Agenda item 1.2

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REPORT OF THE FIFTY-THIRD 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 53rd Programme Coordinating Board meeting.

Cost implications for the implementation of the decisions: none

1. Opening

1.1 Opening of the meeting and adoption of the agenda

1. The UNAIDS Programme Coordinating Board (the Board or PCB) convened in person, with online participation as approved in the modalities paper, for its 53rd meeting on 12-14 December 2023.

2. The PCB Chair, Paul Zubeil, Germany's Deputy Director-General for European and International Health Politics, welcomed participants to the meeting. A moment of silence was observed in memory of everyone who had died of AIDS.

3. The Chair briefed the meeting on logistical arrangements and the conduct of the meeting and recalled the decisions made intersessionally by the PCB.

4. The meeting adopted the agenda.

1.2 Consideration of the report of the 52nd meeting of the PCB

5. The Chair said that a written request had been received from a Member State requesting changes to the report of the 52nd PCB meeting. The requested changes were approved by the PCB Bureau and a revised version of the report had been posted on the UNAIDS website.

6. The meeting adopted the report.

1.3 Report of the Executive Director

7. Winnie Byanyima, Executive Director of UNAIDS, welcomed delegates to the 53rd meeting of the PCB. She said that the global HIV response had shown the world that it was possible to achieve the "impossible". Without a vaccine or cure, the pandemic had been reversed with cutting-edge science, community mobilization, human and women's rights advocacy, and world-changing political leadership. AIDS has been one of the deadliest pandemics of our time and has claimed 40 million lives, she said, but the world could also celebrate the other nearly 40 million people who are alive today and living with HIV.

8. The deadline for the goal of ending AIDS as a public health threat by 2030 is seven short years away, Ms Byanyima said. But it was possible to achieve a world where, instead of losing a life to AIDS every minute, very few people die of AIDS, and discrimination based on identity and HIV status is eradicated. Reaching the 2030 goal would make it possible to shift from an emergency response to sustaining the HIV response, ensuring people have access to life-saving treatments and can claim the rights that will enable them to thrive.

9. Meanwhile, however, the world was still confronted with a major pandemic. Three-quarters of people living with HIV were on antiretroviral therapy (ART), but 9.2 million people living with HIV were not receiving that treatment. The number of new HIV

infections had fallen by 38% globally since 2010 but was on the rise in some countries and regions. Warning against complacency, Ms Byanyima said that relaxing HIV programmes now would allow the pandemic to resurge. Pandemics do not sleep, she said: if we don't make progress, they resurge—and the least powerful get left behind. The world was fighting a pandemic in circumstances of growing turmoil and inequality, amid a crisis of international cooperation. Yet it was multisectoral partnerships of governments, civil society, communities and UN agencies that had brought the world to a point where there was a realistic path to end AIDS.

10. Ms Byanyima celebrated the five countries in sub-Saharan Africa which had already reached the 95–95–95 targets and the 16 other countries aropround the world that were close to doing so. But countries also had to reach the 2025 targets for key populations, for community-led services, and for ending stigma and discrimination, she said.

11. Ms Byanyima proposed a set of new commitments to action. UNAIDS would commit to providing the strongest support to countries to plan and implement actions that can reach the 2025 targets for knowledge of status, HIV treatment, prevention, stigma and discrimination, law reform and community-led services. She summarized the changes the Secretariat had already embarked on, including reducing its core staff by 11% and its footprint in Geneva by 90 positions. It had set in motion prioritized biennial work planning and was committed to plotting a sustainable course for the future, she said.

12. Throughout 2024, the UNAIDS Secretariat and Cosponsors would continue to gather data and chart a path for the global HIV response to reach and sustain the 2030 goals. A mid-term review of the current Global AIDS Strategy would be conducted in mid-2024, based on the 2023 Global AIDS Monitoring data and other sources. The process for developing the next Strategy would begin in late 2024/early 2025.

13. In 2025, building on work done during 2024, the UNAIDS Secretariat and Cosponsors would outline a long-term vision for the Joint Programme’s role in the global HIV response to 2030 and beyond. This would be based on scenario planning and discussions with Cosponsors, people living with HIV, partners and across the broader UN system. UNAIDS was already planning for supporting the global AIDS response’s sustainability in the long run and working with countries to develop sustainability road maps that incorporate financing, policy and programmatic shifts.

14. While UNAIDS planned for the long term, Ms Byanyima said, it would also remain focused on the present, which required resources, strong policies and programming, and political support. She expressed concern that some donor countries were scaling back investments and that others were failing to follow through on commitments to remove harmful laws and combat stigma and discrimination. To get on track to reach the 2025 and 2030 targets, everyone had to deepen their commitments. She proposed six specific commitments:

- Know your inequalities and use data to close them.
- Join with UNAIDS in immediately building an urgent HIV prevention approach that revolves around choice.

- Regarding policies and laws, follow the evidence. Two-thirds of countries did not criminalize LGBTI persons, but the remaining third had to follow their examples.
- Further increase domestic resources for HIV.
- Use the newest technologies available and work together to make them affordable. Long-acting pre-exposure prophylaxis was still reaching almost no one in Africa (even though the drugs had been trialed in that continent) and currently recommended antiretrovirals (ARVs) were still unaffordable in some middle-income countries.
- Maintain and strengthen a truly multisectoral HIV response, because many of the current barriers lay the outside the medical system.

15. Ms Byanyima proposed that donors commit to supporting the work of developing countries and support their efforts to expand their fiscal space for HIV responses by pushing for multilateral solutions such as debt cancellation and reform of the international financial architecture.

16. Calling on donors to front-load resources via the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and bilateral channels, she said that having enough resources available now would have a bigger impact on AIDS than making them available a few years down the road. She also called for a fully funded Joint Programme via multiyear funding so that it can provide the in-country presence, strategic information and advocacy that were needed to achieve the 2025 targets and 2030 goals.

17. UNAIDS was committed to aligning closely with partners, including the Global Fund and PEPFAR, bilateral partners and civil society so it can use scarce resources as effectively as possible, Ms Byanyima continued. It would work on a coherent vision for the long-term sustainability of the AIDS response beyond 2030. It would deliver a new, evidence-based, and highly consultative strategy to help fashion an HIV response that achieves the goal of ending AIDS as a public health threat by 2030 and that contributes to preparedness to fight the next pandemic.

18. The Chair opened the floor for comments. Members and observers thanked the Executive Director for her comprehensive report and expressed support for the proposed action points. They agreed that the world needed UNAIDS more than ever.

19. The evaluation by the Multilateral Organisation Performance Assessment Network (MOPAN) in 2023 had confirmed the value of the Joint Programme, speakers told the meeting. They welcomed the Secretariat's response to the assessment and said they looked forward to the implementation of the MOPAN recommendations. Emphasizing the need to "future proof" the Joint Programme, they offered their support for that process.

20. Referring to the overall lack of progress towards the Sustainable Development Goals (SDGs), speakers said that if the world reached SDG 3, it would be due largely to the achievements of the HIV response. They called on countries not to abandon their collective efforts to end AIDS as a public health threat. They reiterated that a clear path to end AIDS existed and agreed on the importance of grounding all HIV programmes in strong data and science.

21. However, the goal of ending AIDS had not yet been achieved. Over 600,000 people were still dying of AIDS-related causes each year. Sub-Saharan Africa was home to two-thirds of all people living with HIV, and access to newer ARVs was still limited in many countries. Men, members of key populations, and children were experiencing large treatment gaps. Only 57% of children had access to HIV treatment and only 46% were virally suppressed. Treatment gaps were especially big for children aged 0–4 years. Health systems were also contending with aging populations of people living with HIV, many of whom had other comorbidities, which complicated countries' HIV responses. In addition, existing prevention technologies, such as condoms and pre-exposure prophylaxis, were not yet easily or sufficiently accessible in many countries. The meeting was told that additional funding was needed to build awareness about prevention choices and roll out the tools and technologies, and international action was needed to bring down prices.

22. Highlighting the importance of a multisectoral response that closely involves affected communities, speakers called for unfailing support to the populations who were most vulnerable to HIV. They urged members to let communities lead and to support and empower them in decision-making. Communities' roles in the HIV response had been central to the achievements thus far, they said, and HIV responses were succeeding because they were people-centered and focused on the social determinants of health. However, backtracking around financing, political will, human rights, sexual and reproductive health and rights, and key populations was holding back further progress. Overlapping global crises were also pushing HIV responses off-track in the context of declining funding. Speakers called for a shift from an emergency response to a sustainable one.

23. Speakers said the HIV response also held many lessons for confronting other global challenges, not least the value of multisectoral, inclusive governance and of working closely with affected communities. Those approaches would increase the impact and sustainability of actions addressing many other SDGs.

24. Speakers agreed that the world needed a strong, accountable and fit-for-purpose Joint Programme, and insisted that UNAIDS should have sufficient resources to fulfil its mandate. Noting the UNAIDS budgetary shortfall, they said effective prioritization was vital and urged UNAIDS to focus on its core mandate. It was important to show donors which of UNAIDS' contributions were making the biggest impact. Noting that UNAIDS' strength lay in its evidence-based approaches and reliance on strong country-level data, speakers emphasized that the Joint Programme had to continue providing related technical and other support to countries.

25. Some members told the meeting that the Joint Programme had helped them bolster political commitment, reduce infections, and increase treatment coverage among key populations, as well as reduce vertical transmission rates. They commended UNAIDS' support for community leadership to address societal factors.

26. The meeting was told that large proportions of new infections were occurring among key populations and their partners, but human rights barriers made it very difficult for those

populations to access HIV and other health services. Speakers stated their strong concerns about an ongoing pushback against human rights (including the rights of women and of LGBTI communities) and sexual and reproductive health services, as well as shrinking civic space, especially for community and grassroots activities. This was not a matter of ideology, but of people's health, they said. The meeting was informed about the launch of several new HIV accountability reports, which showed the impact of anti-rights groups that were seeking to roll back sexual and reproductive health services, including the provision of condoms to young people.

27. Speakers reiterated that stigma and discrimination had no place in the HIV response, and they insisted that the 10–10–10 and 30–60–80 targets should remain priorities. Noting the lack of progress towards the 10–10–10 targets, especially for people who inject drugs, they supported the Executive Director's call for stronger commitment to legal reforms and stigma reduction. All countries were urged to uphold their obligations under international agreements and charters.

28. There was strong concern that global resources for HIV were decreasing. Countries were trying to increase domestic resources, speakers said, but they were faced with fiscal and other constraints (including high debt repayment burdens). Members were urged to ensure that the global HIV response was adequately resourced and to support country-led sustainable systems. Not ending AIDS would be much more expensive than ending it, they said. Speakers also stressed the need for a sustainable HIV response and said this priority should be reflected in the next Political Declaration on HIV and AIDS. They reminded the meeting that investments in communities were also investments in a sustainable post-2030 HIV response.

29. Speakers thanked the Executive Director for clearly laying out the implications of UNAIDS' funding situation and for providing details of steps taken to mobilize additional resources. They thanked existing donors for supporting the Joint Programme and called for sustainable, predictable, and full funding of the Unified Budget, Results and Accountability Framework (UBRAF). Germany announced that it would increase its contribution to UNAIDS by Euro 1 million for 2023 and was considering a further increase in 2024. France also announced that it was increasing its voluntary contribution.

30. Cosponsors welcomed the "triple commitment" call made by the Executive Director and said they were ready to apply the full value of their comparative advantages to the HIV response. They also supported the resolve to sustain the Joint Programme model and ensure it is fit for the future. The scenario planning for the short-, medium- and long-term should be done simultaneously, they said.

31. Several members updated the Board on recent developments in their HIV responses and on support received from the Joint Programme. For example, one member noted UNAIDS' support for mobilizing sustainable resources (including from the Global Fund), updating of its national strategic plan; collecting and analyzing strategic information; boosting engagement with communities and strengthening community-led activities; and participating in global partnerships and platforms.

32. Achievements cited by speakers included the elimination of vertical transmission of HIV; near-achievements of the 95–95–95 targets; improved diagnostic and treatment services; and providing HIV treatment to refugees. Challenges including funding gaps; rising numbers of new infections (especially among men in some countries); and the prohibitive cost of and limited access to new HIV commodities. Several speakers called for a fairer system of technology transfers and production, and more support for local manufacturing and regional centers of production. They also expressed concern about the negative impact of the decision to close the UNAIDS regional office for the Middle East and North Africa.

33. Speakers said they looked forward to the forthcoming mid-term review and to consultations for the next Global AIDS Strategy and called for a disciplined approach to work planning and budgeting. Highlighting the importance of strong oversight and accountability, members commended the work of the Independent External Oversight Advisory Committee (IEOAC).

34. In reply, the Executive Director thanked speakers for their remarks, which underscored the many important ways in which UNAIDS supported national HIV responses. She said she was encouraged to hear that the World AIDS Day theme, "Let Communities Lead", was resonating and was grateful for the support for the process outlined towards 2030. The next seven years were critically important. She told the meeting that the mid-term review of the current Global AIDS Strategy would be followed by a consultative process to develop the next Strategy and define the role of the Joint Programme.

