Agenda item 4

UNAIDS/PCB (57)/CRP1

REPORT OF THE SECOND MULTISTAKEHOLDER CONSULTATION ON THE GLOBAL AIDS STRATEGY 2026-2031

22-23 October 2025

UNAIDS

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UNAIDS Programme Coordinating Board
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Executive Summary:

1. On 22-23 October 2025, UNAIDS held a second hybrid multistakeholder consultation on the next Global AIDS Strategy 2026-2031, with the participation of more than 200 representatives of Member States, civil society, nongovernmental organizations, international organizations other than the UN, the private sector and academia, along with representatives of all 11 UNAIDS Cosponsors and the UNAIDS Secretariat.

2. With less than five years left to deliver against the global goal of ending the AIDS epidemic as a public health threat by 2030, UNAIDS has been developing the next Global AIDS Strategy 2026-2031. The next Strategy, which is planned to be considered and adopted by the UNAIDS Programme Coordinating Board (PCB) in December 2025, will be a road map for all countries and partners in the global AIDS response to reach the Sustainable Development Goals (SDG) target of ending AIDS by 2030 as a public health threat ad putting the HIV response on a sustainable path.

3. The second multistakeholder consultation was a critical milestone in the consultative process towards the finalization of the Global AIDS Strategy 2026-2031 and provides a platform for stakeholders to reflect on and refine the Strategy's focus, finetune any priority areas and enhance its overall political resonance. The expected outcomes of the consultation were:

   a) To review and build consensus on the presentation on the draft of the Global AIDS Strategy 2026-2031 to ensure that the Strategy accurately reflects the feedback and guidance from the 56th PCB meeting and identify any required adjustments;
   b) Assess the overall ambition and strategic alignment of the draft Strategy in relation to the current epidemiological trends, as well as social and political context, and recommend adjustments to ensure it is both visionary and feasible;
   c) Facilitate an open and results-oriented dialogue among PCB stakeholders to refine the Strategy's focus, enhance its political resonance, and ensure consensus on a bold and actionable draft for PCB consideration in December 2025.

4. UNAIDS received a significant amount of feedback on the draft Global AIDS Strategy 2026-2031 at the consultation. Themes ranged from the importance of centering the lived experiences of people living with HIV; facilitating integration of services without marginalizing stigmatized or criminalized groups; developing sustainable domestic financing plans; addressing prevention without deprioritizing treatment; ensuring that the 'non-negotiables' of human rights, gender equality and innovation are implementable; and acknowledging, funding, and supporting communities to lead within the global AIDS response, among other key recommendations.

5. The Global AIDS Strategy 2026-2031 will be presented to the 57th meeting of the PCB in December 2025. The Global AIDS Strategy 2026-2031 will provide a critical link to inform the preparations for the next United Nations General Assembly High-Level eeting on AIDS in June 2026.

Opening remarks

6. The second multistakeholder consultation on the development of the Global AIDS Strategy 2026–2031 opened with a call to remember those lost to AIDS-related causes and a welcome to participants joining from around the world. The PCB Chair outlined the agenda for the two-day meeting, emphasizing the importance of an inclusive and time-efficient dialogue to review the draft Strategy 2026-2031 and ensure that it

captures the realities and needs of countries. This consultation, a critical milestone in shaping the next Global AIDS Strategy, served as an opportunity for stakeholders to refine priorities, strengthen political resonance, and align strategic ambitions toward the shared goal of ending AIDS as a public health threat by 2030. With inputs from PCB stakeholders and partners, the meeting aimed to build consensus on the draft Strategy 2026-2031, evaluate its strategic alignment, and foster a results-oriented dialogue to finalize a bold and actionable framework for consideration at the 57th PCB meeting in December 2025.

7. Speaking against the backdrop of a global funding crisis and shifting multilateral landscape, the Chair highlighted both achievements and challenges in the current AIDS response. The Mid-Term Review of the 2021–2026 Strategy showed record progress in reducing new infections and AIDS-related deaths, yet significant inequalities, stigma, and funding shortfalls persist. As the world approaches the 2030 Sustainable Development Goals deadline, the Chair underscored the urgency of maintaining political momentum to safeguard gains and close persistent gaps, calling for renewed solidarity and ambition to ensure that the vision of ending AIDS as a public health threat becomes a reality. The Chair emphasized that this an important opportunity for Member States and stakeholders to provide substantive input and that the Strategy 2026-2031 will guide collective action toward ending AIDS as a public health threat by 2030.

8. The UNAIDS Deputy Executive Directors, Christine Stegling and Angeli Achrekar, then provided welcoming remarks on behalf of the UNAIDS secretariat. Ms. Stegling appreciated that many participants were committed to ending AIDS. She highlighted the feedback received from the first multistakeholder consultation in April 2025 and the June 2025 PCB meeting, where stakeholders reaffirmed their commitment to the goal of ending AIDS as a public health threat, and gave UNAIDS clear guidance to ensure that the new Strategy is fit for the world as it is today. Ms. Stegling and Ms. Achrekar outlined three key points: first, the current draft Strategy reflects the collective feedback of stakeholders and is designed to be simpler, sharper, and more focused, placing countries and communities at its center. It anchors implementation in strong national leadership and sustainable financing while keeping human rights, gender equality, and community leadership at the heart of the HIV response. Second, the Strategy is coming at a time of global uncertainty. It serves as a collective plan for action and continuity—to safeguard progress, sustain proven approaches, and ensure no one is left behind. Third, it is a call to action – this consultation marks a defining moment to focus efforts where they will have the greatest impact, calling for unified, decisive, and committed action from all partners.

9. On behalf of the Cosponsors, Mr. Kofi Amekudzi from the International Labour Organization, welcomed participants and reaffirming a shared commitment to persevere until AIDS is defeated. He described the AIDS response as one of hope and courage, demonstrating how progress is possible when the world stands united behind science, compassion, and human rights. Despite operating in an uncertain global context marked by strained cooperation and funding challenges, Mr. Amekudzi emphasized that every crisis can bring both danger and opportunity. With advances such as long-acting treatment and prevention options, community leadership, and digital health innovations, there are new ways to sustain gains, confront challenges, and secure the future. The Cosponsors expressed deep gratitude to the communities at the forefront of the response and to countries that view health as an investment, noting that humanity has never been closer to victory—and that history should remember this generation as one that never gave up.

10. Mr. Jeremy Tan spoke on behalf of the PCB NGO Delegation. He highlighted that people working on the HIV response were operating under conditions of uncertainty and strain, but continue to act with determination, finding ways to reach people often left behind. The consultation was a pivotal moment to renew hope and trust, with the new Global AIDS Strategy 2026-2031 aiming to reflect the realities of the current context. The NGO Delegation reaffirmed civil society as essential partners in the HIV and health response, emphasizing that sustainability depends on community-led services genuinely shaped through participation and grounded in lived experience. Mr. Tan called for stronger collective action—particularly with leadership from UNAIDS—to confront anti-rights movements threatening communities, stressing that the heart of the response lies in people's persistence, fairness, and shared commitment to keeping the goal of ending AIDS alive.

11. The UNAIDS secretariat then played an inspirational video. The video highlighted that scientific progress had enabled over 40 million people living with HIV to thrive, but warned that funding cuts, stigma, and criminalization threaten these gains. It called for urgent, collective global action and sustained financing to prevent setbacks, ensuring that no one was left behind and that ending AIDS by 2030 remained within reach.

