



SUMMARY REPORT

2nd APEC Policy Dialogue to End the HIV Epidemic

22 August 2026, Dalian, People's Republic of China
APEC Health Working Group | Project HWG_14_2026S

Executive Summary

The 2nd APEC Policy Dialogue to End the HIV Epidemic was convened on 22 August 2026 in Dalian, during China's APEC host year, co-organized by the National Disease Control and Prevention Administration (NDCPA) of the People's Republic of China and the Ministry of Health of Chile. The 1st Dialogue, held in Incheon in August 2025, examined the barriers to ending HIV across the region. This 2nd Dialogue opened the implementation phase of the APEC Action Plan to End the HIV Epidemic 2026–2031, which the Health Working Group endorsed on 25 March 2026 and launched on 7 May 2026, and shifted the discussion from *what economies should do* to *how to do it*. Approximately 28 participants attended in person. Economies represented included Chile; China; Hong Kong, China; the Philippines; the Republic of Korea; and the United States.

The dialogue focused mainly on two priorities from the Action Plan: opt-out HIV testing in routine healthcare settings, under Pillar 4, together with the associated policy and regulatory barriers under Pillar 2; and rapid initiation of antiretroviral therapy (ART), under Pillar 5. Both address the weakest links in the regional care cascade: the people who are never diagnosed, and the people who are diagnosed but lost before treatment begins. Neither requires new medicines or technologies, and in most economies neither requires new money. Both depend on how existing services are organized.

Key Themes and Insights

- **The remaining questions about opt-out testing and rapid ART initiation are operational:** The clinical evidence for both interventions is well-established. Where economies differ is on operational choices such as which tests are offered as standard care, how many days pass between diagnosis and prescription, and whether confirmation and treatment happen at the same site.
- **Single-site confirmation and initiation:** Across economies at very different income levels, the change most consistently linked to faster treatment start was removing the transfer between the place of diagnosis and the place of prescription.
- **Clinician confidence outside infectious disease specialties:** Routine offering depends on general clinicians who are trained and permitted to offer a test, and on reimbursement and financing rules that do not penalize them for doing so.
- **Consent within a routine offer:** Expanding routine or opt-out testing must preserve informed consent, confidentiality, counseling, and the right to decline. The Philippines was explicit on this point. China described its hospital-based model as operating under a principle of informed non-refusal.
- **Retention and suppression are the measures of success:** Rapid initiation is a means to keeping people in care and virally suppressed, not an end in itself. Economies described the supporting requirements as peer navigation, commodity continuity, and follow-up when patients do not return.
- **Published time-to-treatment data:** The economies reporting the strongest results publish their intervals from diagnosis to care, to ART, and to viral suppression each year, and hold themselves accountable for those figures.
- **Progress has not closed the diagnosis gap:** Even economies reporting sustained declines in new diagnoses named late presentation and undiagnosed infection as their principal remaining gaps.

Welcome Remarks and Keynote

Dr. Junghwan Park, Chair of the APEC Health Working Group, and Dr. Hector Castro, Vice President, Access Partnership opened the Dialogue. Dr. Castro traced the initiative from Incheon through the October 2025 Issues Paper to the endorsement and launch of the Action Plan, noting that the APEC region is home to roughly seven million people living with HIV and accounts for about a quarter of new infections worldwide. He was also frank about the limits of the Action Plan itself: it is a statement of intent, and on its own it does not diagnose anyone or start anyone on treatment.

Director Li Zhenhong, Director of the HIV/AIDS Prevention and Control Division, NDCPA, delivered the keynote. She observed that the 2026 UN General Assembly Political Declaration on HIV/AIDS reaffirmed commitments to national ownership, international cooperation, and meaningful community participation, and then described China's response across five areas: governance through the State Council's AIDS Working Committee, chaired at Vice-Premier level; strategic continuity through successive five-year and action plans; a service system covering all population groups across the full lifecycle; a treatment-as-prevention strategy delivered through a one-stop model from diagnosis to treatment; and high-profile public advocacy. China has essentially eliminated transmission through blood products, brought mother-to-child and injecting drug use transmission under control, and kept national prevalence low. As China enters its 15th Five-Year Plan, Director Li called on APEC economies to deepen regional cooperation toward the 2030 global AIDS targets.

