UNAIDS STRATEGY DEVELOPMENT

UNAIDS STRATEGY REVIEW:
Focus Group Synthesis template

Country: Global

Organizer: EGPAF, PATA and Aidsfonds

Date: 26 August 2020

UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Please use the template to organize your feedback from the session. Please keep responses succinct and as clear as possible to ensure our synthesis is a reflection of the focus groups hosted.

You can enter your report directly into a form on SurveyMonkey:
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SECTION 1: Information about the focus group (to be completed by host of Focus Group)

Organization leading discussion: Elizabeth Glaser Pediatric AIDS Foundation, PATA and Aidsfonds

Date of discussion: 26 August 2020

Theme to be discussed: Towards transformative and disruptive action to accelerate efforts to end HIV in children

Participants (types of organizations participating):

Name	Organization	Name	Organization
Angela Mushavi	*MOH, Zimbabwe*	Jackie Okinyi	*WOFAK*
Aisha Dadi	*Society for Family Health*	Linda-Gail Bekker	*Desmond Tutu*
Alasdair Reid	*UNAIDS*	Luann Hatane	*PATA*
Anne Magege	*Elma Philanthropies*	Lynette Mudekunye	*REPSSI*
Annette Sohn	*TREAT Asia*	Mamadi Yilla	*OGAC*
Anock Kapira	*RIATT-ESA*	Mame-yaa Bosomtwi	*OAFLAD*
Asia Russell	*Health GAP*	Mari Luntamo	*Nweti*
Benjamin Djoulbaye	*AIDS Watch Africa/AU*	Marissa Vicari	*IAS*
Catherine Connor	*EGPAF*	Mary Mahy	*UNAIDS*
Catherine Ngugi	*MOH*	Maureen Milanga	*Health Gap*
Chewe Luo	*Unicef*	Maurine Murenga	*Lean on Me Foundation*
Chip Lyons	*EGPAF*	Merian Muzinguzi	*Aidsfonds*
Corinna Csasky	*CCABA*	Morkor Newman	*WHO*
Cosette Audi	*EGPAF*	Musa Hove	*SAFAIDS*
David Ruiz Villafranca	*EGPAF*	Nicholas Niwagaba	*UNYPA*
Denis Tindyebwa	*ANECCA*	Nokuthula Heath	*Zoe Life*

Dewald Heath	*Zoe Life*	Patrick Oyaro Owiti	*Health Innovations Kenya*
Dorothy Mbori	*UNICEF*	Sabrina Erné	*Aidsfonds*
Elaine Abrams	*ICAP*	Sasha Volgina	*GNP+*
Eleanor Namusoke-Magongo	*MOH*	Shaffiq Essajee	*UNICEF*
Francesca Merico	*Consultant*	Shana Basdeo	*CHAI*
Hanna Mekonnen	*OAFLAD*	Solange Baptiste	*ITPC*
Helen Hallstrom	*ADPP*	Yogan Pillay	*CHAI*
Henriette van Gulik	*Aidsfonds*	Yvette Fleming	*PATA*
Hilary Wolf	*OGAC*		

Country, regional or global focus: Global focus

Introducing the theme

Please enter the main characteristics of the theme being explored in 5 sentences (please share the presentation if possible by email)

Today, 1.8 million children live with HIV. New pediatric HIV infections are on the rise in a handful of countries, jeopardizing the gains made towards eliminating pediatric AIDS. Pediatric treatment coverage has stalled and we have failed to identify and reach almost half of the children living with HIV. Although there has been global progress, none of the targets set out for 2018 or 2020 have been reached. An AIDS Free generation is not only possible; it is a human rights imperative. And it is achievable with leadership and strategic interventions.

The focus group discussion focused on the following items:

- *Reinvigorating advocacy and political leadership globally and in country to ensure transformative and disruptive action to accelerate efforts to end HIV in children, adolescents and families now, with no further delay*
- *Discussing opportunities for new metrics of success, tailored targets and indicators, and the collection and use of better data*
- *Ensuring programmatic and technological innovations work for children and their mothers*
- *Sharing impact and opportunities for differentiated service delivery models, integration of services, community-based service delivery models and other community interventions, including advocacy, to scale up access to quality services for children and their families*

