Challenges to Continued U.S. Leadership Ahead of Global HIV's Next Phase

By Margaret V. McCarten-Gibbs and Sara M. Allinder

THE ISSUE
This is an important year for the global HIV response. The first milestones toward the Joint United Nations Program on HIV/AIDS (UNAIDS) Fast Track goals toward controlling the global epidemic come due at the end of 2020. The world is off-track to meet them. Concerted, well-financed, and targeted action is needed now to sustain progress against HIV, mitigate the threats posed by Covid-19, and get on track to end HIV as a public health threat by 2030. The feasibility and impact of this action is limited by five key challenges: 1) waning domestic and global political and financial leadership, 2) persistent new infections, 3) failure to reach treatment and viral suppression targets, 4) high rates of comorbidities and syndemics combined with pressure to move beyond singular health programs toward Universal Health Coverage (UHC), and 5) limited country capacity to assume greater management and financial ownership of their own national responses.

Over the next year, the global community will look to the United States for leadership. Its actions could make or break the next phase of the HIV response. Sustaining or expanding funding with an updated business case, rightsizing investments for current realities, and keeping human rights a central focus will be key.

SHIFTING GLOBAL POLITICAL AND FINANCIAL PRIORITIES
U.S. GOVERNMENT LEADERSHIP
The United States remains the global leader in the fight against HIV. U.S. investments through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the multilateral Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) have shifted the dynamics of the global pandemic.

U.S. government programs targeting HIV outside the United States expanded greatly under President George W. Bush. In 2002, the United States played a key role in the creation of the Global Fund, providing its founding contribution. It remains the largest single donor and maintains a permanent seat on the Global Fund Board. In his 2003 State of the Union, President Bush announced the creation of PEPFAR, which remains the largest health initiative targeting a single disease.

A two-pronged bilateral and multilateral approach has enabled the U.S. government to leverage its resources and expand its reach. More than $90 billion have been disbursed through PEPFAR since 2004, and congressional appropriations of more than $19 billion to the Global Fund have been leveraged to raise more than $65 billion in funding from governments and the private sector.

Broad bipartisan support in Congress has facilitated high levels of annual investment, but a decade of flat funding and the attrition of HIV congressional champions pose threats to the progress that has been made. HIV competes
against other high priority global health needs, which often are overshadowed by more pressing political and economic issues.

President Donald Trump has proposed significant reductions in U.S. global HIV funding in each of his four annual budget requests. The fiscal year (FY) 2018 request proposed an 11 percent reduction from the FY 2017 spending level, and the FY 2019 request included a 16 percent cut. The FY 2020 request proposed an even larger decrease of 25 percent to the Department of State’s global health budget. Congress rejected the proposed cuts in each of the first three budget cycles and continued to fund PEPFAR at a flat level. The FY 2021 request proposed a $1.6 billion cut to global HIV funding, but the request is pending action as of this paper’s publication.4

**DONOR SUPPORT DECLINES**

Driven by U.S. investment, resources for global HIV exponentially increased through the rest of the naught decade but have stagnated since. The economic recession in 2008, coupled with the migratory crisis in the Middle East and Europe starting in 2015 and the resulting populist isolationism, has led many donor governments to reduce their HIV contributions. Several ended bilateral programs in lieu of support to the Global Fund, and 2015 saw the first real reduction in overall global HIV resources since 2002. Heading into the Global Fund’s Sixth Replenishment Conference in October 2019, many observers were concerned that efforts would fail to meet the funding target. Surprising many, the Global Fund raised $14 billion from more than 75 donors for the next three-year period, including a $4.6 billion pledge from the United States.5 The U.S. FY 2019 budget included $6.8 billion for global HIV, including $1.35 billion for the Global Fund.6

However, despite a strong showing by the Global Fund and congressional leadership to sustain U.S. global HIV investments, a significant gap remains between what is available and what is needed to fund the global HIV response. In 2018, $19 billion was available, falling $7.2 billion short of the estimated amount needed to reach the 2020 goals.

