Agenda item 8

UNAIDS/PCB (47)/CRP 4

REPORT OF THE UNAIDS MULTISTAKEHOLDER CONSULTATION ON NEXT GLOBAL AIDS STRATEGY

UNAIDS

15–18 December 2020 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 30 November 2020

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Executive Summary

1. On 16 September 2020, UNAIDS held an online multistakeholder consultation on the next global AIDS Strategy, with more than 170 representatives[1] of Member States, civil society, nongovernmental organizations, international organizations other than the UN, the private sector and academia taking part, along with representatives of all 11 UNAIDS Cosponsors and the UNAIDS Secretariat.

2. With only 10 years left to deliver the Sustainable Development Goals, including the target of ending the AIDS epidemic as a public health threat by 2030, UNAIDS is developing its next global AIDS Strategy. The next Strategy, which is expected to be adopted by the UNAIDS Programme Coordinating Board by March 2021, will be a road map for all countries and partners in the global HIV response to get back on track to reach the SDG target of ending AIDS by 2030.

3. The first phase of the development of the next Strategy took place from May to August 2020, during which UNAIDS held broad consultations and conducted a review of the current UNAIDS 2016–2021 Strategy and its implementation. Over 8000 stakeholders had been consulted through a global online survey, interviews with key informants, focus group discussions and workshops by end of August 2020. The UNAIDS evidence review raises critical questions about how to sustain or scale up what is working, where we are falling behind and how to overcome the gaps and obstacles for the next global AIDS Strategy in order to remain ambitious, visionary and evidence-based. The evidence review and the Strategy consultations that UNAIDS has conducted to date indicate that the priorities in the current UNAIDS Strategy remain relevant, but progress and results need to be accelerated across all countries, contexts and populations.

4. Drawing on the expertise and facilitation of UNAIDS Strategy development partner Reos Partners, the multistakeholder consultation featured presentations, break-out groups, and inputs across a range of issues and strategic priorities arising from the review of the current Strategy. Some of the issues that were discussed during the consultation included: political leadership and financing; partnerships and accountability; COVID-19; key populations; adolescent girls and young women; community-led responses; eliminating stigma, discrimination and punitive laws; regional specificity; HIV and universal health coverage; multisectorality; and inequalities. The multistakeholder consultation explored these 11 issues in detail, generating inputs on how to amplify game-changers, how to move from commitment to action and how to measure and monitor action to drive accountability.

5. Government representatives emphasized the importance of having the voice of countries, at the government and community levels, at the forefront in the development of the next Strategy. Civil society representatives highlighted the need to further strengthen youth empowerment and leadership, an area noted as a major shortcoming in the current Strategy, in order to seize the potential of communication, education and capacity-building for the next generation. Representatives of international organizations reinforced the critical importance of the next UNAIDS Strategy to maintain and enhance community engagement, including in closer coordination with the next Strategy being developed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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[1] Special efforts were made to include broad and equal representation of multistakeholder participants in the meeting by limiting participation to one representative per member state, institution, or organization.

6. The UNAIDS Strategy development process now transitions into the next phase, with updates to be considered during briefings and meeting of the UNAIDS Programme Coordinating Board. A detailed annotated outline of the next UNAIDS Strategy, which will integrate next global HIV targets for 2025 and resource needs estimates, will be presented to the 47th meeting of the Programme Coordinating Board in December 2020. The next UNAIDS global AIDS Strategy will provide a critical link to inform the preparations for the next United Nations General Assembly high-level meeting on AIDS.

Background

7. The process to develop UNAIDS next global AIDS Strategy is an opportunity to reaffirm the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths and reignite the political commitment, activism and urgency that will accelerate progress to end AIDS as a public health threat by 2030.

8. At its 46th meeting in June 2020, the UNAIDS Programme Coordinating Board (PCB) requested the UNAIDS Executive Director to:
   - present the findings from the completed review of the current UNAIDS Strategy (2016-2021) and the implications for strategic priorities beyond 2021, along with the findings of the independent evaluation of the UN System Response to AIDS 2016-2019 for consideration by the multistakeholder consultation no later than September 2020;
   - following this consultation, present the outcome of the multistakeholder consultation with options for the UNAIDS Strategy beyond 2021 at a briefing for Programme Coordinating Board members and observers;
   - present, through the PCB Bureau, a paper on the outcome of the review and consultations with an option for the UNAIDS Strategy beyond 2021 for intersessional approval no later than the end of October 2020; and
   - present to the 47th PCB meeting in December 2020 an annotated outline of the UNAIDS Strategy beyond 2021, ensuring that it remains ambitious, visionary and evidence-based.

9. In response to these requests, UNAIDS held a multistakeholder consultation on 16 September 2020. The objectives of the consultation were to:
   - present the findings of the review of the current UNAIDS Strategy 2016-2021, including the evidence review, global survey, informant interviews and focus group discussions;
   - discuss the strategic priorities arising from the review of the current Strategy; and
   - invite inputs and identify answers to key strategic questions arising from the Strategy review.

Opening remarks of Winnie Byanyima, UNAIDS Executive Director: Setting the path for a new global AIDS Strategy

10. Winnie Byanyima, UNAIDS Executive Director, provided opening remarks. She stressed that there is a need for a renewed sense of urgency in the HIV response. She said the focus must be on how to make progress across the areas and issues where we are off-track. She emphasised that multisectoral engagement and high-level political leadership are required to accelerate progress. .

11. Ms Byanyima set the scene for the multistakeholder consultation, she cautioned that the strategic, winning multisectoral, all-of-government, all-of-society approach pioneered by

the HIV response, was weakening. HIV was falling off the political agendas of many governments, donors and some international organizations. Many national HIV responses were lacking the strong, multisectoral engagement and high-level political leadership that was required. Civil society, in particular key population organizations, whose leadership and service capacity are key to ending AIDS, was increasingly criminalized, marginalized, and some organizations were under constant attack.

12. Ms Byanyima stressed that if the next Strategy was to protect and advance the gains in the HIV response, planning for fully funding the Strategy had to start immediately. She told the meeting that a detailed resource needs estimation up to end-2025 were being completed. The next Strategy had to be a mechanism to secure adequate resources for the global HIV response. Without the necessary resources, millions of lives will continue to be lost. While the world's attention is focused on global health and the COVID-19 pandemic, there is a vital window of opportunity to ensure the next chapter of the global HIV response is fully funded.

13. The full statement is available here: EXD Opening Remarks

Findings of the evidence review of the current UNAIDS 2016–2021 Strategy: measuring impact, successes and challenges

14. Shannon Hader, UNAIDS Deputy Executive Director (Programme) presented the evidence review of the current UNAIDS 2016–2021 Strategy. A summary of her remarks follows.

15. UNAIDS carried out a global review of available data to assess the implementation of the current Strategy and the results obtained. The review looked into what was working and needed to be sustained or scaled up, especially in areas where the evidence-informed approaches of the current UNAIDS Strategy remained sound but have not been implemented with sufficient speed, quality or scale. The review also provided an analysis of where the global and country HIV responses were falling short. It explored the questions of whether we need to do things differently or whether we need to intensify what we are already doing. The review was organized around themes that arose from the 2016 Political Declaration on Ending AIDS and the strategic results areas of the UNAIDS 2016–2021 Strategy.

16. The review revealed that at times, there is a need to overcome generalities, conventional wisdom and sometimes outdated assumptions to make progress. For example, the review examined available data to understand where and how HIV is linked to inequality. It found that many of the inequalities and differential patterns that define HIV in different settings are unexpected and counterintuitive. For example, countries with the most resources are not always the ones with the strongest or most sustainable HIV responses. Additionally, while unequal gender norms increase the vulnerability of women and girls to HIV infection, men generally have poorer outcomes than women across the HIV testing and treatment cascade often influenced by gender norms that impact on men's health seeking behaviour. Women generally are more likely than men to know their HIV status, receive antiretroviral therapy and achieve viral suppression. However, there were some countries where women had worse testing and treatment outcomes than men.

