

REPORT OF THE 57TH PROGRAMME COORDINATING BOARD MEETING

Additional documents for this item: N/A

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

- *Adopt* the report of the 57th Programme Coordinating Board meeting.

Cost implications for the implementation of the decisions: none

1. Opening

1.1 Opening of the meeting and adoption of the agenda

1. The UNAIDS Programme Coordinating Board (the Board or PCB) convened in Brasília and online in accordance with the approved modalities for its 57th meeting on 16 December 2025.
2. Mariângela Simão, Vice-Minister for Health and Environment Surveillance in Brazil, opened the meeting. She said that new geopolitical conditions and pushback on human rights-based approaches were complicating the struggle to end AIDS and insisted that UNAIDS' transition had to preserve people's health, the representation of people living with HIV and the defense of human rights.
3. She thanked participants for their work during the pre-meetings and consultations and thanked the Secretariat, the UNAIDS Brazil Country Office, the Pan American Health Organization Office, and colleagues in the Brazilian Government for preparing the PCB meeting. She then briefed the meeting on logistical arrangements and the conduct of the meeting, and recalled the intersessional decisions taken by the PCB on the modalities and procedures for the meeting.
4. The meeting adopted the agenda.

1.2 Consideration of the report of the Special Session of the PCB (8 October 2025)

5. The meeting adopted the report.

1.3 Report of the Executive Director

6. Winnie Byanyima, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), welcomed delegates and thanked the Government of Brazil for hosting the meeting in Brasilia.
7. After praising Brazil's HIV programme, she said the PCB was meeting at a time of great disruption and shifting financial realities which was affecting HIV responses and the work of the Joint Programme across the world. This was affecting people's access to HIV services. Over two million adolescent girls and young women had been deprived of essential health services and community organizations were being devastated, she told the meeting. The stakes were incredibly high, she said.
8. She told participants that the meeting would consider the new Global AIDS Strategy 2026-2031, which was setting ambitious targets. Inaction was not an option, she stressed. If the world failed to reach the targets, some 3.3 million more people would acquire HIV by 2030.
9. UNAIDS had been born into crisis, she said, and it had adjusted radically several times to meet the needs of the evolving AIDS pandemic. It could do it again. By 1996, she reminded the Board, almost seven million people had died of AIDS and 20 million people were already living with HIV, most of them in Africa. Experts were predicting a potentially catastrophic impact, yet the conventional view was that widespread antiretroviral therapy (ART, which became available in high-income countries in 1996) was not feasible in low- and middle-income countries.
10. At the time, she continued, the United Nations (UN) response was overly medicalized and fragmented. The Joint Programme was created by the UN Economic and Social

Council (ECOSOC) to provide global leadership and coordination, mobilize a multisectoral response, convene actors, engage communities, and provide strategic information to enhance and keep country actions on track and accountable.

11. That approach had achieved great results, the Executive Director said. The world was now closer than ever to ending AIDS, with 77% of people living with HIV on ART. The global HIV response had saved almost 27 million lives, new HIV infections had been reduced by 61% from their peak in 1996 and AIDS-related deaths had been reduced by 70% since their peak in 2004.
12. But AIDS was not over, Ms Byanyima warned. There were 1.3 million new infections and 670 000 AIDS-related deaths in 2024, each of them preventable. Some 9.2 million people with HIV were still waiting for treatment and new infections were increasing in several regions, including in Latin America, where 120 000 people had acquired HIV in 2024.
13. She said that the world was facing the crisis of a major gap in funding for the UN, with geopolitical instability, conflict and shifting political programmes causing great disruption. The Joint Programme was adjusting in line with the vision set out in the UN80 process to make it fit for the future, she said. It was doing so while safeguarding the five key elements that were critical for success: political ambition; driving innovation; setting bold targets and tracking progress; ensuring the response is multisectoral; and guaranteeing inclusive governance with civil society and communities.
14. The aim was to have clear funding plans in place to ensure that each of those five elements was properly safeguarded and that the UN did not abandon its role in combatting AIDS. Ms Byanyima then discussed each of the five elements in greater detail, along with the global efforts, including at the UN, to create the means for overcoming the pandemic.
15. She reminded the meeting that Brazil had been one of the first among low- and middle-income countries to provide free ART, a move that had inspired a global movement to bring free treatment to everyone who needed it. She praised South Africa and Brazil for also leading initiatives to promote the local production of antiretrovirals (ARVs) and other essential medicines and to make them affordable. She described recent steps to achieve more affordable pricing for long-acting ARVs and generic manufacturing of ARVs and other HIV products. After referring to the great promise of long-acting pre-exposure prophylaxis (PrEP) and arrangements to supply those versions at affordable prices, Ms Byanyima noted that most Latin American countries unfortunately had been excluded from those arrangements.
16. Reminding the PCB that an estimated 12 million Africans had died of AIDS even after ART had been developed, she said the Joint Programme worked diligently with governments to use their laws to facilitate generic production of ARVs and with companies to license and transfer life-saving technologies. UNAIDS also worked with global funders and innovators to ensure a robust pipeline of new technologies.
17. UNAIDS had helped achieve wide access to technologies and services and spurred and supported innovation, the Executive Director said. By forging partnerships, it had helped HIV responses take treatment out of hospitals and into communities. It had inspired innovations and facilitated and brokered arrangements to make technological breakthroughs like long-acting ARVs widely accessible.
18. Ms Byanyima said another key dimension of the Joint Programme's work was to establish bold targets and track progress in their achievement. In 2011, it had launched the Global Plan to eliminate the vertical transmission of HIV, which went on

to set clear goals and actions, with UNAIDS tracking the progress. By 2015, new HIV infections in children had been cut by half and the World Health Organization (WHO) had begun certifying countries that met the elimination criteria. She told the meeting that Brazil had very recently been certified for eliminating vertical transmission, making it the first country with more than 100 million people to achieve that goal.

19. In 2014, she recalled, only 66% of people who knew they were living with HIV were getting ART. In 2016, the Joint Programme set the 90–90–90 targets, which required new ways of collecting and analysing testing and treatment data. The initiative worked. By 2025, seven countries, some with very high HIV burdens, had already reached the 95–95–95 targets set in 2021.
20. Without such targets and the data for tracking progress, there would be no global HIV global response and no accountability, Ms Byanyima told the PCB. Each year, UNAIDS published the authoritative data report, monitoring country progress on the global AIDS pandemic and response, an accounting that guides the global response.
21. The Programme ensured a multisectoral response at global and at country level, she continued. In many countries, HIV infrastructure had provided the backbone for the COVID-19 response, she said. Even with reduced resources and in a complex political environment, multisectoral action remained vital for a successful HIV response.
22. Inclusive governance was also essential, she said. HIV responses had been built by people living with HIV and their communities; they had pushed past the denialism that hobbled responses and had helped build national programmes that were rooted in communities' experiences and needs. UNAIDS had been built to reflect that approach. Its committed engagement with communities lay at the heart of its success, as did the synergies it forged with governments, donors, UN agencies and other partners. The question, Ms Byanyima said, was whether the rest of the UN System was ready and able to continue that work.
23. She reminded the PCB that the Joint Programme had been transforming itself well before the current crisis. She noted that the UN Secretary-General had recently proposed an accelerated pathway, whereas the PCB had agreed to a two-phase roadmap while recognizing the Secretary-General's call for a more ambitious timeline.
24. The Executive Director said the first phase of UNAIDS's transition was underway and would be completed by April 2026. It involved moving to a model with six "lead" Cosponsors, reducing Secretariat staff by 55%, sharply lowering costs, reducing the country footprint, and integrating UNAIDS functions into the Resident Coordinator system in 20 countries. This entailed a painful and difficult process, she said, thanking all UNAIDS staff for their commitment and professionalism under very trying circumstances.
25. The Secretary-General's overall UN80 ambition was achievable, Ms Byanyima said. UNAIDS could guide the HIV response through the second phase of change while transitioning UNAIDS's functions into the wider UN System and beyond. But she insisted that it was crucial to safeguard the progress made, prevent backsliding and deliver on the promise of ending AIDS as public health threat.
26. This was not the time to walk away, Ms Byanyima told the PCB. Three decades of hard work, billions of dollars and countless negotiations had been invested; and the world could not abandon the achievements made or the work that remained. She said the prerequisites for keeping the response alive were clear: political ambition; innovation; setting targets and tracking progress; multisectoral action; and inclusive governance with civil society and communities. Time after time, UNAIDS had overcome the odds, transformed the HIV response for people living with, affected by

and at risk of HIV.

27. After reminding the meeting that 2025 marked the 40th anniversary of the HIV response in Brazil, Ms Simao opened the floor for comments. Members and observers thanked the Executive Director for a timely and sobering report that accurately captured UNAIDS's role in the achievements of the HIV response, alongside communities, governments, donors and other partners.
28. Speakers agreed that the global HIV response was at a crossroads. The decisions taken now would shape the response for at least the next decade they said. The current PCB meeting was crucial: it had to agree on how to transition the UN's role in the response.
29. Speakers commended the Joint Programme for its global leadership for a people-centred HIV response and praised its achievements. The Secretariat was thanked for its forward-looking leadership in seeking to preserve an effective and sustainable HIV response. Great progress had been made, but the fight to end AIDS was far from over, they said; in fact, it was in grave danger.
30. New HIV infections continued to occur; millions of people were not receiving HIV treatment, especially children and key populations; structural barriers, inequalities and stigma and discrimination were blocking people's access to services; human rights were under sustained attack; and external funding was plummeting (especially affecting prevention and community responses). All this was occurring in a rapidly shifting global health and development landscape and in a context of conflict, displacement and widening inequalities, which affected countries with limited resources the most.
31. Donor investment remained vital for catalytic programmes, innovations and reaching the most marginalized populations, speakers said, while recognizing that the era of overreliance on donors was ending. The current fiscal context leads countries, communities and also the UN to change.
32. Countries had to act immediately to achieve epidemic control and reduce the long-term costs for their health systems, they said. If they delayed action, it would take years and much greater resources to achieve that goal. But not all countries were able to do so rapidly, speakers told the PCB. Germany announced that it was contributing an additional Euro 700 000 in core funding and Euro 1 million in non-core funding.
33. The world could not risk backsliding, speakers said. If the foundations of HIV responses were allowed to weaken further, the human and financial costs would grow considerably, they warned.
34. A clear transition path for the sustainable integration of UNAIDS into the UN system and beyond was needed. Crucially, it had to preserve strong leadership for driving the global response forward. Speakers insisted that the reforms and changes must strengthen, not undermine the global HIV response.
35. They reminded the meeting that many strengths and opportunities were at hand. The world had the tools to end AIDS, new innovations like long-acting antiretrovirals were available, and effective new service delivery methods were being used. Countries increasingly were leading national responses and communities remained committed to play their crucial roles. The new Global AIDS Strategy for 2026–2031 presented a forward-looking vision and the upcoming High-Level Meeting on AIDS and political declaration were opportunities to reaffirm global commitment to reach the 2030 AIDS targets.
36. Speakers said there was momentum for rethinking public health and HIV funding. They

saw the transformation of the Joint Programme as an opportunity to build on decades of lessons learned from the HIV response and to chart a course that would be country-led, people-centered, evidence-based, and focused on impact and sustainability.

37. At the same time, speakers reiterated, political commitment, innovation, robust data systems and the leadership of communities laid at the heart of the HIV response's achievement and had to be protected. Experience showed that successful HIV responses required government leadership aligned with partnerships across society; predictable and transparent domestic resource mobilization; funding arrangements to support community-led organizations to do what they do best; strong data and accountability mechanisms; and legal and policy reforms to remove barriers to service access.
38. Ultimately, speakers said, governments, communities and civil society were the main drivers of country progress against the AIDS pandemic. In planning for UNAIDS's transition, the UN had to ensure support to those actors. The future of the HIV response should be built around the needs of people living with and affected by HIV, particularly key and priority populations, and it should be grounded in human rights.
39. Members and observers unanimously reaffirmed their strong support for the Joint Programme. They said UNAIDS was more than "just another UN programme": it was a unique platform that anchored community leadership, coordinated across the UN system, and kept equity and rights at the centre of the HIV response. Its technical support and convening roles were vital for successful multisectoral action against AIDS.
40. For affected communities, UNAIDS was uniquely important, speakers said. Even in challenging legal and policy environments, it managed to maintain space for dialogue, protect access to services and reinforce the importance of human rights in public health. In a period of shrinking resources, rising inequalities and ongoing backlashes against human rights and gender equality, losing such a platform without safeguards would be a significant setback.
41. Some members briefed the meeting on recent developments in their HIV epidemics, emphasizing the importance of prevention programmes and described key features of their responses, the institutions they had created and the approaches they had adopted. They said UNAIDS had been supporting and cooperating with those institutions for 30 years.
42. The central challenge was to preserve UNAIDS's unique added value while transitioning it more deeply into the wider UN system, speakers said. They warned that proceeding without transparent timelines, mitigation measures and a clear vision for how UNAIDS's distinctive mandate and core functions would be carried forward could jeopardize hard-won gains and leave those most affected by HIV and inequalities behind.
43. Speakers insisted on a smooth, carefully managed transition process that would meet the needs of affected communities. A safe landing for the Joint Programme was needed to preserve strong country support, accountability with data, and the leadership of communities, they said. Achieving this required a realistic, well-sequenced approach, grounded in shared responsibility and attentive to the risks of disruption.
44. A responsible and clear transition was essential. Speakers said the transition had to be accompanied by strong multilateral cooperation and continued leadership, with the full functions of UNAIDS preserved. UNAIDS's transition was not simply about dividing and reallocating responsibilities but about ensuring coherence and complementarity. In

mapping and carrying out the transition, it was crucial not to lose sight of the fundamentals that make HIV responses successful. For example, technical support brokered or provided by UNAIDS was vitally important as countries assumed full ownership of their national responses.

45. Members and observers reaffirmed their support for the UN Secretary-General's broader reform efforts under the UN80 initiative, but expressed concern about the proposed accelerated timeline. They acknowledged the need for further reform of the UN system to enhance efficiency and impact but warned that rushing UNAIDS's transition would have major negative consequences for the global HIV response. Shortcuts would backfire, they warned; experience showed that poorly planned transitions disrupted services, weakened accountability and eroded trust.
46. The transition should proceed in an orderly and planned fashion to safeguard the HIV response while being coherent with the UN80 initiative, the PCB was told. That would require difficult decisions and compromises, speakers acknowledged, but it was essential for integrating UNAIDS's unique capacities and ensuring that the UN retains an impactful role in the global HIV response.
47. The PCB was told that a transition should be guided by several non-negotiables: no disruption to HIV services; no loss of community leadership; and no weakening of human rights accountability. Decisions had to be evidence-based and anchored in human rights and equity, involving meaningful engagement with affected communities and protecting and advancing the hard-won gains of the HIV response. Wide and equitable access to HIV services and tools and the meaningful participation of civil society must remain priorities, and communities played indispensable roles, speakers said. UNAIDS's transformation should sustain community systems and help secure the political and fiscal space for them in the long term.
48. Speakers added that the transition should be handled with care, transparency and support for staff at all levels. They thanked UNAIDS staff for their ongoing commitment to the HIV response.
49. They called for strong leadership from the Board and said it had a collective responsibility to preserve the gains of the global HIV response as the Joint Programme was integrated further into the wider UN System and beyond. The Board had agreed on a new operating model for the Joint Programme and a vision for further transformation, they said: it now had to translate that vision into a concrete and realistic plan.
50. A timebound transition roadmap with clear milestones and accountability mechanisms was vital, speakers said. It would have to set out which functions are to be carried by which Cosponsors, informed by their concrete proposals on how they would assume those functions and the capacities required to deliver them. The roadmap would also have to outline how transfers would be managed, how institutional knowledge would be safeguarded, how civil society's involvement and voice would be protected, and how the transition process would align with UN80 reforms—with clarity regarding timelines, affordability and practicality. Also needed was a budget and workplan that laid the basis for a sustainable and orderly implementation phase.
51. While recognizing the importance of a "joined-up" planning process, some speakers said this had to happen quickly: a time-bound plan for the full transition of the Joint Programme was needed by end-2026.
52. There was strong support for the creation of a working group to guide the transition. Such a group would have to be fully accountable to the PCB, they said. It should have a realistic mandate that would allow it to deliver an actionable plan for the most

appropriate way to transition UNAIDS by preserving the approaches and methods that had brought success to the HIV response.

53. Cosponsors reminded the meeting that Cosponsor principals had unanimously committed their respective agencies to continue to contribute to the HIV response, safeguard progress and strengthen integration. They said they took note of the intention to establish a working group for a responsible transition of the Joint Programme and reaffirmed their commitment to UNAIDS while preserving its legacy of innovative and effective partnerships across the UN with governments, civil society and other partners.
54. There was insistence that global solidarity remained essential during the transition. Speakers urged political leaders to choose equity over convenience, people over processes, and long-term sustainability over short-term efficiencies. The world was watching, they said, and the lives of people living with and affected by HIV depended on the choices and decisions that were being taken.
55. Speakers strongly welcomed the new Global AIDS Strategy and its approach, including the central role it reserves for community leadership. They also welcomed the shift towards increased domestic ownership and leadership, including through the development and implementation of country-led and country-owned sustainability roadmaps. While international support would remain important, the pivot toward resilient, country-led systems was both timely and necessary.
56. An appeal was made to maintain eastern Europe and central Asia as a distinct region within the HIV response (and not merged with Asia-Pacific as a region). Eastern Europe and central Asia's epidemiological, legal and political profile was entirely different from that of Asia and the Pacific, they explained. Merging the two regions would put at risk communities' access to meaningful support, data and accountability mechanisms. It would also risk creating new geographic blind spots in the HIV response. Keeping Eastern Europe and central Asia as a standalone region, with staff based there, was the only way to achieve appropriate handover arrangements with the right mix of Cosponsors and other relevant support.
57. In reply, Ms Byanyima thanked the speakers for their remarks and support. She said the new Global AIDS Strategy could generate new momentum to end AIDS. It reinforced multisectoral and people-centred approaches and continued to position the core of the work at country level, supported by international and global actors.
58. She agreed with calls for the meaningful participation of civil society in all aspects of the response and UNAIDS's transition and said it was heartening to hear countries' commitment to ensure that services could be accessed by everyone who needed them and to maintain multisectoral approaches.
59. She emphasized that reliable and up-to-date data had catalyzed and shaped effective action and were thus vital for accountability. Strategic information assets had to be protected and could not be fragmented, she advised. Although the HIV response was larger than UNAIDS, the Joint Programme had an important and clear role to play. Even though the previous 12 months had almost upended the HIV response, there was cause for hope, she said. UNAIDS was uniquely positioned to address the challenges even as it embraced its transformation.
60. The Executive Director reminded the meeting that the Joint Programme was funded entirely through voluntary contributions. Thanking donors, she said UNAIDS existed because governments at every income level contributed to its funding. It was a "small-budget, high-impact" programme which operated prudently, anticipated and addressed crises, and remained viable, she told the PCB, and it was taking tough decisions to

adapt for the future.

