Center for Strategic and International Studies

TRANSCRIPT

Event

"Takeaways from the 2026 International AIDS Conference"

DATE

Monday, August 31, 2026 at 9:00 a.m. ET

FEATURING

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J. Stephen Morrison:

Welcome to this CSIS roundtable on the outcomes of the International AIDS Conference held in Rio de Janeiro, Brazil from July 24th to the 27th. Special welcome to those who are here in person and those joining us online. The video is posted on the CSIS.com website, and we'll post in the next 24 hours a transcript, also on the CSIS.com website.

I'm J. Stephen Morrison. I'm a senior vice president here at the Center for Strategic and International Studies in Washington, D.C., where I direct our work on global health and health security.

This roundtable is hosted by the CSIS Bipartisan Alliance for Global Health Security, co-chaired by former Senator Richard Burr and former CDC Director Julie Gerberding. Special thanks to my colleague Priya Chainani for her tireless, sterling work pulling all of this together. She also did the same in Rio, where we had two very successful high-level dinners that we hosted.

Special thanks to my colleague Katherine Bliss, a senior director – senior fellow and director here at CSIS. She cannot be with us this morning and sends her regards. She heads up our alliance work on HIV/AIDS.

And special thanks and congratulations to Dr. Beatriz Grinsztejn and the Brazilian government on hosting the conference in Rio.

And a special congratulations to a close friend and ally, Birgit Poniatowski, head of the International AIDS Society, who also pulled this off remarkably well.

We've been holding these sessions post international AIDS conferences for over two decades, frequently with Jen Kates and the Kaiser Family Foundation, KFF. They're meant to distill some of the most important developments in new thinking and be able to engage with our audience here in Washington, and beyond.

We're very privileged to have with us today as roundtable participants several key leaders. Coming in from Zambia is Lloyd Mulenga, professor of infectious diseases, University Teaching Hospital in Lusaka. Welcome to you, Lloyd. We're joined by Doris Macharia, president of the Elizabeth Glaser Pediatric AIDS Foundation, EGPAF. And we're joined by Omar Sued, HIV treatment and care regional advisor at the Pan American Health Organization, based here in Washington, D.C., PAHO. He's also a member of the International AIDS Society governing council. And we're joined by Jirair Ratevosian, a close friend and a senior associate here at CSIS, and a research scholar at Duke University.

A few – bear with me for just a few minutes. I want to say a few things before we begin the roundtable. Since she passed away last week, Dolly Parton has

dominated the news, the global news. And we've all come to better appreciate the many remarkable, compassionate, creative, and courageous things that she did over the course of her 60-year career. From the earliest days in the 1980s and extending over the next coming decades, she spoke out repeatedly in defense of those living with AIDS. She contributed to many charities and many rallies of talent to focus on HIV. She was an advocate of science and a supporter of scientific research, and a longstanding advocate of LGBTQ+ people and marriage equality. She financed the Academy Award-winning documentary on the AIDS Memorial Quilt. I think that was 1989, "Common Threads: Stories from the Quilt." We're going to dedicate today's convening in Dolly Parton's honor.

Before we get started, a few framing thoughts. The gathering in Rio occurred at a moment of unprecedented uncertainty and challenge for global HIV/AIDS. It's the first International AIDS conference since the unforeseen and swift rupture that began with the advent of President Trump's second term in office in early 2025. We did have the Kigali conference that same year and the off-cycle meetings, which revealed a lot. But that rupture led to the dissolution of USAID, reductions in PEPFAR – and disruptions in PEPFAR funding, considerable upheaval and uncertainty.

Rio de Janeiro was really the first – was the first occasion for the U.S. government team that's been charged over the past year with standing up the America first global health security – global health strategy to engage with those assembled in Rio on the status of the MOU compacts with 34 countries, the approach that's unfolding right now, and the special interest that the administration has taken in promoting lenacapavir and other innovations. There was, in the middle of the conference, the map debacle, which became a distracting sideshow, regrettably. But far more important, in my estimation, was the fact that the U.S. team showed up and engaged in earnest in multiple ways. It hosted a preconference, participated in many panels and other events. That took a certain amount of guts and patience, and was very timely and very important. And I hope we can build on that.

It was not made easier, however, by several related things. The Trump administration has yet to admit any responsibility for the rupture. And that, of course, comes to the minds of many. And the day before the conference opened, Elon Musk, who led the DOGE charge against USAID, held an 80-minute conversation with the managing editor of The Economist, in which he denied that any lives had been lost and insisted that philanthropies and NGOs could fill the gap. So this particular – this particular unfortunate convergence created great awkwardness.

The U.S. occupies a very peculiar place today, when you think about it. For 25 years, the U.S. was the unipolar guardian of global HIV/AIDS, accounting for three quarters of the money, accounting for investment of leadership in

creating PEPFAR, and the Global Fund, and other innovations. That reversed in early '25, when the U.S. became the lead in in in challenging and undermining these very initiatives. In later 2025, there was the reversal in which the U.S. aspired to become a reformer, with the advent of the America first global health strategy. And it still found itself, even as the financial baseline declined 30 or more percent – found itself still accounting for the majority of dollars.

So, you can imagine, these quick – these quick back-and-forth changes created considerable dissonance and made it even more important that the U.S. be there engaging. There are many questions and issues that cut across the Rio conference. We'll hear about some of them today. Money, the financial baseline has dropped significantly and is not likely to recover. There's major uncertainty as to where, if at all, that that gap begins to be covered again, particularly from the major impacted countries themselves. There's only been fairly modest increases coming from the countries impacted themselves.

Leadership. The rupture begged the question of how African and other leaders would respond to the exposure of their critical dependence. We've had the Accra reset. We've had health sovereignty emerge as a major concern. Questions here are what does that mean – what does that mean in reality, in translation into new ideas, new commitments politically and financially? The high-level meeting in New York City had been held just before, in June. And it was a very mixed outcome. It was exposing a very fractured community of states. We're still looking to see where does – where does the very highest levels of leadership enter these conversations?