Presentation of the draft Global AIDS Strategy 2026-2031

12. The UNAIDS Deputy Executive Directors, Christine Stegling and Angeli Achrekar, presented on the draft Global AIDS Strategy 2026-2031 and the evidence review. Ms. Achrekar acknowledged the voices that have shaped the Strategy thus far and highlighted the multitude of consultations that have occurred over the last few months, noting that UNAIDS listened carefully to Member States, civil society organizations, communities, researchers, programme implementers and others who have participated. This draft Strategy is simpler, grounded in country leadership, community strength, evidence, and sustainability. It responds directly to the feedback to be bolder and realistic, and fit for the world that is today. The Strategy development has been grounded in data, understanding where the HIV response on progress towards 2025 global targets. While there has been good and moderate progress towards many of the 2025 targets, Ms. Achrekar expressed concern about targets where progress is off track, especially for HIV prevention, gender equality, human rights, and eliminating stigma as it related to HIV services. Looking at trends over time, since the height of the pandemic since the 1990s, there has been impressive progress in terms of reduction in new HIV infections and AIDS-related deaths – but countries are off track to reach the 2030 targets. The response continues to shift – and since the beginning of 2025, the global HIV response has been severely disrupted.

13. It is against this background of data that the Strategy development began, with extensive input and consultation. Ms. Achrekar noted that the Strategy development is in phase five, with this multistakeholder consultation to guide finalization of Strategy 2026-2031 to be submitted to the board in December, and at a High-Level Meeting on HIV in June 2026. UNAIDS has held wide ranging – in terms of breadth and depth – regional and global consultations that occurred from March to May 2025, and brought an annotated outline of the Global AIDS Strategy 2026-2031 to the June PCB. The feedback from the PCB both affirmed the content and provided adjustments. Among the important feedback: the process has been inclusive; the framework must provide innovative perspective and specificity in country and community-led responses; the

global targets must be adaptable to local contexts; structural barriers must continue to be addressed; the role of the Joint Programme in supporting countries to implement the Strategy should specified. Ms. Achrekar noted that the Global AIDS Strategy 2026-2031 begins and ends with the people; it involves country leadership for sustaining inclusive multisectoral responses; reducing inequalities and upholding people's rights to access HIV services; and community leadership at all levels.

14. Ms. Achrekar noted that the Strategy 2026-2031 is based on four building blocks – the Mid-Term Review; the recommended 2030 targets; the sustainability roadmaps; and ongoing Strategy consultations. She highlighted the importance of going from what "was" in the HIV response (in 2025) to where we were going (in 2030): from scaling up HIV responses to ending AIDS and ensuring sustainability; from intervention-centered services to people-centered; from many targets to fewer targets; from vertical programming to integrated programming; from provider service provision to differentiated models of care; and from donor dependence to country-owned and led responses.

15. Ms. Stegling highlighted the three priorities of the Strategy: (1) sustaining the response in the long-term; (2) ensuring people focused services (including tackling stigma and discrimination); and (3) powering communities to lead (for service delivery and accountability), using a lens of inequalities. This inequalities lens must be carried over from the current Global AIDS Strategy. The three priority areas have eight results areas:

16. Priority 1 – Sustained response – country-led, resilient, systems
    - Results area 1 – financing – diversifying income/financing instruments; evolving towards greater domestic investments and investments towards rights-based approach; building on joint work on sustainability roadmaps
    - Results area 2 – integration – simplifying and integrating community systems into broader health and social development systems; integrating HIV community systems into public health systems
    - Results area 3 – investing in information and data – creating, strengthening robust data systems; linking to innovative data sources; formalizing collaboration between govt and community data systems

17. Priority 2 – People-focus
    - Results area 4 – prevention scale up across the continuum – know that we must be successful in this area if we want to reach ultimate goal – only be successful if drastically decreasing new infection; scaling up programs for key populations and addressing societal barriers to prevent new infections
    - Results area 5 – availability, accessibility, acceptability and quality of treatment – strengthening DSD; exploiting innovation; ensuring equitable access to everyone in every geography
    - Results area 6 – end stigma and discrimination and uphold human rights and gender equality; embedding human rights-based approaches into health systems and funding such approaches, as this is consistently underfunded

- Results area 7 – ensuring equitable access to scientific, medical and technological innovation – fostering local and regional production; improving market transparency; leveraging AI and digital health solutions

18. Priority 3: Results area 8 – community leadership – funding/resourcing all component of community responses in HIV; promoting and enacting social contracting mechanisms and ensuring community-led monitoring is resourced in national response.

19. All of the priority areas only work if there are partnerships at local, regional and multilateral levels to end AIDS. Local action has the greatest impact, but it also needs support from regional and global levels. Ultimately, the world will need inclusive multilateralism to underpin the global AIDS response. The Joint Programme will evolve – how it will look, feel, and act in the future will be important to drive the Global AIDS Strategy 2026-2031.

20. Ms. Stegling then presented an overview of regional priorities, underscoring a shared focus on sustainability, equity, and community leadership. In Asia Pacific, priorities included strengthening health systems, integrating services, scaling up HIV prevention and treatment for key populations, and community leadership. The Caribbean's priorities centered on financial sustainability, climate-resilient systems, youth-led services, and community monitoring. Eastern and Southern Africa emphasized sustainable financing, integrated services, scaling up HIV testing, treatment, and care, gender equality, youth-focused strategies, and community leadership. Eastern Europe and Central Asia were prioritizing sustainable financing, combination prevention, stigma and discrimination reduction, and civic space protection. Latin America, the Middle East and North Africa (MENA), and West and Central Africa all highlighted the need for domestic or sustained financing, integration of HIV and health systems, robust data and accountability mechanisms, and stronger legal and rights-based approaches to reach marginalized populations. MENA also had a specific priority of integrating HIV programmes into humanitarian responses. Western and Central Europe and North America focused on service integration, equity-driven data, digital innovation, and community engagement.

21. Ms. Achrekar highlighted the work of the Global Task Team that culminated with 16 topline targets. These targets had three ultimate goals: (1) to reduce new infections by 90% from 2010; (2) reduce AIDS related death by 90% from 2010; and (3) ensure the sustainability of the HIV response after 2030.

22. Ms. Achrekar noted that UNAIDS had modeled the resource needs to achieve 2030 targets globally and by region. Overall, approximately US$21.9 billion were needed annually to achieve HIV targets in low- and middle-income countries. This was down from the US$29 billion estimate, showing a shift related to reduction in prices of ARVs and efficiencies in the response over time. UNAIDS financial data showed that more countries are increasing domestic funding for HIV in 2026. She noted that achieving 2030 targets will bring most countries within reach of the goal of ending AIDS by 2030 – this means closing the current gaps in services and enabling environments. Ms. Achrekar highlighted that the 2030 targets would mean reaching 60 million people: 40

million people living with HIV would be on treatment and virally suppressed + 20 million people would be using ARV-based prevention options, and all of these people would have stigma- and discrimination-free care by 2030. She ended by giving thanks to everyone for contributing to this Strategy and accountability system that UNAIDS is leading.

23. The Chair then opened the floor for comments. A stakeholder welcomed the opportunity to comment on the Global AIDS Strategy 2026-2031, commending its evidence-based and well-developed approach and emphasizing sustainability and regional collaboration. Questions focused on the role of regional institutions and support for civil society organizations (CSOs). Ms. Stegling and Ms. Achrekar responded that UNAIDS aimed at better leveraging regional partnerships—such as through its MoU with Africa CDC—and promoting South-South learning and inclusive sector engagement. Another participant praised the inclusion of mental health in the draft Strategy but requested measurable indicators and ensuring investment for integration and implementation of mental health services; Ms. Achrekar confirmed that mental health indicators would be incorporated into future monitoring frameworks.

