Agenda item 3

UNAIDS/PCB (55)/24.27

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 54TH PROGRAMME COORDINATING BOARD MEETING

Sustaining the gains of the global HIV response to 2030 and beyond

UNAIDS

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

- *Takes note* of the background note (UNAIDS/PCB (54)/24.22) and the summary report (UNAIDS/PCB (55)/24.27) of the Programme Coordinating Board thematic segment on "Sustaining the gains of the HIV response to 2030 and beyond";
- Noting the centrality of sustainability as countries' ability to have and use, in an enabling environment, people-centred, human rights- and gender equality-based systems for health and equity; empowered and capable institutions and community-led organizations; and adequate, equitably distributed resources to reach and sustain the end of AIDS as a public health threat by 2030 and beyond, upholding the right to health for all, *requests* Member States to:
    a. Accelerate the work towards long-term sustainability planning in all aspects of the HIV response, advancing integration of different dimensions of the response, especially in UHC and PHC, ensuring greater synergies with sexual and reproductive health and reproductive rights, TB, gender-based violence programmes and other sectors that affect HIV outcomes;
    b. With participation from communities and partners, advance the development of country-owned HIV response sustainability roadmaps that enable effective, context-specific, people-centred, integrated HIV services with full respect of human rights for equitable and sustained impact, including community-led HIV services;
    c. Strengthen political mobilization to sustain the HIV response, remove existing barriers to ending AIDS, and make sustainability a central component of the long-term vision beyond 2030 and next Global AIDS Strategy;
    d. Advance data-collection and -analysis system capacities, including monitoring and evaluation, to ensure that HIV epidemiological, community, societal and financial priorities are effectively identified and addressed;
    e. Prioritize an adequately resourced health care system that increasingly includes integrated, differentiated, people-centred, accessible, and country-led HIV interventions that ensure gender equality, uphold human rights, and meet the needs of all, including key[1] and vulnerable populations and acknowledging and supporting the contribution of community-led organisations;
    f. Ensure enabling policies and legal environments that support equitable, accessible and high-quality HIV services that leave no one behind with strong community leadership and engagement, and societal enablers to end HIV-related stigma, discrimination, criminalization, and gender inequalities including through the promotion of U=U (undetectable = untransmissible) messaging, as appropriate, taking into account WHO guidance, while continuing scientific research on the role of viral suppression of HIV transmission;

g. Ensure implementation of evidence-based interventions to prevent, diagnose and treat HIV and its co-infections and comorbidities and to ensure access to safe, effective and affordable medicines, including the most innovative health technologies, diagnosis and treatment for all, without discrimination particularly in low- and middle-income countries;

h. Facilitate local production of medicines, including by promoting technology transfer, supporting the improvement of manufacturing capacities in low- and middle-income countries, and promote increased access to affordable, safe, effective and quality diagnostics and medicines, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of International Property Rights (TRIPS Agreement) as amended, and also reaffirming the 2001 WTO Doha Declaration on the TRIPS Agreement and Public Health which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to essential health tools for all, and notes the need for appropriate incentives in the development of new health products;

i. Reinvigorate domestic and international financing that is adequate, sustainable, evidence-based and equitable, including both a robust increase of domestic investments and adequate donor financing through the Global Fund's next replenishment;

j. Note with concern the current obstacles to further domestic investment in the HIV response faced by low- and middle-income countries due to low revenue collection and high debt service costs that exceed their health expenditure, and call for solutions to increase countries´ fiscal space in the medium term, allowing for a robust growth trajectory in HIV and health financing;

k. Ensure that both domestic and donor financing increasingly support community-led HIV responses and monitoring, including through the development and implementation of social contracting models;

- *Request* the Joint Programme to continue to support and facilitate countries' efforts, under national leadership, with robust community participation, to develop and implement holistic, country-owned long-term HIV Sustainability Roadmaps.

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

Introduction

1. The thematic segment focused on the sustainability of the HIV response. Participants discussed lessons and ways of introducing the necessary foundations for a sustainable HIV response up to and beyond 2030.

2. The Chair began by highlighting some of the progress made by his country, Kenya, towards achieving sustainable HIV progress. Innovative actions included developing social contracting modalities, accelerating HIV combination prevention, deeper integration of HIV services into the overall health system and Universal Health Coverage (UHC) as well as other convergences.

3. **Anne Githuku-Shongwe**, Director of the UNAIDS Regional Support Team for eastern and Southern Africa, and **Jaime Atienza Azcona**, Director of Equitable Financing Practice, UNAIDS, moderated the thematic segment. Noting that there were different perspectives of the meaning of sustainability, Ms Githuku-Shongwe presented the agenda and purpose of the thematic segment.

Opening and keynote addresses

4. Winnie Byanyima, UNAIDS Executive Director, said the HIV response was at a crossroads. Even if the 2030 targets were reached, about 30 million people would be living with HIV and their health would have to be protected. Yet the current financial system was stacked against a sustainable HIV response, she said. Fiscal space for investments in health, education and social protection was tighter than ever. Half of the countries in sub-Saharan Africa were spending at least three times more on debt servicing than on health and were subject to high interest rates. The international financial system disadvantaged low- and middle-income countries, she told the PCB.

5. Financial, programmatic and political sustainability were vital, she continued. Therefore, UNAIDS was working closely with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, with governments in the lead, to support the development and implementation of sustainability roadmaps, in response to a call from the UN Secretary-General. She urged governments to conduct high-level assessments and draft these roadmaps over the next six months. A successful long-term response required strong national and global political leadership that includes meaningful partnerships with all stakeholders, Ms Byanyima said programmes and systems had to be efficient, resourceful and impactful, and laws and policies had to uphold the right to health for everybody, she said.

