Agenda item 4

UNAIDS/PCB (55)/24.28

FINDINGS OF THE MID-TERM REVIEW OF THE GLOBAL AIDS STRATEGY 2021–2026

10–12 December 2024 | Nairobi, Kenya
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:

- *Take note* of the report on the findings of the mid-term review of the Global AIDS Strategy 2021–2026 (UNAIDS/PCB (55)/24.28);
- On the basis of the findings of the mid-term review of the Global AIDS Strategy 2021–2026, the progress of the 2030 target-setting process, and the ongoing review of the Joint Programme operating model, *request* the Executive Director to:
    - *present* the annotated outline of the Global AIDS Strategy 2026–2031, developed through a multistakeholder consultative process, for consideration by the PCB at its 56th meeting in June 2025;
    - *present* the one-year transitional UBRAF Workplan and Budget for 2026, within the framework of the current UBRAF at the 56th PCB meeting;
    - recalling decision point 7.5 of the 50th PCB meeting, *establish* a working group for the development of the next UBRAF to be operational by September 2025; and
- Recalling decision point 6.5 of the 53rd PCB meeting, *look forward* to the report at the 56th PCB meeting on the recommendations from the review of the Joint Programme operating model by the High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response at the 56th PCB meeting.

Cost implications for the implementation of the decisions: *none*

Executive summary

1. The next 2026–2031 Global AIDS Strategy will be among the most important in the four-decade-long global HIV response. The Strategy will guide that response to the 2030 Sustainable Development Goals deadline and provide the foundation for sustaining the response beyond 2030.

2. The current 2021–2026 Global AIDS Strategy has guided the response with a bold vision of ending inequalities that fuel the AIDS pandemic. The mid-term review of the current Strategy, published as part of the *Global AIDS update* in July 2024, highlights key achievements and remaining challenges to inform the development of the next phase of the response.

3. Under the current Strategy, fewer people acquired HIV in 2023 than at any point since the late 1980s. Almost 31 million people were receiving lifesaving antiretroviral therapy, reducing AIDS-related deaths to their lowest level since the peak in 2004. Significant gains have been made in sub-Saharan Africa, underscoring the power of existing interventions to end AIDS as a public health threat by 2030.

4. Despite this progress, the world is not on track to meet the 2025 targets set out in the Strategy. Uneven progress, deeply entrenched inequalities, insufficient prevention programming, a failure to raise up and support the work of communities, hurdles to accessing treatment, and a lack of political will and financial support threaten the response.

5. This paper, *Findings of the mid-term review of the Global AIDS Strategy 2021–2026,* summarizes the main findings of that review and kicks off the process for the development of the next Global AIDS Strategy, including laying out the role and engagement of the Programme Coordinating Board in the development and adoption of the Strategy and the accompanying 2027–2031 Unified Budget, Results and Accountability Framework.

6. The review of country progress toward the current Strategy, its implementation and results will be presented during the next year to multistakeholder consultations for discussion to develop the next Global AIDS Strategy. These consultations will consider findings from the mid-term review and recommendations from the High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response.

7. An annotated outline of the next Strategy, informed by these consultations, will be presented at the 56th Board meeting in June 2025 for consideration and comment. The finalized Strategy will be presented for adoption at the 57th Board meeting in December 2025.

Introduction

9. The HIV response is at a crossroads: groundbreaking achievements and scientific advances are shadowed by diminishing global commitment and investment for ending AIDS as a public health threat.

10. We know what it will take to achieve that goal. Universal access to HIV treatment and its integration with other health programmes; investment in technologies and scaled-up HIV prevention programming; enabling legal and social environments; reinforced commitment to human rights and values of equity; investments in communities; and sufficiently and sustainably funded programmes will enable the world to end AIDS as a public health threat. The most recent data show that the 2025 targets are within reach for some countries and that many more are poised to make rapid advances.

11. We also know where some of the biggest gaps are. Political commitment to full financing of the HIV response and to upholding human rights as it relates to HIV prevention and treatment is at risk, threatening the HIV response and worsening disparities between populations and regions. The increased frequency and scale of conflict-related and climate-induced emergencies underscore the need to adapt HIV responses to humanitarian contexts. Key populations continue to lack access to essential services, putting them at heightened risk of HIV.

12. The mid-term review of the Global AIDS Strategy 2021–2026 was published as part of the *2024 Global AIDS update, the urgency of now: AIDS at a crossroads*.[1] The review takes stock of global and country progress made under the current Strategy, detailing the latest data and analysis of the pandemic and response, and assessing progress towards the 2025 targets.

13. Success will depend on recognizing the urgency of the current moment. The mid-term review underscores this urgency by showing that the path chosen by leaders in the next few years will determine whether the world ends AIDS as a public health threat. The upcoming Global AIDS Strategy beyond 2026 will lay out a path for achieving and sustaining that goal.

Background

14. At a meeting on 21 August 2024, the UNAIDS Executive Director, in collaboration with the Programme Coordinating Board (PCB) Bureau, proposed that a dedicated discussion on the outcome of the mid-term review and upcoming Strategy process be included in the agenda of the 55th meeting of the PCB in December 2024.

15. Building on the experience and lessons learned from the development of the Global AIDS Strategy 2021–2026, including the evidence review and multistakeholder consultations, this paper presents the findings of the mid-term review of the current Strategy, with a focus on the implications for the strategic priorities beyond 2026.

16. The paper was also developed in follow-up to two PCB decision points on the development of related processes, including an assessment of the Joint Programme's operating model to maximize and sustain the role and contribution of the Joint Programme to the next Global AIDS Strategy[i] and the anticipated development of the

[i] Decision point 6.5 from the 53rd PCB meeting: "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

2027–2031 Unified Budget Results and Accountability Framework (UBRAF).[ii]

17. The paper consists of three sections:

- Section I summarizes the key findings of the mid-term review of the Global AIDS Strategy 2021–2026 and implications for strategic priorities beyond 2026, highlighting both key progress and challenges;
- Section II provides a high-level overview of the process for the development of the next Global AIDS Strategy, with a focus on the PCB's involvement; and
- Section III provides an overview of the anticipated complementary process to develop the 2027–2031 UBRAF, which will operationalize the contribution of the Joint Programme to the next Global AIDS Strategy.

Section 1. Findings of the mid-term review of the Global AIDS Strategy 2021–2026 and implications for strategic priorities beyond 2026

18. The mid-term review of the 2021–2026 Global AIDS Strategy was published in July 2024 as part of the *Global AIDS update*. The results documented in the mid-term review will inform the consultations for the development of the next Strategy. Key findings from the review are summarized below.

19. The global HIV response achieved remarkable gains towards the 2025 milestones set at the United Nations (UN) General Assembly in June 2021 to end AIDS as a public health threat by 2030, a commitment enshrined in the Sustainable Development Goals (SDGs).[2] Despite this progress, the world will not reach the 2025 targets on schedule. The HIV response is threatened by inadequate political will; a lack of sufficient and sustainable resourcing; lack of progress on HIV prevention and societal enablers that are critical for services; inequalities that put key populations[iii] and other priority populations at significantly heightened risk; and uneven progress across countries and regions.

Table 1. Summary of progress against the 2025 AIDS targets

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."

[ii] Decision point 7.5 from the 50th PCB meeting: "Requests the Executive Director to establish a working group, for the development of the next UBRAF, to be operational by January 2025".

[iii] People from key populations include sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, and people in prisons and other closed settings.