24. A participant raised questions about financial feasibility regarding how much of the required funding was likely to be raised (including having a plan B) and implementation planning/thinking about the “how” in achieving the Strategy aims. Ms. Stegling and Ms. Achrekar explained that the “how” will be determined at regional and country levels, with UNAIDS supporting countries in operationalization. On a “plan B” for financing, Ms. Stegling noted that the Strategy 2026-2031 remained ambitious and that it wa premature to discuss a “plan B” yet.

25. Another stakeholder expressed satisfaction with the revised, more grounded Strategy and stressed the importance of practical implementation guidance; Ms. Achrekar noted how seriously UNAIDS has considered the feedback provided thus far and was pleased to see that this consideration has been duly noted. In terms of responding to supporting countries to implement the Strategy, she said that national strategic plans will follow at country-level after the High-Level Meeting in 2026 – this is where the specificity for country implementation would be. Other speakers highlighted integration and equity concerns: participants called for maintaining cervical cancer screening, addressing sanctions that limit access to medical commodities and innovations, and ensuring both integrated and stand-alone HIV services, especially for marginalized and criminalized populations. In response, Ms. Stegling and Ms. Achrekar underscored the importance of integration of other health services with HIV services, noting that integration should not happen, however, at the expense of some groups. There was a lot to be learned of where integration did and did not work – this will be the task for all stakeholders over the next Strategy period. They underscored the importance of community-led monitoring as a method to ensure quality of HIV services. Regarding the comment on restrictive measures and equitable access to quality-assured health technologies, the Deputy Executive Directors took note of it.

26. A participant’s query on restructuring/downsizing of UNAIDS and its impact on country support was met with reassurance about multi-country office support. Ms. Achrekar

noted that UNAIDS was moving into the future with a coordinated hub of staff to ensure that it can provide support where needed. Another stakeholder sought recognition of youth-led responses, which Ms. Achrekar acknowledged the importance of and confirmed youth-led responses would be integrated under community-led action. A participant asked about further clarity on the reduced resource estimates and humanitarian focus; Ms. Stegling and Ms. Achrekar cited lower commodity prices and improved service efficiencies as key reasons for the lower estimate. The Deputy Executive Directors took note of the point on humanitarian contexts. A further question focused on integration of reproductive and maternal health with HIV services, and specifically on maternal mortality metrics, with Ms. Achrekar noting that WHO was actively working on maternal morality measures and that UNAIDS continued to look at ways to better integrate HIV with other services, including antenatal care.

Panel/Priority 1: Country-led Sustainability

27. The first panel focused on priority 1, country-led sustainability. The moderator, Yogan Pillay, Gates Foundation, opened the session by expressing appreciation for the progress made on the Strategy 2026-2031 and encouraged discussions on ensuring country-led sustainability, strengthening its framing, and identifying practical ways to enhance clarity, feasibility, and real-world implementation.

28. Dr. Tia Phalla, Cambodia, emphasized three key lessons for achieving sustainable progress in the HIV response. First, sustainable and equitable financing had been advanced through increased domestic investment (up to 50%) and the decentralization of the national response to address local priorities. He noted, however, that continued external support remained necessary in the near term. Second, deeper integration across sectors was vital, requiring coordinated commitment from non-health ministries, with social protection measures—such as enrolling people living with HIV in national health insurance. Third, community leadership must be central, empowering people living with and affected by HIV to participate fully in all aspects of the response. Dr. Phalla affirmed Cambodia's support for the proposed UN framework on international cooperation to help finance the SDGs, noting that Priority 1 of the Global AIDS Strategy 2026-2031 is both realistic and essential in the current political and fiscal context, with Cambodia's transition planning experience serving as a model of sustainable progress.

29. Ms. Malaya Harper, UNFPA, highlighted that declining HIV prevention funding and weakened community systems are contributing to rising new infections. She emphasized three priorities: (1) linking epidemic intelligence with demographic foresight to sustain HIV investments by integrating HIV data into population and financing models; (2) advancing integration of HIV and sexual and reproductive health services within primary health care and national health systems to ensure sustainable access; and (3) reaffirming the central role of communities in primary health care and accountability for human rights, noting UNFPA's commitment to support these priorities.

30. Ms. Rose Nyirenda, Malawi, noted that, for Malawi, as a low-income country facing a debt crisis, moving rapidly toward sustainability in the HIV response was imperative. The Global AIDS Strategy 2026-2031 aligned closely with Malawi's broader health

sustainability framework, which integrates HIV within national health and financing strategies. Malawi had revised these strategies to address emerging global challenges and was prioritizing domestic resource mobilization, ensuring health priorities — including HIV — are fully costed to identify and address funding gaps. Political commitment to sustaining and owning the HIV response was strong, though external development assistance remained essential under Results Area 1. Ms. Nyirenda emphasized that sustainability should encompass the entire health sector, highlighting the need to embed HIV into primary health systems. Malawi was happy with Results Areas 1, 2, and 3. Ms. Nyirenda recommended that with regards to disaster preparedness plans, it was important that the plans be implementable. Under Results Area 3, there was also a need to simplify data systems, and maintain transparency in the use of domestic and external financing, and to continue to focus on where there are remaining gaps.

31. Immaculate Owomugisha, International Community of Women living with HIV (ICW), commended UNAIDS' leadership and urged that the Global AIDS Strategy 2026-2031 more explicitly recognize women as key leaders and stakeholders. Communities should be engaged right from the start of planning processes (including grassroots to national-level and beyond). There should also be gender-sensitive budgeting that goes towards human rights and gender equity needs, especially as these are traditionally underfunded areas. Highlighting Uganda's experience with community-led monitoring, Ms. Owomugisha raised concerns about maintaining communities' accountability role while collaborating with government. She also noted ongoing challenges such as criminalization of communities and limited political will, stressing that true sustainability requires addressing enabling factors, ensuring gender responsiveness, and affirming the leadership and inclusion of women living with HIV and other community actors.

32. Aniedi Akpan, Drug Harm Reduction Advocacy Network, Nigeria, spoke about concerns of whether sustainability or integration would maintain focus on HIV outcomes. He noted that prior to 2018, Nigeria did not have harm reduction programming. Since then, the Global Fund has been supporting key populations interventions in the country – they were able to form a drug user network, which had collected evidence about people who were injecting drugs to inform programming for this community. Mr. Akpan said the Strategy 2026-2031 is well-aligned – it is aspirational but takes into account the realities of funding. Mr. Akpan highlighted the challenge of high out-of-pocket health expenditures in low- and middle-income countries and emphasized the need to ensure sustainable financing for key population interventions, which currently rely heavily on donor funding.

33. Jules Kim, Network of Sex Work Projects (NSWP), reaffirmed UNAIDS' definition of sustainability as a country's capacity to maintain people-centred, rights-based, and gender-equitable systems supported by empowered institutions, community-led organizations, and sufficient, fairly distributed resources to end AIDS as a public health threat by 2030. She stressed that human rights are fundamental to this vision, noting

that failure to meet the 10-10-10 targets[1] increases HIV vulnerability. The UNAIDS Reference Group on HIV and Human Rights called for centering human rights in sustainable responses, including robust monitoring, redress mechanisms, and community-led accountability such as community-led monitoring. In the context of rising anti-rights movements and funding constraints, embedding human rights principles in national strategies was urgent. Ms. Kim further underscored that differentiated and community-led service delivery, as well as service integration efforts, must be grounded in a human rights-based approach that ensures accessibility and appropriateness for key populations.