61. Ms Byanyima acknowledged the appeals for UNAIDS to remain present in all regions and assured the meeting that it remained committed to safeguard the special needs of eastern Europe and central Asia. There were lessons to be learned from the closure of Country Offices in the previous realignment, she said.
62. The upcoming High-Level Meeting of the General Assembly would be a watershed in HIV response, she said. Decisions taken at previous High-Level Meetings had moved the HIV response forward significantly and she hoped that the June 2026 meeting would adopt a bold new Political Declaration with ambitious targets.
63. Regarding the transformation of the Joint Programme, the Executive Director said she was heartened by the passion shown by speakers. There was a shared understanding that transformation had to happen and had to be accelerated, she said. However, it was also clear that this had to be done responsibly, preserving the critical elements that had brought success to the global HIV responses. Millions of lives depended on the choices that were being made, she concluded.
64. The meeting adopted the decision point.

1.4 Report by the NGO Representative

65. Amanita Calderón-Cifuentes, on behalf of the NGO Delegation, presented to the PCB a summary of the report of the NGO Delegation “Community-led integrated HIV services: The future of a sustainable HIV response”. As an example of community-led integrated HIV services, she described the work of the Tangerine Clinic in Thailand, a community-led clinic that integrates HIV testing, treatment and prevention with sexual and reproductive health and rights, mental health support, and harm reduction. She said the clinic was widely recognized as a regional reference point for effective community-led care, yet it had been defunded in 2025.
66. She told the PCB that entities like Tangerine could achieve even greater impact if they were formally recognized, sustainably funded and embedded within national HIV and health systems. She said their impact was grounded in the concept of intersectionality, which captures the ways in which social, political, and legal dynamics shape people’s lives. Poverty, gender discrimination, lack of education, violence, stigma and mental health difficulties were among the factors rendering people at high risk of HIV infection, she reminded. Since those factors interact in complex ways, an integrated response was needed.
67. While discussions about integration focused on folding HIV services into government-run systems, less attention was paid to the role and impact of community-led models, she said. At the same time, crises in global health financing put those models at even greater risk of being sidelined. She also said the NGO report presented recommendations to ensure that community-led integrated services are recognized, resourced and embedded as key pillars of sustainable and equitable HIV responses.
68. Ms Calderón-Cifuentes then explained the definitions of key concepts, including community-led integrated HIV service delivery, which refers to models where HIV prevention, testing and treatment are delivered alongside other essential health and social services via platforms that are led and governed by as well as accountable to communities. Community-driven models work because they are grounded in lived experiences, cultural competence and safety, integrating HIV and non-HIV needs, she explained. The evidence showed that they improve HIV outcomes, she mentioned.
69. She reminded the PCB that people living with HIV had built the first care systems in

the absence of government support, and that drug user groups had created underground needle exchange projects which later became the foundations for modern harm reduction programmes. She also described examples of pioneering activities of sex worker communities, gay men and other men who have sex with men, and transgender people. Those models had become a blueprint for the rights-based, people-centered, integrated HIV services which were being promoted across the world, and which had been formalized in the 2021 Political Declaration on HIV and the Global AIDS Strategy 2021–2026. Specifically, the Global AIDS Strategy had introduced the 30–60–80 community targets and the 10–10–10 societal enabler targets, she recalled.

70. Ms Calderón-Cifuentes explained that the NGO report was based on surveys and other research to determine the main challenges and success factors for integrated community-led responses. She described the methodology of the biggest study.
71. Funding was among the key challenges identified by communities, she said. The study showed that short-term, project-based grants tended to undermine planning, workforce stability and service quality. Three viable funding pathways were identified: public contracts, direct multiyear funding, and formal budget recognition for frontline community health workers.
72. Communities had warned of transition risks, with responsibilities being shifted onto community systems that lack adequate resources. She said communities had also highlighted the need for sustained training and capacity building to professionalize their workforces. Many community health workers already provided specialized services, but required more training, mentorship, supervision and certification. Formal recognition through accreditation and service contracts was essential, she concluded.
73. The study found that service integration had to occur in ways that preserve community ownership and leadership. Community-led services had emerged because public systems often failed to provide safe and stigma-free care and support, she said. Also important were enabling legal and policy environments, advocacy space and social contracting.
74. Turning to recommendations, she said Member States must adopt integrated service packages that link a full HIV continuum of care with other relevant services, such as harm reduction programmes, comprehensive sexuality education, sexual and reproductive health and rights, mental health support, peer support, and basic social protections. Those services must be delivered by community-led organizations that are formally recognized and properly resourced as essential service providers, she urged.
75. Funding should also shift to services which communities trust and use, and it should cover overhead costs and include social contracting arrangements, she mentioned. Sustained investment in capacity building, workforce development, financial management, and advocacy was also essential to strengthen community-led organizations, Ms Calderón-Cifuentes told the PCB.
76. Other needs included the meaningful involvement of communities in all stages of decision-making, and in monitoring and accountability frameworks. According to the NGO Delegation, community-led monitoring must be adequately resourced and incorporated in programme monitoring and other strategic information systems. Legal reforms were foundational, she stressed, as was the protection of civic space.
77. She concluded by saying that community-led models must be preserved and supported as permanent components of national systems and community representatives must be included on the boards and staff of UN and regional agencies involved in the HIV response.

78. The Chair opened the floor for discussion. Members and observers thanked the NGO Delegation for an important and results-focused report, and for the thorough evidence and research presented in it. The report was a timely reminder that the world was missing key HIV targets, and that pushback on human rights and gender equality were hindering HIV responses in a context of decreasing civic space and major funding losses, they said, highlighting that community leadership was more critical than ever, including in humanitarian settings.
79. Speakers welcomed the proposals in the report, including the recommendations for an integrated community-led services package. They said the report vividly confirmed the centrality of community-led, integrated services and the importance of the principles of justice, dignity and human rights in HIV responses. It also showed that communities were the backbone of HIV responses and that they held governments, the UN and donors accountable, speakers mentioned.
80. There was strong agreement that the full participation of affected communities was indispensable for success in the AIDS response. Community-led HIV organizations had been the backbone of the HIV response for over 40 years, speaker reiterated. They built trust, boosted effectiveness, and functioned as lifelines: they reached people when formal health systems failed, including in countries facing humanitarian crises, speakers added, indicating that when communities functioned as core partners, health outcomes improved, and systems were more efficient. Community-led HIV service delivery should be a permanent feature of national health systems, speakers urged.
81. Speakers added, however, that they had been struck by the warnings about the fragility of community systems. When communities were weakened, national responses suffered, they noted and insisted on having clear plans that can safeguard community leadership in HIV responses. While welcoming the examples of communities innovating and closing service gaps, speakers also reminded the meeting of the unpaid work which communities often performed in HIV responses.
82. Cosponsors assured the Board that they recognized the importance of investing in community-led systems as a strategic imperative for realizing equity, justice, sustainability and human rights, and said they would continue to partner with civil society.
83. There was strong agreement on the importance of integrating community-led HIV services into wider health systems and beyond (including social protection systems) and integrating community leaderships in the governance, planning and monitoring of national responses.
84. Speakers said true integration entailed governments and community-led services operating together, each doing what it does best, while building trust and sharing responsibility. That required predictable, direct and flexible financing to reach community organization, along with enabling legal environments and shared decision-making. Speakers also stressed that integration must preserve, not dilute, the autonomy, expertise and reach of community organizations.
85. There was strong agreement that sustainable HIV responses were impossible without strong, autonomous and well-funded civil society organizations. The Board was told that shrinking global health financing, increasing inequalities and growing attacks on human rights were converging at a time when HIV responses require urgency, scale and political courage and commitment. Community-led HIV services had relied on unreliable, short-term funding, but even that was now under threat, with donors withdrawing funding for community responses at a rapid pace, speakers alerted.

86. The Board was informed that funding cuts had forced many organizations to shut down in 2025, leaving communities without vital HIV services, including for harm reduction. The cuts were having a disproportionate impact on key populations, women and young people, speakers noted. They said communities were trying to respond with solidarity and by sharing resources, but this was difficult and unsustainable. Although national contexts differed, there was a clear need to increase resources for human rights-based and community-led HIV responses, the meeting was told.
87. Speakers strongly supported the report's call for protecting and allocating direct funds for community-led HIV responses, and for safeguarding civic space and human rights as core enablers of effective HIV programmes. Predictable and direct financing, including through social contracting and the integration of community-led services in domestic HIV budgets, would allow communities to plan, retain skilled staff and continue to serve the people who were most affected by HIV and left behind, speakers said. Such institutional funding arrangements should be in place *before* donors "transition" their support away from HIV programmes, they advised.
88. Also emphasized was the importance of ensuring that sustainability planning and domestic financing strategies are inclusive, transparent and co-created with communities. It would be a strategic and costly mistake to weaken civil society's role in the HIV response, they said.
89. In addition, it was noted that financial management, governance, contract readiness and accountability systems in many community organizations were uneven. This highlighted a need for targeted, sustained capacity strengthening, especially as countries move towards social contracting.
90. Speakers underscored that HIV responses could not be effective if civic space was constrained, or if the social, legal and policy determinants of risk and vulnerability were neglected. Credible HIV responses required decriminalization, legal reforms, the removal of discriminatory practices and actions that reduce gender inequality, alongside predictable long-term funding, they said. Governments were urged to divest from punitive policies, including the war on drugs, and to invest rather in community-led harm reduction.
91. Several speakers described the ways in which communities were facilitating, driving and strengthening HIV responses and some of them shared examples of the support that could boost community-led activities. Ending AIDS was only possible, speakers said, if communities were fully empowered, had the necessary resources and were meaningfully included in the decisions that affect their lives.
92. Speakers agreed with the report's call for UNAIDS' transition to preserve its unique role in stewarding rights-based, evidence-informed and community-led HIV responses. They also stressed the importance of developing, with communities, a forward-looking approach to safeguard critical functions currently delivered or coordinated by UNAIDS, particularly those that support key populations in difficult legal environments.
93. In reply, Ms Calderón-Cifuentes thanked the speakers for their comments and said that, ideally, UNAIDS should continue to operate until the AIDS pandemic was over. She said the NGO report was a practical guide for governments and agencies, as it featured approaches that were evidence-informed, cost-effective and grounded in knowledge, solidarity and kindness.

2. Leadership in the AIDS response

94. Introducing the panelists for this agenda item, Ms Byanyima said the Global Council on Inequality, AIDS and Pandemics had been tasked with examining why, at the

beginning of the 21st century and despite great technological advances, pandemics and health crises continued to accumulate. She said the Lancet Commission on investing in health had estimated that there was a 23% chance of a pandemic as big as COVID-19 occurring in the next ten years. She then described the Council's research and its key findings that rising inequality was driving an inequality-pandemic cycle.

95. Ms Byanyima introduced the participants in the discussion: Nisia Trindade Lima, former Minister of Health of Brazil and former president of the Oswald Cruz Foundation; Matt Kavanagh, Director and Associate Professor of the Georgetown University Center for Global Health Policy and Politics; and Mariangela Simão, Vice-Minister for Health and Environment Surveillance at Brazil's Ministry of Health.
96. In his presentation, Mr Kavanagh said pandemics were becoming more frequent and severe. The core finding of the Council's research was that inequality not only intersects with pandemics but is a major causal factor. Inequality disables effective pandemic responses, while pandemics increase inequality between people and between countries, he explained.
97. He described the major rise in economic inequality and the ways in which it intersects with social inequalities of gender, race and sexuality. The interplay of inequalities makes it more likely that disease outbreaks are not contained, while the social determinants of pandemics drive health inequalities that fuel the spread of disease, Mr Kavanagh said. The Council's research also showed that international inequality between countries undermines pandemic preparedness at all levels and makes pandemics more deadly and economically disruptive.
98. He presented some of the evidence showing that higher levels of inequality were associated with higher likelihood of infections, morbidity and mortality. Analysis of urban inequality showed that people living in urban informal settlements had higher rates of HIV infection than other urban dwellers. However, this was not universally true, he explained. Such apparent anomalies showed that robust HIV responses in those countries were at least partly addressing the impact of inequality on the epidemic.
99. Regarding inequalities between countries, Mr Kavanagh emphasized the importance of a fiscal capacity to respond to pandemics. He reminded the meeting that low-income countries had spent much less on their COVID-19 responses than high-income countries had done. There was also inequality in access to medicines; in the 1990s it had taken at least 10 years before new HIV medicines were available in low-income countries. The result is a cycle in which inequalities fuel pandemics, which then drive inequalities, he stated.
100. Ms Nisia Trindade Lima discussed the recommendations from the Council and said there were ways to interrupt the inequality cycle. She said it was important to address each of the main drivers of that cycle. She indicated that countries must invest in addressing social determinants of health, using social protection mechanisms to reduce socioeconomic and health inequalities, and building societal resilience to prepare for and respond to pandemics. During health crises, social protection should be "surged" through systems that can reach everyone in need, she said, adding that, in the longer-term, actions were needed to make societies healthier and stronger, with strategic actions focused on the social determinants of health.
101. The second driver was related to the engagement of communities, she explained. Health services often do not reach the most vulnerable people, who also tend to have low trust in institutions. There is also insufficient action by sectors other than health to tackle inequalities that drive pandemics. The Council recommended strong efforts to

build trust, equality and efficiency in pandemic responses by investing in multisectoral and community-led pandemic infrastructure in partnership with governments. While reminding the meeting that communities do not replace the role of governments, she said that, during pandemics like AIDS, funding had to be available to community organizations so they can reach people who are being missed by public and private health services.

102. Ms Trindade said the third driver pertained to global financial infrastructure and unequal access to pandemic science and technologies. People's lives, not profits, should be priority when it comes to addressing pandemics, she said. The Council recommended that debt and financing barriers be removed, with debt swaps for health spending among the options for doing so. She added that local and regional production capacity must also be built alongside an overhaul of governance of research and development to ensure the sharing of health technologies as public goods. In the longer term, she said, the Council recommended that global intellectual property rules on pandemic technologies be waived once a pandemic is declared.
103. She reminded the PCB that the AIDS pandemic existed in a larger context and that many of its drivers were not unique to it. The overarching solutions for overcoming Ebola, COVID-19 or HIV were often very similar, she said.
104. Ms Simão said the report was very timely and clearly highlighted the inequalities between and within countries. It showed that well-established health crises like AIDS and COVID-19 existed along worsening environmental and other crises. She said the report rightly showed how the global financial architecture limits the capacity of many countries to prevent disease outbreaks from becoming epidemics and pandemics. Yet, she said, the lessons from HIV had apparently not been heeded during the COVID-19 pandemic. For example, high-income countries had bought more vaccines than they needed, which led to the delay of vaccines reaching low- and middle-income countries.
105. Ms Simão reminded that the focus for the health sector should also be to tackle inequities, which was not the same as inequalities: removing inequities meant ensuring that the people most in need of services and care can get those services, she explained. Both concepts were relevant, but it was important for actions to resonate within the politics of health, she concluded.
106. Ms Byanyima said the Council's findings were very worrying and showed that inequalities between countries were deepening. However, they were also encouraging in that they revealed the inequality-informed, evidence-based actions that can be taken. She said it was important to address the inequalities that drive pandemics before pandemics develop, and to respond to those inequalities during pandemics. She congratulated Brazil for taking public policy actions to address the roots of health crises and for building social protection and universal health coverage in ways that engage affected communities and build trust.
107. It was also necessary to address inequalities between countries, she said. Countries need fiscal space to respond to pandemics, including financing mechanisms that allow them to "surge" social protection when a pandemic hits. To achieve that, the debt crisis afflicting many low- and middle-income countries must be resolved, she told the meeting and reminded it that many countries were spending more on servicing their debts than on health. Also vital was stronger cooperation to ensure that breakthrough health technologies are available to everyone who needs them, she added.
108. In closing, she said the recommendations of the Council aligned well with the new Global AIDS Strategy. Both called on Member States and the multilateral system to ensure that responses to HIV and other pandemics are sustainable, multisectoral, community-led and reach all people without discrimination.

109. The Chair opened the floor for discussion. Members and observers thanked the panelists and said that controlling HIV requires social and economic arrangements that are equitable, along with stronger institutional cooperation.
110. They reiterated that increased access to HIV care and treatment was made possible by activism and partnerships. However, they warned that hard-won gains in human rights were experiencing setbacks and inequality was rising—reminders that progress was never permanent and required constant commitment. They also reminded that “rights on paper” did not necessarily lead to thorough change. Despite strong political support for rights and gender equality in Brazil, for example, transpeople and women still experienced high levels of violence. Changing laws was important, but not enough, speakers said.
111. The importance of a pandemic preparedness and response system was emphasized. Such a system should be acceptable to all parties; implementable and grounded in the practical reality of scientific research and development; and conducive to swift and effective public health responses to health emergencies, the PCB was told. Speakers also urged that various stakeholders work together to help invest in more regional manufacturing capacity.
112. Some countries shared examples of steps they had taken to achieve more equitable access to medicines and health services and underlined the importance of strong political leadership and collaboration of civil society. They warned, though, that funding cuts were now undermining those achievements and said that a rush to prematurely close UNAIDS would create gaps that would worsen exclusion and degrade the ability to respond to pandemics.

3. Progress update on sustainability in the HIV response

113. Jaime Atienza Azcona, Director of Equitable Financing Practice at UNAIDS, presented this agenda item. He said the need to transform HIV responses had existed in 2024 already, but funding cuts and disruptions in 2025 had accelerated the process. The next year would be critical, he said, adding that HIV responses had to become more self-reliant and integrated, with strong government leadership and community involvement, and with donors incrementally channeling resources through government systems. While a push for greater health sovereignty and increased domestic spending was underway, continued advocacy and support were needed to keep that momentum going, he stated. Business as usual was no longer an option, he told the PCB; HIV responses had to transform.
114. He reminded the meeting that sustainability had several dimensions: political, programmatic and financial. Domestic HIV-related funding in 2024 had risen by 28% compared with 2010. However, the funding disruptions of 2025 had again widened the HIV funding gap and were leading to reversals in treatment coverage and quality and to setbacks for prevention, key population programmes, community-led services and efforts to bring about enabling environments. While these disruptions also prompted intensified focus on planning for the sustainability of national HIV responses, they prompted countries to prioritize short-term resource mobilization to preserve essential services and slowed some national processes for developing sustainability roadmaps.
115. Alongside the shortfalls and the structural shifts in international financing for HIV and health care, he said, many countries were facing more limited fiscal space which made it difficult to prioritize health spending. The new reality was characterized by major shifts in global health financing and HIV response funding. Despite some renewed commitments, the available funding was well below the levels needed and below the levels before the reductions in 2025, he informed. Referring to the African Union Roadmap, the America First Global Health Strategy and the new investment case of

the Global Fund, he said it was also clear that there would be major changes in how the HIV response would be funded in the years ahead.