**DOMESTIC RESOURCE MOBILIZATION**

Country governments have increased their own funding in recent years as the Global Fund has made government contributions a requirement for securing new grants. At the end of 2018, 56 percent of resources for HIV in low- and middle-income countries were provided by domestic sources.7 However, the hope that countries would proportionally take on more of the funding needs has not materialized.

In many countries, PEPFAR and the Global Fund still contribute 80 percent of resources.

**DIRECTION OF FINITE FUNDS**

Tough choices have had to be made about where to invest finite resources. As funding for PEPFAR has remained flat since FY 2011, the program has narrowed its focus, prioritizing 10 high-burden countries with the goal of achieving epidemic control in each by the end of 2020. Even in hard-hit countries, resources are insufficient to cover all areas of need at scale, leaving many vulnerable to infection or treat-
However, the Covid-19 pandemic also demonstrates the Covid-19 leadership. 

More difficult decisions will be required to mitigate the impact of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) on people living with HIV (PLHIV), including redirecting existing resources. PEPFAR is allowing country teams to reallocate funds to address Covid-19 (e.g., $150,000 toward Covid-19 prevention measures among PLHIV in Zimbabwe). The Global Fund is enabling countries to use up to 5 percent of grant funding—$500 million available in total—toward their Covid-19 efforts. The Global Fund has made an additional $500 million available through its Covid-19 Response Mechanism. The Covid response has exposed fragility in health systems around the world, and extreme care will be needed to ensure any redirection of resources minimizes disruption to HIV service delivery and provision of prevention and therapeutic services.

PRECARIOUS FUNDING LANDSCAPE

The HIV financing landscape was already precarious before the unwelcome introduction of Covid-19. As other donors have exited and partner governments have not expanded their commitments, the HIV global financing landscape has dangerously concentrated, depending overwhelmingly on PEPFAR and the Global Fund. There are significant concerns about the long-term sustainability of HIV efforts, as well as the ability to increase the numbers of people on antiretroviral therapy (ART) and invest in the interventions needed to reduce new infections, should there be declines in PEPFAR and Global Fund resources.

The Covid-19 pandemic introduces more uncertainty, but also potential opportunity. As the world slides into a global recession, donor countries are likely to face internal, nationalist pressures to target precious resources to their domestic coronavirus response and economic mitigation measures. It may become less politically feasible to maintain large overseas development portfolios, including support for multilaterals such as the Global Fund. That pressure exists in the United States as well, where there has been attrition of early congressional HIV champions, growing interest to focus more on the domestic HIV epidemic, and animosity toward the World Health Organization (WHO) over its Covid-19 leadership. However, the Covid-19 pandemic also demonstrates the interconnectedness of the global community and necessity for strong preparedness and response mechanisms. There is opportunity to leverage the crisis and global health’s ongoing bipartisan support to overhaul the U.S. approach to global health with a fresh infusion of additional resources. For example, in April 2020, 105 members of Congress sent a letter to Speaker Nancy Pelosi and House Minority Leader Kevin McCarthy asking for $1 billion in emergency support to the Global Fund. 

U.S. investment at a time like this does more than fight disease—it helps keep Americans safe. Health security knows no borders and pandemics can bounce back on U.S. citizens. As Covid-19 spreads to developing countries, it threatens to derail years of progress fighting HIV, TB, and malaria by disrupting essential prevention and treatment services and interrupting supply chains for critical drugs and medical supplies. Experience from recent Ebola outbreaks in Africa has shown that unless mitigating action is taken, the additional death toll from AIDS, TB, and malaria could well exceed the number of deaths from Covid-19 itself. Covid-19 is on a trajectory to overwhelm communities and health systems in developing countries with potentially catastrophic consequences.

Given the tough choices already being made in the global HIV fight, a strong case can be made for not only ensuring current levels of resources are sustained, but also that additional investment is made to protect the gains already achieved and ensure future progress.

FAST TRACK GOALS

In the first half of the last decade, several important developments came together to demonstrate that ending HIV as a public health threat could be attained if specific concerted actions were taken. Studies demonstrated that, if used correctly, ART could reduce a person’s viral load to an undetectable level, resulting in that person being unable to transmit the virus. Modeling done by UNAIDS indicated that the window to scale up treatment worldwide and drive down new infections was very short.