SECTION 2: People-centered response to HIV – key emerging messages

Please enter the main messages coming out, up to 5 points maximum per section

REACHING THE PERSON	
How do we see the current situation?	➢ **We witness a lack of global and country leadership and accountability on elimination of vertical transmission and pediatric HIV.** We are missing a unique momentum to capitalize on all the commitments, guidance and opportunities to ending AIDS in children, mothers and young women and adolescents. Despite high levels of PMTCT coverage in many countries, new child infections persist. In fact, new pediatric HIV infections are on the rise in a handful of countries, jeopardizing the gains made towards eliminating pediatric AIDS. 43% of the incident infections among pregnant and breastfeeding women are among adolescent girls and young women age 15-24. Pediatric treatment coverage has plateaued and viral load suppression among children is very low. We have failed to identify and reach almost half of the children living with HIV. Evidence is telling us that we truly need transformative and disruptive action on pediatric HIV. ➢ We observe that **integration** is happening at a very slow pace and in very limited settings. There are examples (mentioned below "What constrain our ability to achieve our goal") that should be explored further, supported and implemented. **Differentiated service delivery models, and community-based service delivery, community monitoring, community advocacy** are game changers in pediatric HIV and should be properly supported, politically and financially. ➢ **With the innovations, technologies and programmatic knowledge and expertise we have now, we should not be where we are today.** But the global HIV response has not been "children centered". Instead of using 2020 to charge towards achievement of the fast track targets for children and youth, our pace has slowed and our resolve has weakened. We need to: question whether we are focusing on the right models of care (high PMTCT coverage, but new infections persist); push to bring to scale proven interventions (POC EID adoption has slowed, PrEP for pregnant and breastfeeding women has not been adopted widely); innovate to reach the missing children (for instance having specific indicators, improved data collection by implementing robust monitoring frameworks and dashboards, innovative models of care/service delivery to improve access and demand); urgently provide better pediatric ARVs formulations; and plan for the next generation of innovations like long-acting injectable ARV for these populations. ➢ **Stigma and discrimination** continue to prevent pregnant women, mothers, children, families, key populations and their partners from accessing quality services. These barriers are especially pronounced for already vulnerable groups, such as pregnant adolescent girls and young women and key populations. ➢ There is not enough attention paid to the transition from adolescence to youth in HIV service delivery. The global strategy has approached children and adolescent as a one group, with lack of differentiated approach and strategies. **UNAIDS should adopt a more strategically approach the unique specific needs of school aged-children, pre-teens, and adolescents**.
What concerns us?	

	• **We are concerned, because progress has stalled**. HIV treatment enrollment is still virtually flat-lined for children, as it has been for the last decade. Between 2018 and 2019 the number of children on treatment rose from 940,000 to only 950,000. We are concerned about the **lack of urgency and politically leadership** on pediatric HIV and eliminating mother to child transmission within UNAIDS and in country – it feels as though the last decade of progress has lulled donors and policymakers into a place of complacency. We see the fast track strategy as a missed opportunity for achieving an AIDS free generation. Significant progress has been made towards eliminating mother to child transmission, but this progress has been uneven and political energy is sporadic. Reaching missing children through community structures needs investments. Finding the harder to find HIV-positive children – going "the last mile" – will be far more expensive per child found than earlier in the epidemic when children could be more easily identified. • We are concerned about the **insufficient emphasis on primary (e.g. PrEP) and secondary (e.g. safe conception) prevention for pregnant women**. There is a need to increase testing (and retesting) at ANC and RMNCH facilities, and need to provide HIV-negative pregnant women with comprehensive prevention services throughout pregnancy and the breastfeeding period. • We know that **integrated health services are critical, but progress towards this goal has been wholly inadequate**. This has been made all the more clear by the results of the ECHO trial. Strengthening the linkages between HIV/AIDS and other health services, such as sexual reproductive health care, antenatal care, tuberculosis, cervical cancer, nutrition, triple elimination, and immunization programs is absolutely essential. • **Innovative technologies like new pediatric formulations, point-of-care early infant diagnosis and PrEP need investment and are not being introduced and scaled up quickly enough**. Pediatric formulations of medicines to treat HIV and related comorbidities typically lag years behind drug development for adults. Increased investment and collaboration are needed to make sure that the pediatric formulations that come to market are optimized for pediatric patient use (e.g. dispersible, taste-masked, etc.). Some ground-breaking pediatric innovations that have been introduced, such as POC EID, have not been sustained due to insufficient funding. We also need bolder efforts to block HIV transmission during breastfeeding through access to repeated infant testing, PrEP for HIV negative pregnant and breastfeeding women, and quality treatment programs that support women to ensure retention in care with suppressed viral load for their health and the health of their families. • We are concerned that **stigma, discrimination in health care settings, education, employment and within the community, and lack of health workforce capacities** continue to prevent mothers from going to health facilities, especially pregnant adolescent girls and young women and mothers who belong to key populations.
What gives us hope?	○ **Data collection is slowly improving** and is helping illuminated missed opportunities. As age-disaggregated data is more commonly collected and data on vertical transmission is reviewed, we are getting a clearer picture of where the old ways of doing things aren't working and where we need to redouble our efforts. The UNAIDS stacked bar analysis is allowing us to improve every step of EMTCT programming. Age disaggregated viral load suppression rates in children have illuminated issues around quality of pediatric treatment service, not just the availability of those services.

