

# UNAIDS EXECUTIVE DIRECTOR REMARKS

WINNIE BYANYIMA

---

UNAIDS | 2026



23 MARCH 2026, PHILADELPHIA, PA, USA

PERRY WORLD HOUSE, UNIVERSITY OF PENNSYLVANIA



It is a great honour to be here today.

My name is Winnie Byanyima, Executive Director of UNAIDS.

At first glance, I may seem an unlikely choice for this role. I am not a doctor or an epidemiologist. I came to this position from Oxfam, an international NGO. Before that, I was a revolutionary in Uganda's Bush War, fighting for democracy. I have led women's movements, social justice movement across Africa and globally.

At heart, I am an activist—someone shaped by a lifelong struggle for human rights, social justice, and equality.

And that is precisely why I am here.

Because ending AIDS has never been only a medical challenge. It is a battle shaped—and often determined—by inequality.

I was asked to lead UNAIDS because HIV is not just a virus; it is a mirror of the world's economic and social inequalities.

Today, I want to share two things:

- how social justice has driven one of the most successful public health responses in history;
- and why that model is now under strain. We can think together about solutions.

It has been over forty years since HIV was first identified. There is still no vaccine, and no cure.

And yet, AIDS-related deaths have fallen by about 70%, and new infections have fallen by 60% since their peaks.

How was this possible?

Of course, through science—through powerful tools for prevention, testing, and treatment.

Today, people living with HIV who are on treatment can suppress the virus to undetectable levels and live long, healthy lives without transmitting it.

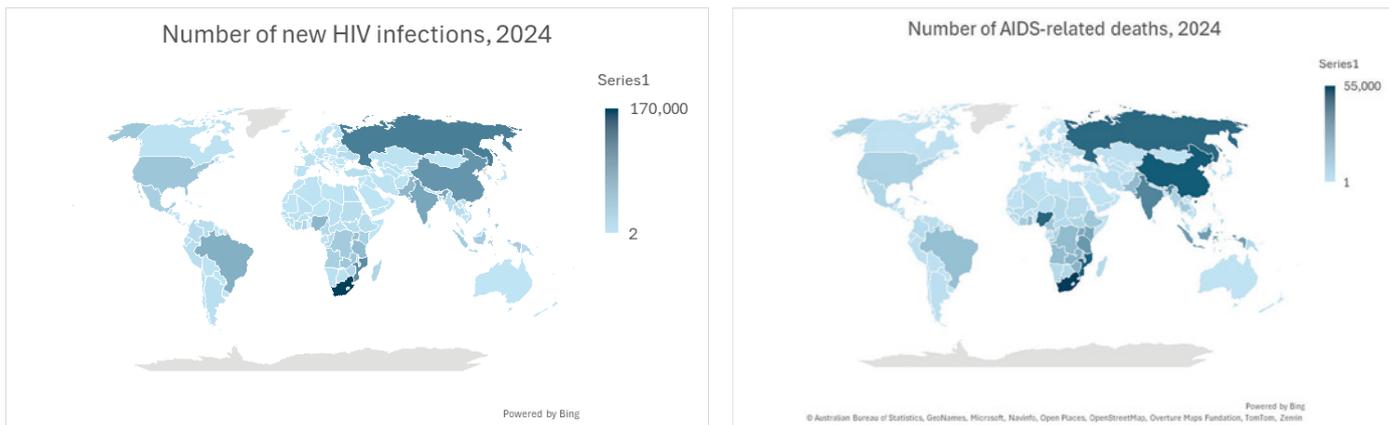
But if that were the whole story, the epidemic would be over.

Instead, at the last count, in 2024, there were still 1.3 million new infections globally and 630 000 people died of AIDS-related illnesses.

Why?

Because when the data is unpacked—when it is examined who is newly infected and who is dying—a clear pattern emerges.

Figure 1. Showing impact of HIV treatment



The burden falls overwhelmingly on the Global South, particularly Africa.

And within countries, it falls on those pushed to the margins: adolescent girls and young women, LGBTQ people, sex workers, and people who use drugs.