17. The review also demonstrated that HIV responses are often lagging behind are in contexts where epidemics are heavily concentrated among key populations who are often marginalized and/or criminalized by mainstream society and who are denied equal

access to services. These key populations include gay men and other men who have sex with men, people who inject drugs, people who live in prisons or other closed settings, sex workers and transgender people. The review also found that there are major differences in service access within countries. Even in regions where recent gains in the HIV response are encouraging, such as eastern and southern Africa, the response is badly off-track in some countries and subnational settings.

18. The review showed that where combination prevention approaches have been scaled up, HIV incidence has declined. However, new HIV infections have declined globally just 23%, far behind the 75% called for in the current UNAIDS Strategy. The evidence review also shows that one size does not fit all. Strategies and actions need to be tailored to the needs of those who need them most. The review revealed, for example, that although there is HIV incidence among adolescent girls and young women in sub-Saharan Africa, not all young women face equal risk. There is a need to target actions and services to those girls and young women who are most affected.

19. There has been overall good progress in scaling up HIV testing and treatment and reducing AIDS-related deaths. However, the review shows that some countries have surpassed the 90–90–90 targets and are close to reaching 95 95 95, whereas some countries are still off-track. In addition, even the countries that have reached the targets, or are close to reaching them, may still be missing those who are most vulnerable. The gaps along the testing and treatment cascade vary per country and setting. Some countries are not on-track to reach "first 90"with the knowledge of their HIV status among people living with HIV. In other countries, some people living with HIV who know their status are still not initiated or sustained on HIV treatment. To address this, the next Strategy will need to have a laser focus on who is left behind, with strategic actions tailored to context to address the specific gaps.

20. The review showed that no country has made the kind of progress needed toward eliminating stigma and discrimination and creating enabling legal environments. Although stigmatizing attitudes towards people living with HIV have declined in some countries, stigma persists at high levels. Punitive laws which hinder access to HIV and other services remain common. Key populations often face harassment and violence, including from law enforcement officials. Access to justice remains restricted in many settings.

21. The review demonstrated that different actions are needed in different contexts to eliminate vertical transmission of HIV and ensure effective HIV treatment for children. Data shows that in countries with advanced programmes for the elimination of vertical transmission, notably in eastern and southern Africa, most new HIV infections among children are due their mothers acquiring HIV during pregnancy or breastfeeding. This points to the need for a stronger emphasis on primary prevention among pregnant women. In other settings, notably in western and central Africa, pregnant women are not accessing antenatal care services at all. There is therefore a need for urgent action to reach women through different models, while also working to increase antenatal care coverage.

22. The review confirmed the crucial role played by communities most affected by HIV. It also confirmed that funding for community-led responses has been insufficient and that the space for civil society has been shrinking.

23. The resources available for the global HIV response do not match the needs. HIV funding has plateaued in recent years and it decreased in 2019. The reviewed showed that funds are not always applied to the actions that are most likely to have the greatest impact. The review findings indicated that as the global HIV response approaches the end of its fourth decade, the epidemic defies simple descriptions. Only by recognizing

and responding to the epidemic's complexities will it be possible to get back on-track to end the epidemic by 2030.

24. The evidence review, "Implementation of the 2016–2021 UNAIDS Strategy: on the Fast-Track to end AIDS", is available here: Evidence review of UNAIDS Strategy 2016–2021. The full presentation is available here: Strategy review presentation.

Global consultations: feedback from stakeholders—survey, key informant interviews, focus group discussions

25. Gloria Bille, Fast-Track Adviser, UNAIDS Country Office Kenya presented on the global consultations. A summary of her remarks follows.

26. **Global survey:** UNAIDS carried out a global online survey between 27 May and 2 August 2020 to get inputs on priorities, as well as barriers and game-changers in the future of the global HIV response. The Survey included mainly quantitative questions, as well as a set of qualitative questions. It was administered in 16 languages. More than 8300 responses were received from 163 countries across all regions.

27. The survey responses demonstrate that all the Strategy areas of the current UNAIDS Strategy remain relevant. HIV testing and treatment; HIV prevention; promoting gender equality and addressing gender-based violence; human rights; reducing stigma and discrimination; investment and efficiency; and service integration were rated especially important by respondents. A variety of responses indicate that more attention is required specifically to addressing punitive laws, policies and practices, eliminating stigma and discrimination, looking at funding and investment as well as informing and clarifying integration. The survey also identified areas that are not featured strongly enough in the current UNAIDS Strategy. These included issues such as re-emphasizing the importance of having communities at the centre of the HIV response, as well as leveraging science, technology and innovation to find a vaccine and a cure, better diagnostics treatment, more efficient service delivery.

28. The importance of political will at national and global levels to advance essential priorities, increased investments and the need for a multisectoral approach were identified as areas to be strengthened. Other areas identified by the survey for greater attention included increased focus included universal quality education and keeping girls in school, putting a priority on communication and making use of virtual platforms, and finally the need to address humanitarian crises impacting the progress of the HIV response. Through the open-ended data survey, respondents from all different regions also voiced the need for regional specificity and contextualization for policies and programmes, asking for the next UNAIDS Strategy to consider a more targeted approach.

29. The global survey report is available here: Global survey report

30. **Key informant in-depth interviews**: A total of 65 semistructured dialogue interviews were carried out among 70 individuals from across the HIV response to draw out their views of the current UNAIDS Strategy and harvest lessons from the past—including what has worked, what has been challenging and why—to surface what the next Strategy needs to be paying attention to, including in the external, contextual environment, and recommendations for the Strategy development process and outcomes. With the goal of keeping the people and communities most affected by HIV at the centre of the Strategy development process, people living with HIV, representatives of key population networks and women’s networks were prioritized for the interviews.

31. Several themes emerged from the interviews:
    - the current UNAIDS Strategy is good on paper, but its full implementation has been a challenge. There is a gap between aspiration and action;
    - structural drivers of HIV risk and vulnerability have not been adequately addressed;
    - stigma, discrimination and punitive laws must be tackled in a meaningful way;
    - HIV responses must become more granular and context specific;
    - community-led responses need to be strengthened and fully funded;
    - collaboration, partnerships and multisectoral approaches are more important than ever;
    - we will not achieve the goals without sustainable financing;
    - we must learn from the COVID-19 pandemic and leverage the lessons learnt from the HIV response in response to emerging epidemics, but also stay focused on the target of ending AIDS as a public health threat by 2030; and
    - the role and contribution of UNAIDS Joint Programme to the global HIV response needs to be made clearer.

32. The interview report is available here: Interview report.

33. **Focus group discussions**: Civil society, partners and UNAIDS Secretariat and Cosponsors carried out over 35 focus group discussions as of 1 September 2020. UNAIDS will continue to provide support to partners to organize focus group discussions on specific issues until mid-October 2020. A full report on the outcomes of the discussions will be made available after all the focus group discussions have been concluded.

34. Focus groups discussions are conducted as an integral part of the multipronged approach to stakeholder consultations throughout the Strategy development process. To ensure maximum inputs from stakeholders, discussions were invited to identify themes for in-depth dialogues which would explore issues such as: geographical scope (from global to local); thematic areas (from prevention and harm reduction, to treatment and emergency preparedness, to social protection and financing health); population groups (young people, people living with HIV, key populations, etc.); and the overall response to HIV. The discussions focused on identifying what to stop, start and continue in the next global AIDS Strategy. The focus group discussions were conducted virtually.