	○ **We have new tools** - things that work and can be scaled up as we continue to innovate. Innovations, such as new forms of PrEP (long acting injectable ARVs, dapivirine ring), better ARV formulations, POC EID, multi-disease testing machines are game changers entering the market. Health systems must be prepared to roll out and scale up these innovations to ensure they are accessible to the populations most in need. We have hope in multi-stakeholder initiatives that are facilitating dialogue to bring new technologies more quickly to the market. ○ **Facilities and community collaboration is working** and improving case finding, retention in care and viral load suppression. We must continue to invest in and develop these collaborations. ○ **Local power, local solutions and local expertise give us hope**. Peer support models, community monitoring, community outreach and advocacy, and psychosocial support is working and showing results. Additionally, we are hopeful about local innovation and must continue to facilitate and provide support. ○ **We are hopeful that integration can benefit children, mothers and the health system** to respond to people in a more holistic way. We must see a stronger push towards the integration of health services and leverage the universal health care agenda.
What constrains our ability to achieve our goals?	▪ **Challenges around integration constrain our ability to achieve our goals**. We need better coordination between the different disease programs which function in silo; donors need to develop innovative financing mechanisms for combining diseases; more evidence based data required to demonstrate the health impact and cost effectiveness when integrating services. There are innovations that can be adopted to support strengthening of linkages such as: offering incentives for joint planning and integration of services across relevant MOH departments such as RMNCH, HIV, STI, hepatitis and laboratory; Routine use of dual rapid diagnostic tests (RDTs) for HIV/syphilis as the preferred HIV test for use in screening of pregnant women; Introduction of hepatitis B birth dose vaccination and innovative methods of delivery outside birth facilities to reduce HBV MTCT; Adopting the hub-and-spoke model to deliver healthcare services to peripheral sites bringing care geographically closer to patients and creating linkages between referral networks, samples and patients across different health facilities. ▪ **Messaging around PMTCT** does not feel applicable to AGYW. It needs new, more relevant language. Additionally, PMTCT messages should be linked to messaging around new HIV infections in children, retention in care for mothers and infants, and the importance of viral suppression. Programmatically PMTCT must go hand in hand with enrollment of children born with HIV into care and treatment. We also need strong collaborations with the education system and school leadership – to find and support children living with HIV (CLHIV) and young girls who become pregnant. ▪ **There is a lack of political will to bolster the global healthcare workforce**. We need more trained, compensated, incentivized and sensitized health providers and community health workers to be able to provide quality pediatric and maternal HIV services. Health workers must have the necessary tools to succeed, including training on how to work confidently and effectively with children and young mothers, without stigma and discrimination. ▪ We cannot achieve **epidemic control** without prioritizing the needs of positive pregnant women, newborns, children and adolescents. We need better and more child friendly and rights-based services and education materials/messaging. There is an urgent need for mental health support for CLHIV. Mental health issues should be addressed proactively during

	adolescence for all HIV-infected youth. In addition, care systems need to pay greater attention to how mental health support is integrated into the care management for HIV, particularly throughout lifespan changes from childhood to adolescence to adulthood. ▪ We need a paradigm shift to focus on updated indicators, new metrics and open and even more in-depth analysis of pediatric and maternal HIV prevention and treatment services, where we have failed and the challenges countries are facing. We need to focus less on coverage metrics and more on quality metrics (e.g. using viral load suppression as an indicator of program success). It makes sense from an epidemiological, moral, and economic perspective to focus on these populations, and we must dramatically shift our thinking to move towards our global targets.