116. At the same time, many countries were rising to the challenge by increasing their HIV and health financing, he said. Twenty-six of 61 countries had committed to increase HIV and healthcare financing in 2026 and bold national ownership was emerging, advancing the Lusaka Agenda, the Future of Global Health Initiatives and the Accra Reset.
117. He reminded the PCB that, in early 2025, UNAIDS had designed the rapid AIDS response emergency financing tool which allowed countries to track and map the gaps created by the funding disruption and needs in terms of funding, services, procurement and human resources. The tools were being used by 32 countries and two regions to advocate for new investments, resulting into increased domestic allocations to maintain live saving services.
118. HIV response sustainability had gained momentum by early 2025, with more than 30 countries having developed part A of their HIV sustainability roadmaps, he told the Board. Seventeen countries had completed part A of their roadmaps, 11 were developing part B, and 13 were developing both parts A and B. Countries were prioritizing integration and multi-disease approaches; the protection of HIV priorities, especially key populations and enabling environments; people-centered health and community infrastructure; boosting domestic investments to laboratories, supply chains, procurement systems and local production capacities; and unified national health information systems. Also emphasized were primary prevention and differentiated service delivery modalities, as well as community leadership and public financing of community-led responses, especially through social contracting.
119. He said sustainable and equitable financing required setting domestic milestones, which has been advanced in some countries, while also relying on global solidarity. That involved, he added, diversified financing strategies, using a mix of health and HIV taxes, increased budget allocations for HIV and health, increased revenue collection, the expansion of fiscal space (including through debt reduction and efficiency gains) and the integration of HIV into health benefit packages and financial protection. He stressed that global solidarity remained vital for epidemic control. Discussing the way forward, he said HIV gains were at risk and stressed the need for responsible transitions and investing in national system transformations to sustain impact. Political leadership and clear strategies were vital, along with integration and system strengthening, and implementation of the country-led sustainability roadmaps, he stated, stressing the need for investments to secure community engagement, enabling environments and strong accountability.
120. Raymond Yekeye, Director of Programmes of the National AIDS Council of Zimbabwe, then described his country's recent experiences. Zimbabwe had achieved the 95–95–95 targets, he said, but it faced major challenges. About 15 000 people were acquiring HIV per year and 110 000 people with HIV were not receiving treatment. The AIDS Levy covered about one quarter of HIV funding needs, but that left the HIV programme highly exposed to external funding, which accounted for about 75% of funding. About 98% of external funding came from only two funders: the Global Fund and PEPFAR. A volatile macroeconomic environment added to the challenges, he said.
121. Funding cuts were having a huge impact at community level, Mr Yekeye told the PCB, with health workers, laboratory systems, supply chain management and blood sample transportation systems badly affected. After the funding freezes and cuts had been announced, Zimbabwe had swiftly modeled the impact of the funding losses, conducted an impact assessment, and convened a team to use the Rapid AIDS

Response Emergency Financing Tool to make the case for more domestic resource mobilization.

122. A minimum service package was also developed, he said. It had involved deciding, for example, which packages of services could be provided sustainably for adolescent girls and young women with mainly domestic funds. Another change had been the development of a single, integrated HIV and TB strategy. The conversations had also broadened to include the establishment of a national health insurance scheme, with an emphasis on including HIV as one of the basic packages. However, the continuous changes were making it difficult to arrive at a settled response and to implement an orderly transition process, he said.
123. Continuing the discussion, Inad Quinones Rendon of the Global Network of People living with HIV (GNP+) said country-led sustainability discussions centred on two key players: governments and communities. Engagement of people living with HIV should be institutionalized in national HIV integration frameworks, not tokenistic, and integration should be clearly defined and shaped by local contexts and realities, he said, stressing that it must enable social support and economic development; build on, not replace, the HIV response; not render people living with HIV invisible; and guarantee dignity, confidentiality and freedom from discrimination. He said global frameworks must recognize and institutionalize the leadership of people living with HIV in HIV responses.
124. It was vital to examine how funding was structured and allocated in systems, not just where it came from, he said. Sustainable HIV responses required funding mechanisms that consistently resourced community organizations through sufficient, flexible and empowering funding models, he explained. Also highlighted was the ongoing importance of capacity strengthening, which should be linked to leadership and sustainability.
125. Finally, he said it was crucial to acknowledge that support for some communities was impossible in some countries due to legal and political constraints. The criminalization of key populations often prevented organizations serving their needs from registering or accessing public funding mechanisms. Efforts to promote domestic financing for key population-led HIV responses should be grounded in a more nuanced understanding of the legal, political and social realities in countries, he pointed out.
126. Tia Phalla, Deputy Director of the National AIDS Authority in Cambodia, said Cambodia had almost reached the 95–95–95 treatment targets but now faced major challenges in reaching the remaining undiagnosed people living with HIV and sustaining the response in the face of reduced funding.
127. He said Cambodia had moved from an emergency mindset to a sustainable, domestically owned response. The goal was not just to end AIDS but to secure long-term resilience based on domestic resources; one of the objectives was to increase domestic resources by 50% by 2028. HIV was now embedded as a permanent component of public health, he explained, and the country was finalizing arrangements for social contracting of non-state providers. For service delivery, he said social contracting would be used to find undiagnosed people living with HIV, mostly gay men and other men who have sex with men and young people, and link them to the health system.
128. Cambodia had committed to end AIDS as a matter of national sovereignty, Mr Phalla told the PCB. However, it needed investments to strengthen its transition capacity, as well as bridging finance to cover gaps. It was also looking for support to introduce advanced HIV tools like long-acting lenacapavir, implement data integration and integrate HIV more deeply into primary healthcare and universal health coverage. As

Cambodia entered the “final mile” of its HIV response and its transition to local ownership of that response, it was vitally important to strengthen governance and accountability mechanisms, he said.

129. Speaking from the floor, participants thanked the Secretariat for the presentations which showed that the global health financing landscape was changing at an alarming pace, with huge reductions in support for HIV threatening national programmes. They said they welcomed the emphasis in the accompanying paper on domestic resource mobilization, integration into national systems and community-led HIV responses.
130. Sustaining the HIV response required strong political leadership, diversified financing, integrating HIV into universal health coverage, and resilient health systems that can protect long-term health gains, speakers told the Board. Three core principles for sustainability were highlighted: strengthened country ownership; predictable and transparent financing; and protection of people and services.
131. Sustainability depended not only on mobilizing more resources, speakers noted, but on adapting programmes, prioritizing, making trade-offs, and introducing system reforms. They said it would be useful to analyse in greater detail which features and activities in countries’ HIV responses should be protected at all costs, which services and functions could be integrated, and which were no longer needed.
132. Speakers welcomed the progress made towards developing national HIV response sustainability roadmaps and thanked UNAIDS for supporting the processes. The roadmaps were becoming key tools for guiding evidence-based national transitions, priorities and timelines, and they helped align governments, communities and donors around shared visions, speakers said.
133. It would be useful, they added, to have a clearer understanding of how the sustainability roadmaps were being embedded in core budget processes, medium-term expenditure frameworks, and financial management reforms. A more explicit discussion of risks was also necessary, since sober scenario planning and contingency options were integral to sustainability.
134. Also noted were the growing linkages of sustainability planning with broader health financing and universal health coverage reforms, including integration of HIV into insurance schemes and benefit packages. Speakers commended countries that were already expanding domestic HIV allocations, integrating HIV services into national health systems, and aligning reforms with broader health financing agendas. They said the examples shared confirmed the importance of pursuing country-owned transformation in close collaboration with community-led HIV organizations and other relevant civil society organizations and partners.
135. Nevertheless, speakers added, international support remained vital as countries advanced to greater country ownership and sustainability. External partners shared a responsibility to support country transitions and to ensure that they are gradual and responsible. Global solidarity must not weaken at the very moment when it was most needed, they insisted.
136. Speakers welcomed the strong recognition that community-led HIV responses are key for sustainable impact, and they stressed the need to include communities in roadmap processes. Community-led organizations had crucial roles in shaping public policies, defending rights, supporting adherence and retention in care, and confronting stigma and discrimination, they said. Sustainability therefore also required stable and predictable financing for community systems, including through social contracting and meaningful participation in governance. There was a request for more guidance for introducing social contracting at scale, including on what proportions of domestic HIV

budgets should reach community-led organizations and how legal and policy reforms could be sequenced alongside fiscal reforms.

137. Speakers called on the Joint Programme to sustain its support to countries so they can navigate the shift from donor dependence to nationally owned responses while ensuring continuity of services, the protection of key population programmes, and integration of HIV services into broader health systems without compromising quality, equity or human rights.
138. While affirming the need to continue embedding HIV services in primary healthcare and universal health coverage frameworks, speakers also advised caution. Since the funding cuts and freezes of early 2025, communities were being redirected into public health facilities where they were experiencing stigma and discrimination, confidentiality breaches and denial of care, they said. Those realities were clearly not conducive to sustainability.
139. Similarly, the pursuit of social contracting had to reckon with the fact that many governments continued to impose restrictions on community-led organizations and criminalize key populations. Countries were urged to achieve responses that are grounded in human rights and, therefore, could be truly sustainable.
140. Several country representatives shared updates on their sustainability roadmap processes, which they said were invaluable for navigating rapidly evolving financing conditions and shifting from donor dependency to sovereign programme management. They described how they were anchoring their sustainability plans on core principles, including strengthened governance and accountability frameworks; integrated service delivery systems; efficient health products and technologies management; and sustainable financing mechanisms. They noted that sustainability encompasses building robust institutions, strengthening human resources, leveraging technological innovations, and fostering community leadership.
141. Some donor representatives also updated the meeting on their efforts to support partner countries to transition from emergency responses to long-term sustainability and build durable national systems. They stressed the importance of adequate budgets, appropriate targets and the integration of HIV into multi-disease primary healthcare delivery systems that simultaneously support HIV, tuberculosis, malaria, and maternal and child health.
142. Speakers reminded the meeting that countries faced varied challenges and that uniform approaches were therefore not always appropriate. Some members said that, in implementing the Global AIDS Strategy 2026-2031, countries should not have to adopt practices or approaches that conflict with their national legislation or contradict cultural and religious traditions.
143. The PCB was told that external factors, such as economic constraints and unilateral coercive measures, can undermine national HIV responses by restricting access to essential health commodities. There was a call for the development of mechanisms to guarantee equitable access to health commodities for countries affected by these measures.
144. Invoking the right of reply, one member told the meeting that these measures were lawful and legitimate tools and were not being used in a punitive manner. The speaker disputed the claim that they worsen human suffering or hinder development.
145. In response, one speaker invited the PCB to consult with WHO and the UNAIDS Secretariat to discover the impact of unilateral coercive measures on people living with and affected by HIV and on access to health-related products.

146. The decision points were adopted.

4. Consideration of the Global AIDS Strategy 2026–2031

147. The Chair introduced this agenda item by providing brief background to the development of the new Global AIDS Strategy. Angeli Achrekar, Deputy Executive Director for Programmes, and Christine Stegling, Deputy Executive Director for Policy, Advocacy and Knowledge, UNAIDS, presented the agenda item.

148. Ms Achrekar told the meeting that it was still possible to end AIDS, despite multiple crises and setbacks. The necessary science and tools existed, and communities remained firmly committed, she said. But political will and financing were fragile. As affirmed by her, this could be the world's last window of opportunity to end the pandemic.

149. She said the new Global AIDS Strategy represented a collective recommitment to end AIDS by 2030. It was not a "business as usual" strategy, she stressed. It responded to a world of overlapping crises, widening inequalities, shrinking civic space and new health and economic shocks and was geared at transformation through decisive actions.

150. She described the Strategy's development, which involved extensive consultations with over 5,000 people and networks, as well as surveys, dialogues and research. The Strategy had four building blocks: a mid-term review of the current Global AIDS Strategy; target setting; sustainability roadmaps; and ongoing consultations, she explained.

151. Ms Achrekar told the PCB that the Strategy highlighted country leadership; reducing inequalities and upholding people's rights to access people-centered HIV services and support; and community leadership at all levels of the response. It was focused on reaching all the people that were left behind; on sustainability; on a deep commitment to human rights, gender equality, decriminalization and communities as leaders and decision-shapers; on better integration within broader health and development agendas; and on clearer lines of accountability.

152. The Strategy laid out three core priorities: sustaining the HIV response; people-centred services; and community leadership. Those priorities aligned with eight results areas.

153. The action areas under Priority 1 focused on financing, systems, integration and data. For financing the HIV response, national strategic plans had to be integrated with national structures for a coherent national response and funding sources had to be diversified, she explained. The HIV response also needed to be integrated into national health and community systems and beyond. Multisectoral integration was vital, while strong data and information systems were needed to achieve accountability, she affirmed.

154. Priority 2 involved people-focused services and had four results areas, with the recommendations focusing on the scale-up of essential HIV prevention, testing, treatment and care, and on service delivery improvements, Ms Achrekar said. Thus, results area 4 involved scaling up all proven options for HIV prevention; results area 5 called for ensuring equitable access to services and tools; and results area 6 demanded actions to end stigma and discrimination and uphold human rights and gender equality. Priority 3 was focused on strengthening community leadership in the HIV response and better integration of community-led systems.

155. Ms Stegling continued the presentation and said the Strategy would enable countries to achieve 16 topline targets towards ending AIDS as a public health threat. Some

targets were new, while others had been extended from the previous Global AIDS Strategy since they had not been achieved by 2025. The new Strategy aimed to reach people with the HIV treatment and prevention services they needed, within safe and supportive environments.

156. She explained that ending AIDS was defined as a 90% reduction in the numbers of people acquiring HIV and dying of AIDS-related causes, compared with 2010. Achievement of the targets stipulated in the Strategy would bring most countries within reach of that goal and would avert 3.3 million new HIV infections and 1.5 AIDS-related deaths by 2030.
157. Ms Stegling said approximately US\$ 22 billion was needed annually until 2030 in low- and middle-income countries to end AIDS by 2030. This was a reduction of over US\$ 7 million from previous estimates.
158. Continuing, she said the new Strategy reflected regional specificities and included eight regional sections. She described the key features of the AIDS epidemics in different regions and highlighted the challenges, priorities and focus for HIV responses in each of them. The Strategy also defined important roles for various actors at all levels, she told the PCB, and it recognized the importance of regional organizations and showed how such entities could support domestic financing, South-South cooperation and more.
159. Multilateral actions remained vital, Ms Stegling added, as did accountability. A four-pronged approach was envisaged, starting with the new Strategy, which would lead to the next High-Level Meeting, which in turn would feed into national strategies, which would be monitored and tracked. The new Strategy would serve as the basis for the High-Level Meeting on AIDS in June 2026.
160. Ms Stegling said it was fitting that the Global AIDS Strategy was being adopted in Brazil, which had showed what can be achieved by combining political will, community leadership and rights-based approaches.
161. In discussion from the floor, members and observers unanimously welcomed the new Global AIDS Strategy and commended the Joint Programme for the evidence-informed and inclusive process, which had involved over 5,000 stakeholders.
162. They said the Strategy arrived at a decisive moment. It brought renewed ambition, commitment and clarity to the actions that were needed to end AIDS, and it responded to the challenges confronting countries. While the world could be proud of the progress made, it had to recognize that major barriers still stood in the way, speakers said. Countries' determination to end the AIDS pandemic was being disrupted by widespread crises, geopolitical instability, fiscal constraints, sharp declines in donor funding, attacks on human rights, and ongoing stigma and discrimination. Indeed, the progress achieved thus far appeared to rest on increasingly fragile foundations, they warned.
163. Speakers welcomed the Strategy's call for a renewed sense of urgency and for strengthened solidarity and they supported the priorities and results areas, which mapped well onto the main gaps in the HIV response.
164. Speakers stressed that HIV responses needed to be country-owned, resilient and prepared for future shocks, with services centered on people rather than systems. Reducing structural inequalities and ensuring equitable access to services and medicines were not optional components of the response, but central to ending the pandemic. They said the Strategy correctly emphasized that progress depended especially on closing persistent gaps and addressing structural barriers. Cosponsors

stressed that the task of ending AIDS was inseparable from strengthening health systems and addressing gender and other inequalities.

165. The increased focus on access to services, integration, sustainability and country ownership and the shift to greater domestic financing were also well-aligned with broader shifts in the global health ecosystem, they said. The inclusion of regional context would help countries tailor their actions, they added. It was suggested that the Strategy should respect national contexts and priorities, including national legislation and societal values.
166. Speakers said the new Strategy provided a clear roadmap for ending AIDS and presented concrete actions for reaching the 2030 targets. They welcomed the streamlined set of targets, including having 40 million people on treatment and virally suppressed and having 20 million people using ARV-based prevention options by 2030. The targets should help focus national efforts, they said.
167. Speakers agreed with the focus on resilient health systems, strengthening HIV services within broader health systems, eliminating inequalities and other structural barriers, and upholding human rights. They also supported the emphasis on multilateralism for coordination, accountability, normative guidance, and shared learning.
168. For Priority 1, on country-led responses, speakers welcomed the shift from a donor-driven approach to a country-owned and -led one and supported the emphasis on long-term domestic financing and diversified resource mobilization, while recognizing the difficult decisions which countries would have to make to prioritize HIV funding. Also welcomed was the emphasis on moving away from fragmented, donor-dependent systems and towards integration of HIV within primary health care and as a part of universal health coverage.
169. Speakers welcomed the domestic financing targets. They recognized, however, that increased domestic funding would be difficult to achieve in countries with severely constrained fiscal space. Even as domestic ownership and financing expanded, global solidarity would remain a foundation for progress, they said. The funding disruptions showed that responsibility for the HIV response had to be shared across the global community.
170. Cosponsors said they recognized the impact of disrupted financing on countries, communities, cosponsoring entities and the UN system overall. They reaffirmed their commitment to maintain institutional, programmatic and policy support for implementation of the new Strategy.
171. Speakers noted the focus on government stewardship and on clear responsibility for results. Genuine collaboration among governments, communities and institutions was essential, they insisted, and health services had to be adapted to incorporate the participation of all people living with, affected by and at risk of HIV.
172. There was broad support for the Strategy's emphasis on integrating HIV services within broader health systems and on expanding effective prevention. AIDS could not be addressed in isolation, they said. It required a multisectoral approach and deeper integration with broader health and development agendas. They therefore supported the focus on integrating HIV services in primary health care as a core element of universal health coverage, which was also key for sustainability.
173. However, speakers warned that integration could not lead to marginalization and to services becoming inaccessible or unsafe. This was a danger especially for key populations, they said. The meeting was reminded that, in many countries, community-

led organizations were operating under tight restrictions and in fear. Integration, speakers said, was unrealistic if organizations could not operate safely and legally; it should be accompanied by legal reforms, safeguards and direct community financing. They insisted that the new Strategy prioritize the protection of community spaces and hold governments accountable for ensuring meaningful community leadership, as stipulated in Priority 3.

