Future of HIV Markets Forum

Co-hosted by Unitaid and CHAI

Future of HIV Markets Forum

Post-Meeting Report

Co-hosted by Unitaid and CHAI

June 9–11, 2026 | Nairobi, Kenya

Unitaid SAVE LIVES FASTER

CLINTON HEALTH ACCESS INITIATIVE

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Disclaimer: This report has not been reviewed and endorsed by all meeting participants. This document is intended to prompt further discussion and action as circumstances evolve, some of which have shifted even since the meeting. Please send any questions or feedback to futureofhivmarkets@clintonhealthaccess.org.

EXECUTIVE SUMMARY

The global HIV response is at a pivotal moment. Decades of hard-won progress are under threat from abrupt reductions in donor financing leading to fragmentation of procurement and disruptions to service delivery, precisely as a new generation of long-acting tools offers the potential to transform outcomes and enable more integrated care. Realizing that potential for people living with and at risk of HIV requires deliberate, coordinated action precisely when the market architecture that has enabled such coordination is under greatest strain.

Convened by Unitaid and CHAI on June 9–11, 2026 in Nairobi, the Future of HIV Markets Forum (FHMF) brought together Ministries of Health, communities, civil society, donors, partners, researchers, industry, and technical agencies from more than 28 countries and 80 organizations to align on the access conditions and market coordination mechanisms required to stabilize the HIV market and support the successful introduction and scale-up of priority tools. This report summarizes the Forum's key discussions, the takeaways that emerged, and the structures and next steps established to carry this work forward.

Key cross-cutting Forum takeaways:

Access planning for new innovations must begin earlier and connect decisions across the full pathway to scale.

- ✓ Long-acting prevention and treatment are converging on shared molecules and delivery platforms, and diagnostics and monitoring must evolve alongside both.
- ✓ Evidence generation for long-acting products has been too slow, constrained by limited study-drug access; too few studies, including on product combinations; and insufficient community engagement.
- ✓ Diagnostics built for one treatment era must now be reimagined to serve the next.
- ✓ Access cannot be achieved without the interdependent quality, regulatory, financing, and supply chain foundations these tools depend on.

Progress on any single tool or market lever will require close coordination and improved visibility amongst stakeholders to ensure new innovations' transformative potential reaches people living with and at risk of HIV.

Strengthened coordination mechanisms must be stood up to preserve key market conditions and secure access to life-saving care amid growing fragmentation.

- ✓ Procurement is fragmenting as more countries shift to domestic channels, threatening the price security, quality assurance, supply continuity, and demand predictability that consolidated procurement has historically delivered.

- ✓ Preserving these conditions and supporting the introduction of a new wave of tools within a new, distributed architecture will require renewed engagement, leveraging lessons and strengthening the coordination mechanisms already in place, in particular the ARV Procurement Working Group (APWG).
- ✓ As procurement fragmentation increases, low-volume products — including for pediatrics and people living with advanced HIV disease (AHD) — become particularly vulnerable, requiring targeted attention as new procurement channels take shape.

The new HIV procurement architecture must maintain and strengthen coordination and demand alignment across a more distributed system.

Country ownership and community engagement must be structurally embedded in the HIV market.

- ✓ As donor-built supply chain functions transition to national systems, many countries are inheriting quantification, inventory management, and data visibility responsibilities that partners previously carried — often without the systems, human resources, or plans in place to take them on.
- ✓ Community monitoring and programming structures are facing funding threats precisely as their role in the new HIV landscape becomes more critical, not less.
- ✓ Community and civil society actors have long carried disproportionate responsibility for advocacy, negotiation, and linkage to care, without matching resourcing or decision-making authority.

Moving forward, global coordination mechanisms — spanning evidence generation, procurement, and regulatory processes — must position country and community actors as structural partners in governance. National programs, in turn, must be supported through the transition to full ownership of supply chain data and decision-making.

To carry this alignment forward, the Forum established the following immediate next steps ***(see full list on page 26)*****:**

1. **Advance engagements with the Future of HIV Markets Group** to convert the Forum's shared near-term priorities into actions and hold members accountable to one another. A key mandate of the group moving forward is to ensure Ministry ownership and community engagement is structurally embedded into all working groups and outputs.
2. **Evolve and empower the APWG** as the coordination mechanism for this transition, spanning institutional, regional, and domestic procurement, with a more consistent supplier, Ministry, and community voice, and more integrated product coverage. The expanded mandate will include greater capacity to monitor the Global Health Supply

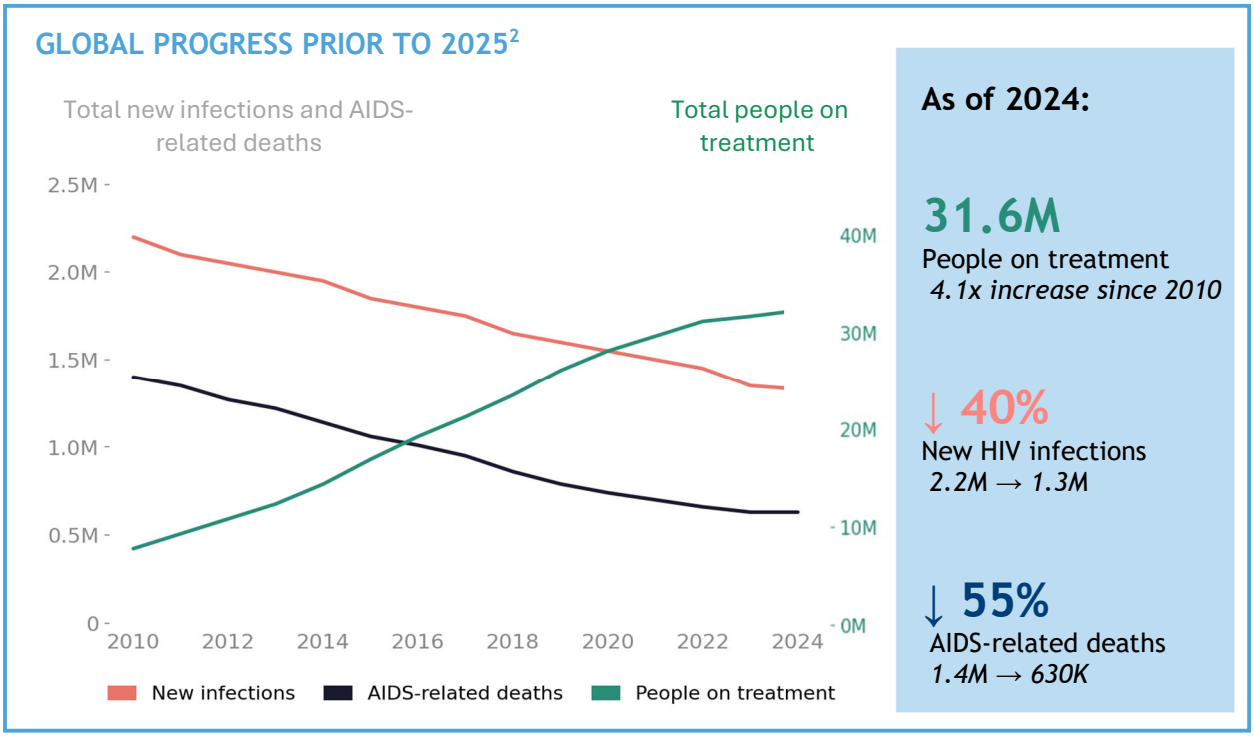
Chain – Procurement and Supply Management (GHSC-PSM) transition, escalate breaking points as they arise, and get ahead of risks as procurement and financing become more complex and fragmented.

