



# REMARKS

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UNAIDS EXECUTIVE DIRECTOR

UN HIGH-LEVEL MEETING ON PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE (PPPR), 2023

MULTISTAKEHOLDER PANEL 2: "ENSURING EQUITY THROUGH CAPACITY BUILDING FOR PPPR AND

HARNESSING TIMELY, SUSTAINABLE AND INNOVATIVE FINANCING AND INVESTMENT"





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WINNIE BYANYIMA,  
UNAIDS EXECUTIVE DIRECTOR  
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Thank you, co-chair.

Excellencies, distinguished delegates, ladies and gentlemen.

I speak on behalf of the Joint United Nations Programme on HIV/AIDS and I thank the Co-Chair for asking about access and equity.

Recently, the Global Council on Inequality, AIDS, and Pandemics released a paper and this paper showed that countries with high inequality had higher rates of HIV infection, higher rates of AIDS deaths, and higher rates of COVID mortality. There is a strong association.

Inequality is driving pandemics within countries and between countries. We have to break the inequality pandemic cycle.

I put it to you that the AIDS response *is* Pandemic Prevention, preparedness, and response.

We have over 40 years of experience fighting one of the deadliest pandemic, AIDS. A pandemic that isn't over yet. But where we have registered so many successes and there is so much to learn from. What have we learned?

First, that a global pandemic requires a global solution.

That sounds like common sense. That you need a global response and a global plan to end a pandemic. The world came together in 1994 at the height of the AIDS pandemic and agreed on a global response, set up a Joint United Nations Programme on HIV/AIDS, which I lead today, set global targets and a plan with targets and mechanisms for resourcing that plan. Soon after that first political declaration, there was a declaration by President Bush creating PEPFAR, which is now 20 years old. That is the President's Emergency Plan For AIDS Relief. That came with huge resources to support countries to fight HIV/AIDS. A year before the Global Fund, led by France and other countries, was set up to provide resources for a global response. There have been many other investments.

This is what we didn't have with COVID. No global plan. Targets were set without a plan. Resources were not put behind it and you see what we had.

So a global pandemic needs a global plan, backed by resources and clear targets that are reviewed from time to time.



*In conclusion, as we develop a global architecture for pandemics prevention, preparedness, and response, we need to draw on lessons from over 40 years of responding to AIDS.*

The second is sharing technology.

12 million lives were lost in the Global South, mostly in Africa, at a time when antiretroviral treatment was already on the market. But eventually access to sharing of technology happened and access to ARVs happened. But 12 million died, lives were lost for ten years as people waited.

This also happened with COVID. 1.3 million lives could have been saved if COVID vaccines were equitably distributed.

The key elements for sharing technology for AIDS were these: first, people living with HIV gathered, organized, and led a struggle for their right to health and right to life.

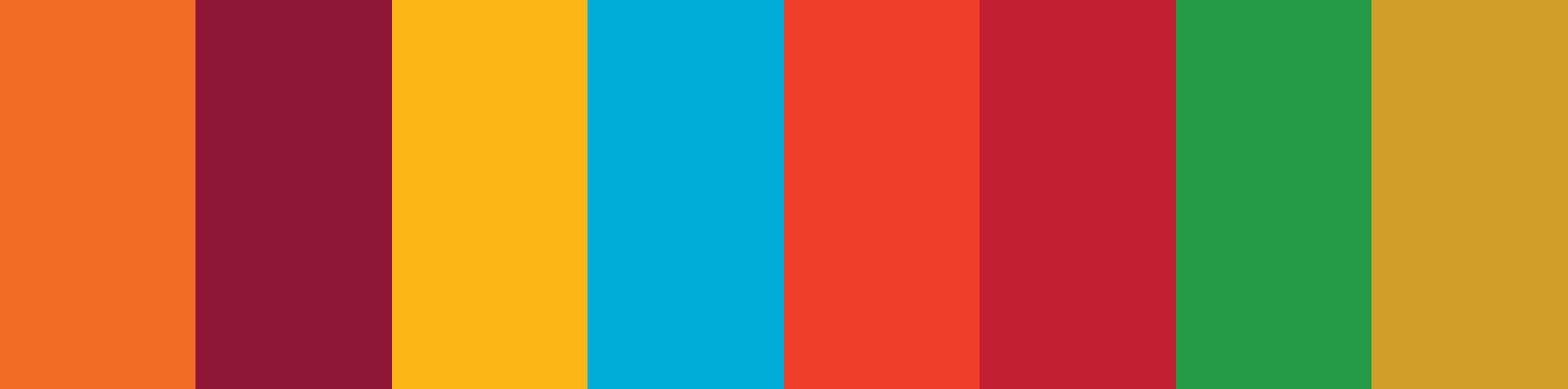
Leaders also rose—President Mandela, President Clinton, President Bush—rose and took a side with the people for access to technology, for equal access to medicines.

