduction programme in 2005 had marked a major policy shift. Financed by the Government and implemented by private healthcare providers and community organizations, the programme was expanded in 2011, after which the Government increased its investment and began replacing Global Fund support with national funding. Harm reduction was also integrated into primary healthcare and the broader health system, which improved efficiency and sustainability, Mr Ngadiman said. A national harm reduction task force was set up, bringing together law enforcement agencies, correctional services, drug intervention services, civil society and development partners. That enabled Malaysia to expand OAMT services into some prisons and drug rehabilitation centres, thereby demonstrating that public health and public safety can work together. He said Malaysia's experience showed the importance of political commitment and evidence-based investment. Sustainability, he added, was not just about replacing donor funding

with domestic funding, but about building resilient systems to ensure that no one is left behind.

322. Andrew Scheibe, of the University of Pretoria and TB HIV Care, South Africa, said more HIV services for people who use drugs were being introduced, mostly with donor funding, enabling OAMT and needle and syringe programmes to reach about 34 000 people who inject drugs. Service coverage, however, was far short of what was needed. The country's only municipally funded harm reduction programme was active in the city of Tshwane where, in 2025, it had engaged over 128 000 people, distributed over 400 000 needles, and supported around 1,000 people on OAMT, in addition to providing psychosocial and medical services. The programme's reliance on funding from local government, however, meant its sustainability was not guaranteed. At national level, he said, a small national Department of Health pilot project was underway to integrate methadone treatment in primary healthcare.

323. Ganna Dovbakh, Executive Director, Eurasian Harm Reduction Association, told the meeting that the previous 30 years had seen much wider recognition of harm reduction emerge in Eastern Europe and Central Asia. However, governments seemed more willing to fund the medical elements of harm reduction than the social components. Integration of OAMT and broader harm reduction with mental health was also progressing and there was growing recognition of the value of outreach workers, community navigators, peer supporters and community-led organizations. Community-led harm reduction can be made sustainable, Ms Dovbakh said, through state procurement of services, especially via social contracting mechanisms. Czechia, Estonia, Lithuania, North Macedonia, Poland, and Ukraine were showing that sustainable public investments in harm reduction were possible. The most sustainable approach was to fund community-led organizations directly through public budgets. She emphasized the importance of catalytic funding from the Global Fund and support from the Robert Carr Fund and the Elton John AIDS Foundation for sustaining community networks, community-led monitoring and advocacy. Asked about the impact of legal restrictions, Ms Dovbakh described the ways in which so-called "foreign agent" and "drug propaganda" laws were stifling community organizations and harm reduction in her region.

324. Asked about implementation challenges for integrating harm reduction into public health systems, Mr Scheibe said it was difficult to have person-centred services in systems that were over-stretched. In addition, stigma and discrimination from health and social services providers discouraged uptake of services and reduced the quality of care. Healthcare workers needed training on harm reduction and substance use to counter misconceptions and they must understand which approaches work, he said. The capacity of healthcare workforces was also an issue. Ultimately, effective integration needed strong partnerships between governments and community-led organizations.

325. Mr Ngadiman was asked what factors favour acceptance of harm reduction as part of a national HIV response. Rather than view public health and law enforcement as competing priorities, he said, it was important to establish common ground and show that the protection of public safety and public health was compatible. Even where legal frameworks were not entirely aligned with public health policy, common ground was still possible, he insisted. In Malaysia, a multisectoral approach, led by strong leadership from the Ministry of Health, and involving law enforcement agencies, religious leaders, civil society organizations and communities, had helped build trust and understanding. The focus had been on reducing HIV transmission and achieving public health benefits, he explained. Sustained advocacy and sharing of scientific evidence had shown that harm reduction did not encourage drug use but did increase

the use of health services that improve people's health and well-being. Gradually, this had allowed for some interventions to be implemented even while legal reforms were evolving. Engagement with multiple ministries had led to the expansion of OAMT. While enabling laws and policies remained important, it was not always necessary to wait for comprehensive legal reforms, Mr Ngadiman said. Progress could be made by identifying opportunities for collaboration, building trust across sectors, and focusing on shared, desired outcomes. Another lesson was that communities were indispensable partners for reaching under-served populations and making interventions more equitable, effective and people centred.

326. Speaking from the floor, participants thanked the panelists for an insightful discussion. They underscored the concerns raised about the use of “foreign agent” and other restrictive laws, and shared details about specific restrictions that were being introduced in their countries. Speakers commended UNAIDS, UNODC and WHO for their normative support and welcomed the latest WHO guidance on needle and syringe programmes. The evidence showed that needle and syringe programmes, OAMT and naloxone overdose services worked and were good value for money, they said, but coverage remained poor. While broadly supportive of integration, they cautioned that it should not make it harder for people to access services, and they reiterated that community-led organizations were vital for providing safe and trusted services.