HIV is, at its core, about inequality.

Inequality between countries—where global economic rules shape who can access medicines, technologies, and financing.

And inequality within countries—where social and economic status determines who is protected, and who is left behind.

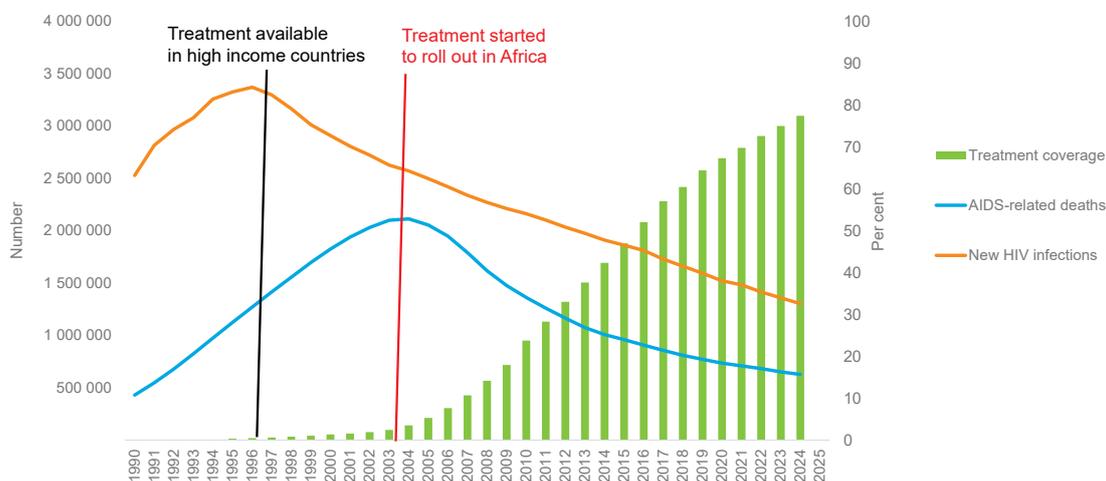
Let me explain.

### First, access to medicines

After more than a decade of devastation from AIDS, a breakthrough came in 1997 with the development of highly effective antiretroviral therapy. In high-income countries, infections and deaths quickly began to fall.

Figure 2. Showing impact of HIV treatment

New HIV infections, AIDS-related deaths and the percentage of people living with HIV receiving treatment, global, 1990–2024



Source: UNAIDS 2025 epidemiological estimates available at [aidsinfo.unaids.org](https://aidsinfo.unaids.org)

But in low- and middle-income countries, access did not follow. For nearly a decade, millions were left without treatment, and an estimated 12 million people in Africa lost their lives. The divide was stark: lifesaving medicines existed, but they were not reaching those most in need.

This was not an accident—it was the result of how the global system for medicines operates.

New treatments were protected by strict intellectual property rules that granted companies monopoly control, even where public funding had contributed to their development.

Prices were set at around \$10 000 per person per year—completely out of reach for countries facing millions of people living with HIV.

Figure 3. Showing Treatment Action Campaign demonstration



Faced with this injustice, activists across Africa, Asia, and Latin America mobilised.

They organised, protested, and demanded action from their governments. They were joined by allies globally, including communities in the United States, particularly gay men, and Europe who had fought for access to treatment and refused to accept a world where access depended on geography or income.

Under this pressure, governments in low- and middle-income countries made use of flexibilities in global trade rules to import affordable generic medicines, particularly from India, despite the strong opposition from pharmaceutical companies. This, combined with sustained activism, forced a shift: companies began to license their technologies, and prices fell dramatically—from \$10 000 to under \$70 per person per year.

This transformation was matched by political leadership and global solidarity. That's when the United States launched the PEPFAR program, launched by President Bush, the largest HIV programme in history, the largest global health program. The Global Fund was established to pool resources and expand access. Communities were placed at the centre of delivery.

