UNAIDS 2025

Strategic Data to Accelerate the HIV Response

Global consultation

Contents

Executive summary

The Global Consultation on Strategic Data to Accelerate the HIV Response, held virtually from 16–18 September 2025, convened global, regional and country stakeholders to assess the current state of HIV data systems and disscussed recommendations for sustaining and strengthening HIV data systems through 2030 and beyond. The consultation was structured around three thematic days: (1) considerations for prioritizing HIV data sources; (2) addressing data challenges, innovations, and factors that help country informed HIV data frameworks to be actionable and successfully implemented; (3) exploring community led monitoring, governance, and ethics.

At the end of 2024 with the number of people newly acquiring HIV and dying of AIDS-related causes were at their lowest levels in 32 years, and several countries achieving the globally endorsed 95-95-95 targets, the HIV response is entering a phase where sustaining the previous progress made is critical. However, declining HIV incidence has resulted in difficulties in measurement, reduced donor funding, and emerging health priorities pose challenges. The consultation aimed to identify essential HIV data sources, best practices, and strategies for sustaining HIV data systems and surveillance such as country ownership, governance, and integration with broader health systems.

Key Themes and Findings

1. Considerations to inform data decisions for prioritizing investments for data sources

Notable differences between concentrated and general HIV epidemic essential data needs were acknowledged. There was consensus on the need for sustainable, locally adaptable data systems that empower decision-makers and reflect the realities of the epidemic.

2. Prioritization of HIV Data Sources

Routine program data emerged as the most prioritized data source across all resource scenarios. Use of sentinel surveillance, viral load metrics, and community-led monitoring were emphasized as critical for tracking progress and guiding interventions.

3. Country Experiences and Innovations

Presentations from Cambodia, Malawi, Rwanda, Uganda, and highlighted diverse approaches to HIV data collection. Innovations included modified biobehavioral surveys (BBS-Lite) (Cambodia), scannable paper registers (Malawi), institutionalized technical capacity, governance and analytics fellowships (Uganda), and digital integration with Civil Registration and Vital Statistics (CRVS) (Rwanda). These examples underscored the importance of sustainability, adaptability, and local capacity for technical and human resources.

4. Community-Led Monitoring (CLM)

CLM was recognized as a core strategy for real-time information, early warning, and accountability. It empowers communities to identify service gaps and influences national responses. Integration of CLM into national systems and recognition of community-generated data as valid and essential were strongly supported.

5. Data Governance and Ethics

Robust data governance frameworks are needed to ensure safe, equitable, and ethical use of HIV data. Principles of protecting individuals, promoting health values, and prioritizing equity can guide the full data lifecycle. Ethical surveillance, especially in politically sensitive contexts, requires transparency, informed consent, and community engagement.

6. Integration with Broader Health Systems

Strategic integration of HIV data with systems for hepatitis, maternal and child health, noncommunicable diseases, sexually transmitted infections, and tuberculosis was widely embraced by meeting participants. A phased approach, maintaining confidentiality and data granularity, was considered prudent. It was widely considered important that integration efforts support bi-directional data flow and alignment.

7. Sustainability and Financing

Countries can work to strengthen domestic resource mobilization, institutionalize financial tracking, and build local technical capacity. Recommendations included co-financing models, earmarked taxes, and partnerships with academia and regional bodies to support long-term viability of the HIV response.

Countries have different needs, priorities, and capacities and are at different stages of reaching an ideal HIV data ecosystem, the following recommendations, however, can apply to most, if not all situations:

- Institutionalize routine, sustainable HIV data systems
- Use data to identify gaps and adjust national responses
- Integrate community led monitoring into formal monitoring of the HIV epidemic
- Strengthen data governance, legal frameworks, and ethical standards
- Promote strategic partnerships and regional collaboration

This report provides a foundation for shaping the future of HIV data, ensuring that data systems remain responsive, inclusive, and resilient in the face of evolving challenges.

Background

The global community is committed to ending AIDS as a public health threat by 2030. In 2024, global estimates yielded the lowest levels of new HIV infections and AIDS-related deaths in 32 years. At least seven countries have achieved the globally endorsed 95-95-95 targets, with more nearing them. The HIV response is entering a phase where sustaining and building on recent gains amid shifting health and development priorities is critical. Over the past 40 years, HIV surveillance has evolved from basic sentinel site testing to complex systems involving general population and key population biobehavioral surveys, biomarkers, case surveillance, data ecosystems, phylogenetics, and statistical modeling. Collaborative efforts among countries, UNAIDS, WHO and other stakeholders have supported this evolution.

As progress in the HIV response creates a perception that the epidemic is under control, attention and resources are increasingly shifting toward other health priorities, including mpox and the rising burden of noncommunicable diseases. Nevertheless, data remain essential for accountability and tracking progress against the epidemic. HIV surveillance is at a crossroads in many low- and middle-income countries for several reasons, including but not limited to:

1. Survey-based prevalence monitoring presents new challenges where lower incidence leads to higher sample size requirements, and associated costs.
2. As people living with HIV age, monitoring must expand beyond antiretroviral treatment and viral suppression to include broader health indicators such as hypertension and diabetes.
3. Changes in how sex workers and men who have sex with men connect (by moving online) challenge the utility of the most common sampling methods used for surveys among at risk populations.