We've had a lot of discussions around changes in in approach – in service delivery approaches. I think many people, and we'll hear from our speakers and from you – there seemed to be a shift towards a very pragmatic, informed, forward look on how to carry forward in this period. And I think many people welcomed that. Technological innovations fueled optimism and dominated a lot of attention, particularly around long-acting prevention and treatment agents. There is always the question of what's the value of this conference. And this conference came in on the small side, but it but it rose to about 7,500 people participating. It drew remarkably high level of global media attention. But there's still this question of what is the fit for the conference in the world that we live in right now. I know the governing board for the International AIDS Society just met a few days ago, and this question was on the – on the table.

Community resilience. I think there was enormous evidence around the – not just the discussions of service delivery approaches, but questions around how the communities themselves are going to organize, and inform, and shape national decision making and international decision making. There's a

new generation of leaders coming forward that we've seen, which was very inspiring. And then – and there's a – you know, this is a community – this is a very unusual conference that brings together scientists, implementers, philanthropies, those that lead the social movement.

In this moment of rupture, post-rupture, enormous uncertainty, there is this outstanding question of whether the protest culture takes new form and comes back in another way. I didn't see a whole lot of that. I saw a lot – a little bit of the old protest culture. But in terms of what kind of new movement might we see, and is it going to be targeting governments that need to do more? What is the – what does the struggle translate into in these periods? Obviously, there was a lot of discussion around access by Brazil, and Latin American, and other lower-middle income countries to lenacapavir and other new technologies. These are source of great debate.

So we're going to have a quick discussion here over the next – over the balance of this hour. We're going to ask – we're going to have two rounds of questions, then we're going to come to – come to our speakers. And we will bring microphones to you. And we do want to hear from our audience here. We're going to begin with a first round to hear from our participants here about what were the two or three top-line things that you're taking home from this conference. I'm going to ask Lloyd to kick off, since you've patiently been waiting there from Lusaka with us. So, Lloyd, I'm going to turn to you at this moment to kick us off. We need to keep things very brisk. We want to do a quick round and hear from everyone. Just the top two to three things in just a few minutes. Over to you, Lloyd.

Lloyd Mulenga: Thank you so much for inviting me. And I think this AIDS conference was really something which we are looking forward to, those of us who have been really been in the thick of it, trying to see how you can navigate around resource mobilization, trying to see how you can move things around where the gap was left for HIV implementation after there was withdrawal of certain areas of support from the U.S. government. As you rightly said, last year the Kigali conference was a very gloomy meeting. The picture was really that of people who are mourning, not knowing where to go. And I think this conference brought to light that the programs have been sustained over the past one year, showing some form of resilience. And I think it was good to interact with a number of colleagues who are facing the same challenges as those of us who had been running country programs and needed to make those tough decisions.

But also, the conference, besides sharing the experiences, it also brought in another picture of looking forward. It was good to see that we are still thinking of innovations. I think the long-acting prevention was a huge topic. And it was good to start knowing that likely in the near future, maybe late next year or so, we may have the long-acting oral ARVs for PrEP. So, again,

that is looking to the future. So besides looking at what had happened the previous year and where we are now, I think looking to the future and trying to bring in science was really good. And I think the theme was speaking to the fact that we need to rise beyond what has happened. Thank you so much.

Dr. Morrison: Thanks, Lloyd. Over to you, sir.

Omar Sued: OK, thank you. Thank you for having me here. I think there are three issues that I will select to discussion what we got from the conference. In first place in prevention, I think there is no other moment before that we have so many options for prevention. I say we saw more data on lenacapavir, the extended information of the studies. We have more information in the every four months cabotegravir as Dr. Lloyd said, this potential of the oral alimatravir that could be very – I mean, could increase the access to so – to many people. So for first time we can really talk about choice. That is a critical component of combined prevention. And this can be a reality, because different people have different needs. And this is very good.

For treatment, my second takeaway is that also we have a lot of new treatment. We have a – but we have a lot of information about the incredible impact that TLD had in low- and middle-income countries. And as Lloyd and many others say or know, it's very effective, durable, cheap. And also, we have in the conference more information about resistance and how to move forward with that, in addition to very interesting new drugs and combination. I would say that the data for cabotegravir regarding adolescents in The Lancet is very encouraging. And also the ISL/LEN studies; I mean, potentially a combination of lenacapavir-islatravir that can be given once a week that could suppress or maintain the suppression of people that were already suppressed. But if we had that in the future for viremic patient can be a very good option and alternative for TLD in low- and middle-income countries.

And finally, it was a very good place to show a lot of experience from Latin America. I mean, Latin America has incredible national and strong national program, and a strong health-care system in many countries, so – and more than 90 percent of the response is being paid by domestic fund in the region. So this was a beautiful place to launch the HIV Alliance for Elimination, the PAHO Alliance for Elimination, which is a collaborative platform with the Ministry of Health. We have the presence of Ministry of Health of Uruguay, authorities from Dominican Republic, Honduras, the U.S. government participating in this launch. And this is a collaborative place for government donors and also industry to really inform and dialogue in order to make elimination a reality in the country.

So I was very optimistic, very happy in the conference, but also very aware of the long way to go. And the conference provide evidence, also guidance, for the future.

Dr. Morrison: Yeah. I was very encouraged that your boss, Dr. Jarbas Barbosa, was a very strong presence there. He kindly joined one of our convenings, one of our dinners. But he was quite present. The minister of health in Brazil, quite present. It was – the Brazil government, the PAHO, many of the other countries within the region seemed to take this quite seriously.

Dr. Sued: Yeah. Whereas he was always a leader in the HIV response. And Dr. Jarbas was part of this movement also. And he's very committed in PrEP, and prevention, and treatment for everybody. So it was – we were very lucky to have him.