Mixed results at the halfway mark to the 2025 targets

Table 0.1 Summary of progress against the 2025 targets

COMBINATION HIV PREVENTION FOR ALL	TARGET	2023 STATUS
Reduce new HIV infections to under 370 000	370 000	1 300 000
Reduce new HIV infections among adolescent girls and young women to below 50 000	50 000	210 000
95% of people at risk of HIV access effective combination prevention	95%	50%/40%/39%/39% (medians) (sex workers/gay men and other men who have sex with men/people who inject drugs/transgender people)
Pre-exposure prophylaxis (PrEP) for 10 million people at substantial risk of HIV (or 21.2 million who used PrEP at least once during the year)	21.2 million	3.5 million
50% opioid agonist maintenance therapy coverage among people who are opioid-dependent	50%	0 of 8 regions
90% sterile injecting equipment at last injection	90%	11 of 27 countries
90% of men aged 15 years and over in 15 priority countries have access to voluntary medical male circumcision	90%	67%
95–95–95 FOR HIV TESTING AND TREATMENT	**TARGET**	**2023 STATUS**
Reduce annual AIDS-related deaths to under 250 000	250 000	630 000
34 million people are on HIV treatment by 2025	34 million	30.7 million
95–95–95 testing, treatment and viral suppression targets	95–95–95	All ages: 86–89–93 Women (aged 15+ years): 91–91–94 Men (aged 15+ years): 83–86–94 Children (aged 0–14 years): 66–86–84
		Key populations: unknown
90% of people living with HIV receive preventive treatment for tuberculosis (TB) by 2025	90%	17 million people living with HIV initiated on TB preventive treatment between 2005 and 2022
Reduce numbers of TB-related deaths among people living with HIV by 80%	80%	71%
PAEDIATRIC HIV	**TARGET**	**2023 STATUS**
75% of children living with HIV have suppressed viral loads by 2023	75%	48%
100% of pregnant and breastfeeding women with HIV receive antiretroviral therapy and 95% achieving viral suppression	100%	84%
GENDER EQUALITY AND EMPOWERMENT OF WOMEN AND GIRLS	**TARGET**	**2023 STATUS**
<10% of women and girls experienced physical or sexual violence from a male intimate partner in the past 12 months	<10%	13% [10–16%]
<10% of people from key populations experience physical and/or sexual violence in the past 12 months	<10%	21%/8%/28%/24% (medians) (sex workers/gay men and other men who have sex with men/people who inject drugs/transgender people)
< 10% people support inequitable gender norms by 2025	<10%	24.2% (median)
95% of women and girls aged 15–49 years have their sexual and reproductive health-care service needs met	95%	Median of 50.8% of women currently married or in union make their own decisions regarding sexual relations, contraceptive use and their own health care (data from 16 countries)
REALIZE HUMAN RIGHTS AND ELIMINATE STIGMA AND DISCRIMINATION	**TARGET**	**2023 STATUS**
<10% of countries criminalize • Sex work • Possession of small amounts of drugs • Same-sex sexual behaviour • HIV transmission, exposure or nondisclosure		 169 countries 152 countries 63 countries 156 countries
<10% of countries lack mechanisms for people living with HIV and people from key populations to report abuse and discrimination and seek redress	<10%	52% of countries have mechanisms established by the government, 66% of countries have mechanisms established by communities
<10% of people living with HIV and people from key populations lack access to legal services	<10%	39% of countries
>90% of people living with HIV who experienced rights abuses have sought redress	90%	31% of people sought redress
<10% of people in the general population report discriminatory attitudes towards people living with HIV	<10%	47% (median)
<10% of people living with HIV report internalized stigma	<10%	38%
<10% of people from key populations report experiencing stigma and discrimination	<10%	26%/16%/40%/49% (medians) (sex workers/gay men and other men who have sex with men/people who inject drugs/transgender people)
<10% of people living with HIV experiencing stigma and discrimination in health-care and community settings	<10%	13% (HIV care) 25% (non-HIV care) 24% (community)
COMMUNITY LEADERSHIP	**TARGET**	**2023 STATUS**
Community-led organizations deliver 30% of testing and treatment services	30%	
Community-led organizations deliver 80% of HIV prevention services for populations at high risk of HIV infection and women	80%	
Community-led organizations deliver 60% of programmes to support societal enablers	60%	
UNIVERSAL HEALTH COVERAGE AND INTEGRATION	**TARGET**	**2023 STATUS**
Systems for health and social protection that provide 90% of people living with, at risk of, or affected by HIV with integrated HIV services	90%	
90% of people in humanitarian settings access integrated HIV services.	90%	
45% of people living with, at risk of, or affected by HIV have access to social protection benefits.	90%	
INVESTMENTS AND RESOURCES	**TARGET**	**2023 STATUS**
Fully fund the HIV response by increasing annual HIV investments in low- and middle-income countries to US$ 29 billion	US$ 29.3 billion	US$ 19.8 billion

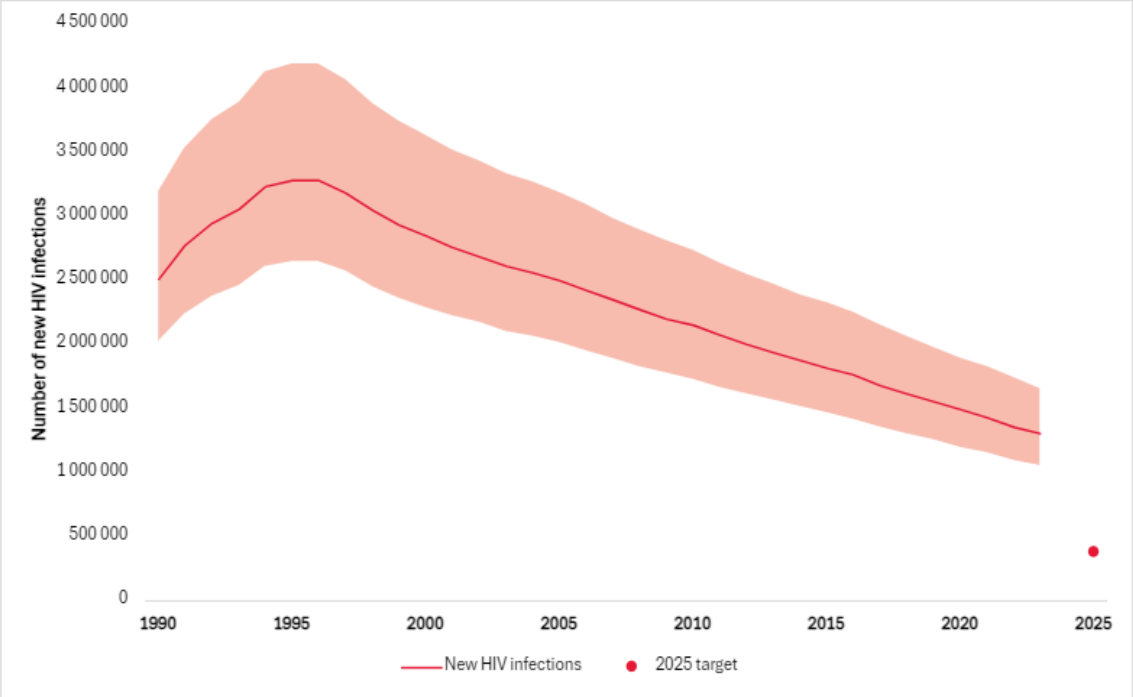
Progress is off track | Moderate progress | 2025 targets are within reach | No data are available

The HIV pandemic today

20. Fewer people acquired HIV in 2023 than at any point since the late 1980s. Globally, about 39% fewer people acquired HIV in 2023 compared with 2010, with sub-Saharan Africa achieving the steepest reduction (−56%).

21. Nonetheless, an estimated 1.3 million [1.0 million–1.7 million] people acquired HIV in 2023—over three times more than the target of 370 000 or fewer new infections in 2025. Three regions are experiencing rising numbers of new HIV infections: eastern Europe and central Asia, Latin America, and the Middle East and North Africa (Figure 1).

Figure 1. Number of new HIV infections, global, 1990–2023, and 2025 target

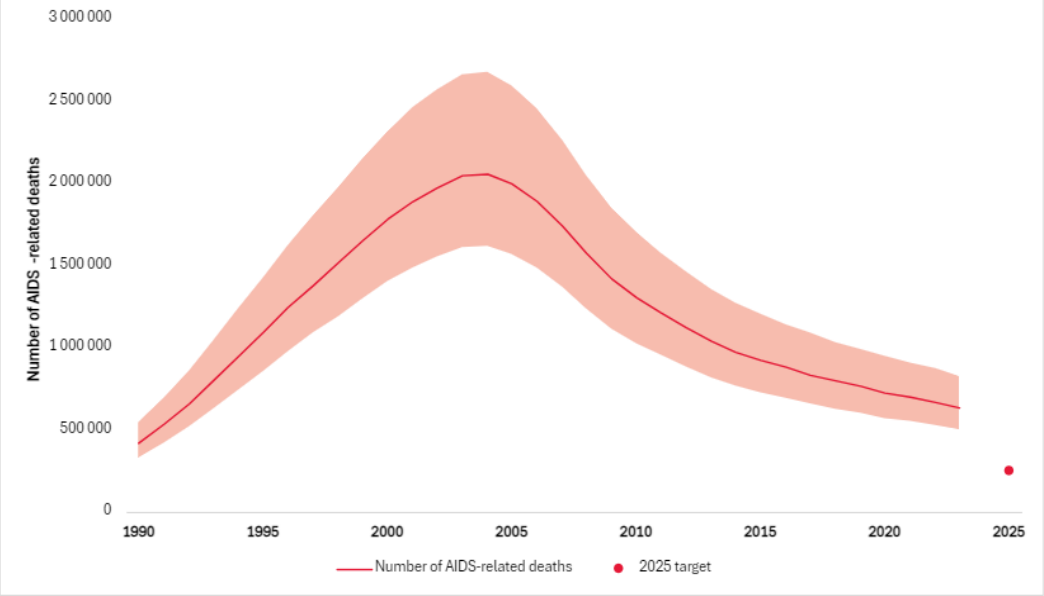


Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org/).