THE STRUCTURES THAT RESPOND TO HIV	
How do we see the current situation?	➢ UNAIDS' past and current strategies mobilized leadership, built initiatives and scaled up innovations to respond to HIV among children and adolescents. However, we do not see the leadership and accountability we need from UNAIDS family. Without UNAIDS leadership, efforts around EMTCT and pediatric treatment for children of all ages will most likely continue to plateau or even decline and falter. **We need to do more to translate our international commitments and global guidance into on the ground action, track our failures and overcome the weaknesses of the health system**. Political commitment and engagement is urgently needed, and UNAIDS must critically diagnose the current situation (including our failures) to best understand how to move forward. ➢ We need **more relevant targets at regional and country level.** We need to change our metrics to ensure our data is actually helping inform our programs: from PMTCT to viral suppression in pregnant and breastfeeding women, from focus on all women to a focus on young women and key populations, from EID to final outcome testing of exposed children, from child ART coverage to viral load suppression among children. We need indicators that help us reaching the missing children. We need targets for *differentiated* service delivery models. For instance, EID has been scaled up because we made specific targets out of this. For this purpose, we need to navigate better country data, experiences and opportunities. ➢ Progress is varied across regions and underlying issues for new child infections need to be addressed. Maintaining and enrolling children on ART requires differentiated interventions and scale-up of point of care interventions and appropriate linkages in the continuum of care to ensure support (both at community and peer levels). **The Global Fund and PEPFAR are essential mechanisms** to achieve our targets and we need them to better support game changing innovations. Countries must use their data to inform country grants, and UNAIDS must work closely with those mechanisms to increase awareness and sensitization and provide high quality technical support. This information must be used to increase domestic contributions to national HIV responses as well. ➢ **We are concerned with weak data collection** and how data is being used. We still do not see sufficient data disaggregated by age and other key factors. This disaggregation is essential for better understanding the nature of the epidemic. Additionally, we are concerned about the accuracy of existing data, such as Spectrum data, and therefore need more data points to be widely distributed. It is vital that we are collecting data for more than just informing donors, but also collecting and analyzing information that can help us better understand the current situation, improve our programs, and plan for the

	future, such as through data-driven Global Fund proposals. We must listen to what data countries and service providers need to improve their work. ➢ **A coherent approach to innovation is need** – from research and development to uptake and delivery, treatment and prevention innovations require investment, planning, and extensive stakeholder engagement. Ensuring availability and affordability of quality treatments and diagnostics is critical to ensure children and their mothers receive quality treatment and are not only able to survive, but thrive. We are encouraged by interesting initiatives and collaborative partnerships, such as the Rome Action Plan, that support a multi-stakeholder approach to advocate for and coordinate rapid access to innovative treatment and diagnostics for children. We are also excited by the progress in long-acting injectable and multipurpose prevention technologies for HIV and family planning.
What concerns us?	• **We are concern about "One size fits all" models of care**. We are not maximizing the use of differentiated service delivery models and scaling up models that work and have impact. Communities are working in a complex financial and political environment that make their work difficult. • We need to do some landscape analysis on politics: **Why is pediatric HIV not a higher priority within the broader HIV policy agenda? Why is it so difficult to move past talking points and put meaningful political attention on pediatric and maternal HIV issues?** The 90-90-90 targets by definition exclude much of the prevention cascade, so we have to better integrate prevention tools within the cascade. We have need UNAIDS, WHO and Unicef to provide continuous and visible leadership, including accountability on implementation at national and global levels. • **We are concerned about health systems' capacity to make innovations accessible and sustainable** within the country. We have watched as the adoption and scale up of documented game changers like point of care EID have been hindered and even stopped in some countries. We need innovative solutions to ensure health systems are up to the challenges of accessing better formulations and innovations, adapting guidelines, training health care workers, managing drug resistance, operating an effective pharmacovigilance system, managing a cold chain and sample transport, etc. More effort is needed in providing and monitoring quality care to people living with HIV. Poor retention or frequent stock out of ARVs are particular risk factors. Children and adolescents on treatment are at higher risk of resistance emergence, requiring close monitoring. • **We are concerned about the availability of financial resources** for HIV/AIDS in the coming future, from both domestic and international sources, and our ability to transition and adapt to the future of the HIV response. Responding to the COVID-19 pandemic introduces an additional strain on the already limited resources for global health. We must properly analyze the funds available region by region to better understand each funding situation and respond accordingly. For example, the Asia region is composed largely of MIC countries relying on domestic resources. In this region, ART coverage for pregnant women is at only 56% and there is not sufficient funding to scale up. UNAIDS must support the urgent need for further investment at the global, regional, country, and community level. • **More effort is needed to ensure policies and a child rights-based approach to health are implemented** at all levels within a health system. Additionally, communities and individuals often do not have access to necessary information and data. We must ensure that information is flowing down to the community level and that information from the frontline is also moving upward to information policy and associated guidance.