35. Expectations were high and required a fully funded UBRAF, yet the Joint Programme was operating with the bare minimum, she said. Core income for 2023 stood at US$ 153 million, with a further US$ 5 million anticipated. The expectation for 2024 was to raise US$ 160 million, which was lower than the level of funding needed. Resource mobilization was occurring in a challenging context, with overseas development funding under increasing pressure. UNAIDS was responding to this by prioritizing and focusing and high-impact delivery, and by boosting its resource mobilization efforts. Positive momentum was building, Ms Byanyima said. Australia had unveiled a new partnership in addition to its core commitment to the Joint Programme, while France had doubled its commitment and was investing in a multiyear stigma and discrimination project in western and central Africa. The Joint Programme had also received generous additional support from Germany and other donors.

36. The Executive Director called on all members to contribute to the Joint Programme. She thanked Luxembourg for its ongoing support, along with Cote d'Ivoire, Netherlands, Switzerland, and the United States of America. She also thanked the Global Fund for reiterating the importance of the Joint Programme for its work.

37. In closing, Ms Byanyima said the pushback against human rights and civic space had to be opposed. Key populations were disproportionately affected by HIV and were subject to constant stigma and discrimination. For all the achievements made, major gaps still had to be addressed, she said.

38. Ms Byanyima announced that the Constitutional Court of Uganda had admitted UNAIDS as a Friend of the Court, allowing it to provide evidence about the public health impact of a new law outlawing homosexuality. She said this was another example of UNAIDS' vital rights-based work around the world.

1.4 Report of the NGO Delegation

39. Aleksei Lakhov, Steering Committee member, Eurasian Harm Reduction Association, presented the Report of the NGO Delegation. He told the PCB that numerous crises were unfolding around the world. Listing some examples, he said that more than 110 million people had been displaced in 2023, the highest number since World War II, and that 2023 had also witnessed the highest number of military conflicts in decades (183 conflicts).

40. Noting that a shared definition of humanitarian emergencies, encompassing both "man-made" and natural disasters, had not yet been achieved, he urged the Joint Programme to work with relevant stakeholders to consider the issue from a public health perspective.

41. A key message in the report, he said, was the need to develop a minimum package of interventions for people during humanitarian emergencies. It should include a three-month supply of ARVs; sufficient food; HIV-related health commodities; testing and treatment for viral hepatitis, treatment, and care for survivors of sexual violence; first-aid; and psychosocial support. The report also underscored the vital roles communities play in responding to HIV and other threats during humanitarian emergencies. Listing examples of that work, Mr Lakhov called for greater support to community-led organizations, including by ensuring that funding reaches them in a timely manner.

42. Mr Lakhov said it was important that all actors recognize the specific health and psychosocial needs of people living with HIV in humanitarian emergencies and that they integrate appropriate responses into national and strategic plans. In closing, he said humanitarian emergencies often highlighted the failure to protect human rights. The report charted a path towards changes that would help protect people's human rights and health in humanitarian emergencies. He encouraged UNAIDS to report on, at future PCB meetings, progress made in implementing the recommendations.

43. The Chair opened the floor for discussion. The meeting was asked to observe a moment of silence to commemorate UN workers who had lost their lives in war and conflict.

44. Speakers welcomed the overall proposals in the report, including the need to clearly define a minimum package of interventions to protect the health of people living with HIV in humanitarian emergencies. Doing so could also help build resilient societies more generally, they suggested.

45. Humanitarian crises disrupted HIV services and increased people's vulnerability to HIV infections, especially for women and girls and for key populations, the meeting was told. The crises hindered efforts to end AIDS and compounded the vulnerabilities that robbed people of their health. Noting that over 300 million people required humanitarian assistance in 2023, Members warned that the situation may become worse in the

coming years. It was noted that the MENA region had the second-highest concentration of internally displaced people worldwide.

46. It was important to acknowledge the impact of war and conflict on the health and wellbeing of affected communities, including people living with HIV, speakers said. New ways were needed to address HIV and other health threats in humanitarian emergencies, including by ensuring access to HIV and sexual and reproductive health services. If a fraction of the money countries spent on wars was directed at preserving people's health during these crises it would make a significant difference.

47. Describing the HIV-related and other hardships experienced by people in humanitarian emergencies, speakers said it was vital to avoid interruptions in essential services and to integrate HIV into all humanitarian efforts. This was best achieved through partnerships and by including affected communities, including people living with HIV.

48. Speakers said they were struck by the compelling examples of community leadership and activities in humanitarian emergencies. However, they also noted that resources for community organizations were scarce, and many humanitarian responses still failed to include key populations and people living with HIV. Speakers supported the call to empower and support the community organizations that are at the frontline of HIV responses. They asked whether communities were fully engaged in UN coordination around human emergencies, whether UN Joint Plans on HIV were allocated responsibility for humanitarian services, and how that was being done.

49. An appeal was made for urgent collaborative actions to integrate HIV into emergency plans; the development of minimum packages for HIV interventions suitable for the region; and substantial investment in strengthening health systems in crisis-affected areas. Also advised were inclusive policies to safeguard the rights of people living with HIV and of key and vulnerable populations during humanitarian crises.

50. Speakers supported the development of a set of guiding principles to serve the basic needs of people living with HIV in humanitarian emergencies and for increased coordination among UN agencies to address those needs. Effective humanitarian responses required coordination between all stakeholders and affected populations, they reminded the meeting. They also supported the development of a minimum package of HIV services in humanitarian emergencies and for including it—and sexual and reproductive health services—in the essential packages of services. They called for more donor support to facilitate those and related initiatives.

51. Countries were urged to use existing instruments, including guidelines on UN responses to HIV in emergencies. There was a suggestion to consolidate the 2010 guidelines for addressing HIV in humanitarian settings with more recent guidance prepared by the Inter-Agency Task Team on HIV in Emergencies, and a question about whether a new position, which Cosponsors were supporting in the western and central Africa regional support team was in the 2024–2025 Workplan and Budget (UBRAF). Speakers supported a call for a regular update on the HIV situations and responses in countries experiencing humanitarian emergencies.

52. UNAIDS Cosponsors shared details of their work to address these issues and said the Interagency Task Team on HIV and emergencies was ready to drive the process of developing an update on the 2010 guidelines for tackling HIV in humanitarian settings. A senior humanitarian adviser had already been contracted to assist in identifying opportunities for impactful change, they told the PCB. Several members briefed the meeting on steps they had taken to ensure that migrants, refugees and other people affected by humanitarian emergencies can access essential health-care services.

53. In reply, Mr Lakhov thanked speakers for their comments and thanked the contributors who had helped develop the report. He urged the Joint Programme to step up their efforts in the context of humanitarian emergencies.

54. The Executive Director thanked the NGO Delegation for the important report and highlighted the experiences of refugees, especially those who are additionally marginalized due to their sexuality or other factors, such as living with HIV. UNAIDS was working hard to keep services operating for people on the move, she said. But a reality check was needed. In 2016, there were 60 million people on the move, a number which had almost doubled subsequently. The crises kept growing, she said, but the support should be increased to address these crises.

55. Ms Byanyima outlined the work that was needed to realize the rights and serve the health needs of people who are vulnerable to HIV. Funding and other support was necessary to expand that work. Cosponsors had the technical capacities but lacked the resources to use them to full effect in humanitarian emergencies, she said.

2. Leadership in the AIDS response

56. Ms Byanyima introduced the speaker, Her Excellency Monica Geingos, the First Lady of Namibia, who also chairs the Global Council Inequality, AIDS and Pandemics.

57. Ms Geingos cited criticism voiced by the South African President, Cyril Ramaphosa, about the hoarding of vaccines and unfulfilled climate pledges and said that there remained a sense that life in the northern hemisphere was much more important than life in the southern hemisphere. UNAIDS' focus on inequality made it a powerful voice on social and justice issues and its achievements were due to the rights-based, multisectoral and community-driven nature of its work, she said. Its inclusion of civil society and community-led bodies made it a unique UN entity.

58. The issue of inequality had become more politicized and contentious, Ms Geingos noted. But it was also clear that the world could neither control nor end pandemics without also dealing with the fault lines that allow pandemics to emerge and grow. She said the Global Council on Inequality, AIDS and Pandemics (Council) recognized the centrality of inequalities across the world. The priorities that the UNAIDS Executive Director had emphasized in her report were among the core issues that the Council wanted to address.

59. A new analysis produced by the Council showed that countries with higher rates of income inequality had higher rates of death from both COVID-19 and AIDS, Ms Geingos

told the PCB. Other analyses showed that, in most African cities, rates of HIV were higher in urban areas, especially among the poor. The same inequalities that drove the AIDS pandemic would continue to drive future pandemics unless they are removed. Fresh thinking and approaches were needed, she urged.

60. Cutting-edge technologies were available, but they reached the rich first and the poor last, she reminded. There were no guarantees that new life-saving technologies would be available to all. Long-acting injectable pre-exposure prophylaxis, for example, had the potential to revolutionize HIV prevention, but it was not equitably available. Do we really have to repeat this for every disease, every health issue, every time?, Ms Geingos asked.

61. The inequitable distribution of production capacity left some countries at a huge disadvantage, a state of affairs that generated widespread distrust and resentment. Debt was another major obstacle, she said. Many countries were spending more on servicing debt than on health and other social programmes. The world's multiple crises were also drawing attention away from health. Even when political will existed, the fiscal space for action was limited and this made it exceedingly difficult to seek sustainability.

62. Ms Geingos told the PCB that the Council believed there was a moral imperative to address AIDS and other pandemics and to make societies fairer and more equitable; that there was an economic argument for finding new ways to finance pandemic responses; and that it was in countries' self-interest to adopt those actions.

63. The Council's main objectives, she said, were to: build awareness about the links between inequality, AIDS and other pandemics; analyse and use empirical evidence on the relationship between inequalities and AIDS and other pandemics; generate innovative thinking on strategies, policies and ways to combat the inequalities that perpetuate epidemics; and galvanize the political will to implement those plans. In doing so, the Council would support countries and societies to be better prepared to deal with future pandemics, she said.

64. Matthew Kavanagh, Director of the Global Health Policy and Politics Initiative and Assistant Professor in the School of Health at Georgetown, United States, told the meeting that new research showed that income inequality was linked to outcomes for AIDS and other pandemics in a number of respects. Inequality undermined the ability of the state to "see" or "recognize" all its people; at the individual level, it increased risk and undermined effective responses; and it politically destabilized coherent and well-coordinated responses. As an example, he referred to the 12,000 new mpox cases in one country in western and central Africa (more than had been diagnosed in the entire rest of the world), which still lacked an effective treatment programme.

65. Mr Kavanagh described some of the Council's forthcoming research, which would serve to increase public and political awareness of the links between inequality and pandemics. The Council had set up a human rights and gender equity group, as well as a working group on the global economic order, he said. It was bringing together experts and academics from the AIDS world and beyond to engage in new dialogues and analysis that could inform and help build better and more effective HIV responses. In

closing, he thanked the countries and entities that were supporting the Council's work.

66. The Chair opened the floor for discussion. Speakers praised Ms Geingos for her leadership in supporting key and vulnerable populations, countering gender inequalities and rooting her work in a feminist and intersectional approach. They thanked her for insisting on recognizing communities in all their diversity and for calling for a fully funded UBRAF.

67. Speakers said that the COVID-19 and AIDS pandemics showed that epidemics lodged especially among the people who were most disadvantaged and discriminated against. Each day, they reminded the meeting, about 1700 people died due to HIV-related causes and 3500 people acquired HIV. Meanwhile, 9 million of the 39 million people living with HIV were yet to start ARV treatment. Life-saving health commodities continued to be unequally available and social and market failures were widening health and other inequalities. This was evident in one country in western and central Africa, for example, which had reported 700 deaths from mpox, but lacked both treatment and vaccines.

68. Equal access to health commodities was an urgent priority, including through local production and other means, speakers insisted. They congratulated the Council for helping to break the silence on these issues and said they looked forward to seeing the fruits of its work. The need for greater attention to inequalities in access to sexual and reproductive health services, comprehensive sexuality education, and for services that address gender-based violence was also highlighted, and the Council was urged to strengthen links with communities, including women and young people.

69. Speakers said the Council's work was highly pertinent to their HIV epidemics. In the Middle East and North Africa (MENA), for example, HIV incidence was rising, with new infections concentrated especially among ostracized populations such as men who have sex with men and people who inject drugs. HIV and sexual health services were difficult to access (especially for key populations, women and youth), while key populations were criminalized and driven away from health facilities.

70. They said the closure of the UNAIDS regional office in the MENA region had brought additional challenges, including fundraising and the inclusion of civil society in Global Fund and other governance and decision-making structures. They asked that UNAIDS and PCB members facilitate collaborations to counter the reduced commitment shown by international partners; increase funding for HIV programmes in MENA countries, with a focus on civil society organizations; and increase support for the inclusion of civil society leadership, including in PCB meetings.

71. Several members described steps they had taken to reduce inequalities and increase the involvement of key populations in their HIV responses. One member said its Constitution defined health as a universal right and assigned to the state the responsibility to realize that right, while another member shared information about actions to ensure fair access to sexual and reproductive health and rights. One member described its work with BRICS (Brazil, Russian Federation, India, China and South Africa) countries and with countries in Africa, including through medical assistance and debt relief.