Dr. Morrison: Yes. Thank you.

Doris.

Doris Macharia: Yeah. First of all, thanks for having me. And it was really a wonderful, obviously, conference. And apart from lenacapavir and a lot of the prevention options that were being discussed, was there was a lot of buzz about triple elimination. And as I see Lloyd there, and I know he was such a great advocate and really spoke so strongly about triple elimination, just a good – to see so much momentum from moving from single disease to focusing more on mothers, on babies, I think that was really, really fantastic.

The information and some of the data that was being presented in terms of triplex, the testing of HIV, syphilis, and hepatitis B, I think was very good in terms of it being cost-effective, being able to expand coverage of syphilis testing, hepatitis B, among mothers, as well as averting congenital syphilis and as well as chronic hepatitis B infections among children. I think it was very, very good. However, we also, you know, were humbled to hear that we still have persistent gaps in the PMTCT cascade.

And things that we can address – late maternal HIV testing, especially around breastfeeding. We heard from colleagues from Uganda sharing about how 43 percent of women are being tested, being tested for HIV, and found to be living with HIV when they are breastfeeding. Something that we can do something about, not only with new PrEP options, but also ensuring that we have testing available for women across – not only during pregnancy, during delivery, but also during breastfeeding time.

I think for me the other very interesting aspect came from Brazil. Brazil had a very interesting report out of the national cohort of women that they had been following up. I think about 95,000. Very, very interesting. And what they

noticed is that viral load suppression was optimal until after delivery. Then, across the board, women were just getting unsuppressed, but more so women from poorer areas, women with low education attainment, as well as also Black women. Again, these are areas that we can do something about. So with those conversations about how much we've made progress in terms of the triple elimination, the maternal and neonatal child health, I think has been important. But these areas of persistent gaps in the PMTCT cascade need to be addressed.

I think the second thing Omar, you've mentioned it, in terms of adolescent – exciting, exciting reports on cabotegravir, rilpivirine, and really potential there of decreasing pill burden among adolescents. And we are hoping very much, with the new information that is coming out – it's still investigational in terms of lenacapavir and some of the neutralizing antibodies – hopefully that can be, I think, in the near future where adolescent can really be able to take up these newer options for treatment and decrease the pill burden, and obviously have a better quality of life.

Third thing for me, and maybe finally, is we have done a tremendous job in terms of decreasing new infections among children. And this was reported out during the conference. We are now under 100,000, I think about 93,000 new infections worldwide among children – new infections of HIV. So what does that mean for children who are HIV-exposed, but uninfected? That was, again, a wonderful conversation during the conference, but something that we need to start picking up on because are our systems ready for these children who have neurodevelopmental challenges and other sort of challenges that we have not really been prepared for? We've not been tracking children who are HIV-exposed and uninfected. And this is going to be the new cohort that's going to bulge. We need to be ready for those children, to be able to support them, so that they can also live the lives that they need to live, to thrive as well.

I think that was the last one, but maybe the very last one, Stephen – (laughter) – was, of course, community-based. I can't leave you without saying, in terms of the community-based support and community-based antenatal care. That was, I think, so welcoming for me, just to hear some of the good, good reports out from Nigeria, in northwest Nigeria, working with traditional birth attendants, community health workers, and faith-based organizations. That was wonderful, in terms of uptake of testing, linkage of mothers to care and treatment. Absolutely amazing. Again, things that we can be able to replicate and scale up quite easily. Yeah, I think those are four questions. Thank you.

Dr. Morrison: Thank you. Good job

Jirair, you have written a couple of really useful Substack commentaries

during the preconference that the USG hosted. You enumerated 14 or 15 key points that came out of that. You have also been super active on the AI agenda. We had – one of the very important revelations at Rio was the release of the amfAR study around service disruptions, 1,700 clinics, there was this whole question around the impacts on health workforce, impacts on service delivery and closure, getting a clearer picture of what the impacts were. Say a few words.

Jirair Ratevosian: Thanks, Steve. You know, Doris said it all, but I'll try to fill in a few blanks. I think, you know, as Lloyd said, we really saw the impact of all of the major decisions that had been made from donor governments over the last year unfold in real life. And I actually found the conversations in Rio and the presentations a lot more refreshing than the ones we're having here in Washington, to be frank. We heard a lot from governments about how they're making difficult choices around prevention, prioritization, and then modernizing their treatment regimens. So Sierra Leone gave a presentation on how they're bringing down their number of ART regimens from 15 to three, for example. Other governments talked about how they're making difficult choices about what priority – what populations to prioritize as it relates to prevention scale up.

So governments were presenting, I thought, refreshing presentations around how they're dealing with big changes to donor funding and how they're integrating HIV services more into primary health care, into TB, into malaria. All of that was really refreshing. I think we all have to unpack it, understand some of the good things that are happening, and then identify some risks that are associated with all of these shifts. But I thought all of those presentations were great. And we have to hear more from governments.

As you mentioned, AI was big. I think this conference will be remembered as mainstreaming AI into HIV programming. There were – there was a plenary talk given on AI. There were a number of satellites, a number of abstract-driven sessions. Researchers from China, from South Africa, from Brazil had shared new insights in terms of how AI is being incorporated into service delivery. Chatbots are being used to identify who could be at risk. Chatbots are being used to identify geographically which populations to be prioritized. What we don't have yet in the AI space is linking all of that to outcomes, to health outcomes. And I think that's coming, but it's an area where the evidence is still a bit lacking.

But I think AI has entered the HIV mainstream, and it's also part of the way governments are also trying to adapt to the moment. In the government presentations, I heard how governments are using AI to modernize supply chain delivery. And we heard from both the major donors, Global Fund and PEPFAR, how they're actually signaling interest in AI and what they might fund in the future. So it's an area to watch for.

