ANNE
GITHUKU-SHONGWE

UNAIDS | 2026

UNAIDS REGIONAL DIRECTOR **SPEECH**

12 NOVEMBER 2026, OPENING REMARKS, MEETING OF SADC MINISTERS OF HEALTH AND HIV

Introduction

Honourable Ministers, Your Excellencies, Executive Secretary and representatives of the SADC Secretariat, distinguished partners, representatives of civil society and communities, ladies and gentlemen. Good morning.

It is an honour to join you at this important gathering of SADC Ministers, at a defining moment for the future of the HIV response, our health systems and the development of our region. Let me recognise the leadership of SADC Member States and the Secretariat in sustaining regional cooperation and political commitment to ending AIDS.

A moment of change and an opportunity for regional ownership

We meet at a time of profound change in global health and development financing. International assistance is becoming less predictable, fiscal pressures are intensifying, and countries are being required to take greater responsibility for financing their own priorities. For our region, this is both a challenge and an opportunity: a challenge to protect decades of progress, and an opportunity to accelerate national ownership, regional cooperation and health sovereignty.

I come with a clear message: Africa's health future cannot depend indefinitely on external financing, external supply chains or decisions made beyond our region.

The abrupt funding cuts in 2025 showed us the consequences:

- In Zambia, 32 wellness centres serving more than 20,000 key population clients had closed by May.
- In Eswatini, several community-led facilities stopped functioning.
- In Malawi, 18 drop-in centres reduced operations, affecting around 7,600 people living with HIV receiving treatment and 7,000 people accessing PrEP.
- In Zimbabwe, central condom stocks were estimated to have just 5.5 months of supply.

We must also remember the thousands of adolescent girls and young women affected by the closure of DREAMS programmes, and the health workers who lost their livelihoods. The lesson from the disruption is that we must build the political, financial and institutional capacity to finance, produce and deliver on our own health future.

Countries across the region are already taking bold steps towards greater self-reliance. Tanzania, for example, historically relied on external resources for more than 90% of its HIV prevention response. It is now introducing a health levy, with a substantial portion of the revenue directed to HIV services, signalling a shift towards more sustainable domestic financing.

1. Make HIV prevention a higher political and fiscal priority

Eastern and Southern Africa remains the region most affected by HIV globally. While considerable progress has been made, with 85% of people living with HIV now receiving treatment and new HIV infections declining by 62% since 2010, the pace of progress is still not fast enough to meet our 2030 targets and commitments.

Sustained investment in treatment has saved millions of lives and transformed the HIV response. We must protect these hard-won gains. But treatment alone will not end the epidemic. Ending new infections is ultimately what will make the response sustainable. Therefore, HIV prevention must be elevated to the same level of political priority and financing.

This is not about choosing between treatment and prevention. People on treatment still need access to prevention services, and treatment itself is also a form of prevention. We must, however, close the tap on new infections. Every new infection brings a lifetime of treatment costs, adds pressure to already stretched health systems and places an avoidable burden on families, communities and the nation.

Investing in prevention today is a public health imperative, but it is also a sound long-term financial investment. The cost of failing to prevent new infections will ultimately be borne by national budgets and future generations.

I urge Member States to increase domestic resource mobilisation, ensure predictable allocations for prevention in national budgets and track how much is invested, which populations are reached and whether these investments are reducing new infections.

2. Confront human rights, gender inequalities and structural barriers

During a visit to Angola last year, I met a young woman who was just 15 years old and already a mother of two children, aged three and one. The fathers were absent from their lives. With no means of supporting herself, she exchanged sex for survival. The two children she was struggling to care for were the consequence of that reality, but so was the end of her education and the loss of the opportunities that should have been hers. At just 15, her childhood was already behind her, and her future was being shaped by circumstances over which she had little control.

Her story is not unique to Angola. We know that similar realities play out across our region every day. But hers offers a glimpse into the life of someone our systems have failed, someone who has been left behind. And she is precisely the person we must be asking ourselves whether our HIV response is reaching.

Her experience reflects the disproportionate vulnerability faced by adolescent girls and young women, often because of unequal economic opportunities, harmful gender norms, violence and limited power to make decisions about their own bodies and health. Key populations and other marginalised communities also face discrimination, punitive legal environments and barriers to prevention, testing and treatment.

A service may exist in a health facility, but if a young woman cannot access it safely, if someone fears discrimination or arrest, or cannot afford transport to a clinic, that service is not meaningfully accessible. Instead of relying on the metrics of commodities procured and facilities established, we must ask ourselves whether services are available, affordable, accessible and acceptable to everyone, particularly those most affected by HIV.