The next global AIDS strategy for 2026 – 2031 is currently under development. Sixteen top-line targets have been proposed which, if reached, will allow countries to meet three overarching goals:

1. Reduce new HIV infections by 90% from 2010 levels by 2030, with a 5% annual decline post-2030
2. Reduce AIDS-related deaths by 90% from 2010
3. Ensure sustainability of the HIV response through 2030 and beyond

Recent funding cuts to HIV programmes in many of the poorest countries require countries to tailor data systems to their resources, distinguishing between essential and optional tools. National ownership, sustainability of data systems, and a culture of routine data use, in collaboration with communities, is critical.

Meeting purpose and objectives

Purpose

To develop recommendations with countries, communities, partners, and key stakeholders on the essential approaches for HIV data collection.

Objectives:

- To prioritize HIV data sources essential for HIV programs and decision makers to align with in-country prioritization and resources
- To identify recommendations to support in country prioritization in various resource scenarios
- To provide key elements that can be used to strengthen country ownership/stewardship, data governance, and integration of HIV into a broader health data collection and monitoring system

Meeting structure

The consultation convened a diverse group of global and country stakeholders to assess the current state of HIV data systems and strategize for the future. It was structured around plenary presentations, panel discussions, and breakout sessions:

Day 1: Setting the scene with global and national perspectives and exploring the need to identify criteria to inform decisions to prioritize HIV data and surveillance collective efforts.

Day 2: Sharing country experiences, addressing data challenges, and debating technology and AI.

Day 3: Exploring the role of communities, governance, ethics, and enabling factors to support the continuation of HIV data and surveillance 2026-2031.

Links to other initiatives

This consultation builds on previous HIV data and surveillance meetings convened by UNAIDS, co-sponsors, countries, and global stakeholders. UNAIDS typically convenes surveillance meetings every five years with previous meetings occurring in Bangkok, Thailand and virtually during the COVID-19 pandemic. It was informed by previous HIV data and surveillance reports and guidance, the current status of the HIV epidemic, and insight from UNAIDS strategic information advisors. A pre-meeting survey sent to a broad group of stakeholders also guided the meeting with in-depth country and global perspectives for prioritizing HIV data sources.

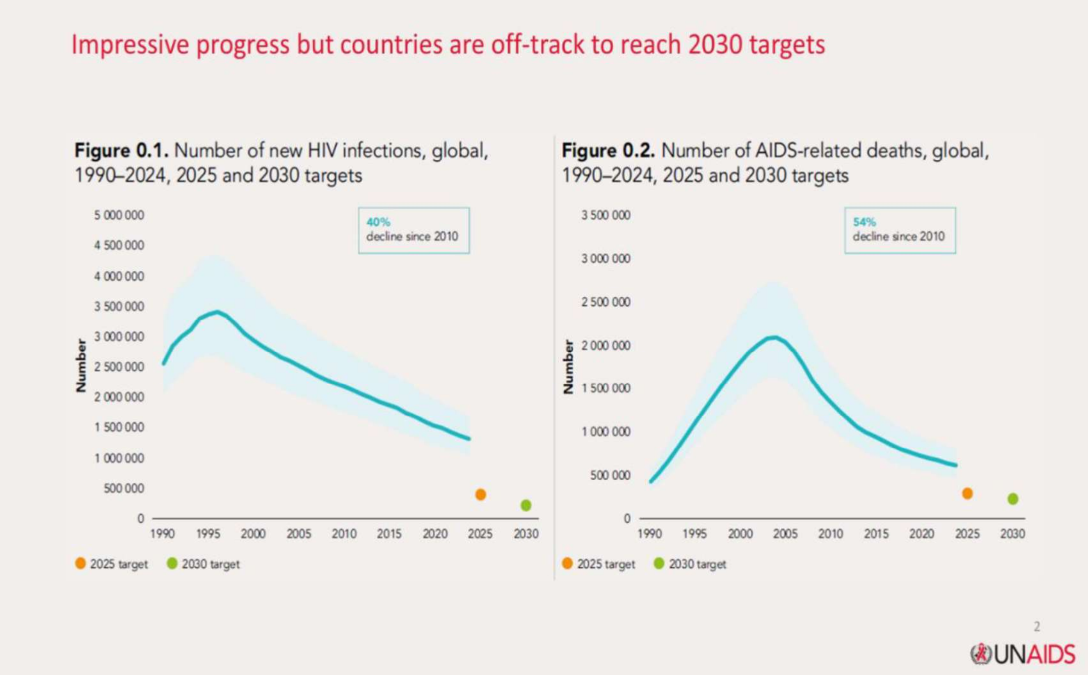
The HIV Response and the need to prioritize data decisions

During the Day 1 session, conversation was initiated with meeting attendees to consider the need to prioritize HIV data decisions in a changing landscape. The meeting was chaired by Keith Sabin.