Dr. Morrison: You know, we've had this recent proliferation of long, very powerful statements on AI. We had the pope issue an encyclical – a very powerful encyclical. We had Bill Gates release a 6,000-word essay at the end of last week. The Trump interview – I mean, the Musk interview with The Economist that I referenced on July 23rd, the main point was his thesis around where this is all going in terms of robotics and AI in the broader economies, and what can we expect. Some very dramatic estimations. But the debate is shifting dramatically around AI.

And I just wanted to ask you, let's go back to Lloyd, what did you observe in Rio in terms of the way that people are talking about AI? It's not just a question of applications and utility and beginning to understand what the benefits may be. We've entered a whole different era of debate right now on AI, certainly in this country but way beyond that, with – as I mentioned. Lloyd, what was your – what was your thoughts?

Dr. Mulenga: Yeah, interesting. I think around AI, as a country – in fact, Zambia, we had been trying to see how can we look at some of the health outcomes being improved with the utility of AI? And what we also did discuss in Rio is the possibility of having some of these layered on our electronic health systems, which can help us maybe predict those who are likely to fall out of care and also, you know, when the resources are also going down, how can we utilize that to have the predictive models as well?

Then also, how can we utilize that to help the community health workers? We have now about 15,000 community health workers. And we expect, especially if we have the MOUs concluded with the USG, commitments to them going to up to about $40,000, so – or, 40,000 community health workers. So how can we utilize the AI to also help improve capacity and also help improve skills in the community health workers? So we see a value of AI making the delivery cheaper, but also to enhance the skills of the various community health workers. And this was, again, what was resonating among some of the programs, especially from the resource-limited settings, on how we can embed these in our own programming and also in our health information systems.

Dr. Morrison: Thank you. So, before we move on to the second round, I want to come back to two questions around U.S. policy. One is that the South African – the U.S. relationship with South Africa has gone through an extraordinary transformation. By early next year, there will be a complete dissolution of the PEPFAR relationship. There's been dramatic disruption of NIH grantmaking and other – maybe we will see some return to eligibility, but the three-decade-long partnerships built with South African scientific talent and expertise, all on the table at this particular time.

And a bit outside of all consideration around the America first global health strategy, this is a policy that gets pulled back to Stephen Miller, and the White House, and allegations of genocide against Afrikaners, and promoting migration. I mean, it's a different – it's a whole different political current that is driving this, which complicates things. What does this – what does it mean that that we have this significant new hole in the engagement of the U.S. in Africa, on science and programs? What does this mean?

Dr. Ratevosian: I'm happy to say a few words. Steve, you know, first, it's important – two things. One, it's striking that we didn't see South Africa being promoted in association with PEPFAR's success, which is traditionally what we've been accustomed to seeing. As PEPFAR's numbers go up, South Africa's numbers goes up, and vice versa. So South Africa was always the biggest portfolio within PEPFAR's work. And so when the U.S. hosted something, South Africa was always nearby, in terms of communicating success. So that was, I think, a stark realization of the moment that we're in.

But South Africa also showed up in massive ways. They had a big delegation, senior ministries –

Dr. Morrison: Deputy minister.

Dr. Ratevosian: The deputy minister was there. The South African – SANAC, the South African National AIDS Council, brought examples of countries – sorry – of companies ready to license lenacapavir. They brought that to show to Gilead. And South Africa also communicated their LEN results. And they now have the most number of people on LEN in the entire world – more than in the United States, by the way. And so – but their communication also, I think, exposed some areas of risk. For example, in LEN rollout key populations are still lagging behind. And that's in South Africa, where you have constitutional protection for LGBTQ+ people. So they showed up in big ways but, again, the implications of PEPFAR's withdrawal were evident.

Dr. Morrison: Yeah. Doris.

Dr. Macharia: Yeah. I was just going to just add, I mean, even just being with the South African delegation at Rio, one of the things that was also very – the realization in terms of their own LEN rollout, and what that informs especially for us, as Elizabeth Glaser Pediatric AIDS Foundation, and many children and mother advocates, is they've got the largest cohort of pregnant and breastfeeding women who are enrolled in LEN. And that in itself can be able to tell us more in terms of how these populations are – of course, in terms of acceptability, how they are how they're doing in terms of LEN rollout. I think they'll be able to set and be a pace setter as we're thinking about LEN rollout, especially around the MNCH work that we are doing. So I think that's going to be really, really critical.

I think second thing is that their own resource mobilization, domestic resource mobilization, I mean they've done a tremendous job in terms of the national health insurance. And they continue to do that. And I think they are – they are showing up in terms of making sure that they can try and bridge that gap that they currently have to continue supporting the large, large numbers of people who are living with HIV in South Africa. So I think there's a lot to be learned. They are, I think, bravely trying to make sure that they lead. But there's also a lot for the rest of the communities within Africa to sort of learn, whether it's LEN rollout, and other – and other initiatives that the South African government is doing. Yeah. Yeah.

Dr. Morrison: Thank you. I want to quickly hear from all of you about the value of the U.S. government coming and engaging as it did in the preconference, and then during panels and plenaries and other events. Lloyd, you were – you were on one – you were on a very important panel during the preconference of implementing partners. You participated. What was the value, in your mind, of the U.S. coming and engaging in the way that it did around the America first global health strategy?

Dr. Mulenga: I think that was really, really important for people to see, for countries to see that America is still engaged. I think the gap which America would leave if they are not involved really, really huge. I don't think anyone can fill it, if the U.S. government is not engaged. So it was good to see that a lot of colleagues that we have worked with over the years from the U.S. government were there. I think that representation was also very, very, very key to us. It was also, I think, another area were we started seeing that they are willing also to invest in areas around prevention, particularly around the pregnant and breastfeeding population. But also, you know, when these resources start flowing into the country, if there is a need, if there is a partner to a pregnant and breastfeeding woman who needs LEN, I think you can utilize it to that partner as well.