34. John Fogarty, World Health Organization – Primary Health Care (PHC) Programme, emphasized that the Global AIDS Strategy 2026-2031 presents a critical opportunity to deliver practical, people-centered solutions, noting that success depends on keeping individuals on treatment, ensuring timely diagnosis and linkage to treatment, and maintaining access to laboratory and monitoring services. He underscored that integration of HIV services within primary health care (PHC) must be inclusive and stigma-free for key populations, and not lead to marginalization. Drawing on the WHO/UNICEF PHC operational framework, he outlined key "strategic levers" for implementation: equitable financing to strengthen PHC; integrated models of care that link HIV prevention, testing, and treatment with primary care and universal health coverage (UHC) packages; expanded and inclusive health workforce training; access to essential products, including self-testing, at entry points of care; greater use of telemedicine and digital technologies; and robust monitoring and evaluation systems, including WHO's forthcoming PHC facility self-assessment tool. Embedding HIV services within strong PHC systems, he concluded, would accelerate progress toward ending AIDS while strengthening overall health systems.

35. Faith Thipe, Y+ Global, speaking on behalf of youth-led organizations, stressed that the Global AIDS Strategy 2026-2031 and related processes, including the High-Level Meeting, must fully include young people living with HIV and reflect their lived realities. Representing insights from consultations with over 500 youth voices worldwide, the Y+ issued a statement calling for evidence-based priority actions such as education for economic empowerment, strengthened social protection, and integrated, confidential, and non-discriminatory sexual and reproductive health and rights (SRHR), HIV, TB, and mental health services within primary health care, including expanded digital access. They emphasized, under Results Area 4, the need for comprehensive sexuality education and education on how to reduce risks on digital platforms and by youth-led organizations; and under Results area 6, the reform of discriminatory laws, including those criminalizing key populations. Y+ Global also urged that youth-led associations be recognized and resourced under Results Areas 1 and 8, with mentorship and peer collaboration to build sustainable youth leadership in the HIV response.

[1] Less than 10% of countries have punitive legal and policy environments that deny access to justice, Less than 10% of people living with HIV and key populations experience stigma and discrimination, Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.

36. Dr. Naemi Shoopala (Namibia) commended UNAIDS for its work on the Strategy 2026-2031 and questioned why it remains titled a “Global AIDS Strategy” rather than a “Global HIV Response Strategy,” given its broader focus on human rights and stigma reduction. She highlighted Namibia’s strong domestic commitment—covering 70–80 percent of the national HIV response and fully funding treatment—and suggested reinforcing the Strategy’s emphasis on resilience, including pandemic preparedness, throughout all the Results Areas under Priority 1. Dr. Shoopala also called for the Strategy to have a stronger focus on global partner coordination, particularly with regional bodies, and for greater predictability and stability in global financing guidance as countries transition toward domestic funding. She noted the importance of addressing co-financing and earmarking issues and ensuring that a people-centered approach that keeps a focus on HIV. Finally, she recommended developing global guidance on standardized packages of essential HIV care services.

37. One participant welcomed the progress on the Global AIDS Strategy 2026-2031 and suggested that, given the timeline, an updated draft be shared so countries can better understand how their feedback has been integrated. The stakeholder expressed support for the Strategy’s focus on sustainability, including financial sustainability, and emphasized that integrating HIV services strengthened the response. They further endorsed the integration of HIV services into primary health care to expand reach, highlighted the importance of adopting digital technologies, and welcomed ongoing efforts to ensure strong data protection given the sensitivity of health information.

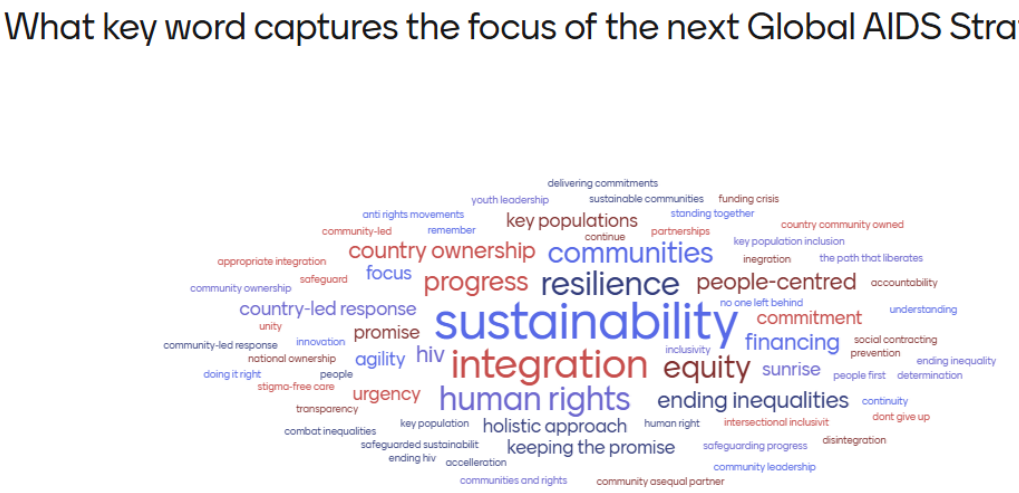
38. Another stakeholder emphasized that as health technologies evolve, their adoption within the HIV response must be grounded in strong human rights safeguards. Without these protections, digital health tools could exacerbate inequities, reinforce stigma, and risk misuse of personal data, particularly affecting key and vulnerable populations. The stakeholder therefore called for the Strategy 2026-2031 to underscore that human rights, equity, and community participation are fundamental and non-negotiable principles in all digital health investments and innovations.

Mentimeter

39. Muleya Mwananyanda and Anne-Claire Guichard, UNAIDS secretariat, ran a Mentimeter that allowed for stakeholder participation on key questions for the Global AIDS Strategy 2026-2031. The questions included:
    - *What should be the focus of the title of the next Global AIDS Strategy?*
    - *Urgency*
    - *Keeping the promise*
    - *Standing together*
    - *Ending inequalities*

40. The majority of votes were given to option 2 – Keeping the promise, confirmed in the zoom chat as well.
    - *What key word captures the focus for the next Global AIDS Strategy?*

41. The word cloud of the mentimeter is provided below and it highlighted sustainability, integration, human rights, resilience, and communities.



- *Possible global numeric targets for 2030*

42. Mary Mahy, UNAIDS Secretariat, explained the purpose of the topline targets. The numbers came from modeling of the impact of achieving those targets.
    - *40 millions people on treatment and 20 million on ART-based prevention; and all people receive discrimination free HIV services*
    - *40 million people on treatment, 20 million on ART-based prevention = zero new HIV acquisitions*
    - *Zero new HIV acquisitions, zero AIDS-related deaths and zero discrimination*

43. Twenty-six participants voted for option 1, 10 participants voted for option 2, and 37 participants voted for option 3. A number of additional votes were also provided in the chat and comments in support of option 1 or 2. Consultations on this will continue after the multistakeholder consultation.

- *Other suggestions for global targets or taglines?*

44. There were limited other suggestions for the global targets or taglines.

Panel/Priority 2: People-centered services (RA 4 & 5), HIV prevention, testing, treatment, and care

45. Nduku Kilonzo, Kenya, moderated this session. She stressed that this consultation will build on areas that have already received extensive feedback, highlighting areas that could be strengthened, and collecting real world experiences that can ground the strategy. Ms. Kilonzo asked panelists to give specific recommendations rather than only pointing out gaps and challenges, and asked for speakers to keep collegial and inclusive in their interventions.

46. Dr. Douglas Bosire, Kenya, was asked if there was a balance between prevention, treatment, and care in the Strategy that is consistent with the Global HIV Prevention Coalition[2] guidance. Dr. Bosire recalled this guidance emphasizing that prevention remains the weakest link in the HIV response and expressed appreciation that the new Strategy 2026-2031 strengthens this focus. Prevention must remain central to avoid rising new infections and governments will have greater responsibility and obligation to increase domestic investment to sustain progress. Dr. Bosire welcomed attention to new prevention technologies such as long-acting PrEP, but noted that uptake remains low in Kenya, with only about 30% of eligible populations in Kenya accessing oral PrEP, highlighting the need for stronger public education and outreach to vulnerable groups. He cautioned that new technologies should complement, not replace, proven tools like condoms, and called for addressing tariffs and taxes that restrict access to prevention commodities. He further emphasized the importance of comprehensive sexuality education linked with broader awareness-raising, noting low levels of prevention knowledge among young people and calling for intensified public education beyond formal schooling.