22. Far fewer children aged 0–14 years are acquiring HIV, a trend that is due largely to successes in eastern and southern Africa, where the annual number of new HIV infections in children fell by 73% between 2010 and 2023. The overall decline in vertical HIV infections, however, has slowed markedly in recent years, particularly in western and central Africa. An estimated 120 000 [83 000–170 000] children acquired HIV in 2023, bringing the total number of children living with HIV globally to 1.4 million [1.1 million–1.7 million], 86% of whom are in sub-Saharan Africa.

23. Almost 31 million people were receiving lifesaving antiretroviral therapy (ART) in 2023, a feat that has reduced AIDS-related deaths to their lowest level since the peak of 2004 (Figure 2). In sub-Saharan Africa, these successes have led to a rebound in average life expectancy from 56.3 years in 2010 to 61.1 years in 2023.

Figure 2. Number of AIDS-related deaths, global, 1990–2023, and 2025 target

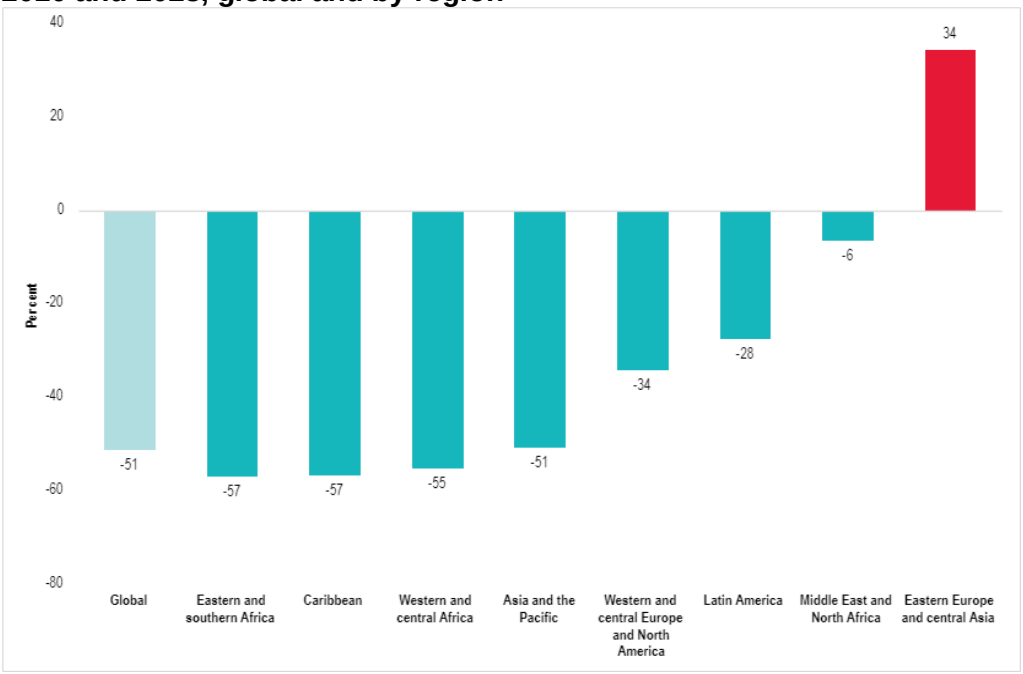


Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org/).

24. Widening access to ART—much of it provided free of charge and through the public health sector—has more than halved the annual number of AIDS-related deaths, from 1.3 million [1.0 million–1.7 million] in 2010 to 630 000 [500 000–820 000] in 2023.

25. Treatment programmes are also driving down the number of new HIV infections. An estimated 30.7 million [27.0 million–31.9 million] people were receiving HIV treatment in 2023. The world can reduce the number of AIDS-related deaths to fewer than the 2025 target of 250 000 if it achieves further rapid increases in diagnosing and providing HIV treatment to people living with HIV (Figure 3).

Figure 3. Percentage change in annual number of AIDS-related deaths between 2010 and 2023, global and by region



Source: UNAIDS epidemiological estimates, 2024 (https://aidsinfo.unaids.org/).

26. The progress is highly uneven, however. The global HIV response is moving at two speeds: relatively swiftly in much of sub-Saharan Africa, but hesitantly across the rest of the world. The number of people acquiring HIV is rising in at least 28 countries and three regions, some of which already have substantial epidemics.

27. AIDS is claiming a life every minute. Globally, 9.3 million people were not receiving life-saving treatment in 2023—nearly a quarter of the 39.9 million people living with HIV. The world pledged to reduce annual new infections to below 370 000 by 2025, but annual new HIV infections are still more than three times higher than that, at 1.3 million in 2023.

28. For the first time in the history of the pandemic, more new infections are occurring outside sub-Saharan Africa than in that region. This reflects both the prevention achievements in much of sub-Saharan Africa and the lack of comparable progress in the rest of the world, where people from key populations and their sexual partners continue to be neglected in most HIV programmes, elevating their already-high risk of acquiring HIV.

29. In sub-Saharan Africa, the annual number of new HIV infections has decreased more rapidly among young men than among young women, and women generally continue to be at disproportionate risk of acquiring HIV. Although decreasing, the incidence of HIV among adolescent girls and young women aged 15–24 years remains extraordinarily high in parts of sub-Saharan Africa. Prevention programmes and efforts to reduce gender inequalities, violence against women and harmful gender norms are not having a big enough impact yet.

30. Prevention programming is lacking and investments are urgently needed to accelerate progress and address underlying barriers. Prevention and treatment services will only reach the people who need them if human rights are upheld, laws that harm
31. women and marginalized communities are removed, and discrimination and violence are reduced. Equitable access to HIV medicines and innovations, including new long-acting technologies, is vital.

32. Persistent stigma and discrimination related to HIV status, gender, behaviours or sexuality also stand in the way. The HIV-related needs of people from key populations are often served by nongovernmental organizations, including community-led organizations, whose work tends to go unrecognized and underfunded.

33. AIDS is not over—a great deal of unfinished work lies ahead.

Mixed progress in serving people's prevention needs

34. Globally, the 2025 prevention target (95% of people at risk of HIV infection have access to and use effective combination prevention options) is not currently within reach. Prevention programmes continue to be underfunded, uptake of low-cost HIV prevention methods has slowed, and access to prevention tools such as pre-exposure prophylaxis (PrEP) products and the dapivirine ring remains unequal.

35. Recent innovations have the potential to become a breakthrough for HIV prevention if made available rapidly and affordably to potential users. For example, a six-month long-acting injectable PrEP product, lenacapavir, has shown extremely high efficacy in preventing HIV among adolescent girls and women in Africa.

36. The global HIV prevention response is proceeding at an encouraging pace in sub-Saharan Africa, but it has stalled in other regions. Persistent and, in some countries, widening gaps in basic HIV prevention must be resolved urgently.

37. The total number of people using oral PrEP rose from a little over 200 000 in 2017 to about 3.5 million in 2023 but falls far short of the global 2025 target of 21.2 million people. Only a few countries in Africa are making progress towards reaching the 2025 PrEP targets.