35. A consistent message coming out of the focus group discussions is that there is a need to bring back the sense of urgency to the HIV response. There is a strong affirmation of the principles underpinning the current Strategy as well as an affirmation of continued relevance of the current eight results areas. Participants in focus group discussions also emphasized the need to strengthen the multisectoral approach to the HIV response. There was a recognition that reaching HIV targets that contribute to achieving Sustainable Development Goal (SDG) 3, SDG5, SDG10, SDG16 and SDG17 will require new investments and sustained coaction across development sectors and stakeholders, and the global HIV response is uniquely placed to facilitate this.

36. A key message across multiple focus group discussions is that social enablers are not optional. A sustainable and rights-based HIV response requires a global AIDS Strategy that reached communities with HIV treatment and prevention and also reduces the vulnerabilities, marginalization and discrimination that drive the epidemic. Discussion participants emphasized that biomedical strategies must be accompanied with strategies that acknowledge that the right to health can only be achieved if all pathways of change work together: law, policy, services, communities, evidence, inclusive governance and social norms that can be challenged and changed. The need for more explicit

mechanisms for collective responsibility and accountability for results and failures was also highlighted.

37. Although the focus group discussion participants consistently affirmed the need for distinct results areas in the next Strategy, they also emphasized that the HIV response must stop operating in silos. A holistic approach is needed across areas, including between health and human rights, treatment and prevention, people-centred services and systems for health. Another message from the discussions was that HIV responses must follow the epidemic and prioritize the most-affected locations and populations with evidence-based interventions implemented with urgency and scale. Other key themes included the importance of community-led responses and of meaningful engagement of communities in all aspects of the HIV response, as well as the role of the HIV response as a catalyst for development and broader social change. Discussion participants recommended these areas as specific strategic priorities for the next global AIDS Strategy.

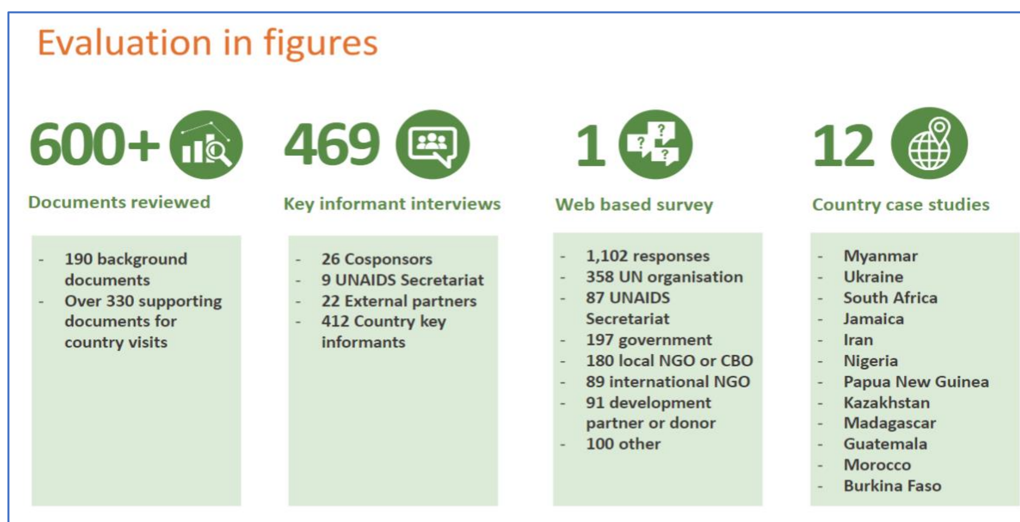
38. The focus group discussion reports are available here: Focus group discussions reports (and preliminary analysis). The full presentation is available here: Global consultation presentation.

Independent Evaluation of the UN system response to AIDS in 2016–2019

39. Joel Rehnstrom, UNAIDS Director, Independent Evaluation Office presented on the Independent Evaluation of the UN system response to AIDS in 2016–2019. A summary of his remarks follows.

40. The purpose of the evaluation was to conduct a structured review of the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) and the performance of the Joint Programme at the global, regional and country levels. It also provided robust evidence-based recommendations to support learning and forward-looking planning, specifically the development of the next UNAIDS Strategy/UBRAF and the future positioning of the Joint Programme.

41. The evaluation highlighted several key issues.
    - A coordinated UN response to HIV remains relevant and the work of UNAIDS at country level shows the advantages of a joint and cosponsored programme.
    - Significant decreases in resource availability have resulted in tensions within the Joint Programme, further exacerbated by demanding reporting requirements.
    - A potential, continuing cycle of decline must be prevented, and new and more effective ways of working together and demonstrating results must be established.



42. Recommendations from the evaluation included:
    - prioritize programming in a more strategic and pragmatic way;
    - revise the "theory of change" and associated monitoring and evaluation systems;
    - address head-on the future architecture of the Joint Programme;
    - invest more in working better together across the Joint Programme;
    - develop and implement a Joint Programme resource mobilization strategy;
    - sharpen (and possibly overhaul) the resource allocation processes;
    - develop a concise and clear joint UN "HIV and gender" plan; and
    - act now to maintain HIV technical expertise in the Joint Programme.

43. Several implications and considerations emerged from the evaluation.
    - The architecture of the Joint Programme and the roles and responsibilities of the Cosponsors and Secretariat need to be re-examined at the level of the Committee of Cosponsoring Organizations for the Joint Programme to be able to effectively support efforts to end AIDS by 2030.
    - How resources are mobilized and allocated and the extent to which Cosponsors can leverage their organizational mandates and resources beyond HIV-specific funds will need to be considered if the Joint Programme is to remain viable.
    - Uncertainties related to the overall impact of the COVID-19 pandemic on the HIV response (most likely compounding existing challenges of mobilizing resources for UNAIDS) could jeopardize the current model of the Joint Programme.
    - A consultative process to develop UNAIDS' next budget and accountability framework is needed (in parallel with the Strategy process) to ensure continuous support from the Joint Programme to countries.

44. The report of the evaluation of the UN System response to AIDS Report is available here: Independent evaluation of the UN System response to AIDS 2016–2019. The presentation is available here: Independent evaluation presentation.

UNAIDS Joint Programme interim management response to the independent evaluation of the UN system response to AIDS 2016–2019

45. Tim Martineau, UNAIDS Deputy Executive Director (Management) *ad interim,* presented on the interim management response to the independent evaluation of the UN system response to AIDS 2016–2019. A summary of his remarks follows.

46. The interim management response was submitted to the Evaluation Office on 1 September, in line with UNAIDS' Evaluation Policy. The response was developed through a joint and inclusive undertaking bringing together teams from across the entire Joint Programme. A Joint Programme steering group, co-led by the Committee of Cosponsoring Organizations chair (UNDP) and the Secretariat, guided the development of the management response. A Secretariat working group solicited and consolidated inputs from country level and regional joint teams and coordinated with global cosponsor technical leads.

Summary of management response to recommendations

Strategic Recommendations	Management response
1. Joint Programme: prioritise programming in a more strategic and pragmatic way.	• Continue to strengthen the strategic focus of support to countries and their HIV, health and development strategies and plans. • Ensure that the HIV response is fully resourced through domestic investment and leveraging support of Global Fund and bilateral programmes including PEPFAR
2. Revise the UBRAF Theory of Change, results framework and M&E systems to better capture the contribution of the Joint Programme to global and country-level outcomes	• A more fully elaborated theory of change and updated results framework will better reflect the Joint Programme's contributions to outputs, outcomes and impact. • The results framework will reflect UNAIDS' role in the development and implementation of policies and strategies that are nationally-owned and led
3. Address head-on the future architecture of the Joint Programme	• The Joint Programme will evolve in line with what is needed to best respond to an evolving epidemic; including in relation to the COVID-19 pandemic • Through the next UBRAF, the Joint Programme will better articulate the skills, knowledge, experience and partnerships towards achieving the goals of the Strategy
4. Joint Programme: invest more in working better together	• Further strengthen the emphasis on joint planning aligned to people-centred targets; enhance the programmatic focus of joint planning at the global level • Improve the strategic focus and the catalytic power of the joint planning at country and regional levels; and maintain and expand technical partnerships beyond the Joint Programme.