47. In response to the question about specific recommendations for the Strategy related to integration and government stewardship, Dr. Bosire emphasized that effective integration of HIV services under government stewardship requires reorienting health worker training, including updating curricula and providing on-the-job learning to prevent stigma and discrimination that disrupt treatment. Integration must extend beyond health service delivery to include supportive sectors such as education, social welfare, and security, maximizing resources and ensuring sustainability.

48. Francois Venter, South Africa, was asked whether the 2030 targets are realistic. Mr. Venter noted that the HIV response was in a period of intense flux, making it difficult to predict future developments or interpret current data. Each country faced distinct challenges, but reports from civil society indicate that the situation in South Africa is far from stable, with three-quarters of key population programmes—comprising most of the country's formerly world-leading PrEP initiatives—now shut down. Similar setbacks were noted elsewhere, including the closure of Botswana's programme and a collapse in Lesotho's, which has driven people to South Africa where they face discrimination in accessing services. Against this backdrop, Mr. Venter cautioned that setting new targets without recognizing the current instability risks disconnecting aspirations from reality. He expressed deep concern over the dismantling of donor-funded data systems that once enabled accurate monitoring of testing, treatment, and outcomes, leaving government programmes effectively "flying blind" despite prior success in reducing incidence, mortality, and morbidity. While reaffirming his belief in setting measurable goals and ensuring accountability, Mr. Venter emphasized that governments and partners must share responsibility for sustaining data systems and innovation, since progress in treatment and prevention requires deliberate investment and coordinated stewardship.
49. When asked about how to narrow the gap between aspirational targets and current realities, Mr. Venter suggested that bridging the gap will require "radical imagination" in rethinking service delivery. While interventions such as PrEP are effective, they have

[2] https://hivpreventioncoalition.unaids.org/en

failed to reach most people who need them, particularly following the collapse of donor-funded key population programmes. Similarly, multimonth dispensing has faltered due to funding challenges. He called for renewed innovation and collaboration to re-envision existing approaches and ensure proven tools and services effectively reach key and vulnerable populations.

50. Florence Riako Anam, GNP+, was asked whether integration with broader health systems was possible without weakening the HIV response. Ms. Anam emphasized that with 40 million people living with HIV globally, integration—one of the three pillars of the Global AIDS Strategy 2026-2031—must be grounded in the real experiences of people living with HIV. She noted that while about 10 percent of PLHIV engage in advocacy and leadership, most engage at the service delivery level, underscoring the need for health systems to learn from and adapt with them. Decision-makers must balance ambition with practical, immediate opportunities and must clarify what integrated clinical and public health services should look like. She stressed the importance of government leadership, ongoing learning with people living with HIV, and including population viral suppression (i.e., treatment as prevention) as a key prevention measure. Ms. Anam expressed concern that children are insufficiently addressed. On Results Area 5, she was unclear why integration was in this area, as it would be good to have clear outputs and recommendations on what is meant to be achieved. This Results Area should have an ambition to moving beyond HIV literacy to broader systemic change. Welcoming the "40 and 20 by 2030" formula, Ms. Anam affirmed that services must be accessible without structural, economic, or social barriers.

51. When asked about her recommendations to bridge aspirational targets vs. current realities, Anam recommended that the Strategy 2026-2031 more clearly center people living with HIV, noting this focus is missing, particularly under result area 4. She emphasized the importance of integrating self-care approaches and exploring innovative methods—such as artificial intelligence, point-of-care technologies, and private-sector partnerships—to enhance service delivery and ensure that people living with HIVremain at the core of the HIV response.

52. Leandro Cahn, Fundación Huésped, Argentina, was asked to reflect upon gaps and equity regarding people-centered services. He echoed earlier speakers and shared insights from Latin America, noting that while the region had achieved expanded treatment coverage, increased domestic financing, and elimination of mother-to-child transmission in some countries, these gains have not been sufficient to control the epidemic. Persistent social and structural barriers—reflected in high rates of late presenters (50–55 percent) and rising new infections and AIDS-related deaths—continue to exist. The next Global AIDS Strategy 2026-2031 must explicitly address these inequalities. Mr. Cahn emphasized the need to reach key and vulnerable populations, including migrants, peri-urban and rural communities, indigenous peoples, transgender people, sex workers, and address gender inequality. The Strategy 2026-2031 must not only address different realities between regions and countries, but also within them. He underscored disparities in access to affordable prevention tools, citing that while PrEP costs as little as US $60 per year through PAHO, prices in some middle-income countries remain prohibitively high, especially for new technologies like lenacapavir.

Truly people-centered HIV services in Latin America will only succeed if the Global AIDS Strategy 2026-2031 confronts these structural barriers and ensures no one is left behind.

53. In response to the question of how to leverage the private sector to address inequalities and structural challenges, Mr. Cahn emphasized that engaging the private sector is essential for integrating HIV services into primary health care and fostering better understanding of HIV and AIDS within workplaces. He noted that workplaces can provide supportive spaces where employees feel more comfortable discussing sexual orientation, gender identity and expression (SOGIE), and HIV status, and promoting well-being and productivity. Addressing HIV in collaboration with the private sector also creates opportunities to advance broader issues such as SOGIE inclusion and stronger connections between employees and the health system.

54. Yolanda Baker, Mothers to Mothers, was asked to discuss what is required to address the gaps for women and children. She emphasized that women, adolescent girls, children, and key populations—who form the primary clients of community health workers (CHWs)—must be central to the Global AIDS Strategy's focus on accessibility. Structural barriers, such as distance and cost, often limit access to services. Investing in and adequately resourcing CHWs, who are trusted and embedded within communities, is critical to overcoming these obstacles. While welcoming innovations such as long-acting prevention and treatment options (e.g., lenacapvir), Ms. Baker stressed that the Global AIDS Strategy 2026-2031 must articulate how these would reach those most in need (i.e., accessibility), rather than focusing solely on availability. Ms. Baker also underscored the importance of service integration, ensuring clients can access all necessary services in one visit, and called for stronger recognition and financial support for CHWs as the vital link between communities and the formal health system.

55. In response to the question of whether she had any specific recommendations on how to integrate strengthening of community health systems into the Strategy, Ms. Baker emphasized that strengthening such systems requires broader investment beyond community health workers alone, particularly as HIV services are increasingly integrated into general primary health care. She stressed the need to use resources efficiently and ensure that CHWs and other community health staff are well-trained, empowered, and equipped to deliver or coordinate comprehensive services that meet the needs of people living with or at risk of HIV.

56. Andy Seale, WHO, was asked whether the current framing of the Strategy is realistic. He emphasized the need for the Global AIDS Strategy 2026-2031 to better address the treatment gap, particularly among children, and to strengthen the link between treatment and prevention rather than presenting them as separate or competing priorities. Both treatment and prevention are interdependent and essential for improving the quality of life of people living with HIV. Mr. Seale noted that some elements of the Strategy still reflect a "business as usual" approach and could be strengthened to reflect current realities, including emerging health challenges such as Mpox, which underscores the importance of ensuring widespread treatment access. He further stressed that while innovation is vital, equal focus must be placed on expanding access to existing, effective

solutions and ensuring robust, integrated services that meet the needs of all affected populations.