So I think them just coming out and seeing that this is what we have, and we are engaging governments for those countries that have signed MOUs as well, it was a good thing to just have the American representatives, the American government representatives, around. Which was not there last year. And I think it gives hope, and also that it gives room for governments and also implementers to know where they can rely on certain services. The U.S. government may not provide all the solutions, but if this does not provide can we leverage on domestic financing, can we leverage on other forms of financing as well to fill in those gaps? But also, sometimes we just want to think through with our colleagues from the U.S. government who have been working on this program for a long time. It may not just be the resources, but it may just be that technical thinking through with them,

which was very key. And it was good, really, to have the representation from the American government.

Dr. Morrison: Thank you.

Let's just quickly hear from folks here. What was the value of the U.S. engagement, in your estimation? Omar?

Dr. Sued: Well, I think it was very important to have the dialogue open. It was for – it was – I mean, the government was very missed in Kigali, and so having it in Rio was a very good news. For Latin America, obviously, the impact is not so big as in other regions, but still there is an impact in Central America and Dominican Republic, in particular in the PrEP program. And obviously in Haiti, where almost all the response depends on the U.S. government. But I think it was a very good opportunity to see that there is at least the possibility to talk and start to build again some of these responses.

Dr. Morrison: And there's a continued discussion around what happens in the U.S. support and relationship with PAHO.

Dr. Sued: Oh yeah.

Dr. Morrison: Which is a small question out there.

Dr. Sued: (Laughs.) Yeah.

Dr. Morrison: And I would think that proof of value in engagement in Rio could only help strengthen the hand for that.

Dr. Sued: Yeah. I hope to be – continue being optimistic that with PAHO we can continue having those discussions and having U.S. as one of the member states engaging in – because PAHO covered all the Americas, from Canada to Argentina. So we have to continue working very closely.

Dr. Morrison: Thank you, Omar. Doris.

Dr. Macharia: Yeah. I think for me it's – I think it was really, I think, important to have the U.S. engagement at Rio. I think one of the things that, especially now with the government-to-government discussions, the MOUs, I think critically important. When we think about some of the data that we are seeing in terms of children being left behind, even with Heidelberg, the information that was shared during the conference. I think it was important to have those not only bilaterals with the U.S. government team that was there, but also to see what difference can we make now? How do sort of rebuild – and rebuild, rethink right, right? I think that was, I think, very critical for us.

And even thinking about this whole triple elimination conversation, even the last mile. How are we thinking about these countries, the countries where these MOUs are being developed and being signed, getting them to that sort of last mile in terms of elimination of mother-to-child transmission of HIV, syphilis, and hepatitis? I think, for me, that was really critically important. And also, I think that also acknowledged that we are going to build together. However, there are gaps right now. But also countries, African governments, and other governments in other regions, need to also show up. They also need to mobilize resources. I think that was, I think, also very important.

Obviously, we need to have more deeper conversations going beyond, yes, resource mobilization domestically. What does that mean at district level, at provincial level, at ward level, et cetera? But I think that was important, to say that things are not going to be the same. However, we have an issue here. We have children, mothers, and families that we need to sort of move ahead and forge ahead together. And we can do that together. But it's not going to be the way things were done before, but certainly different in terms of how we'll move forward. So for me, it was heartening to see that. And I think we'll be able to forge ahead and rebuild. And we will rise together. We are rising together anyway. So we'd have to – yeah.

Dr. Morrison: Thank you. Jirair, you wrote this terrific Substack – almost instantaneous Substack – (laughter) – that you drafted from your seat, I think.

Dr. Ratevosian: I was. I was in the back, yeah.

Dr. Morrison: So any further reflections?

Dr. Ratevosian: Just, in addition to everything that's already been said about recognizing the importance of U.S.'s presence, I think the composition of the team was important too. You had senior bureau officials there articulating a vision for the future. Technical experts were in the room. I think that was important, so that we understand what the programmatic priorities are of the U.S. government funding. And then you had private sector leaders as well, representatives from the U.S. government willing to meet with private sector, being around roundtables with private sector, identifying the next deal as part of the innovation fund. I think that the mix of the different USG representatives was good.

Dr. Morrison: Thank you. OK, we're going to turn now to question of what next. What's the advice you have on the topline priorities in the next few years to move a bit farther out of this uncertain period? What are the two to three things that need to happen, in your view? And I'm going to turn to you, Lloyd, to lead off, and then we'll go Jirair, Doris, Omar. And then we'll open it for questions from our audience.

Over to you, Lloyd.

Dr. Mulenga: So the next few things that need to happen really is how do we make sure, like, for IAS itself, it's responding to the current needs? And also for – especially around how do we use the resources well? Do we need to have – do we need to relook at the frequencies of these conferences as well? I think those discussions need to be held. And also, to me, how do we make sure that we have communities as active participators driving the response as well, under IAS and when we have these gatherings? I think that needs to happen. Then, for countries, I think serious discussions around domestic financing being real, making sure that governments are demonstrating that they are able to take care of their own people, which is largely for the African region. I think those things need to happen quickly during this transition phase.

Dr. Morrison: Thank you. Jirair

Dr. Ratevosian: Steve, I think I want to say, prevention. I think the prevention revolution has started. And not only because of the details and the rollout of long-acting PrEP from lenacapavir, but I think we also heard a lot about investigational products. Merck announced licensing even ahead of phase three results, which was even better than Gilead's licensing agreements. And I think the emphasis on prevention, the tough choices that governments were making around prioritizing prevention. And then my favorite thing about the whole week was Brazil's dispensing machine for prevention products.

And I think it was a demonstration of what we all need to – the future in terms of how we have to make prevention easier for people, but put choices in the matter of people's hands, not be limited by the health systems. So this was all about prevention, making it easier, de-medicalizing prevention, using AI to get more prevention to people. And I think we're going to see a lot more on prevention moving forward. And this conference, I think, spearheaded a lot of it.