38. At least half of all people from key populations are not being reached with prevention services, according to data reported to UNAIDS. Men and women who inject drugs, gay men and other men who have sex with men, and transgender people are particularly neglected. In addition, more than half of the areas with high or moderately high HIV incidence in sub-Saharan Africa are not adequately served by prevention programmes that are tailored for adolescent girls and young women.[3]

39. Condom use remains the most effective low-cost HIV prevention method,[4 5] but condom programmes have been defunded and social marketing schemes cut back in many countries.[6] Household survey data suggest that condom use has declined in recent years, including among young people aged 15–24 years, and it is highly infrequent during sex with non-regular partners. About 36% of adults in eastern and southern Africa and 25% in western and central Africa used a condom at last sex.

40. Sex workers in some countries report high levels of condom use with clients, but their access to potent prevention tools such as PrEP is minimal.[7] It is also true that gay men and other men who have sex with men and transgender people lack access to PrEP, except in a few high-income countries. Access to harm reduction services for people who inject drugs is extremely low in all but a few countries.

41. Rapid, wider access to PrEP, including long-acting versions, could massively reduce the numbers of new HIV infections, especially among people from key populations and among women in areas where HIV incidence is high—if costs come down and stigma and discrimination are reduced.

42. There are also opportunities for voluntary medical male circumcision (VMMC) programmes to make a bigger impact.[8] The 35 million circumcisions that were conducted in 2008–2022 in 15 priority countries in eastern and southern Africa averted an estimated 670 000 HIV infections.[9] There is scope in most of those countries to increase VMMC uptake further—if they can overcome funding shortages and expand the services to older age groups.

43. Interventions that address social and structural barriers will be continue to be crucial for preventing new HIV infections. Prevention programming for key populations must be fully funded and must address legal and social barriers, including stigma and discrimination, that impede access. Comprehensive sexuality education remains important for adolescent girls and boys to protect themselves from HIV by improving their knowledge of HIV and related services. Investments must be ramped up to prevent violence against women and other harms and inequalities that place women at significant risk.

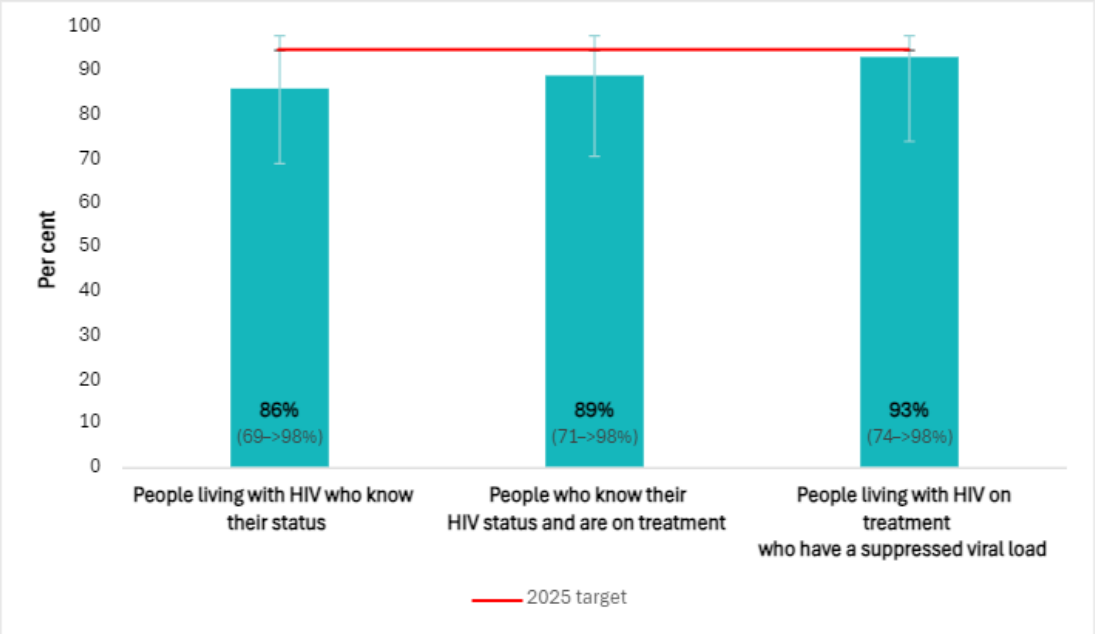
44. HIV prevention programming requires partnerships. Nongovernmental organizations, including community-led organizations, serve the HIV-related needs of many people, including hard-to-reach populations. Recognizing, supporting and funding their work will help ensure that everyone has access to HIV prevention services.

Access to HIV treatment continues to expand

45. 2023 marked a landmark public health achievement in access to HIV treatment. Approximately 30.7 million [27.0 million–31.9 million] of the estimated 39.9 million [36.1 million–44.6 million] people living with HIV globally were receiving ART in 2023. Global treatment coverage has soared from 47% in 2015 to 77% in 2023.

46. The 95–95–95 targets are within reach: 95% of people living with HIV know their status, 95% of people who know they are living with HIV, and 95% of people receiving ART have viral suppression. In 2023, approximately 86% of people living with HIV worldwide knew their status. Among them, approximately 89% were receiving ART and 93% of people on treatment had suppressed viral load (Figure 4).

Figure 4. Percentage of people living with HIV who know their HIV status, are receiving ART (among those who know their HIV status) and have a suppressed viral load (among those receiving ART), global, 2023



Source: Further analysis of UNAIDS epidemiological estimates, 2024.

47. Supporting people living with HIV to start and stay on ART has enormous personal and public health benefits. People with an undetectable viral load[iv] have zero risk of transmitting HIV to their sexual partners, and people with a suppressed viral load have a near-zero risk of doing so.[10] [11] This has given rise to the campaign Undetectable = Untransmissable, or U=U. The successful treatment of HIV is therefore also crucially important for preventing new HIV infections.[12] In 2023, almost three in four adults (73% [66–81%]) living with HIV globally had a suppressed viral load, a huge improvement compared with the 40% [36–45%] in 2015.

48. Some of the biggest gains are being made in sub-Saharan Africa, often in unfavourable conditions. Health and community systems have become better at offering HIV tests to people who may have been exposed to HIV, and at linking them

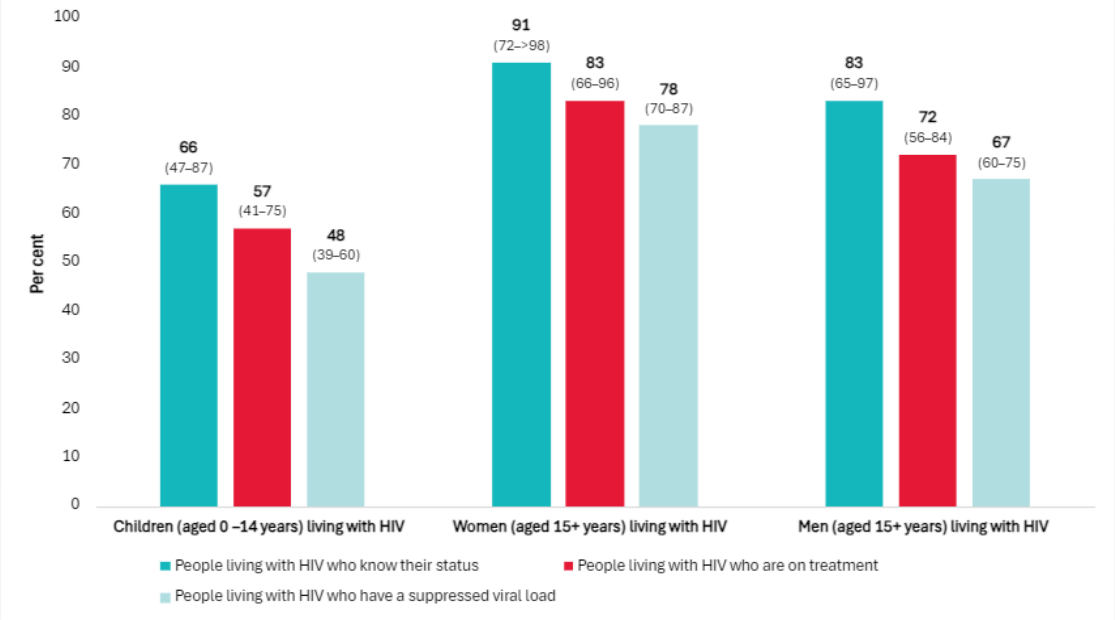
[iv] A viral load is undetectable when it is so low that a polymerase chain reaction test cannot measure it. A suppressed viral load is defined as equal to or below 1000 copies/mL.

to reliable treatment and care services. More tolerable and effective treatment regimens are making it easier for people to keep taking their antiretroviral (ARV) medicines and have suppressed viral loads.