57. Upon opening the floor for comments, multiple participants shared diverse perspectives on the focus, content, and priorities of people centered services for HIV prevention, testing, treatment, and care for the Global AIDS Strategy 2026-2031. One stakeholder emphasized that, given limited financial resources, UNAIDS should concentrate on areas where it can deliver the greatest impact. The speaker highlighted the need to strengthen HIV prevention through messaging that encourages healthy lifestyles, responsible sexual behavior, and HIV literacy—especially among adolescents—while noting that concepts such as comprehensive sexuality education and harm reduction were not universally agreed. The speaker also requested clarification on the terms “rights-based approaches” and “rights-based interventions”.

58. Other speakers voiced concern over growing political hostility toward key populations and marginalized groups, stressing that integration must not be used to justify the withdrawal or weakening of community-led services. They called for measurable government commitments to protect and fund key population programming and to include trans-specific health care within primary health frameworks.
Several stakeholders, including civil society organizations and Member States, underlined that harm reduction approaches are evidence-based, effective, and rooted in human rights, urging that they remain central to the Strategy 2026-2031. They called for alignment with UNAIDS and Cosponsor guidance.

59. Additional contributions highlighted the importance of addressing psychosocial and structural barriers, such as hunger and social exclusion, that impede treatment adherence and service access. Participants advocated for stronger linkage between health and social services, better articulation of prevention “leakage points,” more emphasis on long-term, integrated care for people living with HIV who are aging, and clearly defined differentiated models of care. Others emphasized confidentiality and flexible scheduling within health services, as well as adopting region-specific approaches that respond to gender inequality and the needs of adolescent girls and young women. Across interventions, stakeholders urged that the next Global AIDS Strategy 2026-2031 remain evidence-driven, inclusive, and responsive to local realities while maintaining community leadership at its core.

60. In closing, Ms. Kilonzo highlighted key points from the speakers, including the need to strengthen the centrality of people living with HIV in the Strategy 2026-2031, address pediatric treatment gaps, reinforce government accountability for funding and service delivery, and maintain a stronger public health focus. She highlighted the importance of balancing ambition with reality through robust data systems, clear targets, and context-specific approaches, while ensuring that innovation and programme availability translate into true accessibility. Integration must extend beyond HIV services to include community health systems, chronic care, and multisectoral collaboration. Ms. Kilonzo also called for clearer definitions of sustainability in specific contexts, greater emphasis on HIV literacy (especially for young people), and the consistent use of evidence-based approaches—questioning whether current progress is sufficient to truly reach the “last

mile" in ending AIDS. Ms. Stegling noted the need to do better at integrating the people living with perspective, and the importance – and difficulty – of finding the right balance between ambition and reality when realities change so quickly. Ms. Achrekar concurred with Ms. Stegling, thanking all participants for their specific feedback on the Global AIDS Strategy 2026-2031, and noting that the team would be continuing to listen, revise, and update it.

Panel 3: People-centered services (RA 6&7) – Human Rights and gender equality and access to innovations

61. Alessandra Nilo, Gestos, moderator, opened the discussion by emphasizing the importance of developing a Global AIDS Strategy 2026-2031 that confronts current challenges while advancing an ambitious, just, and sustainable AIDS response. The Strategy must be grounded in three non-negotiable pillars—human rights, gender equality, and innovation—which should be fully integrated and strategically framed to ensure progress despite global political constraints. Ms. Nilo underscored the need to address persistent gaps in accountability and implementation, calling for clear commitments to decriminalization, rights protections, and gender equality as actionable priorities. She further highlighted the importance of equitable access to innovation and technology transfer, as well as robust accountability mechanisms—particularly regarding stigma and rights indicators—to ensure tangible improvements in health outcomes.

62. Jirair Ratevosian, Duke University, was asked how to move from the powerful rhetoric around the three non-negotiables – rights, gender equality and innovation – to enforceable, inter-disciplinary implementation. He emphasized that innovation, human rights, and gender equality are interdependent pillars of the HIV response. Focusing on digital technologies and new innovations, he noted that true innovation must be equitable and accessible to all, yet global prevention targets remain off-track, with key populations accounting for half of new infections amid widening funding gaps. He urged making HIV prevention a top priority while ensuring that prevention and treatment receive equal attention. Mr. Ratevosian highlighted the transformative potential of digital health and artificial intelligence (AI) in predicting HIV hotspots, improving patient retention, and supporting self-care, particularly for adolescent girls, young women, and key populations. However, AI must be ethically governed, transparently implemented, and firmly grounded in human rights and privacy principles, with communities central to design, implementation, and evaluation. The Global AIDS Strategy 2026-2031 should treat innovation and AI as core enablers of an equitable, people-centered response, and that the ultimate goal extends beyond 2030—to building fairer, more inclusive health systems worldwide.

63. Sandra Nobre, Abbott Diagnostics, was asked about the most pragmatic, actionable mechanisms that UNAIDS can embed in the Global AIDS Strategy 2026-2031 to compel pharmaceutical and tech partners to dramatically accelerate research, development, and deployment of HIV prevention and treatment tools across marginalized communities in the Global South. She expressed appreciation for the inclusive and transparent process guiding the Global AIDS Strategy 2026-2031, the strong involvement of the private sector, and emphasized that achieving the 2030 goals will require new ways of

thinking, especially within the diagnostics field. Progress toward global HIV targets was lagging – this underscored the importance of scaling up HIV self-testing, particularly when implemented in partnership with communities to ensure privacy, trust, and effectiveness. Ms. Nobre stressed the need for timely diagnostic services to prevent vertical transmission and reach key populations, as well as for adopting innovative, high-quality rapid testing technologies that save lives and resources. She urged the Strategy to incorporate a health-economics lens, recognizing that innovation must be matched with strong education, community partnerships, and stigma-reduction efforts. Resilience, science, and humanity must work together to ensure equitable access to effective diagnostics; human rights and gender equality should be embedded in all these elements.

64. Violeta Ross, World Council of Churches, was asked how the Global AIDS Strategy 2026-2031 could ensure that global commitments are translated into explicit, interlinked, and rights-based mechanisms that effectively track and mitigate issues around inequitable access, human rights abuses, and other situations that continue to fuel vulnerability to HIV. She emphasized that HIV must remain a global and national priority, with rights, gender equality, and equitable access to innovation treated as non-negotiable pillars of the Strategy. Ms. Ross called for clearer, measurable actions to ensure accountability, citing unequal access to innovations such as long-acting injectables due to economic constraints and limited government investment. Gender equity must go beyond mother-to-child prevention and address the needs of women in all their diversity, promoting transformative interventions and economic empowerment for young women and communities. She also urged that all people living with HIV have access to the most effective treatments available, ensuring dignity and accountability across the response.

65. Carolyn Gomes, UNAIDS Reference Group on HIV and Human Rights, was asked how the new Global AIDS Strategy 2026-2031 can be made more actionable and enforceable on rights and gender equality, ensuring effective implementation even in challenging environments. She emphasized that lasting change in the HIV response has always been driven by committed individuals and communities rather than institutions alone, noting that many key innovations and successes have stemmed from community demand and leadership. For example, the COVID-19 pandemic demonstrated the essential role of equity, community engagement, and mindset in achieving progress. The absence of meaningful community involvement and differentiated service delivery has hindered progress, as formal health systems alone cannot effectively reach or serve key populations. Ms. Gomes called for empowering communities to lead, educate, and deliver non-discriminatory, stigma-free services, highlighting that human rights must be seen as indispensable pillars of health systems. Ms. Gomes urged that the new Global AIDS Strategy 2026-2031 complete the loop by fully embedding community-led and human rights-based approaches to ensure a sustainable and effective HIV response.