Operational Recommendations	Management response
5. Secretariat: develop a Joint Programme resource mobilisation strategy that is linked directly to the UN System Strategy and Unified Budget.	• Ensure that expectations of Strategy and UBRAF, and resources for the Joint Programme are aligned. • Review and enhance UNAIDS Resource Mobilization Strategy 2018-2021, with a view to ensuring a fully-resourced UBRAF
6. Joint Programme: sharpen – and possibly overhaul – its resource allocation processes.	• Review allocation of resources showing the deployment of human and financial resources that will best support countries to achieve their HIV targets. • A more fully articulated theory of change and the revised results framework will promote greater clarity regarding the required inputs and associated costs across the Joint Programme for delivery of the new UBRAF.
7. Joint Programme: develop a concise and clear Joint UN 'HIV and gender' plan to facilitate the implementation of strategic gender commitments	• Management agrees with the need to clarify strategic directions and focus vis-a-vis gender and HIV. • This is best accomplished not through a separate HIV and gender plan but through a dual approach to gender: (1) maintaining a specific results area in the UBRAF; (2) ensuring gender mainstreaming across all deliverables and results areas.
8. Act now to maintain HIV technical expertise in Joint Programme Response	• Staff are the greatest asset across the Joint Programme and primary investment vis-à-vis UBRAF resources. • The new UBRAF will reflect the mix of HIV-specific and non-HIV-specific (HIV-sensitive) expertise being leveraged to support countries to achieve HIV targets

47. Next steps of this process involve:
- stakeholder engagement to develop the next UNAIDS Strategy and elaborate the new UBRAF, the institutional review of the UNAIDS Secretariat, while overall leadership of the CCO will ensure that UNAIDS keeps up with an evolving epidemic and context;
- the interim management response will be updated and refined, as necessary, taking into account the ongoing Strategy consultations and based on the discussions on the

next Strategy and the next UBRAF at the November 2020 meeting of the Committee of Cosponsoring Organizations;
- during the 2nd half of September 2020, a Joint Programme Working Group will be convened to conceptualize and develop the next UBRAF; and
- the evaluation report and management response will be submitted to the PCB ahead of its 47th meeting in December 2020.

48. The Interim Management response to the Evaluation of the UN System Response to AIDS is available here: Interim Management Response. The presentation is available here: Interim Management Response presentation.

Update on the 2025 target-setting and resource needs estimates process

49. Peter Ghys, UNAIDS Director, Strategic Information Department, presented on the 2025 target-setting process. A summary of his remarks follows.

50. As we approach the end of this year, the 2020 targets will soon elapse. While the current UNAIDS Strategy concludes at the end of 2021, we are looking at the SDG horizon through to 2030. UNAIDS is in the process of producing the mid-term programmatic targets for 2025; estimate of epidemiological impact from 2021–2030 and global price tag/resource needs for 2021–2030.

51. A steering committee for this work has been established. With inputs from the Impact Modelling Advisory Group, members of the steering group (comprising representatives from countries, civil society stakeholders, the U.S. President's Emergency Plan for AIDS Relief [PEPFAR], the Global Fund) have conducted thematic technical consultations to produce programmatic targets for: (i) testing and treatment; (ii) prevention; (iii) PMTCT; (iv) social enablers; and (v) integration.

52. The results are scheduled to be released by November 2020. Indicative draft targets cover the following areas:
    - 95–95–95 testing and treatment targets achieved within all subpopulations and age groups;
    - person-centred, prioritized combination prevention approaches which provide choices that can achieve 90% utilization of appropriate prevention options among all people at risk of HIV infection;
    - people-centred and context-specific integrated approaches that support the achievement of 2025 targets and that can result in 90% coverage of TB, sexually transmitted infection, viral hepatitis, human papillomavirus, cervical cancer, mental health, cardiovascular disease, diabetes and sexual and gender-based violence services among people living with HIV and all populations at risk of HIV infection; and
    - targets towards supportive legal and policy environments, access to justice, gender equality and a society free of HIV-related stigma and discrimination.

53. The presentation is available here: Target-setting presentation.

Global AIDS Strategy and UNAIDS Strategy key terms and next steps

54. Tina Boonto, Coordinator, Strategy Development, UNAIDS, presented on the Global AIDS Strategy and next steps. A summary of her remarks follows.

55. As requested by the PCB, UNAIDS has undertaken a review of the current UNAIDS Strategy and its implementation to assess what has worked and what needs to change

for the next global AIDS Strategy to remain ambitious, visionary and evidence-based. The review will inform the development of the next global AIDS Strategy.

56. It is envisaged that the next Strategy will be a road map to guide global, regional and country-level HIV responses and will define the UNAIDS contribution and its support to countries, communities and partners. It is also expected that the Strategy, with new global targets and resource needs estimates for 2025, will help inform the next UN General Assembly High-Level Meeting on Ending AIDS and the political declaration expected to be agreed on at that meeting, and will build momentum and political commitment for achieving the goal of ending AIDS as a public health threat by 2030 as part of the SDGs.

57. The following actions have been undertaken by UNAIDS thus far:

Month	Strategy Development Process
February 2020	Established an internal Strategy development team
February 2020	Organized a Joint Programme retreat
On-going	Engaged the UNAIDS Advisory Group on programmatic and crosscutting issues that are critical to ensure the next UNAIDS Strategy addresses gaps and areas where the current HIV response in not on-track.
July 2020	Completed an evidence review of the implementation of the 2016–2021 UNAIDS Strategy, which assesses what is working and what needs to be sustained to build on positive momentum, especially in the areas where the evidence-informed approaches in the current UNAIDS Strategy remain sound but have not been implemented with sufficient speed, quality or scale.
May-August 2020	Conducted a global online survey in 16 languages with a total of over 8300 respondents from 163 countries to gauge stakeholder feedback on the current Strategy as well as priorities, barriers and "game-changers" for the next Global Strategy.
June 2020	Conducted 65 in-depth stakeholder interviews.
On-going	Held a series of focus group discussions with additional focus group discussions carried out by partners and stakeholders.
August 2020	Organized a workshop to examine the inputs received so far and review recurring themes and issues which need to be addressed in developing the next Strategy.

58. Next steps to deliver the next UNAIDS global AIDS Strategy:

Month	Strategy Development Process
October 2020	Briefing to PCB members and observers on outcome of Multistakeholder Consultation and presentation of recommended Strategy option.
October 2020	Submission of a proposal for the Strategy option to PCB for intersessional decision.
December 2020	Submission of annotated outline of the Strategy for PCB consideration at the 47th PCB meeting.
March 2021	Submission of the next UNAIDS global AIDS Strategy for PCB approval in March 2021.

59. Participants of the Multistakeholder Consultation were invited to send additional inputs in writing to Strategyteam@unaids.org.

60. The background note for the Multistakeholder Consultation is available here: Background note to consultation. The presentation is available here: Key terms and next steps presentation.

Breakout group discussions: Building priorities with focus, coherence, and impact

61. The evidence review and stakeholder consultations demonstrate that the strategic priority areas of the current UNAIDS Strategy remain highly relevant. The review also demonstrates that some areas of the Strategy have not received adequate attention and that there is a need for a serious rethink on how to regroup and accelerate results across all countries, contexts and populations. Key themes and priorities arising from the evidence review and stakeholder inputs on the review of the current UNAIDS Strategy set out the key strategic questions that were discussed during the Multistakeholder Consultation.