327. Speakers emphasized the importance of sustainable financing and strategic information. Harm reduction interventions were very fragile and tended to be sacrificed during funding cuts, humanitarian crises or political changes. Citing the example of Ontario province, in Canada, they said hard-won gains can be undone in a single budget cycle. This underscored the importance of UNAIDS and UNODC for sustaining advocacy and mobilizing support for harm reduction, the meeting was told. Reiterating that the Global Fund remained a key supporter of health interventions for people who use drugs, they urged countries to fight misinformation, strengthen their domestic policies and support equitable access, and they called on the Joint Programme to continue providing technical support and guidance.

Closing—Conclusion and ways forward

328. Angeli Achrekar, UNAIDS Deputy Executive Director, said that progress in expanding access to harm reduction had been far too limited and stressed that ending AIDS as a public health threat required reaching 90% of people who inject drugs with a combination of effective HIV prevention options, including comprehensive harm reduction services. She urged countries to move away from criminal sanctions for drug use in favour of public health and human rights-based approaches. Recounting key themes that had emerged during the discussion, she said people who use drugs were not a homogenous group but comprised diverse communities who faced intersecting challenges. Criminalization, nonetheless, remained one of the biggest barriers blocking the protection of their health. She said financing for harm reduction was at great risk, adding that community-led responses were central to building trust, advancing policy change and delivering effective harm reduction services and must be institutionalized and sustainably funded. Also important, she said, was the integration harm reduction into national health frameworks and the use of social contracting to boost public financing for community organizations. In closing, she highlighted the need for strengthened and protected community leadership, and for improved data collection and use, including from communities themselves and translate the commitments of the new Political Declaration into action.

10. Any other business

329. The Chair thanked the UNAIDS staff, Bureau members and participants. There was no other business.

11. Closing of the meeting

330. Presenting her closing remarks, UNAIDS Executive Director, Winnie Byanyima, said this had been a critical meeting for the Joint Programme. There had been a clear rejection of the “sunsetting” language in favour of talking about a responsible transition. She said the path forward involved deciding on an actionable, sustainable and costed plan which would be developed through an inclusive, transparent and consultative process led by the PCB Working Group.

331. UNAIDS’ work would continue to be guided by what countries and communities needed, not by institutional convenience, she told the Board, adding that it was clear that the ECOSOC mandate was a red line for communities and for the Joint Programme.

332. She expressed deep gratitude to donor countries, particularly those providing core contributions, many of which also provided multiyear contributions. She also recognized China, Sweden and the US Centres for Disease Control and Prevention for providing significant noncore funds, as well as countries that were funding UNAIDS Offices.

333. Ms Byanyima said the Joint Programme was committed to support the ongoing work of the Working Group and it deeply valued the work and support of the oversight structures. She also thanked the USSA for its commitment to staff, the co-facilitators of the Working Group for leading an inclusive process, and the PCB Bureau and governance team, the interpreters, the IT team and the communications team. She said she was proud to work alongside such dedicated colleagues.

334. The 58th meeting of the Board was adjourned.

[Annexes follow]

PROGRAMME COORDINATING BOARD

UNAIDS/PCB (58)/26.1

Issue date: 30 March 2026

FIFTY-EIGHTH MEETING

DATE: 30 June – 2 July 2026

TIME: 09:00–18:00 (CET)

VENUE: Geneva, Switzerland

Draft annotated agenda

TUESDAY, 30 JUNE

1. Opening

1.1 Opening of the meeting and adoption of the agenda
The Chair will provide the opening remarks to the 58th PCB meeting and will present to the Board the draft agenda for adoption.
Documents: UNAIDS/PCB (58)/26.1; UNAIDS/PCB (58)/26.2; UNAIDS/PCB (58)/26.3

1.2 Consideration of the report of the 57th PCB meeting
The report of the fifty-seventh Programme Coordinating Board meeting will be presented to the Board for adoption.
Document: UNAIDS/PCB (57)/25.39

1.3 Report of the Executive Director
The Executive Director will present her report to the Board.
Document: UNAIDS/PCB (58)/25.4

1.4 Report of the Chair of the Committee of Cosponsoring Organizations
The Chair of the Committee of Cosponsoring Organizations will present the report of the Committee.
Document: UNAIDS/PCB (58)/26.4

1.5 Report by the NGO representative (postponed)
The report of the NGO representative will highlight civil society perspectives on the global response to AIDS.