Session I: Economy Spotlights

United States (San Francisco): Rapid ART as a citywide standard. Dr. Oliver Bacon, Medical Director, San Francisco City Clinic, San Francisco Department of Public Health, and Associate Clinical Professor of Medicine, UCSF, contributed a pre-recorded presentation on making ART initiation on the day of diagnosis, or within five working days, a citywide standard across a decentralized, multi-payer system. The work sits within the city's Getting to Zero initiative, which targets a 90 percent reduction in HIV transmissions and preventable deaths. Implementation began in 2015 and rested on four components. First, a multi-sector RAPID subcommittee spanning academia, public health departments, community providers, and the public agreed a consensus definition of rapid initiation and a citywide protocol. Second, citywide epidemiological mapping traced the testing-to-treatment pathway, on the reasoning that a fragmented system cannot be redesigned until it is clear where people are being lost. Third, dissemination combined local clinical champions, public health detailing modeled on pharmaceutical outreach practices, and medical grand rounds. Fourth, the city published its rapid metrics annually in the Department's HIV report: median time from diagnosis to first care, from first care to ART initiation, and from ART initiation to first viral suppression. Dr. Bacon advised starting small: piloting at one clinic or testing site allows protocols and expertise to develop before citywide expansion. Under this approach, the interval from diagnosis to treatment fell from weeks to days.

Hong Kong, China: Ten consecutive years of decline. Dr. Bonnie Wong Chun Kwan, Consultant, Special Preventive Programme, Centre for Health Protection, Department of Health, reported ten consecutive years of falling HIV incidence, from a peak of 725 new diagnoses in 2015 to 331 in 2025, a 54 percent decline achieved with domestic funding, without international aid, and through close partnership between government and community. She organized her remarks around the six pillars of the Action Plan. A dedicated Advisory Council on AIDS, established in the early 1990s with representation from health, education, and social welfare, has provided interministerial coordination, and successive local HIV strategies have maintained continuity of direction for more than three decades. A domestic trust fund has supported community-delivered services since the 1990s; in 2026 it was restructured into a data-driven model integrated into the healthcare budget, which reduced fragmentation and removed reliance on ring-fenced funds vulnerable to shifting priorities. HIV testing and counseling have been free and anonymous since 1985, and treatment is heavily subsidized with a means-tested waiver, reflecting the standing policy that no one should be denied adequate healthcare through lack of means. The Commons (Yi Tong), the first integrated sexual health clinic for MSM and transgender communities, provides HIV and STI testing, hepatitis and mpox vaccination, and on-site psychological support free of charge. The "One Plus" mechanism, introduced in late 2023, allows a new drug to receive marketing authorization on recognition by any one of 36 international reference regulatory authorities, shortening approval pathways.

Against the 95-95-95 targets, 2024 data show 91 percent of people living with HIV diagnosed, 92 percent of those diagnosed on treatment, and 98 percent of those on treatment virally suppressed, up from 54, 66, and 81 percent in 2010. The remaining gaps sit on the first two targets. Late presentation accounts for half of newly reported cases, and three quarters of those outside recognized key populations had never previously been tested. In response, Hong Kong, China is scaling up HIV self-testing, has run an annual HIV Testing Month each December since 2024, and is introducing new NGO and community-based outreach programs from 2026. Dr. Wong closed with a caution: “An epidemic that is shrinking is not the same as an epidemic that is ending.”

The Philippines: The investment case for earlier diagnosis and rapid ART. Dr. Jan Aura Laurelle L. Llevado, Medical Officer V, Disease Prevention and Control Bureau, Department of Health, framed the Philippine response as an investment question: how to deploy limited resources for the greatest health and economic return. Annual new infections rose from approximately 4,600 in 2010 to 33,700 in 2025, and AIDS-related deaths from 300 to 2,700 over the same period. As of June 2026 the national cascade stands at 56–65–59, with an estimated 183,686 people living with HIV not on treatment, a population that could reach 430,300 by 2030 on current trends. The response is largely domestically financed, but identified financing in 2025 was approximately USD 67 million against an estimated requirement of USD 240 million. Closing that gap requires better allocation as well as more money, since investment earlier in the cascade avoids larger downstream clinical and fiscal costs.