List of topics for breakout group discussions	
Political leadership and financing (parallel breakout groups were conducted in English and French)	Partnerships and accountability
COVID-19	Key populations
Adolescents girls and young women	Community-led responses
Eliminating stigma, discrimination, and punitive laws: towards enabling social and legal environments	Regional specificity
HIV and Universal Health Coverage (UHC)	Multisectorality
Inequalities	

62. Highlights of the group discussions are summarized below and the detailed notes from each group are available in Annex 4.

A. Political leadership and financing

63. Participants in the group discussion emphasized the need to demonstrate the value for money of HIV responses and produce evidence that HIV programmes are catalysts for positive economic and health outcomes. Participants stressed that the economic, social and health consequences of failure in the HIV response must also be articulated more clearly. The next Strategy should amplify the role of communities as "game-changers" on human rights and gender equality as well as in increasing access to health services. Predictable financing for community-led responses should be increased. Participants suggested pursuing dialogues with ministers of finance. It was also suggested that resources should be tracked at subnational level and that there should be greater transparency in how money is being used for results.

B. Partnerships and accountability

64. Given the complex, multisectoral nature of the AIDS epidemic and response, no single entity or sector can drive the HIV response on its own, underscoring the need for strategic, results-driven partnerships and collaborations that synergize the contributions of diverse actors. Especially in an era of resource constraints, ensuring the accountability of each partner and sector for results is pivotal for maximizing the efficiency, effectiveness and impact of the HIV response.

65. Partnerships and accountability have long been cornerstones of the HIV response. The UNAIDS Strategy 2016–2021 adopts as an operating principle the meaningful involvement of civil society, including people living with HIV. It also prioritizes actions to strengthen and adapt the Joint Programme's partnerships across diverse elements of the response. Towards accountability for results, the HIV response has developed a series of concrete, time-bound targets and established among the most detailed, timely and comprehensive systems in global health for monitoring progress towards targets. The Joint Programme's UBRAF incorporates indicators and regular reporting, to enable stakeholders to link resources and efforts with specific outcomes and results.

66. The participants in the group discussion emphasized the importance of alignment of the UNAIDS global AIDS Strategy with the strategies of other global partners, such as the Global Fund, PEPFAR, UNITAID and the Stop TB Partnership, with different roles and accountabilities clearly defined. The need to have sustainable partnerships and build local capacity was emphasized, as was the need for appropriate kinds of technical support, including South-South collaboration. The role of the UNAIDS Joint Programme was also discussed and increasing the capacity of UN country teams was stressed. Discussion participants also suggested that community-led monitoring be strengthened for increase accountability and that people living with and affected by HIV must be at the centre and fully involved in decision-making.

C. COVID-19

67. The COVID-19 pandemic poses profound threats to the sustainability and effectiveness of the HIV response. The pandemic has disrupted both health service delivery and the supply chains for medicines and other essential health commodities. Due to COVID-19 control measures, such as lockdowns and physical distancing requirements, the face-to face encounters relied on in HIV prevention service delivery, HIV testing, peer-led adherence support and other HIV services have been rendered more challenging or sometimes impossible.

68. COVID-19 has the potential to divert HIV funding toward other health priorities, and the sharp economic downturns associated with the pandemic may diminish national fiscal space and reduce future investments in HIV and other health programmes. Although it is uncertain how long the world will be living with COVID-19, it is clear that the HIV response will need to be flexible, adaptable and innovative in navigating the challenges of this new era. While COVID-19 is challenging the HIV response, it is also offering important new opportunities that should be seized. In dozens of countries, national HIV leaderships are playing leading roles in COVID-19 responses, highlighting the strategic value of HIV leadership, investments and expertise.

69. Participants in the group discussion stressed that the COVID-19 pandemic has taught us the importance of coordination across communities, government sectors and private entities. It has shown the importance of service providers, laboratory networks and civil

society to work together with public health infrastructure and private sector to avoid duplication. The COVID-19 epidemic has also highlighted the need for strong social protection measures that should be maintained post-COVID. The COVID-19 epidemic has also highlighted the fragility of the gains in the HIV response and the need to prepare better for a response in crisis. This should be recognized in the next Strategy. The participants emphasized that the next global AIDS Strategy should stay focused on HIV but there should be increased emphasis to social protection, food security and clean water as elements that impact on HIV outcomes, especially in a crisis.

D. Key populations

70. Effectively addressing the HIV-related needs of key populations is crucial for ending AIDS as a public health threat. In 2019, key populations and their sexual partners accounted for 62% of new HIV infections, including a majority of new infections in every region except for eastern and southern Africa. Key populations disproportionately experience stigmatization, social marginalization and criminalization that block access to services that are readily available to other people. Lack of robust data on access and outcomes for key populations undermines the ability to monitor progress in these populations.

71. Funding for key population-led organizations remains limited, although key population networks have had success in some settings in mobilizing resources from private sources. HIV programmes for key populations are largely dependent on international funding, with limited domestic public sector investments to date. In many upper-middle-income countries, the withdrawal of donor support for key population programmes has led to diminished service access and the disruption of service systems.

72. Participants in the group discussed the role of the UNAIDS Joint Programme in brokering and strengthening relationships between networks of key populations and governments and emphasized that key populations, including young key populations, need to be engaged and represented in the planning and delivery of services to their peers. Discussion participants stressed the need for structural interventions for key populations and the imperative of multisectoral responses that include law and policy reform, training of police and judiciary and addressing violence and harassment of key populations. Participants called for population size estimates, disaggregation of data and better data on the coverage of programmes for key populations.

E. Adolescents girls and young women

73. The AIDS epidemic cannot be ended without marked and sustained progress in addressing the HIV-related needs of adolescent girls and young women. This is especially true in sub-Saharan Africa, where national epidemics are often driven in large measure by HIV acquisition among adolescent girls and young women. Young women aged 15–24 years make up 10% of the population of sub-Saharan Africa but account for 24% of the region's new HIV infections. Although the number of young women who newly acquired HIV declined by 34% from 2010–2019, the number of new infections in this population in 2019 (280 000) was nearly three times higher than the 2020 target of 100 000 per year. Compared to adults living with HIV, young people living with HIV are less likely to know their HIV status, receive antiretroviral therapy, remain engaged in HIV care and achieve viral suppression.

74. The group emphasized the need for a holistic approach and for service integration beyond just health. The role of schools was emphasized for comprehensive sexuality education, as was the need for social protection measures for out-of-school adolescent

girls, young mothers and others who are highly vulnerable. Participants stressed that combination prevention should be scaled up, with PrEP and other female-controlled prevention tools integrated into the package of interventions for at-risk adolescent girls and young women. The participants also emphasized the importance of community-led interventions, engagement of men and boys, as well as empowerment of adolescent girls and young women to access services and make their voices heard. The need to lower the age of consent for independent access to services was also discussed. There were calls for more granular data and improved age disaggregation of data.

F. Community-led responses

75. Communities have served as a critical partner in the HIV response, which has long been committed to the greater involvement of people living with HIV in all aspects of decision-making on the response. Communities are uniquely effective as advocates for a stronger and more people-centred HIV response, fulfil an essential accountability watchdog function, provide mutual support and deliver vital prevention, treatment and care services.

76. Community engagement in national AIDS commissions, country coordinating mechanisms and multilateral governing bodies helps identify key issues and gaps that otherwise often go unnoticed or unaddressed. As a result of community leadership, the depth and breadth of information available on key gaps in the response have increased. Community-led monitoring and advocacy in norm setting spaces, such as with UN Treaty Bodies, has also improved the human rights climate for an effective HIV response. The essential role of communities in the HIV response has been underscored during the COVID-19 pandemic, as communities have rapidly filled gaps left by health system disruptions to ensure preservation of HIV services. For the future of the HIV response, empowering communities and putting communities at the centre of the response were ranked among the most important “game-changers” in the online survey on the next UNAIDS Strategy.