174. It was suggested that the integration of HIV and TB services could be more prominently reflected under Results Area 2 and incorporated as a top-line target.
175. The emphasis on strategic information was strongly endorsed. The PCB was told that interventions should be scientifically proven and should respond to the different epidemiological, legal, and social cultural contexts, and the different needs of countries.
176. For Priority 2, speakers welcomed the clear actions proposed for people-focused services and the call to protect, respect and promote civic space. They commended the Strategy for putting equity, rights and communities at its core: community-led, rights-based actions were essential for ending AIDS, they stressed. The emphasis on people-centered, integrated and rights-based services and community leadership was also praised, as was the emphasis on gender equality and the elimination of stigma and discrimination.
177. The PCB was reminded that the AIDS epidemic was intensifying in several countries among the most vulnerable populations. Differentiated services and the participation of key populations in decision-making processes were needed to change the trajectory of those epidemics, speakers said.
178. Speakers welcomed the Strategy's recognition that criminalization of drug use, forced treatment, police violence, stigma, and exclusion from health systems were major barriers to HIV prevention, treatment and care. They said that many of those barriers were due to policy choices that could and should be changed. They said they agreed with the Strategy's insistence on removing legal barriers, addressing discrimination, safeguarding sensitive personal and health data, and protecting civic space. It was noted that the highlighted HIV prevention measures lacked reference to drug use prevention and treatment, including therapy for people seeking to stop using drugs.
179. Also highlighted was the importance of equitable and affordable access to medicines, which was closely linked to the Strategy's priorities. Speakers reminded the meeting that licenses provided through the Medicines Patent Pool had played a key role in expanding access to WHO-recommended, quality-assured and affordable generic HIV medicines for more than 24 million people across 148 countries. The PCB was told that voluntary licensing and technology transfers, manufacturing capacity building and local production were becoming ever more critical to enable equitable and timely access to needed medicines and other health products.
180. On Priority 3, speakers welcomed the focus on communities as a central pillar and the insistence on the need for inclusive multilateral action. Ultimately, they said, adaptability, transparency and the meaningful involvement of all stakeholders were needed to ensure that the global HIV response remained capable of delivering on the Strategy's targets. That demanded strong political will, sustained investment in equitable and resilient systems, and an unwavering commitment to an inclusive gender and human rights-based approach.
181. Next steps should involve guidelines for implementation at country level to help translate the vision into operational actions, speakers said. It would be crucial to adapt the work ahead to the evolving transition of UNAIDS. Ultimately, implementation of the

- new Strategy would depend on the UN system's ability to sustain critical support in key areas, such as strategic information, technical guidance and community engagement.
182. While welcoming the dialogue on the revised operating model for UNAIDS, speakers expressed strong concern about its envisaged premature closure, which they warned would risk derailing critical work. The cost would be more preventable deaths, more women and children falling through the cracks, and the loss of the gains made against the pandemic, they said.
 183. UNAIDS was needed more than ever, the PCB was told, and it remained vital for implementation of the Global AIDS Strategy. Speakers questioned whether there would be sufficient capacity to guide, coordinate and support national processes if UNAIDS's resources were not carefully transferred elsewhere in the UN system. They asked who would support and monitor implementation of the Strategy in countries; to whom and how would progress be reported; how accountability would be maintained; and who would support countries encountering challenges. Those questions must be resolved with clarity, they demanded.
 184. The roles played by UNAIDS in countries across the world were repeatedly highlighted, especially in relation to political mobilization; reducing stigma and discrimination; monitoring programmes and ensuring accountability; advocating for social justice, human rights and equity; understanding the epidemic and response; technical support; normative guidance; striving for sustainability; and more.
 185. The proposals to transition and integrate UNAIDS into the UN system and beyond as part of UN80 reforms had huge consequences for affected communities, the meeting was told. Speakers said UNAIDS was a focal point for communities at all levels and was the only UN body to formally embed communities in its governance. For many LGBTQ communities, they added, it provided one of the few spaces in the UN where they were recognized, respected and able to engage meaningfully.
 186. Speakers urged that the UN Secretary-General not press for an accelerated transition timetable and called for the Joint Programme to be maintained until continuity of core functions, accountability and system-wide coordination could be credibly ensured. A well-structured, realistic and timebound process was crucial, they said.
 187. Speakers insisted that UNAIDS's transition be based on a clear plan that presented a credible and fully articulated strategy for safeguarding the HIV response in countries. The plan should strengthen accountability and improve efficiency while protecting space for civil society engagement.
 188. They supported the creation of a global working group to prepare such a plan and demanded that civil society be represented on it. They also stressed the need for sustainable, innovative and predictable financing models, including increased domestic financing and continued international support. Crucially, this support had to reach community organizations, they said.
 189. The importance of international funding for community-led responses was underscored. Several speakers asked how communities could be expected to lead and mobilize resources locally when they could not operate safely and openly in their countries. The potential closure of UNAIDS, the reduction of European Union funding for community organizations and shrinking support for the Robert Carr Fund were creating a perfect storm that would make implementation of the new Strategy far more difficult, the PCB was told.
 190. The United States representative thanked the UNAIDS Secretariat for its tireless work on behalf of shared goals. It also noted that it was important to have a robust Strategy

that addressed issues by following the epidemiology and data produced via the widest possible consultation, including with those who are living with and most at risk of acquiring HIV. The United States representative added that it was not bound by the language put forward in the Strategy because it was not a Member State-drafted document. The representative said it would not endorse some terminology in the Global AIDS Strategy and in a resolution, without adequate caveats and qualifications, including affirmation of sovereign prerogatives. The representative for Iran said it was not bound by any part of the Global AIDS Strategy that contradicts its national priorities, laws and regulations, policies, Islamic principles, cultural norms, traditions and values. It therefore did not consider itself bound by a legal obligation to implement the Strategy. The representative for the Russian Federation said it did not support language in the Strategy related to sexual rights and gender diversity.

191. Several country representatives said the new Strategy aligned with their own visions for transforming health systems, including strengthening primary health care and building community-led systems (e.g. by absorbing thousands of community health workers into formal systems). Some country representatives described ways in which the Global AIDS Strategy was aligned with its national strategy and priorities.
192. The decision point was adopted.

5. Update on the implementation of the revised operating model of the Joint Programme

193. Ambassador Erica Schouten, Permanent Representative of the Kingdom of the Netherlands to the UN in Geneva, began her presentation by reminding the meeting that the update had been prepared in response to decision point 8.6 from the PCB meeting in June 2025. She described the process that had led to the update's finalization.
194. She said the PCB Bureau had proposed the creation of an inclusive PCB working group, reporting through the Bureau, to develop a plan including a timeline for the further transition and integration of the UNAIDS Joint Programme within the wider UN system, including timelines and key milestones. The Bureau had reaffirmed that civil society inclusion was critical for legitimacy and joint decision-making and had noted that civil society needed to be actively involved in such a PCB working group. It had also emphasized that the work had to be anchored in the needs of people living with and affected by HIV and should safeguard the continuity of the UN's multisectoral role and its ability to support meaningful community engagement in HIV responses.
195. She said the Bureau had agreed that timelines should be designed to safeguard continuity of the Joint Programme's core roles throughout the transition. The working group's recommendations would be submitted for consideration by PCB members in the second half of 2026 (earlier than the previously envisaged timeline which extended to June 2027).
196. The Bureau had also emphasized that the plan should preserve the jointness of the UN's role in the HIV response, maintain an inclusive governance structure and ensure accountability of all stakeholders involved. It had highlighted the need for coordination and coherence between the UNAIDS Secretariat, Cosponsors, the Office of the Deputy Secretary-General, and the PCB Bureau to facilitate smooth implementation of the transition plan. In addition, the Bureau had noted that it was critical to maintain inclusive governance structures and ensure accountability of all the involved stakeholders.
197. Ms Schouten explained that the paper accompanying this agenda item had four sections: process, key content and analysis, milestones and timelines, and draft

proposed recommendations.

198. Mahesh Mahalingam, Chief of Staff, UNAIDS, referred to UNAIDS's strong tradition of inclusive multisectoral engagement. He said a key proposal in the paper was the establishment of a PCB working group, with members reflecting the composition of the PCB. The group would lead the development of a comprehensive plan to guide the further transition and integration of the Joint Programme into the UN Development System and beyond, while ensuring meaningful engagement of all relevant constituencies, civil society, governments, Cosponsors, and other partners.
199. That approach would ensure that future decisions reflect the needs and priorities of countries and of the communities who are most affected by HIV. The PCB would request the Bureau to finalize the working group's terms of reference after receiving inputs from all relevant stakeholders, Mr Mahalingam explained. It would then seek the PCB's approval and establish the working group. The Bureau would also develop a costed workplan for approval by the PCB. The working group would be time-limited and would conclude upon submission of its final report to the Bureau in 2026. This approach would ensure that the planning process is inclusive, transparent and has clear milestones.
200. The terms of reference would be critical, he said. The working group would have to provide a range of recommendations, including for future governance and institutional arrangements (with representation of civil society) and for safeguarding and strengthening core functions. The latter included stewardship and coordination of the Global AIDS Strategy 2026-2031, support to countries to report on progress, facilitating stakeholder engagement (specifically for communities living with and affected by HIV) and country ownership, advancing human rights-based approaches and human rights programming, and analysing and disseminating data and other evidence.
201. The working group also would have to provide recommendations for ensuring operational continuity and managing human resource transition, as well as review financial sustainability and resource mobilization to maintain funding for the HIV response during and after integration. Finally, it would have to present recommendations for promoting inclusive and transparent stakeholder engagement and advise on a timeline with key milestones and endline for the integration of the Joint Programme into the UN system and beyond.
202. Mr Mahalingam then summarized the core content of the accompanying paper: programmatic, operational, political and governance, and financial (including future resource mobilization). Those four areas provided the frame for the analysis which the working group would conduct, he explained.
203. He then presented in greater detail some of the key questions which the working group would need to consider. They included which entities would support countries to track progress to 2030 targets; which entity would compile and report the data on progress and ensure cooperation among actors; what integration would mean for communities, governments, civil society, academia and financing partners; how programming and service continuity would be maintained; and how advocacy and support for human rights, gender equality and the elimination of HIV-related stigma and discrimination would be maintained.
204. Also important was clarity on how the country presence of the UNAIDS Secretariat would be integrated practically into the UN Resident Coordinator system and how institutional knowledge and data would be retained and kept accessible as public goods. Those questions went to the heart of why UNAIDS had been so central to the HIV response for the past 30 years, he told the PCB.

205. The working group would also have to examine how operational continuity and human resource issues were to be addressed during the transition; what timelines would ensure compliance with UN staff regulations and rules while safeguarding staff well-being and maintaining operational efficiency; what options existed for transferring staff to other UN entities; how planning and duty of care would be guaranteed for staff and affiliate workers; and what considerations would help to ensure that staff, including those living with HIV, are protected during the transition, including their access to essential medical care.
206. Regarding political and governance issues, key questions included what processes would guide decisions during the integration; what models should be adopted for a UN multisectoral role; whether there was a need for a global hub or coordinating mechanism in the future; how such a structure would be organized and resourced and where it would be located; how the involvement of affected communities would be ensured in a future governance structure, on par with current arrangements; and what mechanisms would be put in place to oversee the integration process.
207. Turning to the financial dimension, Mr Mahalingam said the issues included how to ensure transparent and comparable cost estimates and commission independent fiduciary reviews; what the funding model of a future coordinating entity should be; what models could support civil society engagement and action and sustain HIV response; how resources would be secured for continuing technical assistance; how the cost of integration would be covered; and how donor “buy-in” and commitments beyond 2026 would be achieved.
208. He said these and other key decisions taken in 2026 would shape the entire HIV response. It was clear, he said, that a rushed transition carried far greater risks than taking the necessary time to get the transition right: integration without a clear, realistic pathway was a great risk. This was not about slowing the process down, he said, but about building a foundation for success.
209. Ambassador Schouten presented the proposed key milestones for 2026. These included: finalization and approval of the working group’s terms of reference and its establishment; the first meeting of the working group to define its activities, workplan, milestones, stakeholder engagement plan, etc.; the first multistakeholder meeting on the transition and integration plan; consultation with the Committee of Cosponsoring Organizations at heads-of-agencies level at the biannual; presentation of the working group’s interim report to the PCB; and presentation of the final working group report for subsequent transmission to ECOSOC.
210. Deputy Secretary-General of UN, Amina Mohammed, then addressed the meeting. She praised the new Global AIDS Strategy for its clarity, inclusivity and clear division of labour. However, she said, implementation depended on having enough resources and asked whether it was realistic to expect that this could be achieved primarily through increased domestic investments from countries that were under huge economic and fiscal stress. It was necessary to try and convince the international community to provide donor support for development and the work set out in the Strategy. Financing implementation of the Strategy had to be discussed.
211. Ms Mohammed said UNAIDS had played a vital role in the HIV response, had achieved major successes, and had done so on the basis that everyone is a citizen with rights. She summarized some of the progress and said the achievements went far beyond health and gave people around the world a fair chance in life.
212. It was important to find ways to strengthen the UN System’s ability to support populations that are most in need, she said. The UN80 report had set out a vision for further integrating UNAIDS’s capacity and expertise across the UN System. This was

not about diluting UNAIDS's impact, but rather about strengthening it and building on its successes, she told the PCB. It was therefore in the spirit of renewal that the Secretary-General had proposed that UNAIDS be "sunset" by 2026. Noting that millions of people would still be living with HIV beyond 2030, she said the proposed changes were aimed at ensuring that the UNAIDS mission remained alive.

213. She said the Secretary-General had asked her to work with the PCB and UNAIDS to help guide that process. The discussion at the PCB and the voices of civil society would influence her report back and discussions with the Secretary-General, Ms Mohammed said.
214. Turning to priorities, Ms Mohammed said the uninterrupted delivery of HIV services had to be ensured, and UNAIDS's capacities and expertise had to be very carefully transitioned into those parts of the UN System that were best positioned to carry forward that mission effectively and sustainably. The UN's collective expertise and programming from across its entities and agencies would be brought into a reimagined structure to support governments and civil society, she told the PCB. Governments and civil society would remain at the centre of the HIV response, according to her.
215. The UN would continue to support national leadership, helping countries sustain and integrate HIV services in their broader health and social systems, she continued. A successful transition could only be achieved in full partnership with all UNAIDS stakeholders, she assured the meeting. Since UN Resident Coordinators would have an important role in coordinating and convening a multistakeholder HIV response in the future, it was important to explore how that role could be optimized. The UN System had to collaborate more cohesively and efficiently, drawing on the comparative strengths of its entities, she said. She also mentioned that it had to do things differently and argued that the current reform process was long overdue.
216. She emphasized that sustained financing underpinned the entire enterprise. HIV had to stay visible and prioritized in national budgets, and advocacy for the HIV response had to continue and deepen, she said.
217. Ms Mohammed stated that the Secretary-General's timeline for a decision by June 2026 was ambitious but achievable. She said that ECOSOC and the Cosponsors held formal decision-making authority for the transition and that the PCB would continue to play a critical role in ensuring a smooth and responsible transition. She said she looked forward to the PCB's guidance regarding a more progressive timeline.
218. Ms Mohammed agreed that the timelines proposed by UNAIDS were constructive but said she hoped they could be accelerated even further. However, while there was a sense of urgency, she said "we're not in a hurry to fail". According to her, it was vital to achieve common ground on all the concerns raised by the PCB and civil society. Ms Mohammed insisted that the UN remained committed to the mandate of ending AIDS and that UNAIDS's transition did not amount to a retreat. It was about preserving and enforcing the mission while addressing unprecedented realities and pressures in the current context, she concluded.
219. Speaking from the floor, members and observers thanked the Deputy Secretary-General for engaging directly with the PCB and sharing her perspectives, and thanked the PCB Bureau and the Secretariat for the comprehensive report and the inclusive process that had underpinned its development.
220. They welcomed the Deputy Secretary-General's commitment to safeguard the HIV response, but said it was unclear how core functions like strategic information and accountability would be preserved in the envisaged rapid transition being proposed under UN80, nor how country-level support would be maintained. They asked for

clarification on how Member States, through the PCB and ECOSOC, in line with their mandates, would be involved meaningfully in decision-making processes to ensure a responsible and inclusive transition.