Three directions shape the 2026–2030 Health Sector Plan for STI, HIV and viral hepatitis: scaling services across prevention, testing, treatment, and viral suppression; strengthening the financing, human resource, supply chain, and information systems that underpin them; and expanding the roles of local governments, civil society, and the private sector. PhilHealth is the principal lever for shifting recurrent service costs onto a sustainable base. On testing, the Philippines is expanding self-testing, social and sexual network testing, index testing, and community navigation, prioritizing the settings where a missed diagnosis costs most: antenatal care and triple elimination, TB and STI services, and youth- and key-population-friendly access points. Dr. Llevado was explicit that any routine or opt-out approach must remain rights-based, preserving informed consent, confidentiality, counseling, and the right to decline. On treatment, the objective is for the day of diagnosis to be the first day of treatment, which in practice depends on referral systems, trained providers, commodity continuity, peer navigation, and retention support. Success, she noted, is measured by whether clients stay in care and reach viral suppression.

Session II: Panel Discussion on Rapid Start and Opt-Out Testing

Professor Dong Wei, Deputy Director, Health Education and Intervention Section, National Center for AIDS/STD Control and Prevention, China CDC, on testing. Annual testing volume in China has grown from 284 million tests in 2020 to 474 million in 2025, roughly 34 percent of the population, and the national diagnosis rate has risen from 79 to 87 percent against a target of 95. Three models have done most of that work. Hospital-based provider-initiated testing and counseling, operating under a principle of informed non-refusal, accounted for 63 percent of newly reported cases in 2025. Province-level innovation in high-burden areas has added mandatory HIV testing with every blood draw and integration into routine health check-ups for older people, newly married couples, and university students. Targeted outreach reaches female sex workers, MSM, and partners of people living with HIV, supported by digital platforms for test-kit ordering and appointment booking. Technical advances include urine-based self-test kits, rapid nucleic acid testing, and AI-assisted clinical screening models that help clinicians identify individuals at risk.

Prof. Dong was equally direct about the challenges. Medical insurance authorities in some regions classify outpatient HIV testing as “excessive,” which discourages clinicians from offering it routinely. Clinician-initiated testing on clinical indication remains insufficient, so patients present late with advanced disease. Some populations are hard to reach because their social networks have moved online: internet-based sex workers and MSM, new drug users, migrant workers, sexually active older adults, and partners of people living with HIV. Regional disparities are large, with some provinces testing over 70 percent of their population at diagnosis rates approaching 90 percent while others cover as little as 20 percent. Screening-positive individuals are also lost when they do not return for confirmatory testing. Prof. Dong named six requirements: supportive multi-sectoral policy environments; training for clinicians outside infectious disease specialties; blended financing drawing on medical insurance, public health funds, and other budget lines; referral pathways connecting confirmatory testing to treatment without additional steps; public education and stigma reduction; and digital and AI-assisted

tools. “What works well is not any one factor,” she concluded. “It is a whole system of people, policy, and technology.” Asked for a single priority, she named a permissive environment in which knowing one’s HIV status becomes an unremarkable part of routine healthcare, alongside blood pressure and blood sugar checks.

Professor Zhao Yan, Director, Treatment Section, National Center for AIDS/STD Control and Prevention, China CDC, on rapid ART. Prof. Zhao traced China’s policy from early CD4-based thresholds, to treatment regardless of CD4 count from 2016, to same-day initiation where clinically feasible today. The evidence base came from a 2012 pilot, in which newly diagnosed patients were transferred directly from any hospital level to ART-prescribing facilities through a single-step procedure. The pilot cut the interval from diagnosis to ART from approximately 50 days to five and raised ART coverage from 50 to 90 percent, and its findings were published and cited in WHO consolidated guidelines as evidence for rapid initiation. Rapid initiation was mandated nationally in 2023, with same-day start recommended where clinical preparation allows and a benchmark of 30 days for all patients. By end-2025, more than half of newly diagnosed patients were receiving ART within seven days and 89 percent within 30 days.