72. Speakers said UNAIDS had much to contribute to preparations for future pandemics and noted that the latest draft of the global accord on pandemic prevention, preparedness and response did not reflect the fact that ending the existing HIV and TB pandemics was vital for preparing for future pandemics. The draft also failed to mention the vulnerabilities of key populations and the essential roles of community-led responses in pandemic preparedness efforts. They invited UNAIDS to work with civil society organizations to achieve a pandemic accord that would acknowledge, strengthen and advance the collective efforts to end AIDS.

73. Ms Byanyima thanked speakers for their contributions and said that the inequality lens was a powerful tool for understanding and combating AIDS and other pandemics. It linked HIV responses to the world of rights and the efforts to claim rights, including the rights to health, to equality before the law, to equal access to life-saving technologies, and to gender equality. She concluded by describing some of the fora in which the Council was active.

3. Follow up to the thematic segment from the 52nd PCB meeting: Priority and key populations, especially transgender people, and the path to the 2025 targets

74. Suki Beavers, Director of Gender, Equality and Community Engagement at UNAIDS, presented the follow-up to the thematic segment. Summarizing the process for preparing the segment, she said it had brought together diverse participants from around the world and yielded significant recommendations. Key messages included the disproportionate impact of HIV on key populations in all epidemic settings, and the continuing inequalities in access to prevention, testing and treatment for key populations. Many of inequalities driving HIV stemmed from legal and structural barriers that impeded HIV responses at every step and limited access to other vital health services. Despite some progress having been made in some countries, she said, efforts to further criminalize key populations were continuing in others.

75. Funding for HIV prevention among key populations comprised a small proportion of total HIV spending in low- and middle-income countries, a gap that increased funding and prioritization of investment needs to address, Ms Beavers said. For example, HIV spending for key populations in western and central Africa came to just 2% of total HIV spending in 2021, compared with an estimated need of 16% for 2025.

76. Transgender people were disproportionately affected by HIV, Ms Beavers told the PCB, though more data and analysis centred in an intersectional approach are needed to achieve a comprehensive understanding of that impact. Data gaps were especially large for transmen. High levels of criminalization and marginalization meant that disproportionate numbers of transgender people were in prison, while transgender sex workers faced severe stigma, discrimination, abuse and violence, and transgender youth experienced high rates of homelessness.

77. Ms Beavers said that the Global AIDS Strategy offered an evidence-informed route for getting the HIV response back on track. Noting that several countries were moving in the right direction, she described some of the positive actions being taken in some countries.

78. In conclusion, Ms Beavers referred to recommendations that had emerged from the thematic segment. They included:

- Implementing tailored and data-informed programmes and closing the gaps on population size estimates and disaggregated data on key populations, with a special focus on transgender populations.
- Optimal resourcing for scaling up tailored HIV prevention, testing and treatment services that address the needs of key populations, especially transgender people.
- Increasing community-led services and funding to reach the 30–60–80 targets.
- Addressing discrimination and legal barriers, including by reviewing and removing harmful and punitive laws and policies.
- Strengthening an evidence-based, gender responsive and human rights based public health approach to key populations and HIV.
- Integrating social protection in health and HIV responses.
- Adopting people-centered approaches that address socioeconomic inequalities.
- Enhancing the meaningful engagement and leadership of key populations, with specific emphasis on transgender individuals.

79. Speaking from the floor, participants commended the Secretariat for organizing the thematic segment and thanked participants for sharing their experiences and insights. They highlighted the diverse character of key populations and the intersecting inequalities and inequities affecting their lives. The lack of decisive action on these issues undermined the global HIV response, they said.

80. Speakers noted that most new HIV infections outside sub-Saharan Africa were among key populations and their partners. They stressed that improved data—including through community-led data gathering—were needed to inform impactful responses and that key populations had to be able to participate safely in such data collection efforts. More generally, HIV programmes had to listen to and work with key populations if they were to be effective in reaching and benefiting everyone who needed them.

81. The meeting was told that the disproportionate impact of the AIDS pandemic on key populations reflected deep-seated social inequities that heightened their vulnerability and limited their access to HIV services. Speakers insisted on the adoption of rights-based principles and approaches and said the exclusion of key populations from HIV and other health services was unacceptable. Some speakers supported the central message that communities should lead HIV responses and emphasized that countries had a "non-negotiable" obligation to protect everyone's sexual and reproductive health and rights.

82. Cosponsors told the meeting that consolidated guidance for key populations had been published and that specific guidance for transgender people was being prepared. Those evidence-based guidelines stated the need to uphold everyone's human rights, ensure their access to sexual and reproductive health and rights, and provide appropriate and safe services for key populations.

83. Programmes that address the diverse needs of key populations had to be scaled up, speakers insisted. However, funding for those programmes was inadequate. In 2022, there was an estimated 90% funding gap for prevention for key populations in low- and middle-income countries measured against the projected funding need in 2025.

84. Some donors told the meeting that health equity for priority and key populations was at the core of their HIV support and that it was important to hear the views of key populations to improve treatment and care services. They also called for better data to guide action (including community-led data that includes people's experiences of HIV services), and more efforts to bolster the leadership of key population organizations.

85. Speakers also noted progress made in recent years, including that currently two-thirds of countries did not criminalize LGBTI persons. But strong concerns remained about the persistence of punitive laws that block access to HIV and other health services for key populations, and about ongoing stigma and discrimination. The world was not on track to meet 10–10–10 targets, the PCB was told, and there was an emerging trend of increased criminalization of key populations in some countries. Speakers called on all countries to reform harmful and criminal laws against key populations, especially transgender people, and to promote community-led HIV responses.

86. Some members described how they were updating their key population size estimates via countrywide exercises, including for gay men and other men who have sex with men and for transgender people. Others said they were diversifying their prevention programmes to cater to the varied needs of different populations who struggled to access health services. They described some of the services and innovations, including tailored prevention and care packages, the use of differentiated service models, and engagement with civil society.

87. In reply, Ms Beavers thanked the speakers for their comments and noted the common themes regarding data gaps and the impact of criminalization, stigma and discrimination, and structural factors on key populations, including transgender people, and the need for the HIV response to effectively address them. She recognized the examples shared of tailored service delivery and its importance for key populations but emphasized that much remained to be done to reach the 10–10–10 targets. In closing, she thanked members for sharing examples of efforts to provide improved data and differentiated services, and for emphasizing the importance of dedicated investments to scale-up those kinds of initiatives.

88. Referring to the decision points for this agenda item, The Russian Federation said it disassociated itself from the decision points. It asked that this be reflected in the report and in the decision points.

89. Iran (Islamic Republic) and Libya said that they disassociated themselves from the decision points for agenda item 3 and asked that their statement be reflected in the report.

4. Follow-up actions to the 2024–2025 Budget and Workplan

90. Christine Stegling, Deputy Executive Director for Policy, Advocacy and Knowledge, UNAIDS, presented this agenda item. She reminded the Board of the relevant decision point from the 52nd PCB meeting regarding scenario planning for the 2024–2025 budget, an integrated budget with projected core and noncore Secretariat resources, and an assessment of the impact of insufficient core revenues on execution of the 2024-2025 workplan.

91. Ms Stegling sketched some of the context, including prioritization efforts aimed at retaining UNAIDS' core capacity to fulfil a multisectoral coordination role in the global HIV response. She told the meeting that the projected core funding available in 2024 would be 52% lower than in 2015 in real terms (i.e., taking inflation into account). This was happening in the context of funding challenges across the entire UN system, which also reduced Cosponsors' capacities to compensate for UNAIDS funding losses. She explained that 75% of core resources for the Secretariat went towards personnel costs since staff were the biggest expenditure in an organization that plays a fundamentally coordinating role.

92. The 2023 ECOSOC resolution and the MOPAN assessment had reaffirmed the importance of the Joint Programme, Ms Stegling said, including for providing comprehensive data and strategic information for effective HIV responses; for convening, coordinating and supporting communities, countries and partners; and for supporting country programmes and accountability mechanisms, including through civil society.

93. Ms Stegling explained that core funding went towards the basic strategic funding of the Secretariat and towards catalytic funding for the work of the 11 Cosponsors. Noncore funding mainly entailed earmarked funds that were designated for specific countries or purposes. She emphasized that noncore funds had limited flexibility and complemented but did not substitute core funds. She directed the meeting to the background paper for further details.

94. The 52nd PCB meeting had approved the UBRAF at two levels, she recalled: at US$ 210 million and US$ 187 million. In response to decision point 6.8 from that meeting, the Secretariat had developed three funding scenarios, including a projected core income of US$ 160 million annually for the 2024-2025 biennium. Ms Stegling then briefly discussed the three different funding scenarios.

95. Angeli Achrekar, Deputy Executive Director of the Programme Branch, UNAIDS, discussed the critical focus across the whole Joint Programme for four overarching priorities undertaken by UNAIDS with an eye on achieving the 2025 targets and on ensuring that the Joint Programme continued to drive progress around prevention, access to treatment, the promotion of community-led HIV responses including community-led HIV services and monitoring, and equitable financing for HIV programmes and sustaining the HIV response. Undergirding that work were efforts to end HIV inequalities including protecting human rights, removing punitive laws, policies and other social structural barriers, and ending stigma and discrimination, she explained. The prioritization already applied for the 2024-2025 workplanning, was aligned with the Global AIDS Strategy, overall Joint Programme priorities and the 10 UBRAF result areas, and took into account local realities and needs.

96. More specifically, she highlighted the financial, programmatic and geographic prioritization for UNAIDS country envelopes which fund Cosponsors' priority work in countries. She said the revised country envelopes model had been informed by findings of the external evaluation of country envelopes and, that, as a result of funding shortfall, further prioritization was further applied for 2024-2025: overall reduction in the amount allocated to country envelopes (from an annual $25 million in 2022 to an annual $17.5 million from 2024), reduction in the number of country envelope countries benefiting from a country envelope (from 91 in 2022-2023 to 79 from 2024 and programmatic prioritization for the four overarching priorities. The country envelopes allocation across and within countries is informed by evidence and local contexts and needs, she stressed.

97. She then discussed the impact of the US$ 160 million scenario on the Joint Programme's capacities which had been reduced to the lowest possible amount. Funding shortfalls and unpredictability of funds had already led to the closure of some UNAIDS offices, less HIV visibility among Cosponsors, and affected the targeted leveraging of core capacities and complementary roles of Cosponsors. The funding situation had also weakened multisectoral coordination, which affected several result areas. The country-level impact was being reduced due to the smaller footprint across countries and the loss of capacity and expertise. This was also affecting the Joint Programme's work with and support for civil society and communities, which was a major concern in the context of shrinking civic space. Capacities to respond to humanitarian and other crises have also slowed. The Joint Programme's limited budget was also affecting its oversight, governance, evaluation and ethics work, along with its leveraging power in the UN system.

98. Despite efforts to stabilize the Joint Programme, the lack of core resources was taking a major toll, said Ms Achrekar. Yet the funding shortfall could be drastically reduced, even removed, by exceptional support from one or two donors, or small increases from several donors. Looking ahead, she discussed some of the milestones for 2024 and 2025 and said UNAIDS would continue to develop the sustainability agenda with countries, communities, major donors such as PEPFAR and the Global Fund, and regional entities. Working with Cosponsors, the Secretariat would further accelerate its efforts to fully fund the UBRAF. It would present a mid-term review of the current Global AIDS Strategy and, in late 2024/early 2025, it would commence the consultative process for developing the next Strategy. In 2025, it would present an outline of the longer-term vision for the Joint Programme for 2030 and beyond.

99. In discussion from the floor, speakers thanked the Secretariat for the report and said that the significant progress achieved in the global HIV response testified to the impact of UNAIDS' mobilizing and coordinating work at all levels. They highlighted the hard work and dedication of staff despite the challenging fiscal context and strained capacity and acknowledged the impact of cost-cutting measures on staff's health and well-being.

100. Speakers said they appreciated UNAIDS' actions to reduce costs within the Workplan and its scenario-planning efforts but expressed concern about the impact of the funding situation on the Joint Programme's work, including the closure of offices, staff reductions, loss of capacity, and the destabilizing effect of constant changes. Reduced resources for

the Joint Programme would have a negative long-term impact on the world's efforts to end the AIDS pandemic, they warned.

101. Reductions in core staff were weakening the Joint Programme's presence in several regions and the lack of core funding affected the multisectoral approach. Several speakers pointed to the closure of the UNAIDS regional office in the MENA region, even though it was experiencing major humanitarian crises and a growing HIV epidemic. Steps for avoiding the impact of the closure of UNAIDS offices were noted, including the creation of multicountry offices and the posting of HIV advisers within certain UN Resident Coordinator Offices.

102. Cosponsors emphasized that staff were the most important asset in the Joint Programme and said that a capacity assessment in 2022 had shown a decline in the number of staff members working on HIV, with overall capacity already below the "mission critical" level. Cosponsors continued to lose institutional memory and dedicated HIV expertise and were increasingly reliant on non-staff to relieve gaps. This had an adverse impact on the Joint Programme's ability to work and engage at country levels. Vital, core work was under threat. Speakers emphasized the need to ensure ongoing availability of the country envelopes and asked the Joint Programme to further improve the current country envelope model. It was suggested that funds for Cosponsors could be allocated more equitably and proportionally.