3. **Develop and disseminate practical resources to support access to priority HIV products and respond to changing market conditions.** These will include a combined long-acting prevention and treatment Target Access Profile[1], a treatment monitoring access framework and supporting resource allocation model, information to support country CD4 network optimization, and a pediatric portfolio-level Target Access Profile. These resources will be grounded in community and Ministry-driven requirements for access across regulatory and quality assurance, affordability, demand and adoption, supply, and equity, and will draw on further analysis of required evidence — including which populations and combinations remain understudied — alongside continued industry engagement to keep decision-making grounded in a public health approach.
4. **Support national programs and communities through both the near-term procurement transitions and introduction planning** for new, innovative tools. Community engagement should be embedded as a permanent, structural function across the market, and governments should remain the central supply chain steward, using collaboration, integration, and partnership with communities and groups such as the APWG to extend national capacity rather than displace it.
5. **Disseminate the Forum's conclusions and outputs**, including through the meeting report, engagement at AIDS 2026, and targeted publications.

[1] Target Access Profiles (TAPs) are a core component of Unitaid's access work. Unitaid uses this tool to define access objectives for innovative products needed in LMICs — capturing both the access barriers and the interventions required to address them, which then inform multistakeholder access roadmaps.

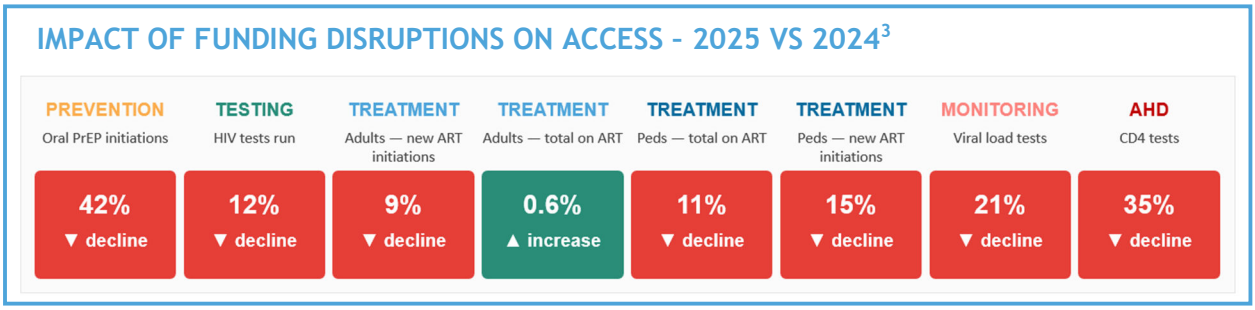
BACKGROUND

Prior to the aid disruptions in 2025, tremendous progress had been made by the global community in the fight against HIV[2]:



These achievements were not inevitable, but resulted from deliberate, coordinated action across governments, communities, donors, manufacturers, and technical agencies. Significant gaps remained, however. As of 2024, nearly 9.2M people living with HIV (PLHIV) were not receiving treatment. Pediatric treatment coverage stood at 55%, far behind the 78% rate for adults. The median time to HIV diagnosis remained 2.6 years, and 1.3 million new infections per year put the 2030 UNAIDS prevention target of below 370,000 firmly out of reach on current trajectories[1].

The 2025 funding disruptions have sharply worsened this picture[3]:



[2] UNAIDS Global AIDS Update 2025
[3] Percentage change calculated as aggregate across all reporting countries, comparing full-year 2024 to full-year 2025 totals. Country-level data collected by CHAI on nationwide, public sector HIV services across 13 countries in Africa and Asia. Source: CHAI June 2026 Market Impact Memo.

Co-financing obligations embedded in U.S. Government (USG) Memoranda of Understanding (MOUs) project declines in USG's HIV funding by 42–97% by 2030 across reviewed countries, while Global Fund Grant Cycle 8 (GC8) allocations declined by an average of 18%, with 35 countries phased out and 12 more expected in GC9.

These disruptions are accelerating a structural shift from consolidated global procurement toward fragmented domestic purchasing, threatening the architecture that underpinned price reductions, supply continuity, and quality assurance in the historical ARV market and thereby critical access to life-saving care for people living with and at risk of HIV. Managing this transition while simultaneously introducing a new generation of long-acting prevention and treatment tools, integrating HIV services into primary health care, and building country-owned supply chains defines the challenge this Forum was designed to address.

The innovation pipeline adds both urgency and opportunity. Long-acting prevention tools are beginning to reach people in low- and middle-income countries (LMICs), but progress on long-acting treatment, diagnostic and pediatric innovations continue to face major evidence, licensing, affordability, and delivery barriers.

Realizing the potential of new innovations for recipients of care requires deliberate and coordinated market planning, precisely when the architecture supporting such coordination is under greatest stress. Alignment on public health priorities, access conditions, and market coordination mechanisms is essential. Without it, new tools risk slow uptake, pricing that excludes LMIC programs, or market failure. This Forum convened against this backdrop — bringing together Ministries of Health, communities, donors, procurement partners, industry, and technical agencies to agree on what access must look like, and what is required to deliver it.

The HIV market is being remade in real time: "We would rather shape that than be shaped by it, and we're only going to manage that together" – Forum Participant

ACCELERATING ACCESS TO PRIORITY HIV TOOLS

A new generation of prevention, treatment, and diagnostic tools could address persistent gaps in the HIV response, but their impact will depend on earlier and more coordinated access planning.

LONG-ACTING TREATMENT AND PREVENTION

Current Status – Prevention

Progress reducing new infections has stagnated in recent years, and daily adherence with existing oral pre-exposure prophylaxis (PrEP) options has proven challenging. The prevention pipeline[4] is robust with new and emerging long-acting tools, which could change the curve of new infections while offering increased choice.

PREVENTION PIPELINE AS OF JUNE 2026[4]

In Development Pre-clinical & early clinical	In Development Efficacy / late-stage trials	Regulatory Review Ongoing	Approved
Long-Acting Implants	LEN 12-Month (IM)	DVR 3-Month (vaginal ring) *EMA*	LEN 6-Month (SC) *FDA; EMA; Originator approved in 16+ countries*
Preventive Vaccines	LEN 6-Month Generic (SC)	Dual Prevention Pill (DPP) *WHO PQ*	CAB-LA 2-Month (IM) *FDA; EMA; Originator approved in 50+ countries*
Broadly Neutralizing Antibodies (bNAbs)	CAB-LA 2-Month Generic (IM)		DVR 1-month *National regulators; Originator approved in 12+ countries*
Multipurpose Vaginal Ring	CAB-LA 4-Month (IM)		TDF/FTC Oral PrEP *FDA; EMA; WHO PQ; Generics widely approved*
Inserts	MK-8527 Monthly Oral		F/TAF Oral PrEP *FDA*
Patches			

A few products are nearing regulatory submission or in early rollout: Gilead's twice-yearly lenacapavir is already rolling out in several countries, with generics expected from 2027 at ~US$40 per person for injections per year thanks to landmark pricing deals. Merck's monthly oral alimatravir (MK-8527), now in Phase 3 trials, offers a promising alternative for those who prefer oral formulations and a potentially simplified and de-medicalized service delivery pathway compared to long-acting injections. Long-acting products can dramatically expand the LMIC PrEP market and offer further choice, but key access challenges need to be addressed.