49. Disparities in access to HIV testing and treatment, however, continue to undercut the overall impact of these accomplishments. The biggest gaps involve people who do not know they are living with HIV and people who have been diagnosed with HIV but have not started or been able to stay on treatment. Persistent disparities in treatment coverage—between regions, between adults and children, and between women and men—continue to undercut the overall impact of the HIV response.

50. Children aged 0–14 years living with HIV remain considerably less likely than adults to be diagnosed and receive ART: about 43% [31–57%] of the global total of 1.4 million [1.1 million–1.7 million] children living with HIV were not receiving treatment in 2023. Children accounted for 12% of all AIDS-related deaths, even though they constitute only 3% of people living with HIV. More than one third (36%), or 370 000 [250 000–470 000], of older adolescents aged 15–19 years living with HIV were not receiving ART in 2023 (Figure 5).

Figure 5. HIV testing and treatment cascade among children, women and men, global, 2023



Source: Further analysis of UNAIDS epidemiological estimates, 2024.

51. Across much of the world, boys and men aged 15 years and over living with HIV are less likely than their female counterparts to know their HIV status and receive HIV treatment; their treatment outcomes also tend to be poorer. ART coverage among some key populations may have increased in recent years,[13] but those living with HIV still have lower ART coverage and worse treatment outcomes than other people living with HIV, especially in sub-Saharan Africa.[14]

52. Consequently, one quarter (23% [19–27%]) of all people living with HIV were not receiving ART in 2023. Access to treatment was especially low in eastern Europe and central Asia and the Middle East and North Africa, where only about half of the 2.1 million [1.9 million–2.3 million] and 210 000 [170 000–280 000] people living with HIV,

respectively, were receiving ART.

53. There are other challenges too. It is estimated that at least 1.8 million [1.6 million–2.0 million] people have advanced HIV disease (AIDS). AIDS used to be seen mainly as a problem of late diagnosis and treatment of HIV infection. These concerns remain, but AIDS is now most common among people living with HIV who have received ART and then stopped treatment.[15] [16] This puts their health at risk, increases the risk of HIV transmission, and adds to the burden on health systems, including by undermining the benefits of U=U.[17] [18] There is an urgent need for effective interventions and support so people can stay on HIV treatment and those who have interrupted their treatment can be re-engaged in care.

54. The success of HIV treatment has led to a rise in the average age of people living with HIV. As people living with HIV grow older, they are likely to encounter a growing range of comorbidities, including noncommunicable diseases such as hypertension and diabetes, that require care. Now is a critical time to bridge the inequalities in access to HIV testing and treatment services by expanding access to those services and reducing stigma and discrimination. Closer integration of HIV and other health services, equipment and supply chains, and upgraded training for health workers are among the changes that will boost and maintain access to life-saving HIV treatment.

Slow progress in reducing stigma, discrimination, social inequalities and violence

55. The 10–10–10 and the 30–80–60 targets set for 2025 are not within reach. Punitive laws targeting people living with HIV and people from key populations are still on the statute books in almost all countries, thereby threatening access to HIV prevention and treatment services. Stigma, discrimination, social inequalities and gender inequality, including gender-based violence, make it hard for people to stay free of HIV and protect their health.[19] People from key populations are especially vulnerable.[20] Recognition of these hindrances has increased, but it is not yet sufficiently reflected in laws, policies and practices. Rising authoritarianism and attacks on human and civil rights are making it more difficult to remove the barriers that block access to HIV services.[21] Progress in removing these obstacles is essential to achieving the HIV prevention and treatment goals.

56. Gender-based violence, including against women and girls, remains a threat everywhere. Across 42 countries with recent survey data, in median almost half (47%) of people harboured discriminatory attitudes towards people living with HIV. These attitudes continue to be found also at health facilities. Almost one quarter of people living with HIV reported experiencing stigma when seeking non-HIV-related health-care services in the previous year, according to an analysis of Stigma Index surveys conducted in 25 countries.[22]

57. These prejudices are reversible, but very few countries are close to achieving the 2025 target of reducing to less than 10% the percentage of people living with HIV and people from key populations experiencing stigma and discrimination. Prompted by the activism of affected communities, a few countries have repealed or reformed laws that target people living with HIV and people from key populations. Overall, however, only three of 193 countries did not have any laws that criminalize sex work, same-sex sexual relations, possession of small amounts of drugs, transgender people, or HIV nondisclosure, exposure or transmission.

58. The interplay between intimate partner violence and HIV is an ongoing concern in high-prevalence settings. Gender-based violence harms hundreds of millions of people and intimate partner violence is a painfully common ordeal and a human rights violation against women and adolescent girls especially.[v] Although the prevalence of physical or sexual violence by an intimate partner in the previous 12 months was below 10% in a little over half (82) of the 156 countries with available estimates, the prospect of experiencing physical or sexual violence remains unacceptably high.[23]

59. The experience or fear of physical and sexual violence can impede the use of HIV services. Women who have experienced physical intimate partner violence in the previous year have an average 9% lower likelihood of having viral suppression compared with those not exposed to such violence, according to analysis of data from seven surveys in countries in sub-Saharan Africa.[24] National health policies increasingly recognize the need to curb such violence, and there is strong evidence supporting the integration of violence prevention in health-care settings.[25] [26] [27] Implementation is often held back, however, by a lack of training and support for health-care workers and by scarce referral systems for survivors of violence.[28]

60. Nongovernmental organizations, including community-led organizations, help provide services and support to people, especially people from key populations, whose HIV and other health-care needs tend to be neglected by public and private health providers.[29] Community leadership has been a cornerstone of the HIV response and is enshrined in the GIPA principle that was adopted in 1994 at the Paris AIDS Summit[30]—"nothing about us without us".

61. It is essential that community-led organizations have the civic space and the legal and regulatory environments that permit them to receive funding and operate, as well as functional links with public health and wider government systems. These conditions are lacking in many countries. Well over two thirds (71%) of the world's population lives in 78 countries where civic space is now either entirely closed or heavily controlled—threatening people's basic human rights, including the right to universal health.[31] There is a persistent need for consistent and sustainable support (including financial) for community engagement in the HIV response in order to secure sustainability of the HIV response into the future.

Integration of HIV and other services is making an impact

62. When integrated well, HIV and other health services can improve health outcomes, strengthen health systems and support progress towards universal health coverage.[32] Integration across sectors has also been a feature of HIV responses, with workplace interventions, education initiatives, humanitarian programmes, and social protection schemes being linked progressively with HIV-related interventions.

63. There has been a marked shift towards the integration of HIV and other health-care services in recent years. Although still in a minority, an increasing number of countries have national strategic HIV plans that are integrated with other health issues or diseases and with broader health strategies or plans. Thirty-nine of 151 reporting countries have national health strategies or policies that incorporate the HIV response (seven more than in 2022). Of the 60 countries that have adopted universal health coverage schemes, 38 include ART and 21 include PrEP in their health benefit and

[v] Intimate partner violence is behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.

financing packages.[33]

64. These changes are making a mark. Often, both HIV and other health outcomes are better within integrated services than in separated services and the uptake of non-HIV services also tends to rise.[34] Linked or integrated tuberculosis and HIV treatment for people living with both HIV and TB, for example, averted an estimated 6.4 million [5.5 million– 7.3 million] deaths between 2010 and 2022.[35] Interventions that prevent and treat HIV, sexually transmitted infections and viral hepatitis can be both cost-effective and cost-saving, especially when combined.[36] The recent rapid emergence of Mpox has reiterated the importance of integrated care.

65. Integration of services can address interrelated issues and risks. However, these processes are uneven. Some progress has been made in integrating services for eliminating vertical transmission of HIV with sexual and reproductive health and rights programmes, but integrated services for HIV and sexual and reproductive health, for example, are not yet widespread.[37]

66. Integration of primary health-care and HIV programmes is seen as an important opportunity to broaden and sustain the gains made in the HIV response. Current programmes in sub-Saharan Africa, for example, may support integrating primary health-care services into existing HIV services and vice versa.[38] But this also requires rethinking current HIV and primary health-care programming models—for example, by incorporating into primary health-care models the shift towards person-centred, differentiated care, which increasingly distinguishes HIV programmes.