66. Uluk Batyrgaliev, Eurasian Coalition on Health, Rights, Gender and Sexual Diversity, commended the Global AIDS Strategy 2026-2031 for recognizing that ending AIDS requires addressing criminalization, discrimination, and gender inequality, noting that Results Area 6 is its backbone but needs clearer implementation pathways. He identified

three major gaps: the absence of concrete steps to remove criminalization, the lack of measurable indicators for stigma and discrimination, and insufficient inclusion of sexual orientation, gender identity, and expression (SOGIE) communities. The Global AIDS Strategy 2026-2031 should build on community-led efforts such as legal environment assessments and strategic litigation already under way, and governments should develop decriminalization plans with community participation and UNAIDS support. Mr. Batyrgaliev recommended integrating stigma and discrimination indicators into Global AIDS Monitoring, expanding the gender equality framework to include SOGIE and gender-based violence, and strengthening data privacy safeguards for digital health tools. Linking rights and innovation under Results Areas 6 and 7 would make the Strategy both ambitious and truly implementable.

67. Anurita Bains, UNICEF, noted that many key ideas on integrating rights and innovation had already been echoed in previous discussions and emphasized the need to balance community roles in both service delivery and accountability. She underscored embedding HIV within strong primary health care systems while ensuring integration does not erase key populations, and highlighted the importance of eliminating punitive laws. Ms. Bains emphasised three priorities: first, investing in robust data systems to measure inequities, particularly as women and children remain underserved (e.g., HIV treatment), and incorporating broader indicators such as adolescent pregnancy and gender-based violence to inform rights-based metrics to expose gaps and drive action; second, ensuring that rights-focused programming is adequately financed and monitored through transparent funding and budgeting processes; and third, demonstrating that the HIV response contributes to overall health and well-being by linking lessons from decades of HIV progress to broader health outcomes and stronger system-wide gains.

68. Upon opening the floor, participants provided a range of perspectives on strengthening equity, access, and accountability within the Global AIDS Strategy 2026-2031. One stakeholder emphasized that HIV services must be delivered without discrimination—an approach that should also protect service providers—and noted that access to testing, treatment, and innovations remains constrained in some countries due to medicine shortages and regulatory barriers. They urged UNAIDS to help countries remove unlawful restrictions and support domestic production of essential HIV commodities to reduce dependence on external aid. Other participants, focusing on mental health integration, called for mental health to become a measurable priority in the Strategy, with indicators included in Global AIDS Monitoring and dedicated domestic and international financing to sustain mental-health-inclusive HIV services.

69. Several stakeholders addressed the enabling legal environment, with one participant stressing the need for legal frameworks that allow sustained funding for civil society and community health workers as national ownership increases. Others raised concerns that while the Strategy highlighted discriminatory laws, it lacked clear guidance on implementation and accountability. Multiple participants stressed that gender equality within the Strategy 2026-2031 must be measurable, accountable, and transformative. They called for gender-responsive indicators, targeted funding, and stronger

participation and leadership of women in decision-making and resource allocation, emphasizing that representation alone is insufficient to achieve equity.

70. Additional interventions highlighted the importance of inclusivity, participation, and coherence across UN mechanisms. Participants urged genuine inclusion of networks of key populations and people living with HIV as vertical programmes transition into broader health systems, peer- and youth-led indicators to track progress, and the incorporation of gender-sensitive and digital-rights safeguards to ensure equitable access to new technologies. Some also stressed the need for stronger alignment between UNAIDS and other UN human rights mechanisms to reinforce accountability across countries. One stakeholder further called for explicit integration of harm reduction—particularly opioid substitution therapy, needle and syringe programmes, naloxone provision, and drug policy reform—reaffirming the commitment to advancing the health and rights of people who use drugs.

71. Ms. Nilo closed the session by highlighting the following key points: that innovations must be accessible; that there is a strong need to support communities to increase pressure to realize their rights; that while rights, gender equality, and innovation are non-negotiable pillars, the challenge is to move to inter-disciplinary implementation; and that the “how” and metrics need to be strengthened in the Global AIDS Strategy 2026-2031.

Panel 4/Priority 3: Communities (and equity) – Community leadership, service delivery, and monitoring

72. Solange Baptiste, International Treatment Preparedness Coalition, moderated the session. She opened by emphasizing that communities are not merely channels for service delivery but vital, enduring pillars of the HIV response—often the first to detect changes, the fastest to adapt, and the ones that remain after external projects end. The Global AIDS Strategy 2026-2031 must go beyond rhetoric to operationalize this reality by clearly defining how community leadership, service delivery, and monitoring are embedded and funded within the Strategy’s architecture. Ms. Baptiste called the speakers to reflect on whether the framing truly positions community systems as integral, fundable components of a sustainable HIV response.

73. Aditia Taslim, International Network of People who Use Drugs (INPUD), underscored that the AIDS movement was built by communities, whose leadership remains essential for accountability and progress, yet their recognition and support at the country-level remained limited. There are persistent financing challenges for key population organizations – although commitments to community funding exist in global frameworks, they are rarely realized locally. Many community-led networks were small, unregistered, and therefore excluded from funding opportunities dominated by large NGOs that often controled decision-making. Mr. Taslim called for direct, flexible, and core funding to strengthen community infrastructure, not just programmatic activities, and highlighted the need to address restrictive national laws that hinder foreign funding and expose community organizations to risk. Genuine community leadership was impossible without sustained empowerment, resources, and protection.

74. Valeriia Raschinka, 100% Life, Ukraine, emphasized the need for clear indicators in the Global AIDS Strategy 2026-2031 that specify funding amounts or percentages allocated directly to community-led activities. Directing financial resources to communities has strengthened their capacity and impact during implementation – for example, in Ukraine, community groups, with funding and expert support, successfully drafted three laws. Ms. Raschinka urged that resources earmarked for addressing criminalization be channeled directly to communities, enabling them to sustain advocacy and legal reform efforts. The Strategy 2026-2031 should also go beyond decriminalization to include addressing a broader range of legal recognition and protections—such as addressing travel restrictions, gender identity documentation, same-sex marriage, and adoption rights—to fully advance equality and inclusion.

75. Ehab Salah, UNODC, emphasized that community leadership, service delivery, and monitoring are central to an effective HIV response, with community leaders needing full participation in decision-making spaces. He described UNODC's longstanding collaboration with civil society and community groups since 2013, including joint workplans and partnerships to address HIV in prisons and among people who use drugs. UNODC engaged communities at every stage—from contributing data for the annual World Drug Report to co-developing guidance on stimulant drug use and HIV—and fostered dialogue between civil society, law enforcement, and governments. Mr. Salah acknowledged that limited funding and shrinking civic space continue to constrain community engagement and service delivery, but noted positive progress, such as community-led monitoring initiatives in Eastern Europe and Central Asia. There should be more involvement from people with lived experience – their participation was essential to shaping sustainable, inclusive responses.

76. Erika Castellanos, GATE, commended the inclusive consultation process and reminded participants that the HIV response is about people's lives, not abstract goals. Drawing on her experience as a long-time activist, she affirmed that communities have always been the operating system of the HIV response and that their leadership rightly anchored the Global AIDS Strategy 2026-2031. She proposed three key shifts to make this real in practice: first, move from rhetorical recognition to regulatory action by embedding community-led organizations as core implementers through formal social contracting, domestic budget lines, and procurement frameworks that treat them as vital health infrastructure; second, ensure predictable and protected financing—particularly domestic resources—so integration of HIV services does not erode budgets for community-led programmes; and third, make accountability co-owned by establishing robust community-led monitoring that feeds into national data systems and triggers corrective action. These mechanisms should be hard-wired into the Strategy's architecture, emphasizing that communities are indispensable partners in delivering, sustaining, and measuring the HIV response.