77. Participants of the group discussion discussed the ways in which community-led responses can become part of Universal Health Coverage. It was also suggested that a basic package of services be defined for community-based implementation to reach key populations. Participants suggested that social contracting with civil society organizations should be the norm rather than an exception. Participants stressed that long-term investments were needed to allow communities to be at the centre of the response. The need for communities to maintain their independent watch-dog roles, with adequate funding, was also seen as crucial going forward. Participants emphasized that community-led responses should be integrated across all strategic areas. The need for capacity building and technical support to community groups was also noted.

G. Eliminating stigma, discrimination, and punitive laws: towards enabling social and legal environments

78. Stigma, discrimination and social exclusion continue to drive the AIDS epidemic, increasing vulnerability to HIV, deterring people from seeking essential health services and exposing people living with or at risk of HIV to social and physical harm. Among the principles guiding the HIV response, stakeholders who provided feedback on the next Strategy regarded removing stigma and discrimination as the most important.

79. The group discussion focused on some key issues which the group agreed were important to advance progress on eliminating stigma and discrimination. They include ensuring sufficient resources are available to support community and key population

actors for monitoring and documenting cases of human rights violations and discrimination, for advocating for and ensuring access to legal protection, and for capacity strengthening and campaigns for change. There is urgent need to link up with broader national agendas to address discrimination and ensure information and antidiscrimination campaigns are well understood and supported by the broader general population.

H. Regional specificity

80. A one-size-fits-all approach is not effective for HIV, which requires tailored approaches that fit epidemiological patterns and political economies in different regions and countries. Slow progress in many regions and countries underscores the need for new strategies that are specifically designed for different settings.

81. Key messages from the group discussion included the need to make accessible to programme implementers and decision-makers accurate data and evidence are is specific to regions and countries, and to mobilize political will and commitment with corresponding resources. Each region needs to invest in strengthening data systems and updating data systems by maximizing state-of-the-art technologies and innovations. The group highlighted how COVID-19 has demonstrated the interconnectedness of health, economy inequality and social development, which provides entry points for regional advocacy to strengthen health systems, Universal Health Coverage, revive multisectoral, people-centred approaches and address social protection and preparedness for humanitarian crises by ensuring sustainable, resilient HIV responses. Political will and commitment and corresponding resources will need to be secured at regional and national levels.

I. HIV and Universal Health Coverage

82. In 2019, UN Member States adopted a high-level political declaration on Universal Health Coverage to protect people from financial ruin due to health costs and to reach those who are furthest behind first; implement high-impact health interventions to combat diseases, protect health and promote wellbeing; strengthen the health workforce and infrastructure; and to reinforce governance capacity to achieve these goals. Commitments to ending AIDS and achieving Universal Health Coverage are mutually reinforcing: the latter will not be achieved without ending AIDS, and ending AIDS will not be achieved without a clear commitment to Universal Health Coverage.

83. Group discussions highlighted key issues, including the need to define concrete targets for domestic financing of sustainable and resilient health care for people. There needs to be more urgent and consistent coordination, collaboration and cooperation between health and finance ministries to implement multisectoral responses (beyond governments, and including communities and the private sector) and for a people-centred approach that provides integration of services to promote the health and wellbeing of people across the entire life-cycle (human rights, gender, and TB and HIV integration are obvious areas that are insufficiently covered).

84. HIV is still not adequately integrated in Universal Health Coverage. In addition to treatment, integration needs to occur across all six building blocks of the health system: (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance. The group also stressed the importance of having data systems to collect evidence and monitor programme implementation, and which are accessible to programme implementers, communities, policy- and decision-makers.

J. Multisectorality

85. Since the early phases of the HIV response, it has been clear that HIV cannot be effectively addressed only by the health sector. Education has been shown to reduce young people's risk of acquiring HIV; employers and workers play key roles in raising HIV awareness and increasing access to HIV services; diverse social protection services minimize HIV vulnerability and mitigate the epidemic's impact; justice and law are pivotal for combating HIV discrimination and enabling robust service access; and trade and economic systems have a profound effect on countries' fiscal capacity to invest in HIV responses. The multisectoral, all-society approach pioneered by the HIV response is now also a key principle of the 2030 Sustainable Development Agenda. Stakeholders who provided input for the next UNAIDS Strategy emphasized the need for a more multisectoral approach to HIV.

86. The group discussion focused on how multisectorality must emphasize a people-centered approach. Multisectoral responses must involve civil society, and the public and private sectors. Clear indicators for multisectoral activities will be essential for ensuring corresponding resource allocation. It is also important to address the linkages between multisectorality and integration, and to leverage the political will that exists for the COVID-19 pandemic also for HIV and TB responses.

K. Inequalities

87. The review of the current UNAIDS Strategy demonstrates that HIV is often driven by inequalities. Unequal access to health and social services often mirrors, exacerbates and overlaps with other inequalities, including gender inequalities and inequalities resulting from discrimination based on income, race, age, ethnicity, disability, educational attainment, immigration status or sexual orientation. However, many of the inequalities and differential patterns that define HIV in different settings are unexpected and counterintuitive. For example, the countries with the most resources are not always the ones with the strongest or most sustainable HIV responses.

88. The group noted that addressing inequality is a common threat in the 2030 Sustainable Development Agenda and that the next UNAIDS Strategy is an opportunity to strengthen the inequality lens in the HIV response. The group stressed the importance of data collection, disaggregation and analysis, including the need to look beyond HIV-related data. The role of communities in collecting data on inequalities was emphasized. The group also stressed the imperative for action even in situations where there are gaps in data, especially in situations where there is a lack of political will to collect data that is needed to better target the HIV services to the people who need them most, including marginalized and criminalized populations. The group highlighted the importance for the next Strategy to reach the most excluded and hardest to reach and disenfranchised individuals, populations and communities as priorities.

89. The group discussions also noted that the COVID-19 pandemic illustrates how intersecting inequalities shape the health outcomes of people in different ethnic and income groups. This emphasizes the importance of data disaggregation and information on employment, education, civil engagement, inequality and underlying health and social needs and gaps. The group recommended that UNAIDS expand the evidence base to include data from other sources in order to advocate for robust action on inequalities that present barriers to reaching targets.

Conclusion

90. The Multistakeholder Consultation on 16 September 2020 was an important milestone in the Strategy development process. It brought together stakeholders to inform, engage and solicit feedback on priorities for the next global AIDS Strategy. The stakeholders provided critical inputs and guidance for the development of the draft framework of the next Strategy, which will include: (i) guiding principles; (ii) strategic priorities; (iii) result areas and actions; and (iv) an accountability framework.

91. The UNAIDS Strategy development process now transitions into the Strategy development phase, with updates to be considered during briefings and meeting of the UNAIDS PCB.

92. Following the PCB briefing on 15 October 2020 and the adoption of the intersessional decision on the option for development of the UNAIDS Strategy, the outcomes of the Strategy review and the inputs provided during the Multistakeholder Consultation will be considered as a basis for discussion and further consultation with PCB members and observers.

93. A detailed annotated outline of the next UNAIDS Strategy, which will integrate new global HIV targets and resource needs estimates for 2025, will be presented to the 47th meeting of the PCB in December 2020. The next UNAIDS Global AIDS Strategy will provide a critical link to inform the preparations for the next UN General Assembly High-Level Meeting on AIDS. During this Strategy development phase, UNAIDS will continue to consult and collaborate with stakeholders in drafting and finalizing the Strategy.