221. Speakers praised UNAIDS for its work in combating HIV for the past three decades. Many countries were on course to achieve and sustain epidemic control, which would not have been possible without the Joint Programme, they said. The importance of UNAIDS's role in coordination, mobilization of political leadership, technical support and normative guidance, human rights protection, monitoring and accountability, and data collection and reporting could not be overemphasized, speakers told the PCB. Those functions supported and complemented the work of national programmes and helped ensure that the world remained on course to end AIDS as a public health threat by 2030, speakers said. They also noted that the Secretariat was working with countries to craft plans to achieve and sustain HIV control. It was the platform for translating global commitments into regional and national action.
222. UNAIDS played key roles in providing strategic leadership, coordination, data and accountability, promoting community leadership, and facilitating technical support for a comprehensive, multisectoral and human rights-based HIV response, speakers mentioned. UNAIDS Country Offices were also instrumental in supporting national ownership of HIV responses and ensuring that the needs of affected communities remain central, they added, stressing that those core functions had to be safeguarded and sustained. They note that UNAIDS's transformation had to be done in a careful, sequenced and responsible manner.
223. Speakers stressed that UNAIDS's data and strategic information functions (including HIV estimates modeling, AIDS spending assessments and investment cases) and technical support functions remained critical for accountable, evidence-informed and human rights-based HIV responses. They noted that even in countries where HIV services were increasingly integrated with primary health care and universal health coverage, specialized technical support remained critically important.
224. The meeting was also reminded that UNAIDS was a critical partner of the Global Fund: the data UNAIDS collected and analysed (including progress monitoring, key populations size estimates and AIDS spending assessments) were vital, including for enabling the Global Fund to determine grant eligibility and allocations.
225. The meeting acknowledged the Secretary-General's efforts to strengthen the effectiveness, coherence and impact of UN System. Speakers recognized the urgency of UN reform and affirmed their broad support for the UN80 Initiative. The UN System clearly had to adapt to a swiftly changing political and financial landscape, as did UNAIDS, they said. They voiced great concern, however, that a rushed transition risked dismantling the architecture that was driving progress against the AIDS pandemic. They also reminded that UNAIDS had been ahead of the curve in planning for its deeper integration in the UN system.
226. Cosponsors said they had committed to the Secretary-General's vision at the most recent meeting of the Committee of Cosponsoring Organizations and had called for coherence between previous PCB decisions and the UN80 report of the Secretary-General.
227. However, numerous other speakers argued forcefully against rushing any decision on phasing out UNAIDS, while some said they were entirely opposed to the sunset of UNAIDS. AIDS was not over, they told the PCB, and the UN System had to continue playing its role effectively in the global HIV response.
228. Speakers warned that what was being demanded by the Secretary-General was not

- "routine" modernization, but the dismantling of a structure whose time had not yet come. Nothing was to be gained from a demolition on the scale and at the speed that was being demanded, they said. They warned that the proposed 2026 timeline for sunseting was reckless, as it sent a message to the world that AIDS was over.
229. Noting that Africa continued to be disproportionately affected by AIDS, they said that any transition had to be gradual, carefully sequenced and attentive to potential operational disruptions. The transition should be tied to epidemiological milestones, not calendar dates, they insisted.
 230. A rushed sunseting would not allow time to stabilize and protect the core functions of UNAIDS, they warned. While there was real urgency, there should be no hurry to fail, speakers said, echoing the remarks of the Deputy Secretary General. They argued that the Joint Programme's transition should not sacrifice its proven effectiveness in carrying out the ECOSOC mandate, providing technical support, guidance and monitoring and evaluation functions, and that the fundamental objective should be a smooth transition of the core functions of the Joint Programme in order to sustain the HIV response.
 231. Members and observers insisted on a realistic timeline and process that safeguards countries' efforts to end AIDS as a public health threat by 2030 and sustained that accomplishment. They asked the Deputy Secretary-General to take that message back to New York and the UN80 process and to stand with affected communities until the job of ending AIDS was complete.
 232. The PCB was reminded that the Joint Programme had been created precisely to overcome fragmentation, align diverse mandates and ensure a multistakeholder response. Its value laid in its convening power, strategic leadership, and accountability functions—which could not be replicated by individual agencies acting alone. Lessons should be drawn from previous reform efforts, speakers urged.
 233. Cosponsors said the Joint Programme stood as one of the UN System's most innovative and successful models, thus that legacy, along with the expertise and institutional memory of UNAIDS, had to be preserved. Cosponsors said they were united in their commitment to achieve a transition and integration process that strengthens rather than weakens the global HIV response.
 234. Speakers told the PCB that the UNAIDS model had brought science, rights and accountability together and proved that multilateralism and inclusion worked, which was clear in the roll-out of HIV treatment. Before the generalized provision of antiretrovirals, speakers said, some 10 million people had died of AIDS in Africa—more than all the people who had perished in World War One.
 235. Speakers reiterated that UNAIDS was often the only UN entity consistently advocating for and defending a human rights-based response to HIV, including decriminalization and harm reduction in politically difficult environments. It played a critical role supporting countries to promote and protect human rights and tackle stigma and discrimination, they insisted.
 236. They highlighted UNAIDS's success in advancing collaborative governance, civil society inclusion and a rules-based approach to rights and development. UNAIDS was one of very few UN entities that consistently opposed injustices like HIV criminalization, promoted the involvement of vulnerable populations in policy discussions, and called governments to account, they said. UNAIDS Country Offices were also rare safe spaces for key and vulnerable populations. There should be no compromise on those vital functions, they said. Some speakers warned that an accelerated sunseting of UNAIDS would amount to a capitulation to those who

- opposed multilateralism and inclusion and who were comfortable silencing communities.
237. Speakers noted that over 1,000 civil society organizations across the world had issued a warning against accelerating the closure of UNAIDS. Premature closure of UNAIDS would be a monumental error, with the cost borne by affected communities for generations to come, the PCB was told.
 238. Given the recent disruptions of HIV responses, UNAIDS should continue to function as the global compass for HIV response in the years immediately ahead, some speakers said, providing technical leadership to guide countries through differentiated service delivery and innovative prevention strategy; stewardship of the global HIV surveillance and accountability framework; human rights advocacy to protect the most vulnerable and ensure no one is left behind; and using its convening power to sustain partnerships.
 239. Speakers said the transition process was being driven forward too quickly and that the proposed accelerated timelines for sunsetting did not allow sufficient time for reviewing and safeguarding core functions. They pointed out that the proposed timeline did not match the transition timeline and approach decided previously by the PCB and affirmed by ECOSOC.
 240. Alignment between intergovernmental decision-making on UNAIDS's reform and transition, and ongoing discussions under the UN80 initiative were essential for clarity, coherence and confidence in the process and for maintaining the trust of communities of people living with, affected by, or at risk of HIV, the meeting was told. Speakers insisted that the PCB and ECOSOC retained central roles in deciding on any structural or programmatic transition of UNAIDS.
 241. Speakers insisted that sunsetting UNAIDS in just 12 months was artificially rushed, untenable and unethical. They said the UN80 proposal had emerged not from due diligence among experts, but through a process that appeared to be driven by objectives that were in tension with the obligations to 40 million people living with HIV around the world and to the others who are at risk of acquiring HIV. The transition had to occur in an appropriate timeline, and it had to involve affected communities, they demanded.
 242. Speakers agreed with the Deputy Secretary-General that the UN80 Initiative must strengthen, not dilute, multilateralism. It must serve the priorities and concerns of developing countries, and it must remain multisectoral and inclusive, including affected communities and civil society. Community leadership had to be maintained, they insisted. The transitioning of UNAIDS needed to preserve and strengthen the key functions and resources of UNAIDS, including ensuring the meaningful involvement of and support for affected communities.
 243. Dismantling UNAIDS without a realistic plan and before national systems were fully prepared would put decades of progress at risk, especially in the current context of steep reductions in external funding support and shifts away from multilateralism, speakers cautioned. A carefully managed transition was essential to preserve the gains and prevent further disruption, they insisted.
 244. Speakers demanded that the transition should safeguard the multisectoral and inclusive nature of the HIV response and that the principles, processes and protections built over decades should survive UNAIDS's transition. They called for explicit safeguards for human rights-based leadership, continuity of core functions and meaningful community participation. It was essential to protect UNAIDS's unique governance model, especially the role of communities in it, and guarantee meaningful

space for communities within a multisectoral HIV response, they insisted.

245. Speakers called for absolute clarity about how UNAIDS's core features and functions would be preserved, where responsibilities would be located and how accountability would be assured.
246. UNAIDS' transition therefore should proceed only on the basis of clear and credible proposals from the identified agencies about how they would assume the Joint Programme's core functions and preserve its core values, including preserving the place and role of communities and civil society as key partners in the HIV response, the meeting was told. Community representatives asked Cosponsors to clarify how they would assume UNAIDS's role in engaging with people living with HIV, communities and key populations. The defense of human rights required a clear plan, they stressed.
247. Speakers also expressed concern that funding currently allocated to the Secretariat would not necessarily flow to Cosponsors, leaving them without resources to take vital work forward. They noted that many other UN entities were themselves experiencing funding and staffing constraints and therefore a structured, transparent and well-sequenced plan was essential before the transfer of functions and capacities could begin.
248. Key roles and functions highlighted by speakers included UNAIDS's global convening role; the consolidation of data and evidence-generation; accountability processes; technical and implementation support; engagement with communities and civil society; HIV-related human rights advocacy; and support for institutional processes and resource mobilization. Proposals needed to also protect the institutional knowledge and expertise that supported country responses, the meeting was told.
249. Speakers reiterated that the institutionalized inclusion of civil society was foundational to the legitimacy and work of the Joint Programme, but noted that the proposal to accelerate the timeline for the transition of UNAIDS had been presented without consulting the communities affected by that decision. The search for an optimal solution was not just an internal UN discussion, they said, as civil society partners had to be part of a transparent process. Shared governance was essential, they said, adding that there was wide agreement about the centrality of civil society in future governance structures.
250. There was unanimous support for a transition process that is evidence-informed, adequately resourced and responsive to the realities and needs of countries. Transition planning should be careful, preserving what works, adapting to what must change, and ensuring that the global response remained fit for purpose, members and observers said.
251. They underscored the importance of establishing a clear framework for integrating key UNAIDS functions within the broader UN System. That framework needed to safeguard the unique value of the Joint Programme, including its role in sustaining political leadership and broad-based social mobilization; advance progress on HIV-related human rights and reduction of stigma and discrimination, as well as equality and decriminalization; and enable a governance model that preserves a central leadership role with that communities and civil society meaningfully engaged in decision-making and accountability. Speakers also demanded an inclusive process that meaningfully engages affected communities.
252. Speakers expressed support for the proposal to set up a PCB working group to develop a plan and timelines for the transition of UNAIDS into the wider UN System and beyond, in a manner that is coherent with the UN80 Initiative and previous PCB

decisions. They said they had full trust in the proposed working group and stated their expectations that the political leadership of the UN would support the group's plan and timeline, through the PCB Bureau, and subsequent PCB decision making.

253. Speakers underscored that the credibility of the transition process depended on achieving alignment between the PCB decisions and the broader UN80 reform trajectory. They cautioned that this would not be easy, as substantial programmatic, operational, governance and financial issues had to be addressed. This was crucial to safeguard core functions of UNAIDS, they added. The working group would have to make a clear, practical and realistic plan, including a timeline, through the PCB Bureau, for protecting the different functions and responsibilities of UNAIDS as they are reallocated and integrated across the UN System, the meeting was told.
254. The paper accompanying this agenda item provided strong guidance for the working group, speakers said. The elements of the group's terms of reference identified there addressed many of their core concerns, but they advised some flexibility in case the working group or the PCB Bureau identified other, important matters.
255. There was general support for the proposals in the accompanying update on the issues which the working group should cover. The meeting was told that the objective should be a resilient model that strengthens coordination across the HIV response; preserves a strong, credible country-level presence; safeguards technical support and strategic information functions and upholds human rights and community leadership.
256. Speakers added that UNAIDS's mandate had to be protected during the transition: global stewardship of the HIV response, accountability mechanisms, multisectoral coordination, data collection and monitoring, and leadership on human rights, community systems and legal reforms. Transition planning needed to preserve what works and set out necessary adaptations so the global response remained fit for purpose, they reiterated.
257. Speakers highlighted as priorities a governance and decision-making model that guarantees institutionalized involvement of civil society; safeguards that preserve an integrated system for monitoring and accountability, including community-led data across all relevant dimensions of the HIV response (not solely the biomedical aspects); and measures to maintain the jointness of the HIV response and prevent fragmentation and discordance. Also noted were guarantees for Secretariat staff throughout the process.
258. In determining this plan and timeline, the working group should strike a balance between the desired transition timelines and the imperative to protect lives and ensure meaningful consultation with affected countries, they meeting was told. Due to concerns about the wide scope of tasks set for the working group, it was proposed that technical assistance be provided to the group.
259. Speakers agreed that the working group be fully accountable to the PCB Bureau and the PCB, and that it operate transparently and inclusively. They asked for the working group members to have the necessary technical expertise, knowledge and experience in national programme implementation, and to reflect the diversity of PCB membership (i.e. representatives from the main PCB constituencies, including Member States, communities and Cosponsors). They called on a geographically balanced composition of the working group.
260. Several specific deliverables for the working group process were proposed. Speakers said the working group needed to recommend a governance structure that includes meaningful civil society and community participation; a responsible, and costed transition plan, with proposals for an orderly transition of core UNAIDS functions; an

assessment of how core programme functions would be maintained to ensure continuity, such as which functions should remain centralized and which could be integrated; how human resource transitions should be managed; and a realistic timeline for implementation of the transition plan.

261. Some of those elements elicited more detailed suggestions from the floor. For example, also highlighted were operational considerations, such as duty of care for staff, and risk mitigation measures to prevent disruptions to HIV services, including ART community-led service delivery. Credible financial scenarios would be needed; the plan would have to include transition and closure costs, as well as forward-looking resource mobilization models, the meeting was told. It was suggested that a permanent resource mechanism for community engagement be embedded in the new operating model. Also suggested was ring-fenced, predictable funding for HIV and key population networks within the 2027 workplan.
262. Speakers stressed the importance for clarity on what the working group had to deliver and by when. They called for a clear guiding mandate for the working group that sets out priority considerations and takes into account, without being driven solely by, the dynamics of the UN80 process.
263. The transition plan would have to be ready for implementation as soon as adopted, speakers urged. Some speakers said the timelines proposed in the accompanying paper were acceptable but could, if possible, be accelerated even further.
264. The group would have to provide a transition plan detailed enough so that implementation could begin in January 2027, the meeting was told. Decisions on the plan and the Joint Programme's financial and programmatic planning should be tabled during a special session of the PCB no later than end-October 2026, the PCB was told, though that deadline might require that some of the details and decisions be finalized during implementation. Speakers acknowledged that it would be challenging to move at that pace while ensuring legitimacy and accountability.
265. Several speakers reiterated that the transition effort was complex and the stakes were high; it therefore should not be approached as a race against time but with the focus on an accountable and just outcome for people living with and affected by HIV. For that to happen, the necessary safeguards highlighted at this PCB session would need to have supreme priority, they added.
266. Ms Byanyima thanked speakers for their remarks and thanked the Deputy Secretary-General for attending the meeting. She stressed that communities were the backbone of the HIV response and central to accountability. Their work was not optional, but indispensable, she said, reiterating that any transition had to strengthen community leadership.
267. The transition must be co-created, not driven from the top, and it must be responsible, orderly, transparent and accountable, she urged. Invoking the principle "Nothing about us, without us," the working group must be inclusive, she added.
268. Ms Byanyima said the Global AIDS Strategy was a compass for the global HIV response and that the proposed reforms would have to advance implementation of the Strategy while reshaping the "vehicle" that facilitates implementation.
269. She told the PCB that the four key roles of UNAIDS would have to be integrated responsibly and effectively: its leadership role in setting goals; its convening and coordination across sectors and society; its accountability role, which includes critical data functions; and its community engagement and securing of space for communities. She offered her assurances that she and the PCB would continue working with the

Secretary-General to achieve the UN80 ambitions.

270. The Deputy Secretary-General, in response, said the process had been serious and thoughtful, and had been conducted within the UN System and with Member States. Ultimately, the solution had to reflect what Member States wanted to see happen. She acknowledged that the proposed timeline was very tight. This was not simple due to the 2025 funding cuts, though the setbacks during 2025 were the proverbial “straw that broke the camel's back”, she said.
271. UN80 contained many work packages and UNAIDS was one of them, Ms Mohammed said. A task force and steering committee had to deliver the overall reform “package” and they were working on a very short timeline,. The aim was for final decisions to be presented to the General Assembly in September 2026, before the end of the Secretary-General’s term, she noted.
272. Ms Mohammed noted that the crisis of funding required timely decisions on how the Joint Programme’s work would be sustained, which would involve Cosponsors and determining how to deepen partnerships. She agreed that the Joint Programme was a highly effective programme but asked whether it remained the best model for meeting the challenges that had led to its creation 30 years ago.
273. She noted that speakers had emphasized that key roles and features of the Joint Programme had to be protected, and said she hoped that space for civil society would be maintained in Cosponsor entities.
274. Ms Mohammed assured the meeting that the UN was “not in the business of creating more harm”; funding losses were doing so, she said, not UN80. Responding to remarks from the floor, she said UN80 was not simply a detached, administrative exercise, and that people and communities were the priority. She assured the PCB that she believed the UN System could achieve a responsible and appropriate transition and said she hoped that stakeholders would trust her and the Secretary-General as they sought to do so.
275. Although a lot of work laid ahead, she said she believed that the proposed working group could make the process work. Its terms of reference would need to be decided with the full engagement of civil society, she added.
276. In closing, she reiterated the timeline pressures but added that a “shoddy package” should be avoided and that the outcome should not be an arrangement that produces less than what UNAIDS was currently capable of. She said the transition would continue and she hoped that Member States would contribute the resources that were needed to make it succeed, including multiyear financing and more support for civil society. Civil society had shown it can absorb resources and deliver, she told the PCB. Appealing for trust, she said she looked forward to working with the Board in the coming year.

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

277. Alankar Malviya, Representative of the Staff Association, UNAIDS, acknowledged and welcomed the report of the Executive Director and the Bureau’s proposal for the transition.
278. He briefly summarized the background of the USSA and said its constitution was being changed in line with the restructured Secretariat. He noted that half of the Staff Association's Executive Committee had left UNAIDS yet had continued to work to safeguard staff well-being. The revised constitution of the Staff Association had been

endorsed by almost all the members who had voted. The memorandum of understanding was also being revised.