6. **Edwin Dikoloti**, Minister of Health, Botswana, told the meeting that his country's HIV response had been driven from the highest political level and guided by the domestication of global guidance and policies. The support of the Joint Programme had been vital, including its technical assistance for developing national policies and strategies and for collecting and analysing data. More than 70% of HIV funding came from the national government, he said. Noting that HIV incidence had been reduced to 0.2%, he summarized the achievements of Botswana's HIV response but added that adolescent girls and young women were still at high risk for HIV, unintended pregnancy and gender-based violence. Mr Dikoloti said Botswana was one of first countries to develop a sustainability roadmap, which was currently being implemented.

7. **Florence Riako Anam**, co-Executive Director of GNP+, said her life and the lives of millions of others had been saved by a HIV response that was driven by solidarity and rights-based approaches and that brought people and good science together. She told the meeting it was important to be clear and transparent about the sustainability process and how it would affect people living with HIV. For people living with HIV, quality services and social enablers were the primary concerns, she said. Standard

packages of services had to be defined in ways that meet people's different needs. Also important was a mechanism for monitoring social enablers.

8. While an ageing population of people living with HIV and the ongoing need to provide young people with sexual and reproductive health (SRH) services highlighted the need for more integration, she cautioned that quality of care and inclusivity had to be safeguarded, and services had to be devoid of stigma and discrimination. She reminded the meeting that, unlike other chronic diseases such as diabetes and hypertension, HIV was still marked by stigma and discrimination and this called for unique responses. Communities contributed hugely to the HIV response, Ms Anam said, and this had to be sustained through consistent support for community organizations, including core funding. She concluded with a call for continued investment in a vaccine or cure for HIV.

9. **Michelle Bachelet**, former President of the Republic of Chile, addressed the meeting via video. She stressed that the AIDS epidemic was not over and that the threat of resurgence remained, with women and girls still inordinately affected, particularly in sub-Saharan Africa. A sustainable response was therefore vital, and it required concerted action and solidarity of governments and the international community, strengthened health systems, solid human rights frameworks, gender equality and ensuring that no one was left behind. Affected communities and countries should "own" the HIV response, she said. Also vital was an enabling environment, which included facilitating local production of medicines, affordable access to innovation and debt reduction.

Session overview

10. The session reviewed highlights from the thematic segment background note, with a focus on "tipping points" that shape the sustainability of the HIV response. It included a presentation on charting the future of HIV.

11. **Kathy Ward**, Health, Nutrition and Population Global Practice, World Bank Group, provided an overview of the context. She said the world was evermore interconnected and that crises were becoming the "normal" operating environment, with leaderships and resources drawn in multiple directions. Agility, integration and creative collaboration were needed, along with an awareness that systems had to respond quickly to the unexpected. She said that sustainability implied interconnectedness -- no entity could "go it alone" -- and a robust vision that spans the political, programmatic and financial areas and that focuses on equity and communities. She mentioned key requirements for each of those areas, such as multidisciplinary research, multisectoral responses, and strong health and social support systems. Integration would be essential in the health sector and beyond, including for social enablers such as education and social protection, Ms Ward said.

12. Tight fiscal space was a major challenge, she continued. Low- and middle-income countries relied on international resources for more than two thirds of their HIV work. However, the economies of countries accounting for more than 80% of the global population would still be growing more slowly up to 2026 than before the COVID-19 pandemic. In addition, some 60% of low-income countries were in or at high risk of debt distress, with a great deal of the debt held by private bond holders. Those constraints would have to be tackled. Sustainability road maps were one of the tools countries could deploy at country level to help their HIV responses manage the difficulties, she said.

13. **Jérôme Salomon**, Assistant Director-General for Universal Health Coverage, Communicable and Noncommunicable Diseases at WHO, noted the extraordinary

achievement of having almost 30 million people on antiretroviral therapy (ART) but cautioned against focusing solely on sustaining such gains. There was nothing sustainable about an expanding epidemic, he said: 1.3 million people still acquired HIV each year and some 600 000 died of AIDS-related causes. Progress had to quicken. He told the meeting that WHO was combining its HIV work with its work on sexually transmitted infections and viral hepatitis, given the common modes of transmission and determinants of health and the fact that many of the populations most affected by these diseases overlap. All three areas of work were organized under UHC and were delivered through the primary health care (PHC) approach. Sustainability initiatives had to be informed by a people-centred framework for action, he said.

14. Given that many of the indicators for the 2025 and 2030 global targets were off-track, stronger political will and accelerated action were needed. WHO's most recent progress report had highlighted five priorities for action, Mr Salamon said: policy and financial dialogues to develop crosscutting investment cases and national sustainability plans; aligning the plans with the PHC approach; addressing the criminalization of most-affected populations and stigma and discrimination in health settings; expanding multidisease elimination approaches; and strengthening a focus on primary prevention. All the diseases required a clear focus on inclusive governance, country ownership and sustainability.

