Agenda item 1.3

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Report of the Executive Director

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

Take note of the report of the Executive Director.

Cost implications for implementation of decisions: *none*

Introduction

1. Excellencies, welcome to the 52nd meeting of the UNAIDS Programme Coordinating Board (PCB). It's wonderful to see so many of you at our first full in-person meeting in Geneva in more than three years. We appreciate your efforts to join us. I would like to especially thank Germany for chairing the PCB this year, Kenya, for serving as vice-Chair and Brazil for serving as Rapporteur.

2. I deliver this report to you at a time when the acute crises I referenced when we last met have since multiplied and intensified and the inequalities both within and between countries that drive AIDS and other pandemics have worsened.

3. There were almost 1.5 million new HIV infections and more than 600 000 AIDS-related deaths in 2021. This is unacceptable, especially when new HIV infections and AIDS-related deaths are entirely preventable and we know it is possible to decrease both, as some regions and countries have done-some even in an increasingly complex environment.

4. The continued economic impact of the COVID-19 pandemic, more frequent and dire ramifications of climate change leading to record numbers of displaced people and widespread suffering and a growing number of humanitarian crises, the effects of war in countries like Ukraine and Sudan, unsustainable levels of debt, rising interest rates and inflation are all disproportionately impacting developing and emerging economies.

5. This has pivoted political attention and reduced critical investments in HIV, health, education and social protection especially in many of the countries hit hardest by AIDS.

6. The polycrisis world in which we all live in now presents new challenges for people living with HIV. People living with HIV in regions like southern Africa are being further hit by the effects of climate change; for example, tropical cyclone Freddy—the longest-lived tropical cyclone ever recorded—wreaked havoc across Malawi and Mozambique, impacting the HIV responses there. Several countries with the highest HIV prevalence also top the list of countries with the most inflated food prices in the world.[1]

7. Pakistan, with rising rates of AIDS-related deaths, faced floods covering one third of the country, the worst malaria outbreak since 1973,[2] and record high inflation rates,[3] making it significantly harder for the country to help people living with HIV meet their basic needs. These same factors impede access to HIV prevention services. Meanwhile, the wars in Ukraine, Sudan and beyond complicate the landscape and impact the global economy and, in turn, negatively impact resources for HIV and for health.

8. I was recently in Mozambique with Ambassador John Nkengasong of PEPFAR and Mark Edington of the Global Fund. A country with the third highest number of new HIV infections in the world and the second highest number of new vertical infections, where AIDS is still the number one killer of its people and where thousands of people living with HIV had their life-saving treatment washed away in devastating floods. A nation facing insurgency in its northeast corner, buffeted repeatedly by climate change-related

[1] https://thedocs.worldbank.org/en/doc/40ebbf38f5a6b68bfc11e5273e1405d4-0090012022/related/Food-Security-Update-LXXXVII-June-15-2023.pdf
[2] https://www.who.int/news-room/feature-stories/detail/It-was-just-the-perfect-storm-for-malaria-pakistan-responds-to-surge-in-cases-following-the-2022-floods
[3] https://www.reuters.com/markets/asia/pakistans-annual-inflation-rose-38-yy-may-2023-06-01/

disasters, a nation previously highly in debt, is now, due to these concurrent crises, in extreme debt distress and without the ability to borrow further to rectify the situation.

9. But Mozambique is also a nation with the political will to continue the fight against HIV even in face of major challenges—something they are doing in tandem with a strong civil society who have been given the space to act and lead. Even amid all the challenges, Mozambique has managed to reduce new HIV infections by 41% from 2010 to 2022 (from 160 000 in 2010 to 97 000 in 2022). I left inspired full of hope and committed to ensuring we give better support countries like Mozambique.

10. The economic impact of the polycrisis is further stretching many countries that were already struggling financially. In 2021, debt repayments for the world's poorest countries reached 171% of all spending on health care, education and social protection combined, choking countries' capacities to respond to HIV.

11. This has widened inequalities between nations, especially their capacity to fight pandemics, including AIDS.

12. While low-income countries could barely afford to spend 3% of their gross domestic product to respond to the shock of COVID-19, high-income countries invested more than 11% of their gross domestic product. Global financing and solidarity were not enough to help low-income countries offset the impacts of COVID-19. When reverberations of the Ukraine war raised food and fuel prices, the need to fight inflation in high-income countries spiked global interest rates and depreciated the currencies of weaker economies, further incapacitating them.

13. A report[4] out from the World Bank this month on 78 low- and middle-income countries shows that per capita government health spending grew at the height of COVID-19 to an average of 25% above 2019 levels, but that progress has reversed since then. Notably, a few of the countries with the highest HIV prevalence were able to buck this trend and boost spending significantly and keep it high—countries like Mozambique. There, the government was not only able to raise its health spending significantly during COVID-19, but also kept it significantly higher, despite all the challenges they face. But this has not been possible for most countries.

14. About 30% of countries were unable to raise health spending at all during the COVID-19 pandemic. And in over half of countries, spending either fell back to the same level as 2019 or, in many cases, fell well below where it had been in 2019. In nearly half of the countries, the share of total government spending dedicated to health shrunk to below 2019 levels. I am very worried about what we are seeing. The countries in the worst position on health spending—lacking investment, and now falling back—include many of those with the highest HIV burdens. This must be fixed if we are to continue to make progress against AIDS and other pandemics.

15. This is why, in partnership with PEPFAR, the Global Fund and the US Treasury, we convened 13 African Ministers of Finance on the sidelines of the IMF and World Bank spring meetings in April. I can report that even the governments most committed to fighting AIDS are struggling to do so due to a mix of reduced growth, high debt burdens, and inflation, all of which are squeezing fiscal space. New data show that in Africa, for example, economic growth slowed from 4.1% in 2021 to 3.6% in 2022; and is expected to drop further to 3.1% this year. Meanwhile, the public debt-to-GDP ratio hit 56% in western and central Africa and 64% in eastern and southern Africa.

[4] https://www.worldbank.org/en/topic/health/publication/from-double-shock-to-double-recovery-health-financing-in-the-time-of-covid-19

16. I was very glad to hear the news last week that Zambia has struck a debt deal with creditors. When I met with President Hakainde Hichilema in Addis Ababa, we talked extensively about the need to increase public spending on AIDS. I hope this recent deal will help. But the issue is systemic and far-reaching, and it is harming our fight to end the AIDS pandemic.

17. Income inequality in countries around the world is growing[5]—and we should worry about this, since new analysis done for us by the head of the African Health Economics and Policy Association (AfHEA) which shows that higher income inequality is also associated with higher rates of HIV transmission. There have been improvements made in gender inequality in recent years, but major gaps remain—particularly in education for girls in Africa and rising rates of gender-based violence.[6] And this should worry us, too, since those two factors are also associated with HIV transmission. Reports since we last met do not suggest we're closing these gaps.

18. With these multiple factors exacerbating needs and contributing to constrained resources for HIV, we are struggling to secure the funding we need to implement the Global AIDS Strategy, a strategy which all countries have committed to.

19. And money is not the only problem.

20. We are also facing major challenges across a broad spectrum of human rights issues worldwide—women's rights, girls' rights, sexual and reproductive rights – including the right to information about sexuality, the human rights of LGBTI+ people, freedom of civil society to associate and express themselves, and more. This affects our ability to connect people to health services in order to control AIDS and all pandemics.

21. Increased levels of homophobia, transphobia and a global anti-gender equality movement are undermining global commitments to diversity and human rights, and hindering progress in the HIV response, as well as undermining individual and public health. We must all be concerned about an increasing number of discriminatory laws and policies that drive people away from HIV testing, prevention and treatment services, which will ultimately prevent us from reaching our global AIDS targets.

22. Since we last met in December, we have responded to human rights emergencies in six countries. I am particularly concerned about the pushback on the human rights of LGBTI+ people around the world. While African examples have received the most global attention, there are also examples in North America, Europe, and Asia that also cause us concern. Because when, instead of protecting rights, we criminalize and penalize people for their sexual orientation or gender identity, we push them away from accessing HIV services. We lose the essential trust we need to fight AIDS and other pandemics. And we harm the AIDS response at a population-level overall, not just among LGBTI+ people. That's the effect of lost trust—preventing fewer HIV infections, less HIV testing, fewer people starting treatment and fewer people staying on treatment.

23. In the case of pandemics, individual health is public health, and public health is global health. We are all in this together.