67. A major concern is how to move towards more integrated systems while maintaining safe, stable services for people from key and other priority populations. The actual status of primary health care in a country also needs to be factored in. Public health workforces often are overburdened, undertrained and poorly supported; health infrastructure tends be unevenly available and erratically maintained; and user fees and other out-of-pocket expenses frequently pose problems for people seeking care.

68. Successful integration holds great promise for the HIV response and other health outcomes. Modelling shows that in Nigeria, for example, the integration of HIV and sexual and reproductive health and rights services could, over a decade, reduce the number of infants acquiring HIV by 56% and avert over eight million unintended pregnancies. In Kenya, the integration of HIV, diabetes and hypertension screening services, if linked to sound referral systems, could avert over 240 000 AIDS-related deaths and over 215 000 new infections, and reduce HIV incidence by 44% over a similar period.[39]

69. The rise in conflict-related and climate change-induced humanitarian emergencies underscores the need for integrated emergency responses that address people's health, nutrition and safety needs.

70. Integration is not without challenges or costs, however. The benefits are context-specific and they require a range of enabling changes, including adequate staffing levels, efficiently functioning health systems (including well-resourced and adequately linked community health systems) and decisive actions to prevent stigma and discrimination.[40] [41] [42] Moreover, it is vital that integration is pursued in ways that strengthen rather than weaken the person-centred and equity-based principles that define successful HIV programmes.[43]

A widening funding gap is holding back the HIV response

71. A growing funding shortfall is holding back quicker progress. Approximately US$ 19.8 billion (2019 United States dollars) was available in 2023 for HIV programmes in low- and middle-income countries—almost US$ 9.5 billion short of the amount needed in 2025. Total resources available for HIV, adjusted for inflation, are at their lowest level in over a decade.

72. The regions with the biggest funding gaps—eastern Europe and central Asia and the Middle East and North Africa—are making the least headway against their AIDS epidemics. Most funding for HIV comes from domestic resources (about 59%), but both international and domestic HIV funding are under stress. Adjusted for inflation, domestic HIV funding declined in 2023 for the fourth year in a row and international resources were almost 20% lower than at their peak in 2013.

73. Financing support from bilateral donors has dwindled dramatically. The overall reductions in external HIV resources would be much steeper were it not for sustained and high levels of funding from the Global Fund and the United States Government. Development assistance for HIV will continue to be crucial.

74. The ongoing underfunding of HIV prevention, societal enabler programmes and community-led activities does not bode well for the HIV response. Interventions for people from key populations are especially neglected, even in regions where the vast majority of new HIV infections occur in people from these populations. An estimated US$ 1.8 billion–2.4 billion was available for primary prevention programmes in low- and middle-income countries in 2023, compared with the US$ 9.5 billion that will be needed in 2025. Spending on societal enabler programmes amounted to US$ 0.9 billion–1.1 billion, far short of the US$ 3.0 billion needed in 2025.

75. The prices of vital HIV products are a major factor in countries' abilities to sustainably finance their HIV programmes with domestic resources. Although the prices of many ARV medicines have continued to decline in recent years, low- and middle-income countries spent approximately US$ 3 billion on ARV medicines in 2020–2022. Procurement prices still vary drastically across regions and country income groups.

Looking beyond the crossroads—strategic priorities going forward

76. If HIV programmes remain on their current course, UNAIDS projections show that about 46 million people will be living with HIV in 2050. Even if the world achieves the 2025 targets and sustains those gains, there will be almost 30 million people living with HIV in 2050. Each of them will need lifelong HIV treatment and support to live long and healthy lives. In the absence of an effective and universally accessible vaccine or cure, HIV transmission will continue.

77. For 2030, the primary goal is to reduce numbers of new infections and AIDS-related deaths by 90% from their 2010 levels and to do so in ways that prevent a future resurgence of the epidemic.[44] This requires a resilient and durable HIV response.

78. Countries that are struggling to control their epidemics can achieve steeper declines in HIV incidence by rapidly increasing treatment coverage and adherence,[45] [46] and by intensifying their most effective primary prevention interventions. Projections show that high-burden countries that reach the 95–95–95 treatment targets could continue reducing new HIV infections by 20% every five years if they invest simultaneously in effective HIV primary prevention programmes.[47]

79. HIV investments need to occur in environments that are free of stigma and discrimination, which in turn require financial and political investments in critical enabler and community-led programmes. But a constantly evolving AIDS pandemic calls for other changes, too. As the population living with HIV ages, the risk of acquiring HIV will keep shifting towards older age groups, and prevention strategies will have to adjust to this trend. HIV programmes will need to make common cause with broader health programmes by responding to the growing impact of noncommunicable diseases, including among people living with HIV, and the ongoing toll exacted by other infectious diseases.[48 49]

80. As HIV programmes are integrated further into broader health systems, there will also be ample room for mutual learning. Successful HIV responses have shown the importance of fortified health and community systems; boosted the roles of affected communities; singled out the societal and structural factors that fuel the epidemic; and made human rights and equity central priorities. More extensive integration with other health programmes can spread those attributes more widely, but it should not dilute the distinctive features that make HIV responses successful.[50 51] This is especially important when serving populations who may be subject to stigma, discrimination and marginalization.

81. All of this must be achieved in a context that is shaped by inequalities within and between countries, a burgeoning threat of repressive governance, and ongoing discrimination against people who are inordinately exposed to HIV and other health threats. The fiscal constraints imposed by debt distress and low economic growth, especially in Africa, are also reducing low- and middle-income countries' abilities to invest more in their HIV responses, while some donors have diverted their assistance to other priorities. An evolving pandemic and shifting context have brought the HIV response to a crossroads. The remarkable progress of the past decade is not self-sustaining. Decisions and actions taken now will have a lasting impact on the world's effort to end AIDS as a public health threat.

Section 2. Development of the next Global AIDS Strategy 2026–2031

82. The current *Global AIDS Strategy 2021–2026 – End inequalities. End AIDS*, provides a framework for reducing inequalities that drive the AIDS epidemic and sets out evidence-based priority actions and targets to achieve SDG 3.3 by 2030. The 2021–2026 Strategy was adopted by consensus at a special session of the PCB in 2021.

83. Later in 2021, the Political Declaration on HIV/AIDS envisaged a transformative response to end AIDS as "a public health threat by 2030". Countries agreed to a set of targets for 2025 that would put them on the path to achieve that goal by 2030.

84. The development of the next Global AIDS Strategy will take place during 2025, with final adoption occurring at the 57th PCB meeting in December 2025. In 2026, the next High-Level Meeting on HIV/AIDS will be convened at the UN General Assembly, where countries will commit to implementing the new 2026–2031 Global AIDS Strategy and achieving specific targets by 2030.

Building on the work of UNAIDS in 2024 to develop the next Global AIDS Strategy in 2025

85. Throughout 2024, UNAIDS has laid the foundation for the development of the next Global AIDS Strategy through: the (1) mid-term review of the 2021–2026 Global AIDS Strategy, highlighting the need for further accelerated action on HIV prevention and

societal enablers while continuing to advance and sustain the gains on HIV treatment; (2) the establishment of an advisory Global Task Team on Targets for 2030; and (3) support to countries to develop sustainability roadmaps.

Developing 2030 HIV targets for the next phase of the AIDS response

86. The UNAIDS Joint Programme has convened a high-level Global Task Team of leading experts in the HIV response to develop a set of evidence-informed targets for 2030. The objectives of the target development process are to generate consensus around key targets that will:

- ensure countries significantly reduce new infections and AIDS-related deaths by 2030;
- ensure sustainability of the HIV response beyond 2030; and
- estimate the potential impact of those targets and the global resource needs for 2026–2030.

87. The Global Task Team, co-chaired by Chewe Luo and Michel Kazatchkine, is composed of 33 experts from government, civil society and networks of people living with or affected by HIV, public health experts, and multilateral or bilateral donors, supported by a group of metric experts. The Team began its work in March 2024 and will complete its time-limited mandate by December 2024.

88. The co-chairs outlined the actions undertaken by the Team to develop the recommended set of targets for 2030 at a missions briefing in October 2024, which was attended by over 150 stakeholders. The comments and guidance received from PCB members, Cosponsors and civil society will inform the Team's work.