To mobilize collective global action, UNAIDS released new Fast Track Targets in 2014 that, if met, would avert nearly 28 million new HIV infections and end the AIDS pandemic as a global health threat by 2030. The first set of Fast Track milestones come due on World AIDS Day (December 1) 2020. They include eliminating stigma and discrimination and reducing new infections to less than 500,000 annually. In addition, the milestones include achieving “90-90-90” (i.e., 90 percent of PLHIV know their HIV status, 90 percent of those who know their status...
are on ART, and 90 percent of those on ART are virally suppressed). The goals increase to 95-95-95 in 2030. The world is off-track to meet those goals.

**THE FIERCE PERSISTENCE OF NEW INFECTIONS**

From its peak in the late 1990s, the rate of new infections has decreased by 40 percent. However, the annual number of new infections has hovered at or just below 2 million per year for the last decade because of population growth, especially in Africa. Over the last almost four decades, many prevention strategies and tools have been utilized to try to stymie the spread of HIV with moderate success. HIV prevention programs have been hindered by the absence of a robust mix of tools that meet the needs of different populations in different places. The prevention tools available up until the last several years have been insufficient to meet the variety of vulnerabilities that put certain people at risk.

In recent years, there has been hope that using HIV “treatment as prevention” would drive the infection rate down, but that early promise has yet to be realized and existing tools, such as oral pre-exposure prophylaxis (PrEP), have not yet reached the scale needed to have an impact in many countries. Stigma—societal, institutional, and self-stigma—continues to be a formidable access barrier to prevention information and tools around the world. Prevention programs have faced a variety of structural barriers even as new tools have come to market, including inadequate financing, regulatory and guideline obstacles, and inefficient delivery of services.

In order to reach UNAIDS’s Fast Track goal, the rate of new infections must decrease by over two thirds by the end of 2020—a momentous effort even before the interference of Covid-19. Approximately 1.7 million people, primarily young adults, were newly infected in 2018. With the youth population growing at a swift pace in many areas of the world, specifically sub-Saharan Africa which expects a doubling by 2040, the sheer numbers of PLHIV—should prevention among that population fail—could overwhelm health delivery systems and lead to a risk of disease resurgence. Continuing to add nearly two million more PLHIV per year would make bringing the global pandemic under control an elusive goal.

**VULNERABILITIES OF KEY POPULATIONS**

Of increasing concern is the high vulnerability to infection of certain population groups, including adolescent girls and young women (AGYW), members of the LGBTI community, sex workers, and injecting drug users. More than half of all new HIV infections in 2018 were among members of key population groups and their partners. Among new infec-
tions in adolescents aged 15-19 years in sub-Saharan Africa, nearly four in five are girls.\textsuperscript{23}

Female sex workers are at 21 times greater risk of infection, while transgender women are at 12 times greater risk, and people who inject drugs and men who have sex with men (MSM) are 22 times more at risk.\textsuperscript{24} Because these individuals face legal and societal discrimination and often intense stigma, many choose to avoid health care services,\textsuperscript{25} thus limiting opportunities to provide HIV prevention and treatment services.

The third UNAIDS Fast Track goal—eliminating stigma and discrimination—is intended to address some of the human rights constraints. There are numerous examples where laws and rhetoric have fueled higher HIV rates as affected populations are driven underground and away from services.\textsuperscript{26} The implications of these policies can be seen across the globe. In regions outside of eastern and southern Africa and the Caribbean, key populations comprise anywhere from 62 percent to more than 95 percent of new HIV infections.\textsuperscript{27}

**VARIATION IN REGIONAL EPIDEMICS**

Eastern and southern Africa remain the highest-burden regions, but rates are falling in many countries due to the significant investment by PEPFAR, the Global Fund, and other partners. Unfortunately, the same is not true for all regions. Infections are rising in other areas of strategic importance to the United States.\textsuperscript{28} The fastest-growing regional epidemic in the world is in Eastern Europe and Central Asia, with new infections rising between 10 and 15 percent every year,\textsuperscript{29} driven by crackdowns in Russia on MSM and injection drug users that drive those populations into the shadows and prevent them from accessing prevention services. The Philippines has the fastest-growing epidemic in the western Pacific. Between 2010 and 2017, the HIV incidence there increased by 174 percent, with MSM accounting for 84 percent of all new infections.\textsuperscript{30} Chile has seen a rise in new infections among youth in recent years.\textsuperscript{31} There also have been concerning increases in mother-to-child transmission in Nigeria.