What gives us hope?	○ **We have built a strong HIV architecture** to respond to all the challenges ahead. However this structure cannot work without community engagement (from political engagement to the provision of services to data collection) and must adapt to the changing environment. We must build on that to move faster, together, and to ensure resilient health systems for health. ○ **We are hopeful about the Global Fund's impact and potential to contribute to an AIDS free generation.** Donors are confident in the Global Fund working mode, and we must better capitalize on its potential when addressing maternal and pediatric HIV epidemiological trends. Technical agencies and partners must help the Global Fund improve and expand its work for children, pregnant women and mothers, including by addressing any potential funding barriers. ○ **We have mobilized more political support around structural barriers**. There is more awareness on the importance of community responses, the need to respond to human rights barriers for women, children and youth and repositioned the right to health. ○ **We are encouraged by country-specific programmatic reviews against frameworks** with all stakeholders (client, clinic, health provider, community, care givers, MoH, INGOs, local NGOs and CBOs) for joint and coordinated programming. All stakeholders must be engaged to ensure effective programming. Preferably this process is done by a third party that is only interested in the overall goal and has no political agenda and/or financial interest. ○ **We are hopeful that new/more leadership emerged** from the current global health situation, including from COVID-19, UHC, social justice movements, new leadership around childhood tuberculosis and other diseases. UNAIDS must ensure support to leverage this new leadership by providing safer spaces, mentorship and capacity strengthening, and garner political opportunities for them to speak out.
What constrains our ability to achieve our goals?	▪ **User fees**, both formal and informal, have served as a barrier for pregnant women and children to access health services. We must prioritize affordability for all services. ▪ **Policies that prioritize only high-yield testing methods** have made case finding more challenging in some contexts. We need to re-invest in widespread testing and retesting at antenatal care facilities to ensure we are identifying pregnant women living with HIV. ▪ **National and global financing doesn't prioritize pediatric HIV programming**. We currently have no costed investment case for children; we are not aware about how much money is needed to address the pediatric HIV crisis; and we are not clear how the Global Fund and other donors are investing in children, pregnant women and adolescents. More coordination to address these constrains are urgently needed. ▪ **Vertical programming** constrains opportunities to implement maternal and pediatric HIV service delivery in integrated ways that simplify the patient experience and maximize overall patient health outcomes.

CONTEXTUAL ENVIRONMENT	
How do we see the current situation?	➢ **COVID–19** has disrupted the provision of services. This could result in more HIV infections, increased rates of mother to child transmission, and more AIDS-related deaths according to modelling studies. Differentiated service delivery models have been put in place to continue the provision of services as much as possible. Political leadership have emerged in this global pandemic, able to make difficult decision and to mobilize billions of USD to respond to the pandemic. The HIV architecture has been critical responding to COVID-19 and HIV, learning from the past and applying new lessons. As COVID-19 restrictions are here to stay, we need new country level strategies to prevent upheaval to service delivery affecting children living with HIV and their communities. ➢ We have to go out of our bubble and **learn from other diseases**, responses, and experiences. This past month, Africa was declared free of Polio, What can we learn from the end of Polio in Africa these days? It invites us to change narrative and inspire people. For instance, we should ask ourselves: *what is the endgame?* ➢ **Countries continue to work to move towards UHC** and so work beyond the health sector: community system, social protection. HIV is contributing to UHC, and the integration of HIV and other services will be essential for making UHC a reality. For example, focusing on the elimination of vertical transmission of not just HIV, but also of hepatitis and syphilis will help to integrate services and move us towards UHC. However, UHC does present a risk by only focusing on basic packages of care. We must ensure that in the transition to UHC, we do not lose access to more costly yet effective interventions, particularly for children and pregnant women.
What concerns us?	• We are concerned about **the effects of poorly managed COVID-19 restrictions**, which threaten to destabilize the pediatric HIV response even further. Already several countries including Zimbabwe and Uganda are observing declines in pregnant women being able to attend antenatal care, reduced rates of infant HIV testing and families unable to move to clinics to pick up pediatric treatment refills. From preventable deaths of women in labor caused by poorly executed lockdowns, to spikes in teen pregnancy, to waves of violence - the burden exacted on HIV positive mothers and children by COVID-19 must be eased. • **COVID 19 presents an unprecedented threat to progress in the fight to end HIV**. The impacts of the virus and of mitigation strategies have significantly impacted people's ability to access health care services. Additionally, the diversion of funds, commodities, and personnel from HIV to COVID-19 has introduced an additional strain on the global HIV response. • **A number of environmental factors**, including poverty, gender-based violence, and stigma, prevent pregnant women from accessing care. These factors are particularly impactful for adolescent girls and young women. • **UHC is focusing on basic packages**. What will happen with game changers interventions like POC EID that are costly but effective? How will UHC factors in interventions outside health systems? How can we make sure that no population, such as children or pregnant women, is left behind in the transition to UHC?