There was also strong public investment in R&D. This is often forgotten, that innovations often behind health technologies are funded publicly, by citizens. This was also there for COVID, even though the profits went to companies. But the investment came from governments. Sharing technology, this is how it happened with HIV/AIDS. Today, with HIV, when new drugs come to market, global organizations have collaborated with pharmaceutical companies to share that technology by getting low cost generics to be made in Asia, Latin America, Africa. That is how everybody can have access to what they need. Where countries only want to allow brand name drugs, like in the US and Europe, they maintain the monopolies. But monopolies in the case of HIV aren't global. Factories have been built and funded, patents are shared and government can use their legal power to force companies to share where necessary. This is important. The result is that prices have come down by 99%. So the pandemic accord needs to support technology transfer, needs to be clear on local production in every region, and on flexible licensing. These are things that if they are not addressed in the Pandemics Accord, we will not have done much.

We need to lock in that Accord a new way of sharing health technologies. There are many ways to incentivize innovation, including public resources that are put in R&D.

The third point is financing.

At the height of the AIDS pandemic, we had a massive debt crisis in the countries most affected, countries of Africa and Asia particularly. There was a major move toward debt cancellation to free up the fiscal space for



countries to deal with the crisis of HIV/AIDS and other crises. That was the Heavily Indebted Poor Countries initiative that relieved over \$100 billion debt from the countries that were highly burdened by HIV. Actually we were at the same point with COVID. In 1996, at the height of AIDS only 1% of ARVs that were on the market were reaching Africa. When COVID hit us and there was a vaccine, only 1% of all vaccines in 2021 were reaching Africa. But we did not do what we did for HIV/AIDS. And now we need to lock such arrangements in a treaty that will secure us for the future.

In 2022, Kenya spent 53% of its revenue on debt servicing, nine times higher than Kenya spent on health. We need a quick mechanism to access financing when a pandemic hits. I also want to remind you that Africa paid \$79 billion in 2021 in debt repayments, so it wasn't just Kenya, it was the whole of the low-income countries trapped in debt. You cannot come out of a pandemic without creating fiscal space.

It is short sighted to make this pandemic accord and not take into account the need to have, as part of pandemic preparedness and response, an emergency financing mechanism for pandemics that is accessible to all countries, particularly the countries that need the resources most.

My fourth point is on communities. AIDS transformed global health in this respect. Putting communities at the centre to lead and reach all those in need. In the AIDS response, communities connected the most excluded people to services. Communities have won vital successes in access to health technologies. Who doesn't know the Treatment Action Campaign of South Africa, it is an iconic movement that led us to where we are. Communities have challenged prejudice, they challenged stigma and discrimination every single day. It is communities who do this work. Communities pioneer new approaches. Communities have held duty bearers to account through their community-led monitoring. So it is important to fund local community-led organizations that reach where governments cannot reach. This should be part of any pandemic accord. We should spell out and make firm commitments in such an accord how communities will play their role, set standards that countries know they need to achieve to get out of a pandemic.

In conclusion, as we develop a global architecture for pandemics prevention, preparedness, and response, we need to draw on lessons from over 40 years of responding to AIDS. What is true for a successful AIDS response was also true for COVID, even if not done. It was true for Mpox and will be true for the next pandemic.

I thank you so much.