Annex 1

Agenda

UNAIDS Multistakeholder Consultation on next Global AIDS Strategy

Virtual ZOOM Platform, 16 September 2020, 13h00 – 17h00 (Geneva time)

Time	Duration	Description	Speakers
Framing a new vision			
13h00	5 min	**Welcome, meeting objectives and technical housekeeping**	Moderator
13h05	15 min	**Opening session: Setting the path for a next global AIDS Strategy**	Winnie Byanyima, Executive Director, UNAIDS
Gathering the evidence to framing a next Strategy that continuous to be visionary and evidence-based			
13h20	15 min	**Findings of the evidence review of the current UNAIDS 2016–2021 Strategy: Measuring impact, successes and challenges**	Moderator Shannon Hader, Deputy Executive Director, Programme, UNAIDS
13h35	10 min	**Global consultations: feedback stakeholders** Evidence from survey, key informant interviews, focus group discussions and the workshop	Gloria Bille, Fast-Track Adviser, UNAIDS
13h45	5 min	**Independent Evaluation of the UN system response to AIDS in 2016-2019**	Joel Rehnstrom, Director, Evaluation, UNAIDS
13h50	5 min	**UNAIDS Joint Programme interim management response to the independent evaluation of the UN system response to AIDS 2016-2019**	Tim Martineau, Deputy Executive Director a.i, Management, UNAIDS
13h55	10 min	**Update on the 2025 target-setting and resource needs estimates process**	Peter Ghys, Director, Strategic Information, UNAIDS

14h05	25 min	**Based on the evidence, what are we noticing that needs to change for us to move the dial on the Global AIDS Strategy?** 1. In our approach? 2. In our ecosystem?	Plenary discussion

Moving from evidence and inputs into a next Global AIDS Strategy			
14h30	10 min	**Global AIDS Strategy and UNAIDS Strategy Key terms and next steps**	Tina Boonto, Coordinator, Strategy Development, UNAIDS
Discussion in groups around priority themes			
14h40	5 min	**Building priorities with focus, coherence and impact**	Moderator
14h45 - 15h45	60 min	**Themes:** 1. Political leadership and financing 1B. Political leadership and financing (French language) 2. Partnerships and accountability 3. COVID-19 4. Key populations 5. Adolescents girls and young women 6. Community-led responses 7. Eliminating stigma, discrimination and punitive laws: towards enabling social and legal environments 8. Regional specificity 9. HIV and Universal Health Coverage 10. Multisectorality 11. Inequalities 12. Independent Evaluation of the UN system response to AIDS	Moderator
15h45 – 15h55 Break (10min)			
Learning from each other, moving to Phase 2			
15h55	5 min	**A closer look to evidence and resulting strategic priorities**	Moderator
16h00	30 min	**Gallery walk**	Groups

16h30	22 min	**Participant reflections**	Moderator
16h52	8 min	**Closing**	Winnie Byanyima, Executive Director, UNAIDS

Annex 2

List of participants

NEXT GLOBAL AIDS STRATEGY /

PROCHAINE STRATEGIE MONDIALE DE LUTTE CONTRE LE SIDA

As at: September 22, 2020

UNAIDS MULTISTAKEHOLDER CONSULTATION / CONSULTATION MULTIPARTITE DE L'ONUSIDA

Date: 16th September 2020 / 16 septembre 2020

Venue: Zoom virtual conference

List of Participants – Liste des Participants

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Annex 3

Detailed notes from group discussions

Political leadership and financing

What needs to be amplified that would be a ”game-changer” to the response?

- We need to remind politician and stakeholders that AIDS is not over, and it is still killing people. We need to counter the false sense of security and complacency that AIDS is over.
- We need to speak clearly about what have we not done, and revitalize political commitment to address issues where there are major gaps, such as paediatric treatment.
- Demonstrate the value for money to leaders and produce evidence that HIV programmes are a catalyst for economic and health outcomes, and that the negative consequences will be worse if we do not address HIV.
- Articulate the consequences of failure in maintaining progress against HIV in impact measures that draw attention of politicians and policymakers—economic impact, impact on human capital and growth—and demonstrate that addressing AIDS will have a broader social impact and address a range of issues.
- Learn from the response so far and amplify how the role of community-led responses, addressing rights and gender, and access to medicine have been "game-changers" with impact on other health issues.

What will help us to move from commitments to action?

- Expand the dialogue with the Ministers of Finance to make the case that HIV investments are investments in human capital and economies that will deliver for health and broader SDGs.
- Financing: there will either be a recession or a major transformation. We must position the HIV response, Global Fund resources in the financing dialogue and global solidarity.
- Link and build HIV movement activists and campaigners to take a lead role in the broader UHC movement, bringing the needs of the HIV movement to the broader health sector and UHC and to broader SDG discussions and movement, particularly on issues that cut across HIV and beyond it, and use this to maintain pressure on parliamentarians and governments.
- Influence parliamentarians to support harm reduction programmes.
- Continue lobbying with political leaders to increase domestic resources to sustain the results. There is need for technical assistance to build arguments tailored to the political leaders' interest; different political leaders might have different interests.
- Working with communities on the ground and building a joint movement and advocacy/lobbying for DRM can be influential.
- Increase predictable financing for community-led responses.

What is needed to improve our capacity to measure and monitor accountability in responses?

- Demonstrate that investing in AIDS has improved systems and challenge the belief that AIDS is vertical, advocate for HIV and UHC without losing our focus on outcomes.
- Granularity and tracking resources at subnational level and be transparent that the money is being used for results, including how money is being used by communities to deliver results.

- Measure and demonstrate how investments on AIDS have impact on broader social and development issues.

Partnerships and accountability

What needs to be amplified that would be a ”game-changer” to the response?

- Alignment with the strategies of key partners will be a big “game-changer”, e.g. PEPFAR, Global Fund Strategy, Stop TB.
- We need to be able to describe different roles and accountabilities. There is always going to be some crossover; we need clarity on who is accountable for what. In addition to sharing strategies, we should be driving towards a shared vision for the global HIV response—this should be cascaded and amplified throughout other strategies.
- We need to be able to review progress, to be flexible and recognize when we need to change direction, which can sometimes go against key populations. Maybe this is a governance issue. Maybe it is about "how"; we need to use lessons from COVID-19 and be prepared to shift modalities of delivery.
- On the point of addressing human rights issues, what are our mandates? All enabling environment modalities need to be clearly articulated in relation to health outcomes and make them measurable as much as possible.
- We also need to understand where resources are being allocated so there is no vacuum.
- We need more transparent accountability mechanisms and capacity building. We must also engage with key populations.
- About linking to other strategies and accountability, there is a key role for community and civil society that needs to be budgeted for. The response needs mechanisms to channel money where it exists and to ensure adequate resourcing for all partners.
- We need to leverage health systems strengthening for social systems. There is an opportunity to do this in context of COVID-19.
- Building sustainable partnerships. There is an important case for ensuring that when support comes in it must sustain local capacity. This should also be linked to technical support. We need to ensure the right kinds of technical assistance (e.g. South-South support) are being delivered in the right way.
- We need to do capacity building in parallel to what we are doing so we can keep our timelines moving. We need a shared vision of the future.
- We need to ensure everything we do links to countries.
- We need to enhance our focus on prevention. Keep the balance between biomedical, treatment and prevention interventions. We need to sharpen our focus on prevention in right places with the right modalities and approaches.

What will help us to move from commitments to action?

- We need to note the roles and accountability of all players. The Global Action Plan needs to be brought out as a stronger theme. We need to go beyond linking strategies to embedding accountability in key populations and targets.
- We need to ensure there is adequate funding to support civil society organizations and community partners and key populations in moving community participation from aspirational to actual.
- We need to get better at using data for decision making and generating the data we need to have, e.g. gender-disaggregated data and other data to help us understand inequities and how to address them. There needs to be an ongoing focus and scale-up of community-led monitoring. We need a better understanding of which partner is best placed to play what roles.