24. We are also seeing challenges to sexual and reproductive health and rights for women and girls around the world. UNAIDS remains committed to ensuring women and girls

[5] https://wir2022.wid.world/www-site/uploads/2023/03/D_FINAL_WIL_RIM_RAPPORT_2303.pdf
[6] https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures

are empowered to stay safe from HIV, and securing their sexual and reproduction rights is critical for doing so.

25. The trends on rights are not all bad. Indeed, next month we will share the latest data in our Global AIDS Update report which will include significant progress in the global HIV response, including on improving the legal environment for gay men and other men who have sex with men. 2022 was a remarkable year in which multiple countries removed laws criminalizing same-sex relationships—10 countries from India and Singapore to Angola and Barbados have done so since 2018. These countries are leading the way, not just toward justice but also towards ending AIDS.

26. Since 1996, UNAIDS has been an important global voice on the need for a public health approach that embraces human rights and gender equality as it is the only way we will achieve our collective goal of saving lives and ending disease.

27. We were proud to stand with civil society and the leadership of PEPFAR and the Global Fund to call for the reconsideration of Uganda's Anti-Homosexuality Act so Uganda may continue to ensure equitable access to health services and end AIDS as a public health threat by 2030.

28. Combatting the well-orchestrated, heavily financed efforts to advance anti-women and anti-LGBTI+ agendas will take significant coordination, diverse partnerships, customized outreach strategies, evidence-based arguments and high-level, sophisticated political advocacy capable of influencing policy and legal reforms. We must halt and reverse these harmful trends. Doing so requires longer-term funding as such efforts succeed over time and funding is critical for staying ahead of the curve of such developments and protecting the space for pragmatic, evidence-based and people-centred HIV programming.

29. Because of your support, UNAIDS can support countries around the world to collect and analyze data across the globe and at granular levels, engage political leadership across multiple sectors, and use its trusted relationships with communities of people living with and affected by HIV—drawing on decades of experience supporting effective responses to the epidemic. Through the Global AIDS Strategy, you have provided us with the mandate to galvanize action to end the inequalities that stand in the way of success. We cannot end AIDS unless we can create enabling environments in which *all* people feel safe coming forward to access the information and tools capable of saving their lives in the face of AIDS.

30. That is why a full day of this PCB is dedicated to the legal, policy and programmatic shifts required to ensure the human rights, safety and dignity of key populations—with a focus on transgender people—and their access to HIV services. Doing so is essential for ending AIDS.

31. This moment of intersecting crises, global economic hardship and anti-human rights societal headwinds is a time to bolster, not cut, funding for HIV.

32. In the past two years, we have seen a small, but persistent, decline of 2% in domestic investments in HIV; this corresponds to a significant reduction in donor resources for overseas development assistance (ODA) for health and HIV.

33. This is particularly notable in a context where the OECD[7] reports that foreign aid from official sources rose 14% to an all-time high of US$ 204 billion in 2022. The money is

[7] https://public.flourish.studio/story/1882344/

there. But bilateral ODA towards least-developed countries and sub-Saharan Africa declined by 0.7% and 7.8%, respectively.

34. This moment calls for global solidarity and a renewed commitment from all of us to get the job of ending AIDS done, for everyone, everywhere. Our hard-won progress must be protected to maintain the health of all people living with HIV and to ensure millions more avoid contracting the virus.

35. The PCB plays a very important leadership role in helping the world understand that continued investments in HIV are essential not only for ending AIDS but also for tackling the pandemics of the future and ensuring health and development broadly.

36. The 2021, Global Health Security Index found that no country was fully prepared for the next pandemic, and that the world overall was no better prepared than in 2019, before the outbreak of COVID-19.

37. This must change. Let me put it clearly: There is no scenario in which we succeed in ending AIDS without investing in critical needs that also help prepare for future pandemics. It's laboratories, clinics, health workers and also community-led infrastructure for outreach and accountability and much more. Our success on AIDS is inextricably tied to a smart, strategic pandemics agenda.

38. And the reverse is also true—a world that cannot end the pandemics of today, including the AIDS pandemic, will never succeed in stopping the pandemics of tomorrow. Fighting, investing in, and ending AIDS builds capacity to prevent and prepares us to respond to future pandemics.

39. The global AIDS response has also proved capable of simultaneously supporting efforts on COVID-19, we saw that, Mpox, Ebola and is capable of helping the world prevent, and respond to future pandemics.

40. Robustly investing in the expansion of the current health architecture, health and community systems, data systems, surveillance, laboratory and supply chain systems and health work forces (including those led by communities) designed to end AIDS is a smart and effective approach for helping the world prevent, prepare for and respond to pandemics to come.

41. As the international community considers important changes in the global health structures, governance and financing for pandemics, and considers a new Pandemics Accord and amendments to the International Health Regulations, UNAIDS is calling for these to reflect the core principles that drive success and reduce inequality in the HIV response. They include: a multisectoral approach that goes beyond the health sector, including human rights and gender equality capacity as a core function of tackling disease; commitments to invest in community-led responses that put people impacted by pandemics at the centre; serious commitment and systems to ensure equitable and affordable access to health technologies; and smart, sustainable financing.

42. Those of us who have spent decades building a response to the AIDS pandemic, with neither a cure nor a vaccine, have much to offer those contemplating the best approach to pandemic preparedness and response (PPPR), and to learn from others as well. And we need the PPPR agenda to help propel the AIDS response to victory, as well as ensure the world can sustain that victory into the future.

43. The work we do together to end AIDS is not only crucial for overcoming pandemics broadly, it is also essential for progress against the UN Sustainable Development Goals (SDGs).

44. The UN Secretary-General's 2023 report showed that just 12% of the SDGs are on-track; close to half, though showing progress, are moderately or severely off track and some 30% have either seen no movement or have regressed below the 2015 baseline. Here is the good news for us: one of the only examples of progress is that toward the achievement of SDG 3 on health: “To ensure healthy lives and promote well-being for all ages.”

45. Specifically, there is progress being made toward SDG 3.3 and we are within sight of the ability to end AIDS as a public health threat by 2030. This progress is also reinforcing efforts on other SDGs. So, the global AIDS response is the pathway to addressing or advancing progress on other SDGs.

46. As the UN Deputy Secretary-General said at the General Assembly’s Annual Review of HIV/AIDS: “Mid-way toward the endpoint of the SDGs, global and local inequalities are blocking progress. Ending AIDS as a public health threat is integrally linked to broader efforts on poverty, hunger, governance and access to health care for all. [It is also] linked to progress on human rights and social inclusion, from gender equality to tackling stigma and discrimination.”

47. Make no mistake. When those of us focused on ending AIDS speak about inequalities, gender issues, education or human rights, it’s because from the earliest days of our work on AIDS, we recognized that HIV is more than just a health issue; it has always required a multisectoral response and it has always yielded multiple dividends, beyond HIV—including health, social and economic dividends. The Joint UN Programme on HIV/AIDS was created to harness the collective power of the UN—galvanizing the multifaceted expertise, diplomatic efforts and in-country presence of its 11 UN Cosponsor agencies (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank) around a specific mandate to end AIDS.

48. The Joint Programme stands firmly with all countries working to achieve the HIV targets they have committed to, towards our shared goal of ending the AIDS epidemic by 2030. A key part of our resilience is the AIDS response investment in building political will. I am glad to be able to report that even with all the challenges, we have continued to engage at the highest levels of government, reminding them that despite our important progress, our work remains unfinished, particularly among children, adolescent girls and young women and key populations.

49. In the many meetings I have had in the past six months with political leaders—including Heads of State and Government (7), Deputy Heads of State; (3) Ministers (40); First Ladies (12); ambassadors, parliamentarians and former Heads of State and Government from across the world—we have discussed the current landscape and agreed on the importance of us coming together to ensure that we finish the unfinished business of AIDS.

50. We will have some powerful opportunities to collectively reinvigorate our commitment to the promises we have made to the world—and to the people we serve.

51. We will carry the message that we can end AIDS even in a polycrisis world to the UN General Assembly, the SDG Summit, the High-Level Meeting on PPPR, special meetings of the African Union, the UN Summit of the Future, and beyond. The global AIDS response is working and we must finish the fight and sustain the gains.

52. We hope you will stand strongly with us and bring others along to join us in this fight.

53. Our work to end AIDS is not easy, but it is appreciated, and it is being acknowledged in places like the Netherlands, where I recently accepted the Amsterdam Dinner Award 2023 on behalf of HIV activists, people living with HIV and UNAIDS colleagues for our collective work to end stigma and discrimination around HIV.