Current Status – Treatment

TLD is highly effective, widely available, and priced below US$35 per person per year, yet people continue to cycle in and out of care, and 9.2M PLHIV were not receiving treatment as of 2024. New long-acting options offer the opportunity to reduce treatment interruptions and improve retention and long-term viral suppression. While new long-acting treatment regimens are advancing through development, progress has been far slower than for long-acting prevention[5]. The only existing, approved long-acting regimen, CAB/RPV, is not optimal for scale in LMICs (due to cost, cold chain, delivery complexity). However, there is nonetheless interest in this product for certain populations and settings with willingness from ViiV (the originator of CAB) to supply it, but unfortunately J&J, the originator of rilpivirine, has stopped supplying LMIC markets. Generic development has been slow for each part of this combination. CAB/LEN, the priority candidate identified at the October 2024 Long-Acting Treatment meeting in Washington, D.C., has seen no trial start in the 18 months since,

[4] Source: AVAC ARV-Based Prevention R&D Pipeline, December 2025; CHAI 2025 HIV Market Report; PrEPWatch.org
[5] Source: TAG ARV Pipeline Report 2025; CHAI 2025 HIV Market Report

despite overwhelming consensus in the field of the need to study this combination. A key barrier has been access to the study drugs and agreement on study sites, which has prevented otherwise ready studies from moving forward.

LONG-ACTING AND NEW TREATMENT PRODUCTS AS OF JUNE 2026[5]

In Development Pre-clinical & early clinical	In Development Efficacy / late-stage trials	Regulatory Review Ongoing	Approved
LEN + bNAb combos	LEN/ISL Oral Weekly	BIC/LEN Oral Daily *FDA*	CAB/RPV LA (IM) *Originator only - FDA; EMA*
GS-3242	CAB-LA (2 Monthly) + LEN (6 Monthly)		LEN SC (MDR adults) *Originator only - FDA; EMA*
VH184 + VH499	CAB-LA + lotivibart IV		Idvynso (ISL/DOR) *Originator only - FDA*
GS-1219 / GS-1614	LEN + TAB + ZAB bNAbs		Oral Tx: TLD, ALD *FDA; EMA; WHO PQ; Generics widely available*
MK-4646, VH4527079	ISL/ULO once-weekly	GS-4182/GS-1720 ✕ TERMINATED	Oral Tx: Biktarvy, Dovato *Originator only - FDA; EMA*

WHO's first, still-narrow recommendation for CAB/RPV as a conditional switch for suppressed adults without hepatitis B virus (HBV) came in July 2025; broader use (initiation, viremic patients, pregnancy, pediatrics, HBV co-infection) awaits evidence expected in 2027–2028.

Key Forum Takeaways

Historically, evidence for underserved populations, licensing terms, and delivery considerations have often been addressed slowly and sequentially, after products reach the market. The FHMF participants, and wider global HIV community, have an opportunity to avoid these repeated mistakes by setting these requirements upfront and advancing in parallel.

Evidence generation has been too slow, constrained by limited study-drug access and an overreliance on too few studies

WHO's current recommendation for CAB/RPV reflects the limited clinical evidence. But, the evidence gaps are not only clinical — long-acting tools will require new service-delivery models, backed by evidence translated into policy. Closing these gaps will require reliable drug access for all credible, funded studies. Multiple complementary studies for preferred candidates should run in parallel across populations, geographies, and research questions, rather than waiting for one study to conclude before the next begins. Further, not all operational evidence needs to precede introduction – it can be generated through phased implementation, building on the delivery systems, infrastructure, and healthcare worker capacity already established for long-acting prevention.

The most pressing challenge is enabling coordination across the full pathway to scale. This includes ensuring study-drug access, tracking progress and evidence across parallel studies in multiple populations, aligning regulatory and guideline updates, advancing licensing and supply planning, and preparing countries and delivery systems for introduction. TLD's introduction demonstrated that iterative coordination, with stakeholders engaging and course-correcting along the way, can be a

successful strategy. This strategy will be more critical than ever with long-acting tools, as separate, siloed pipelines and access strategies for treatment and prevention are no longer adequate.

"We need to make a product that is a public health good, not just something for clinical practice." – Forum Participant

As product choice expands, service delivery still lacks the person-centered models needed to keep pace

New long-acting options offer major advantages. Scheduling, testing requirements, and regulatory frameworks all need to be worked out in parallel with the trials themselves, not after they conclude. As daily oral, monthly oral, bi-monthly injectable, and six-monthly injectable options increasingly coexist, the field needs more than a basket of choices: it needs person-centered delivery models that reach clients with acceptable products where they are and when they need it. Without coordinated delivery models, that added complexity — for recipients of care, healthcare workers, and supply chains — can overwhelm programs and undercut the very flexibility choice is meant to deliver. Expanding coverage will also require a sharper focus on the populations that programs are currently struggling to reach, including adolescent girls and young women and key populations.

Licensing terms are still being negotiated after launch, when leverage to protect excluded countries and populations is already gone

Licensing is the permission an originator grants to other manufacturers to manufacture and sell a drug, and the mechanism that can significantly accelerate generic entry. For long-acting tools, licensing needs have not kept pace with development.

To ensure access, meeting participants discussed that licensing terms should:

- ✓ *Be non-exclusive*
- ✓ *Cover both finished products and active pharmaceutical ingredient (APIs)*
- ✓ *Include all LMICs, with no carve-outs*
- ✓ *Not be indication-specific*
- ✓ *Extend to no-patent or compulsory-license situations*
- ✓ *Contain conditional or adaptive language, rather than pre-specified indications, to allow negotiations to start before full clinical certainty exists*
- ✓ *Provide tech transfer and regulatory support, if necessary*

Often these conditions fail because negotiations and advocacy happen in silos, rest on community and civil society alone, and stakeholders lack basic shared information about what leverage exists and how to pool it. The Pan American Health Organization's (PAHO's) joint negotiation process, which groups countries by the type of licensing challenge they face and works price negotiation and technology transfer strategies in parallel, is one model for what that pooling could look like. The Medicines Patent Pool (MPP) offers a further model, with licensing strategies grounded in a public health approach rather than siloed, bilateral deals. These strategies can and should be implemented immediately for emerging tools.

Stakeholder coordination and community engagement must be prioritized

Suppliers showed renewed commitments to community engagement, pipeline transparency, and access planning, but feedback from participants was that far more is needed to meaningfully close the gap, including further commitments from originators as highlighted above.

Critical action and coordination are needed across partners to accelerate the transition from pipeline progress to equitable access at scale — spanning clinical development, trials and evidence, licensing, country readiness, and strategies to reach priority populations. Communities need to be prioritized as market actors from the start, both through formalized, institutionalized community engagement hubs that outlast individual trials and products, and as actors in their own right who can engage governments, conduct market access research, generate values and preferences data, and influence policy.

Outputs and Next Steps

A Target Access Profile can define and coordinate stakeholders around access conditions from the start

A Target Access Profile (TAP)[1], a key component of Unitaid's access framework, defines the conditions required for rapid, equitable, and sustainable access to a health product. It complements a Target Product Profile, which focuses on the attributes of the product itself, by setting out the wider requirements for access across regulatory and quality assurance, affordability, demand and adoption, supply, and equity. A TAP matters because normative guidance drives national adoption regardless of regulatory approval and because clinical efficacy alone is not enough: without deliberate planning across partners, introduction risks slow scale-up, poor fit for low-resource systems, and access limited to a small subset of PLHIV.