279. A mid-year “check-in” had revealed several issues of concern, Mr Malviya said, including transparency and communication during the restructuring process; staff involvement and consultation; equity and fairness; efficiency and cost-cutting; support and well-being; and accountability.
280. He said the USSA had extended legal support to 37 staff members to safeguard their rights since the June 2025 PCB meeting. It had also developed an alumni platform, arranged pre-retirement seminars, and it was working with Staff Health Insurance and the staff well-being unit at UNAIDS to support staff. He said the Staff Association sat on the Restructuring Consultation Group and was represented on the Recruitment Review Board, as well as on the Senior Leadership Team, and it was often invited to share its views with the Cabinet.
281. After thanking the PCB for supporting UNAIDS staff, he said staff continued to deliver admirably on UNAIDS' mission despite unprecedented upheavals. However, the UN80 report's proposal to accelerate UNAIDS' closure had been a huge shock in the wake of an already rapid restructuring process. The announcement had occurred without any consultation with staff and did not consider the fragility of the HIV response, Mr Malviya told the Board.
282. He said it was deeply saddening to see one of the most successful UN programmes earmarked for rapid closure even as it implemented a restructuring that was removing 55% of staff. It felt as if UNAIDS was being victimized for its success, he said. He applauded the PCB for seeking a pragmatic way forward and said the Staff Association was deeply saddened by the loss of so many members.
283. Delivering on a new Global AIDS Strategy would be difficult with limited resources and amid the current uncertainties about UNAIDS's future, he said. Reassurances were needed so staff could focus on completing the unfinished agenda of ending AIDS, as the world could not afford to drop the ball at this stage in the HIV response.
284. Mr Malviya asked the PCB to guide UNAIDS along a realistic process that ring-fences the gains made and ensures service continuity to communities. He asked UNAIDS senior management to keep staff fully informed about the transformation process and to consult staff on any decisions that affected them. Staff should not be referred to as generic “capacities”, but as “staff”, he advised.
285. He said the Staff Association requested that all UNAIDS staff, including those whose posts had been terminated during restructuring, be considered for posts related to tasks that were being distributed among Cosponsors. The timelines and proposed milestones of restructuring should be guided by the PCB, he added, and UNAIDS staff expected UN senior management to reaffirm its commitment to safeguard the rights and entitlements of all staff. Finally, he thanked Staff Association members and all UNAIDS staff for their hard work and commitment and asked that the PCB continue to show leadership in a very difficult time.
286. In discussion from the floor, members and observers thanked the Staff Association for a frank and sobering statement, expressed their solidarity with staff, and welcomed the adoption of the new USSA Constitution.
287. Speakers said they recognized the impact of funding cuts on countries and staff, and the stress and disruption this was causing. They thanked and praised UNAIDS staff for their professionalism, resilience and commitment to the HIV response despite great turmoil. They declared their full solidarity with staff and insisted that close consultation

with staff during the transition was essential.

288. Speakers appealed to the Secretariat to prioritize staff well-being. Excessive workloads and staff's mental health had been consistent concerns, they said, but the emphasis had now shifted from work conditions to the impact of the transition and staff separation. They insisted that senior management manage the transition with the highest degree of humanity and care and fully uphold staff rights. That included a structured dialogue between staff and the Secretariat throughout the transition. The proposed working group could help ensure that robust safeguards for staff well-being were in place, it was suggested. Speakers also called on the UN Secretary-General to ensure that there is timely and genuine consultation with staff about their future.
289. Some concerns raised in the report had been aired multiple times already, speakers noted. Those concerns included the lack of consultation prior to the UN80 report proposals and timeline; the protection of staff rights, entitlements, and dignified treatment and exit; unclear communication from senior management; and the impact of staff morale on UNAIDS's ability to deliver on its mandate. Speakers said they took serious note of issues surrounding the UN80 proposals and were particularly concerned about insufficient consultation, compressed timelines, and uncertainty about staff separation, entitlements and prospects. This risked undermining staff morale, eroding institutional memory and weakening UNAIDS' capacity to support countries when the global HIV response was already under very severe strain, they told the meeting.
290. Speakers recognized the Staff Association's request for greater transparency in managing UNAIDS's transition. They said meaningful engagement with staff was an institutional management obligation, not an option: consultation that was late, under pressure or after key decisions had been made did not meet the standards of good governance. They called on the Board to exercise its oversight role with vigilance and to actively guide UNAIDS through a realistic and inclusive process that protects the gains made, ensures the continuity of services and involves consultation with civil society and staff.
291. Replying, Mr Malviya thanked PCB delegates for their support and solidarity. He said it was clear that the UN80 proposal for premature closure had been "top-down": staff must be properly consulted on the process, he insisted. Mr Malviya asked the PCB and communities to support staff through the restructuring process and said the Staff Association would continue to work with UNAIDS management to ensure dignified exits for departing staff and to prevent burnout among those who remained.
292. Ms Byanyima thanked the Staff Association for the report and for working with management to find ways to manage the difficult situation for staff. She thanked all staff for their continued dedication and hard work in very difficult conditions. She thanked donors who had agreed to and committed resources for a phased change, but said it was clear that the timeline had been accelerated now. She said the UN80 proposal had emerged from a "top-down" process and there had not been consultation about the references to UNAIDS's closure in that report. However, this was now the reality, she told the Board. Finally, she concurred with the suggestion to include the Staff Association in the proposed working group. If inclusion in the working group itself was not possible, inclusion in workstreams of the working group should be considered, she said. This was for the Board to decide, she concluded.
293. The draft decision point was adopted.

7. Evaluation report and management response

294. Adan Ruiz Villalba, Director of Independent Evaluation Office, presented this agenda item. He began by discussing the evaluations that had been planned for 2024–2025 and said two had been completed, one was in progress, and two had been incorporated in another evaluation due to budget constraints. Overall, in the 2024–2025 biennium, seven of the nine planned evaluations had been completed or were underway. Fully 94% of budget resources had been implemented, though the Office had lost a staff member, leaving it with only one active staff member.
295. Regarding the first evaluation on UNAIDS’s multi-country offices and the placement of HIV advisors in UN Resident Coordinator Offices, he said the evaluation had found that the approach being applied was not entirely systematic. The Secretariat had been advised to identify priorities and clearly communicate them to partners, as well as define typologies of country presence that are flexible and adaptable to national contexts.
296. Also completed was the evaluation on progress towards new generation of UN Country Teams. It had found that UNAIDS Country Offices were fully part of the Resident Coordinator process. Recommended improvements included streamlining the cooperation framework cycle, revisiting the UN Country Team configurations, enhancing accountability, removing institutional obstacles, and improving funding quality.
297. The evaluation of the Joint Programme’s role in sustaining the HIV response was ongoing and involved a review of 21 evaluations from the past four years, he told the Board. The process was in the data analysis and drafting stage and was expected to be ready for presentation in early 2026.
298. Mr Ruiz Villalba said that although the UN Evaluation Group had not been able to conduct a peer review, it had done some preparatory work. This had identified several necessary adaptations in light of ongoing organizational changes. Even though resources were shrinking, he said, expectations for accountability, learning and efficiency remained high. Independence, credibility and usefulness remained key evaluation policy principles but may have to be reinterpreted in the new context. Evaluations should be used as a strategic tool to guide management and decision-making and to focus on efficiency and impact, he added.
299. He then shared the key principles that would guide the evaluations in 2026. Firstly, the new Global AIDS Strategy would be the central unit of analysis for evaluations, which should yield evidence for learning, feedback and accountability. Secondly, resources of Cosponsors, the Secretariat and other partners should be combined to conduct more evaluations in more efficient ways. Thirdly, evaluations should contribute to sustainability and enhance evidence-based decision-making.
300. He concluded by summarizing advice received from the Evaluation Expert Advisory Committee, which included the presentation of the results of the evaluation on the role of the Joint Programme in the HIV response, and the need for a professional peer review of the UN Evaluation Group.
301. Mr Mahalingam presented the UNAIDS management's response. He said management appreciated the report, its high quality and the relevant evaluations that had been done during a very challenging period.
302. He said management agreed with the postponement of the professional peer review to 2026, recognized the two reports which had been received, and took note of the third report which was being drafted. It also noted that two evaluations could not be completed as planned due to various constraints. He said management welcomed the

decision to integrate questions from those two evaluations into the ongoing evaluation on the role of the Joint Programme in sustaining the HIV response.

303. Management also agreed with the proposed adaptation of the evaluation function, the proposed 2026 Evaluation Plan and the proposal to align it with the one-year UBRAF plan, Mr Mahalingam said, noting that it had worked closely with the Evaluation Office team on follow-up to previous evaluations. He said management's responses to previous evaluations had been developed and were being implemented.
304. Speaking from the floor, members and observers thanked the Evaluation Office for the rigorous report and for the high-quality work that was being done in difficult conditions.
305. They said the completed evaluations had provided valuable insights, including on the contribution of the Joint Programme to the UN Sustainable Development Cooperation Frameworks. They acknowledged that budget constraints and capacity losses had hampered planned evaluations and welcomed the decision to incorporate questions from two evaluations into another evaluation.
306. The evaluation findings had underscored persistent challenges that were particularly acute across Africa, speakers said. Those included sustaining HIV programmes amid shrinking external funding and uneven domestic financing. They advised that evaluation findings should inform strategic resource allocations.
307. Speakers said they were disappointed not to see a clearer articulation of management's responses on highlighted issues and their implications for UNAIDS's transition. They said they looked forward to management's response to ongoing evaluations and hoped the Secretariat would continue to engage closely with the Evaluation Office to ensure implementation of all recommendations.
308. Speakers said evaluations must remain a strategic tool for accountability and learning. The evaluation on the role of the Joint Programme in sustaining the response to HIV could provide useful insights for the proposed working group and other discussions on sustaining the UN System role in the HIV response, they noted. UNAIDS management was asked how it would ensure that evaluation findings guide decisions on the Joint Programme's transition and whether, in the future, management responses would be provided alongside evaluation reports.
309. The findings of the evaluation on multi-country offices and the placement of HIV advisors in Resident Coordinator offices were sobering and had to be addressed, speakers noted. Regarding multi-country offices, they agreed on the need for systemic models that are based on best practices and for enhancing efficiency and joint work. However, they expressed concern about a lack of structured mechanisms for institutional learning across multi-country offices and advisor placements. They warned that internal barriers were hindering transformation at country level towards having a functioning, clustered organization. Referring to plans to embed UNAIDS staff in the Resident Coordinator system, speakers recalled that the coordinating function of that system in the HIV response remained unclear.
310. Evaluations should never be treated as an afterthought, the meeting was told. Speakers emphasized the value of a strong independent evaluation function that provides credible evidence for decisions that can contribute to the sustainability and impact of the HIV response. They stressed the need for a dedicated budget and sufficient capacity for independent evaluations. There was strong support for the 2026 Evaluation Plan. However, it was also suggested that the evaluation policy be reinterpreted for a leaner structure. In light of a reduced Secretariat, it may be necessary to prioritize fewer, more focused evaluations, the Board heard.

311. Also underscored was the need for independent scrutiny of the evaluation function. While noting the financial pressures, speakers said it would still be beneficial to conduct a peer review of the Evaluation Office to inform PCB decision-making on the implications of UNAIDS reform for the evaluation function. In addition, a peer review was a matter of good governance and accountability, they noted.
312. Cosponsors said that key evaluations would focus on the sustainability of the HIV response among key populations, the integration of innovative prevention tools, and the strengthening of communities at country level in the context of sustainability efforts. They said the involvement of Cosponsors in evaluations went beyond resource sharing and included contributions to assessments of the effectiveness and sustainability of interventions. This had been evident, for example, in the joint evaluation with the UN Office on Drugs and Crime on the sustainability of HIV responses among key populations.
313. In response, Mr Ruiz Villalba thanked speakers for supporting the work of the Evaluation Office and for their recommendations. He agreed on the suggestion to reflect the “feedback loop” between recommendations and the Joint Programme in future annual reports. He added that a peer review of the evaluation function would be done in 2026 and agreed on the need to focus evaluations on the most pressing questions.
314. In his response, Mr Mahalingam said UNAIDS management continued to place high value on the work of the Evaluation Office. Management was using the evaluation report on the multi-country office system and the placement of senior advisors in the Resident Coordinator system to shape future actions and would apply the findings and lessons. However, since the full report had been received only a few weeks earlier, a comprehensive management response still awaited. He agreed that the evaluation of the role of the Joint Programme in sustaining the response to HIV would provide critical input for work in 2026 and for the transition.

8. Next PCB meetings

315. Mr Ussing, Director of Governance, UNAIDS, presented the proposed themes for the thematic segment of the 59th PCB meeting, as well as the dates for the 60th and 61st PCB meetings.
316. He explained that the theme for the 58th meeting had been decided through an earlier intersessional decision and recalled that the session had been postponed from the previous PCB meeting due to a congested agenda. The theme was: “Beyond 2025: Addressing health inequities through sustained HIV response, human rights and harm reduction for people who use drugs”. This would be the theme for the June 2026 thematic segment, he confirmed.
317. Regarding the thematic segment for the December 2026 meeting, Mr Ussing first described the process and criteria for selecting the theme. The PCB Bureau had noted that the two proposed themes were linked and sought to combine them into a segment on “Addressing the impact of funding cuts on people living with, affected by, and at risk of HIV, and on the response to HIV and AIDS”.
318. Regarding the next set of PCB meeting dates, Mr Ussing said that fixing the dates did not imply financial commitments at this stage. The proposed date for the 62nd PCB meeting was 27–29 June 2028 and the date for the 63rd meeting was 12–14 December 2028.
319. Speakers supported the proposed theme for the thematic segment for the December

2026 meeting and said it would be a valuable opportunity to synthesize data and evidence from across the world to understand the full scope of the impact of the funding cuts. They reiterated their support for the thematic segment planned for June 2026.

320. The decision points were adopted.

9. Election of Officers

321. Mr Ussing informed the meeting that 21 Member States were eligible for elections as officers of the Board. After explaining the selection process, he said convention held that the current Vice-Chair was expected to be elected as Chair for the next year. The Netherlands therefore would assume the position of Chair, starting 1 January 2026. There had been an expression of interest from the Philippines for the position of Vice-Chair and from the Africa Group for Kenya to serve as Rapporteur, which Kenya had agreed to.

322. The meeting was then briefed on the process for recruiting incoming delegates to the PCB NGO Delegation for the 2026–2027 term. It was told that the process was rigorous and transparent, ensuring that the NGO delegation has strong, diverse and competent representation in the PCB. The selected new delegates were: for Africa, the National Empowerment Network of People Living with HIV and AIDS in Kenya; and for Latin America and the Caribbean, the Trinidad and Tobago Community for Positive Women and Girls Living with and Affected by HIV.

323. The decision point was adopted.

324. The Executive Director paid tribute to Sarah Boulton of the United Kingdom. The new NGO delegates were welcomed by the Board. The representatives of the Netherlands, Philippines and Kenya thanked the meeting for entrusting them with their respective roles.

325. The representative of the Chair told the meeting that agreement had been reached on all the outstanding decision points. The representative from Iran told the meeting that it acknowledged the decisions made, in particular for agenda item 1.4. However, in accordance with its national laws and regulations and its social, cultural principles and values, it dissociated itself from the decision point for that agenda item.

10. Thematic segment—Beyond 2025: Long-acting antiretrovirals: potential to close HIV prevention and treatment gaps

326. The thematic session focused on long-acting ARV medicines and how rapid, equitable access to these medicines could close gaps in HIV prevention, treatment and care and advance the goal of ending AIDS as a public health threat.

Introduction and keynote addresses

327. The moderators for the session were: Andy Seale, Global Coordinator and Technical Officer at the World Health Organization (WHO); and Paula Auberson-Munderi, Team Lead, Science, HIV Prevention and Pediatrics at UNAIDS.

328. The first speaker, Mariângela Simão, Secretary of Health and Environmental Surveillance, Brazil, said long-acting technologies had a transformative potential when used in addition to existing, proven technologies. However, implementation studies were needed to understand how well new technologies worked in real-life conditions. While the efficacy of a tool may be high, actual impact in real-life settings required that people who need the tool could actually access and use it, she added, highlighting that

affordable prices therefore mattered.

329. Technical evidence indicated that, with high enough coverage, PrEP would contribute to a decline in new HIV infections, Ms Simão said, but she cautioned against relying on a single approach. In public health, there were no “silver bullets”, she said. Long-acting ARVs for prevention should be an additional choice in the prevention package, she said. She also advised against contrasting daily oral PrEP to long-acting versions: they were complementary and both effective, she said.
330. According to her, it was important to tackle demand generation and address intellectual property issues that affect long-term access to these technologies. More generally, ways should be found to increase investments in vital medical products that may not seem profitable enough to companies. That concern, she said, applied not only to HIV and neglected tropical diseases, for example, but potentially also to an HIV cure. It was also crucial to increase local production of essential medicines, she said.
331. Yvette Raphael, co-founder and co-director of Advocates for Prevention of HIV and AIDS, South Africa, paid tribute to the activists and organizations who were holding governments and advisory boards accountable. She said evidence showed that community-led actions increased uptake of HIV services, reduced stigma and improved health outcomes. Community involvement in designing and delivering integrated services ensured that they were people-centered and context-appropriate. She reinforced the need to use a human rights lens and ensure equity.
332. Long-acting innovations had the potential to transform the AIDS epidemic in Africa and globally, Ms Raphael said; however, rapid and equitable rollouts required the understanding, acceptance and readiness of communities. They should be engaged in shaping demand, dispelling myths and promoting the value of community and youth leadership, integrated service delivery and rights-based, gender-sensitive approaches, she concluded.
333. Ms Byanyima said the HIV response could be in a radically different position by 2030 if wide, equitable access to long-acting ARVs for prevention and treatment is achieved. She said that once-a-month oral PrEP tablet was in late-stage trials; long-acting, twice-monthly injections of cabotegravir were already available and trials were underway for a four-monthly version; the first doses of injectable lenacapavir, which is administered once every six months, had already arrived in Eswatini and Zambia; and trials for a once-per-year dosage of lenacapavir had begun. These innovations offered alternatives for people for whom current prevention options were not ideal and this was the closest the world had come to a vaccine for HIV, she said.
334. Commending the pharmaceutical companies that had developed long acting ARVs, she said more could be done to expand access. Like much of Latin America, Brazil had been excluded from the generics agreement and a realistic price for lenacapavir was not yet on offer there. It was also necessary to increase demand for these innovations; large purchases would reduce prices, she said, noting that Unitaid and the Gates Foundation had secured a price of US\$ 40 per person per year for lenacapavir for PrEP, and that sufficient demand could lower that to US\$ 25 per person per year.
335. Ms Byanyima said that tiered pricing models showed that monopolies were not the only way to reward innovation, that technology sharing did not destroy profits, and that generic competition and licensing benefited everyone involved. She stressed that civil society was key for raising demand and enforcing accountability. She said UNAIDS modeling showed the world needed to have 20 million people on PrEP, 13 million of them on long-acting PrEP, to achieve the targets of the global AIDS Strategy. She urged all stakeholders to ensure that long-acting ARVs reach everyone who needs them.

