Agenda item 1.3

UNAIDS/PCB (55)/24.25

OUTLINE OF THE REPORT OF THE EXECUTIVE DIRECTOR

UNAIDS

10–12 December 2024 | Nairobi, Kenya
UNAIDS Programme Coordinating Board
Issue date: 28 November 2024

Additional documents for this item: N/A

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

- *Take note* of the report of the Executive Director;

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

Introduction

1. It is wonderful to be with you here in Kenya—a country that shows what can be achieved through HIV programmes and policies that reduce barriers to access by following the evidence and data.

2. Today, we can choose to enter a new era—one in which we make full use of breakthroughs in science, including long-acting medicines for both treatment and prevention, to leap forward in the fight against AIDS.

3. We all remember our excitement when the era of antiretrovirals began 28 years ago. But we also all remember our anguish as we waited a decade for the new science to reach us in Africa.

4. We—together as Member States, civil society and the UN—can make sure that doesn't happen again.

Mid-term review of the Global AIDS Strategy 2021–2026

5. The mid-term review shows positive progress, but also the challenges and opportunities that lie ahead.

6. Achieving the 95–95–95 targets by next year will be a significant challenge—but it is possible, with serious investment and commitment from Member States.

7. However, we must reckon with some hard truths.

8. The global HIV response is being held back by a widening funding gap that is now almost US$ 9.5 billion. The regions with the biggest resource gaps—eastern Europe and central Asia and the Middle East and North Africa—are making the least headway against their AIDS epidemics.

9. We are extremely unlikely to reach our global prevention target of ensuring 95% of people at risk of HIV infection have access to and use effective combination prevention options by 2025.

10. We have opportunities ahead, including the game-changing potential of long-acting HIV medicines.

11. If governments make the political and financial decisions needed to end inequalities, drive down new infections, and harness new technologies, we will meet our shared goals.

Strategy, targets and High-Level Panel

12. 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.

13. Over the coming year, we will set out how we can reach the 2030 goals and set our targets to sustain progress beyond the end of this decade.

14. We expect that the next Global AIDS Strategy will build on the inequalities framing of the current Strategy.

15. Greater accountability on human rights and girls and women's rights, and the cost of inaction in the context of climate shocks and humanitarian crises, will all be key.

16. An independent High-Level Panel is reviewing the operating model of the Joint Programme to make us fit for the challenges of the future.

17. ILO Director-General Gilbert Houngbo is co-convening the High-Level Panel with me, representing the Committee of Cosponsoring Organizations. Our three co-chairs, Erika Castellanos, Executive Director of GATE (Global Action for Trans Equality); Dr John Nkengasong, US Global AIDS Coordinator, Senior Bureau Official for Global Health Security and Diplomacy; and H.E. Dr Cleopa Kilonzo Mailu, former Cabinet Secretary for Health and former Permanent Representative of Kenya to the United Nations in Geneva, are steering the Panel, while my co-convener and I are at arm's length.

18. The panel has now convened twice.

19. Sub-groups have developed thinking on programming, partnerships and resourcing.

20. The Panel is expected to present its report with recommendations around the end of February next year to the Co-conveners.

21. Subsequently, consultations will take place with stakeholders to further prepare for the PCB's deliberations.

22. I am confident that the CCO and I will present bold and robust recommendations to the PCB in June next year on changes to the Joint Programme's operating model.

Financial outlook of the Joint Programme

23. The financial outlook for 2025 is concerning, and the Joint Programme is taking action to adapt to the changing circumstances.

24. We are sincerely grateful to all donors who have continued their support for UNAIDS and paid-up pledged amounts in 2024 despite the challenging global economic context. We count on your support in 2025. We welcome Spain's return as a donor.

25. The projected core contribution for 2024 remains at US$ 140 million. This is US $20 million less than the agreed core operating budget of US$ 160 million. In 2025, core contributions are expected to amount to approximately US$ 125 million.

26. For donors who have not yet made pledges for 2025, we urge you to pledge and pay your contributions for 2025 in full as soon as possible. This will enable UNAIDS to deliver on the objectives planned for 2025.

27. We also acknowledge that some of our long-standing partners have had to make difficult decisions regarding their level of support to the UN System, including UNAIDS. We appreciate that these partners remain active and committed to the mission of UNAIDS. We also appeal to them to facilitate non-core resources where annual core contributions have been reduced.

A vision for shared science

28. New long-acting prevention and treatment innovations have the potential to usher in a new era of the global AIDS response. Whether they reach this potential depends on what we do together.

29. We in UNAIDS are already working in concert to seize this moment, but we need your help to move faster.

30. The science is extraordinary. The latest innovation, Lenacapavir, has shown that with just two injections per year, it can prevent transmission of HIV with efficacy in one trial reaching 100%.

31. It is just one of several new technologies, alongside injectable cabotegravir, a three-month dapivirine vaginal ring, and longer-acting (monthly) oral PrEP moving into phase 3 trials next year.

Avoiding mistakes of the past

32. After ARVs were proven to be effective and rolled out in high-income countries, 12 million people on this continent still died waiting for those drugs. Oral PrEP was first approved in December 2012, but it was 10 years before as many people started on oral PrEP in South Africa as in the United States.

33. We can and must do better with long-acting HIV medicines. So today, I ask all of us to reflect together on how we can capture this opportunity.

What we need to do together

34. First, we need high ambition. Governments, funders, we at the UN are ready to help you plan to deploy long-actings at scale.

35. Second, we need speed. As of September 2024, cabotegravir had been approved in 13 African countries. How can we move faster, though with Cabotegravir, Lenacapavir, and other emerging options as they arrive?

36. Third, at the root of low ambition so far is price and supply. So, we need to move faster to manufacture long-acting ARVs in every region.

37. Studies have shown that Lenacapavir could be produced for around $40 per person per year.

38. Too many developing countries have been left out of Gilead’s and ViiV’s voluntary licensing agreements to produce generic forms of Lenacapavir and Cabotegravir.

39. I urge the companies to expand the licenses. And I urge governments to make use of your legal flexibilities to get access to affordable medicines.

40. Fourth, we need to prioritize long-acting treatment for Africa, Asia and Latin America, including research on new combinations. Long-actings have been approved and used for 3-4 years in high-income countries but have not been rolled out in the Global South.

41. High cost and limited supply are significant factors. But we also need better options. For example, researchers and communities are asking why there has not been a trial of Lenacapavir and Cabotegravir combined.

Conclusion

42. There are no silver bullets. New medicines do not remove the health system challenges or the urgency of tackling stigma and discrimination.

43. But we can leap forward—if, together, we can push ourselves into a new long-acting era.

44. Science, shared is an essential path to help us to end the world's deadliest pandemic.

Proposed decision points

The Programme Coordinating Board is invited to:

45. *Take note* of the report of the Executive Director.

[End of document]