89. The proposed 2030 targets will build on the 2025 targets; ensure that the targets remain relevant to countries and programmes; link with existing strategies and targets from the broader UN system to support overall cohesion and coordination; and provide a balanced, measurable, evidence- and human rights-based framework for ending AIDS as a public health threat.

90. This process will be a critical input for the development of the next Global AIDS Strategy. The targets developed by the Task Team will highlight what the HIV response has to achieve by 2030 and the 2026–2031 Global AIDS Strategy will describe how those objectives can be achieved.

Sustainability of the HIV response

91. In 2015, the world committed to end AIDS as a public health threat by 2030 through the adoption of SDG 3.3. The next Global AIDS Strategy will cover the final five years leading to that deadline and must position the world to sustain the achievements of the HIV response after 2030.

92. Political, financial and programmatic sustainability will require immediate, medium-term and long-term visions for meeting the 2025 targets; maintaining and accelerating progress through 2030; and bringing about strengthened systems that allow for effective and increasingly country-owned responses after 2030.

93. In 2024, UNAIDS has worked closely with countries to begin the development of individual long-term HIV response sustainability roadmaps. The roadmaps are intended to build on regional and global partnerships to achieve sustainable HIV

responses. They will provide frameworks for all relevant stakeholders to align their action plans with overarching, country-owned visions, and they will sketch pathways for countries to leverage multisectoral collaboration and resources within their borders, with a special role for communities.

94. The roadmaps will ensure that sustainability planning is integrated into all aspects of HIV responses. They will also indicate the transformations that are necessary to ensure that those responses can adapt to evolving epidemics and shifting social and financial environments. In doing so, the roadmaps will recognize that the strategies and delivery modalities required for scaling up prevention and treatment services to reach the 2030 goal will differ from those needed for long-term sustainability.

95. As countries look to boost and sustain their HIV responses, the roadmap processes will also highlight the priorities and areas of work that must inform the target-setting process and the development of the next Global AIDS Strategy.

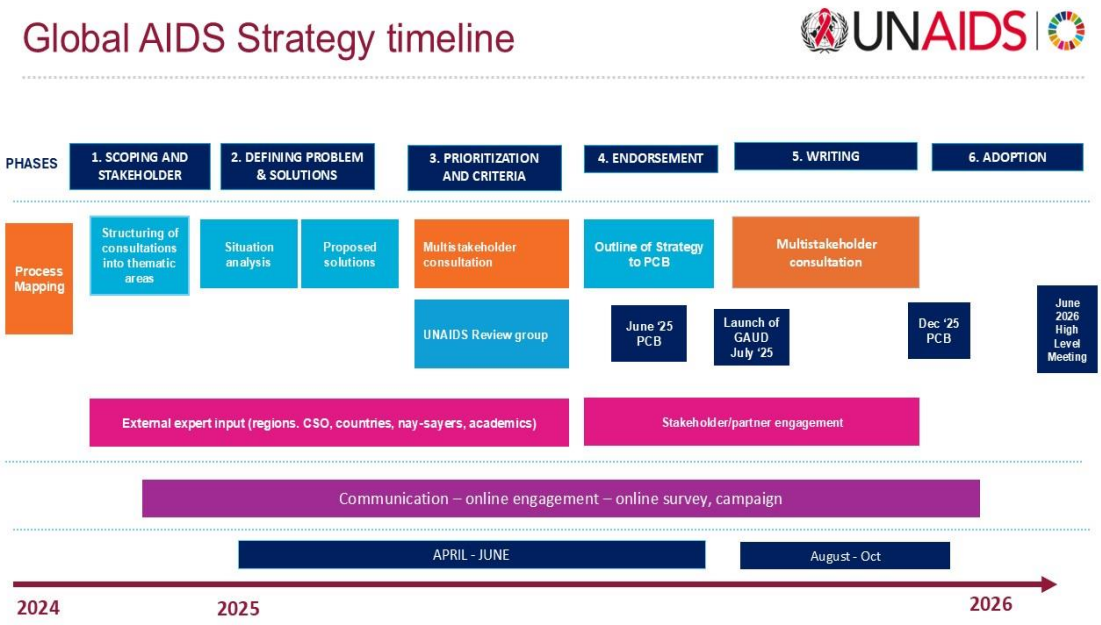
Vision, timelines and process for the development of the next Global AIDS Strategy

96. The next Global AIDS Strategy will set the global priorities for the period leading up to 2030 and beyond, as well as the culmination of the SDGs, including the goal to end AIDS as a public health threat by 2030. The Strategy will guide countries, communities, donors, policy-makers and stakeholders in the next phase of the HIV response.

97. The next Strategy will envision a unified global movement to end AIDS as a public health threat—a movement that is driven by innovation, equity and a commitment to eliminate inequalities that fuel the pandemic. The Strategy will be a call to action to redefine what we can achieve together in the coming years and to reimagine how that can be done, including by involving stakeholders from beyond the traditional “AIDS space”.

98. The Strategy will be developed through an inclusive, multistakeholder-driven process during 2025. Five phases will guide the process, which includes multiple entry points for consultation with relevant stakeholders. PCB members will have opportunities to contribute to the development of the Strategy in the scoping and proposal development phase and through two multistakeholder consultations, to be held in the spring and fall of 2025.

Figure 6. Global AIDS Strategy timeline



99. The PCB will receive the outline of the proposed Strategy for consideration and comment at its 56th meeting in June 2025 and it is scheduled to adopt the Strategy at its 57th meeting in December 2025.

100. UNAIDS will develop the Strategy using a phased, consultative approach.

- **Phase 1: Scoping and sourcing solutions (January – March 2025)**. Consultations on key thematic areas for the next Global AIDS Strategy will ensure clear problem identification and source solutions from numerous stakeholders to achieve progress towards the high-level goals and 2030 targets. Stakeholders from different sectors in the HIV response will be invited to contribute to these thematic groups.
- **Phase 2: Selection and prioritization (April – May 2025).** Proposals emerging from the thematic groups and from a multistakeholder consultation (including with PCB stakeholders) to be held in spring 2025, will inform the development of an outline of the Strategy.
- **Phase 3: Development of outline and proposal to PCB (June 2025)**. The PCB will consider and provide comments on the draft outline. The comments will inform the finalization of the framework and development of the final Strategy.
- **Phase 4: Writing and final consultations on the draft Strategy (September – October 2025).** A second multistakeholder consultation (including with PCB stakeholders) will be held to finalize the Strategy for adoption.
- **Phase 5: PCB submission and approval (November – December 2025).** The final Strategy will be shared with the PCB for adoption at its 57th meeting.

101. The phased process will provide for inclusive consultations with relevant stakeholders in the context of a shorter and more concise exercise than in previous years, taking into account both resource constraints and lessons learned.

Section 3. The 2027–2031 Unified Budget, Results and Accountability Framework (UBRAF) and the revisiting of the operating model of the Joint Programme

102. Complementary to and in parallel with the development of the new Global AIDS Strategy and the target-setting process, a new strategic framework to operationalize the work of the Joint Programme will be developed for the period 2027–2031.

103. The Joint Programme—and the HIV response—is at a crossroads. It is more crucial than ever that UNAIDS is resilient and fit-for-purpose and embodies the spirit of innovation, multisectorality and global solidarity that has brought the HIV response so close to ending AIDS as a public health threat. The Joint Programme must build on its best-practice models for collaboration and coordination within the UN system, while ensuring that it evolves to meet changing epidemic, political, social and economic contexts.

104. The 2022–2026 UBRAF endorsed by the PCB at its 48th meeting, articulates the contribution of the Joint Programme to the 2021–2026 Global AIDS Strategy. The UBRAF is further accompanied by biennial workplans and budgets to ensure the Joint Programme can deliver on its mandate.

105. Funding for the UBRAF during this period has fallen far short of the approved core budget at the level of a core baseline budget of US$ 187 million and a full budget of US$ 210 million. Projected core contributions for 2024 amount to US$ 140 million, a shortfall of US$ 20 million against the reduced agreed core budget of US$ 160 million. The core contributions for 2025 are projected to amount to approximately US$ 135 million.