Dr. Morrison: Thank you. Doris, what needs to happen?

Dr. Macharia: Yeah. I think there was a lot of discussion on domestic resource mobilization. I think that was in almost all conversations. But I think moving from the sort of topline to getting to what does that actually mean for an African government, in this case, to mobilize domestic resources for particular activities, services, at a district level? I think that's where the conversations probably did not reach. And maybe it was – maybe it was a – maybe the conference being the way it was maybe a bit unrealistic, but that needs to happen because we are saying governments need to mobilize their money. How are they going to actually provide those services? And how are they going to resource mobilize at that particular level, at the lower level? I think that was one.

Two is adolescents. I think that came out quite loud and clear. Nothing with us, without us. And now thinking of in the last one year, two years, we've seen a lot of the adolescent services, youth-friendly services, some of them are, you know, non-existent. And we are looking at how we have these new formulations for HIV treatment for adolescents, for instance, prevention. How are we going to meet the adolescents? Where are we going to provide those services? We need to think about that as well. And that, I think, is something that was brought up during the conference, that we need to be very much aware that as we are thinking about adolescents, about children, we must remember where we are going to be able to meet them at their own points of need, and making sure that we have the services that are tailor-made for adolescents, especially. And that is obviously a big and a huge population that is at risk. And we need to be mindful of that. Thank you.

Dr. Morrison: Let's hear from our audience members. We have a microphone. Let's try and hear from three or four folks at a time, and then we can come back.

Q: I was thinking – (off mic).

Dr. Morrison: Oh, OK. Sorry. I'm sorry. (Laughter.) Oh, apologies.

Dr. Sued: No problem. No problem. I think that it is very important to see what the people want to say. And thank you, Vicky (sp).

I think there is two main message for our region, or for us in PAHO. First place is maintain the gains that we have now. For this, we need to be, again, innovative, resilient, in order to provide more – or continue providing treatment in a simplified way, optimizing what we have, but also integrating this into primary care, as Lloyd said. In particular, because of burden of coinfections and comorbidities. In coinfection, many pollsters from Latin America show the impressive volume of tuberculosis that can be detected with a simple strip that is $3, and that increase or duplicate the number of cases that if we only rely in molecular tests. And this was great. And for comorbidities The Lancet Commission of Aging presented recommendation on how we need to start thinking, and also in low- and middle-income countries in longitudinal care and cardiovascular diseases. And this is very important for Latin America also.

The second – for me, the second priority is access, again, as everybody say. But not only in access to innovation, but also in reducing the time between we know that the technology is good until this is accessible to governments and also from the government to people. And we need to really create different ways to discuss with the industry from the beginning. It was a good news with alimatravir to starting making agreement even before the result of the EXPrESSIVE studies are launched. So this is very good. And from PAHO,

we can also provide some inspiration to other region with the PAHO Revolving Strategic Fund. That is a full procurement mechanism to purchase for countries vaccine, supplies, medicine, at a very low cost, high-quality medicine. So we are discussing in this, in the strategic fund, how to really incorporate some medicines and some specific innovation for making more easy to deploy in different countries. So for me, this is two important priority for us in the region.

Dr. Morrison: Thank you. Thank you.

Let's hear from our audience. We'll bring you a microphone. Please identify yourself and give us a quick comment or question.

Q: Mark Lagon, Friends of The Global Fight Against TB and Malaria.

I wanted to ask about key populations and prevention. There was a rich conversation about technologies and opportunities. It's not surprising that a non-Bolsonaro government might be forward-leaning, and a number in the region that you work on, at PAHO, but what was the – you know, the discussion of an elephant in the room? Which is, if you have government-to-government agreements between the United States with countries, responsibility turns to them, and government is in the driver's seat, what will be the political will for prevention for key populations, in particular, such as in Africa or Asia?

Dr. Morrison: Thank you. Thank you.

Other comments or questions? Paul, and then –

Q: Yeah. Thanks. Paul Friedrichs, senior advisor here at CSIS.

And I'll build off of that question, to some extent. So we have the Brooke Nichols article that projected that by the end of this year 781,000 additional deaths would occur as a result of changes in funding for programs like PEPFAR and others. We have Elon Musk saying that's completely untrue, that there have been no deaths. And we've got people like myself, who care deeply about this, who are trying to find some objective source that everyone is using that describes what's actually happening, both by continent – whether it's in Africa or in South America – but also by disease. And, to the point that you made, understanding access. Is it improving? Is it getting worse? So what is the definitive source that we should all be using so that we're providing apples to apples comparisons to inform political discussions and decisions here and elsewhere?

Dr. Morrison: Thank you, Paul. I have two others.

Q: Thanks. Hi. I'm Elisha Dunn-Georgiou with Global Health Council.

I actually wanted to ask Doris a question about the adolescent piece. One of the things that disappeared when the Trump administration reconfigured PEPFAR and foreign aid is DREAMS, which was, of course, a program that was specifically for adolescent girls and women. I appreciate that there's a lot of focus on mothers, women who want to have children or are having children. We don't hear a lot now, and this is maybe tied to Mark's question about key populations, about protection for non-pregnant adolescents or women. And so I'm just curious. I mean, you said adolescence was a prevalent topic there. Did you get a sense that there was a movement towards forming another kind of big initiative, like DREAMS, or that this is being left up to individual countries?

Dr. Morrison: Thank you. Shannon.

Q: Well, thank you, everybody. Shannon Hader from American University.

I'm curious. Understandably, a lot of the conversation is about where to for government leadership in the switch with U.S. foreign policy and PEPFAR. But we're also in a big, huge year for dynamic changes in the multilateral situation. Whether it is we are amidst electing a new secretary-general for the United Nations, we are at the UN80 reform. We are electing a new WHO lead. We might be getting rid of some agencies, like UNAIDS and things like that. So what was the discussion about perhaps what's needed for building will in the multilateral space about continued health? And what might be the demands of the community on making that effective?