103. Speakers said they were struck by the fact that the projected funding for UNAIDS in 2023 amounted to less than 50% of what had been available in 2015 in real terms. This had disturbing implications, they said. The multisectoral human rights-based approach pioneered by UNAIDS, the mainstreaming of HIV, and the emphasis on inclusive governance and community engagement were all at risk. Also troubling was the prospect that the crucial strategic information work performed by UNAIDS might suffer budget cuts. The budget shortfall would also affect the Joint Programme's ability to promote and support community leadership in the HIV response.

104. The NGO Delegation appealed to the Secretariat to "let communities lead" and stressed the importance of a fully funded NGO Delegation in 2024 and 2025. There was also concern about reduced funding for the Ethics and Evaluation Offices.

105. Speakers welcomed the integrated budget, and recognized the steps taken and the plans to align the budget with reduced income. They supported the proposed focus on HIV prevention and treatment; the empowerment of communities; and securing financing for a sustainable response. The Secretariat was asked for additional information about some aspects of the Workplan and Budget. Noting that the budget cuts were spread more or less equally across result areas, speakers said it was unclear how that fitted with efforts to protect UNAIDS' core functions.

106. Speakers commended the efforts of the resource mobilization team to expand the donor base in a challenging context and urged the Secretariat to also draw on its multisectoral character to secure additional funding. Donors were asked to renew their commitments and to contribute a fair share to a fully funded UBRAF in order to safeguard the gains made in the global HIV response. The emphasis should be on ensuring sufficient core

funding for UNAIDS, preferably through multiyear, predictable commitments. Broadening the donor base through a more strategic approach was important.

107. Achieving the 2030 targets and goals depended on an innovative, efficient and fully resourced Joint Programme, the meeting was told. Speakers underscored the need for a resilient UNAIDS that was capable of pursuing a clear and realistic Workplan: risk management and prioritization now would pay off in the future. UNAIDS was encouraged to build on upcoming processes, including the mid-term review and the development of the next Global AIDS Strategy, and members were urged to seek ways to augment their support to their Joint Programme.

108. While it was vital to secure additional funding, UNAIDS also had to prioritize its work, the meeting was told. The representative from the United States (US) told the meeting that the contributions made by the US Congress could not be increased at the moment. The need for an effective Joint Programme was indisputable, but an impasse had been reached around funding and ways had to be found to overcome that impasse. A different vision, based on the available resources, was needed. Other speakers concurred, saying that the function and form of the Joint Programme had to be adjusted to ensure it was fit for purpose. This work had to start immediately.

109. While agreeing on the need for systemic change, they said UNAIDS could not reasonably be expected to do "everything": other multilateral entities, including and beyond the Cosponsors, may be better suited to contribute to areas that reflect their core mandates. They suggested that both the Secretariat and the Joint Programme clarify their distinct advantages and "value-adds" and treat those as core functions.

110. Speakers felt it was important that the prioritization proposed by the Secretariat should focus on the core HIV mandate of the Joint Programme and said the MOPAN assessment offered important guidance for further prioritization. Speakers said they would appreciate regular updates and consultation with the PCB on the prioritization and trade-off decisions that were being considered, given the PCB's responsibilities as outlined in the Modus Operandi. It was suggested that an independent evaluation of the Joint Programme, drawing on the mid-term review, could inform the further evolution of UNAIDS business model. While welcoming the proposed prioritization, speakers also appealed to donors to achieve a fully funded UBRAF.

111. Some speakers described steps they had taken to make their HIV responses more resilient and sustainable, including through the use of data and by mobilizing additional funding for priority programmes.

112. In reply, Ms Stegling thanked speakers for their remarks and suggestions. She reminded the PCB that 60% of the global HIV response was being funded by countries themselves and that a fully funded UBRAF would require only about 1% of total global expenditure on HIV. Referring to remarks about further fine-tuning UNAIDS' priorities, she said it was important to have an honest conversation about how to strike an appropriate balance between close oversight and effective management. She also reminded the meeting that the Joint Programme's work had an important bearing on other HIV investments globally

and said it would explore ways to connect those dimensions more effectively.

113. Ms Achrekar thanked speakers for their constructive input. It was important to recall that the Joint Programme had been created in an unprecedented move to bring together different sectors, entities and resources and to devise new ways of working to tackle a massive pandemic. This had led to enormous success across the world, with huge returns on investments for public health and development more broadly. The focus should be on how to sustain and elevate that work and the Joint Programme's role in it, she said.

114. In reply to a request for further information on the Workplan, Ms Achrekar said this would be provided as part of the report-back at the June 2024 PCB meeting, as was normally done. In 2024, UNAIDS would also draw on new data inputs and the mid-term review to make it more fit-for-purpose and would consider options to further optimize all available resources, including but not limited to the country envelope. Ultimately, evidence and country-level realities had to guide its work, how it operates most effectively, and how it allocates its resources and sets its priorities, she stressed.

115. The Executive Director took the floor and shared examples of the unique contributions of the Joint Programme, such as appearing in court challenges and bringing communities into decision-making forums. UNAIDS had a presence in over 76 countries, with 80% of Secretariat staff working in countries and regions, she said, but funding shortages made it difficult to maintain that level of in-country presence. While the discussions should be about sustaining the work of the Joint Programme in difficult conditions, Ms Byanyima said, it was being asked for more information on the Workplan and Budget. Resources were shrinking but UNAIDS was expected to report on the use of those resources in increasing detail. The reporting and accountability duties imposed on the Secretariat had to be fulfilled by the same overworked staff who were responsible for carrying out its mandate. She appealed to donors to restrain increasing reporting demands.

116. Regarding the NGO Delegation's funding concerns, Ms Byanyima said the Delegation would always be supported to the best of UNAIDS' ability. She said the Delegation's budget had been kept at the same level as previous years, but that the requested increase could not be granted.

5. Evaluation annual report and Management response

117. Joel Rehnstrom, Director of Independent Evaluation, UNAIDS, introduced the report and said the independent evaluation function was now well-established. The MOPAN assessment had considered the evaluation function and concluded that it performed well, while noting that more was expected from the Joint Programme on evidence-based design of programmes (i.e., learning from evaluations). The Office's overall financial implementation rate was 92%, he said. Recent evaluations had highlighted the value of the country envelopes, the need to promote HIV-sensitive social protection, and the need for further guidance on integrating HIV into primary health care.

118. Mr Rehnstrom briefly described the roles and responsibilities of the PCB, the Expert Advisory Committee on evaluation, and the evaluation offices of the Cosponsors in

relation to the UNAIDS evaluation function. He noted that the role of the Evaluation Office was to assess the performance, effectiveness, efficiency and sustainability of the Joint Programme, not of national or global responses to HIV. He then briefly discussed the current and proposed membership of the Expert Advisory Committee on evaluation.

119. Ms Jyothi Raja Nilambur Kovilakam, Senior Adviser, Independent Evaluation, said the 2024–2025 Evaluation Plan was based on the UNAIDS Evaluation Policy and was in line with the Global AIDS Strategy and the UBRAF and had been developed through a consultative process. Topics had been discussed with the Expert Advisory Committee on evaluation and with Cosponsors' evaluation offices and UNAIDS staff. She reviewed the criteria for selecting evaluation topics and said the 2024–2025 Evaluation Plan included six proposed evaluations, of which four were joint evaluations and two were Secretariat evaluations. The proposed budget was US$ 1.4 million per year, including staff costs (for three positions), evaluations, follow-up and other activities. The proposed budget for the Office had been set at 0.7% of total organizational expenditures.

120. Good progress had been made in implementing the 2022–2023 Evaluation Plan, which had generated valuable evidence on the role and contributions of the Joint Programme, Ms Kovilakam told the PCB. Looking ahead, she said additional emphasis would be placed on analysis and syntheses across evaluations to feed into UBRAF planning. Evaluation findings would be disseminated widely to guide future actions and additional support would be provided for the development of management responses and for monitoring the implementation of recommendations. Close collaboration with the evaluation offices of Cosponsors and other UN agencies was critical and would continue. She appealed to the Secretariat to ensure that the Evaluation Office received all necessary resources and support while it completed its move to Bonn, Germany.

121. Mahesh Mahalingam, Chief of Staff of UNAIDS, acknowledged the production of high-quality and relevant evaluations in constrained circumstances and lauded the important role of the Evaluation Office in deepening an evaluation and learning culture in UNAIDS. He welcomed the proposed topics for evaluation in 2024-2025 and said they would further refine UNAIDS activities and the development of the next Global AIDS Strategy.

122. He briefly described the three evaluation reports that had been received and the actions taken. The evaluation of the effectiveness of country envelopes had shown that the envelopes were greatly appreciated and needed at the country level, he said, and the evaluation was informing efforts to improve that system. UNAIDS would strengthen mutual accountability processes to promote the efficient use of country envelopes with an enhanced role for the Joint UN Team on AIDS at the regional level. Management responses to the evaluations of HIV and primary health care and of HIV-sensitive social protection would be developed shortly, he said.

123. Mr Mahalingam said the Secretariat supported the planned evaluations for the next biennium and looked forward to the independent review of the Evaluation Policy in 2024. He assured the PCB that the Secretariat was committed to a smooth transition of personnel to the new office in Bonn and provided an update on the recruitment of a successor to Mr Rehnstrom, whom he thanked for his excellent service and

contributions. A total of 45 applications for the director's post had been received, of whom 12 had been short-listed, he said.

124. The Chair opened the floor for discussion. Speakers thanked the outgoing director for his outstanding contribution to UNAIDS. They commended the Evaluation Office for promoting accountability and evidence-based decision-making and for strengthening the evaluation culture in recent years. They also noted that the MOPAN assessment had reaffirmed the important work of the Office and requested that the Executive Director ensure that the evaluation function was fully resourced. Evaluations were vital for demonstrating the impact of the Joint Programme's work and showing how resources and capacities could be used optimally, they said.

125. Speakers also thanked the current Expert Advisory Committee on evaluation for its important work in providing guidance on the evaluations. They reiterated the Office's call that all regional groups propose experts to the Committee in line with the criteria laid out in the terms of reference. There was a request that nominations to the Committee be shared with PCB members well in advance.

126. Discussing the evaluations conducted in the previous year, speakers highlighted the timeliness of the social protection evaluation and said the recommendations should advance efforts in that area of work. The evaluation of HIV and primary health care was also very timely, they said, given the emphasis on the sustainability of HIV services and community engagement. The evaluation had confirmed the importance of prioritizing the needs of key populations. Speakers said the evaluation of the country envelopes had yielded important findings and noted that both the average allocation amounts and the number of recipient countries for country envelopes had been reduced. They urged that further changes to the country envelopes be made in close consultation with Cosponsors.

127. Members acknowledged the commitment in the management responses to apply the recommendations from the evaluations and asked that the response include detailed and timebound commitments for implementation. They said they looked forward to the implementation of the recommendations and to seeing the outstanding management responses to other evaluations.

128. Speakers supported the proposed Evaluation Plan and topics for 2024–2025 and welcomed efforts to leverage the evaluation capacities of the Secretariat and of Cosponsors. Expressing concerns about the impact of resource constraints on evaluations, speakers said they supported plans for more joint evaluations with Cosponsors and for the reduced number of evaluations (but with additional emphasis and budget for planned knowledge translation and learning from evaluations). Speakers requested clarification about the timing of the evaluation of the Joint Programme’s role in achieving the 2030 goal and sustaining gains and asked that this evaluation be initiated in 2024 rather than in 2025, aligning with the PCB thematic segment in June 2024. They also asked whether all parties had agreed to finance the shared evaluations and how the proposed evaluation between the Global Fund and the Joint Programme would be co-funded.

129. Speakers questioned the decision to postpone the evaluation of human rights and HIV, which they said was central to the future planning and work of the Joint Programme. It was suggested that human rights be a cross-cutting theme for future evaluations. It was also suggested that community-led monitoring include youth-led monitoring, given the difficulties young people in many regions experience when trying to access HIV and other services. The Secretariat was asked how community-led generation of data would find its way into the evaluation processes and recommendations of the Joint Programme.

130. Speakers noted the resource constraints, but strongly urged the Secretariat to adequately resource the Evaluation Office and to respect the 1% spending target. Good oversight and evaluation required resources, they stressed.

131. In reply, Mr Rehnstrom thanked speakers for their comments. Addressing the specific issues raised, he said that not all evaluations were captured in the evaluation plan. Units and departments also conducted internal reviews and evaluations, and the Evaluation Office assisted them in designing those reviews.

132. Regarding the HIV and human rights evaluation, he said that human rights would continue to be integrated as a crosscutting theme in all evaluations, along with gender. However, he acknowledged that this did not remove the need for a specific evaluation and said the Evaluation Office would pursue the possibility of conducting such an evaluation with the Cosponsors. He added that an evaluation conducted in 2022 on the Joint Programme's work on key populations had included many human rights issues, and said an upcoming evaluation on community systems would also have a strong focus on human rights. Regarding community-led data collection, he said one of the evaluations in 2024 would include a component on community-led monitoring. The Evaluation Office would also focus on the issue in its evaluation on community systems.