15. **Mary Mahy**, Director for the Data for Impact Practice at UNAIDS, reviewed the status of the epidemic and response and highlighted recent changes and their impact. Past approaches were not necessarily the most appropriate options in the future, she said. While the HIV response was moving towards "controlling" the disease, continued improvements were needed to maintain the reductions in HIV incidence and AIDS-related deaths. The declines were not yet strong enough to achieve "disease control". Even if stronger progress were achieved, the world would still face a formidable challenge, she cautioned. Modeling showed that, on current trends, there would be about 46 million people living with HIV in 2050, while a stepped-up response that reached the 2025 targets would have some 29 million people living with HIV in 2025, all requiring lifelong treatment.

16. Significant demographic changes were occurring, she continued. For example, Malawi had very high treatment coverage of about 91% and was seeing increases in the average age of people living with HIV. Its epidemic was shifting towards older age groups, alongside the ongoing need to protect adolescents living with HIV. By contrast, Jamaica's lower treatment coverage (about 56%) meant that new HIV infections were not declining as quickly and HIV was still spread evenly across age groups. Ageing populations of people living with HIV implied aging populations with viraemia, older partners who are at risk of HIV, and older populations who need prevention and care, Ms Mahy explained.

17. Outside sub-Saharan Africa, about 80% new infections were among key and marginalized populations, a proportion that was unlikely to decrease in the foreseeable future. Barriers to service access had to be removed, she stressed, including stigma and discrimination. High levels of harassment, denial of service and fear of seeking health-care services persisted. Integration would be crucial, she noted, but much still had to be done on that front. Even HIV and TB—often thought to be well-integrated—needed more work. Health and social system capacities and infrastructure were likely to be tested as they converged, she said. For integration to work best, community organizations had to be able to provide or partner in at least some key services. She said tailored responses should focus on prevention where most risk occurs, treatment plans should be based on projected population needs, and services should be accessible to all populations. Inequalities in services and systems had to be removed, she emphasized.

18. Speakers congratulated UNAIDS for arranging the segment and commended it for its efforts to support sustainability. They asked whether there was clarity about the risks and gains of the choices that were being made and reminded the meeting that, although speedy action was needed, the world was trying to “build bridges over wild waters”. It would not be easy, they said. There was a request for more clarity on whether the goal was sustainability or resilience, which were not necessarily the same concepts.

19. They stressed the importance of following up on the MOPAN recommendations for achieving a suitable long-term operating model and said lessons learned during COVID-19 should also be used to guide the quest for a sustainable response. The integration of HIV into PHC was emphasized, along with awareness that this also involved challenges. Speakers strongly supported enhanced sustainability of the human rights dimensions of HIV responses. Other remarks touched on whether data existed to identify the most efficient programmes and their financial implications, and on the use of artificial intelligence (AI) in HIV modeling and estimates.

20. Replying, Ms Anam said sustainability was a transformational process that involved learning and therefore was also a means towards achieving a resilient response. Mr Salamon reminded the meeting of the usefulness of the HIV response in responding to the mpox outbreak. He stressed the need to focus on key populations and human rights: there could be no health without human rights and without equal access to services and support. He said there were many opportunities to combine services when people seek health care and to maintain rights-based and bottom-up approaches in doing so.

21. Ms Ward said the HIV response could not be sustainable unless it was also resilient, which required being agile and adaptable. Reminding the meeting of how COVID-19 had disrupted programmes and systems, she urged that the necessary, adaptable systems be built ahead of time. Doing so only once a crisis hit was too late, she warned. Strategies and services also had to recognize that people do not prioritize different health issues and other threats: they seek care for the complaint or issue that affects them at a given point. Disease responses had to reflect this, she said.

22. Ms Mahy, responding to a question from the floor, said the HIV response had produced a great deal of very good research on vertical transmission and that UNAIDS was working with countries to track, estimate and assess their relevant epidemic trends, responses and needs. Those data existed at country, regional and global levels and were available for sharing. A lot of work was being done to also support countries to know their HIV needs and expenditures at disaggregated levels. She added that there were many opportunities to use AI in the HIV response, from clinics to the global level, both to enhance responses and to better understand what sorts of interventions were not working well. UNAIDS was actively exploring those opportunities, she said.

23. Ms Byanyima highlighted two major risks. Country ownership had to be enhanced, but that meant governments had to lead *with* civil society and other actors. This was not easy, she cautioned. Partners, especially donors, should be clear about their roles and should support rather than steer the process by telling governments what to do. The other big risk was financial, she said. Reform of the international financial architecture was needed. If countries remained trapped by debt and were unable to borrow on international markets, sustainable health responses would stay out of reach. She reiterated that integration had to go beyond health systems to encompass enabling legal and social environments.

Round table 1: The context and urgency of sustainability planning and response

24. **Jaime Atienza Azcona**, Director, Equitable Financing Practice, UNAIDS, introduced the session, which focused on the need for sustainability planning to sustain impact.

25. **Christoph Kurowski**, Global Lead for Health Financing, World Bank Group, said real central government health spending in low- and lower-middle income countries had soared during the COVID-19 pandemic but had then receded to roughly the 2019 levels. In the poorest countries, spending had dropped below the 2019 levels. Macroeconomic growth was projected to be slow over the next five years, he said, with low- and middle-income countries on a lower growth trajectory than before the COVID-19 pandemic, while high-income countries were generally resuming their earlier trajectories. There was widening divergence across countries, he said, with a risk that low-income countries would fall further behind in the next five years.