The results have been extraordinary. Today, three-quarters of people living with HIV are on treatment—31.6 million people out of 41 million people living with HIV. Whether in Philadelphia or in Phakalane in South Africa, you have access to life-saving HIV medicines and you can be on the same cutting-edge treatment.

This progress was not inevitable—it was achieved by challenging an injustice.



Photos: Perry World House.

Yet the structural barrier of intellectual property rights, was not fully dismantled. Intellectual property rules continue to limit access to newer medicines, particularly in middle-income countries that are often excluded from licensing agreements. So the lessons from HIV are not consistently applied to other health crises, and we saw this during COVID-19.

That unfinished agenda remains.

## Second, access to finance

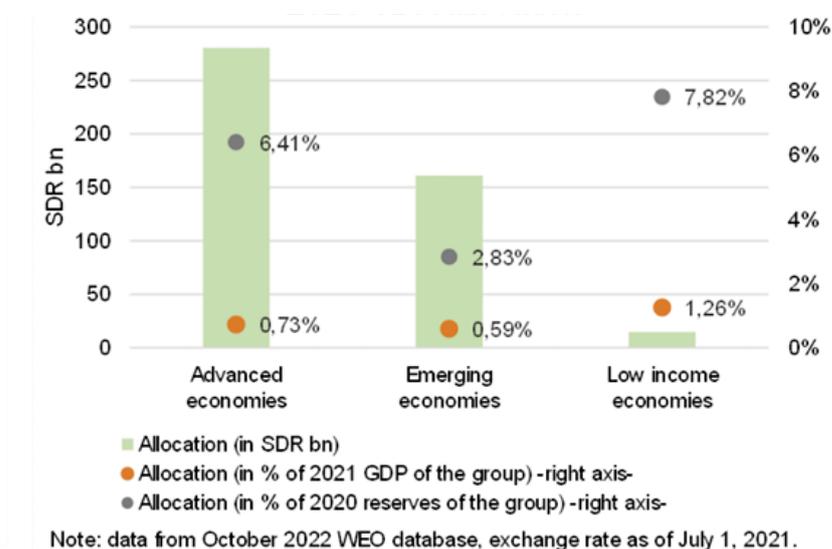
The global financial architecture is structurally skewed against developing countries because it was designed by neoliberals in rich countries.

It gives the richer countries disproportionate influence in institutions like the IMF and World Bank while setting rules that prioritize creditor interests over development needs. Developing countries often borrow in foreign currencies at higher interest rates, leaving them exposed to exchange rate shocks and rising global interest rates.

As a result, many are trapped in cycles of debt: they take on new loans to service old ones, diverting public resources away from health, education, and needed infrastructure.

This dependency is reinforced by conditionalities and limited access to fair restructuring of debt mechanisms, making it difficult to escape indebtedness and to invest in health and education, and other priorities.

Figure 4. Showing COVID-era SDR allocation



The COVID-19 pandemic exposed the deep inequalities in access to global finance.

As lower-income countries sought resources to procure vaccines and essential medical equipment, to save lives during COVID, the IMF issued \$650 billion in Special Drawing Rights (SDRs)—effectively creating new liquidity.

But because these were allocated according to existing quota shares, over 60% went to high-income countries, while low-income countries who needed it because they were indebted, received just 3%, leaving those most in need with the least support.

There were efforts to correct this imbalance, because the creation of new liquidity was about helping those countries that needed to buy the vaccines. So there were efforts, including voluntary reallocation of these SDRs, but it all came too little and too late to alter the course of the crisis. There was another framework, by the G20, called the Common Framework for Debt Relief, to suspend the debt repayments so that countries could buy life-saving vaccines. That too, proved very slow and inadequate—in fact, only four countries accessed it, and they got it as COVID was ending.

So the lender of last resort, the one that was supposed to cushion countries from economic shocks, the IMF, could not respond. Neither could the World Bank, that was designed to end poverty.

The result is that a structural injustice in the global finance architecture remains unchanged. If another global health emergency were to strike, and it will strike, there is still no effective mechanism to ensure timely and equitable access to financing for the countries most in need.

Come to domestic resources, then.