The TAP for long-acting treatment was first developed following the October 2024 meeting convened by the Gates Foundation, NIH/NIAID, GHSD-PEPFAR, WHO, and CHAI, defining conditions across five domains: regulatory and quality, affordability, demand and adoption, supply chain, and equity.

Given the increasing overlap between long-acting treatment and prevention, including shared molecules, evidence needs, delivery platforms, and access barriers, the Forum proposed adapting this into a single long-acting prevention and treatment TAP. The combined TAP would provide one accountability framework for the two converging pipelines, helping stakeholders align evidence generation, study-drug access, regulatory and guideline pathways, licensing, affordability, supply planning, country readiness, and delivery requirements.

The Forum will also continue to convene the Future of HIV Markets group to convert the Forum's highest priorities into actions and hold members accountable to one another. The group and corresponding focus groups will generate the inputs, track progress, and update the TAP as the pipeline and access environment evolve.

DIAGNOSTICS

Current Status

Despite available testing technologies (including low-cost HIV rapid diagnostic tests (RDTs) and HIV self-tests), the median time to diagnosis remains ~2.6 years, highlighting the need to scale accessible, decentralized models of HIV testing to close the gap between infection and diagnosis. Remaining gaps in knowledge of status are greatest among men and key populations, indicating that hard-to-reach and at-risk populations are not well served by current testing options.

Current HIV treatment monitoring models rely on outdated monitoring algorithms that create barriers to differentiated care in the era of optimized ARVs. Further, many of the existing and upcoming molecular tests used for HIV viral load, both laboratory-based and point-of-care, can be integrated for use with other critical needs (e.g., TB, hepatitis, cervical cancer, etc.) creating more efficient and optimized diagnostic systems. All of these innovations[6] – across both testing and monitoring – will require adoption, procurement, testing algorithms, and community engagement to keep pace with current needs.

DIAGNOSTICS PIPELINE AS OF JUNE 2026[6]

In Development Pre-clinical & early clinical	In Development Efficacy / late-stage trials	Regulatory Review Ongoing	Approved / Available
Next-gen multiplex platforms (HIV+TB+HCV)	SD Biosensor Triple Test (HIV+Syph+HBV)	KHB HIVST *WHO PQ*	Low-cost HIV RDTs* *WHO PQ; Available as low as US$0.53 EXW*
Near-POC VL and EID	InTec Triple Test (HIV+Syph+HBV)		HIV Self-Test *WHO PQ; Wondfo & InTec available at or below $1 EXW*
Dual Self Test (HIV+Syph)	bioLytical Truplex Triple Test (HIV+Syph+HBV)		Dual RDT (HIV+Syph) *WHO PQ*
Quad Testing (HIV+Syph+HBV+HCV)	4th Generation HIV Ag/Ab RDTs		Abbott ANC Panel (HIV+Syph+HBV) *WHO PQ*
Disposable molecular VL and EID			POC and Centralized VL *WHO PQ*
			POC and Centralized EID *WHO PQ*
			Abbott 4th Generation HIV Ag/Ab RDT *WHO PQ*

Key Forum Takeaways

A key challenge is that monitoring has not evolved alongside treatment itself. Current viral load algorithms were developed in 2019–2020, using evidence from the TLE era, when time to suppression was longer and resistance risk higher. That era is over: roughly 95% of people on ART are now on TLD, with suppression near 94% globally[2]. Monitoring everyone in care with a viral load every year made sense when treatment failure was common, but it no longer reflects clinical reality. This misalignment will only widen once long-acting treatment, built on the same molecules as long-acting prevention, enters the same population.

[6] Source: 2025 CHAI HIV Market Report; WHO prequalification database; Unitaid MADE program

Diagnostics built for one treatment era are now being asked to serve the next - we need a paradigm shift

Countries have already begun updating their algorithms even ahead of global guidance. For example, after 2025 funding disruptions, Zimbabwe found that 57% of suppressed recipients of care had been undetectable for over two years and proposed moving that group to two-year viral load intervals. If moved forward this would enable an estimated US$6.8 million a year to be redirected toward CD4 testing and adherence counseling — services that nearly 1,000 recipients of care had been going without entirely.

The new funding landscape and treatment era demand a paradigm shift, from a single approach for routine monitoring of all patients to a purposeful and differentiated monitoring approach that can 1) identify treatment problems earlier, 2) reduce unnecessary monitoring, and 3) redirect resources to the greatest needs. Initial proposals include the following adjustments:

- ✓ Earlier first viral load at ~3 months post-ART initiation for faster access to differentiated service delivery care;
- ✓ Recipients of care with suppressed viral loads shifted to differentiated, less-intensive, more empowered monitoring approach that includes 2–3 year viral load intervals with annual, personalized visits that can address other health needs (e.g., non-communicable disease screening);
- ✓ Recipients of care with an unsuppressed viral load to receive intensive support, including CD4 and AHD package of care, enhanced adherence counseling, etc., funded by the additional freed-up resources.

This updated algorithm would shift from an equal distribution of resources to an equitable distribution, directing support to those who need it.

With more limited resources, the emergence of long-acting treatment, and convergence of prevention and treatment tools, there is now even more need and opportunity to fundamentally rethink monitoring. Critically, this shift must consider the complete care package, not just alterations to VL monitoring alone. Further, laboratory systems that underpin treatment monitoring must improve their overall delivery and supporting systems, so that timely result return and clinical use is a routine reality and translates to a better, more functional care package.

"The message is: we need anticipation. Diagnostics should not be left behind. We need them to ensure that people's treatment and the new molecules we're going to have will be useful for longer." – Forum Participant

Outputs and Next Steps

The priority now is turning country-led momentum into shared practice, including supporting differentiated viral load transitions with technical and financing support and timely normative and implementation-related guidance to enable effective planning, updates to care algorithms, and appropriate resource allocation.

As an immediate next step, stakeholders will develop practical resources to support the shift in treatment monitoring, including a treatment monitoring access framework and supporting resource allocation model.

ADVANCED HIV DISEASE (AHD)

Current Status

There were 630,000 AIDS-related deaths in 2024, many from preventable and treatable causes associated with AHD[7]. Funding disruptions have weakened early identification, including through a 35% decline in CD4 testing from 2024 to 2025 in a subset of countries[8], increasing the risk of late diagnosis, delayed treatment, and mortality. A growing share of the AHD burden is now among people returning to care after treatment interruption, rather than those newly initiating ART. Investments in product innovation and market shaping aim to accelerate access to new and optimal diagnostics and therapeutics, which will help expand AHD and opportunistic infection (OI) screening and treatment. VISITECT CD4 has expanded access to decentralized CD4 testing, and optimal cryptococcal meningitis treatment is now available across 21 LMICs with available data. Pipeline tools like AccessoBio quantitative POC CD4, CrAg SQ, Histo LFA, Generic L-AmB, and regionally sourced azithromycin and fluconazole will improve diagnosis of AHD and increase screening, prophylaxis, and treatment of OIs[9]. However, AHD product availability will not reduce mortality unless programs are able to finance, procure and deliver the complete package of care for AHD.