54. On this long journey, it is helpful to recognize that we are headed in the right direction.

State of the AIDS response: sustained progress and unfinished work

55. Which is why I also want to relay some good news. Even in the face of challenging circumstances and constrained funding, we continue to save more lives every year. This is in large part thanks to the extraordinary sacrifices so many of you and our partners around the world, especially those on the ground, make to advance the work on AIDS.

56. Our new *Global AIDS update*—to be released in July—shows that in the past 12 months, together we further reduced the number of new HIV infections and AIDS-related deaths in many countries.

57. Almost 30 million people living with HIV (three out of four people living with HIV) are accessing life-saving antiretroviral therapy.

58. Whilst we are closer to our 2025 target on connecting people living with HIV to treatment than we are on our target on prevention, the trends for both continue to head in the right direction.

59. This empirical progress across a range of countries is proof that we can end AIDS.

60. But we can only end AIDS by ending AIDS for everyone, everywhere. And we do that by challenging and closing the inequalities that drive it.

61. We have more tools than ever before. More experience. More collective knowledge. More expertise. And we have evidence we can get it done, even in particularly challenging landscapes.

62. The next step is to tackle the toughest element blocking our continued progress: inequalities.

Overcoming inequalities to end AIDS

63. While the overall rates of new HIV infections and AIDS-related deaths are declining, they are not doing so fast enough for every person, in every place. That is our challenge. This reflects the underlying disparities of movement in the right direction for many, but no progress or even increases for some. Fighting a pandemic, unchecked virus in some communities undermines the response as a whole. I am glad to report that our collective commitment to focus on inequalities is bearing fruit, but we have much more work to do.

64. Data from the Fast-Track Cities effort show that, for example, in most African cities HIV rates are significantly higher among the urban poor. For example, in South Africa HIV prevalence among the urban poor is twice that among other urban people. But in

Zimbabwe the difference is almost zero. In Côte d'Ivoire the urban poor actually have lower HIV rates.[8] This reflects the work of decades of a multisectoral AIDS response that functions well beyond the health sector—and we need to know more about what exactly is working in some urban contexts that can be transferred to others.

65. We also know that key populations, including gay men and other men who have sex with men, sex workers, transgender people, incarcerated people and people who inject drugs, are markedly more burdened by HIV than the general population.

66. As of 2021, UNAIDS key populations data show MSM have 28 times the risk of acquiring HIV compared to people of the same age and gender identity while people who inject drugs have 35 times the risk, sex workers 30 times the risk, and transgender women 14 times the risk.

67. And as we mark World Drugs Day today, let me say that punitive approaches to people who use drugs have increased health risks, including HIV risks, and have exacerbated stigmatization and marginalization. Starting instead from respect and empathy for all people has been shown to improve the health of people who use drugs, widen opportunities to address individual needs and wider social challenges, and benefit everyone in society.

68. Our data also show that some countries are making real progress in reducing inequality for key populations. Around the world, gay men are more likely than other adults to be living with HIV. In Thailand, for example, where gay men are not criminalized, their HIV prevalence is 12 times higher than the rate for other men, but in Malaysia, where gay men are criminalized, it's 72 times higher than for other men.[9] This is the result of harmful laws, policies, and social norms. Approaches that avoid criminalizing or arresting gay men, and instead support community-led efforts to empower them to meet their health needs—that is what's needed to end AIDS.

69. In another example, HIV treatment coverage in many contexts is lower among female sex workers than among other women. But in Kenya the data show this is not inevitable: three counties show equal or even higher treatment coverage among female sex workers.[10] Let's learn from those counties and spread it worldwide.

70. This is what we mean when we talk about fighting inequality.

71. In the first five years after pre-exposure prophylaxis was developed, 66% of all those accessing it were in North America and Europe. In key communities there, HIV rates fell rapidly. We advocated to get PrEP to those who needed it in the global South and I am glad to report that now 70% of all PrEP users are now in Africa. I am saddened, however, to report that the newest injectable PrEP—one advertised on billboards in the train station the last time I was in Washington, DC—remains out of reach today throughout Africa.

72. We also see sustained inequality gaps for children living with HIV, who are far less likely to be connected to lifesaving antiretroviral therapy than adults living with HIV. In 2021, three quarters of all adults living with HIV were on treatment, but only half of all children were. Only half. We are failing children. I'll talk a little later about the new

[8] Katz I, Thomson D, Ravishankar S, Otwombe K, Macarayan ER, Novak C, et al. Intersectional forces of rising urban inequality and the global AIDS pandemic: a retrospective analysis. Pre-print. (https://www.inequalitycouncil.org/wp-content/uploads/2023/06/Research-paper.pdf).
[9] UNAIDS data, https://trello.com/c/CJ58fCuf/24-fact-sheet
[10] Dangerous inequalities: World AIDS Day report 2022. Geneva: UNAIDS; 2022.

Global Alliance to End AIDS Among Children by 2030, which we launched with Cosponsors.

73. So, we have work to do. We can be even more focused on fighting inequality and we can close more disparities. When last measured, in several countries in western Africa the HIV prevalence among young women (aged 20–24 years) was over five times more than among men of the same age group. So, let's give them the option to access PrEP and combine it with education, empowerment and social change so we get to the heart of both within-country and between-country inequality.

74. We can shake our heads and keep doing the same thing and hope for a different outcome. Or we can address the structural drivers and build a pandemic response that attacks the inequalities instead of perpetuating them. We have shown in the AIDS response it's possible, but it has to be the norm not the outlier.

75. Once, the challenge of responding to AIDS was entirely scientific. Now, it is largely societal—the science is remarkable, our task is overcoming the barriers to everyone accessing that science. And of course, it has always been political—from people living with and affected by HIV mobilizing and demanding their rights, to the political commitment made within and across countries.

76. Many of the inequalities spurring today's biggest global social justice movements—those focused on feminism, racial justice, support for LGBTI rights, and beyond—are the same inequalities preventing us from ending AIDS. And, as we saw with COVID-19 and Mpox, they are also exacerbating other pandemics.

77. To deepen our work to end inequalities and to amplify it, we have started a new Global Council on Inequality, AIDS, and Pandemics. I am pleased to share that lawyer and renowned human rights leader the First Lady of Namibia, Monica Geingos, together with Nobel Laureate Economist, Joseph Stiglitz, and Sir Michael Marmot of the University College London Institute on Inequalities have agreed to co-chair this effort. They are joined by a host of global leaders, including Erika Castellanos from the NGO delegation to this PCB, Minister Nisia Tridade from Brazil, who hosted our announcement earlier this month, Jerome Solomon of the World Health Organization, Erika Placella of Switzerland, and many others.

78. The role of this council is two-fold. First, we need to dig deeper into our understanding of inequality as a cause and a driver of AIDS and other pandemics and we need to elevate this issue globally. The council will help us make these connections about the inequalities that drive AIDS and other pandemics, and why it's important for this discussion to inform global policy processes, such as the Pandemics Treaty being negotiated, such as the review of the SDGs that we are going to do in September. Some of our Council leaders will help us innovate—looking at this problem in new ways, showing us new ways of measuring, and helping us delve deep into some of the places that have seen the most success in equalizing the AIDS response so the whole world can learn. And we will identify more on the policies that are working.

79. Secondly, we will elevate this issue globally. AIDS remains a pandemic. And inequality is not only fueling AIDS but also helping outbreaks of mpox and COVID-19 become pandemics. And so our Council leaders are well-positioned to draw the world's attention to these issues. Pandemic response can be reduce inequality or exacerbate it—and as yet the world has not done nearly enough to reduce inequality. But we know we can.

80. The Secretariat is also committed to help the Joint Programme operationalize an inequalities approach through the development of a conceptual framework on intersecting inequalities and how they affect the HIV response. This is accompanied by a toolkit to help countries with detailed guidance to help them to identify, analyze, prioritize and address the key inequalities in their context that affect the response. I am happy to report that the inequalities framework has been developed in partnership with the Inequalities Institute of the University of Southern California and the support and inputs from Cosponsors and Joint Programme colleagues in countries. It is available in four languages and has been published on the UNAIDS website, and we will be working with our Joint Programme colleagues to disseminate these tools so that they are used widely. The accompanying toolkit was piloted in partnership with Cosponsors in Brazil, Cambodia, Ghana, Moldova and South Africa, and it is being adapted and refined for global roll-out.