Developing countries—especially in Africa—lose billions of dollars each year to tax dodging enabled by global loopholes that allow multinational companies to shift profits from where they create the value, to low- or no-tax jurisdictions, depriving governments of vital revenue for health, education, social protection, and other critical needs.

The current global tax rules, largely shaped by wealthy countries, prioritize where companies are headquartered rather than where economic activity actually takes place, systematically disadvantaging developing countries.

In 2023, Africa received \$61 billion in aid (OECD via ONE) but it spent \$85 billion on paying interest on its debt (Christian Aid, 2024) and lost an estimated \$88 billion to illicit financial flows—mostly tax evasion (UNCTAD 2020, UNOSSA, Nov 2022). So, even before the aid cuts of the last two years, for every dollar of aid flowing into Africa, \$2.80 was draining out—a total net transfer to the richer countries.

Social justice movements have long campaigned for reforms to increase transparency, to tax profits where value is created, to establish a fair global minimum tax, and to close the tax loopholes.

There are currently ongoing negotiations at the UN to establish a fairer global tax framework, without which developing countries will never be able to raise the domestic resources needed to fund health and other development priorities.

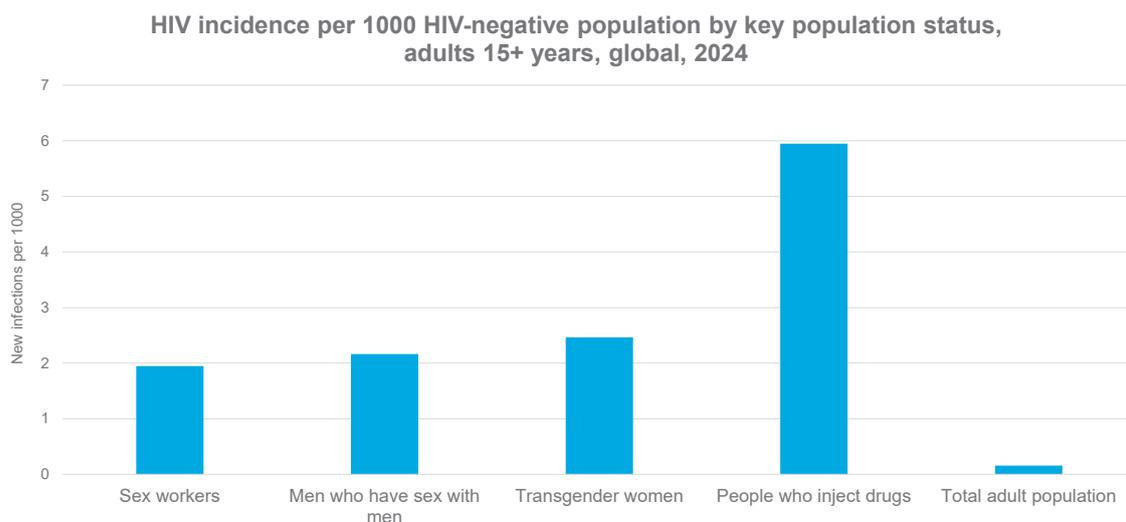
So those are inequalities in the global system that deny developing countries the opportunity to meet the health needs of their people.

### Third, inequalities in social status

Social inequalities—expressed through stigma, discrimination, criminalisation, and the denial of human rights—shape who is most exposed to HIV and who is least able to access prevention, treatment, and care.

Those facing these structural barriers bear the greatest burden: adolescent girls and young women account for nearly two in three new HIV infections in sub-Saharan Africa, with around 3300 young women acquiring HIV every week.

Figure 5. Visualising data on key pops higher rates



Source: UNAIDS Special analysis of 2025 epidemiological estimates.

While global adult HIV prevalence is about 0.7%, it is around ten times higher among gay men, transgender people, and people who inject drugs; around four times higher among sex workers; and roughly double among people in prisons.

These disparities are driven not only by stigma, but by laws and policies that institutionalise inequality.