**U.S. HIV EPIDEMIC**

The United States is not immune to the same challenges to preventing new infections. A decade ago, the number of U.S. infections was declining substantially each year, but since 2013, progress has stalled and approximately 39,000 people have become newly infected every year, with an estimated 20 percent unaware of their status. Members of key population groups and people of color are particularly vulnerable, with the highest-burden in 48 counties largely around major metropolitan areas; the cities of Washington D.C. and San Juan, Puerto Rico; and seven Southern states with substantial rural HIV burden that account for 50 percent of the new cases. In his 2019 State of the Union address, President Trump announced *Ending the HIV Epidemic: A Plan for America* to address the domestic epidemic and achieve epidemic control in the United States by 2030. Implementation started at the beginning of 2020, but progress is on hold due to the coronavirus pandemic.

**OPPORTUNITY OF ORAL PREP**

HIV prevention has suffered from major challenges including the absence of discreet, easy-to-use methods under the direct control of the individual person seeking to prevent infection.\textsuperscript{32} Oral PrEP was the first tool to give individuals control of his or her own HIV prevention in a discreet and user-friendly way. Mathematical models predicted that oral PrEP could have a large and fast impact if introduced rapidly and at high coverage for people at risk.

Unfortunately, oral PrEP has not been introduced at that same level of scale and coverage in most places with high HIV infection rates. It has been four years since the WHO expanded its guidelines yet only 580,000 people in 78 countries are using oral PrEP.\textsuperscript{33} Further, most of the current oral PrEP users are concentrated in a few countries. Only 14 countries worldwide have more than 10,000 people enrolled on oral PrEP, accounting for 91 percent of all enrolled, and only seven countries with any users are high-burden countries in Africa.\textsuperscript{34} Even in the United States, where approximately 157,000 people are on oral PrEP, the Centers for Disease Control and Prevention (CDC) estimates that 1.1 million people are at high risk for HIV and should be using it.\textsuperscript{35}

**OFF TRACK ON TREATMENT AND VIRAL SUPPRESSION GOALS**

**PROGRESS TOWARD 90-90-90**

With big pushes by PEPFAR and the Global Fund, the number on ART increased to more than 24.5 million PLHIV—approximately 65 percent of all PLHIV—\textsuperscript{36} as of June 30, 2019.\textsuperscript{37} Six countries had reported achieving 90-90-90\textsuperscript{38} at the end of 2019, along with several cities. The current global 90-90-90 progress stands at 79-78-86 (end of 2018 data),\textsuperscript{39} leaving 13.4 million PLHIV without treatment and at risk of passing on the virus.\textsuperscript{40}

While progress is being made, global data shows that the pace has slowed and there are concerning trends below...
the topline numbers. Beyond the impact of HIV on key population communities, men and young adults (15-23 years old) are especially unlikely to know their HIV status, be on ART, and be virally suppressed. Further, both rates of linkage to care post-diagnosis and retention on ART once started continue to be problematic, especially for men, young adults ages 15-35, and those who are asymptomatic, which is one reason only 53 percent of all PLHIV were virally suppressed in 2018.

These issues highlight weaknesses in traditional public health delivery, which has often relied on the use of clinics as the most cost-effective approach. Because men and young people tend not to visit facilities unless they have suffered a major injury, getting them diagnosed and on treatment has proven exceptionally challenging. Community delivery, including mobile clinics and other approaches that take prevention and treatment services to the places where people go to school, work, or otherwise congregate, have proven to be impactful in reaching men, young adults, and key population groups. These approaches are generally more expensive given the cost of the mobile vans themselves and the additional human capital required.