133. Regarding the collaboration with the Global Fund, he said it had not been possible to schedule an evaluation in 2024 and that it had been moved to 2025; the possibility of joint financing of that evaluation was being explored. He said it would be helpful if members of the Global Fund board would highlight the importance of such an evaluation. The Evaluation Office was actively pursuing co-financing and cost-sharing arrangements for joint evaluations and had already received contributions (often in-kind contributions) from several Cosponsors. He doubted, however, whether Cosponsors would be able to contribute much more funding but said that the contribution of expertise from Cosponsors was also very valuable (as seen in the social protection evaluation).

134. Mr Rehnstrom welcomed the suggestion to turn evaluation findings and recommendations into organizational learning. He also welcomed the appreciation shown for the importance of the Expert Advisory Committee and the need for an optimal mix of expertise and experience on the Committee and noted the need to allow for more time for nominations of Expert Advisory Committee candidates. He agreed that the timing of evaluations had to be considered carefully given all the other ongoing processes.

135. Responding to other remarks, he said national evaluation capacity was being strengthened by engaging national consultants and teaming them with international evaluators. The Office was also working with Cosponsors, other UN agencies and civil

society partners to share rosters of national consultants and build their capacities. He also noted the important role of civil society in designing evaluations. In closing, he told the meeting that a conflict-of-interest procedure was being used for staff recruitment and for consultants. The Office would review the procedure to ensure it was up to date.

136. Mr Mahalingam assured the PCB that UNAIDS management would continue to support and strengthen the Evaluation Office and work with it to integrate learnings as part of knowledge management. Management had taken note of the concerns about the Office's budget, he said. The budget estimate presented by the evaluation office is based on a percentage of core and non-core funds while the funding for the office comes entirely from core funds, which is limited. However, management will work with the evaluation office to try and address this issue.

137. Ms Byanyima, on behalf of UNAIDS and the PCB, thanked Mr Rehnstrom for his leadership, for pioneering the establishment of the Evaluation Office, and for 25 years of work with UNAIDS.

6. Consultation on the follow-up to the 2023 ECOSOC Resolution

138. A representative of Brazil, PCB Rapporteur, on behalf of the PCB Bureau, provided background to the consultation. They said the Joint Inspection Unit (JIU) had conducted a review of the management and administration of UNAIDS in 2019 which included an informal recommendation that the PCB initiate a dialogue with the UN Secretary-General on the term limit for the position of UNAIDS Executive Director, performance expectations and other related issues. The PCB had established a working group to consider all the JIU recommendations that had been addressed to the PCB. The final report of that working group had been presented at the 47th PCB meeting in 2020 and had concluded that some recommendations were not in the immediate remit of the PCB, but rather in that of the Economic and Social Council (ECOSOC) or the Secretary-General. The PCB reported on those recommendations in its report to ECOSOC in 2021.

139. In its resolution E/RES/2021/26 from 2021, they continued, ECOSOC had requested that the Secretary-General submit a report, after consultation with the Programme Coordinating Board, on the establishment of two four-year term limits and performance expectations for the position of UNAIDS Executive Director, in line with the practices of the UN system and as recommended by the JIU. In addition, in its resolution E/RES/2023/30 from 2023, ECOSOC had reiterated its request to the Secretary-General to submit to the Council, before its 2025 session and after consultation with the PCB at its 53rd meeting, a report on the follow-up to the 2021 ECOSOC resolution regarding the establishment of term limits and performance expectations for the position of the Executive Director.

140. They said the UN Secretary-General had decided, in line with the current established practice for senior appointments, not to establish term limits for the position of UNAIDS Executive Director. The Executive Office of the Secretary-General had also requested information from the PCB on the exercise of its role in overseeing the performance of the Executive Director. They explained that the report prepared by the PCB Bureau

responded to ECOSOC's request for a consultation with the PCB at its 53rd meeting and served as background to the current discussion.

141. The report summarized the role of the PCB in oversight and accountability of the Joint Programme, based on its founding ECOSOC resolutions and the recently amended PCB Modus Operandi. It clarified that the Secretary-General "holds the oversight responsibility for the Executive Director position whereas the PCB is responsible for the oversight of the UNAIDS Joint Programme." In that capacity, the Secretary-General was responsible for selecting and directly supervising the performance of the UNAIDS Executive Director.

142. The PCB Bureau had proposed that the Board discuss perspectives on the establishment of performance expectations for the Executive Director, which the Secretary-General would then consider. That discussion would take into account the objectives of the Joint Programme, the functions of the PCB and the Executive Director (as set out in the Modus Operandi), and the competencies for the role of the Executive Director. A report summarizing the discussion would then be circulated to PCB members and participants for comments, after which it would be transmitted by the PCB Bureau to the Executive Office of the UN Secretary-General.

143. The Chair opened the floor for discussion. Members thanked the PCB Bureau for the comprehensive report on the follow-up to the 2023 ECOSOC resolution and said the issues of performance management and term limits addressed in the report lay at the heart of good and appropriate governance.

144. Reiterating their commitment to an open, transparent and independent Joint Programme with robust systems, some speakers said they welcomed efforts to strengthen the role of the PCB and the Executive Director in line with their respective mandates. They stressed that accountability was a cornerstone of the UN mission and said that the 2023 ECOSOC resolution had also underscored the paramount importance of accountability, transparency and leadership. They emphasized the importance of continuously strengthening the governance and accountability of the Joint Programme and said the JIU in 2019 had provided important recommendations for doing so, among them recommendations for setting clear parameters for leadership through the introduction of term limits and performance expectations for the position of Executive Director. They also noted that the PCB working group of 2020 had concurred with the JIU's view that the introduction of term limits and performance expectations for the position of Executive Director were important.

145. Speakers also recalled that the PCB working group had recommended in 2020 that the Secretary-General was the appropriate authority to consider the JIU's recommendations related to term limits and performance expectations for the position of Executive Director. This, they said, was in line with the PCB's modus operandi, which established that the Secretary-General held the oversight responsibility for the Executive Director position, whereas the PCB was responsible for oversight and accountability of the Joint Programme (in line with the founding ECOSOC resolution).

146. Speakers welcomed the PCB Bureau's proposal that the PCB discuss ways in which the Secretary-General might consider the establishment of performance expectations. Those

discussions, they said, should take into account the mandate of the Joint Programme, the functions of the PCB and the Executive Director, and the competencies for the role of the Executive Director.

147. Some members encouraged the Secretary-General to consider the PCB's perspectives on the introduction of performance expectations as recommended by the JIU in 2019. They stressed the importance of strong governance processes with transparency and effective accountability. The introduction of performance expectations would strengthen governance and accountability of the Joint Programme and enhance the confidence and trust of stakeholders, some speakers argued. While noting the Secretary General's decision not to establish term limits for the position of Executive Director, some members reiterated the need to establish clear performance expectations for that position. Clear criteria for performance expectations would help improve transparency and provide clarity.

148. Several members reminded the meeting that performance management frameworks for senior executives were common best practice across the public and private sectors. They recalled that the PCB working group had noted that several UN agencies and organizations indeed had performance compacts. A similar compact would be suitable for UNAIDS, they proposed, and could be managed by the Secretary-General, given that the Modus Operandi clearly stated that the Executive Director was accountable to the Secretary-General.

149. Several potential reference points for defining the criteria for performance expectations were proposed, including the performance compacts used in other UN organizations, one speaker said. Some speakers highlighted criteria such as: achieving objectives and high-quality results, compliance and effective delegation of authority, responsible stewardship, and implementation of oversight body recommendations. They also suggested that the criteria and competencies which had guided the selection of the Executive Director could help shape the performance expectations to be considered by the Secretary-General. The PCB might also propose additional elements that reflect the criteria used to assess the Joint Programme overall.

150. Speakers suggested that the Office of the Secretary-General propose performance management expectations, and mechanisms for implementing them, in line with the criteria outlined in the PCB Bureau's report.

151. While noting the need for an open and transparent UNAIDS, other members said that the PCB should restrict itself to its mandate, which was to establish policies and priorities and provide oversight for the Joint Programme in order to guide its operations and activities within the UN Development System. They reminded the meeting that the Secretary-General held responsibility for the Executive Director position, while the PCB was responsible for oversight of the Joint Programme. They also reminded that the PCB working group had recommended that the Secretary-General was the appropriate authority to consider the JIU's recommendations on term limits and performance expectations for the position of Executive Director.

152. These members acknowledged that some entities in the UN system had performance compacts in place which outlined performance expectations for executive heads. However, they believed that the reports which the Executive Director presents to the PCB biannually, as well as the reports submitted to ECOSOC via the UN Secretary-General's Office were effective in terms of performance expectations.

153. Regarding term limits, some speakers noted that the letter from the Executive Office of the Secretary-General had informed that the Secretary-General had decided not to establish term limits for the position of Executive Director. They referred to the JIU's recommendation that term limits be set and told the meeting that some of the heads of similar UN organizations (e.g., UN Women and UNHCR), also appointed by the Secretary-General, were subject to two-term limits of four years each. Expressing the view that term limits would bring greater accountability to the Joint Programme, they asked why the Secretary-General was deviating from that practice in the case of UNAIDS.

154. Other members told the meeting that, in accordance with the ECOSOC resolution, the PCB was entitled to set political, financial and management guidelines for the position of the Executive Director and regularly examine how they were being observed. However, the PCB could not decide on term limits for the Executive Director. They therefore supported the decision of the Secretary-General, in line with what they said was current practice for senior appointments in the UN System, not to establish term limits.

155. It was noted by some speakers that the respective recommendations under discussion were longstanding and had been clearly articulated in the JIU's 2019 report.

156. One member said it was important to ensure that the consultation process was complete and that the Secretary General receives all the information presented in this segment of the PCB meeting.

7. Next PCB meetings

157. Morten Ussing, Director of Governance, UNAIDS, briefly outlined the paper, including the process for determining the themes for the thematic segments of PCB meetings. He said 10 proposals had been received in 2023 and the PCB Bureau had agreed on the 2 topics for 2024, based on 4 criteria (broad relevance, responsiveness, focus, and scope for action) on the following themes:

- *Sustaining the gains of the global HIV response to the 2030 and beyond* for the 54th PCB meeting in June 2024; and
- *Addressing inequalities in children and adolescents to end AIDS by 2030* for the 55th PCB meeting in December 2024.

158. The PCB meeting dates had also been decided: 30 June–2 July 2026 (58th PCB meeting) and 8–10 December 2026 (59th PCB meeting).

8. Election of officers

159. Mr Ussing, Director of Governance, UNAIDS, informed the meeting that the 22 Member States represented at the PCB had been identified. After explaining the process for selecting officers of the Board, he said expressions of interest had been received from Brazil to serve as Vice-Chair and Netherlands to serve as Rapporteur, while Kenya would assume the role of Chair in 2024.

160. He also described the process for electing the NGO Delegation. In 2023, seven delegates were eligible to continue for a third year in the NGO Delegation, leaving two vacancies to be filled for 2024 and 2025. The new delegates proposed were Frontline AIDS (Europe) and LetsStopAIDS (North America). He thanked the outgoing NGO Delegates: Erika Castellanos, for Europe, and Christian Hui, for North America.

161. In discussion from the floor, speakers thanked Germany for its excellent work as Chair during 2023 and congratulated Kenya, Brazil and the Netherlands on being elected to serve respectively as Chair, Vice-Chair and Rapporteur. They also thanked the outgoing members of the NGO Delegation for their dedication and hard work. Germany, as outgoing Chair, thanked the Vice-Chair, the Rapporteur and the Secretariat for their support and assistance. Kenya, as incoming Chair, paid tribute to Germany for its chairing of PCB meetings in 2023 and said UNAIDS' unique multilateral model had helped transform the global HIV response. The world was closer to ending the pandemic, but still faced major gaps in access to testing and treatment and in preventing new infections, including for children and adolescents. Kenya urged all Members to intensify their actions to reach the goal of ending AIDS. One member asked for greater diversity in the selection of NGO delegates.

9. Renewal of terms for the UNAIDS Independent External Oversight and Advisory Committee (IEOAC)

162. Morten Ussing, Director of Governance, UNAIDS, briefly reviewed the establishment of the Independent External Oversight Advisory Committee (IEOAC) following the decision taken at the 45th meeting of the PCB. Noting that the Committee had seven selected members, he reviewed the terms of reference regarding term limits for members. He explained that the members were at different stages in their terms and said that the Board was being asked to renew the terms of four members who were seeking a renewal of their terms for an additional two years.

163. In discussion from the floor, speakers thanked the out-going Vice-Chair and Chair for setting very high standards, while the Executive Director thanked the outgoing delegates for their work and support, and praised Germany, as outgoing Chair, for steering the PCB through sensitive discussions in the previous year. She welcomed the new PCB Bureau members and NGO delegates.