Highlights

- Global HIV targets re off track despite progress
- Data needs to be actionable and locally relevant
- Routine program data is the most prioritized source
- India's Integrated Surveillance Framework offers a a best practice model
- Country-specific HIV data frameworks can be based on epidemic type, resource availability, and program needs

Figure 1



Impressive progress but countries are off-track to reach 2030 targets

Figure 0.1. Number of new HIV infections, global, 1990–2024, 2025 and 2030 targets

Figure 0.2. Number of AIDS-related deaths, global, 1990–2024, 2025 and 2030 targets

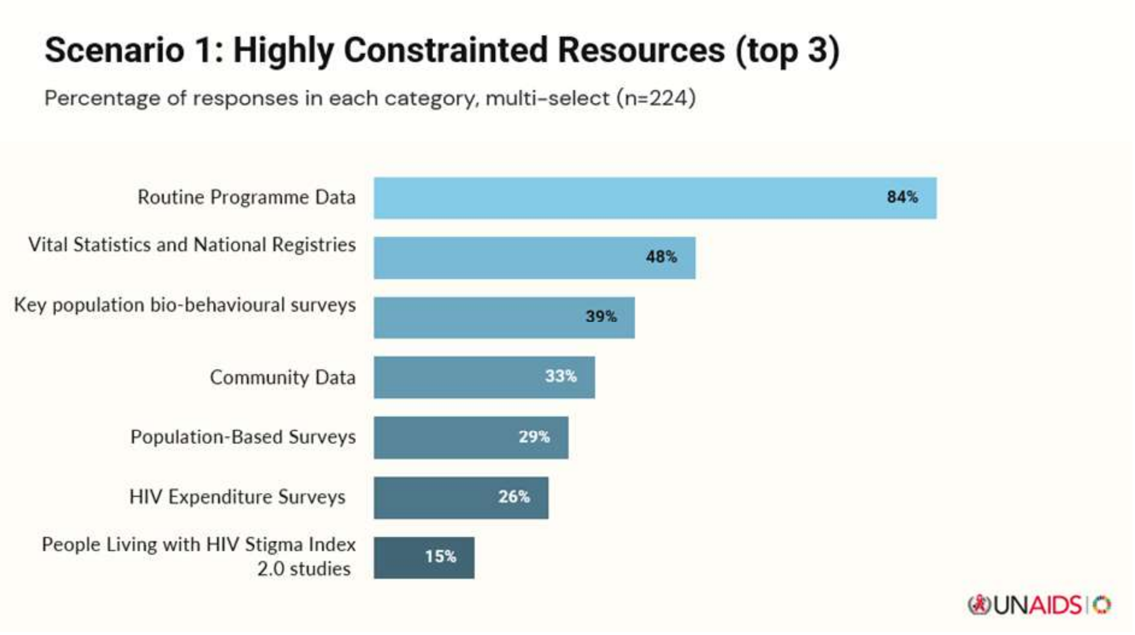
Angeli Achrekar opened the meeting with a comprehensive overview of global HIV epidemic trends, noting a 40% decline in new infections and a 54% reduction in AIDS-related deaths from 1990 to 2024. Despite these gains, she emphasized that the world is off track to reach the 2025 global HIV targets. Achrekar highlighted persistent inequalities in treatment access across age and population groups, particularly among children and men. She underscored the impact of punitive laws on service delivery, especially for sex workers and transgender individuals, and stressed the importance of integrating epidemiological, policy, and financial data in programme reviews. Notably, 42% of countries reported plans to increase domestic HIV funding in 2026, signaling a shift toward sustainability. She also introduced the updated 2026**–**2030 Global AIDS Strategy, which includes 16 top line targets to reach the ambitious goals of reducing new infections and AIDS-related deaths by 90% from 2010 levels and ensure the long-term sustainability of the HIV response.

Yogan Pillay followed with a pragmatic and programmatic lens, drawing on his experience as a former national programme manager in South Africa. He emphasized the need for data to be timely, disaggregated, and actionable, especially for district-level decision-makers. Pillay outlined essential tools such as real-time dashboards, cohort monitoring, epidemic projection models (e.g., Spectrum and Naomi), and community feedback mechanisms. He stressed that data can lead to action, advocating for this framework **"Data → Red Flags → Action → Better Outcomes."** Pillay identified key red flags in testing (e.g., declining positivity rates, late diagnoses), treatment (e.g., retention below 80%, suppression below 90%), and prevention (e.g., poor PrEP continuation, condom stockouts). He also discussed the potential of AI and predictive analytics to improve stock-out monitoring and resource allocation, citing examples from Uganda and South Africa. Pillay concluded with a call to empower managers, integrate HIV data into primary health care systems, and ensure community participation in data collection and use.

Pradeep Kumar presented a comprehensive framework aimed at addressing key questions in the evolving landscape of HIV data systems in India. Kumar outlined how India was adapting surveillance mechanisms to meet changing programmatic needs and emphasized the importance of mortality surveillance as a critical component in understanding the epidemic. He outlined how India is navigating the integration of traditional civil registration and vital statistics (CRVS) systems with HIV case surveillance to strengthen data collection and analysis. The framework shared reflects a strategic approach to ensuring continuity and effectiveness in HIV monitoring, particularly in the face of donor transitions and shifting resource allocations. Kumar stressed that resilient data systems can support both immediate programmatic decisions and long-term public health goals.