ADVANCED HIV DISEASE PIPELINE AS OF JUNE 2026[9]

In Development Pre-clinical & early clinical	In Development Efficacy / late-stage trials	Regulatory Review Ongoing	Approved / Available
AccessoBio VITA CD4 - *quantitative POC CD4 test*	Fujifilm TB LAM *qualitative POC urine-based LFA*	IMMY CrAg SQ - *semi-quantitative POC (LFA) test (CE IVDD)*	VISITECT CD4 *first device-free and lowest cost to date CD4 test*
IMMY Histoplasma LFA - *POC (LFA) test*	Sustained release 5FC *antifungal drug in the form of slow-release pellet*		5FC *oral antifungal used in combination therapy to treat CM*
APX2039 *Good CNS activity against crypto in animal studies*	Regionally manufactured azithromycin		TestCard RDT reader *currently available for VISITECT, engagements ongoing for other AHD RDTs*
Encochleated Amphotericin B *oral administration for CM. Successfully completed phase 2.*	Regionally manufactured fluconazole		SmartSpot EQA solution *ISO accredited and available for CD4 and GeneXpert, option to add additional tests*
Oteseconazole *In phase 2 comparing against current CM SoC therapeutics*	SRA-approved generic itraconazole		Miravista Histo LFA CE
	Generic L-AMB *For cross-indication use in LMICs*		Alere/Abbott Determine TB LAM Ag
			IMMY CrAg LFA
			BioSyntex CrAg SQ

Key: LFA Quantitative, device based POC Injectable Oral tablet/pellet

[7] Source: UNAIDS
[8] Percentage change calculated as aggregate across all reporting countries, comparing full-year 2024 to full-year 2025 totals. Country-level data collected by CHAI on nationwide, public sector HIV services across 13 countries in Africa and Asia. Source: CHAI June 2026 Market Impact Memo.
[9] Source: 2025 CHAI HIV Market Report

Additionally, these AHD products are entering an already fragile market. Many AHD products depend on a single supplier, face low and fragmented demand, and require a production lead-time exceeding six months. Reduced donor procurement and the shift toward fragmented domestic purchasing now threaten both immediate product availability and the commercial sustainability of the market.

Key Forum Takeaways

AHD access depends on protecting and delivering the full WHO-recommended package of care.

Expanding access to CD4 testing alone will not reduce mortality, but CD4 remains critical for identifying people living with AHD and as the gateway to the AHD package. The expanding product landscape, including VISITECT CD4, conventional laboratory platforms, Abbott's new all-inclusive pricing offer and, in the future, AccessBio's new quantitative point-of-care platform, gives countries a range of lateral-flow, point-of-care and conventional testing options across different levels of the health system. Programs need to continue to assess how these fit together to form a national CD4 network, where each should be deployed and how demand is allocated across products.

However, identifying AHD is only the first step. People living with AHD need timely access to OI screening, prophylaxis and treatment, and clear referral pathways. Funding and procurement decisions must therefore sustain commodities across the full AHD package rather than individual commodities. This needs to happen before current funding windows close, with civil society and communities playing an important advocacy role.

Low-volume AHD products require greater transparency and coordinated demand planning

Suppliers, procurers, and national programs need a consistent mechanism to share forecasts, volume commitments, order delays, cross-indication demand, production constraints, instrument functionality, and stock risks. Without reliable visibility, suppliers cannot plan production and countries cannot identify or mitigate risks early enough.

Community and facility-level systems provide critical visibility into access gaps. Community-led monitoring and decentralized service-delivery models can identify stockouts of AHD products, non-functioning diagnostic platforms such as CD4 platforms, missed screening and referral failures that routine national reporting may not capture quickly. These systems have faced major funding reductions and require dedicated support if they are to provide a sustainable feedback loop between communities, facilities, and national programs.

Outputs and Next Steps

The key next step is strengthening information sharing between governments, communities, and suppliers to ensure programs optimize their CD4 network within the resources available. Additionally, investing in coordinating market mechanisms, including the APWG and diagnostics procurement oversight, to improve visibility into stock issues and the ability to address them, will help address longstanding access challenges for AHD diagnostics across programs.

At country level, partners should support national programs to protect the full AHD package within current funding cycles, clarify accountability across HIV, laboratory, TB, and hospital budgets, and strengthen identification and referral for people returning to care after treatment interruption.

As an immediate next step, partners will consolidate information on available and pipeline CD4 technologies, pricing, and supportive tools to help country programs make informed network decisions that optimize resources and expand access. Additionally, AHD diagnostic commodities will be incorporated into the APWG's scope to strengthen coordination and minimize stockout risks during procurement transitions.

PEDIATRIC HIV

Current Status

Children continue to lag unacceptably behind adults on treatment coverage – 55% of children living with HIV are on ART – and bear a disproportionate share of HIV-related mortality[10]. Funding disruptions have led to further treatment interruptions and missed identification (new ART initiations fell 15% from 2024 to 2025), which will further widen the mortality gap for children[11]. Finding children undiagnosed and linking them to care and strengthening retention and adherence remains a major challenge, and even brief treatment interruptions can increase mortality risk. Pediatric DTG-based formulations, including pALD, have improved viral suppression, but pediatric innovation continues to trail the adult pipeline. The pipeline still relies on optimizing existing treatment products, with a focus on pTAF/FTC/DTG, a fixed-dose combination that is in generic development. Other new innovations for children are still many years away[12].

PEDIATRIC TREATMENT PIPELINE AS OF JUNE 2026[12]

In Development Pre-clinical & early clinical	In Development Efficacy / late-stage trials	Regulatory Review Ongoing	Approved
bNAbs	BIC/LEN oral combo	pDRV/r *Generic: FDA review paused due to nitrosamine issue for RTV**	Daily Oral Tx: pDTG, pALD *Generics: FDA; EMA; WHO PQ; widely registered across countries*
CAB+RPV *Younger children (10-40 kg, 2-12 years old)*	CAB/RPV LA *(12+, ≥35kg; detectable VL)*	Dovato DTG/3TC *Originator: EMA (children >3months,>6 kg)*	CAB/RPV LA (12+, ≥35kg; suppressed VL) *Originator only: FDA*
	LEN + OBR injection		pTAF/FTC (15/120mg) *Originator only: FDA*
	pTAF/FTC/DTG FDC Daily Oral *Generic development*		pLPV/r (for infants) *FDA; EMA; WHO PQ; Generics widely available*
			Dovato DTG/3TC *Originator and adult approval only*

[10] Source: UNAIDS Global AIDS Update 2025
[11] Percentage change calculated as aggregate across all reporting countries, comparing full-year 2024 to full-year 2025 totals. Country-level data collected by CHAI on nationwide, public sector HIV services across 13 countries in Africa and Asia. Source: CHAI June 2026 Market Impact Memo.
[12] Source: TAG ARV Pipeline Report 2025; CHAI 2025 HIV Market Report

Outside of treatment, there has been minimal progress on post-natal prophylaxis (PNP), but ViiV is currently undertaking a neonate study for CAB in this area.

The pipeline for pediatric treatment and PNP is inadequate, and significant investment, stakeholder engagement, and coordinated effort are needed to bring new tools to market, particularly for the youngest children. Alongside this pipeline gap, a shifting financial and procurement landscape poses new challenges for sustaining the pediatric market.

Key Forum Takeaways

Given small pediatric volumes, shifting financing and procurement structures, and an insufficient tool pipeline, sustaining and safeguarding reliable access to pediatric ARVs requires stronger market coordination mechanisms and a renewed focus on service delivery challenges to optimize uptake of existing regimens and expand the market for future innovations.

Product strategy and governance for pediatric ARVs need to be strengthened, proactive, and coordinated — not reactive

Accelerating pediatric introduction and innovation requires clear governance from bodies such as the WHO-led Paediatric Antiretroviral Drug Optimization (PADO) group to discuss pediatric products to prioritize, continue, or phase out, while aligning on fallback treatment options in case of failure. Maintenance and expansion of global coordination platforms (including Global Accelerator for Paediatric Formulations (GAP-f) and APWG), sustained manufacturer incentives despite low volumes, and proactive planning are also essential to maintain market stability.