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 57th PCB meeting

The Board will receive a summary report on the outcome of the thematic segment on PCB meeting on Beyond 2025—Long-acting antiretrovirals: potential to close HIV prevention and treatment gaps.
Document: UNAIDS/PCB (58)/26.6

4. Update on strategic human resources management issues
The Board will receive an update on strategic human resources management issues.
Documents: UNAIDS/PCB (58)/26.7; UNAIDS/PCB (58)/CRP1; UNAIDS/PCB (58)/CRP2; UNAIDS/PCB (58)/CRP3

5. Statement by the representative of the UNAIDS Secretariat Staff Association
The Board will receive a statement delivered by the Chair of the UNAIDS Secretariat Staff Association (USSA).
Document: UNAIDS/PCB (58)/26.8

WEDNESDAY, 1 JULY

6. Unified Budget, Results and Accountability Framework (UBRAF) 2022–2026

6.1 Performance monitoring reporting
The Board will receive a report on the implementation of the UNAIDS Unified Budget, Results and Accountability Framework for 2025.
Documents: UNAIDS/PCB (58)/26.9; UNAIDS/PCB (58)/CRP4;

6.2 Financial reporting
The Board will receive a financial report and audited financial statements for 2025, which includes the report of the external auditors for 2025, as well as an interim financial management update for 2026.
Documents: UNAIDS/PCB (58)/26.10; UNAIDS/PCB (58)/26.11

7. Organizational oversight reports and management response
The Board will receive reports from the following independent functions:

7.1 Internal Auditor's report
The Board will receive the internal auditor's report for the year 2025.
Documents: UNAIDS/PCB (58)/26.12

7.2 External Auditor's report
The Board will receive the external auditor's report for the year 2025.
Document: UNAIDS/PCB (58)/26.13

7.3 Ethics report
The Board will receive the annual report of the Ethics Office.
Document: UNAIDS/PCB (58)/26.14

7.4 Report of the UNAIDS Independent External Oversight Advisory Committee (IEOAC)

The Board will receive the annual report of the IEOAC.
Document: UNAIDS/PCB (58)/26.15

7.5 Management response to the organizational oversight reports
The Board will receive the management response to the independent organizational oversight reports.
Document: UNAIDS/PCB (58)/26.16

7.6 Discussion

8. Interim report of the Working Group on the further transition and integration of UNAIDS into the UN system and beyond
The Board will receive an interim report on the further transition and integration of UNAIDS into the UN System and beyond from the PCB Working Group.
Documents: UNAIDS/PCB (58)/26.17, UNAIDS/PCB (58)CRP5

THURSDAY, 2 JULY

9. Thematic segment: *Beyond 2025: Addressing health inequities through sustained HIV response, human rights, and harm reduction for people who use drugs*
Documents: UNAIDS/PCB (58)/26.18, UNAIDS/PCB (58)/26.19, UNAIDS/PCB (58)/CRP6

10. Any other business

11. Closing of the meeting

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2 July 2026

58th Meeting of the UNAIDS Programme Coordinating Board
Geneva, Switzerland

30 June – 2 July 2026

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(58)/26.3:

- *Agree* that the 58th PCB meeting 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 2026 PCB meetings;
- *Agree* that the Special Session of the PCB foreseen in decision point 7.3 from the 57th PCB meeting will be held virtually in accordance with the modalities and rules of procedure set out in the paper, Modalities and Procedures for the 2026 PCB meetings;
- *Agree* that the 59th PCB meeting will be held virtually in accordance with the modalities and rules of procedure set out in the paper, Modalities and Procedures for the 2026 PCB meetings, on 8–11 December 2026, superseding decision point 9.3 of the 53rd PCB meeting;

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 57th PCB meeting

2. *Adopts* the report of the 57th 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 of the Chair of the Committee of Cosponsoring Organizations

4. *Takes note* of the report of the Chair of the Committee of Cosponsoring Organizations;

Agenda item 3: Follow-up to the thematic segment from the 57th PCB meeting

5.1 *Takes note* of the background note (UNAIDS/PCB (57)/25.37) and the summary report (UNAIDS/PCB (58)/26.6) of the Programme Coordinating Board thematic segment on "Beyond 2025: Long-acting antiretrovirals—the potential to close HIV prevention and treatment gaps";

5.2 *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:

a. Include affordable long-acting antiretrovirals as one option in national HIV prevention and treatment programmes, incorporate relevant indicators in the national monitoring frameworks, and support community-led monitoring mechanisms to consistently measure access, uptake, quality of services, and barriers faced by people living with HIV and key populations,[1] based on the global WHO guidelines and recalling the HIV prevention and treatment targets and goals of the Global AIDS Strategy 2026–2031;

b. Promote equitable access to long-acting antiretrovirals, while recalling the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) as amended, as well as the 2001 WTO Declaration on the TRIPS Agreement and Public Health, which affirms that the TRIPS Agreement should be interpreted and implemented in a manner supportive of the right of WTO Members to protect public health;

c. Note the need for appropriate incentives in research and development, and that, in this context, intellectual property protection is important for the development of new products;

d. Facilitate the development of local and/or regional pharmaceutical manufacturing capacities, in particular in developing countries, to help ensure equitable access to **long-acting antiretrovirals;**

e. Further explore or leverage pooled procurement mechanisms to enhance affordability, and support demand creation, forecasting, and market shaping for long-acting antiretrovirals;