Luisa Frescura presented findings from a pre-meeting survey that gathered 224 responses, primarily from African countries. The survey aimed to assess the prioritization of HIV data sources under varying resource constraints. Across all country scenarios**—**highly constrained, moderately constrained, and unconstrained**—**routine program data emerged as the top priority. Other highly valued sources included HIV case surveillance, civil registration and vital statistics, and biobehavioral surveys. Frescura noted that many data systems remain fragile and require strengthening, particularly data governance, privacy, and integration. Respondents emphasized the importance of external collaboration, technical capacity, and funding for future national and biobehavioral surveys implementation. The pre-meeting survey also revealed regional variations in data prioritization and highlighted the need for sustainable, country-owned data systems that reflect local realities.

Figure 2



Mary Mahy built on these insights by framing the strategic use of HIV data within national programs. She outlined the spectrum of uses of HIV data: patient care, planning and advocacy, clinic-level monitoring, multi-sectoral surveillance, and accountability. Mahy provided examples of helpful metrics such as viral load at population, community, and program-level which can provide estimates of incidence, treatment coverage and treatment success. She advocated for leveraging sentinel populations such as pregnant women and military recruits to monitor prevalence and viral suppression. Mahy also stressed the importance of integrating HIV surveillance with broader health systems and using community-led monitoring to capture qualitative insights on stigma, service quality, and client satisfaction. She called for a simplified, sustainable data framework that prioritizes actionable indicators and supports decision-making in resource-constrained environments.

In the breakout group discussions facilitated by UNAIDS Strategic Information Advisors, participants explored criteria for developing HIV data frameworks tailored to countries with generalized and concentrated epidemics. For concentrated epidemics, proposed criteria included program-driven decision-making, prioritization of key populations, simplicity in methods, community participation, confidentiality, and a mix of macro- and micro-level data. Key data sources identified were health information systems, periodic IBBS surveys, and community-led data for accountability. For generalized epidemics, participants emphasized the availability and richness of data sources, subnational monitoring, equity, and integration with primary health care and sexual and reproductive health services. They also discussed the importance of robust prevention indicators, modeling inputs, cost-effectiveness analysis, and early warning systems. Across both groups, there was consensus on the need for sustainable, locally adaptable data systems that empower decision-makers and reflect the realities of the epidemic.

Data Challenges and innovations in the HIV Response

Day 2 of the consultation focused on the evolving challenges and opportunities in HIV data systems, with a particular emphasis on country experiences, data governance, and the role of emerging technologies. The session opened with a recap of Day 1 by the chair, Eleanor Gouws, highlighting the importance of integrating epidemiologic, policy, and financial data to support accountability and guide strategic planning. The day's agenda built on these foundations, diving deeper into the practical realities of data collection, use, and sustainability.

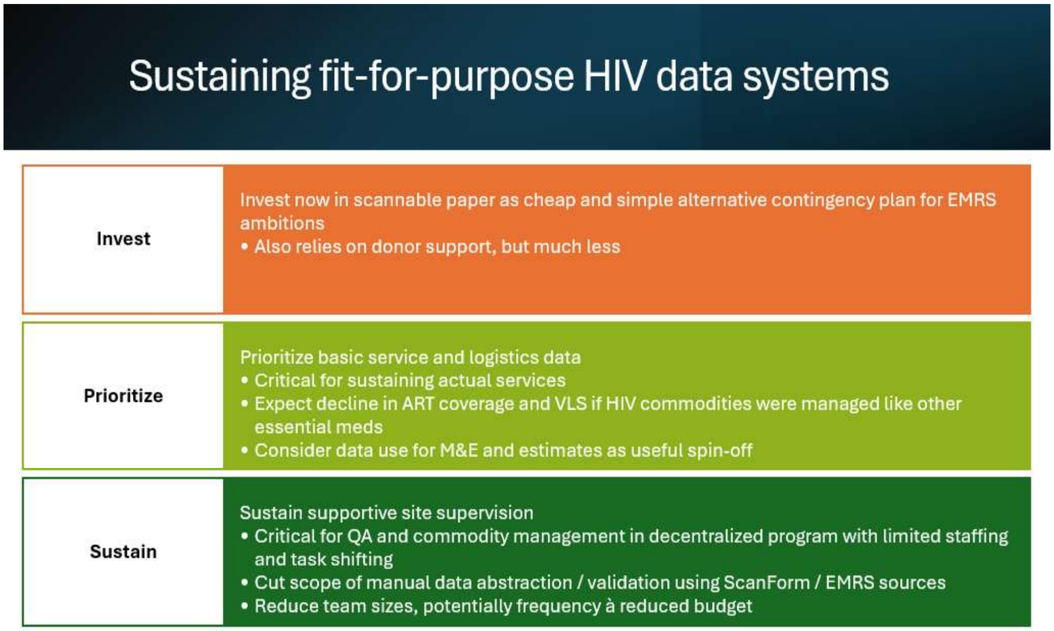
Highlights

- Shift from data quantity to data quality
- Sustainability and country ownership of data systems
- Integration of HIV data into broader health systems country-specific HIV data frameworks can be based on epidemic type, resource availability, and program needs
- Adaptation of surveillance methods to evolving situations
- Ethical use and governance of artificial intelligence (AI) in HIV Programs
- Importance of Strategic Partnerships and Community Engagement