10. Thematic Segment

164. The thematic segment focused on HIV testing as the gateway to HIV prevention, treatment, care and support services, and on practical approaches to make testing services person-centered, individual and community needs-focused, integrated,

functional, effective and sustainable.

Introduction and keynote addresses

165. Angeli Achrekar, Deputy Executive Director of the Programme Branch, UNAIDS, introduced the thematic segment and handed the floor to Winnie Byanyima, UNAIDS Executive Director, who hailed the progress made in expanding HIV testing and treatment services. In 2022, she said, five African countries had reached the 95–95–95 targets ahead of the 2025 timeline and 16 countries, eight of them in Africa, were close to doing so. But major gaps remained. Globally, 86% of people living with HIV knew their HIV status, but only 63% of children living with HIV had been diagnosed and the diagnosis of HIV infection among key populations also lagged. Undiagnosed people living with HIV were not benefiting from combination prevention and treatment services. Various testing modalities were being used, but not yet at the scale required, Ms Byanyima said, while some policies (e.g., strict age-of-consent requirements) made testing access difficult, as did the criminalization of key populations, and stigma and discrimination in health-care services. Yet, some countries were doing well and had important lessons to share, she said.

166. Kevin Fenton, Regional Director for London in the Department of Health and Social Care's Office for Health Improvement and Disparities in the United Kingdom's Department of Health and Social Care, briefly described the HIV epidemic in England, where the 95–95–95 targets had already been reached. He said new HIV diagnoses had decreased markedly since their peak in 2005 although the rate of decline was now slowing. Strong community engagement had been crucial for the achievements, along with strong political commitment. Mr Fenton described the development of the HIV Action Plan, which had been launched in 2021. The Plan focused on achieving equitable access to HIV prevention; scaling up testing; optimizing rapid access to treatment; addressing stigma; and improving the quality of life for people living with HIV. The Action Plan was being led by a national implementation steering group, with a community advisory group providing additional input.

167. As an example of a successful testing approach, Mr Fenton described the scale up of HIV and hepatitis C virus testing in emergency departments in London hospitals, using an opt-out approach. This had doubled HIV testing capacity in the city and had identified 934 previously undiagnosed people living with HIV and 3,000 people living with hepatitis C. HIV-related stigma remained a challenge, however. The Action Plan therefore included interventions such as additional training for health-care workers and partnering with communities to reduce stigma. Ultimately, communities had to be at the centre of the response, Mr Fenton said, with committed leadership, clear governance and strong accountability the other crucial factors for a successful HIV testing strategy.

168. Daughtie Ogutu, Programme Manager at GNP+ in Kenya, credited her survival as a mother living with HIV to being able to access HIV and regular viral load testing. But many people lacked such access, she said, even though it was the first line of defence against HIV; each person who takes an HIV test helps break the chain of HIV transmission. Ms Ogutu also underscored the need for timely diagnosis and treatment of cryptococal meningitis (the second-leading cause of death among people living with

HIV), and called for easier access to CD4 testing and relevant screening. She said it was vital for people living with HIV to know that they cannot transmit HIV once their viral loads are undetectable.

169. Hindrances, Ms Ogutu said, included shortages of testing kits in some countries and social, economic and cultural barriers that still blocked access to testing. Services had to be culturally sensitive, inclusive and respectful: stigma and discrimination kept many people away from life-saving services, she told the meeting. Community-based testing was highly acceptable, including for key and other priority populations, and studies showed that community-led testing can help diagnose people with HIV at early stages and link them to treatment. Access to testing was not a privilege, but a fundamental right, she said and called for greater inclusivity (including of key populations and young people in all their diversity); letting communities lead testing; and more funding for community-led testing.

Session overview

170. Meg Doherty, Director of the Global HIV, Hepatitis and STI Programmes at the World Health Organization, presented a summary of the background note. She said HIV testing innovations, when used widely, were boosting progress towards global HIV targets. However, large numbers of people remained at high, ongoing risk for HIV, but were not being reached with essential HIV services: knowledge of HIV status was only 60–67% across different key populations, for example. Testing services were also missing the partners of people living with HIV, and people with other sexually transmitted infections (stis), and there were gaps in testing and treatment for children, and for pregnant and breastfeeding women. Men generally were underserved by testing and treatment services (about 83% of men living with HIV knew their HIV status compared with 90% of women). If treatment access in sub-Saharan Africa were equal for men and women, new HIV infections in women could be reduced by 50% or more, Ms Doherty said, citing recent study evidence.

171. In addition, CD4 testing levels were declining. She warned that up to 50% of cases of advanced HIV disease would be missed in the absence of CD4 baseline testing. Point-of-care viral load testing access had also stalled during and after the COVID-19 pandemic, though multiplex testing platforms could be leveraged to improve access. Stigma and discrimination also continued to be barriers.

172. Ms Doherty said HIV self-testing was a big opportunity but was being introduced at scale mainly in sub-Saharan and was relatively scarce elsewhere. In Zambia, "one-stop-shop" men's clinics were using self-testing approaches to achieve high testing yields with strong linkage to care. Workplace testing for men was also performing well. Social network testing was increasing among key populations, though it was important to avoid any risk of harm to them. Viral load testing could be scaled up by making full use of diagnostics networks and by using available testing platforms more efficiently, she added. Looking ahead, Ms Doherty highlighted three areas of improvement: mobilize and create demand for testing; use accessible and acceptable service delivery approaches; and ensure linkage to post-test services. She urged countries to pick the most appropriate options, use strategic mixes of differentiated testing approaches, and ensure

that testing services are of a high quality.

173. Speaking from the floor, participants thanked the Secretariat and panelists for staging the thematic. Several speakers described the HIV testing services that were available in their countries and reiterated that testing was an entry point for the prevention and treatment of HIV and other infections, and for realizing people's sexual and reproductive health and rights. They stressed the value of integrating testing services with broader sexual and reproductive health services within a primary health care approach. Also important was public education about HIV testing, including through comprehensive sexuality education, and ensuring that people who take an HIV test receive and fully understand their test results.

174. The meeting was reminded that, although HIV testing science had improved a great deal, the world had not yet reached the target of having 95% of people living with HIV know their HIV status. Discrimination and criminalization were major obstacles and the pushback against human rights and gender equality was aggravating the situation. Community-led organizations needed the space, resources and capacity to play their full roles in bringing HIV testing to everyone who needed it. Health system weaknesses were also undermining testing and treatment. In addition to financial support, successful testing strategies required enabling legal and policy environments; the elimination of stigma and discrimination; increased HIV literacy; sustainable supply chains; and strong leadership, speakers said. Innovative approaches to self-testing could be used to reach populations who were being missed though it was noted that the persistence of late diagnoses of HIV infection had implications for the use of rapid self-testing to improve treatment outcomes.

175. Responding to remarks from the floor, Mr Fenton said the uptake of opt-out testing was very high (>90% in London) and that people who declined the offer typically already knew their HIV status. The opt-out approach was also highly acceptable to health-care workers. He said HIV programmes should attempt to test at the scale needed to achieve their population-level goals. No single testing method or approach was appropriate everywhere, however. Programmes should discover which testing approaches work best for whom—and communities were best-placed to answer those questions.

176. Ms Ogutu stressed the need for inclusivity and for letting communities lead. She called for greater investment in community-led testing and monitoring, which would also boost retention in treatment and care. HIV self-testing remained expensive and unevenly available; it should be made affordable and accessible, especially for communities who are hard to reach, she said. Agreeing, Ms Doherty also noted that linkage to care remained a challenge, partly because it required additional testing for confirmation. More public education about the benefits of HIV testing, including self-testing, was needed. She acknowledged concerns raised about social networking testing approaches, but said they could be addressed.

Panel 1: Testing for HIV—HIV testing modalities

177. This panel focused on different modalities of HIV testing, including community engagement and the use of lay-providers; facility-based testing and integration at

primary health care facilities; and testing for ending paediatric AIDS.

178. Jemma Samitpol, clinic supervisor at the Tangerine Clinic in Thailand, said the clinic provided holistic health services for transpeople, including hormone-replacing treatment and support; HIV and STI testing; pre- and post-exposure and prophylaxis; HIV treatment; vaccination for human papilloma virus; and mental health screening. The difficulties were related mainly to funding, which led to high staff turnover. She stressed that people needed attractive and relevant testing choices, which required constant consultation with communities.

179. Stephen Watiti, Executive Director of the Community Health Alliance in Uganda, said he had been living with HIV for 35 years. Despite fears or misgivings about taking an HIV test, most people tended not to refuse a test when offered one, he said. HIV testing had to be demystified and everyone who could benefit from an HIV test should be offered one. The main barrier was HIV-related stigma, which was based on myths and misconceptions and which could be overcome if people had accurate information about HIV and the benefits of testing (beyond HIV). That, in turn, required HIV-competent service providers.

180. Loyce Maturu, Policy and Advocacy Advisor at Zvandiri in Zimbabwe, said the world had the tools and know-how to ensure that no child was born with HIV and that no mother died while giving birth. Ending paediatric AIDS required repackaging the ways in which prevention of mother-to-child transmission messages and services were being delivered, she told the meeting. HIV literacy for young mothers was also vital. Quality HIV testing and treatment services had to be available affordably to all women who needed them, Ms Maturu said. In reality, though, HIV tests were often out of stock, due to supply chain problems. Social, cultural and religious beliefs also made it difficult for people to take the right steps, and stigma remained a major problem. Evidence-based, differentiated service delivery and community-based support were vital. She shared examples of successful interventions such as young mentor mother projects and community adolescent treatment support projects.

181. Speaking from the floor, participants noted with concern that significant proportions of people were starting treatment with advanced HIV disease. Access to HIV diagnostics was still inequitable, they said, and decreasing funding was affecting countries' abilities to offer effective testing and related services, and reduce stigma and discrimination. Greater investment in HIV testing and new HIV technologies was needed. Speakers described some of their experiences and achievements in rolling out testing and treatment services in their countries (e.g., in Botswana, India and the Russian Federation). They said traditional methods such as facility-based testing should be combined with community-based screening, self-testing, partner testing and index testing. They also noted the value of easy-to-understand and accurate information; initiatives such as integrated testing campaigns in rural areas and for specific populations; and providing free diagnostic services for HIV, viral hepatitis and other stis.

182. While praising the achievements in many countries, speakers warned that obstructive legal and policy environments, weak health systems and counter-productive social norms were major obstacles. They stressed the roles of community organizations in making

testing more accessible and said community-led health-care providers had to be fully funded. Enabling environments were needed so communities could deliver testing services widely and effectively. Countries were urged to decriminalize consensual same-sex relations and to provide full protection to everyone, including LGBTI people.

Panel 2: Testing for HIV—meeting the differentiated testing, prevention and treatment needs of populations left behind

183. This session focused on practical ways to deliver testing services for key populations, including social network testing and community mobilization; HIV testing for adolescents and young people; and testing for the men.

184. Sergey Dugin, General Director of the Humanitarian Action Fund in the Russian Federation, said HIV testing used to be performed at state facilities, but it became clear that some people were uncomfortable of engaging with those institutions. It was decided to offer a wider range of testing and health services to key and marginalized populations via smaller medical centres, which operate as a community service. This made services more accessible, especially to people who lacked the requisite documentation to obtain services at state facilities.

185. Youba Darif, founder of Roots Lab for Gender and Development in Morocco, described some of the challenges faced by young members of key populations, including their lack of knowledge about HIV, the benefits of testing, and prevention options. Stigma and discrimination were persistent barriers and health facilities could be unwelcoming, he said, while confidentiality was seldom observed. Legal and policy barriers, including age-of-consent restrictions, also made service access difficult. Compassionate health-care services were needed and service providers should train health-care staff to be sensitive to the needs of young key populations, he urged. Let young communities lead, he said.

186. Mohammad Afsar, Senior Technical Specialist at the International Labour Organization (ILO), described said a reluctance among workers to take HIV tests was mostly due to stigma and discrimination; a fear that they would be denied work due to their HIV status; opportunity costs (loss of wages), especially for workers in the informal economy; and low health-seeking behaviour. The ILO had designed the VCT@work programme with those concerns in mind. It focused on protecting rights; partnerships (including with workers' organizations and employer associations); advocacy and communication; and ensuring linkage to treatment and care. The programme drew on existing resources such as peer educators, workplace clinics, wellness programmes, occupational safety and health services, and technical assistance was provided when needed. The approach was reaching more men, many of whom were first-time testers or men who had not recently taken an HIV test. Self-testing was being introduced in several countries and was highly acceptable, less stigmatizing and easy to use. If the cost of self testing kits could be reduced further, uptake would increase even more, Mr Afsar said. Lessons learnt included the value of engaging workplace leaders and clearly communicating the benefits of HIV testing to workers.

187. Mohammed Majam, Director of Medical Technology at the University of the Witwatersrand, South Africa, described a project which focused on promoting HIV testing

at communal taxi ranks in Johannesburg. Volunteer workers used mobile phones to collect data from commuters, while trained field workers distributed HIV self-testing kits and assisted with linkage and follow-up support. Acceptability was high, he said. The project reached some 60% of men aged 20–39 years, a large percentage of whom were first-time testers. HIV prevalence was 9% and 54% of the men who tested positive using a self-testing kit had confirmatory testing, with 66% of the latter starting antiretroviral therapy.