What gives us hope?	○ **COVID-19 has re-prioritized disease control in the global agenda**, and has made agencies and governments realize the importance of investing in health systems. It has also helped scale up differentiated service delivery models and raise the importance of multilateralism, collaboration and coordination. ○ **COVID-19 has put a magnifying lens on weak health systems**, the need to task-shift and allow for community HIV service delivery and this could be a good push for maintaining the gains and strengthening those systems. ○ **COVID-19 showed the importance of a capacitated and strong health workforce**
What constrains our ability to achieve our goals?	▪ We need **more research on how COVID-19 impacts pregnant women and children**. At this point, we are lacking large-scale data on the impacts of this disease on pregnant women and children and therefore cannot make assumptions about their risk. It is vital that these populations are included in COVID-19 research, including treatment and vaccine trials. ▪ We need **more clarity and understanding on how UHC is being operationalized in country**, ensure civil society engagement to ensure accountability, identify milestones to progress towards UHC, and ensure UHC is more than a basic package of services.

EMERGING PATTERNS:

- COVID-19 is one of the most important emerging patterns that is impacting the HIV epidemic. We must adapt and continue to respond to the HIV epidemic in this complex times.

- We see how differentiated service delivery models, with a particular emphasis on community models, are making the difference for people living with HIV since the start of COVID-19.

- There are new innovations in the pipeline and already in the market. They can make the difference for CLHIV, pregnant women and adolescents. But we face difficulties to scale up and sustain those impactful and effective innovations (POC EID, new formulations, differentiated service delivery models, community interventions, etc.) There are innovations that can be adopted to support strengthening of linkages such as: offering incentives for joint planning and integration of services across relevant MOH departments such as RMNCH, HIV, STI, hepatitis and laboratory; Routine use of dual rapid diagnostic tests (RDTs) for HIV/syphilis as the preferred HIV test for use in screening of pregnant women; Introduction of hepatitis B birth dose vaccination and innovative methods of delivery outside birth facilities to reduce HBV MTCT; Adopting the hub-and-spoke model to deliver healthcare services to peripheral sites bringing care geographically closer to patients and creating linkages between referral networks, samples and patients across different health facilities.

- We witness an important political momentum to speed up integration of services. We need better coordination between the different disease programs which function in silo; donors need to develop innovative financing mechanisms for combining diseases; more evidence based data required to demonstrate the health impact and cost effectiveness when integrating services.

- We feel there is a lack of urgency and a vacuum in global and country leadership to respond to the epidemic in children and pregnant women.