77. Midnight Poonkasetwattana, APCOM, welcomed the regional focus of the Global AIDS Strategy 2026-2031 and stressed the urgency of addressing Asia-Pacific's growing prevention crisis, particularly among young people, and in accessing new technologies. The response must reflect regional and country-specific realities and place

communities at the forefront of implementation. Highlighting existing regional coalitions that supported community-led monitoring, leadership development, advocacy, and peer learning amid funding cuts, Mr. Poonkasetwattana called for sustained UN support to maintain these spaces and capacities. He urged stronger efforts to unlock domestic financing for key populations, ensure funding reaches community-led organizations, and explore innovative fundraising approaches. He also underscored the importance of addressing mental health and preventing leadership burnout, suggesting inclusion of self-care indicators, and encouraged dialogue on how communities can leverage artificial intelligence to enhance service delivery and outreach. Finally, Mr. Poonkasetwattana called for regular, institutionalized, community-led spaces to foster collaboration, solidarity, and visibility within the HIV response.

78. Ms. Baptiste asked for the speakers to provide one final adjustment to the Strategy to make it truly deliverable. Ms. Raschinka proposed linking human rights conditions with epidemic outcomes through cross-indicator analysis to show how restrictive laws worsen HIV results. Mr. Talim stressed the need for clearer, less politicized pathways for social contracting so community organizations could directly access domestic funding beyond treatment. Mr. Poonkasetwattana highlighted the importance of supporting communities not only as service providers but also as key actors in human rights advocacy.

79. Upon opening the floor, all stakeholders emphasized that strengthening community engagement and sustainable financing remained essential to delivering on the Global AIDS Strategy 2026-2031. One participant noted the importance of continued support from international partners to accelerate social contracting for domestic funding, reflecting differing national experiences in building such systems. Others highlighted growing uncertainty and shrinking civic space for civil society and community-led organizations, calling for a more ambitious and context-specific Strategy that recognized regional diversity, secured political and financial commitments, and created safe environments for advocacy. They stressed that integration of HIV services must include communities as equal partners through task sharing, not token participation, and urged recognition of national and regional networks of people living with HIV and key populations for their critical advocacy contributions.

80. Several participants further noted that communities must be central to governance and accountability mechanisms, with multi-year, dedicated funding to ensure the sustainability of community systems. They underscored that legal and policy reforms were fundamental to enable genuine participation and leadership, emphasizing that communities are not beneficiaries, but the foundation of the HIV response. Additional contributions focused on inclusion of people with criminal records in HIV programmes, arguing that ending AIDS requires ending punitive approaches that exclude marginalized communities. Stakeholders also reflected on the need to revitalize national, regional, and global community networks as advocacy platforms, recalling that past progress was achieved when communities organized collectively around human rights and accountability—an approach that should be renewed and financially supported under the next Global AIDS Strategy 2026-2031.

81. Ms. Baptiste closed the session by emphasizing that the HIV response must be centered on community leadership as a driving force for action. Communities need genuine decision-making power, supported by predictable and measurable financing, with ring-fenced budgets and social contracting embedded as standard practice. Integration should strengthen, rather than weaken, community roles, with community-led monitoring serving as an entry point for broader leadership. Ms. Baptiste noted that accountability must be tangible—communities should lead, be properly funded, and have their impact systematically measured.

Written Comments

82. In addition to the opportunities for oral intervention at the multistakeholder consultation, participants were given until 30 October 2025 to provide written statements. Below, please find a summary of the written statements received from Member States, civil society organizations and Cosponsors. Please note that where a written submission was already read during the consultation, those key points are captured in the sections above.

Member States

83. Participants highlighted several interlinked challenges and opportunities shaping the future of HIV responses within national systems. One stakeholder highlighted the widening gap between fragmented health and social protection systems and pointed to the need for stronger harmonization to ensure effective, people-centered delivery. Stakeholders noted the steep decline in external financial and technical support, which is straining national systems unprepared to shoulder full programmatic and fiscal responsibility. To address these sustainability concerns, there was a call for the Global AIDS Strategy 2026-2031 to lay out concrete, actionable pathways and investments to strengthen domestic financing, local technical capacity, and robust data governance—seen as critical components of maturing and resilient health systems.

84. One participant welcomed the Global Strategy's emphasis on national sustainability and integration of HIV services into primary health care, highlighting the importance of digital technologies, health literacy, and protecting personal data. They stressed the need for country-specific flexibility in prevention approaches, noting – for instance – that harm reduction is not legal in some countries, and recommended replacing terms like "comprehensive sexuality education" and "rights-based approaches" with language that may be more palatable across different socio-cultural contexts. The participant also called for mechanisms to protect health systems from restrictive economic measures that limit access to essential medical products and urged for the Strategy 2026-2031 to support countries in developing local production and strengthening independence from external aid.

85. Stakeholders also emphasized balancing ambition with practicality in developing the Strategy 2026-2031. Several urged that sustainability planning be holistic and equity-focused, maintaining the leadership of communities and key populations amid constrained funding, threats to human rights, and shrinking civic space. Participants

proposed greater specificity in targets related to stigma, discrimination, and gender equality, recommending measurable reductions rather than static percentage thresholds. The need for clearer definitions and indicators to ensure objective reporting on rights-related outcomes was underscored. Stakeholders cautioned that projected increases in domestic financing targets must reflect country realities to avoid unintended financial burdens on people living with HIV or de-prioritization of marginalized groups. They further recommended stronger integration with TB programmes, inclusion of community participation indicators in governance processes, and a reaffirmed commitment to safeguarding rights and gender equality, diversity and inclusion within the Strategy 2026-2031.

Civil Society

86. Civil society organizations welcomed key components of the Global AIDS Strategy, 2026-2031, including the focus on prevention, human-centered quality care, and acknowledged the efforts of all stakeholders in the current draft. They underscored that the next Global AIDS Strategy must be firmly grounded in people- and community-centered prevention and treatment approaches, with a particular focus on equity, dignity, and meaningful community engagement. Several emphasized the critical role of community health workers, community leadership, including community-led monitoring, and differentiated service delivery models in ensuring that prevention and treatment reach those who need them most. Integration of services must be driven by people's needs, not institutional convenience, and communities must be empowered to deliver prevention and treatment in safe, stigma-free environments.

87. Stakeholders also highlighted the need to institutionalize community leadership and accountability within the Strategy's results framework and financing mechanisms. Proposals included dedicated and costed funding streams for community-led interventions, establishment of social contracting mechanisms, and protection of resources for key-population networks through clear standards and annual reporting. Participants called for stronger policy commitments to remove structural barriers such as stigma, discrimination, and criminalization of key populations, and to uphold data equity and access to affordable medicines through TRIPS flexibilities and market-shaping efforts. These combined measures—grounded in human rights, inclusion, and sustainability—were seen as essential to close prevention and treatment gaps and to accelerate progress toward the 2030 HIV targets.

Closing Remarks

88. Ms. Stegling and Ms. Achrekar thanked all participants, including the speakers and moderators. Ms. Stegling noted that while much of the feedback was not new, it has taken on a certain sharpness because the challenges of the current response come from the lack of institutionalization of a rights-based approach, and insufficient meaningful engagement of communities. She thanked stakeholders for the reminder of these key points. Ms. Achrekar reiterated her thanks for the extraordinary feedback, underscoring that people must be at the center of the Strategy 2026-2031.

89. The Chair thanked the UNAIDS Strategy team, as well as the PCB partners and stakeholders for their time, dedication, and thoughtful inputs into the Strategy 2026-2031. She reminded participants that it's important not to lose sight of the fact that the Strategy is for the people.

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