26. Turning to the effects on public spending capacity in low- and middle-income countries, he said that in 23 countries general government expenditure was expected to keep growing over the next five years. For another 32 countries, growth was expected to be slower, while spending capacity in 13 countries would keep dropping. Mr Kurowski said debt servicing obligations were projected to keep growing in 23 countries. Overall, the share of interest payments in government expenditures was at its highest level since the Heavily Indebted Poor Countries (HIPC) initiative of the late-1990s. Likely future health spending would be shaped by such macro-fiscal conditions, he said. In the 13 countries with contracting economies there was a big divergence between their historic spending capacity on health and their projected trends. In the stagnating 32 countries, there were also big gaps, but with a slight rise in spending capacity, while the 23 countries with expanding economies were catching up with the pre-COVID trend. In the 13 countries with shrinking economies, the share of health in government spending was about 9%; it would have to almost double by 2029 to compensate for current trends. For the 32 stagnating countries, the share of health in government spending had to rise by 6%, and in the 23 countries with expanding economies it had to rise by 2%, which was feasible, Mr Kurowski told the meeting.

27. Mr Azcona discussed the interrelated challenges of debt distress and donor dependence in countries with high HIV burdens. In sub-Saharan Africa, he said, several countries were already in debt distress and others were at high risk. There was a widening funding gap for HIV in low- and middle-income countries overall. Funding had risen until 2016, but had fallen subsequently, including from domestic sources. Noting a big drop in contributions from bilateral donors other than PEPFAR and the Global Fund, he pointed to an alarming decrease in external assistance in the past decade in regions experiencing a surge in new HIV infections. The biggest funding gap tended to be for primary prevention.

28. Sustained domestic spending on health and HIV was needed to address funding gaps in broader UHC financing and for ending AIDS, Mr Azcona said. Notably, more than half of 63 countries analysed had increased their domestic spending on HIV in the past six years. While the financing gap obviously had to be closed, he said the economic context also highlighted the need for enhanced efficiency and innovation and for continued solidarity from all funding sources, particularly donors. The integration of HIV services should intensify and more funding should go towards societal and programme enablers, he said.

29. **Yogan Pillay**, Director, HIV & TB Delivery at the Bill and Melinda Gates Foundation, discussed the political dimensions of sustainability. He said the world was at a pivotal point in the HIV and TB responses, with high numbers of people still acquiring these diseases, not being tested and not on treatment. The number of people presenting

with advanced HIV disease (or AIDS) was also rising. HIV responses had changed HIV epidemiology, he said: new HIV infections in sub-Saharan Africa, for example, were beginning to shift from 15–24-year-olds to 25–49-year-olds in some settings. A more granular understanding of the changing epidemiology was needed, which required tools for tracking the changes, as well as new analytics to identify and understand new trends.

30. Mr Pillay suggested that the achievements of the HIV response may also have become its "Achille's heel", with the perception of success undermining funding for HIV. Programmes might have to plan on the assumption of eroding political and funding support for the HIV response. At the same time, the world had to reduce new infections by 90% (against the 2010 benchmark) and keep expanding treatment coverage. This was a big challenge, but there was also cause for optimism—including, for example, recent study results on lenacapavir, which could be a gamechanger if provided at affordable cost and the required scale, he said.

31. Paths to sustainability would differ among countries, depending on their disease burden and abilities to fund their HIV responses, Mr Pillay said, but funding for prevention and for strengthening the PHC and social systems was vital. At the same time, it was not realistic to provide everything to everyone everywhere, he cautioned: interventions had to be prioritized. Cost-effectiveness and cost-efficiency data should guide those decisions and they should be taken in concert with civil society and affected communities. Overall, integrating HIV into the PHC system (he emphasized "PHC", not just "primary care") would be crucial.

32. **Izukanji Sikazwe**, Chief Executive Officer for the Centre for Infectious Disease Research, Africa HIV Control Working Group, Zambia, said the HIV epidemic was still evolving in Africa, a region with the largest youth population in the world, the fastest growing population overall, and more than 20 million people living with HIV. She briefly discussed the heterogeneity of the epidemic and said that men with undiagnosed or unsuppressed HIV were major drivers of the epidemic, along with members of key populations and people in conflict settings. Oppressive laws, stigma, discrimination and violence were major barriers. Ms Sikazwe also pointed to a growing ageing population on HIV treatment, high rates of advanced HIV disease, and large numbers of children still acquiring HIV and dying of AIDS.

33. Those realities and limited fiscal space called for urgent actions from African leaders, who should see the HIV agenda as a national security matter. Urging a shift in mindset regarding HIV and health resourcing, she called for the creation of an African health and wellness fund that would be driven by investments from Africans, not by donations. Also needed were advances in medicines and diagnostic security and African-led research. The lenacapavir study results were inspiring, she said, and showed that science was advancing. But Africans had to benefit. Even though the HIV epidemic continued, external resources were declining, which meant Africans increasingly had to shoulder the burden. The legacies of the continent's current generation of leaders would be shaped by how they respond to the challenges, Ms Sikazwe said.

34. **Edwin Bernard**, Executive Director of the HIV Justice Network, described his experience of living with HIV for over 40 years and emphasized the centrality of the "communities of allies", including key populations, who understand that human rights and health are inseparable. Yet the world was far from reaching the 10–10–10 targets, he told the meeting, and many human rights barriers persisted, including gender inequalities, gender-based violence, discrimination, shrinking civic space and the stifling of community leadership. Almost every Member State fully or partially criminalized one or more key populations and 79 countries retained laws that

criminalized HIV transmission, exposure or nondisclosure, he said.