Jeff Imai-Eaton provided a global perspective on HIV data challenges, emphasizing that the need for innovation in epidemic monitoring transcends the current funding crisis. He noted that many countries in Africa rely heavily on household surveys to inform their modelled HIV estimates, yet most have not conducted one in over five years. Routine data sources such as antenatal care (ANC) and Prevention of Mother-To-Child Transmission (PMTCT) records often fail basic consistency checks, and discrepancies between antiretroviral (ART) program data and household survey estimates are growing. Eaton advocated for a shift from model-derived indicators to proxy indicators that are directly calculable from routine data and correlate with epidemiologic outcomes. He stressed the importance of focusing on data quality over quantity and adapting systems to meet evolving needs.

There were three country presentations that provided in-depth analyses and realistic pros and cons of existing HIV data systems and one presentation outlining the importance of institutionalizing the support needed for these systems. Andreas Jahn presented a detailed account of Malawi's HIV data systems, highlighting both achievements and vulnerabilities. Malawi has invested heavily in electronic medical records (EMRs), supported by the President's Emergency Plan for AIDS Relief (PEPFAR), and maintains quarterly supervision and data audits across all ART and PMTCT facilities. Despite these efforts, donor dependency remains a critical issue. Jahn emphasized the fragility of data systems, especially in light of recent disruptions and overreporting in ART data. He proposed scannable paper registers (ScanForm) as a cost-effective contingency plan, noting their success in digitizing over 13 million client records at a fraction of the cost of EMRs. He called for prioritizing basic service and logistics data and sustaining supportive supervision to ensure quality assurance and commodity management.

Figure 3



Sustaining fit-for-purpose HIV data systems

Invest	Invest now in scannable paper as cheap and simple alternative contingency plan for EMRS ambitions • Also relies on donor support, but much less
Prioritize	Prioritize basic service and logistics data • Critical for sustaining actual services • Expect decline in ART coverage and VLS if HIV commodities were managed like other essential meds • Consider data use for M&E and estimates as useful spin-off
Sustain	Sustain supportive site supervision • Critical for QA and commodity management in decentralized program with limited staffing and task shifting • Cut scope of manual data abstraction / validation using ScanForm / EMRS sources • Reduce team sizes, potentially frequency à reduced budget

**Courtesy of Andreas Jahn*

Navy Chann shared Cambodia’s journey in HIV surveillance, which began in 1991. Historically, Cambodia conducted full integrated biobehavioral surveys (IBBS) using respondent-driven sampling to reach hidden key populations. However, due to funding constraints, the country has transitioned to a modified version (BBS-Lite), which costs significantly less and excludes expensive STI tests and international consultants. While BBS-Lite offers flexibility and faster turnaround, it presents challenges in representativeness and accuracy. Chann emphasized the importance of adapting sampling approaches and leveraging technology to improve data quality and program relevance.

Wilford Kirungi discussed Uganda’s efforts to institutionalize technical capacity for sustainable HIV data systems. Uganda has made progress in governance, platform integration (DHIS2, EMRs, eLMIS), and workforce development. However, challenges persist in financing, staff retention, and system interoperability. Kirungi outlined a 12–18 month action agenda, including issuing a national HIV data governance circular, launching an analytics fellowship, and integrating CRVS and NCD indicators. He stressed that institutionalization requires embedding governance, financing, standards, and a culture of data use within national systems, supported by multi-sectoral partnerships.

Eric Remera presented Rwanda’s approach to HIV data governance, anchored in a robust legal framework including the updated Data Protection and Privacy Law (2023). Rwanda has achieved over 80% EMR coverage and established a National Health Intelligence Center to consolidate and analyze data. Remera highlighted efforts to integrate HIV data with CRVS, noting that only 39% of deaths among PLHIV were recorded in CRVS, and just 25% were attributed to HIV-related causes. This underscores the need for improved mortality surveillance and integration. Rwanda’s digitalization strategy aims to eliminate paper-based records and enhance data quality and service delivery.

The afternoon session featured a dynamic discussion on artificial intelligence (AI) in HIV programs, moderated by Ali Feizzadeh. Shona Dalal (WHO) advocated for AI’s potential to enhance prevention, testing, treatment, and data systems. She presented examples from Brazil, South Africa, and Kenya, where AI tools have supported health promotion and predicted treatment interruptions. Dalal emphasized the need for high-quality data, ethical implementation, and robust governance. Allan Maleche (Kenya Legal & Ethical Expert) provided a counterpoint, raising concerns about privacy, data breaches, and the digital divide. He highlighted risks for criminalized populations and the lack of legal preparedness in many countries to address AI-related violations. Maleche called for clear accountability frameworks and context-specific data protection laws. The discussion concluded with consensus that AI is already part of the HIV response and careful thought is needed to ensure it is used ethically and inclusively. Both speakers agreed on the importance of safeguards, community engagement, and continuous evaluation to ensure AI supports rather than undermines equity and human rights.