Leveraging UNAIDS's 2023–2024 priorities to ensure maximum impact and maximum returns on country, PEPFAR and Global Fund investments

81. The world has reached the midpoint of the implementation of the Global AIDS Strategy 2021–2026.

82. To sharpen our focus and deliver results faster, UNAIDS' is focusing on four main priorities for 2023–2024. They are: (1) advancing the HIV prevention agenda; (2) accelerating access to treatment and new technologies; (3) expanding community-led HIV responses; and (4) providing equitable financing and sustaining the HIV response. Those are the four priorities around which we have organized our work. Underpinning work against all these priorities is our focus on tackling inequalities, achieving gender equality and the full protection of human rights.

83. UNAIDS's core functions support progress across all four priorities. They include: convening and mobilizing partners on the ground across sectors to catalyze targeted political and programmatic action so more people will get tested, access prevention services and get treated for HIV/AIDS; advocating for legal reforms and unlocking policy barriers hindering HIV prevention, testing, treatment and community-led responses; collaborating with countries to gather and publish the only complete set of global epidemiological and financial data on HIV to steer efficient and impactful investments to save more lives, faster; building capacity of civil society organizations leading service delivery and monitoring the HIV response; and promoting sustainable financing and advance sustainability of the HIV response.

84. I'd like to highlight some of the work we are doing against each priority.

Advancing the HIV prevention agenda

85. A renewed focus on HIV prevention is critical as new data show a continued lag of prevention efforts versus those focused on treatment.

86. UNAIDS is working to elevate prevention as a political priority within the HIV response and seeking to secure increased funding for delivering packages of combination HIV prevention that are customized to the end user.

87. Never has the opportunity to prevent HIV been greater than today. New science on long-acting prevention technology has widened HIV prevention choices and presents new opportunities alongside established, but, as mentioned, still not universally available HIV prevention options. Persistent challenges being addressed by the Global

HIV Prevention Coalition include: insufficient political leadership in many countries; a lack of adequate prevention financing; limited implementation at scale; and policy and structural barriers. To address these factors, the Joint Programme and its partners in the Coalition are committed to build a renewed prevention movement towards sustained country and community-led prevention responses.

88. We are supporting countries to remove structural, legal and policy barriers that hinder prevention scale-up, including via our Global Strategic Initiatives on, as mentioned, Education Plus, and decriminalization. Our work on the Global HIV Prevention Coalition is also helping advance progress.

89. Adolescent girls and young women continue to be left behind. That's another huge inequality. In sub-Saharan Africa, adolescent girls and young women (aged 15–24 years) are still three times more likely to acquire HIV than adolescent boys and young men of that age.

90. Every three minutes, a girl or a young woman aged between 15 and 24 years in sub-Saharan Africa acquired HIV in 2022—every three minutes—translating to 3,100 new infections every week in the region.

91. Harmful social norms, gender inequality, lack of agency and decision-making power and economic autonomy are the underlying structural barriers driving new HIV infections in this group.

92. And that's why we launched the Education Plus initiative. This global strategic initiative (jointly led by UNAIDS, UNESCO, UNFPA, UNICEF and UN Women) is designed to ensure girls complete secondary education and provide them with life skills, access to youth-friendly health services, violence-free environments and economic opportunities after school to prevent HIV, empower them and, by doing so, change the trajectory of AIDS on the African continent.

93. Education Plus serves as an important HIV prevention initiative that directly helps reduce new HIV infections in girls and young women. It continues to gain support and momentum. Botswana last week became the 15th country championing Education Plus.

94. Education Plus promotes the rights and autonomy of girls and women, contributes to the fight against the discrimination and violence which girls and women face, and supports Member States' efforts to accelerate the implementation of gender-specific economic, social and legal measures aimed at combating the AIDS pandemic by adopting various policy and legal frameworks including the AU Maputo Protocol.

95. We are seeking to expand access to combination prevention—especially for adolescent girls and young women and key populations.

96. Progress on the prevention of new HIV infections has been much slower in countries with HIV epidemics affecting key populations due to limited funding, low programme coverage and persistent legal and societal barriers.

97. HIV incidence declines in countries with HIV epidemics affecting key populations illustrated that successful responses are entirely feasible when conditions support safe, equitable and affordable access to HIV prevention for all.

98. For example, Viet Nam's report to the ministerial Global Prevention Coalition meeting in May 2023, documented a 60% decline in HIV incidence in a context of scaled-up

HIV treatment and prevention for key populations, including expanding PrEP to 68 000 people, as well as improving harm reduction policies and programmes.

99. Other examples of our work in prevention include:

- In 2023, five additional countries (Colombia, Madagascar, the Philippines, Rwanda, South Sudan) joined the Global HIV Prevention Coalition and have committed to accelerating HIV prevention in line with the 2025 HIV Prevention Road Map. UNAIDS and its partners in the Coalition will deploy joint outreach teams to develop robust and scaled prevention responses in countries with stagnating or rising HIV incidence by designing robust, well-prioritized, effective and scaled prevention response.
- The Joint Programme and its partners have supported countries in introducing and expanding use of ARV-based prevention technology by developing policies, setting targets and rolling out implementation tools. Twenty-seven of the initial 28 Coalition focus countries reported preparing for introducing new prevention technologies. The number of people ever using PrEP in 2022 increased to 2.5 million from 1.5 million in 2021. UNAIDS and partners led a global advocacy effort to accelerate introduction, reduce prices and increase equity in access to new long-acting prevention technologies.
- Through the Global HIV Prevention Coalition, the Joint Programme continues to closely collaborate with the Global Fund and PEPFAR as the main providers of international financing for HIV prevention. The Joint Programme actively supported evidence-informed prevention priorities in Global Fund applications and enhanced dialogues in support of well-aligned, sustainable and nationally owned prevention programmes focusing on key populations, adolescent girls and young women, as well as boys and men.
- To develop more precise prevention responses, UNAIDS developed risk-differentiated population size estimates of young women for 31 countries in sub-Saharan Africa and trained countries in their use for prevention planning. An updated decision-making aide for programmes with adolescent girls and young women was launched in support of Global Fund applications and national programme development in resource-limited settings.
- By the end of 2022, 34.9 million men and boys had accessed the voluntary medical male circumcision package of services in 15 priority countries since the programme's inception, with strong financial support from PEPFAR. The Joint Programme developed an expanded prevention agenda for boys and men.
- We have learned many lessons from the Fast-Track Cities project that can guide wider and expanded efforts. In Nairobi, for example, engaging the community and strengthening the capacity of health-care workers have resulted in the creation of safe environments where key and vulnerable populations can access friendly services, leading to an eight-fold increase in the cumulative uptake of HIV testing and more than ten-fold increase in the uptake of family planning services among young people between 2018 and 2022.

Accelerating access to HIV treatment and new technologies

100. Global data show uneven progress against the “95–9–95" targets that call for 95% of all people living with HIV to be aware of their HIV status, for 95% of all people who know their HIV status to be accessing lifesaving antiretroviral therapy, and 95% of those on treatment having undetectable viral loads, which helps keep them healthy and prevents others from contracting HIV.

101. Progress is uneven for different groups and it is uneven across different regions of the world. Eastern Europe and central Asia and the Middle East and North Africa both lag the rest the world in progress against the 95–95–95 targets.

102. We have seen strong responses in some of the hardest hit countries in the world. Countries such as Botswana, Rwanda, Eswatini are reaching the 95–95–95 targets ahead of 2025 and many others are moving in this direction. UNAIDS has been helping promote WHO guidelines to country implementation in improving treatment services, including multimonth dispensing, treatment optimization and people-centered differentiated service delivery through our support to the development of national HIV strategic plans, capacity building and technical support to countries (as well as assisting them in raising funding requests to promote critical areas of work). For example, we now have at least 12 countries in eastern and southern Africa with national strategic plans that explicitly address differentiated service delivery approaches for testing and treatment service that can reach populations who are left behind. As well, the promotion of multimonth dispensing throughout that region has resulted in 70% of stable patients in almost all countries receiving three months or more ARVs.

103. Community and civil society participation in HIV services is more the norm than exception in many of the hardest-hit countries. For example, community-based service delivery models like community adherent groups, clients-led ART delivery, community-drug distribution points, teen clubs etc. are used in at least 22 countries in Africa. This has helped improve treatment adherence, which in turn helped to achieve the treatment outcome indicator (the 3rd "90"). All nine countries which have achieved 73% viral load suppression in 2021 among people living with HIV have had adopted the differentiated service delivery approach.