35. Brave organizations continued to work on these issues, including the Robert Carr Fund, which performed vital work, Mr Bernard said. Dismantling discriminatory systems that had been built over decades took time and money and needed community leadership, he said. Some relatively simple steps were also available, however, such as decriminalization. The decriminalization of drug use, he said, could produce cost-savings that could be used to fund human rights programmes; it would also reduce new HIV infections among people who inject drugs. Following the science saved money and lives and would help make the HIV response sustainable, he said. All forms of HIV-related stigma and discrimination and criminalization should be ended and countries should strive for greater equality and empowerment, he urged.

36. In discussion from the floor, speakers stressed the need to continue breaking down barriers, building and supporting strong community leadership, and advancing gender equality. They urged Member States to strengthen their legal and other frameworks to protect women and girls, as well as expand access to comprehensive SRH and HIV prevention treatment and care services for all. They also called for strengthening the integration of HIV, human rights and gender equality across sectors and for global mechanisms to facilitate funding for community-led organizations, especially women- and youth-led organizations. Speakers stressed that communities were key: they were the experts in their lived realities, they were trusted and they made the difference in HIV responses. However, key policymakers often did not appreciate those realities and it was difficult to mobilize their support for institutionalizing key population involvement in programme planning and implementation. Limited resources were making it even more difficult to sustain person-centred and rights-based programmes. Speakers appealed to donors, leaders and planners to resist complacency and increase their technical and financial contributions HIV responses.

37. In reply, Ms Sikazwe said that HIV responses had to be country-owned and governments had to recognize that progress on societal enablers was crucial. Mr Bernard stressed the importance of human rights and community leadership and called for the removal of the remaining barriers. He said communities were the experts on what it took to end AIDS and he urged countries to support them (including by replenishing the Robert Carr Fund) and to move forward with decriminalization.

Round table 2: Sustainability challenges and opportunities

The session discussed lessons and experiences pertaining to some of the key challenges and opportunities for sustaining the impact of the HIV response to 2030 and beyond.

38. **Glenda Gray**, President of the South African Medical Research Council, noted the progress made but emphasized that new HIV infections still had to be reduced drastically. This required greater availability and demand for HIV testing and more regular testing in settings with high HIV incidence, along with rapid triage into care and wide promotion of U=U (undetectable = untransmissible). Ante- and post-natal HIV testing for women remained important. In sub-Saharan Africa, stronger demand creation was also needed for voluntary male medical circumcision. She noted the need to understand the service and other barriers causing the comparatively low circumcision rates in southern Africa. Also underlined was the need to address cost issues affecting access to oral and injectable PrEP. AIDS-related deaths were still unacceptably high, Ms Gray continued, but there were many opportunities to reduce those numbers, including the use of long-acting antiretrovirals (especially for breastfeeding women) and ensuring that children with HIV are in care and can access

suitable ARVs. More men with HIV also had to be diagnosed and brought into care, and community viral load monitoring had to be accessible so more people can have suppressed viral loads.

39. Further research was needed to eliminate paediatric HIV infection, Ms Gray said. It was crucial to know which interventions would make the most difference and to understand the potential roles of long-acting ARVs and broadly neutralizing antibodies in the sphere of treatment and therapeutics. The latter promised to become an important tool and required ongoing research. While noting the potential impact of long-acting PrEP, she cautioned that a scale-up held major cost implications. The need to continue research into an HIV vaccine, was stressed. Resources needed for that work should be localized and African scientists should be able to play stronger roles, Ms Gray urged. It was also important to note that pharmaceutical manufacturing capacity in Africa was still lacking, as was the capacity to rapidly analyze and evaluate new candidate vaccines. These manufacturing and related capacity issues on the African continent had to be resolved, she said. Investments in HIV research were also investments in the next generation of scientists and scientific infrastructure in Africa.

40. **Mariângela Simão**, Director-President of the Instituto Todos pela Saúde (ITpS), Brazil, said that innovation and sustainability had always been at the core of the HIV response, which had been driven forward by the engagement of civil society, researchers, public health professionals and communities. The current context, though, brought new challenges, including competing health priorities (such as the increasing burden of noncommunicable diseases in developing countries), fiscal difficulties and spreading conservatism in many countries. This could be seen in multilateral negotiations and at national level, where opposition to human rights and the needs of vulnerable populations was becoming more strident. In addition, there was the ongoing challenge to ensure equitable access to both existing and new technologies—as seen during COVID-19, when the richest countries were the first to get vaccines and other health technologies tools, regardless of need or burden of disease.

41. Importantly, she added, those issues were widely recognized and there were opportunities to address them. Partnerships between research institutions, pharmaceutical companies and governments could speed up technological transfers and increase manufacturing capacities, even though these were difficult processes. But diversifying production, though important, was not enough, she cautioned. A robust framework was needed to ensure long-term access and affordability; the way to achieve that was through changes to the intellectual property (IP) rights regime. IP rights may incentivize innovations, Ms Simão said, but they drive up prices and limit access by facilitating and entrenching monopolies. This complex challenge had to be addressed, including by removing barriers that prevent countries from using existing policy options such as the TRIPS flexibilities, she said.

42. She also called for reaffirming commitments to human rights and social justice, and for devising mechanisms to translate policies into concrete actions. Referring to the earlier discussion of economic challenges, she reminded that economic growth had not been ideal for low- and middle-income countries when the AIDS pandemic had begun either. When Brazil began its treatment programme, she recalled, the World Bank had advised it that the programme would be unaffordable and unsustainable.