For the remainder of the afternoon session, participants joined breakout groups focused on:

Expanding partnerships (academia, parastatal organizations)

Community data integration

Sustainability and country ownership

Integration of HIV into broader health systems

Community Intelligence, Data Governance, and Ethical Surveillance in the HIV Response

Day 3 of the consultation opened with a warm welcome and a recap of the previous day's discussions. Keith Sabin, chair, outlined the agenda, which included presentations on community-led data systems, foundational data governance, and ethical considerations in HIV surveillance. The day was designed to deepen the dialogue around sustainability, integration, and the role of communities in shaping HIV data systems, culminating in breakout group presentations and a final plenary discussion.

Highlights

- Community-Led Monitoring (CLM) as a core strategy
- BBS Lite as a cost-effective survey method
- The importance of data governance and stewardship
- Ensuring ethical surveillance in a changing geopolitical context
- Integration of HIV data systems with broader health systems
- Sustainability, Financing, and Partnerships are key factors in data decisions

The first presentation was delivered by Maka Gogia shared Georgia's experience with community-led data collection and the implementation of BBS-Lite. Georgia's robust harm reduction program, supported primarily by the Global Fund, was staffed by 80% of community members. Georgia's data system is unified across service sites for people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW), and transgender individuals. Quarterly dashboards are submitted to the Ministry of Health and the Country Coordinating Mechanism (CCM), and the data are used to inform national HIV strategic planning and target setting. Gogia highlighted several challenges. The existence of two separate databases—one for Global Fund reporting and another for the state HIV program—creates duplication and inefficiency. The system remains heavily reliant on paper-based processes, which are time-consuming and prone to error. Limited human and technical resources further constrain data management, and centralized data analysis leaves community-level organizations with little capacity to interpret and act on their own data. Gogia advocated for the use of BBS Lite as a cost-effective alternative to traditional biobehavioral surveys, noting that it allowed for faster data collection, shorter interviews, and more frequent tracking of risk behaviors and service access.

Following Gogia’s presentation, Jelena Bozinovski introduced the concept of Community-Led Monitoring (CLM) as a model for generating, using, and influencing HIV data systems. Jelena described CLM as a continuous feedback mechanism grounded in four pillars: education, evidence, engagement, and advocacy. The process begins with communities identifying their own needs and priorities, followed by co-creation of indicators with partners. Mixed methods—quantitative surveys and qualitative tools such as focus group discussions (FGDs) and key informant interviews (KIIs)—are used to collect data. These data are then analyzed to identify gaps and trends, and findings are presented to decision-makers to drive accountability and action. In Malawi, CLM helped detect service disruptions following U.S. funding cuts, including declines in HIV testing, ART initiation, and viral load suppression. In South Africa, CLM contributed to increased pre-exposure prophylaxis initiation and improved tuberculosis treatment success rates. Bozinovski emphasized that CLM is not a separate stream but a foundational layer for real-time course correction and systems feedback. She called for integration of community intelligence into national health information systems, noting that AI and DHIS2 are insufficient without community-generated signals.

The next presentation, delivered by Ali Feizzadeh, focused on the foundational infrastructure of data governance. He defined data governance as the implementation of norms, policies, technical mechanisms, laws, and institutions that enable the safe and equitable use of data. He outlined three core principles: protecting people, promoting health values, and prioritizing equity. These principles guide the entire data life cycle—from creation and processing to storage, sharing, analysis, and eventual destruction or reuse. Feizzadeh detailed the steps required to implement effective data governance, including assessing the current landscape, designing a framework, and executing the plan. He highlighted common challenges such as the absence of regulatory frameworks, unstable infrastructure, siloed systems, and lack of workforce training. He stressed the importance of interoperability, data quality management, and secure infrastructure, especially for community health data. He called for explicit recognition of community data as a valid source within health systems and advocated for participatory governance that includes community representation at all stages of data stewardship.

The final presentation was given by Diego Silva. Silva explored the ethical dimensions of HIV surveillance, urging participants to consider not only how data are collected but why. He emphasized that data collection is not value-neutral and should be guided by ethical principles that respect privacy, confidentiality, and community values. Silva contrasted two key documents: the 2013 UNAIDS guidance, which strongly advocates for informed consent, and the 2017 WHO guidance, which suggests that consent may not be ethically required under certain protections. Silva warned of emerging risks in the current geopolitical climate, including the rise of extremism and the potential misuse of linked datasets. He noted that artificial intelligence and big data analytics are accelerating the integration of disparate data sources, raising concerns about surveillance and data ownership. He posed a critical question: “Who will use this data tomorrow?” Silva called for ethical vigilance, especially when working with vulnerable populations, and stressed the need for transparency, accountability, and community engagement in data governance.