Strengthen alignment between pediatric supply and demand as financing and procurement structures shift, particularly for low-volume markets

A coordinated platform that includes pediatrics is needed to align demand forecasts with supply commitments, facilitate pooled procurement mechanisms, ensure continuity across treatment transitions, develop best practice guidance on procurement for small-volume markets, and avert supply disruptions. Alignment of demand and supply also requires country-led supply solutions, establishing early warning systems at the facility level, stronger forecasting for low-volume products paired with transition away from adult formulations for children in some contexts, and community-led monitoring systems.

Intensifying case finding and linkage to care is essential to translate product availability into increased demand and more equitable access

Pediatric ARV market stability and access can only be realized through intensified case finding and linkage to care to optimize uptake of existing regimens and expand the market for future innovations. Early infant diagnosis remains limited, with further scale-up impeded by funding cuts, significantly restricting timely diagnosis and linkage to treatment and prophylaxis. Diagnostics should thus be integrated into broader pediatric supply and access planning. Dedicated resourcing is also needed for community programs that have faced significant funding cuts, to enable robust, community-led pediatric client linkage and feedback mechanisms between communities, facilities, and national programs to detect and respond to gaps early.

Outputs and Next Steps

Support global coordination platforms to strengthen product strategy and governance and alignment between pediatric supply and demand. Alongside these coordination groups, develop a pediatric portfolio-level TAP[1], reflecting the broader access landscape, across pediatric ARVs, diagnostics, and delivery components. The TAP will include a renewed focus on PNP and determination of where long-acting products are appropriate and desired within the portfolio, with potential product alternatives and key evidence gaps. This effort is intended to complement upcoming PADO discussions on pediatric product prioritization.

STRENGTHENING MARKET SUSTAINABILITY

SUSTAINING SUPPLY IN A CHANGING PROCUREMENT AND FINANCING ENVIRONMENT

Context

For over a decade, consolidated procurement, through Global Fund pooled mechanisms, PEPFAR/USG procurement, and coordination platforms, has delivered four stabilizing functions that keep the HIV market functioning:

- Price and payment security
- Quality assurance
- Supply continuity
- Demand predictability

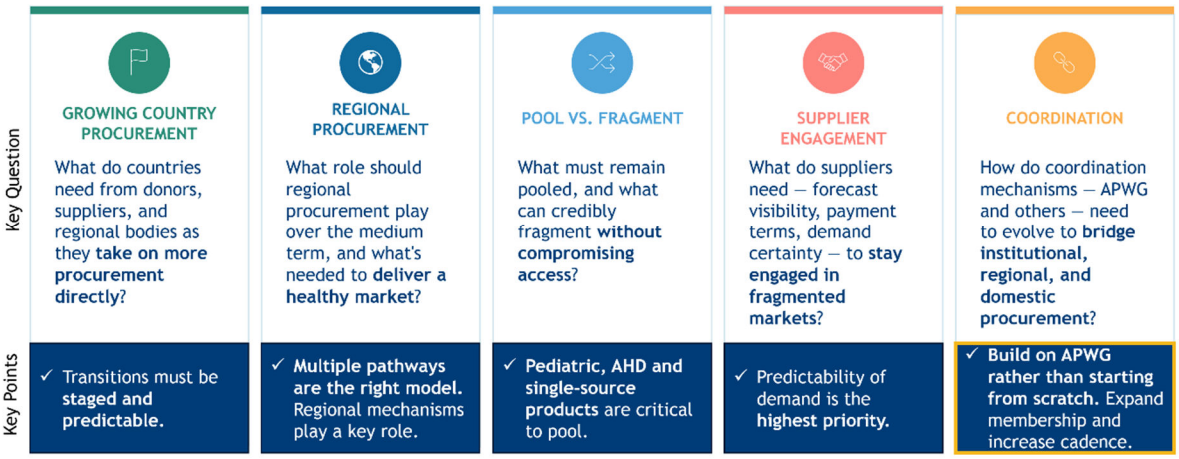
Underpinning all four of these functions has been a financing architecture that matched the procurement model: pooled, predictable, and multi-year. That combination of consolidated procurement and stable financing is what allowed the market to function reliably.

That architecture is now undergoing a structural shift. Financing is moving from external donor pooling toward domestic sources, and momentum is building behind regional procurement. The result is that procurement is fragmenting across three parallel channels: institutional procurement, regional pooled procurement, and domestic procurement, each with different cycles, capacities, and incentives. This simultaneous shift in both financing and procurement has direct implications for the four stabilizing functions that consolidated procurement has historically delivered. Without deliberate coordination, there is a risk that suppliers receive less consistent demand signals, ordering windows are missed, payment reliability varies across channels, and the aggregated volume leverage that once anchored pricing and quality standards is diluted.

The core challenge moving forward is therefore not how to preserve consolidated procurement itself, but how to preserve the conditions it created, within a new, distributed architecture.

"We've been actively working towards this anyway — now we're being forced to do it. But we should have been." – Forum Participant

Key Forum Takeaways



A new donor procurement architecture is taking shape

As USG procurement transitions, a small number of countries will move to government-to-government (G2G) arrangements, receiving funds directly and procuring through their own systems. **The remaining majority of USG procurement will now route through The Global Fund's Wambo platform, merging USG and Global Fund demand into a single mechanism**, with the exception of a few key commodities including molecular diagnostics and bed nets, which USG will continue procuring. In parallel, a smaller set of direct manufacturer contracts is being developed at the global level.

Country financing transitions and regional procurement mechanisms already offer working lessons for the new landscape

It will be important to share and leverage lessons learned across countries as national programs navigate these rapid transitions. For example:

South Africa's conditional grants give provinces their full-year HIV budget requirement upfront, so purchasing envelopes are known well in advance to in-country stakeholders

Kenya's country budget integration preserves HIV funding visibility by ring-fencing HIV allocations within a unified framework, ensuring that as HIV financing integrates into broader budgets, dedicated resources remain identifiable, trackable, and protected from competing priorities. Kenya's structure also guards against the risk that budget for stigmatized populations is deprioritized or reduced — by registering populations onto a universal insurance system, so reimbursement flows regardless of who the person is.

Continental and regional procurement models are increasingly important, including PAHO and Africa CDC's African Pooled Procurement Mechanism (APPM). PAHO's revolving fund credit line was highlighted as a particularly distinctive feature: PAHO places the order and pays the manufacturer directly, and countries repay PAHO within a defined period, creating supply continuity for countries and payment security for manufacturers even when a country's cash isn't yet available. Africa CDC's continental quality assurance policy framework offers centralized regulatory pathways to market access.

Communities should be central stakeholders in the funding and procurement transition conversations

Communities are bearing the brunt of these disruptions, both in the impact on care and in the erosion of institutional capacity. Community organizations have critical experience supporting Global Fund Country Coordinating Mechanisms (CCMs) and PEPFAR Country Operational Plans (COPs) processes, and the Forum agreed this capacity should now be brought explicitly into conversations on how to diversify domestic financing and move forward in the new environment.