43. **Adeeba Kamarulzaman**, President & Vice-Chancellor of Monash University Malaysia, Malaysia, said financing of the HIV response required keeping it on national and global agendas. It was important to celebrate progress and show how investing in the HIV response could bring wider social and economic gains. Financing health was not a cost but an investment in the future, she said. Integration into primary health care and

working alongside civil society could help create more seamless health systems but it also required greater support for the use of information technologies, she said. Civil society organizations were fundamentally important, but they needed enabling environments, financial and technical support, and civic space, along with suitable legal and policy and financing frameworks. Legal and policy barriers had to be removed. It was impossible to end AIDS while retaining laws that criminalize key populations, Ms Kamarulzaman said. Despite the difficulties, there were promising signs of progress on that front, she noted.

44. **Cindy Kelemi**, Executive Director, Botswana Network on HIV and the Law, Botswana, spoke on the role of communities for long-term sustainability. She said Botswana had developed a transition plan and had achieved the 95–95–95 targets, yet "on the ground" it did not seem to be ready yet to transition to sustainability. The HIV response, especially the community response, was still heavily reliant on donor funding (mostly PEPFAR and the Global Fund) and on an expectation that the Government would step in to bridge gaps in donor funding. There may be a political willingness to do so, she said, but the capacity to follow through was not necessarily present. There had been a 30% drop in funding for civil society due to competing demands for funding, for example, with key population organizations often the first to lose funding support. She appealed for ring-fenced support for community organizations. The transition to sustainability should not disempower communities and civil society, she insisted.

45. Stressing the importance of a human rights-anchored response, Ms Kelemi said that Botswana's human rights projects were isolated and the scant funding they received was mostly from donors. Those projects would not necessarily survive the departure of donors, she warned. Sustainable responses also had to address the structural barriers, yet those programmes also tended to be underfunded and it was unclear whether the Government would be able to take on those funding responsibilities. Regarding health system integration, she said supply chain management, for example, was strong for HIV but not for the rest of the health system, which experienced shortages of drugs and other commodities. She warned that integrating HIV into an ailing system carried a risk of eroding the gains achieved against AIDS. Summarizing, she said current budget capacity did not allow the Government to assume full responsibility for the entirety of the HIV response. Building a resilient health system should be a priority, but there was not enough investment in such an undertaking. The lessons from the COVID-19 experience were not being learned, she said.

46. **Ganna Dovbakh**, Executive Director, Eurasian Harm Reduction Association, Ukraine, said her region was not halting the growth of the HIV epidemic because it was failing to reach the 10–10–10 targets. Key populations were treated as criminals, including by health workers and religious leaders. They did not get the information they needed, and they struggled to access services. More countries were restricting civic space and attacks on key populations were increasing. The armed conflict in Ukraine had also disrupted access to essential medicines and social services and increased gender-based violence, especially in the occupied territories. Refugee-receiving countries were also affected, she said. More pragmatic approaches to address the interrelated HIV challenges of human rights, mental health needs, HIV service access and criminalization were needed, she noted. Community-led HIV responses were key, yet community organizations and other NGOs were being targeted and labelled as "foreign agents". Civil society organizations needed flexible funding and other support to change harmful laws and police practices. International support could help ensure that these organizations can operate and do their work, she said.

47. Speakers highlighted the need for funding and other support for community and other civil society organizations and for their meaningful engagement in the HIV response.

They said policy reforms were needed to advance the integration of HIV services and other services in the context of stigma and discrimination and criminalization of key populations. The meeting was told that there was a 94% funding gap for harm reduction, with most of existing funding reliant on the Global Fund. Harm reduction had received only 0.4% of all domestic funding for HIV in 2023. Sustainability was a distant dream in such a context, speakers said. Some speakers urged that decriminalization be made a priority and that the decision point reflect this, including by calling for divesting from the criminalization of drug use. Ending the war on drugs would help achieve a sustainable HIV response, they said. It was also noted that most philanthropic funding for HIV came from only four major donors, which was a risky situation. There was a request that the decision point address the needs in the Middle East and North Africa region, which had a 82% HIV funding gap and rising numbers of new infections in the context of limited robust HIV data and very little domestic funding for HIV.

Round table 3: A vision for a sustainable HIV response

48. The session discussed various visions of sustainability, including initiatives taken by governments, multilateral institutions, civil society organizations and others, and the strategies they have adopted.

49. **Ambassador John Nkengasong**, Ambassador-at-Large, US Global AIDS Coordinator, and Senior Bureau Official for Global Health Security and Diplomacy at the United States President's Emergency Fund for AIDS Relief (PEPFAR), said the end of AIDS was feasible and UNAIDS had to remain the entity guiding and supporting efforts to reach that goal. It needed the resources to continue doing the work it had done for almost 30 years. He cautioned that the gains made against AIDS were fragile and had to be improved on. There were important achievements: several countries had reached or were close to reaching the 95 targets, for example. However, maintaining millions of people on HIV treatment for life was becoming a bigger challenge. About 20–50% people in some settings were presenting for treatment after having stopped or interrupted treatment earlier. The reasons included the cost of treatment and associated expenses, stigma and a lack of consistent drug supplies. In addition, many millions of people with HIV had not been diagnosed yet—most of them children, adolescents, men and members of key populations. Reaching them demanded granular data to focus interventions: the challenge was not to cast a wide net, but to cast it effectively, using data, he said.