Session overview

336. This session focused on evidence for the transformative potential of long-acting ARVs and the enablers and barriers to equitable, affordable access.
337. Tereza Kasaeva, Director, Department on HIV, Tuberculosis, Hepatitis and Sexually Transmitted Infections at WHO, noted that life-long adherence to treatment was challenging and that coverage of effective prevention interventions was falling short. The evidence suggested that rapid introduction of long-acting agents, five of which were already available, could shift the HIV response, she said. They could address hindrances such as pill fatigue, adherence difficulties, stigma and the daily burdens of HIV management, and they were safe, effective and acceptable.
338. She said research suggested that about 60% of users may prefer injectables, potentially reaching 13 million users by 2030. For lenacapavir in high-incidence settings, modeling indicated that coverage of 2–5% could reduce HIV incidence by 25–45% over the next decade. That required integrating it into comprehensive, person-centred packages alongside oral PrEP, condoms, harm reduction and gender-transformative, community-led programmes.
339. She informed that access in low- and middle-income countries was still almost non-existent. For lenacapavir, current manufacturing capacity could meet demand for up to 7.5 million people by 2028, yet the current target was to reach only about 2 million people in those countries.
340. This was not simply a “market issue”, she said: it tested the commitment to solidarity, shared responsibility and the right to health. According to her, experience showed, nonetheless, that markets can be shaped in the public interest. Public health-oriented intellectual property (IP) management, TRIPS flexibilities, accelerated regulatory approvals, pooled procurement, technology transfers and local manufacturing could reduce prices and increase access. Financing must be mobilized for those actions, she urged.
341. Ms Kasaeva said national guidelines and regulatory pathways must support a mixed delivery approach for long-acting ARVs, based on national context and demand. The ARVs should be integrated in WHO-recommended packages and delivered through differentiated models, with target setting reflecting projected demand and manufacturing capacity, she added, indicating that realizing the potential of long-acting ARVs required rapid, joint actions and strong collaboration between governments, civil society, industry and global health institutions.
342. Mary Mahy, Director for Data for Impact Practice at UNAIDS, said approximately 40.8 million people were living with HIV in 2024, but 9 million of them were not on treatment and 11 million were not virally suppressed. The current situation was likely much worse due to the funding cuts and service disruptions of 2025. By improving treatment retention and viral suppression, long-acting ARVs could reduce AIDS-related deaths by about 19% over 10 years, she said, referring to recent study findings.
343. With HIV infections still increasing in some regions, especially among key populations in several countries, the target had been to attain about 21 million people with oral PrEP users by 2025, Ms Mahy said, yet only 3.9 million people had used PrEP at least once in 2024. Uptake had increased, but continuation of use was generally low, which indicated that oral PrEP was not an ideal option for everyone. She said a UNAIDS study had shown that if lenacapavir were used by the 5% of people at highest risk for HIV in high-burden countries, it could avert 25–35% of new infections over 10 years. In concentrated epidemics, if lenacapavir reached 60% of key populations (about 2% of

the total population), it could avert 45% of new HIV infections. The aim therefore was to reach about 20 million people at high risk of HIV infection with ARV-based prevention, including 13 million people using long-acting PrEP.

344. Overall, to achieve the 2030 global AIDS targets, it was necessary to reach 90% of people in need of prevention with effective, appropriate prevention options, she said. Communities and programme managers would have to consider how to build demand and make relevant options available to the people who need them. While noting that long-acting agents were not a “silver bullet”, she said they could help reach prevention goals if their cost were reduced to levels that allow for use at an impactful scale.
345. Speaking from the floor, members and observers thanked participants for the insightful presentations. They said long-acting HIV medicines were potentially revolutionary tools but had to be accessible to everyone who needed them. They applauded the Global Fund and PEPFAR for committing to provide these medicines to 2 million people over the next three years but noted that production capacity existed for 2.5 million doses per year. Greater ambition was needed, they said, along with robust funding for the Global Fund and PEPFAR to reach the scale and equity that could achieve impact.
346. Speakers noted that several middle-income countries were still excluded from generic licensing arrangements for lenacapavir. Equitable access required reduced prices and expanded generic production, they said. They reiterated that lenacapavir could be manufactured at scale for about US\$ 40 per person per year while still generating profits for producers. Presenters were asked for more information about the return of investment for new long-acting ARVs. Speakers also called for a balanced process that preserves incentives for innovation while enabling equitable access to new technologies in public health programmes.
347. In reply, Ms Kasaeva said WHO would continue to assess the evidence, update guidelines accordingly, and provide technical support as requested. She agreed that communities must be involved in building demand, which also would help drive down prices, and assured speakers that the needs of the most vulnerable communities, including people who use drugs, were not being forgotten. Replying to a question, Ms Mahy said a quantified return on investment was not yet available, though the need for further price reductions was clear. Ms Raphael called for greater access and affordability, with time-bound commitments, and said long-acting ARVs must be integrated into national health systems from the outset.

Panel 1: Perspectives on long-acting antiretrovirals

348. Speakers discussed the policy and programme implementation experiences of people at risk of, or living with HIV, and of decision-makers. A short video was screened depicting the experience of a young Zimbabwean PrEP user.
349. Bruce Richman, founding Executive Director of Prevention Access Campaign in the United States of America, said it was a liberating fact that people with undetectable levels of HIV cannot transmit HIV to others. When people understood this, testing increased, treatment adherence improved and viral suppression levels rose. Long-acting treatment could provide a further boost, he said.
350. Daily ARV doses was a challenge for some people, especially those facing stigma, criminalization and other barriers. Long-acting agents potentially addressed some of those challenges. He said four actions could ensure that long-acting treatment helped people reach and sustain an undetectable viral load. Firstly, the message of U=U (undetectable equals untransmittable) should be central to people’s understanding of HIV treatment. Secondly, people living with HIV should be partners in the design,

delivery and monitoring of the rollout of long-acting treatment. Thirdly, transparent and trustworthy information about long-acting treatment should be provided for informed choice and uptake. And fourthly, access and affordability should be prioritized by addressing structural, legal and policy barriers and through public health-driven IP management and procurement.

351. Lloyd Mulenga, national HIV Programme Coordinator for the Ministry of Health in Zambia, said that Zambia had started using long-acting cabotegravir in early 2024. He advised against reserving long-acting agents strictly for certain populations and said one of the lessons learned was that communities should be at the centre of the rollout of these ARVs. Unfortunately, he added, declining funding for community responses would affect efforts to use these tools effectively and equitably.
352. Veriano Terto, Vice-President of the Brazilian Interdisciplinary AIDS Association, said it was a difficult time to sustain and expand HIV programmes in countries in the South. IP regulations enabled product monopolies to be established, which affected equitable access to health technologies, he pointed out, recalling that Brazil and other countries in Latin America were excluded from the licensing agreement for lenacapavir. He urged countries to jointly use TRIPS flexibilities, including compulsory licensing, for fairer access, technology transfers and affordable prices.
353. Beatriz Grinsztejn, President of the International AIDS Society, said the full potential of long-acting ARVs could only be realized if the tools reach the communities who need them the most. Even though they were not a “silver bullet”, they could expand choice, she added, saying that long-acting prevention could be especially useful where HIV was highly concentrated among key populations who faced social and legal barriers; however, many middle-income countries were still excluded from generic access agreements for these ARVs. She called for a broader and more equitable approach to voluntary licensing, pricing and supply of long-acting agents, as innovation without access did not amount to progress.
354. Ms Grinsztejn warned that cuts to HIV programmes would lead to delayed regulatory submissions, stalled procurement, underfunded community programmes and weakened implementation capacity. Referring to the continued criminalization of key populations, attacks on transpeople's right to health, increasing violence and discrimination, and shrinking civic space, she said rollout strategies would fail if people feared arrest or discrimination when seeking services. Protection of human rights was a prerequisite for success, she highlighted.
355. Emphasizing the value of real-world evidence to guide national scale-up, she highlighted the need to integrate long-acting options into routine care, both in standard health facilities and through differentiated service delivery. That required strong public health systems, robust primary care, trained providers, predictable supply chains, digital infrastructure, friendly environments, and meaningful community engagement, she said.
356. Speaking from the floor, members and observers agreed that long-acting ARVs widened the scope for progress against the AIDS pandemic by offering opportunities to reduce pill burden, improve adherence and counteract factors, such as stigma, that can make daily oral treatment difficult. However, realizing that potential required building awareness, regulatory readiness, and affordable prices across low- and middle-income countries. Although one speaker questioned whether expectations of low-cost access, including through relaxing patent protections, were compatible with the ongoing need for costly new innovations, there was wide support for price reductions, including through cheaper, generic production. Speakers supported the use of TRIPS flexibilities, including compulsory licensing, as affirmed in the Doha

Declaration on Public Health, as well as exemptions for least-developed countries.

357. Speakers stressed the need for awareness building, demand generation and the involvement of communities. Several priorities were suggested, including: operational research led by people living with HIV to understand acceptability and real-world barriers; the collection of disaggregated data; focused rollouts in settings with the highest unmet needs; pricing models that allow for prompt access across low- and middle-income countries; expanded viral load testing capacity; support for pooled procurement, voluntary licensing and technology transfers to sustain supplies; and integration into strengthened frameworks for prevention and care of advanced HIV disease.
358. Asked how Zambia approached the allocation of the long-acting doses, Mr Mulenga said the focus was on adolescent boys and girls and young women, but that approach left out other people who clearly could also benefit from these tools. Asked to summarize their key messages, Mr Richman emphasized advocating for and publicizing U=U, while Mr Mulenga noted the need to reform legal barriers that block access to long-acting therapies. Mr Terto called for IP regulation to serve the needs of societies broadly and said collective action could make it easier for countries to use existing flexibilities and pursue local production. Ms Grinsztejn said solutions were needed to overcome commercial barriers that affected access and widened prevention and treatment gaps.

Panel 2: Planning for access—what will it take?

359. This session discussed the steps for having sustained access to long-acting ARVs. Carmen Perez-Casas, Technical Manager at Unitaid, highlighted three factors. She said approval of lenacapavir had been rapid because the necessary evidence had been gathered during trials in low- and middle-income countries among populations who were the anticipated users. Manufacturing aspects also had to be considered early on to ensure a sufficient and geographically diversified supply base. Early licensing was vital and companies must consider voluntary licensing so countries and funders can plan accordingly, she said. For pricing it was important to seek rough parity with the current standard of care, which (for lenacapavir) was oral PrEP. This had been done by negotiating generic production, which could reduce the cost of lenacapavir to about US\$ 40 per person per year. However, not all countries were included in the deal. She said Unitaid was supporting early adopters to take necessary steps (e.g. guidance, training, demand generation and treatment literacy). Work was also underway to document evidence on the most effective and impactful ways to introduce these products; two such studies, involving lenacapavir, were being done in Brazil and South Africa.
360. Jared Baeten, Senior Vice-President, Clinical Development at Gilead Sciences, told the meeting that long-acting ARVs offered the potential to close critical prevention and treatment gaps. Stressing that innovation and access must go hand in hand, he said Gilead was working with PEPFAR, the Global Fund, national programmes and community and clinical partners, to bring innovative medicines to high-incidence, resource-limited countries. It had entered into voluntary licensing agreements with generic manufacturers to enable access in 120 low- and middle-income countries prior to regulatory approvals of the ARV anywhere in the world. A guaranteed supply, with no profit for Gilead, would be available for at least two million people in those countries for the next three years. Regulatory approvals were also widening. He said Brazil's regulatory submission was under review and a filing process has been initiated for Mexico, as well as Argentina and Peru. Lenacapavir had been approved also for people with multidrug-resistant HIV in several countries, he informed.

361. Bryn Jones, Global Medical Lead for HIV at ViiV Healthcare, agreed that choice was important and said long-acting treatment and prevention had the potential to address stigma and other factors that made adherence difficult. He said it took years of work, including with governments, regulatory bodies and NGOs, to bring a product to approval and licensing and reiterated the importance of implementation research and careful planning. Access agreements had already been signed with the Medicines Patent Pool for generic cabotegravir, he informed.
362. Thembisile Xulu, Chief Executive Officer of the South African National AIDS Council, said her country's early adopter experience with lenacapavir had allowed it to move the access process along quickly. She stressed that lenacapavir must complement existing prevention tools and should be used to revitalize the entire HIV prevention system, which meant delivering it as part of routine combination prevention through primary health and community systems. Without integration, she said, access would be compromised. The cost of lenacapavir had been reduced, she noted, but further price reductions would enable a larger rollout. She advised against setting up parallel procurement and other systems for products like lenacapavir. Countries that achieve early policy clarity, credible demand planning, community education and delivery readiness (including training health workers) would shape global access patterns for long-acting agents, she said, adding that regulatory reforms, including those envisaged through the African Medicines Agency, were critical to reduce delays between innovation, registration and access. Local and regional manufacturing, supported by voluntary licensing, technology transfers and predictable demand, would strengthen sub-Saharan Africa's resilience, she said. She thanked Gilead Sciences for showing flexibility regarding the importation of active pharmaceutical ingredients.
363. Mike Reid, Chief Science Officer for PEPFAR in the Bureau of Global Health Security and Diplomacy in the U.S. State Department, said PEPFAR had played a central role in shaping the long-acting PrEP landscape by making large-scale adoption of cabotegravir and lenacapavir viable. That had required market shaping, early demand signaling, regulatory coordination, price negotiations and procurement planning. He said PEPFAR remained committed to getting lenacapavir to people who need it and was working with governments to predict supply and ensure sustainable pricing, and was supporting the rollout of lenacapavir in 10 countries. Mr Reid said it was concerning that long-acting treatment was available in high-income countries, but not in the countries where PEPFAR worked. He said PEPFAR was working to help define a research and access agenda for long-acting ARVs for treatment. A scale up was feasible and the lessons learned in reducing the prices of the fixed-dose combination dolutegravir/lamivudine/tenofovir remained salient, he said.
364. Michael Ighodaro, Executive Director of Global Black Gay Men Connect, Nigeria and the U.S., said that a rollback in policy, rhetoric and propaganda of commitments to equity and inclusion was causing great damage. While commending scientific advancements, he said innovation should not stop at product development. He noted that forecasting, market assessments and access planning for long-acting prevention had benefited from the support of Gilead Sciences and ViiV Healthcare, but said science alone would not deliver impact and equity-driven planning was needed. By 2030, at least 60% of PrEP users should be members of key populations, Mr Ighodaro said, yet the infrastructure for delivering the prevention tools to key populations was being actively dismantled. Funding cuts and freezes in early 2025 had led to clinics shutting down, outreach being halted and staff being laid off, with key populations affected particularly hard, he alerted. In Nigeria, Kenya and Uganda more than 2.2 million people were currently without access to key population-focused HIV prevention services, he said. New prevention tools could not be rolled out with collapsing infrastructure and systems, he concluded.

365. Izukanji Sikazwe, Head of HIV at the Global Fund, highlighted five pillars for sustained and equitable access to long-acting ARVs. First was a secure, affordable and predictable supply chain, which maintains trust and reassures manufacturers of ongoing demand. It was also important to prepare systems to address regulatory requirements, procurement needs and the transition to generic versions once they become available. Secondly, long-acting ARVs must be embedded in routine HIV prevention and delivery packages in ways that maintain choice. Thirdly, community leadership must be central to the planning, rollout and monitoring of new interventions. Fourthly, innovative financing mechanisms must be used to achieve scale and sustainability, with resources channeled to high-impact interventions and populations, based on need and epidemiological evidence. Finally, a strong focus on monitoring and evaluation was needed to track integration, equity and impact and inform continued investments and strategies.
366. Silas Holland, Director of Global Public Policy at Merck, discussed long-acting products that were in the pipeline, including a weekly oral treatment (in partnership with Gilead); another weekly oral treatment which was in phase two trials; and a monthly oral PrEP. which was in phase three trials. He said Merck would work with governments and other partners to ensure simultaneous access across low-, middle- and high-income countries through, for example, voluntary licensing strategies, bilateral agreements, the Medicines Patent Pool and technical support. Noting that delivering the products required training, strengthened awareness and trust in community platforms, he said his company would work with Ministries of Health, communities, procurers and advocacy groups to ensure the innovations have real, equitable impact.
367. In discussion from the floor, speakers underscored the importance of fair and affordable pricing to translate scientific innovations into real public health impact, as prices of long-acting ARVs would determine national decisions on their procurement and use. Implementation challenges should not be ignored, they added, noting that rollouts of long-acting injectable treatment or PrEP require suitable healthcare infrastructure, trained healthcare providers and clinics that can provide regular follow-up. Speakers insisted that the tools should be part of a comprehensive package that includes actions to improve gender norms and tackle gender inequalities. They underlined the need to remove legal, policy and social barriers that limit access and impede sustainability, along with the need to invest in demand generation. Awareness remained a major gap, with many affected populations knowing too little about their prevention and treatment options, they said. Also highlighted was the value of community-led monitoring for collecting data on impact, resistance and safety; for understanding how the tools perform among diverse groups; and for informing policy adjustments.
368. Speakers emphasized the need to strengthen local manufacturing capacity, facilitate technology transfers, coordinate partnerships and investments, and align efforts with global access initiatives to promote equitable access. Local production reduced dependence on imports, shortened supply chains and could improve resilience to global disruptions, they said.
369. Asked for brief key messages, Mr Ighodaro said the aim should be to have 11.5 million person years of PrEP use by 2030, with 60% of new PrEP use occurring among key populations, which required investing in literacy and demand generation and rebuilding infrastructure that was being destroyed. Mr Baeten said innovations should be aimed at achieving impact, while Mr Jones said the discussion had highlighted the importance of partnerships, working with communities, providing choice and acting with urgency. Ms Xulu said every missed prevention opportunity represented a lifetime of treatment costs, while Mr Reid emphasized the need for scaling up and ensuring

equitable access. Ms Sikazwe said it was not innovations alone but delivery systems that stopped new infections, therefore community participation and a rights-based approach to implementation were vital.

Conclusions and the way forward

370. Summarizing the main messages, Ms Achrekar emphasized that access connected innovations with impact and encouraged more resources to go to programmes and community systems that can deliver access. She said the session had illustrated the uniqueness of the PCB, which brought together multiple sectors and stakeholders to share experiences and lessons. It was clear from discussions that speed, scale and equity were essential, along with partnerships that put affected communities at the centre, she concluded.

11. Any other business

371. A delegate noted that the statement posted online by the Office of the Deputy Secretary-General was not the same version as the one the Deputy Secretary-General had delivered at the PCB on the previous day and expressed the expectation that the statement would be updated. The Secretariat was asked to work with the Deputy Secretary-General's office to provide a full transcript, including her full closing remarks.

372. There was no other business.

12. Closing of the meeting

373. Presenting the closing remarks, the Executive Director, Ms Byanyima thanked Brazil for hosting the meeting and said the Board had again showcased its unique governance model and power. It had adopted a new Global AIDS Strategy, which would take the global HIV response to 2031—a major achievement in a world where multilateralism was under strain. The Strategy would also inform the next High-Level Meeting on AIDS at the UN General Assembly in June, as well as the negotiations for a new Political Declaration on AIDS.