After the presentations, participants reconvened in breakout groups to finalize their recommendations. Each group presented their findings in the plenary session.

Group 1, led by James Ndirangu, focused on expanding partnerships to include academia, parastatal organizations, and non-HIV surveillance actors. The group recommended mapping potential collaborators, institutionalizing research and skills transfer, and leveraging regional bodies such as the Africa Centers for Disease Control and Prevention and the Economic Community of West African States (ECOWAS). They emphasized the need for sustainable national data warehousing and strategic engagement with the private sector. Group 2, presented by Isaac Taramusi reframed community data as essential rather than complementary. The group called for integration of community data into national systems, development of standardized indicators, and ethical data preservation. They stressed the importance of feedback loops, stakeholder participation, and innovation through AI, particularly for hard-to-reach populations. Group 3, presented by Lely Wahyuniar addressed sustainability, country ownership, data governance, and financing. The group advocated for institutionalizing resource tracking, strengthening local human resources, investing in digital infrastructure, and promoting domestic financing. They proposed co-financing models, earmarked taxes, and improved spending efficiency linked to epidemiological outcomes.

Group 4, presented by Nalini Chandra focused on integration of HIV data systems with broader health systems. The group recommended a phased approach, starting with closely related programs such as hepatitis, maternal and child health, noncommunicable diseases, sexually transmitted infections, and tuberculosis. They emphasized bi-directional data flow, confidentiality safeguards, and preservation of institutional knowledge. The group also raised questions about the role of community data in integrated systems and cautioned against practices that distort data quality.

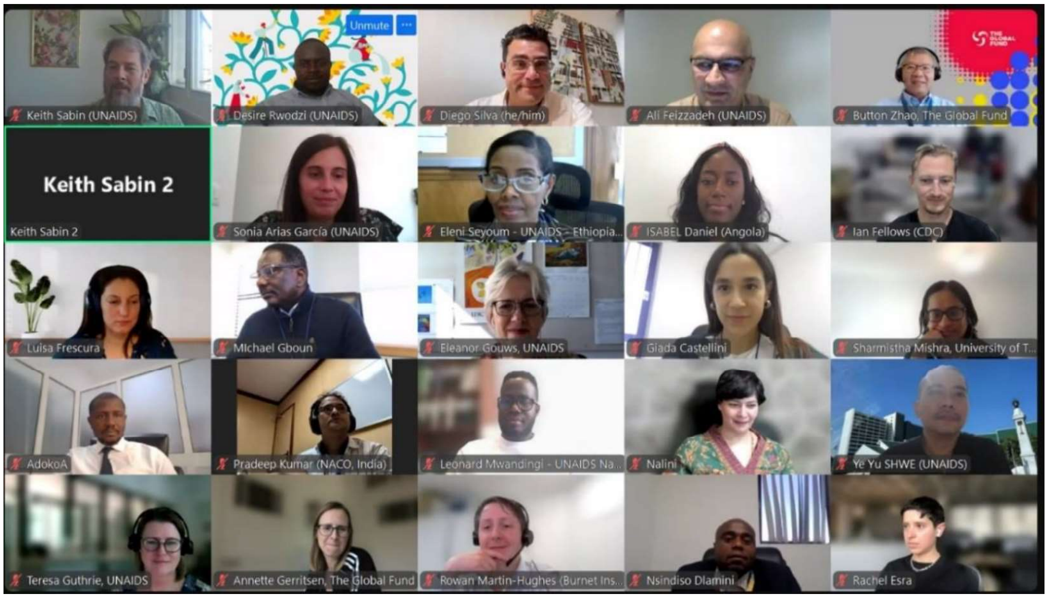
Conclusions and recommendations

The three-day meeting brought together a diverse group of international and country stakeholders. The discussions were rich and indicated an urgency in helping countries to make informed data decisions amidst changing epidemic needs and declining donor funding.

Considerations for prioritizing essential data sources reflecting the realities of countries' respective HIV epidemics include:

- Understanding the differences between concentrated and general HIV epidemics data needs,
- Developing a simplified data matrix, and
- Placing emphasis on sustainable, locally adaptable data systems that empower decision-makers.

Routine facility data will likely increase in its use and inform the HIV response in the near term and the future in resource constrained and non-resource constrained settings. Actionable indicators that can support data decision-making in resource-constrained environments are key to driving efficiency and providing the necessary data to guide HIV programs. Best sustainable data practices mentioned during the meeting included use of scanner paper digital technology, the DHIS2 platform, and modified less expensive biobehavioral surveys. Key elements that can be used to strengthen country data ownership include institutionalizing technical assistance, government support for data governance, increasing domestic funding, and a phased integrated approach with other prominent diseases. As follow up, a prioritizations considerations matrix for informing HIV data decisions will be developed and disseminated in 2026 expanding on the ideas and best practices discussed during this meeting.