[1] As defined in the Global AIDS Strategy 2026–2031. 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.

f. Improve national and regional regulatory systems for continued and accelerated regulatory approvals for long-acting antiretrovirals;

g. Strengthen HIV combination prevention ensuring that all effective prevention options are mutually reinforcing, available and accessible to all in need;

h. Integrate affordable long-acting antiretrovirals into national health systems, both in national health facilities and through differentiated service delivery, and promote equitable access to affordable and quality-assured antiretrovirals, including long-acting antiretrovirals, particularly for populations disproportionately affected by HIV, including key populations and other priority populations through ensuring an enabling legal and policy environment, unhampered by political constraints, that effectively addresses HIV-related stigma and discrimination and enhances access to sexual and reproductive health services;

i. Utilize the existing scientific evidence on U=U to address legal, socio-cultural and economic barriers that prevent people living with HIV from accessing and sustaining treatment and attaining the highest achievable quality of life;

j. Support communities of people living with, affected by, or most at risk of HIV, including through domestic or international funding, to increase community leadership and decision-making across programme and policy design, implementation and accountability, including demand creation for long-acting antiretrovirals, and support community leadership in reaching HIV targets;

k. Strengthen international cooperation, policies and practices to facilitate timely, equitable and sustainable access to life-saving HIV medicines including long-acting antiretrovirals and comprehensive HIV services, including prevention, testing, diagnosis, treatment, care and support for all in need;

Agenda item 4: **Update on strategic human resources management issues**

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

Agenda item 5: Statement by the representative of the UNAIDS Secretariat Staff Association

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

Agenda item 6: Unified Budget, Results and Accountability Framework (UBRAF) 2022–2026

8.1 Recalling decision 7.5 from the 57th meeting of the Programme Coordinating Board, *looks forward* to the 2027 Workplan and Budget for the Joint Programme at the Special Session of the Programme Coordinating Board;

Agenda item 6.1: Performance monitoring reporting

8.2 *Takes note* with appreciation, of the 2025 Performance Monitoring Report, including its scope and depth;

8.3 *Encourages* all constituencies to use UNAIDS' annual performance monitoring reports to meet their reporting goals;

Agenda item 6.2: Financial reporting

8.4 *Accepts* the financial report and audited financial statements for the year ended 31 December 2025;

8.5 *Takes note* of the interim financial management update for the period 1 January 2026 to 30 April 2026, including the decision to cease the annual replenishment of the Building Renovation Fund;

Agenda item 7: Organizational oversight reports and management response

9.1 *Takes note* of the Internal Auditor's report for the financial year ended 31 December 2025;

9.2 *Accepts* the External Auditor's Report for the financial year ended 31 December 2025;

9.3 *Takes note* of the report of the Ethics Office;

9.4 *Welcomes* the annual report of the UNAIDS Independent External Oversight Advisory Committee and *looks forward* to the next report in 2027;

9.5 *Takes note* of the Management response to the Organizational Oversight Reports and recommendations and urges the timely closure of all recommendations;

Agenda item 8: Interim report of the Working Group on the further transition and integration of UNAIDS into the UN system and beyond

10.1 *Considers* the Interim report of the Working Group on the further transition and integration of UNAIDS into the UN System and beyond (UNAIDS/PCB(58)26.17);

10.2 *Requests* the PCB Bureau, in consultation with the Co-Facilitators of the PCB Working Group, to agree and communicate to the PCB the detailed budget required to support the mandate of the Working Group, taking into account the estimated maximum budget outlined in the Terms of Reference;

10.3 *Requests* the UNAIDS Secretariat to advance adequate financial resources to accommodate the detailed budget as agreed by the PCB Bureau, and *encourages* governments to urgently provide resources, as needed, to support the mandate of the PCB Working Group;

10.4 Recalling decision 7.6 of the 57th Programme Coordinating Board meeting, *requests* the Working Group to share, through the PCB Bureau, the detailed options ahead of the next multistakeholder consultation;

10.5 *Calls upon* the Working Group, with the guidance of the PCB Bureau and the Programme Coordinating Board, to present in its final report the recommendation for a concrete, actionable and sustainable plan based on the key transition options considered and their cost estimates;

10.6 Taking these considerations into account and recalling decision points 7.3e and 7.6 of the 57th meeting of the Programme Coordinating Board in December 2025 and the terms of reference approved intersessionally, *looks forward* to the presentation of the final plan for the further transition and integration of UNAIDS into the UN system and beyond, to be presented for discussion and decision-making at a fully virtual half-day Special Session of the Programme Coordinating Board to be held on 26 October 2026;

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