**SUSTAINING CARE FOR DECADES**

Over the last five years, most of the focus has been on getting more people initiated on ART, retained in care, and then virally suppressed. As a result, the demographic profile of PLHIV is changing. Successful treatment regimens have extended life for millions, and more consideration is needed to understand what it means to sustain people on treatment for decades. In 2018, there were an estimated 7.5 million people over the age of 50 living with HIV (19.7 percent).

“As this population lives into its sixth and seventh decades and becomes more susceptible to other health challenges associated with aging, particularly non-communicable diseases (NCDs), initiating and maintaining patients on ART while addressing their health needs beyond HIV has become a critical challenge.”

**COMORBIDITIES, SYNDEMICS, AND UNIVERSAL HEALTH COVERAGE**

HIV does not exist in a vacuum. HIV acquisition risk and HIV care complications are increased by other diseases, health conditions, and societal challenges. In turn, HIV can create vulnerabilities to different infections or occurrence of other health conditions. Syndemics of health conditions such as sexually transmitted infections and tuberculosis (TB), as well as of social conditions such as violence and mental health, help fuel or are fueled by HIV. Comorbidities can lead to worse health outcomes for the individual, as well as additional burden on the health system with more complex clinical management requirements and higher cost. Addressing these health and societal issues is essential to success against HIV, but often falls outside PEPFAR and the Global Fund’s current mandates.

Sexually transmitted infections, such as human papillomavirus (HPV), bacterial vaginosis (BV), chlamydia, gonorrhea, and syphilis, inflame and elicit an immune response that makes it easier for HIV to establish infection. Getting sick with TB while on ART can lead to persistent illness, treatment failure, and death. For PLHIV, there is a 10 percent annual risk TB acquisition for every year of life, but the risk reduces to 5 percent per year if a PLHIV is on ART. Given the susceptibility to TB and higher risk of severe flu symptoms, it is assumed PLHIV, especially those not virally suppressed, have increased chances of serious complications due to SARS-CoV-2. The increase of multidrug-resistant TB cases over the last decade poses additional risk to PLHIV, as do rapidly growing rates of NCDs around the world, such as ischemic heart disease, stroke, and diabetes. Many HIV clinics operate separately from regular public health facilities and do not screen for hypertension or diabetes despite demand from patients and the increased risk for aging PLHIV.

**UHC AND PRIMARY HEALTH CARE**

UHC and primary health care are top priorities for the WHO director-general and the new UNAIDS Executive Director, Winnie Byanyima. WHO has pursued the UHC agenda with health as a human right and a desire to integrate infectious disease services with NCDs and primary health care to address the total health needs of individuals for greater efficiency and impact. UHC has not been a U.S. priority, nor does the United States see health as a human right. Further tension is likely as WHO and UNAIDS become even more committed to a UHC agenda and increased health system strengthening in response to Covid-19.

Ms. Byanyima has focused on poverty alleviation and gender inequality as key drivers of HIV risk, vulnerability to infection, and inability to stay on treatment. Addressing these and other societal issues, such as ethnic, religious, and sexual orientation inequities; school dropout; violence; and mental health; are immensely challenging yet also critical to any success against HIV. Structural interventions, such as PEPFAR’s DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe) partnership, have targeted a
broader range of social, economic, and health issues that increase vulnerability to HIV infection. While DREAMS has demonstrated an impact in reducing new infections among AGYW in 15 target countries, the amount of funding available limits the ability to implement at scale for all who are vulnerable.

ADDRESSING POLICY AND SOCIETAL BARRIERS

The growing pressure for HIV-focused programs to integrate more with primary and chronic health care will need to be balanced with the ability to provide nondiscriminatory or stigmatizing care. Systems providing focused HIV care have been essential to overcome societal discrimination and institutionalized discrimination in the form of laws criminalizing certain behavior, such as homosexuality, sex work, and drug use. As discussed above, such laws make it difficult or even criminal to reach those affected with HIV services. Thoughtful integration with careful, incremental approaches that are well tested and have community buy-in will be important before more widespread use.