Coordination and data visibility are critical to preserving and strengthening healthy market conditions

Participants agreed that demand visibility is one of the most acute vulnerabilities as procurement fragments. Without a shared, reliable picture of what is being ordered across channels, coordination across procurers breaks down and manufacturers lose the signals they need to plan production, sustain pricing, and maintain quality. Both risks compound one another, and both ultimately threaten supply continuity and access. While tools and functions exist, the central supply chain partner support that once ran alongside them is being withdrawn, leaving countries to own demand estimation, communication, and escalation largely for the first time.

"If we don't have an understanding of what is needed at the country level, if that information isn't communicated and elevated when necessary, everything else falls apart" – Forum Participant

Outputs and Next Steps

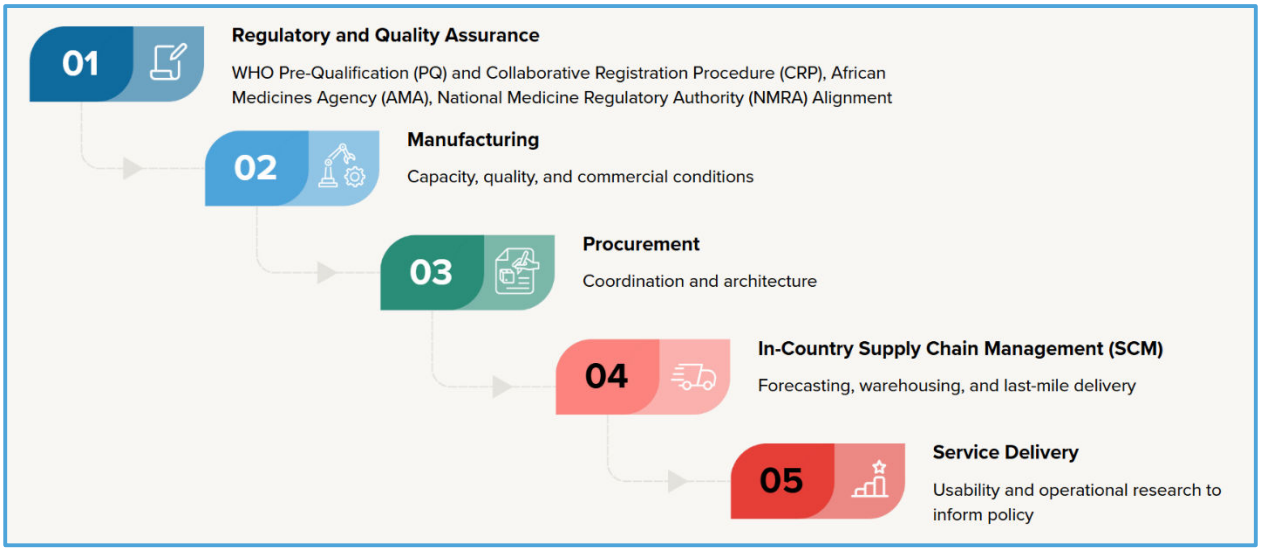
Coordination mechanisms like the APWG emerged in response to historical fragmentation risk in the market, and participants aligned on evolving and empowering the APWG as the near-term coordination mechanism for this transition. The existing framework of the APWG, established in 2011, is the strongest available foundation, but its mandate and membership need to expand to span institutional, regional, and domestic procurement, with a more consistent supplier voice,

more integrated product scope across HIV, and greater capacity to get ahead of risks as procurement and financing become more complex and fragmented.

As an immediate next step, partners will begin scoping this expanded APWG mandate alongside the Future of HIV Markets Forum group and an HIV Market Access Profile (MAP)[1] to capture the cross-cutting market and system conditions that must be in place for any product to be delivered, spanning regulatory and quality assurance, demand and supply, financing, diagnostics, and delivery.

THE ENABLING ENVIRONMENT

Sustainable access to critical HIV commodities within a health market is the output of a value chain, not any single intervention:



Each component of the value chain functions as a link, and breakdowns in one can have cascading impacts. These links are often planned for and optimized in isolation. However, as the financing and procurement foundations now shift underneath them, the value chain can no longer absorb the resulting strain in any single link; participants agreed that it must now be addressed as a coherent system rather than as separate agendas.

Regulatory Mechanisms, Quality Assurance, and Regional Manufacturing

Country registration timelines and regulatory fragmentation continue to delay priority products. On the manufacturing side, regional production at WHO Prequalification (PQ) standard remains limited, and commercial conditions do not sufficiently support investment at scale for regional manufacturers. Current quality assurance systems are not in place yet to support global markets nor a more decentralized procurement landscape. While promising momentum has built in the regulatory and regional manufacturing space, more must be done to align ambition and need with

capacity. Capability to meet international standards for quality assurance must also be addressed and align with progress.

Regulatory and manufacturing constraints directly demonstrate the interdependence across the value chain: manufacturers do not build capacity nor improve systems for markets they cannot reach, so progress on one rests upon the others. Forum participants convened to discuss how to accelerate regulatory pathways, build the financing architecture, and create sustainable demand to make regional manufacturing viable, without compromising quality.

Key Forum Takeaways

Regulatory Mechanisms and Quality Assurance

A lack of harmonization of regulatory standards and realized reliance systems remains a central barrier to regional manufacturing success

The regulatory environment must keep pace with the demands of the new landscape. Standing up regional and continental regulatory bodies, including the African Medicines Agency (AMA) and ASEAN (the joint facilitated registration pathway in Southeast Asia), is a priority, but outstanding country ratifications are still needed before AMA carries a true mandate and ASEAN approvals have been slower than targeted. No equivalent regional regulatory mechanism exists in Latin America, and this is an important gap to address to ensure access in the region.

While reliance mechanisms may exist on paper, implementation lags adoption and enforcement of quality standards is an important and often missing element alongside harmonization itself – as the presence of poor or unknown quality products can threaten trust in the system.

Taken together, these learnings indicate that coordination around regional regulatory bodies and more consistent enforcement of standards will impact how quickly the region can move.

Advancing regulatory reform depends on early planning, transparency, and advocacy

It is critical to ensure broad awareness of regulatory processes and systems -- on what they are, why they matter, and how to mobilize support. For example, regulatory and Ministry of Health consultations play an important role in clarifying and aligning requirements and priorities between the two stakeholder groups. Further, the regulatory process is inherently passive, and so advocacy is critical to moving it forward. Civil society and community thus play a critical role, and support for mechanisms like community advisory boards to press innovators to share the data regulators need to support generic entry is critical.

To help address requirements in some countries for evidence in specific populations, participants in clinical trials can be recorded by sub-ethnicity rather than broader regional categories, a step toward addressing national regulatory needs and reducing delays to introduction.

Regional Manufacturing

Global stakeholder support and investment in regional manufacturing mechanisms are critical

Unitaid's "regional manufacturing for equitable access" strategy sits between continental and local ambition, as a purely local manufacturing base is not commercially viable on its own, regional or continental reach is what makes a company an attractive long-term partner. Unitaid has built a

US$100 million investment platform for regional production in Africa, identified 20 manufacturers across solids, injectables, and diagnostics, and signed collaborative agreements with 15 of them, covering go-to-market strategy, market intelligence, and partnerships with established regional players. This comprehensive model offers important lessons for the broader global community to leverage.

Closing the regional manufacturing cost gap requires diversified portfolios and blended financing

Even with investment in regulatory and manufacturing mechanisms, more must be done to ensure regional bodies can deliver a competitive advantage to be successful and sustainable. Regional manufacturing can meaningfully reduce total costs by reducing freight costs, for example, and total cost of delivery, and thus production cost should not be assessed in isolation. Manufacturers producing a single niche product carry substantially higher cost of goods than those with diversified portfolios, since diversified manufacturers can cross-subsidize pricing across their range. Further, financing must be appropriately structured for small and medium-sized enterprises. A stacked approach to financing, blending grant de-risking, concessional debt, local financing, and company capital, was identified as the optimal model for closing this cost gap.