Appendix

List of meeting participants

Last Name	First Name	Organization
Abimiku Audu	David	National Agency for the control of AIDS (NACA)
Achrekar	Angeli	UNAIDS
Agbo	Francis	National Agency for the Control of AIDS
Agustine	Leonita	UNAIDS
Aliyu Magaji	Ramatu	National Agency for the control of AIDS
Arias García	Sonia	UNAIDS
Bakan	Hasan	UNAIDS
Bendaud	Victoria	UNAIDS
Birungi	Charles	UNAIDS
Boothe	Makini	UNAIDS
Bozicevic	Ivana	WHO CC for HIV Strategic Information, Croatia
Bracamonte	Patricia	UNAIDS
Brar	Savvy	UNICEF
Brar Sarao	Savy	UNICEF
Buzurukov	Azam	UNAIDS
Case	Kelsey	Independent Consultant
César	Freide	Mecanismo de Coordenação do País do Fundo Global
Chandra	Nalini	UNAIDS
CHEN	Fangfang	
Dalal	Shona	WHO
DANIEL	ISABEL	UNAIDS
Davis	Stephanie	US CDC
Dlamini	Nsindiso	UNAIDS
Eby	Pascal	UNAIDS
Elendu	Modupe	UNICEF
Esra	Rachel	UNAIDS
Fellos	Ian	US CDC
Frangioni	Aura	The Global Fund
Frescura	Luisa	UNAIDS
Garcia Demuner	Luis Gerardo	CENSIDA
Gboun	Michael	UNAIDS
Ge	Lin	NCAIDS, CHINA CDC
Gemechu	Eleni	UNAIDS
Genevieve	Ehounou	UNAIDS

Gerritsen	Annette	The Global Fund
Glaubius	Rob	Avenir Health
Gouws	Eleanor	UNAIDS
Govea	Yair	CENSIDA
Gruskin	Sofia	Institute on Inequalities in Global Health, University of Southern California
Guichard	Anne-Claire	UNAIDS
Guo	Wei	UNAIDS
Hakim	Avi	US CDC
Herbeck	Josh	Gates Foundation
Herbst	Sara	GHSD/PEPFAR
Hladik	Wolfgang	CDC
Hosseini	Parviez	U.S. Dept. of State, Bureau of Global Health Security and Diplomacy
Idemili	Chidumebi	University of Toronto
Idepefo	Festus	National Agency for the Control of AIDS
Idepefo	Festus	National Agency for the Control of AIDS
Imai-Eaton	Jeffrey	Harvard T.H. Chan School of Public Health
Jahn	Andreas	Ministry of Health
Kabore		UNAIDS
Kelly	Florence	
Kilonzo	Sally	Yemaya Health Group Limited
Kirungi	Wilford	Ministry of Health - Uganda
Kohler	Julianna	US Department of State
Korenromp	Eline	UNAIDS
Kumar	Pradeep	National AIDS Control Organization
Li	Peilong	
Li	Dm	NCAIDS
Lwamba	Chibwe	UNICEF
Macamo	Silvio	National Aids Council
Mahalingam	Mahesh	UNAIDS
Mahboob0	Rahman	UNAIDS
Maheu-Giroux	Mathieu	McGill University
Mahiane	Severin Guy	Avenir Health
Mahy	Mary	UNAIDS
Manembe	Lourena	Conselho Nacional de Combate ao HIV e SIDA - NAC
Manembe	Lourena	CNCS
Manhice	Estêvão	UNAIDS
Martin-Hughes	Rowan	Burnet Institute
Mazive	Josefa	NAC
Mendoza	Angelo	UNAIDS
Mirzazadeh	Ali	University of California San Francisco (UCSF)

Mishra	Sharmistha	University of Toronto
Mubangizi	Jotham	UNAIDS
Murtala	Khadija	NACA
Mwale	John	UNAIDS
Mwandingi	Leonard	UNAIDS
Ndirangu	James	UNAIDS
NGUETTE WOZA	Fabrice Léonel	ONUSIDA
Nyakane Nkoko	Morongoe	Ministry of Health
Nze Eyo'o	Rodrigue	UNAIDS
Otai	Charles	Uganda AIDS Commission
Parekh	Bharat	US CDC
Patel	Sadhna	CDC
Patel	Monita	CDC
Pillatar	Benjamin	Institute of Human Virology Nigeria (IHVN)
Pillay	Yogan	Gates Foundation
Porter	Laura	CDC
Reid	mike	PEPFAR
Remera	Eric	Rwanda Biomedical Centre
Rolle	Italia	UNAIDS
Rwodzi	Desire	UNAIDS
Sabin	Keith	UNAIDS
Sabin	Keith	UNAIDS
Saffa-Turay	Semion	UNAIDS
Scutelniciuc	Otilia	UNAIDS
Seday	Maryanne	UNAIDS
Selim	Michelle	GHSD
Shiraishi	Ray	US CDC
Sitoe	Mauro	Conselho Nacional de Combate ao SIDA
Sobers	Melissa	UNAIDS
Stover	John	Avenir Health
Sugandhi	Nandita	WHO
Swanson	Megan	US CDC
Sylvester	Ukawa	National Agency for the Control of AIDS
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