188. In discussion, speakers called for greater progress on HIV testing for children and adolescents. Many HIV-exposed infants were not receiving HIV tests within the recommended time frame, they said. Test results (including for viral load tests) also often took weeks or months to be returned to patients or health-care providers, which undermined linkage to treatment and care. UNAIDS was asked to advocate for greater access to rapid diagnostics, including simple, cost-effective tools for use in clinics and community settings. Asked which changes they would prioritize, the panelists singled out more comprehensive testing services; greater involvement of young people; and more effective actions to end HIV-related stigma and discrimination.

Panel 3a: Testing for people living with HIV—comprehensive testing and diagnostic services

189. This session focused on viral load and CD4 testing, planning and implementation; integration of HIV testing services with other disease programmes; and public health laboratory systems for quality assurance and drug resistance monitoring.

190. Alisson Bigolin, Head of the Diagnostics Division in Brazil's Ministry of Health, described the provision of HIV diagnostic and treatment services in Brazil's health system. He said the national Ministry of Health defined the technical features of HIV tests to be procured, while the federal health services determined the anticipated demand and arranged for the transportation of samples, etc. Several platforms existed for viral load and CD4 testing and they were also used for molecular testing for TB and for viral hepatitis testing. He also described diagnostic service suppliers' roles and obligations (including for training and quality assurance) and said Ministry of Health technical teams monitored productivity and equipment maintenance, and investigated incidents. It was possible to identify care gaps by cross-referencing data from the various systems.

191. Maxwell Mumba, UNITAID Community Board delegation member, Zambia, said testing systems were failing young people and health-care workers often lacked understanding of young people's realities and concerns. Youth-friendly spaces were needed, he said, and digital technologies could be used more effectively to encourage and enable people to take HIV tests. He called for a comprehensive approach that recognizes the interconnected nature of young people's health and other needs. Such an approach would use a variety of venues where young people can be reached and it would link the various services they might need, such as mental health, nutrition, and sexual and reproductive health services. Friendlier outreach methods and awareness campaigns were needed and information should be presented in accessible ways and in people's preferred languages. HIV testing had to be normalized for young people, he urged. Other proposed improvements included offering context-specific testing services; promoting

self-testing; advocating for lowering the age of consent; using inclusive and gender-sensitive approaches; decentralizing testing services; and involving young people actively in providing services.

192. Jin Cong, Deputy Director of the National HIV/AIDS Reference Laboratory at the Chinese Center for Disease Control and Prevention, described the HIV testing laboratory network in China, which includes 36 000 rapid test sites, 13 400 screening laboratories, 800 confirmatory laboratories, 35 central confirmatory laboratories, and a national reference laboratory. Service quality was assured by applying national guidelines, conducting training courses on testing techniques and laboratory management, and subjecting HIV testing laboratories to regular evaluations and proficiency tests. Reference laboratories used post-market surveillance of commercial HIV diagnostic reagents to determine the accuracy of tests in use. He emphasized the need to monitor drug resistance: transmitted drug resistance prevalence was 7.8% and had increased over the past two decades, he said.

193. Speaking from the floor, participants said that large numbers of new HIV infections were among key populations, including young key populations, making it important to channel testing services through community-led organizations and make greater use of community-led monitoring. Communities wanted to work with and support government programmes, but they needed systems and approaches that allowed them to collaborate productively. It was important to improve access to sexuality education and to remove age-of-consent barriers. Research was also confirming the role of social protection, with studies showing that members of key populations who accessed economic empowerment and employment support tended to be more likely to use HIV testing and related services.

194. Asked to identify the most important changes that could be introduced, the panelists emphasized scaling up testing through point-of-care services; treating young people as stakeholders, not just beneficiaries; and achieving strong quality assurance of HIV, viral load and CD4 testing.

Panel 3b: Testing for people living with HIV—comprehensive testing and diagnostic services

195. This session shared country experiences regarding age-of-consent regulations for HIV testing; human rights and gender issues in promoting testing; and procurement and supply chain management.

196. Anne Cécile Zoung-kani Bisseck, Director of Operational Health Research in Cameroon's Ministry of Health, discussed some of the legal, psychosocial and other obstacles that made it difficult for adolescents to know their HIV status and receive HIV treatment. She said people younger than 21 years needed parental consent to access certain health services, including HIV treatment. Yet large proportions of adolescents were sexually active: about 21% of 15–19-year-old girls were mothers and the average age of first sexual contact for girls was 16 years. A recently promulgated law sought to ease access to testing services, she explained. Even though it still contained some restrictions, it offered opportunities to circumvent the age-of-consent limitations. It was

also important for health-care workers to receive training so they can properly obtain consent from adolescents, Ms Bisseck said.

197. Aditia Taslim, from the INPUD/UNITAID Communities Delegation, Indonesia, said he had been diagnosed with HIV at 18 years. Because drug use was criminalized he could not disclose his drug use, which blocked his access to other services he needed, including harm reduction services. He said legal obstacles still prevented many people who use drugs from accessing services that could benefit them. Very few service providers had the training to protect and serve women who use drugs, many of whom may also have experienced sexual violence, he noted. Community-led services could fill many of the gaps. It was important to position people who use drugs at the centre of those services, not just as outreach workers. Peer-led services could improve testing, treatment initiation and retention, but peer workers should be properly paid and recognized within the health system, he added. Stigma and discrimination, including the pathologization of drug use, should end and laws that criminalize people who use drugs and other key populations should be repealed, Mr Taslim urged.

198. Sarah Mayuni, lead pharmacist in the Department of HIV, STI and Viral Hepatitis in Malawi's Ministry of Health, said that diagnostics, laboratories and test kits absorbed about 25% of the HIV commodities budget in Malawi. She described the information management system which was used to track service reports from the almost 870 public and private testing sites, including for HIV and syphilis, along with steps taken to shift commodities between facilities when shortages emerged, using "scan flow" technology. The latter system was working well and had been rolled out in 70% of facilities, she said. Strong quality assurance and logistics data were important for efficient management of diagnostic systems, she added. A reliable long-term budget model (working on a three-year grant cycle) made it possible to plan ahead and negotiate better prices for commodities with suppliers, Ms Mayuni said.

199. Speaking from the floor, participants said equitable access to testing was vital for ending AIDS by 2030. Speakers warned that groups opposed to gender equality and sexual and reproductive health and rights were mobilizing to further restrict adolescents' access to testing, treatment and prevention services. New alliances and compelling messages were needed to counter those efforts. Also emphasized was the importance of reducing stigma and discrimination; building stronger supply chains; bringing new technologies into the market; and changing policies and practices that block access to services. Citing a new systematic review, speakers also emphasized that a person with an undetectable viral load had zero risk of transmitting HIV, while a person with a viral load of less than 1000/ml3 had an almost-zero risk of transmitting HIV.

200. In reply, the panelists said public knowledge about HIV was not ideal and said programmes should make greater use of social media platforms to disseminate relevant information. They said it was not a matter of people being hard to reach, but rather that the right people were needed to reach them—which well-trusted community-led organizations could achieve. Programmes also had to become better at exploiting gaps and loopholes in obstructive laws and to remember that laws evolve through precedent and use.

Conclusions and the way forward

201. Christine Stegling, Deputy Executive Director for Policy, Advocacy and Knowledge, UNAIDS, thanked the panelists and participants and said HIV testing remained the first of line of defense against the AIDS pandemic. Advances in testing technologies and approaches were increasing people's choices. She summarized the discussions, using the right to health as the reference point. The right to health, she explained, had four elements—availability, accessibility, affordability and quality—and the discussions had focused on each of them.

202. Discussions had underscored the importance of access, especially for youth and key populations, and of the obstacles posed by barriers such as age-of-consent requirements. The meeting had heard compelling examples of the value of differentiated testing services that offer people a variety of appropriate options. Also emphasized was the importance of the 10–10–10 targets and of continuing to invest in HIV education and awareness. Affordability remained an issue, Ms Stegling said. Some countries were still applying user fees for HIV testing and many still struggled to achieve reliable supply chains for diagnostics. The meeting had heard examples on quality assurance, including for ensuring that services were confidential and accurate. Several speakers had stressed that people living with HIV had to be part of the design and implementation of testing models.

11. Any other business

203. There was no other business.

12. Closing of the meeting

204. Presenting her closing remarks, Ms Byanyima said she was glad the Board had been able to reach strong and substantive conclusions on the issues put to it. The next seven years were of critical importance for the HIV response, she said, reiterating her call during the opening session for a "triple commitment" from members. She said a realistic path to end AIDS existed and it was vital that the UN continue to transform itself and the HIV response; that national governments put in place the most appropriate policies, revolutionize their prevention programmes and align their responses with science; and that donors make sure that adequate resources are available to make the next seven years the last years of the AIDS pandemic.

205. Ms Byanyima reminded the meeting of Ms Geingos's remarks on the opening day about the inequalities that drive the pandemic. The inequalities lens was a powerful tool which reveals that the path towards ending AIDS involves claiming rights and achieving equality so everyone can access the services they need. HIV responses had to be truly inclusive and serve key populations, especially transgender people, she stressed. This was not about ideology, but about people's health and well-being, she said.

206. The Executive Director thanked the NGO Delegation for its report on closing the gap in humanitarian crises and said the Joint Programme had an important role to play on that front. Planning for a sustainable post-2030 future had also been an important part of

discussions, she said. The forthcoming mid-term review would help shape the Joint Programme's planning for the future. She thanked donors—including Australia, Cote d'Ivoire, France, Germany, Luxembourg, Netherlands and the United States America—for their contributions.

207. In closing, Ms Byanyima thanked the outgoing Chair, Vice-Chair and Rapporteur for their excellent work. She also thanked the NGO Delegation for bringing the lived realities of people living with and affected by HIV into the Board meetings, welcomed the incoming NGO delegates, and thanked the UNAIDS staff for their dedication and hard work.

208. The 53rd meeting of the Board was adjourned.

[Annexes follow]

PROGRAMME COORDINATING BOARD

UNAIDS/PCB (53)/23.24

Issue date: 1 December 2023

FIFTY-THIRD MEETING

DATE: 12–14 December 2023

TIME: 09:00 – 17:00

VENUE: Geneva

Annotated agenda

TUESDAY, 12 DECEMBER

1. Opening

1.1. **Opening of the meeting and adoption of the agenda**
The Chair will provide the opening remarks to the 53rd PCB meeting and the agenda will be presented to the Board for adoption.
Document: UNAIDS/PCB (53)/23.24

1.2. **Consideration of the report of the 52nd PCB**
The report of the 52nd Programme Coordinating Board meeting will be presented to the Board for adoption.
Document: UNAIDS/PCB (52)/23.23

1.3. **Report of the Executive Director**
The Board will receive a report from the Executive Director.

Document: UNAIDS/PCB (53)/23.25

1.4. **Report by the NGO Representative**
The report of the NGO representative will highlight civil society perspectives on the global response to AIDS.
Document: UNAIDS/PCB (53)/23.26

2. Leadership in the AIDS response

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

3. Follow-up to the thematic segment from the 52nd PCB meeting

The Board will receive a summary report on the outcome of the thematic segment held at the 52nd PCB meeting on priority and key populations, especially transgender people, and the path to 2025 targets: Reducing health inequities through tailored and systemic responses.

Document: UNAIDS/PCB (53)/23.27

WEDNESDAY, 13 DECEMBER

4. Follow-up actions to the 2024–2025 Workplan and Budget (UBRAF)

The Board will receive a paper that sets out scenarios for the 2024–2025 budget and workplan with prioritized allocation of anticipated revenues (core and noncore) against the approved Workplan with current fund projection, the baseline approved Budget and the fully funded Workplan; It will also include an assessment of the impact of insufficient core revenues on execution of the 2024–2025 Workplan and prioritization across the Joint Programme as it relates to the work and coordination between Cosponsors and the Secretariat.
Document: UNAIDS/PCB (53)/23.28

5. Evaluation annual report and Management response

The Board will receive the annual reporting from the UNAIDS Evaluation Office and the management response to the annual report.
Documents: UNAIDS/PCB (53)/23.29; UNAIDS/PCB (53)/23.30; UNAIDS/PCB (53)/CRP1

6. Consultation on the follow-up to the 2023 ECOSOC Resolution

The Board will discuss the follow-up to the 2023 ECOSOC Resolution on the Joint United Nations Programme on HIV/AIDS regarding the establishment of term limits and performance expectations for the position of the Executive Director of the United Nations Programme on HIV/AIDS.

Document: UNAIDS/PCB (53)/23.31

7. Next PCB meetings

The Board will agree on the topics of the thematic segments for its 54th and 55th PCB meetings in June and December 2024, as well as the dates for the 58th and 59th meetings of the PCB in 2026.
Document: UNAIDS/PCB (53)/23.32

8. Election of Officers

In accordance with PCB procedures and the UNAIDS Modus Operandi paragraph 22, the Board shall elect the officers of the Board for 2024 on the basis of a written statement of interest and is invited to approve the nominations for NGO delegates.