104. Community-led monitoring, as a revitalized and reimagined community-driven monitoring intervention, has gained momentum in recent years. It mobilizes communities affected by health inequalities to monitor how services are provided and co-create solutions with key partners to improve them. In the Democratic Republic of Congo, a community-led monitoring observatory on the quality of care for HIV and TB contributed to a drastic reduction in medicine stockouts—from 95% at the beginning of 2019 to 5% in December 2019. In Côte d'Ivoire, community-led monitoring data showed that user fees prevented people living with HIV from accessing antiretroviral therapy, even when the medicines were free, because they could not afford to pay for doctors' visits, treatment for minor infections and diagnostic tests. After the community-led monitoring implementer Réseau Ivoirien des Organisations de Personnes Vivant avec le VIH/SIDA (RIP+) shared its findings with the Ministry of Health and PEPFAR, the Government issued guidance that all HIV testing and treatment services in the country be free of charge.

105. One acute inequality in HIV treatment that I mentioned earlier is the fact that children living with HIV are far less likely to access lifesaving treatment than adults.

106. This is why the Joint Programme launched the Global Alliance to End AIDS among children by 2030, together with WHO and UNICEF in the lead.

107. The Alliance, launched in February 2023 in Dar es Salaam, aims to garner commitment to end AIDS in children from ministers of health of 12 countries with some of the highest numbers of children living with HIV. With support from technical partners, eight countries (Angola, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Nigeria, Uganda, United Republic of Tanzania and Zambia) have integrated peer-reviewed, tailored, prioritized action plans into their Global Fund cycle 7. In addition, PEPFAR

has been wholly supportive and has integrated into their COP-23 processes the country action plans generated through Global Alliance support to countries.

108. As technical partners we have established regional hubs in eastern and southern Africa and in western and central Africa, which serve to analyze technical support needs as countries implement their plans. We have formed technical working groups that bring together existing initiatives to ensure accessible testing, optimized treatment and comprehensive care for infants, children, and adolescents living with and exposed to HIV, and to address rights, gender equality and the social and structural barriers that hinder access to services.

109. Many of the newest health technologies are still not available to those most in need.

110. UNAIDS welcomed the announcement by Medicines Patent Pool and ViiV of three licenses signed with generic manufacturers Aurobindo, Cipla and Viatris for long-acting cabotegravir for PrEP. PrEP reduces the risk of HIV acquisition during sex or injecting drug use. UNAIDS also called for urgent action by ViiV to be taken to reduce the price and increase the production of injectable long-acting PrEP immediately.

111. The generic production of affordable long-acting injectable PrEP is essential to prevent millions of new HIV infections. The progress made is a testament to the power of campaigning communities, who have mobilized to demand long-acting medicines, and to the determined efforts of access to medicines advocates.

112. UNAIDS thanks ViiV for the commitment to technology-sharing made through these agreements, and urges all patent holders of long-acting HIV medicines, including those still in development, to commit to share, and make their technology available, immediately. UNAIDS hopes that this is only the first announcement of licensing, not the last, and urges ViiV to expand the geographic coverage of the licensing to all low- and middle-income countries. Because it will take several years for generic production of these medicines to come on-line, UNAIDS also urges ViiV to immediately provide its own production of long-acting injectable PrEP to procurers at an affordable price and in volumes that match need. We must all be driven by the fierce urgency of now.

113. The deployment of new technologies such as long-acting injectable PrEP at an affordable price is urgent and will help fill critical HIV prevention needs for people facing the highest HIV risks. It is also welcomes that one of the sub-licensees (Cipla) plans to manufacture in South Africa, in addition to India. This is an important step in support of increased local manufacturing of medicines in Africa.

114. UNAIDS acknowledges this concrete step towards generic production of needed innovative products, but urges that short-term solutions be put in place immediately and until generic products are widely available. UNAIDS is notably concerned with the recent announcements that current supplies of long-acting injectable PrEP are not at all sufficient to meet growing demand and are much less than procurers have said they could purchase. Transparency in sharing information on volumes and prices by ViiV of long-acting injectable PrEP is essential to help drive progress in increasing volumes.

115. It is vital and urgent that long-acting antiretrovirals for PrEP be made available at an affordable price everywhere they are needed. Middle-income countries are now where the majority of new HIV infections occur and are home to many of the key populations most at risk of HIV transmission and who most need access to long-acting ARVs. But many countries are not included in this license despite considerable need for affordable new health technologies.

116. The issuance of these three licenses should pave the way for sharing technology on other innovations for long-acting HIV prevention and for long-acting treatment. UNAIDS urges that licensing help develop a path for accelerated market entry of generic formulations of long-acting antiretrovirals not only for prevention, but also for treatment, when normative guidance is established, and regulatory approvals are in place at country level.

117. UNAIDS calls on the private sector, governments and funders to ensure that everyone who needs long-acting antiretrovirals can access them. UNAIDS will continue working with the Coalition to Accelerate Access to Long-Acting PrEP, which is jointly convened by the Global Fund on AIDS, TB and Malaria, PEPFAR, Unitaid and WHO, with AVAC as its secretariat, to find solutions and ensure equitable global access to pandemic-fighting technologies for all.

Expanding community-led HIV responses

118. The Global AIDS Strategy 2021–2026 recognizes that communities living with and affected by HIV are central to ending AIDS by 2030. The Strategy calls for commitments to the expanded role of communities to ensure more effective responses, especially for people in need of HIV prevention and treatment services who are most underserved.

119. Community-led AIDS responses are vital for addressing stigma and discrimination; providing treatment education and adherence support and prevention interventions; supporting differentiated service delivery; and reaching all people who need those services. People living with and affected by HIV are fundamental to the AIDS response, and their leadership is essential for achieving transformational ways of reaching and serving people.

120. At our last PCB meeting, we considered the first international definition of a community-led response to a pandemic, published after a two-year consultative process that brought together 11 governments, representing each region of the world, and 11 civil society representatives.

121. The agreed definition of a community-led response is: "Actions and strategies that seek to improve the health and human rights of their constituencies, that are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them."

122. New international definitions and recommendations related to community-led responses can help planners and funders for AIDS and other pandemics identify the elements of an effective community response. Community-led organizations—defined as "groups and networks, whether formally or informally organized ... for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and who have transparent mechanisms of accountability to their constituencies”—form a backbone of that response. Crucially, it is noted that "not all community-based organizations are community-led”.

123. As a critical part of the AIDS pandemic response, community-led responses must be prioritized in resourcing. They are also key for tackling other pandemics and for preparing for the pandemics to come.

124. This is why we call for the inclusion of comprehensive “community pandemic infrastructure” in pandemic prevention, preparedness and response efforts. A strong

community infrastructure, working synergistically with government, is a necessary but neglected element of pandemic prevention, preparedness, and response.

125. Community-led organizations bring trust, they open and offer communications channels, and they reach marginalized groups in ways that complement government roles and improve equity. Their unique outreach, trusted voices who can speak to excluded communities, independent accountability mechanisms, and participation in decision-making are essential for ending AIDS and other pandemics.

126. UNAIDS will continue to request that community infrastructure is intentionally enabled, strengthened, monitored, and resourced. To do the latter, we must develop better systems for financing community-led organizations, which often face legal, capacity and eligibility barriers to national and international financing mechanisms. We must also build capacity for community-led monitoring, and integrate data generated by community groups into response management.

127. Community responses to HIV must be integrated at all levels of countries' AIDS strategies, including planning, budgeting, implementation, monitoring and evaluation.

128. Some specific, recent examples of an effective community-led response include:
    - in Thailand, key-population-led health services have reached people at increased risk of HIV, achieving among the most equitable HIV responses in the region;
    - in South Africa, community leaders with Ritshidze, which represents people living with HIV, visit clinics and communities to assess COVID-19, HIV, and tuberculosis services and hold administrators accountable for addressing issues such as long waiting times or confidentiality gaps that keep some people away from health services; and
    - amid war, Ukraine's 100% Life, a network of people living with HIV, is using peer networks to communicate with displaced people, delivering medicines, food, and emergency assistance.

Promoting equitable financing and sustaining the HIV response

129. I want to share with you our commitment to work with Governments, Cosponsors, key partners and civil society to secure a sufficient and equitably financed AIDS response, and to support the most efficient ways of investing scarce resources.