Sixty-four countries still criminalise same-sex relations, 14 criminalise transgender people, and many (more than 100) criminalise sex work, minor drug possession, and HIV non-disclosure, exposure or transmission.

Evidence shows that gay men in African countries that criminalise them face HIV prevalence rates five times higher than in countries that do not—and up to twelve times higher where recent prosecutions have taken place. Globally, countries that criminalise key populations have mounted less effective HIV responses, with lower rates of testing and treatment coverage.

Progress against AIDS has been achieved where these inequalities have been challenged. When the AIDS pandemic began, most of the world criminalised same-sex relations; but it was through sustained advocacy, human rights movements led—and that led to significant legal reforms. In recent years, countries like India, Namibia, Barbados, and Venezuela, have been repealing these laws. These shifts have been critical in changing the trajectory of HIV.

At UNAIDS, we work with communities, we support them to lead HIV responses—LGBTQ communities, young women in their groups, people who use drugs in their own associations, and so on.

Figure 6. showing PCB NGO delegation



Evidence consistently shows that community-led programmes are the most effective in reaching underserved populations.

UNAIDS and the Global Fund have embedded this principle in our governance, with communities represented alongside governments and multilateral agencies on our boards. They work hand in hand with governments at the country level—even in contexts where they face criminalisation.

Uganda has one of the harshest laws in the world on same-sex relations. But in Uganda, I work with associations of gay people. They are not even legal, in the law, but we sit with the Minister of Health to design HIV programs. That is how the HIV movement has been able to succeed—by bringing the communities at the centre of service delivery.

This approach—grounded in confronting inequality and advancing social justice—has helped to build a global HIV response that has saved nearly 27 million lives. And the opposite is also true: without addressing stigma, criminalisation, and the denial of rights, these gains would not have been achieved and cannot be sustained.

## But today, these fundamentals are under threat

Today we have a far more contested geopolitical environment. The HIV response is confronted with a new reality.

Across many regions—including parts of Africa—cultural and political battles that are pushing back against human rights, particularly the rights of women and girls—sexual and reproductive health and rights—and the rights of key populations. A coordinated and well-funded attack on rights. For the first time since UNAIDS began tracking these trends in human rights, we find that the number of countries criminalizing key populations has increased rather than declined.

This is colliding with a sharp contraction in global solidarity—an attack on rights and a contraction of global resources to support developing countries. Aid—long a cornerstone of the HIV response and the wider global health architecture—fell by an estimated 17% in 2025, following a 9% decline the previous year. And we are expecting an almost 30% decline this year.

At the same time, funding is increasingly tied to political conditions, putting at risk the rights-based approaches that have been central to progress.

These pressures are unfolding in a world already marked by overlapping crises. Conflict is displacing communities and disrupting services; climate shocks are straining fragile systems; and the long shadow of COVID-19 continues to affect economies and to weaken health systems. Together, these forces are exposing the limits of an already fragmented and overstretched global health architecture.

And yet, there is also a moment of possibility. Across Africa and other regions, there is growing determination to achieve greater health sovereignty. Countries are coming together, to reduce dependency and to build more sustainable, resilient systems.

There are initiatives such as the Accra Reset and the Lusaka Agenda, alongside ongoing reforms at the United Nations, efforts led by World Health Organization—all pointing toward more coordinated, more country-led, and more resilient approaches.

There is also increasing emphasis on sustainable health financing, including efforts to expand regional production of medicines and health technologies, reducing external reliance, and strengthening local capacity. There are also emerging financing models, such as Global Public Investment, an idea which, I think, its time has come—seeking to position health as a global public good, and supported by all countries, for the benefit of all.

As these new directions take shape, one lesson from the HIV response must remain central: progress is built on social justice.

Human rights must be protected, not traded away, and communities most affected must continue to lead—to shape prevention, to deliver services, and to hold systems accountable.

The future of the HIV response—because we have 9 million people out there living with HIV who are not yet on treatment, and we have a million and more newly infected every year, so there's still a journey—and of global health more broadly, will depend on whether these principles that have led success to where we are, are upheld in the face of the current headwinds.

Thank you very much.