Removal of barriers at national and global policy levels is essential to progress as well. The U.S. government has led on human rights for many years, but the Trump administration has promulgated policies that make it more difficult to reach target populations. Reinstatement and expansion of the Mexico City Policy, for example, limits PEPFAR’s ability to integrate HIV with family planning and reproductive health services, which are an important entry point for reaching women. In spite of such limitations, PEPFAR has remained focused on meeting the needs of key populations and created a Key Population Investment Fund in 2016 to “address the underlying issues that prevent people from accessing HIV services, including formal/informal fees, human rights violations, stigma, discrimination, and violence.” As the needs of PLHIV, the demographics of those most at risk, and the interplay between different health concerns change, policy, programming, and prioritization will have to shift.

COUNTRY CAPACITY TO ASSUME GREATER MANAGEMENT

The significant investment by PEPFAR, the Global Fund, and other global health initiatives has improved capacity and technical competency in many HIV high-burden countries, but most countries are far from having the ability to accept a large transfer of responsibility for their national responses. However, many governments are taking on more ownership, as evident by examples in South Africa and Rwanda. There has been pushback in recent years from governments and civil society about perceived neocolonialism in the way donor governments direct implementation of programs or how donor policies affect implementation in their countries, especially when those policies conflict with domestic law, such as the Mexico City policy in South Africa. Desires for greater country ownership and autonomy away from perceived neocolonial interventions, coupled with a strong national push toward UHC, may lead to confrontation with the U.S. government.

Both the Global Fund and PEPFAR have been concerned about how to increase country ownership with a variety of approaches over the last decade. The Global Fund now requires governments to commit to funding a percentage of resources in grant submissions. PEPFAR has experimented with different approaches from compacts with countries to Partnership Frameworks. Since 2015, PEPFAR has used a Sustainability Index and Dashboard to evaluate progress along a continuum toward greater country ownership. The Sustainability Index and Dashboard is prepared in partnership with the government, civil society, and other relevant stakeholders in-country, including UNAIDS. The dashboard provides an easy-to-read, color-coded grid from green to yellow for a series of indicators.

PEPFAR also has held countries more accountable during recent annual Country Operational Plan cycles for needed changes in policies that hinder the HIV response, including informal fees that discourage health-seeking behavior. In the 2019 Country Operational Plan cycle, seven countries were identified as needing policy changes, with PEPFAR resources partially or fully withheld until change could be demonstrated. Given increased pressure to do more with the same or less annual funding, it is expected that PEPFAR will continue to practice a high degree of scrutiny and accountability on country capacity.

Outbreaks, such as Ebola and Covid-19, demonstrate the importance of a strong public health system capable of surveillance, case detection, response, and containment. PEPFAR and the Global Fund have built impressive laboratory and health system capacity in many countries. Further, many governments are already moving toward UHC and integrating HIV care into the overall health system. Given the Covid-19 pandemic, country governments will need to utilize all existing public health capacity, which could accelerate the breaking down of barriers between standalone HIV programs and the rest of the health systems.
COVID-19

With the Covid-19 pandemic, the HIV community must grapple with sustaining political attention and funding for its programs while mitigating SARS-CoV-2 implications for PLHIV and the risk of erosion of two decades worth of progress. The Covid-19 pandemic adds complex challenges, including potential for HIV disease regression due to SARS-CoV-2 morbidity, service and supply chain disruptions, diversion of donor resources from HIV programs, and a breakdown of health systems in the most affected countries.

The need for strong political and financial leadership on HIV, especially by the U.S. government, remains as great now as ever, as the next phase of the response may be the most challenging yet. There will be increased pressure to once again articulate why maintaining a robust global HIV response is essential to U.S. national security. There is also opportunity to demonstrate how the billions of dollars spent on HIV have strengthened surveillance, case detection, laboratory, specimen transport, health worker capacity, and facility- and community-based health delivery systems around the world.

RECOMMENDATIONS FOR U.S. LEADERSHIP IN GLOBAL HIV’S NEXT PHASE

The global HIV response is entering a period of great uncertainty, with the unknown trajectory and impact of the Covid-19 pandemic. Inevitably, the next phase of the HIV response will need to change and adapt to the evolving economic and political landscape and the impact of Covid-19 on PLHIV and countries’ HIV responses. The economic fallout from Covid-19 and the upcoming presidential election add to the uncertainty about the continued leadership role of the United States. For there to be sustained success against HIV and to prevent erosion of the gains attained over 20 years, the United States will need to lead financially and in its programs.