130. This translates into action at regional level, especially in eastern and southern Africa, in collaboration with the African Union, the Southern African Development Community SADC, and with the East African Community, the Africa Union Development Agency and the Global Fund. As part of the Africa Leadership Meeting initiative, UNAIDS is joining forces with those actors, to strengthen collaboration at country level. We partner on health financing dialogue because, while the AIDS response exceeds the health sector, it requires robust health systems to be sustainable in the future, and the magnitude of AIDS-related investments can operate as the backbone of parts of stronger health systems.

131. We are close to signing a memorandum of understanding with PEPFAR and the Global Fund on data-sharing and resource alignment, because the financial data of governments, which UNAIDS collects, together with those from PEPFAR and the Global Fund, can facilitate a very precise reading of the gaps and opportunities for efficiencies. And is also essential for a better planning for a sustainable future for the response, which will require a progressive move towards increased domestic political and financial leadership in most countries.

132. In February we held a first dialogue co-hosted by African Union, PEPFAR, UNAIDS and the Africa Union Development Agency on the sidelines of the African Union summit focused on health financing and sustaining action to end AIDS and related communicable and non-communicable diseases. African Member States agreed to the convening, by no later than July 2024, of an Extraordinary Session on ending AIDS and addressing preventable maternal deaths, communicable and noncommunicable diseases endemic to the continent, and strengthening health systems by 2030.

133. For UNAIDS, ensuring long-term sustainability beyond 2030 is one of our main priorities, and we want to use the immediate period, as well as opportunities such as the sustainability road maps PEPFAR is planning or the broader health financing national and regional dialogues, to advance steps towards the most equitable and sustainable response to secure political, programmatic and financial sustainability of the HIV response.

134. Ensuring affordable access to the right medicines is also a must for us. We are an active member for the coalition for the introduction of long acting health technologies, which is focusing for now on the introduction of long-acting injectable PrEP. Our approach is ensuring the fastest possible introduction of new products -including others such as the vaginal ring- at a price that can be affordable. At current prices under consideration, we fear countries will either not be able to opt in unless fully funded by donors, or will need additional financing for the purpose.

135. Global trade rules are obstructing low- and middle-income countries' regional production of pandemic-ending medicines, including new and emerging health technologies such as the daviripine ring and long-acting injectable antiretroviral medicines, and keeping prices unaffordable for these countries to procure at scale. At a time when funds are tight, the best, new, game-changing tools for HIV prevention and treatment remain out of reach for those who could benefit from them most.

136. We are actively advocating for an increased local production, with African leadership, building on existing initiatives as those in Kenya, Senegl or the mRNA hub in South Africa. We believe the potential to produce some medical products in Africa is immediate, and we believe that the industrial, medical and economic benefits of increased local production are extensive. We also require the African Free Trade Agreement to advance steadily and ensure a market size that is adequate and subregional hubs to emerge.

137. Finally, while we are calling on donors and governments to fully fund the AIDS response, and as we are aware of the tight fiscal conditions, we are pushing to get resources from debt relief actions that should happen soon, or through SDR reallocations and new blended instruments. Health and HIV need to be part of the next generation of financial instruments.

Closing Inequality gaps in humanitarian crises

138. Assuring minimal life-saving services for health and HIV, specifically for the most vulnerable people in the context of humanitarian crisis situations, is absolutely urgent. I am calling on the Board to address the need for specific resources on HIV to ensure access to services and treatment remains a critical part of the fundamental human rights of internally displaced people and refugees. Some highlights below:

- In Malawi, UNAIDS supported refugees in Dzaleka camp, as well as internally displaced persons affected by cyclone Freddy in six districts, with prevention awareness activities and provided HIV testing and treatment services.
- In Mozambique, UNAIDS implemented a training for the National AIDS Council and civil society organizations on the HIV response in humanitarian settings, based on the IASC guidelines; successfully advocated for the integration of an HIV-related indicator in the Humanitarian Response Plan; strengthened coordination of provincial AIDS councils; and supported civil society organizations in Zambezia province.
- In Rwanda, UNAIDS, in collaboration with partners operating in camps, provided HIV services (including testing, linkage to care and treatment and viral load testing to monitor the response to treatment). Thanks to UNAIDS advocacy, the relevant government stakeholders ensured the uninterrupted supply of HIV commodities, and enabled testing, timely treatment, and viral load testing free of charge. In addition, strengthening of an operational partnership with the International Organization for Migration is underway.
- In Uganda, UNAIDS worked with networks of traditional healers and communities of religious leaders to encourage their networks to go to health-care facilities for treatment. The UNAIDS Country Office also provided support for data collection through community monitors to ensure that the decisions that were made on Ebola were in line with the needs of the communities. In addition, emergency food ratio were provided to people living with HIV in the drought- and conflict-affected area of Karamoja.
- In Chad, with the recent inflow of Sudanese refugees, UNAIDS facilitated discussion with the Global Fund through the Principal Recipient for special support to refugees in the eastern part of the country, including provision of bed nets, drugs and prevention materials.
- In Burkina Faso, support to community organizations for testing, linkage to treatment for displaced children and adolescents in the zones welcoming internally displaced persons (in the periphery of Ouagadougou, the Central and Eastern Central region, and the Mouhoun region).
- In Mali, sensitization of 1,400 refugees and 1,988 internally displaced persons through information programmes focused on prevention and care services for HIV and COVID-19 at the Faladje and Senou sites in Bamako. In Kayes, sensitization of 2,000 refugees and 3,000 internally displaced persons through information programmes focused on prevention and care services for HIV and COVID -19.
- In Cameroon, UNHCR facilitates linkages between health services and refugee people living with HIV for access to ARVs, supporting pregnant women living with HIV and breastfeeding (and their babies) for continued access to HIV services where needed.
- For Ukraine, a crisis response platform (hosted by WHO) enabled coordinated actions by key stakeholders to ensure continued access to HIV/TB/OAT services by people living with HIV and key populations residing in government-controlled areas.
    - WHO carried out a comprehensive review of 2020-2030 national HIV, TB, viral hepatitis and opioid agonist therapy programmes;
    - In 10 cities affected by the war, 29 government and community-based HIV service providers received essential support to ensure continuity of HIV prevention, care and support services among internally displaced people living with HIV and key populations;
    - The World Food Programme, in collaboration with 100% Life (the Ukraine Network of people of living with HIV) provided food packages and/or vouchers

to 210 000 people living with HIV and tuberculosis and people from key population groups .

- UNICEF delivered HIV testing kits for nearly one million people, including pregnant women and HIV-exposed children, as well as HIV viral load testing kits for 200 000 people (through the Global Fund emergency grant.).
- Access to sexual and reproductive health services was sustained with the distribution of emergency maternity and reproductive health kits, including HIV and STI treatment supplies in 50 referral-level maternity hospitals in all 22 regions of Ukraine; and more than 1,300 health-care providers and health managers from primary and secondary facilities completed an intensive training programme on sexual and gender-based violence.

Transforming the UNAIDS Secretariat to deliver on the Global AIDS Strategy 2021–2026

139. The Secretariat has undergone its most ambitious change agenda since we started operations in 1996. Our new structures are enabling us to more effectively engage and unite efforts across the Joint Programme. The CCO Global Coordinators' retreat in March and the CCO Principals' meeting in April were both important and successful moments for unifying the Joint Programme.

140. The reconfiguration of our Senior Leadership Team was completed earlier this year, and the positive impact of our two new Deputy Executive Directors is appreciated both by staff and partners.

141. We are continuing our internal transformation agenda to achieve an equal, safe and empowering workplace, one that is underpinned by feminist leadership principles that are aligned to and supportive of the Global AIDS Strategy.

142. With these changes, UNAIDS is positioned strongly for the future—and is poised to be able to achieve its highest impact in support of countries and communities to help advance progress toward our shared goal of ending the AIDS as a public health threat by 2030.

143. We set out in our change agenda to achieve five things: (1) align ourselves with the Global AIDS Strategy in order to achieve our highest impact; (2) become financially sustainable and more cost effective; (3) increase diversity and inclusion and therefore be more legitimate and credible on the ground where we work; (4) become knowledge-driven and capable of optimizing our world-wide expertise and staff; and (5) align ourselves with UN reform, including within the work on pandemic preparedness. I'm happy to tell you that we have achieved against all five objectives as we look back at how we have changed ourselves.