SECTION 3: RECOMMENDATIONS World Café

Please enter the main messages coming out, up to 5 points maximum per section

What are the key recommendations back to UNAIDS in terms of the strategy specifically?	
CONTINUE	*What is working that we must continue to do?* ➢ **UNAIDS must ensure children, pregnant women and adolescent are a high priority in the global HIV strategy**. We need strong and inspiring goals, targets and indicators to ensure we end pediatric HIV in the next five years. Political leadership is key. ➢ **Ensure political commitment to community engagement, responses and advocacy.** Evidence shows when women and their newborns receive person-centered and supportive services, including adherence support provided by trained, equipped HIV positive "mentor mothers" who are paid a living wage for their work, they and their children are more likely to be retained in care with good clinical outcomes. Without these services, women and their children are extremely likely to fall out of care rapidly, due to health systems that are not accountable to their needs. ➢ **UNAIDS must continue to advocate for the right to health** as a critical component to the global HIV response. ➢ **Continue to advocate for innovations** and quicker and better access to new technologies and programs, including point of care early infant diagnosis, better ARV formulations, PrEP for pregnant and breastfeeding women, family index testing, male engagement, among others. ➢ **Continue to improve accountability and data collection and use.** The UNAIDS stacked bar analysis is allowing us to improve every step of EMTCT programming. Age disaggregated viral load suppression rates in children have illuminated issues around quality of pediatric treatment service, not just the availability of those services. UNAIDS should ensure a good use of data and strengthen their evidence-based advocacy around kids with governments, donors and decision-makers.
STOP	*What must we stop doing that if we don't stop will ensure failure?* ➢ One-size fits all approaches. We need more targeted responses based on age, country, etc. using national and local data that informs where we must focus and what is working/not working that we should focus on. ➢ UNAIDS must function as a joint program. We are concerned about the lack of capacity and political will of some co-sponsors to respond to HIV. UNAIDS and the co-sponsors should be the standard bearers on cooperation and joint planning rather than working in isolation and/or developing competing approaches.
START	*What are we not doing that we have to start doing?* ➢ **Sense of urgency to achieve an AIDS free generation**. We have the tools, knowledge and expertise to achieve our targets. **We need UNAIDS leadership and advocacy** at global, regional, national, and subnational level to prioritize children and pregnant women. We do not see that

	leadership instilled in UNAIDS yet. UNAIDS must build a strong HIV response that fully leans into the needs of children and youth. This is central to the success of any rights-based approach to achieving universal health coverage. ➢ **UNAIDS must emphasize prevention**, both primary (e.g. PrEP) and secondary (e.g. safe conception) prevention for pregnant women. **UNAIDS should develop a landscape analysis on politics**: Why pediatric HIV is falling out of the policy agenda? The 90-90-90 targets by definition exclude much of the prevention cascade, so we have to better integrate prevention tools within the cascade such as by extending the PMTCT cascade to ensure pregnant women who are HIV-negative are provided with prevention services, such as PrEP, throughout the pregnancy and breastfeeding period and tailoring services, particularly PMTCT services, to specific sub populations such as pregnant AGYW and pregnant key populations. ➢ **We need more relevant targets at regional and country level.** UNAIDS must re-think the metrics to ensure data is actually helping inform programs: from PMTCT to viral suppression in pregnant and breastfeeding women, from focus on all women to a focus on young women and key populations, from EID to final outcome testing of exposed children, from child ART coverage to viral load suppression among children. We need indicators that help us reaching the missing children. We need targets for *differentiated* service delivery models. *Finally, we need re-think our* narrative and inspire people. For instance, we should ask ourselves: *what is the endgame?* ➢ **UNAIDS must find effective ways to support local community advocacy** on pediatric HIV (from papers to real actions) – investments are needed for capacity building of local civil society, improving how clinics and communities work together in a coordinated manner, and increased incorporation of local voices in leadership and decisions making. ➢ **More tailored and differentiated support to countries.** We must respond to the specific epidemic a country is facing, rather than attempt to use one approach across a diverse array of county contexts.
What is the one key recommendation you want to reiterate for strong consideration?	*UNAIDS must strengthen its leadership and political advocacy to ensure a transformative and disruptive action to accelerate efforts to end HIV in children, adolescents and families now, by:* ➢ *Setting strong global, regional and country level targets and indicators to reach all children, pregnant women and adolescent living with HIV.* ➢ *Mobilizing and supporting political leadership to scale up innovations, technologies, programs and funding to achieve an AIDS free generation.* ➢ *Advocating for differentiated service delivery models, community engagement and rights based approach to children, pregnant women and adolescents living with HIV.*

Please share with us any references you think would be useful for the Strategy Development, such as examples of case studies that illustrate the challenges or recommendations you outlined in the discussion report.

Please also share a list of names and email addresses of participants who would wish to continue to be informed of the Strategy development process. Note names and contacts will not be shared publicly or with any third party.

You can send us additional documents via e-mail ***strategyteam@unaids.org***

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