Document: UNAIDS/PCB (53)/23.33

9. Renewal of terms for the UNAIDS IEOAC

In accordance with the IEOAC Terms of Reference, the Board is invited to approve the renewal of the terms for the IEOAC membership as submitted by the PCB Bureau.

Document: UNAIDS/PCB (53)/23.34

THURSDAY, 14 DECEMBER

10. Thematic segment: *Testing and HIV*

Documents: UNAIDS/PCB (53)/23.35; UNAIDS/PCB (53)/23.36; UNAIDS/PCB (53)/CRP2

11. Any other business

12. Closing of the meeting

14 December 2023

53rd Session of the UNAIDS Programme Coordinating Board, Geneva, Switzerland

12–14 December 2023

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 nondiscrimination;

Intersessional decisions:

Recalling that, it has decided through the intersessional procedure (see decisions in UNAIDS/PCB(52)/23.2 and UNAIDS/PCB(52)/23.3):

- Agrees that, health situation permitting, the 2023 PCB meetings will be held in person with optional online participation in accordance with the modalities and rules of procedure set out in the paper, Modalities and Procedures for the 2023 PCB meetings;

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

1. *Adopts* the agenda;

Agenda item 1.2: Consideration of the report of the 52nd PCB meeting

2. *Adopts* the report of the 52nd meeting of the Programme Coordinating Board;

Agenda item 1.3: Report of the Executive Director

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

Agenda item 1.4: Report by the NGO representative

4.1 *Recalling* the Global AIDS Strategy 2021–2026, specifically its 95–95–95 treatment targets in all populations, regions, and countries affected by the HIV epidemic; its 95% combination prevention target for people at risk of HIV in humanitarian settings; its 90% target of people in humanitarian settings having access to integrated tuberculosis, hepatitis C and HIV services, in addition to intimate partner violence programmes, sexual and gender-based violence programmes that include post-exposure prophylaxis, emergency contraception and psychological first aid;

4.2 *Recalling* the report by the NGO Representative at the 43rd meeting of the UNAIDS PCB, decision point 4.4, on addressing the diverse needs of migrants and mobile populations as well as refugees and crisis-affected populations, and decision point 4.6, on promoting access to services; improving data about people on the move; adapting laws, policies and practices that prevent access; strengthening health systems; and enabling collaboration between health systems and communities;

4.3 *Takes note* of the report by the NGO Representative;

4.4 *Calls* on the Joint Programme to:

a. Initiate, through the Inter-Agency Task Team on HIV in Emergencies, the update of the 2010 Guidelines for Addressing HIV within Humanitarian Settings (Inter-Agency Standing Committee Task Force on HIV), including specifically addressing the needs of people living with HIV;

b. Provide annually to the PCB, as part of regular reporting, an update on HIV prevalence and incidence in countries experiencing humanitarian emergencies, as well as an update on the Joint Programme's response to HIV in all humanitarian emergencies, including protracted crises, with a specific focus on people living with, at risk of, and affected by HIV;

c. Ensure that the roles of Cosponsors engaged in responding to refugee and internal displacement in humanitarian emergencies are appropriately reflected when the Joint Programme Division of Labour is next reviewed to help ensure a stronger integration of HIV in humanitarian responses;

d. Collaborate with national stakeholders towards ensuring that comprehensive and tailored HIV interventions are routinely incorporated in all humanitarian emergency preparedness and response programmes;

e. Promote and implement the HIV-related elements of existing guidance documents, including the Health Cluster Guide and the quality-of-care toolkit, to ensure appropriate services for people living with, at risk of, and affected by HIV during humanitarian emergencies;

f. Encourage all relevant stakeholders to focus on building the leadership of affected communities, including people living with, at risk of, and affected by HIV, to sustain community-led HIV responses during humanitarian emergencies, and to advocate for support including funding for communities;

g. Ensure that HIV-related elements of the collaboration across Cosponsors and partners are strengthened to improve the collective impact in addressing HIV in humanitarian settings including, where applicable, through further collaboration with the International Organization for Migration (IOM);

Agenda item 3: Follow-up to the thematic segment from the 52nd PCB meeting[1]

5.1 *Takes note* of the background note (UNAIDS/PCB (52)/23.21) and the summary report (UNAIDS/PCB (53)/23.27) of the Programme Coordinating Board thematic segment on “Priority and key populations,[2] especially transgender people, and the path to 2025 targets: Reducing health inequities through tailored and systemic responses”;

5.2 *Recognizes* that each key population, including transgender people, is diverse, and experiences multiple and intersecting forms of stigma and discrimination, and therefore requires evidence-based, data-informed tailored programmes, services and resources that are responsive to their specific needs in the HIV response;

5.3 *Requests* Member States, in close collaboration with community-led HIV organizations and other relevant civil society organizations and partners, with the support of the Joint Programme, to fast-track targeted and measurable actions towards the 2025 targets to:

a. Address gaps in population size estimates and expand disaggregated data on key populations focusing on existing gaps in transgender populations, in diverse situations and conditions, including through community-led data generation;

b. Optimally resource and scale-up tailored and effective HIV prevention, testing and treatment programmes and services that address the diverse needs and circumstances of key populations, including transgender people;

c. Increase the proportion of community-led services for HIV prevention, testing and treatment and for societal enablers to reach the 30–80–60 targets, as described in the Global AIDS Strategy 2021–2026, including through mechanisms to increase and facilitate funding and sustainable financing for community-led HIV organizations, including for those led by key populations;

d. Address gender inequality, all forms of stigma, discrimination and marginalization, and review and reform harmful and punitive laws and policies that hinder access to HIV-related services for key populations;

e. Reinforce an evidence-based public health approach to HIV, particularly in the context of gender equality and human rights;

f. Integrate social protection with health and HIV responses by taking people-centered approaches which address economic inequalities, making education, welfare, and social protection systems more inclusive of key populations;

5.4 *Requests* the Joint Programme to:

a. Reinforce and expand the meaningful engagement and leadership of all key populations, including transgender people, in the HIV response;

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[1] The Islamic Republic of Iran, Libya and the Russian Federation disassociate themselves from these decision points.

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

b. Increase advocacy and funding for reaching the community-led 30–80–60 targets;

c. Deliver joint, coherent and increased support for the needs of key populations, including transgender people, particularly in circumstances where human rights are at risk;

d. Report back on progress towards the achievements of the 2025 targets through the annual UBRAF performance reporting;

Agenda item 4: Follow-up actions to the 2024–2025 Budget and Workplan (UBRAF)

6.1 *Recalling* decision points 6.6, 6.7 and 6.11 from the 52nd meeting of the Programme Coordinating Board in June 2023;

6.2 *Takes note* of the prioritization agreed by the Secretariat and the Cosponsors for a projected core funding level of US$ 160 million;

6.3 *Strongly encourages* donor governments to make renewed commitments to close the continuous funding gap by fully funding the 2022–2026 UBRAF at the annual level of US$ 210 million including by responding to the recommendations, endorsed by the PCB at its 51st meeting in 2022, of the PCB Task Team on the UNAIDS funding situation;

6.4 *Expresses concern* over the continued loss of capacity across the Secretariat and Cosponsors caused by the current funding crisis despite the collective and repeated recognition of the importance of the role of the Joint Programme and the PCB's and Secretariat's efforts to broaden the donor base and have existing donors increase their contributions;

6.5 *Requests* the Executive Director and the Committee of the Cosponsoring Organizations to continue to ensure that the Joint Programme remains sustainable, resilient and fit-for-purpose, by revisiting the operating model, supported by external expert facilitation and through appropriate consultations, including with the PCB members and participants, reporting back at the June 2025 PCB meeting with recommendations which take into account the context of financial realities and risks to the Joint Programme and relevant recommendations of the Joint Inspection Unit, recognizing the importance of the findings of the mid-term review of the Global AIDS Strategy and development of a long-term strategy to 2030 and beyond, in aligning the Joint Programme;

6.6 *Requests* the Joint Programme to continue to incorporate prioritization in its planning as part of its management function, and report back to the PCB at the June 2024 PCB meeting, and future years as necessary when projected revenue falls below the budget threshold of the UBRAF, contributing to organizational resilience, boosting donor confidence, identifying areas for resource mobilization, and identifying needs and opportunities for streamlined, innovative programme delivery;

Agenda item 5: Evaluation Annual Report and management response

7.1 *Recalling* decision 7.4 of the 49th session of the Programme Coordinating Board approving the UNAIDS 2022–2023 Evaluation Plan, as well as decision points 9.1, 9.2

and 9.5 of the 51st session of the Programme Coordinating Board welcoming progress in the implementation of the Evaluation Policy and Evaluation Plan, and requesting the next annual report to be presented to the Programme Coordinating Board in 2023;

7.2 *Recalling* the intersessional decision of the PCB in June 2022, approving the nomination of the candidate from Eastern Europe to serve on the Expert Advisory Committee;

7.3 *Welcomes* continued progress in the implementation of the 2022–2023 Evaluation Plan and the role of the Evaluation Office in generating evidence of the Joint Programme's contributions to results;

7.4 *Takes note* of the management response to the annual report on evaluation and the Evaluation Plan 2024–2025 (UNAIDS /PCB (53)/23.30);

7.5 *Approves* the 2024–2025 Evaluation Plan (UNAIDS/PCB (53)/23.29) endorsed by the Expert Advisory Committee on evaluation;

7.6 *Recalls* decision point 9.3 of the 47th session of the Board on the importance of adequately resourcing and staffing the evaluation function in accordance with the Evaluation Policy approved by the PCB in its decision 6.6 of its 44th session, taking into account the financial situation of the organization;

7.7 *Agrees* to the full composition of the Expert Advisory Committee on evaluation proposed by the PCB Bureau for 2024, including the one-year exceptional reappointment of the candidate from Eastern Europe, as detailed in Annex 1 of the annual report on evaluation and Evaluation Plan 2024–2025 (UNAIDS/PCB (53)/23.29);

7.8 *Approves* the exceptional reappointment of the candidate nominated by the PCB NGO delegation for one year;

7.9 *Requests* the Expert Advisory Committee to appoint a Chair from within its membership for 2024 and amend the Terms of Reference of the Committee accordingly;

7.10 *Looks forward* to the next annual report on evaluation to be presented to the Programme Coordinating Board in 2024;

Agenda item 6: Consultation on the follow-up to the 2023 ECOSOC Resolution

8.1 *Recalling* operative paragraph 23 of the 2023 ECOSOC Resolution on the Joint United Nations Programme on HIV/AIDS, "Requests the Secretary-General to submit to the Economic and Social Council, before its 2025 session, after consultation with the Programme Coordinating Board at its fifty-third meeting in December 2023, a report on the follow-up to the Council resolution 2021/26 on the Joint United Nations Programme on HIV/AIDS regarding the establishment of term limits and performance expectations for the position of the Executive Director of the Joint United Nations Programme on HIV/AIDS" (E/RES/2023/30, undocs.org);

8.2 *Reaffirming* the importance to continue the dialogue with the Secretary-General and ECOSOC, as appropriate, on establishing two four-year term limits for the position of UNAIDS Executive Director as well as regarding the performance expectations for the

position of the UNAIDS Executive Director in line with the best practices of the UN system;

8.3 *Takes note* of the report prepared by the PCB Bureau on the follow-up to the 2023 ECOSOC Resolution;

8.4 *Decides* that the PCB Bureau transmits, no later than March 2024, following circulation to PCB members and participants for comments, the summary of the consultation at the 53rd meeting of the PCB on the follow-up to the 2023 ECOSOC resolution E/RES/2023/85 to the Executive Office of the United Nations Secretary-General;

Agenda item 7: Next PCB meetings

9.1 *Agrees* that the themes for the 54th and 55th PCB thematic segments will be:

a. *Sustaining the gains of the global HIV response to 2030 and beyond (June 2024);*

b. *Addressing inequalities in children and adolescents to End AIDS by 2030 (December 2024);*

9.2 *Requests* the PCB Bureau to take appropriate and timely steps to ensure that due process is followed in the call for themes for the 56th and 57th PCB meetings; and

9.3 *Approves* the dates and venue of the 58th and 59th PCB meetings in 2026 as follows:

a. *58th PCB meeting: 30 June–2 July 2026, Geneva, Switzerland;*

b. *59th PCB meeting: 8–10 December 2026, Geneva, Switzerland;*

Agenda item 8: Election of Officers[3]

10. *Elects* Kenya as the Chair, Brazil as the vice-Chair and Netherlands as the Rapporteur for the period 1 January to 31 December 2024 and *approves* the composition of the PCB NGO Delegation;

Agenda item 9: Renewal of terms for the UNAIDS IEOAC

11.1 *Takes note* of the report prepared by the PCB Bureau on the renewal of terms for the UNAIDS Independent External Oversight Advisory Committee;

11.2 *Approves* the renewal of terms of the UNAIDS Independent External Oversight Advisory Committee membership as submitted by the PCB Bureau; and

11.3 As per the terms of reference, *requests* the Executive Director, in consultation with the PCB Bureau, to initiate the process for selecting the new membership of the Independent External Oversight Advisory Committee for 2025–2026 and 2026–2027.

[*End of document*]

[3] The Russian Federation disassociates itself from the approval of the composition of the PCB NGO Delegation.