50. Mr Nkengasong reiterated that there was a pathway to reach the 2030 targets and to sustain the rising numbers of people on treatment and keep them in care. This required progress on three fronts: political, financial and programmatic. Political visibility was crucial: HIV had to be kept a priority. Programmes had to focus on the right actions and, since countries faced fiscal constraints, resources had to be used effectively and efficiently. Adaptation and change would be needed, combining proven approaches (including behaviour change and working with adolescent girls and young women) with new ones. He concluded by saying a strong and well-financed UNAIDS was vital for the global HIV response.

51. **Peter Sands**, Executive Director of the Global Fund, concurred with other speakers and said a sustainable HIV response became possible when the epidemic was under control. In places where new infections were increasing, suitable programmes had to push the response in the right direction. Ultimately, domestic resources would have to finance the response and this meant that country-led financial sustainability was needed. But it was equally important for the money to be spent effectively and appropriately and for it to reach community organizations. In current circumstances, though, sustainability still required continued support from PEPFAR, the Global Fund

and UNAIDS, since many countries could not yet rely on domestic resources alone.

52. Programmatic effectiveness was vital, he continued, as was ensuring rapid and cost-effective access to new technologies. Programmes should be people-centred and differentiated to the needs of different communities, Mr Sands said, but not all countries were good at that. While the integration of HIV programmes with primary health care was important, it also tended to become more difficult as epidemics diminished, he added. Turning to the political and policy dimensions, Mr Sands said the people most at risk had to be protected and have access to services. If policy issues around LGBTQI+ rights and gender equality were not addressed, the HIV response could not be sustainable. Ultimately, political will was indispensable, he said, but the response had been so successful that many political leaders no longer saw AIDS as a problem. It had to be made clear that merely staying on the current track was not an option with a pandemic like AIDS, which quickly adapts and overtakes country responses, he warned. Standing still was no solution.

53. **Ruth Laibon-Masha**, Chief Executive Officer of the National Syndemic Diseases Control Council and chair of the HIV Multi-Sectoral Leadership Forum of National AIDS Commission Directors, Kenya, reflected on different conceptions of what sustainability might mean. It was important to remember that different social, economic and political determinants were driving the HIV epidemic and that it was constantly evolving. She pointed to the demographic transitions, including ageing populations with HIV, and continued stigma and discrimination as major concerns. While noting that the efficiencies being achieved could be plowed back into systems, she cautioned that cofinancing systems sometimes skewed the ways in which countries handled their budgets. The education, public service and social protection sectors were especially important for country readiness, as were conducive political systems, she said.

54. **Keren Dunaway**, Global Programmes Officer, International Community of Women Living with HIV, Honduras, said that many of the challenges were unresolved and she warned of a risk of losing ground. The resilience, knowledge and trust of community-led organizations were great assets, however. HIV responses were most effective when communities were in the lead, but they could not play those roles while under-resourced and destabilized by the uncertainties of sustainability. Partnerships between governments, the private sector and communities could be a source of sustainability if approached correctly, Ms Dunaway said. However, it was important that the private sector not prioritize economic gain over people's lives. Local ownership of country responses should be promoted and diversified funding had to be available, she added, and young women should be more involved in the policy decisions that affect their lives.

55. Speakers thanked the panelists for their presentations. While noting the need for common understandings of sustainability, they generally agreed that sustainability ultimately demanded strong political will in countries, an active and engaged civil society, and sufficient funding. Sustainability efforts had to be based on robust scientific evidence, they said, and had to push for the elimination of HIV-related stigma and discrimination and the removal of structural and legal barriers. The guiding principle should be the engagement of communities of people living with HIV as partners, not as beneficiaries. All people should have equitable access to HIV prevention, treatment and care services—which required removing social, legal and structural barriers, and promoting human rights and gender equality. COVID-19 had shown how vulnerable health systems and certain populations were, speakers told the meeting.

56. A fit-for-purpose Joint Programme had a key role guiding and supporting countries along this complex journey, they said, but countries themselves were best placed to

understand the issues they faced and how to best to use the funds and support they received. Pointing to the urgent need for increased predictable and sustained funding, speakers said governments, donors and the private sector had critical roles in mobilizing resources, including through innovate mechanisms. They emphasized the importance of long-term core funding for women-, youth- and key population-led responses and of financial protection for people living with HIV and other affected communities.

57. Community responses were successful and had to be funded, supported and engaged, speakers urged. The meeting heard how some country responses had sought to institutionalize activities led by key population and young people. To reduce the reliance of those efforts on donor funding, options such as social contracting were being pursued. Other speakers noted that their HIV programmes were already funded almost entirely with domestic resources and sought to empower communities, including through support for community-led systems strengthening and monitoring. They emphasized the importance of partnerships and of appropriate integration between health and non-health services. A holistic approach to health care was crucial, they said.

58. Some speakers said strengthened PHC and greater synergies with SRHR, TB and gender-based violence programmes could boost HIV programmes and help create more robust and resilient health systems. Harm reduction systems and prison programmes also had to be integrated more fully into public health systems. As countries moved to integrate HIV into primary health care, communities had to remain at the centre, the meeting was told.

59. Also highlighted was the tension between dealing with limited financing and assuring quality services: resource allocation choices would have to be made and they would affect the quality and availability of services. It was also important to recognize the risks which integration may pose for service quality and key populations, speakers said. They urged that all necessary steps be taken to ensure continuity of access and quality.