In Prof. Zhao’s assessment, two factors separate the settings that achieve rapid initiation from those that do not. The first is awareness, on both sides of the consultation: asymptomatic patients feel no urgency, and many clinicians still need training on the benefits of rapid initiation and on how regimen classes differ in speed of viral suppression. Integrase inhibitor-based regimens can achieve suppression within three to six months, an argument a clinician can put directly to a patient. The second is access to medicines. The original free ART list was narrow; coverage through the National Medical Insurance system now allows patients to receive integrase inhibitor-based fixed-dose combinations that are better tolerated, easier to start, and faster to suppress, which makes same-day start more straightforward clinically. Facilities with dedicated ART prescribing authority, proximity to the point of diagnosis, and pre-trained clinical teams initiate fastest. Combining confirmatory testing and treatment initiation at a single site, Prof. Zhao said, makes more difference than any other structural change.

Mr. Jim Jin, Vice President and General Manager, China, Gilead Sciences, on the industry perspective. Mr. Jin argued that the remaining challenge is no longer primarily scientific: effective diagnostics, prevention strategies, and treatments exist, and the gap lies in health system capacity and in translating what works into practice. On testing he set out two priorities. Sustained policy support should make opt-out testing a routine element of healthcare in high-prevalence and high-yield clinical settings, moving it from a special request to standard practice. Testing modalities should also be diversified to fit local context, through self-testing, community-based testing, workplace outreach, peer-led services, and digital referral, so that testing reaches people outside clinical settings. He stressed that every result should lead to a next step: a positive result triggers rapid confirmatory testing and treatment linkage, while a negative result prompts risk assessment, prevention counseling, and access to PrEP, PEP, and other prevention options.

On treatment, Mr. Jin positioned rapid start, including same-day ART initiation where clinically appropriate and aligned with individual readiness, as a core linkage-to-care policy and a standard of care that shortens the path from diagnosis to treatment, reduces preventable loss to follow-up, and supports faster viral suppression. Realizing it, he argued, means adopting rapid start as a national policy priority; aligning reimbursement, procurement, prescribing, and referral policies to remove avoidable administrative delay; and strengthening linkage systems through case managers, peer navigators, digital referral, and community-based support. He commended China’s progress in reducing the time from diagnosis to treatment initiation in several provinces and cities, from approximately 30 days to as little as seven, and in some settings to the same day, and suggested that this experience could become a regional model, supported by public-private collaboration on knowledge exchange, capacity building, and implementation. His closing recommendation was that no person diagnosed with HIV should face avoidable delay in accessing life-saving treatment: “Rapid start should be the expectation, not the exception.”

Closing Remarks and Next Steps

Dr. Leonardo Chanqueo, Project Co-Overseer, APEC HIV Project, closed with three observations. First, no economy in the room was starting from nothing, and none had finished; the range of systems heard across the morning should reassure rather than invite comparison. Second, neither reform under discussion is expensive. They require no new medicine and no new technology, only decisions about organization: which tests are offered

as standard care, and how many days may pass between a diagnosis and a prescription. Those are decisions every economy in the room can make, at any income level. Third, the gap sits in implementation rather than in guidelines. People are lost between the policy document and the clinic visit, and closing that gap takes clear clinical guidelines, health workers confident in offering the test, and services able to initiate treatment the same day or follow up when a patient does not return. He asked participants to take home two recommendations from the Action Plan, each adapted to local context, system capacity, and legislation:

- Integrate opt-out HIV testing into the routine clinical settings where yield is highest: emergency departments, inpatient admissions, STI services, and TB services.
- Adopt protocols for beginning treatment within seven days of diagnosis, and ideally within three days or on the same day, removing administrative steps that add delay without adding clinical safety.

This report will be circulated to participating economies, speakers, and members of the APEC Health Working Group. Work under Project HWG_14_2026S continues through the implementation phase of the Action Plan, including development of a regional mechanism to monitor progress against its targets and indicators, and further opportunities for economies to share domestic implementation experience.