Dr. Morrison: Thank you. Lloyd, I'm going to come back to you first. You can pick and choose which of those questions. I'm certain that Mark's question around the elephant in the room around government-to-government agreements and changing in terms of key populations and protections, and some of these other issues also around objectives – Paul's question around objective sources – what would you like to offer in terms of response to some of these questions?

Dr. Mulenga: I'll start with the issue with the objective data sources. The U.S. government invested highly in data sources across the regions. And that was the first thing which fell off when there was that disruption. Many countries, including where I am here in Zambia, we still are not convinced with the numbers which we have now how many people are living with HIV who are on treatment. We still have a number of people that we cannot account for on prevention, whom we have lost out. So there has been this reality that the investments in the data sources was highly dependent on the USG. And to recover from that, we need to have simpler, more innovative ways of

reporting that, but also to have a bridge funding as well to sustain some of these information sources which are – which are there.

Currently, I don't think that we have any objective data source to get that information from the region, because our data systems are still very fragile. Yes, I can agree that the program has been disturbed for the past one year. What we are seeing on the ground are not really the deaths which people may be. I think it's too soon to see that effect on the deaths. But the prevention pieces, the fact that the way we are doing prevention before, we had people, especially the key populations, who are going to these safe spaces. Those are no longer there. This is the worry which we have. The new infections will keep on increasing. And we need to invest highly in prevention.

The mortalities, the deaths, I think many programs still have a number of people on (inaudible). The commodities have been available. So for us to see the debts, it will take a while. It won't be immediate. But really, the question over which data sources, it's difficult. Right now we don't have good data sources across the region because they were highly supported by the USG. And this fragmentation in the support of the past one year has affected us.

In terms of the key populations, I think there are many regions in countries which have challenges with how do you deal with the health-care provision and also the legal and human rights around the key populations. In fact, the LGBTQ, the female sex workers as well. And we still are operating under that narrow realization that we can only move in with provision of health services. Fortunately, we have been surviving through that. And we need to continue pushing through that. But we still need broader discussions on how to make sure that each person is safe and that each person is respected in the choices that they make. Thank you.

Dr. Morrison: Thank you, Lloyd.
Doris, there's a couple that were directly relevant.

Dr. Macharia: Yeah. I think – yes. I think on the data sources, I just want to agree with Lloyd in terms of for more than two decades PEPFAR really supported and invested quite a lot in terms of the data systems that were built, that were able to trigger and tell us who is lost to follow up, who is transferred out for instance, et cetera. That is not there in the same way that it is now. We have the district health information system, which is aggregated data. So that might not be able to give us the answers in terms of where are – who is lost to follow up, and things like that. However, I think as Lloyd has mentioned, when we're thinking about deaths – and I think this thing of who has died and who has not died – even currently right now we know even – whether it's children, whether it's adults – deaths will always lag behind.

You're probably not going to know who died, if it was last year, probably by doing the this year's analysis is probably when you figure out who is missing. But it's also understanding as you're figuring out, there are 77,000 children, for instance, who are unaccounted for in terms of antiretroviral treatment. But where are they? Are they dead? Are they transferred into the adult program? Where are they? So that also calls to the fact of the data systems we have. They have to be disaggregated at a much better level in terms of what we're used to for us to be able to tell the story in terms of where are the people, what's the impact of HIV testing, of antiretroviral treatment? I think that is a missing link. And even now, as we are talking about resource mobilization domestically, there has to be concerted efforts and investments in the data systems for us to be able to track children and adults, as we used to before.

I think on the issue of adolescents, Elisha, I think this is very, I think, critical. We have adolescent youth-friendly services, but who is – who is supporting that, even in government systems? And that, I think, has been a big gap, even in the conference itself. There was no commitment, at least that I heard, that we would be back to like a DREAMS type of initiative. And even more recently, when various countries were looking at HPV vaccination integration into the HIV services, when we started off last year it was with DREAMS. And then we had to abandon that, and then switch over, use the expanded program of immunization so that we are able to link girls who needed HPV vaccination and were coming to the clinics.

So I think it's to think how can we use the existing services? Obviously, the youth-friendly services, opening hours as well. But those need to be – there needs to be investment by the governments themselves, because I don't think we're going to go back to the days of, I think, DREAMS – big DREAMS initiatives, and even the cash transfers we used to do for adolescents. So I think it's a gap that needs to be definitely addressed one way or the other, if we are to reach those levels of viral suppression, for instance, among adolescents, or ensure that PrEP is available for adolescents who are not necessarily pregnant but also want to be free to be able to live their lives. So I think it's an area that certainly needs a lot – a lot more attention and definitely investment down the road. I think those are the two that – yeah.

Dr. Morrison: Thank you. Thank you so much. Omar and Jirair, maybe you could help us a bit on the multilateral reform question. There wasn't much evidence of streamlining, consolidation, merger underway. There's been a lot of rhetoric around global health architecture reform, but not much that you can point to in terms of consolidation, streamlining, merger, serious reform. But we're clearly, I think as Shannon's question signals, we're at the edge of some big changes. I was very encouraged that Tedros came at the opening, and delivered a very good speech in terms of look forward, be optimistic, look

forward, be pragmatic, insist on more, demand more. I mean, it was a very good speech. Omar, you're part of this multilateral universe, so.

Dr. Sued: (Laughs.) Yeah. I mean, I have my conflict of interest. I work for this system. And I are very, I mean, passionate about the work that PAHO and the WHO is doing. I think that even in all the criticism, it's clear the benefit of having some multilateral mechanism in public health. And we see that not only in the COVID, that there may be a lot of mistakes, everybody made mistake at that time, but also for monkeypox, for mpox, or for Ebola. I mean the work that is doing, WHO and PAHO, is amazing. In America, the Elimination Initiative is pushing and supporting countries in advanced elimination of more than 30 diseases. And it's the only region that eliminate polio, measles in many countries. And we have 14 countries that eliminated the transmission mother to child.