60. In reply, panelists reiterated the importance of keeping communities at the centre of the HIV response and sustainability efforts. They highlighted the needs of young people, key populations and women, and said advocacy for policies that protect, empower and fund communities were vital. A collective effort involving all stakeholders was needed. They agreed that pathways to sustainability had to be defined for each country and had to embody joint accountability and responsibility. This involved bringing politicians and policymakers along and keeping communities at the centre of the processes.

Conclusion

61. **Christine Stegling**, Deputy Executive Director for Policy, Advocacy and Knowledge at UNAIDS, presented a summary of the discussions. She began by saying that affected communities and the most marginalized people stood to lose the most if the HIV response did not achieve its goals. There were still high numbers of HIV infections in many countries, advanced HIV disease was a major concern, and programmes were missing children and key populations. The ultimate goal was to arrive at a point where no one was acquiring HIV, she said, but the current trajectory would not achieve that. Fiscal space was becoming limited, with low economic growth and low investments in health and other social services posing major barriers. HIV responses would have to devise new solutions to these challenges.

62. Country ownership was crucial for sustaining the HIV response, Ms Stegling said.

Sustainability roadmaps had to be country-driven, fit country realities and involve both governments and civil society. There was an opportunity to rethink the multisectoral response for the future and to safeguard and "ring-fence" community systems and human rights support. The most cost-effective ways to reduce new infections were decriminalization, removing human rights barriers, and reducing stigma and discrimination. Integration was important, she said, but there was a lack of clarity about the standards for integration and how to ensure inclusivity. Not all attempts at integration were working as well as hoped, she noted, citing the example of HIV and TB integration.

63. Ms Stegling said it was vital to invest in new solutions, including in research capacity in Africa and elsewhere to find a cure and a vaccine, and to make them affordable to all countries. A continued commitment to radical hope was needed, along with a capacity for radical resilience. Countries like Brazil had shown that even when large treatment programmes had seemed impossible, governments had succeeded in introducing and sustaining them.

Proposed decision points

64. *Takes note* of the background note (UNAIDS/PCB (54)/24.22) and the summary report (UNAIDS/PCB (55)/24.27) of the Programme Coordinating Board thematic segment on "Sustaining the gains of the HIV response to 2030 and beyond";

65. Noting the centrality of sustainability as countries' ability to have and use, in an enabling environment, people-centred, human rights- and gender equality-based systems for health and equity; empowered and capable institutions and community-led organizations; and adequate, equitably distributed resources to reach and sustain the end of AIDS as a public health threat by 2030 and beyond, upholding the right to health for all, *requests* Member States to:

a. Accelerate the work towards long-term sustainability planning in all aspects of the HIV response, advancing integration of different dimensions of the response, especially in UHC and PHC, ensuring greater synergies with sexual and reproductive health and reproductive rights, TB, gender-based violence programmes and other sectors that affect HIV outcomes;

b. With participation from communities and partners, advance the development of country-owned HIV response sustainability roadmaps that enable effective, context-specific, people-centred, integrated HIV services with full respect of human rights for equitable and sustained impact, including community-led HIV services;

c. Strengthen political mobilization to sustain the HIV response, remove existing barriers to ending AIDS, and make sustainability a central component of the long-term vision beyond 2030 and next Global AIDS Strategy;

d. Advance data-collection and -analysis system capacities, including monitoring and evaluation, to ensure that HIV epidemiological, community, societal and financial priorities are effectively identified and addressed;

e. Prioritize an adequately resourced health care system that increasingly includes integrated, differentiated, people-centred, accessible, and country-led HIV interventions that ensure gender equality, uphold human rights, and meet the needs

of all, including key[1] and vulnerable populations and acknowledging and supporting the contribution of community-led organizations;

f. Ensure enabling policies and legal environments that support equitable, accessible and high-quality HIV services that leave no one behind with strong community leadership and engagement, and societal enablers to end HIV-related stigma, discrimination, criminalization, and gender inequalities including through the promotion of U=U (undetectable = untransmissible) messaging, as appropriate, taking into account WHO guidance, while continuing scientific research on the role of viral suppression of HIV transmission;

g. Ensure implementation of evidence-based interventions to prevent, diagnose and treat HIV and its co-infections and comorbidities and to ensure access to safe, effective and affordable medicines, including the most innovative health technologies, diagnosis and treatment for all, without discrimination particularly in low- and middle-income countries;

h. Facilitate local production of medicines, including by promoting technology transfer, supporting the improvement of manufacturing capacities in low- and middle-income countries, and promote increased access to affordable, safe, effective and quality diagnostics and medicines, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of International Property Rights (TRIPS Agreement) as amended, and also reaffirming the 2001 WTO Doha Declaration on the TRIPS Agreement and Public Health which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to essential health tools for all, and notes the need for appropriate incentives in the development of new health products;

i. Reinvigorate domestic and international financing that is adequate, sustainable, evidence-based and equitable, including both a robust increase of domestic investments and adequate donor financing through the Global Fund's next replenishment;

j. Note with concern the current obstacles to further domestic investment in the HIV response faced by low- and middle-income countries due to low revenue collection and high debt service costs that exceed their health expenditure, and call for solutions to increase countries´ fiscal space in the medium term, allowing for a robust growth trajectory in HIV and health financing;

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

k. Ensure that both domestic and donor financing increasingly support community-led HIV responses and monitoring, including through the development and implementation of social contracting models;

66. *Request* the Joint Programme to continue to support and facilitate countries' efforts, under national leadership, with robust community participation, to develop and implement holistic, country-owned long-term HIV Sustainability Roadmaps.

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