The United States should at a minimum sustain its global and domestic HIV funding and resist temptation to divert resources to support the Covid-19 response. The United States should explicitly and purposefully protect its HIV funding commitments and the cumulative impact of its more than $90 billion investment. In addition, it should maintain—and ideally expand—support for PEPFAR and the Global Fund. The bilateral-multilateral approach benefits and amplifies U.S. funding, supports foreign policy goals, and helps address other infectious disease outbreaks, including Covid-19.

A strong case can be made for increasing funding for HIV as a core component of global health security. HIV leaders and advocates will need to support the financial goal with a new business case for why staying in the global HIV fight remains a strategic foreign policy and national security priority for the United States—one worthy of limited U.S. resources. That argument should include the dual-purpose benefits of overall disease preparedness and response capacities gained.

The U.S. government will need to be pragmatic and innovative in how it adapts its investments to support the next phase of the global HIV response. PEPFAR’s current epidemic control strategy ends in 2020. A review of the program in advance of a strategy update should include an analysis of funding allocations and whether they are “right-sized” to current HIV epidemiology and demographics. The strategy should include a plan for how to evolve the program that takes into account the lingering impact of Covid-19.

Consideration also should be paid to how the Global Fund should evolve as the lead multilateral instrument. Initial planning is starting toward a new strategy to be proposed to the board in 2021. The U.S. government has an important role to play in determining whether the Global Fund retains its current mandate or expands to address broader health systems, disease preparedness, and primary health care needs.

Finally, the U.S. government should retain its leadership role on human rights by addressing issues affecting domestic and global HIV programs and ensuring its supported programs protect the service delivery needs of key populations and those most vulnerable to infection. These actions will be even more important as the Covid-19 response affects service availability and access and causes food and other instabilities, which are likely to exacerbate existing vulnerabilities.
Margaret V. McCarten-Gibbs is a program manager with the Global Health Policy Center at the Center for Strategic and International Studies (CSIS), with a primary focus on HIV. Sara M. Allinder is senior associate with the CSIS Global Health Policy Center; she was executive director and senior fellow of the CSIS Global Health Policy Center from April 2016 to April 2020.

Many thanks to Chris Collins, president of Friends of the Global Fight Against AIDS, Tuberculosis and Malaria; Jennifer Kates, senior vice president and director of Global Health & HIV Policy at the Kaiser Family Foundation; and J. Stephen Morrison, senior vice president and director of the CSIS Global Health Policy Center, who provided advice and comments on earlier drafts.

This brief was made possible by the generous support of the Bill & Melinda Gates Foundation.

This policy brief builds on previous HIV-focused work by the CSIS Global Health Policy Center, including “Opportunities for U.S. Leadership at Its Moment of Reckoning on Global HIV,” which was published in September 2017. More information on the background of U.S. leadership and the way PEPFAR operates can be found at https://www.csis.org/analysis/opportunities-us-leadership-its-moment-reckoning-global-hiv.
ENDNOTES

17 The concept is now known as U=U (undetectable=untransmittable).
21 “2019 fact sheet,” UNAIDS.
22 Ibid.
34 “2019 fact sheet,” UNAIDS.
37 “2019 fact sheet,” UNAIDS.
39 To understand the total number of PLHIV virally suppressed, you multiply the proportion of PLHIV who know their status (79 percent) times the proportion of PLHIV who are virally suppressed (73 percent) to get the proportion of PLHIV virally suppressed (79 x 0.73 = 57 percent).
40 “2019 fact sheet,” UNAIDS.
43 The simultaneous occurrence of epidemics of different health conditions in the same geographical area that enhances the transmission and/or virulence of each other.
44 When a patient has two or more health conditions.
46 “Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.” “What is health financing for universal coverage?” World Health Organization, https://www.who.int/health_financing/universal_coverage_definition/en/.
“Primary health care is a whole-of-society approach to health and well-being centered on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing.” “Primary health care,” World Health Organization, https://www.who.int/news-room/fact-sheets/detail/primary-health-care.


Allinder, “Addressing Human Rights is Inherent to Success.”