374. She said she was pleased that the Deputy Secretary-General had joined the meeting and heard the important perspectives and rich discussions concerning the next steps for the Joint Programme's transition. It was clear that AIDS was not over and that the world could not simply walk away, she said, adding that it was vital to preserve the factors that drove progress against AIDS: accountability, community leadership and political commitment. She said she was confident that UNAIDS' transition would follow a Board-led process. The working group would define what a responsible and inclusive transition should look like, and it would address the questions posed in the background paper to ensure that the transition is orderly, transparent and accountable and preserves the progress made, she clarified.

375. Ms Byanyima thanked the Board for recognizing the extraordinary dedication of UNAIDS staff and noted that almost 200 staff members had received their separation messages on that very day. She thanked Australia, Belgium, Canada, Denmark, Germany, Ireland, Japan, Luxembourg, the Netherlands, Norway, Monaco, Spain and the United Kingdom for their support and financial contributions in 2025. She thanked Brazil for its skillful chairing of the meeting and said she looked forward to the Netherlands taking up its role as Chair in 2026, along with the Philippines as Vice-Chair, and Kenya as Rapporteur. She also thanked the NGO delegation for its powerful support of the Joint Programme and welcomed the incoming NGO delegates and PCB members, as well as the incoming chair of the Committee of Cosponsoring Organizations.

376. The Chair said the meeting had been an opportunity to assert and recognize the power of multilateralism, which was under attack. She thanked everyone who had made the meeting possible.

377. The 57th meeting of the Board was adjourned.

[Annexes follow]

PROGRAMME COORDINATING BOARD

UNAIDS/PCB (57)/25.26.rev1

Issue date: 4 December 2025

FIFTY-SEVENTH MEETING

DATE: 16–18 December 2025

TIME: 09:00–18:00 (BRT/GMT-03:00)

VENUE: Brasilia, Brazil

Draft timewise agenda

TUESDAY, 16 DECEMBER

9:00-13:15

1. Opening

9:00-9:10

1.1 Opening of the meeting and adoption of the agenda

Presentation and discussion

Document: UNAIDS/PCB (57)/25.26;

9:10-9:20

1.2 Consideration of the report of the Special Session of the PCB meeting (8 October 2025)

Presentation and discussion

Document: UNAIDS/PCB (EM)/5.4

9:20-12:30

1.3 Report of the Executive Director

Presentation and discussion

Document: UNAIDS/PCB (57)/25.27

10:45-11:15

Coffee break

12:30-14:00

Lunch break

14:00-15:00

1.4 Report by the NGO representative

Presentation and discussion

Document: UNAIDS/PCB (57)/25.28.rev1

15:00-15:30

Coffee break

15:30-16:30

2. Leadership in the AIDS response

Keynote speech and discussion

16:30-17:30

3. Progress update on sustainability in the HIV response

Presentation and discussion

Document: UNAIDS/PCB (57)/25.29

WEDNESDAY, 17 December

- 9:00-11:00** **4. Consideration of the Global AIDS Strategy 2026–2031**
Presentation and discussion
Document: UNAIDS/PCB (57)/25.30, UNAIDS/PCB (57)/CRP1
- 11:00-11:30 *Coffee break*
- 11:30-13:30** **5. Update on the implementation of the revised operating model of the Joint Programme**
Presentation and discussion
Documents: UNAIDS/PCB (57)/25.31, UNAIDS/PCB (57)/CRP2
- 13:30-14:30 *Lunch break*
- 14:30-15:15** **6. Statement by the representative of the UNAIDS Secretariat Staff Association (USSA)**
Presentation and discussion
Document: UNAIDS/PCB (57)/25.32
- 15:15-16:15** **7. Evaluation report and management response**
Presentation and discussion
Documents: UNAIDS/PCB (57)25.33; UNAIDS/PCB (57)25.34
- 16:15-16:30** **8. Next PCB meetings**
Presentation and discussion
Document: UNAIDS/PCB (57)/25.35
- 16:30-16:45** **9. Election of officers**
Presentation and discussion
Document: UNAIDS/PCB (57)/25.36

THURSDAY, 18 December

- 9:00-16:30** **10. Thematic Segment: Beyond 2025: Long acting antiretrovirals: potential to close HIV prevention and treatment gaps**
Presentation and discussion
Documents: UNAIDS/PCB (57)/25.37; UNAIDS/PCB (57)/25.38; UNAIDS/PCB (57)/CRP3
- 10:30-10:45 *Coffee break*
- 12:30-14:00 *Lunch break*
- 16:30-16:45** **11. Any other business**
- 16:45-17:00** **12. Closing of the meeting**

18 December 2025

Decisions

57th Meeting of the UNAIDS Programme Coordinating Board

Brasilia, Brazil

16–18 December 2025

Decisions

The UNAIDS Programme Coordinating Board,

Recalling that all aspects of UNAIDS work are directed by the following guiding principles:

- Aligned to national stakeholders' priorities;
- Based on the meaningful and measurable involvement of civil society, especially people living with HIV and populations most at risk of HIV infection;
- Based on human rights and gender equality;
- Based on the best available scientific evidence and technical knowledge;
- Promoting comprehensive responses to AIDS that integrate prevention, treatment, care and support; and
- Based on the principle of non-discrimination;

Intersessional Decisions:

Recalling that, it has decided through the intersessional procedure (see decisions in UNAIDS/PCB(56)/25.2:

- Agrees that, health situation permitting, the 56th and 57th meetings of the Programme Coordinating Board will be held in-person with optional online participation in accordance with the modalities and rules of procedure set out in the paper, Modalities and Procedures for the 56th and 57th Programme Coordinating Board meetings;
- Agrees that the 56th meeting of the Programme Coordinating Board, in accordance with decision point 10.5 of the 26th PCB meeting, will consist of a three-day decision-making segment and that the thematic segment agreed in decision point 9.1 of the 55th PCB meeting will be postponed to the 58th Programme Coordinating Board meeting in June 2026;
- Agrees that the 57th meeting of the Programme Coordinating Board shall be held on 16-18 December 2025 (final venue to be decided at the 56th Programme Coordinating Board meeting as set out in document UNAIDS(56)/25.21), superseding decision point 10.3 of the 51st Programme Coordinating Board meeting;

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

1. *Adopts* the agenda;

Agenda item 1.2: Consideration of the report of the Programme Coordinating Board Special Session

2. *Adopts* the report of the Special Session of the Programme Coordinating Board;

Agenda item 1.3: Report of the Executive Director

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

Agenda item 1.4: Report by the NGO representative

- 4.1 *Takes note* of the report by the NGO representative (UNAIDS/PCB (57)/25.28);
- 4.2 *Recognizes* the indispensable role of communities as service providers, caregivers, advocates, and monitors, and recognizes that meaningful community leadership and well-resourced community-led HIV responses are fundamental to the realization of the Global AIDS Strategy 2026–2031, to the attainment of the 30–80–60 and 10–10–10 targets, and to ending AIDS as a public health threat;
- 4.3 *Recalls* all decision points from agenda item 1.4 of the 55th meeting of the Programme Coordinating Board in December 2024;
- 4.4 Noting with concern that reaching the goal of ending AIDS as a public health threat by 2030 is being negatively impacted by declining and unpredictable funding for community-led HIV responses, restrictions on civic space and regression of gender equality and human rights as recognized by international human rights law, and persistent stigma and discrimination, and other emerging challenges, *calls upon* Member States to:
 - a. Ensure that predictable, sustainable, and direct financing is directed to community-led organizations engaged in the HIV response, including through institutionalized social contracting, as well as dedicated domestic budget lines and funding mechanisms, including within UNAIDS;
 - b. Address structural, legal, and policy barriers to support equitable and human rights-based, community-led integrated HIV services that leave no one behind including people living with and affected by HIV, particularly key¹ populations, as well as other priority populations taking into consideration the national context, guided by community leadership and societal enablers to end HIV-related stigma, discrimination, and gender inequalities and health inequities;
 - c. Develop, with the support of the Joint Programme, comprehensive and integrated health and social support service packages known to reduce HIV risk and vulnerabilities within national HIV and health plans, that link HIV testing, prevention, including long-acting technologies, and treatment to the specific

¹ As defined in the Global AIDS Strategy 2021–2026. Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

- needs of people living with and affected by HIV, particularly key populations, as well as other priority populations, taking into consideration the national context;
- d. Integrate and strengthen peer-led HIV service delivery and community-led monitoring to improve HIV service delivery quality, efficiency and effectiveness, strengthen health systems, including by putting communities at the centre of all efforts to realize primary healthcare, and enhance health equity, including while encouraging innovative, digital health interventions, within national capacity, and human rights approaches for monitoring and evidence-based decision-making in the national HIV response and broader health sector;
 - e. Ensure that people living with and affected by HIV, particularly key populations, as well as other priority populations, taking into consideration the national context, are actively engaged in the process of integration of the HIV response into related, coordinated multisectoral programmes;
 - f. Strengthen systematic annual reporting through the Global AIDS Monitoring mechanism, in a transparent and disaggregated manner, on donor and domestic budget allocations supporting community-led responses and human rights programming, to monitor and inform progress toward the 30–80–60 and 10–10–10 targets, working collaboratively with Cosponsors and the UNAIDS Secretariat;

4.5 *Requests* the Joint Programme to:

- a. Develop, in the context of UN80, a plan for the continuity of the support to and engagement of communities currently delivered by the UNAIDS Secretariat and in the decision-making on the further transition and integration of UNAIDS into the UN System and beyond, particularly the unique role UNAIDS has played, including the role of civil society in decision-making and the governance structure;
- b. Reaffirm commitment to the meaningful involvement of people living with and affected by HIV, particularly key populations, as well as other priority populations, taking into consideration the national context, in the implementation of the Global AIDS Strategy 2026–2031 and in the UN General Assembly 2026 High-Level Meeting on HIV/AIDS;

Agenda item 3: Progress update on the sustainability of the HIV response

- 5.1 *Takes notes* of the progress update on the sustainability of the HIV response (UNAIDS/PCB (57)/25.29);
- 5.2 *Notes with concern* the rapidly changing health financing context and the need to urgently accelerate the sustainability of national HIV responses and diversify financing sources;
- 5.3 *Recalls* decisions 5.1, 5.2 and 5.3 from the 55th meeting of the Programme Coordinating Board in December 2024;
- 5.4 *Requests* Member States, in close collaboration with community-led HIV organizations and other relevant civil society organizations and partners, with the support of the Joint Programme, to:
 - a. Explore and expand country financing capacity through domestic revenue mobilization, continued global solidarity, leveraging partnerships, including with

- the private sector, and broadening the financing options to fully fund the HIV response and meet the estimated resource needs;
- b. Advance country-owned HIV Sustainability Roadmap design, implementation and milestone tracking to align domestic and donor investments with national priorities, contributing to broader ongoing healthcare and development reforms;
 - c. Advance and support legal and policy reforms that enable community-led service delivery, end stigma and discrimination and uphold human rights and gender equality as essential steps towards sustainability in the HIV response, and in line with the UNAIDS Sustainability Roadmap Companion Guide and the Global AIDS Strategy 2026–2031;
 - d. Accelerate efforts to improve transparency and accountability for domestic and international HIV investments to enable efficiency gains, ensure investments deliver intended impact, and advance continued prioritization and identification of financial gaps;
 - e. Scale up sustainable domestic and international funding for communities in implementing country-owned HIV responses and Sustainability Roadmaps, including through social contracting and integration of community-led HIV responses into domestic budgets and benefit packages;
 - f. Strengthen meaningful engagement with civil society and community-led organizations in the development and implementation of national Sustainability Roadmaps and in wider decision-making and governance structures for sustainability, and ensure predictable, long-term financial investment;
- 5.5 *Recognizes* the role of UNAIDS in supporting sustainable HIV responses through the development, adaptation and implementation of national HIV Sustainability Roadmaps, and to ensure this support continues throughout the further transition and integration of UNAIDS into the UN system and beyond;

Agenda item 4: Global AIDS Strategy 2026–2031

- 6.1 *Adopts* the Global AIDS Strategy 2026–2031;²

Agenda item 5: Update on the implementation of the revised operating model of the Joint Programme

- 7.1 *Takes note* of the update on the implementation of the revised operating model of the Joint Programme (UNAIDS/PCB/57/25.31);
- 7.2 *Recognizes* that UNDP, UNFPA, UNHCR, UNICEF, UNODC and WHO will be lead Cosponsors and that ILO, UNESCO, UN Women, WFP and the World Bank will be affiliate Cosponsors;
- 7.3 *Requests* the PCB Bureau to:
- a. Finalize, as soon as possible and no later than January 2026, the Terms of Reference for a Working Group to develop a plan on the further transition and integration of UNAIDS into the UN System and beyond, in coherence with the

² The Islamic Republic of Iran disassociates itself from certain parts of the Global AIDS Strategy 2026-2031, that contradicts its national priorities, domestic laws, regulations and policies.

- UN80 Initiative, including the elements set out in report UNAIDS/PCB (57)/25.31, and building on the recommendations 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 and the core functions of the Secretariat as set out in report UNAIDS/PCB (56)/25.15.rev2, and present them for the Programme Coordinating Board's intersessional approval;
- b. Outline the composition of the Working Group within the Terms of Reference, to be representative of the composition of the full Programme Coordinating Board membership;
 - c. Establish a Working Group on the further transition and integration of UNAIDS into the UN System and beyond, following the approval of its Terms of Reference as set out in UNAIDS/PCB (57)/25.31, based on the UNAIDS guiding principles, with the first meeting to take place in early February 2026;
 - d. Mandate the Working Group to provide an interim report on the plan, including a timeline on the further transition and integration of UNAIDS into the UN System and beyond, in coherence with the UN80 Initiative, through the Bureau, for the Programme Coordinating Board's consideration and decision-making at the 58th meeting of the Programme Coordinating Board in June 2026;
 - e. Mandate the Working Group to provide its finalized plan for the further transition and integration of UNAIDS into the UN System and beyond, through the Bureau, for the Programme Coordinating Board's consideration and decision-making at a special session of the Programme Coordinating Board no later than the end of October 2026, for subsequent transmission to ECOSOC;
- 7.4 Recalling decision point 8.1 from the 56th meeting of the Programme Coordinating Board in June 2025, *requests* the Executive Director to continue updating the Programme Coordinating Board on the ongoing downsizing of the Secretariat at the 58th meeting of the PCB in June 2026;
- 7.5 *Requests* the Executive Director to prepare the 2027 Workplan and Budget for the Joint Programme, aligned with the ongoing downsizing and informed by the plan of the Working Group for the further transition of the Joint Programme in the context of the UN80 Initiative, for consideration, at the same time as the plan for the further transition and integration of UNAIDS into the UN System and beyond;
- 7.6 *Requests* the PCB Bureau to organize appropriate and inclusive consultations of the Working Group, open to all PCB members and stakeholders, ahead of the scheduled Programme Coordinating Board meetings to inform and guide the Working Group, taking into account the discussions in the UN80 Initiative;
- 7.7 Recalling decision 6.2c from the 55th meeting of the Programme Coordinating Board and decisions 4.1 and 4.2 from the Special Session of the Programme Coordinating Board in October 2025, *agrees* to postpone the establishment of the UBRAF Working Group to the next cycle of the UBRAF beyond 2027;

Agenda item 6: Statement by the representative of the UNAIDS Secretariat Staff Association (USSA)

- 8.1 *Takes note* of the Statement by the representative of the UNAIDS Secretariat Staff Association (USSA);

Agenda item 7: Evaluation report and management response

- 9.1 *Recalls* decision 7.5 of the 53rd Programme Coordinating Board meeting approving the UNAIDS 2024–2025 Evaluation Plan, as well as decision 8.7 of the 55th Programme Coordinating Board meeting requesting the next annual report to be presented to the Programme Coordinating Board in December 2025;
- 9.2 *Takes note* of the 2025 annual report on evaluation and the summary of the main findings from the evaluations undertaken in 2025;
- 9.3 *Takes note* of the management response to the 2025 annual report on evaluation;
- 9.4 *Approves* the 2026 Evaluation Plan (UNAIDS/PCB (57)/25.33) endorsed by the Expert Advisory Committee on evaluation;
- 9.5 *Recalls* decision 9.3 of the 47th meeting of the Board on the importance of adequately resourcing and staffing the evaluation function in accordance with the evaluation policy approved by the Programme Coordinating Board in decision 6.6 of its 44th meeting, taking into account the financial situation of the organization;
- 9.6 Recalling decision 8.5 from the 55th meeting of the Programme Coordinating Board, *agrees* that the Expert Advisory Committee on evaluation approved by the Programme Coordinating Board in 2025, as detailed in Annex 1 of the 2025 annual report on evaluation and evaluation plan 2026 (UNAIDS/PCB (57)/25.33), is reappointed for a second term;
- 9.7 Recalling decision 8.6 from the 55th meeting of the Programme Coordinating Board, *takes note*, in accordance with provision 73 of the Evaluation Policy, that the UN Evaluation Group peer review will be postponed to 2026;
- 9.8 *Looks forward* to the annual report on evaluation to be presented to the Programme Coordinating Board in December 2026;

Agenda item 8: Next PCB meetings

- 10.1 Recalling the intersessional decision on modalities and procedures for the 56th and 57th meetings of the Programme Coordinating Board, *confirms* the theme, *Beyond 2025: Addressing health inequities through sustained HIV response, human rights, and harm reduction for people who use drugs*, for the 58th PCB thematic segment (June 2026);
- 10.2 *Agrees* that the theme for the 59th Programme Coordinating Board thematic segment (December 2026) will be: *Addressing the impact of funding cuts on people living with, affected by, and at risk of HIV, and on the response to HIV and AIDS*;

- 10.3 *Requests* the PCB Bureau to take appropriate and timely steps to ensure that due process is followed in the call for themes for the 60th and 61st meetings of the Programme Coordinating Board; and
- 10.4 *Approves* the dates and venue of the 62nd and 63rd meetings of the Programme Coordinating Board in 2028, as follows:
- a. *62nd PCB meeting: 27–29 June 2028, Geneva, Switzerland;*
 - b. *63rd PCB meeting: 12–14 December 2028, Geneva, Switzerland;*

Agenda item 9: Election of officers

11. *Elects* the Netherlands as the Chair, the Philippines as the Vice-Chair and Kenya as the Rapporteur for the period 1 January to 31 December 2026 and *approves* the composition of the PCB NGO Delegation.

[End of document]