144. In my last report to the PCB, at our December 2022 meeting, I outlined a number of our alignment outcomes and the shifts in the profile of our workforce. This includes a 9% reduction in core-funded posts, a 10.6% reduction in our annual core staff budget—reductions that have touched our work across all regions. We have reduced our footprint in Geneva by some 90 positions and have moved global units from Geneva to Bangkok, Bonn, Johannesburg and Nairobi, leaving a small workforce in Geneva.

145. We have done everything possible to reprioritize and bring down our costs through this exercise. While these difficult changes are necessary for future-proofing UNAIDS and ensuring our sustainability, it is very, very painful letting so many talented people go, who have served UNAIDS and the AIDS response with distinction. I want to recognize

the tremendous commitment of our colleagues around the world. Our people are passionate and driven—by what it takes to protect people from HIV infection, ensuring people have the services they need and that governments have the resources required to drive progress towards their goals and targets. We know that staff are experiencing heavy workloads as a result of this change; they work hard to deliver and meet expectations even with this smaller workforce. And we are working hard as management to ease that burden.

146. Last year we began the process of setting up UNAIDS's Global Centre office in Bonn. We are pleased to share with the Board that last week we received confirmation from Germany that the UNAIDS office hosting vital functions is now formally established in Bonn. UNAIDS can now operate from Bonn with the same privileges and immunities that are accorded to other UN organizations. We are grateful for the financial and in-kind support we have received from the Government of Germany for setting this up. By the end of this year more than 45 staff members will be based there.

147. As we move forward with our transformation, putting our new structures to work, we are socializing our efforts to become a bold, knowledge-driven, networked Secretariat––building our workforce and strengthening our strategic value-add. This requires both hard skills and soft skills, and we are executing on both fronts. We are moving in a phased manner, and Cabinet has identified four key approaches during this stage:
    - knowledge-sharing to better harness the experience and expertise of staff across the board, in real time, in support of countries and communities;
    - equality and inclusion to apply our feminist principles on shared power, for example through matrix management and stronger collaboration;
    - influencing for change and elevating our advocacy efforts for more strategic impact; and
    - effective partnerships, creating a win-win environment that drives results.

148. We are advancing on our culture transformation journey, becoming a more equal, safe, and empowering workplace, aligned with feminist and anti-racist practices. More teams, including us in the Cabinet, have developed our team value charters. These are important discussions, because they are about how we work together and how we commit to each other as colleagues.

149. We have implemented a second Global Staff Survey, helping us with our collective understanding of how staff feel about their teams, leadership, the work culture, and progress on areas of concern since the 2020 edition of the survey. I established these surveys when I joined UNAIDS, benchmarked with 11 other organizations within the UN and beyond. It is a tool to empower our staff to directly voice their concerns and opinions and provides us with a data-driven way of identifying challenges and setting goals for organizational change and growth. The survey shows that our colleagues are dedicated to the mission of the organization and feel a strong sense of personal achievement from UNAIDS's work. More than 80% of respondents trust their managers and are confident that the leadership of their office or team contributes to its success. However, there were some tough, humbling messages. In particular, trust in Cabinet, change management and the alignment process is low, especially among staff most impacted by alignment decisions. We have developed action plans for implementation in 2023 and will keep checking in with our staff to track progress. I am pleased that these efforts are being undertaken in collaboration with our UNAIDS Secretariat Staff Association.

150. Within the area of financial reporting, we are pleased to note that the External Auditor issued an "unmodified" or clean opinion on our financial statements for the financial

year ending 31 December 2022. In relation to—and reflecting our enhanced efforts to promote compliance—we are pleased to also note significant progress with regards to External and Internal Audit recommendations.

151. Risk management continues to evolve, supported by a reinvigorated Risk Management Committee and increased inputs from senior management. To ensure continued progress, extra efforts are being made to ensure UNAIDS risk management processes and registers are compatible with the new WHO enterprise resource planning planned for 2024, the in-built functionalities of which will support the evolution of our risk management approaches in line with the UN High-Level Committee on management's risk maturity framework.

152. On ethics and oversight, I want to express my appreciation to our Ethics Officer, for her important work to provide staff and other personnel with a safe space to seek confidential advice and support, to promote a culture of ethics, and to help us uphold the highest standards of conduct across our activities. I also want to commend the Chair and members of the Independent External Oversight Advisory Committee for their report and the valuable engagement and advice provided to my senior team, and also to you, the Board.

153. With the PCB's support, we have put in place important building blocks of strengthened capacity and systems for management accountability, including the actions taken since 2019 as part of implementing our Management Action Plan. We have continued to strengthen our policy frameworks, including the adoption of a new policy on preventing sexual misconduct, and an updated policy on protection from retaliation will be issued shortly. It is timely to look at how we have invested here, including in the context of wider UN System efforts. We are commissioning an external expert review that will identify the needs and opportunities to further strengthen our overall safeguarding procedures and culture.

154. I am concerned about ongoing challenges, in particular the slow pace of investigations. We depend on WHO for our investigations and I am now beginning to look for other options, as well, if we do not get an improved performance on the pace of investigations. Justice delayed is justice denied, particularly in the case of sexual misconduct. It is a concern shared by our staff association, and one of the issues we discussed at our recent meeting. UNAIDS management is committed to implementing a framework that ensures UNAIDS meets its responsibilities to its personnel and to the members of the communities we serve, and I look forward to keeping you appraised of our further actions.

155. I would like recognize our new Director for IT (or what we intend to call Digital and Technology Solutions), Ingrid Regien. A national of the Netherlands, Ingrid had held a number of senior IT and communications roles, most latterly as director of IT and chief information officer at Vrije University in Amsterdam, and formerly as chief information officer at UNESCO. She arrives at an important point as generative AI and cybersecurity dominate our headlines. The constantly evolving threat landscape and the increasing sophistication of cyber-attacks make it imperative for all organizations to adopt a proactive approach to cybersecurity. UNAIDS has taken measures to increase our security posture by investing in new tooling, outsourcing security services and by working on user awareness, however further investment will be needed.

Financing the Joint Programme

156. In a moment when international solidarity and a surge of funding is essential for ending AIDS, too many high-income countries are cutting back resources for overseas development assistance for health and HIV. Funding for global health is under serious threat and developments in exchange markets, leading to currency fluctuations, are aggravating the situation.

157. In 2021, international resources available for HIV were 6% lower than in 2010. Overseas development assistance for HIV from bilateral donors other than the United States of America (USA) plummeted by 57% over the last decade. Funding for HIV responses in low- and middle-income countries totaled US$ 21.4 billion in 2021, nearly US$ 8 billion short of the target of US$ 29 billion annual funding by 2025. Member States are urged to increase domestic and international donor allocations for the AIDS responses of low- and middle-income countries to enable funding to reach US$ 29 billion annually by 2025, including greater investments in HIV prevention and societal enablers, as set out in the 2021 Political Declaration, and to support sustainability through appropriate integration of HIV-related needs into broader health and development budgets.

158. You know of our own funding challenges at UNAIDS.

159. Since my last report to the PCB in December 2022, UNAIDS' financial situation continues to be of concern.

160. The reduction in funding to multilateral organizations from Sweden has had a significant effect on the Joint Programme, as well as on other UN agencies.

161. We are expecting a serious shortfall of US$ 51 million against the approved core budget of US$ 210 million for our 2022–2026 Unified Budget, Results and Accountability Framework (UBRAF), or a shortfall from the lowest threshold of US$ 187 million of some US$ 26–27 million. We are working hard to close this financial gap, and we deeply appreciate our partners who are already helping us.

162. It is important to note that UNAIDS's decision to identify a lower threshold for funding was not intended to signal that US$ 187 million was sufficient support for the work required by UNAIDS to end AIDS—it is not. It was a temporary, stop-gap measure.

163. We ended 2022 on a positive note, with increased commitments from the Netherlands, the USA, the United Kingdom and Australia, and a new commitment from Spain. We thank these member states again for their support.

164. We are starting to see positive momentum as we implement our new resource mobilization strategy with the support of our partner countries. We have welcomed new commitments from Côte d'Ivoire and Equatorial Guinea. We thank them very much for that strong solidarity. I am glad to report that we have passed an important step, the pillar assessment of the European Commission, towards establishing a direct partnership with the European Union.

165. This is the kind of vision and commitment we need from all Member States and partners if we are going to end AIDS by 2030.

166. We will present our 2024–2025 Workplan and Budget to the PCB for your approval.

167. As our staff represent the greatest contribution and investment for delivering our programme of work, let me come back to the alignment. I've spoken to the five

objectives, directed towards aligning us with the new strategy. We also recognized that we needed to be a flatter structure and to live within a more realistic and sustainable budget envelope.