I know many of these countries are small countries in the Caribbean, but Brazil just eliminated mother to child transmission. So there is a potential there for really put together all the countries at the table and try to share experience and try to push the other countries as a collective thinking. And I think this multilateral mechanism will continue being in place. Even we will be suffering strong reforms, obviously, or reductions, but I'm confident that we will continue working and supporting countries on that.

Dr. Morrison: Now, the season has opened for the campaigning for the next director-general of WHO, right?

Dr. Sued: Yeah.

Dr. Morrison: Saudi Arabia has nominated Hanan Balkhi. We're expecting to see Hans Kluge from Europe, from Copenhagen, as a candidate. Minister Budi from Indonesia. There's some very promising candidates coming forward. And this is the season. There's an opening here for debate about the issues we're talking about and the ones that Shannon has signaled around. What is this going to mean for the agenda that – is it front and center in IAS? Your thoughts?

Dr. Ratevosian: Yeah. Well, you know, I think this is one of the areas where I think the conversation was more refreshing in Rio than it is in Washington, because we didn't talk a lot about the global health architecture reform or any of that. But I do think, especially compared, Steve, to your point about the WHO candidates that are now emerging, and there's a stark contrast between how the WHO is conducting its elections and how the Global Fund is conducting its elections. The Global Fund is much more insular, much more private. I've raised my voice about this before.

And, you know, I think it was a missed opportunity for candidates to come forward with their visions for the future for the Global Fund, which is increasingly more important as it relates to the role of multilaterals. And I think that was a missed opportunity. Maybe that could change. The Global Fund election process is on a trajectory to end by the end of October, we're told. And I think there are still opportunities for when candidates are announced for them to maybe potentially have a public forum the way the WHO will do in November.

But if I may go back to – if we have a minute – on the key population piece. I think – and I want to thank Mark for raising it – we should have talked more about that in our remarks. But every single presentation around challenges with regards to how countries are adapting, with regards to how donors are trying to fill gaps, all came back to key populations. The U.S. was the lion's share of funding for key population programming and PEPFAR, in particular, around the world. And most of those programs are still not allowed to continue, as it relates to the PEPFAR waiver that was issued over a year ago. And so countries are struggling. And key population programming either is not advancing at all, or is happening in new and different kinds of ways. And I think this is an area where, you know, we're not going to end HIV anytime soon, or celebrate success, if we're not focusing on the data, and we're not focusing on populations that increase risk for HIV acquisition.

So I think this is an area where I think donors will have to step up more and governments will have to exert more leadership. Dr. Mulenga talked openly about what their government is doing to prioritize key populations. And I want to hear more of that. And one example in terms of the contrast, when you had PEPFAR and Global Fund supporting lenacapavir rollout, based on a number of priority countries that they had articulated, governments were talking about the scale up. But Cambodia talked about, no one has come to them about lenacapavir or any long-acting PrEP. And so when asked about their ambition to scale up lenacapavir or any long-acting PrEP, they had really no answer. And they're still waiting to prioritize national resources. So there is a big difference between the continued donor support for some of these initiatives in prevention and governments who still have to figure out how to how to prioritize domestic resources for it.

Dr. Morrison: Thank you.

Doris, you had one more? No. OK, we're getting towards the end of the hour here. We're going to start with Lloyd, and then we'll run Omar, Doris, Jirair. Just give us the quick – this is a lightning round – and what gives you the greatest optimism and hope in this period? Over to you, Lloyd.

Dr. Mulenga: I think the fact that there is engagement with the U.S. government gives me optimism that the programs won't shrink. But also we need more discussions

around how governments can really move up. And I think the issue around the key populations are very key to continue discussing. If the first thing which governments do is to cut funding around prevention. So prevention, we need to sustain the talks around that. Thank you.

Dr. Morrison: Thank you very much, Lloyd.

Omar.

Dr. Sued: I wanted to say thank you to Beatriz Grinsztejn. She was a very transformative leader in the IAS presidency. I mean, she demonstrated a big conference like this can be done in low- and middle-income countries. And she ensured that the next round of conference will be having also pivoting between high income and low- and middle-income countries, and also support the next president candidate. So we are very happy also in the governing council with these decisions.

Dr. Morrison: Thank you.

Doris.

Dr. Macharia: What gives me hope is the fact that we definitely have the innovations, not only on prevention, for treatment as well. We also have reengagement, of course, as we are thinking about the U.S. government, in terms of the African countries. I just came from a WHO regional meeting in Addis Ababa. And you can see governments really are very serious about moving this agenda ahead in terms of ensuring that there's not only sovereignty in terms of health, but also taking lead and charge in terms of their people and driving those investments towards better health for their citizenry. So that, to me, is very rewarding. And I, you know, look forward to seeing how we can make sure we push forward, have minimal deaths, and better outcomes for moms, for children, and for families, absolutely. Thanks.

Dr. Morrison: Thank you, Doris.

Jirair.

Mr. Ratevosian: I think it's all been said, but just to underscore science. Science still gives me hope. And it's remarkable that even after all these years, 40 years of investments in research, we're still innovating in long-acting prevention and treatment. I'm excited to see many of these products get approval, and who knows what's around the corner for even more simpler treatments. So I'm excited about science.

Dr. Morrison: Thank you. Thank you. I want to offer special thanks to Theo Chavez, who's produced this event here today. Again, special thanks to Priya Chainani for all

of her efforts. And special, special thanks to these exceptional speakers who've joined us here today, the leaders that we've been able to bring around the table. So please join me in thanking them. (Applause.)

(END.)