106. The Joint Programme plays a vital role in the ability of the world to achieve the goal of ending AIDS as a public health threat by 2030. The next framework to operationalize the Joint Programme's contribution to the Global AIDS Strategy must consider the evolving HIV epidemics, responses and country needs within a broader context, while managing a difficult funding situation.

107. Building on past experiences,[vi] the PCB, at its 50th meeting, requested the UNAIDS Executive Director to establish a working group to guide and support the development of the next UBRAF. At the time, the PCB proposed for this working group to be operational by January 2025.

108. In view of the timeline for the development of the new Global AIDS Strategy, as described above, as well as ongoing, significant complementary processes that are expected to shape the vision and revised operating model for the Joint Programme for the coming years, it is recommended that the working group for the development of the 2027–2031 UBRAF[vii] be established by September 2025.

109. This timeline will permit the Joint Programme, under the guidance of the external working group, to draw on the findings of several processes, such as:

[vi] Information on past PCB Technical Working Groups to review and develop the Results and Accountability Framework of the 2022-2026 UBRAF and 2016-2021 UBRAF is available at: PCB Subcommittees and Working Groups | UNAIDS.

[vii] While noting the exact scope, framing, structure and name of the Joint Programme's strategic framework for 2027–2031 may evolve, it is hereby referred to as the next UNAIDS Unified, Budget, Results and Accountability Framework (UBRAF) in this document for ease of reference and alignment with the related PCB decision point.

- the annual report from the Evaluation Office, including the desk review of the Joint Programme's evaluations, to be presented to the PCB at its 55th meeting;
- the findings from the High-Level Panel on a resilient and fit-for-purpose Joint Programme in the context of the sustainability of the HIV response; and
- the outline of and full development of the Global AIDS Strategy and related PCB feedback in June 2025;

110. **Review of the UNAIDS Joint Programme evaluations and assessments (2024)**. The UNAIDS Evaluation Office has undertaken a review consolidating the evidence from 21 evaluations conducted in the previous four years. This review marshals the evidence on achievements, challenges and lessons learned regarding the Joint Programme's contributions in accordance with its mandate and in alignment with the current Global AIDS Strategy. The Evaluation Office is reporting to the PCB on the desk review in the annual Evaluation Office report at the 55th PCB meeting (UNAIDS/PCB (55)/24.24). A management response to the Evaluation Report will also be provided to the PCB for consideration (UNAIDS/PCB (55)/24.25). These papers, as well as any related PCB decisions, will inform the development of the next UBRAF to ensure that it capitalizes on UNAIDS's strengths and addresses areas of improvement.

111. **The High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response**. At its 53rd meeting, the PCB requested the Executive Director and the Committee of Cosponsoring Organizations (CCO): "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 to the June 2025 PCB meeting with recommendations which take into account the context of the 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."

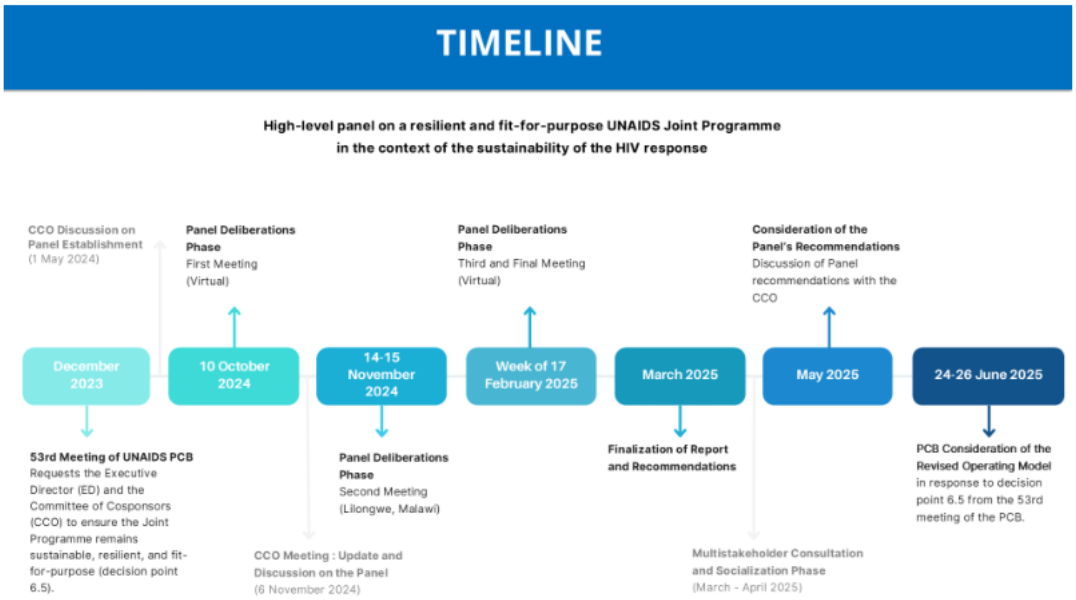
112. In response, the Executive Director and the International Labour Organization Director-General, on behalf of the CCO, convened a High-Level Panel of diverse stakeholders to consider the evolution of the HIV pandemic, the global AIDS response, and country needs and priorities within the overall context of the Joint Programme's mandate, as articulated by the UN Economic and Social Council (ECOSOC).[viii]

113. The Panel is co-chaired by Erika Castellanos, Executive Director of GATE (Global Action for Trans Equality); Ambassador John Nkengasong, US Global AIDS Coordinator, Senior Bureau Official for Global Health Security and Diplomacy; and H.E. Cleopa Kilonzo Mailu, former Cabinet Secretary for Health and former Permanent Representative of Kenya to the UN in Geneva. The terms of reference for the work of the High-Level Panel are available online.

[viii] UNAIDS is mandated, by ECOSOC Resolution 1994/24, to: (a) Provide global leadership in response to the epidemic; (b) Achieve and promote global consensus on policy and programmatic approaches; (c) Strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level; (d) Strengthen the capacity of national governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level; (e) Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions; and (f) Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

114. The Panel began its work in October 2024. It is expected to provide a set of recommendations on the operating model of the Joint Programme by June 2025, which will be received by the Executive Director and the CCO. Based on those recommendations, the Executive Director and the CCO will report back to the 56th meeting of the PCB in June 2025 on the revisiting of the operating model for consideration by the Board. The process will be an important input into the development of the new 2027–2031 UBRAF.

Figure 7. Detailed timeline for the work of the High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response



115. As planned, a one-year transitional UBRAF Workplan and Budget for 2026 will also be presented at the 56th PCB meeting. The current UBRAF biennial workplan and budget covers the period 2024–2025. The one-year plan will bridge the transition between the current Strategy and the new Strategy. It will provide flexibility to respond to evolving circumstances during the preparation of the new UBRAF framework.

Conclusion

116. In the next 12 months, the complementary processes outlined in this paper—the target-setting process, development of the next Global AIDS Strategy, revision of the Joint Programme operating model, and the new strategic framework to operationalize the Joint Programme's contribution—will collectively set the strategic direction for the HIV response to 2030 and beyond, including the multilateral system's contribution. Synergies and efficiencies across these processes will be critical for accelerating progress to reach our goals.

The stakes and the expectations for the communities we serve are immeasurably high, but so, too, is the strength of the Joint Programme's resolve and the world's commitment to ending AIDS as a public health threat.

Proposed decision points

117. The Programme Coordinating Board is invited to:

- *Take note* of the report on the findings of the mid-term review of the Global AIDS Strategy 2021–2026 (UNAIDS/PCB (55)/24.28);
- On the basis of the findings of the mid-term review of the Global AIDS Strategy 2021–2026, the progress of the 2030 target-setting process and the ongoing review of the Joint Programme operating model, *request* the Executive Director to:
  - *present* the annotated outline of the Global AIDS Strategy 2026–2031, to be developed through a multistakeholder consultative process, for consideration by the PCB at its 56th meeting in June 2025;
  - *present* the one-year transitional UBRAF Workplan and Budget for 2026, within the framework of the current UBRAF at the 56th PCB meeting;
  - recalling decision 7.5 of the 50th PCB meeting, *establish* a working group for the development of the next UBRAF to be operational by September 2025;
- Recalling decision point 6.5 of the 53rd PCB meeting, *look forward* to the report on the recommendations from the review of the Joint Programme operating model from the High-Level Panel on a resilient and fit-for-purpose UNAIDS Joint Programme in the context of the sustainability of the HIV response at the 56th PCB meeting.

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