168. To be as effective as we can, we have cut US$ 10–12 million in staff costs (more than 10% of our total staff costs). We've done our best to maintain country presence. That's where it matters the most. But to reduce costs, we had to make tough decisions, including:
    - a decline in total core-funded staff positions from 723 to 658 posts;
    - a 40% reduction in our footprint in Geneva to roughly 20% of total staffing;
    - a cut in our operations capacity in the region of 25%;
    - a 35% reduction in our higher-level P5 staff ,from 132 to 85.

169. These changes were felt everywhere—in the Global Centre and in regions and in countries.

170. We planned to close four country offices: Djibouti, Equatorial Guinea, Eritrea and Laos. Equatorial Guinea has since provided resources to enable us to continue our operations there.

171. We have started recruiting HIV adviser positions within the Resident Coordinator's office in five countries (Congo, Ecuador, Fiji, Gabon and Guyana), and we intend to evaluate it as a possible sustainable model for the future to support Joint Teams on AIDS in certain contexts.

172. We have increased our multi-country model to ten countries, providing support to a further 21 countries. One UNAIDS Country Director may be managing as many as four countries.

173. In 27 of our Country Offices, we are now down to one or two staff, which in some cases is limiting our ability to be fully responsive to the needs of countries and communities, despite the dedication of our people.

174. Even with these changes and cost reductions, we were required to take additional actions as we faced further cuts in funding through 2022, as well as exchange rate losses. These together with the implications of the war in Ukraine led to the following further changes:
    - a reduction in financial support to the Cosponsors and their work;
    - a reduction in the activity budget of the Secretariat, which, in combination with reductions to Cosponsor funding, undercuts our normative work, our technical assistance and our leadership work;
    - we established travel ceilings, which limited our convening, representation and advocacy work;
    - we had further operational cuts, such as office space; and
    - we have frozen 35 positions (that's 5% of our staff) temporarily—which, despite prioritization, still have profound effects: 5 country-level strategic information posts, and 7 country posts helping with prevention and treatment programme scale up, are among those posts.

175. Since we last met, we have had to consolidate our regional support structures, closing our Regional Support Team office in Cairo. First line support to the five UNAIDS Country Offices in the Middle East and North Africa is now being provided by our

Regional Support Teams in Dakar and Johannesburg.

176. Excellencies, it is not possible to make further cuts to go below US$ 160 million. We have exhausted all options for achieving greater efficiency in our delivery. There is no scope for “doing more with less”. Further reductions of, say, US$10 million, if I can be illustrative, if we were to cut another $10 million, would mean something like:
    - removing the equivalent of the entire Secretariat workforce from Asia-Pacific region;
    - halving the country envelopes; or
    - halving the core allocations to the Cosponsors again

177. All this is just unimaginable.

178. We are continuing to deliver because of the commitment of our staff in the Joint Programme but we are concerned about workloads and overstretching our people. This has been a top concern raised by our staff association, as you will also hear during this meeting.

179. Fully funding the UBRAF at the agreed level of US$ 210 million would allow us to regain our capacity and activities, fulfilling our global leadership role and optimally supporting countries and communities, as well as our critical work that we do together with PEPFAR and the Global Fund to enable that huge funding to achieve its highest impact.

Stronger together—UNAIDS, PEPFAR and the Global Fund

180. We are grateful to many of you at this meeting who stepped up to make the 7th Global Fund replenishment a success. While we didn’t reach the goal of US$ 18 billion, we raised more money than ever before for the Global Fund. I want to recognize the diverse coalition of advocates who are working hard to similarly defend PEPFAR and its budget. Thank you for your relentless solidarity.

181. 2023 marks a momentous milestone. Twenty years ago, US President George W. Bush and the American people launched PEPFAR, the greatest single, bilateral contribution made by any country towards ending AIDS. It was a pleasure to meet with President George W. Bush earlier this year at an event in Washington with the Bush Institute to mark this important anniversary for PEPFAR. And it was an honour to thank—in person—the American people who make PEPFAR’s life-saving work possible.

182. Over two decades, PEPFAR has contributed more than US$ 110 billion to fighting AIDS around the world. The legislation governing PEPFAR was reauthorized in 2008, 2013 and 2018, with strong bipartisan support. PEPFAR’s legislation is currently under review by the US Congress.

183. With the lives of tens of millions of people hanging in the balance, the continued strong support from the US Government and the US Congress is critical. We support this reauthorization of the PEPFAR legislation.

184. As President Bush said of the programme at its inception, PEPFAR is an “act of mercy beyond all current international efforts to help the people of Africa".

185. His statement was prescient; the contributions of the American people through PEPFAR have saved entire generations that would otherwise have been lost.

186. UNAIDS's work remains essential for ensuring investments to fight AIDS by countries themselves, by PEPFAR and the Global Fund deliver maximum impact and returns.

187. Working with communities and countries, UNAIDS gathers and publishes the only set of global epidemiological and financial data necessary to guide an efficient and effective response to AIDS. The data help guide the strategies of PEPFAR and the Global Fund to save the most lives, as quickly as possible.

188. UNAIDS and its offices on the ground around the world are integrally involved in PEPFAR's Regional and Country Operational Planning processes. The work UNAIDS does directly with 139 countries to help them develop epidemiological models allows them to better understand, and address, their national AIDS epidemics. This insight informs PEPFAR's strategic engagement with each country in which they operate and, importantly, its investment in the people serviced.

189. In line with PEPFAR's new five-year strategy and the Global AIDS Strategy, UNAIDS has actively contributed to the PEPFAR COP/ROP 23 process at global, regional and country level(s) by providing leadership and strategic engagement in the following areas:

- Convening and mobilizing partners on the ground across sectors in all 55 PEPFAR-supported partner countries and others;
- catalyzing targeted political and programmatic action to advance the HIV/AIDS response;
- advocating for law reforms/policies at country level that hinder progress on HIV prevention, testing, treatment, and community-led services;
- supporting countries to use data to help inform smarter, more effective investments in the response; and
- serving as an objective entity and mechanism to best support community-led monitoring of the HIV response and facilitate the sustainability agenda for the HIV response.

190. UNAIDS supports countries throughout the Global Fund grant cycle from the development of funding requests through to implementation to help enable an effective HIV response. This results in stronger, and increasingly more national and local, Global Fund implementers, stronger CCMs and other decision-making platforms, and more meaningful and active engagement of people living with HIV, key populations and communities.

191. Quality improvements on areas UNAIDS has prioritized: data, HIV prevention, community-led service delivery, human rights and gender.46 of HIV and joint HIV Global Fund applications submitted in Grant Cycle 7 Window 1 and anticipated for Window 2 received technical support from UNAIDS for a total funding of 5.7 billion USD (85% of eligible countries.

192. UNAIDS provided key capacity building support to country stakeholders to enable them to convene and strategize on priority areas for their funding requests. This important step in the GC7 planning process was done by holding three regional workshops (together with the Global Fund, Cosponsors, and other technical assistance providers) for countries, including civil society, in sub-Saharan Africa and Asia and the Pacific.

Conclusion / call to action

193. Those of you at this meeting can steer the AIDS response through its final stages, arguably some of the most difficult, politically delicate, nuanced—and rewarding—work to date. By doing so, you help position the world to effectively prevent, prepare for and respond to other pandemics to come.

194. By investing in the end of AIDS—and in UNAIDS to help get us there—you simultaneously advance progress against multiple SDGs and advance global health and development. As we have seen in several countries, you can do it despite some of the biggest, concurrent challenges the world has ever faced.

195. To end AIDS, we need renewed global solidarity and the resources necessary to end the inequalities that drive it.

196. With just two years to achieve the 2025 targets capable of putting the world back on course to end AIDS, UNAIDS needs to intensify and accelerate, not limit and slow, its efforts.

197. Urgent action—and a fully funded UBRAF—-are required to reach our goal of ending AIDS as a public health threat by 2030 and ensuring that countries can sustain that victory into the future.

198. By fortifying the system built to end AIDS, we enhance the world's capacity for global health and pandemic prevention, preparedness and response. And, all we do to end AIDS helps to achieve the SDGs broadly.

199. We must ensure the AIDS response is as powerful as the challenges it will inevitably continue to face so we can deliver on our promise of ending AIDS by 2030, which is only possible if we reach everyone, everywhere.

200. Thank you.

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