Demand-side de-risking is as critical as supply-side investment for the market, and it hinges on demand visibility

Partner efforts on demand generation, forecasting, and government financing are critical components of incentivizing supply-side manufacturing investment in the market. Understanding and communicating demand visibility is paramount, and thus the work to strengthen bodies like the APWG emerging from the Forum will be critical to advancing regional regulatory and manufacturing efforts.

In-Country Supply Chain Management (SCM)

Two decades of primarily donor-built supply chain infrastructure now needs to be absorbed by national systems within months, risking supply chain functions that sustain critical access to prevention, treatment, and care for people at risk of and living with HIV. USG's GHSC-PSM contract led by Chemonics is closing for most countries by the end of September 2026, with just a few countries granted longer timelines based on assessed risk. While USG is working with the Global Fund, other donors, and governments on transitioning to shared functions, including warehousing and distribution, where possible, the transition of donor-supported supply chain functions is exposing critical gaps in product quantification, inventory management, and supply chain visibility. Countries now face increasing challenges to maintain continuity of supply with reduced support. CHAI's in-country supply chain assessment of risk across 14 countries found that 11 of the 14 countries assessed face medium-to-critical supply chain risk, with procurement, supply planning, and data systems the most frequently at risk.[13]

[13] Source: CHAI procurement risk assessment.

Key Forum Takeaways

CHEMONICS PROCUREMENT AND SUPPLY CHAIN DEPENDENCY AND RISK ASSESSMENT IN 14 COUNTRIES[13]

Country	Overall Risk	USG-Procured ARVs	Supply Planning	Procurement	Clearing	Warehousing	Last-Mile Distribution	Data Systems
A	Critical	50%						
B	Critical	54%						
C	Critical	31%						
D	Critical	39%						
E	High	0%						
F	Medium	30%						
G	Medium	18%						
H	Medium	16%				🖷	🖷	
I	Medium	0%			🖷	🖷	🖷	
J	Medium	0%						
K	Medium	0%						
L	Low	4%						
M	Low	0%	🖷	🖷	🖷	🖷	🖷	🖷
N	Low	0%	🖷	🖷	🖷	🖷	🖷	🖷

Legend: Critical | High | Medium | Low | 🖷 Government Managed

Systems strengthening and digitization are central to government ownership of the supply chain

Countries need support transitioning from multiple donor-dependent and partner-managed HIV supply systems to government-owned and -managed tools that provide full access to and ownership of key supply chain data and decision-making processes. As part of this transition, governments and partners need to closely monitor the GHSC-PSM handover and escalate any breaking points as they arise. In-country digitization, automation, and integration of national supply chain processes will create end-to-end visibility, interoperability, and informed decision-making, enabling strengthened accountability and national ownership.

Collaboration and integration can extend national capacity without displacing it

While governments must function as the central supply chain steward and oversight body, the private sector can support filling operations and logistics roles, such as warehousing and last-mile delivery, to extend capacity and work alongside national programs.

Communities are vital partners in this collaborative model, and must be supported and sit permanently at supply chain tables, across the entire value chain from procurement to last mile. A concrete step in this direction is leveraging and digitizing community monitoring tools and integrating them into existing facility-level systems, which remain paper-based in most settings today.

The expanded APWG will be a critical mechanism to share lessons learned as countries transition, disseminate data between national programs and suppliers, and foster coordination among stakeholders.

CONCLUSION

A major financing and procurement shift in the HIV market is colliding with a transformational innovation pipeline. The Future of HIV Markets Forum brought stakeholders into direct dialogue on these converging pressures, and produced a shared, cross-stakeholder alignment on the priorities for building a resilient, healthy market going forward that safeguards and expands access to life-saving care for people living with and at risk of HIV. Within the tool landscape itself, long-acting prevention and treatment are converging on shared molecules and delivery platforms, diagnostics and monitoring must evolve alongside both, and none of this can succeed without the quality, regulatory, financing, and supply chain foundations that these tools depend on. Progress on any single tool or market lever is contingent on coordination across all.

To carry this work forward, key immediate priority actions include:

1. **Advance engagements with the Future of HIV Markets Group to convert the Forum's shared near-term priorities into actions**, track progress, and hold members accountable to one another.
2. **Evolve and expand the APWG to a modern, fit-for-purpose platform** with broader HIV product coverage, sustaining demand visibility, and strengthening coordination to support market stability.
3. **Advance a combined long-acting prevention and treatment TAP[1],** building on the existing long-acting treatment TAP, to provide governments, communities, donors and suppliers one accountability framework as the two pipelines converge.
4. **Develop a differentiated treatment monitoring framework and associated cost and resourcing allocation model,** and support country-led differentiated viral load transitions with technical, policy and financing guidance.
5. **Consolidate information on available and pipeline CD4 technologies,** pricing, and supportive tools to help country programs make informed network decisions that optimize resources and expand access.
6. **Develop a pediatric, portfolio-level TAP[1]** alongside pediatric coordination groups, reflecting the broader access landscape, across pediatric ARVs, diagnostics, and delivery components.
7. **Secure reliable study-drug access for funded long-acting treatment studies,** including urgently resolving the product-supply barriers preventing the ACTG CAB/LEN trial from proceeding, while enabling multiple complementary studies to advance in parallel.
8. **Map ongoing and funded trials against the evidence needs of priority treatment and prevention tools and combinations to identify coverage gaps.** This analysis should assess which populations, products, and combinations are covered by

current studies and where critical gaps remain, feeding directly into the combined long-acting TAP and informing upcoming CADO and PADO discussions (below).

9. **Support upcoming CADO and PADO processes,** supporting the development of a roadmap for access for forthcoming products.
10. **Support national programs through the transition to full ownership of supply chain data and decision-making,** including the capacity to monitor the GHSC-PSM handover and escalate breaking points as they arise. Governments should remain the central supply chain steward, using collaboration, integration, and partnership with communities and groups such as the APWG, to extend national capacity rather than displace it.
11. **Establish community engagement as a resourced, permanent function across the market:**
    i. Broaden community participation in trial advisory groups and beyond.
    ii. Conduct updated, community-led values and preferences research that goes beyond usability into choice and delivery.
    iii. Convene a dedicated community forum to align on community actions, ownership, and priorities for long-acting innovations, including reaching populations that programs are currently struggling to reach.
    iv. Invest in demand creation for clients and providers.
12. **Disseminate the Forum's conclusions and outputs,** including through the meeting report, engagement at AIDS 2026, and targeted scientific and policy publications.

The Future of HIV Markets Forum and existing complementary groups will translate these commitments into clear workplans, milestones, and accountability mechanisms. Sustaining the momentum and alignment built at the Forum will be critical, allowing stakeholders to translate this moment of disruption into an opportunity to rebuild a resilient, equitable HIV market that centers access to care for people living with and at risk of HIV.

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African Medicines Agency (AMA)
Gates Foundation
Global Fund
Pan American Health Organization (PAHO)
U.S. Department of State
UNICEF
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COMMUNITY AND CIVIL SOCIETY ORGANIZATIONS

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Africa Health Access Consortium (AHAC)
Afrocab Treatment Access Partnership
AVAC
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ITPC Global
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IMPLEMENTATION, RESEARCH, AND PROCUREMENT PARTNERS

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