We cannot credibly commit to ending AIDS while tolerating the inequalities and exclusion that drive the epidemic. Human rights and gender equality are essential to epidemic control.

3. Make commodity security a strategic priority for regional health sovereignty

Global disruptions have exposed the vulnerability of countries dependent on external financing and concentrated international supply chains. No country should have to interrupt essential HIV services because of procurement delays, financing gaps or supply-chain disruptions.

SADC can leverage its collective purchasing power through pooled procurement, group contracting and coordinated forecasting. Our region should not have 16 countries negotiating separately when cooperation can secure better prices, stronger negotiating power and more predictable supplies.

We need to strengthen our position as producers and strategic partners in the pharmaceutical value chain, rather than remaining predominantly consumers and importers.

I acknowledge the SADC–China exchange study tour on commodity security, undertaken in collaboration with UNAIDS and the Global Health Initiative. We welcome the SADC Secretariat's initiative to establish a partnership with the Government of China and its private sector, creating opportunities for knowledge and skills transfer and closer engagement with China's pharmaceutical industry. This partnership could help build local manufacturing capacity and strengthen the region's ability to produce and secure its own essential health commodities.

Lenacapavir, the long-acting HIV prevention medicine, offers a powerful example of why health commodity sovereignty and local manufacturing matter. The breakthrough was made possible in part by research participants from countries such as South Africa and Uganda, including the many women whose participation was critical to demonstrating its effectiveness. Yet despite helping make this innovation possible, African countries have had limited influence over its production, pricing and access.

We must have the capacity to contribute to innovation, but also to produce it, shape access to it and ensure it reaches the people who need it most. Otherwise, we risk perpetuating a system in which those who help create health innovations remain dependent on others for their benefits.

I encourage Ministers to provide the political mandate to turn these initiatives into a concrete regional commodity security agenda, with commitments on pooled procurement, local manufacturing, technology transfer and investment. Commodity security is fundamental to our ability to safeguard the health of our people and reduce dependence on external suppliers.

4. Strengthen sustainable health and community financing

We recognise the fiscal pressures facing Member States. However, underinvestment in health today will create greater economic and social costs tomorrow. The HIV response cannot remain the responsibility of Ministries of Health alone. The HIV response requires a multisectoral response, which means it requires a whole-of-government commitment, particularly from Ministries of Finance, Planning, Trade and Industry, Gender and Social Development.

HIV financing must be integrated into national development plans and fiscal frameworks. Investment in health is essential to sustaining national productivity and protecting future generations.

We must also institutionalise social contracting and predictable domestic financing for community-led organisations. Communities are essential partners in reaching underserved populations, addressing stigma, supporting treatment continuity and holding systems accountable. Their contribution cannot depend on goodwill and volunteerism. If we recognise communities as essential partners, we must finance their role sustainably.

Recognise SADC's decision on the future of UNAIDS

Finally, Honourable Ministers, I wish to recognise SADC's decision on the future of UNAIDS. I commend Member States for adopting Decision 2.5: SADC Statement to Support the Continuation of Operations of the Joint United Nations Agency for AIDS (UNAIDS).

On behalf of UNAIDS, I express our deep appreciation for this demonstration of regional political leadership and solidarity.

We recognise that the United Nations system is evolving and that greater efficiency and a fit-for-purpose institutional presence is necessary. Reform must strengthen, not weaken, the functions required to support Member States. UNAIDS brings a distinctive contribution through political advocacy, regional convening and coordination, strategic information and accountability, technical guidance and community engagement.

We look forward to working with Member States and the SADC Secretariat to translate this political support into a sustainable partnership, responsive to national priorities and aligned with regional leadership. The institutional architecture supporting the HIV response must evolve, but our commitment to ending AIDS must not diminish.

Closing

Honourable Ministers, the future of the HIV response will depend on the decisions governments make today and the priority they give to sustaining the gains we have achieved. I urge SADC Member States to turn these priorities into firm political commitments that will guide the region's response.

Let us not allow the transition in global financing to impact our ambition. Let us use this moment to strengthen regional ownership, protect our gains and accelerate progress towards ending AIDS.

UNAIDS stands ready to work alongside Member States, the SADC Secretariat, communities and partners to turn this ambition into measurable results.

I wish you fruitful deliberations.

I thank you.



unaids.org