- We need to narrow down in terms of what we are doing. We are being overly ambitious. How do we limit ourselves to key priorities, so we are not overwhelmed? We need focus on key priorities that are achievable while still being ambitious and ensure our work remains grounded in our mandate.
- How do we deal with reaching our target groups? Dealing with HIV and human rights issues in a multifaceted situation. How do we make sure we do not lose that?
- What is different about UNAIDS is the country offices and how critical they are to the response. The county office presence needs to be emphasized. They are key to achieving results and have been underplayed. We need greater capacity among country teams.

What is needed to improve our capacity to measure and monitor responses?

- We need to address human rights and legal barriers at the country level.
- Community-led monitoring needs to be strengthened.
- We need to improve capacity at the country level; there is crossover from above.
- We need to better leverage private sector engagement for building capacity.
- Staff need to be on-board and working towards the same goals. We need to do check-ins to remind people of what has been agreed to collectively and individually and how to do course corrections when needed.

What are the priority concerns and Strategy calls for attention to and engagement with people living with HIV?

- Ensure that people living with HIV are at the center of the response.
- UNAIDS was in forefront of engaging people living with HIV. There are a number of other partners that do not really model it to same extent, including some Cosponsors. It would be important to ensure that we are not losing track of that principle across the global health architecture. If we are looking at COVID-19, the meaningful engagement of community is key. We need to ensure that people living with HIV in all their diversity are at the decision-making table, including young women and adolescent girls and young key populations. The HIV movement has a responsibility to ensure meaningful engagement is amplified as needed.
- We need to zero down on what will help us to move fast. What will help us to improve? What kind of measures will help us to be accountable?

Other

- All partners need to ensure their work is clearly and transparently communicated.
- We talk about ending AIDS by 2030; it is important that this is clear and shared.
- How do we ensure that the gains we have made in the HIV response are not lost? It is easy to get lost when other issues arise e.g. COVID-19.
- We should not lose sight of finding a vaccine for HIV. We need to continue pushing science.

<u>COVID-19</u>

What needs to be amplified that would be a "game-changer" to the response?

- Coordination across communities, sectors, public and private entities has worked!
- COVID-19 has taught us the importance of service providers, lab networks and civil society working together with public health structures and the private sector to avoid duplication. UNAIDS should emphasize the importance of this coordination, it has

worked well for the COVID response and could be a pathway to address the AIDS epidemic and potentially serve as a platform for other diseases.

- Protection, food security mental health and better access to technology have all been essential in the COVID response and especially important for marginalized populations such as key populations. We have an opportunity to recommit to these elements. They are ESSENTIAL!
- HIV-sensitive social protection initiatives need to be included in the next Strategy.
- Key population, adolescent and women should be included in the social protection initiatives. Protect key populations: enabling safe spaces and protection measures to key populations so that they can access services.
- Public sector needs to be strengthened with a focus on the "right to health".
- Including initiatives related to water, food and sanitation security to people living with HIV will guarantee a better HIV response.
- Country-specific catch-up plans are needed for services that have been disrupted. We have seen that services that have been in place for decades are actually fragile and easily disrupted. Catch-up is needed and it should be emphasized for all countries to develop specific plans to get back on track.

What will help us to move from commitments to action?

- Keep focusing on good practices like DSD and multimonth prescribing: They have been in the guidance for years with some uptake, but COVID-19 has accelerated this (especially in some regions) and expanded this to other areas (Hepatitis C, TB, opioid substitution therapy, etc.) We must keep this going "post-COVID".
- UNAIDS and Member States should invest in and build capacity of communities. Communities HAVE responded but without specific support of community-led responses this is not sustainable. We need to enable "safe spaces" for vulnerable populations.
- COVID does not need to be a pillar in the next Strategy, but flexibility, community resilience and preparedness are key to take forward.
- Flexibility community resilience and preparedness needs to be key in the Strategy. COVID should not be a pillar, to keep the focus on HIV, but there are important lessons to take forward.
- UNAIDS should not include another pilar on emerging pandemics. We need to have UNAIDS focus on HIV, BUT at the same time we must strengthen our ability to measure and assess some of the "cofactors" that have been driving poor outcomes, e.g. measuring the SP/food security/WASH needs of people living with HIV. We need better data on these issues.
- Strengthen the investments in community-led responses, so they can develop preparedness to respond to COVID-19 and other emergency issues.

What is needed to improve our capacity to measure and monitor to drive accountability in responses?

- Catch-up plans must include specific targets for populations that are left behind. In the context of catch-up plans that are developed, there should be specific targets and focus on the population that have been left behind—women, girls, young people, kids, men, key populations. This will be context-specific and countries should look at their specific gaps and work to address them.
- Community-led monitoring should be supported and valued. Community-led monitoring is key, but at present their inputs are not valued or prioritized. We should change this to give community-led monitoring more value.

- Better systems to measure and monitor self-care. Need more effective ways to measure/monitor self-care approaches (given the pandemic's opportunity to expand this), such as self-testing.
- How are we adapting testing systems to self-testing and understanding coverage?

Key populations

What needs to be amplified that would be a game-changer to the response?

- UNAIDS needs to work more at country level to broker relationships and support Member States to change the legal environments that hinder service delivery to key populations and people living with HIV.
- Investments in key population-led interventions (30%) and sustainability of resources to conduct service delivery, community monitoring and outreach.
- Young key populations engaged and represented in the planning and delivery of service to their peers.
- Resource mobilization plan to cover the underfunding of harm reduction and people using drugs, and mobilization to deliver and access services.
- Putting in place structural interventions especially for gay men, taking lessons from the DREAMS project on adolescent girls and young women (AGYW) to increase accessibility and affordability.
- Training of police and the judiciary to respect basic human rights to ensure the right to health.
- Addressing issues of migration and key populations because many key populations flee their countries due to criminalization. However, there is no follow-up and accountability on continued access to services.
- Addressing structural barriers and decriminalization by governments especially in humanitarian settings.
- Strengthening the multisectoral response and bringing all service providers on-board at the country level.
- Drug users should be engaged as partners in reaching out to their peers with programmes on harm reduction instead of being criminalized.
- The criminalization of transmission of HIV should be stopped in all countries to increase access to testing and treatment.
- Addressing violence, harassment and extortion of key populations at country level

What will help us to move from commitments to action?

- The global Strategy should get HIV out of isolation and amplified as a global agenda on health and development.
- Commitments made at the African Union on key populations need systematic follow-up and securing government commitment to deliver.
- Improve funding to support key population interventions especially in the underfunded regions like western Africa.
- Allocation of a quarter of resources of programmes to young people, including the capacity for mobilizing their peers.
- Policies on social protection to provide legal service and legal support to key populations and people living with HIV.
- Social contracting partnerships between governments, key populations and people living with HIV.
- Address the question of health-seeking behaviours of key populations and why they are not accessing treatment and care.

- Organizations of key populations and people living with HIV strengthened service delivery to their peers, especially during COVID-19.
- Intergation of sexual and reproductive health, prevention and retention in care for people living with HIV needs to be the focus of the global HIV response instead of setting targets.
- Create more space for female key populations, especially transgender women, to improve access to service and representation.
- Programming on mental health for key populations and people living with HIV.

What is needed to improve our capacity to measure and monitor to drive accountability in responses?

- A data evolution going beyond quantitative to qualitative and simplistic comprehensive approaches.
- Collection of disaggregated data on population size estimates, HIV prevalence, HIV incidence and coverage of key populations in every country.
- Sustained and increased investments in size estimates.
- Improve data collection in African countries to address the glaring gaps in data and evidence on key populations in Africa.
- Engagement of key populations in monitoring and reporting with simplified tools at the community level.

<u>Adolescents girls and young women</u>

What we need to be amplified

- Ensure mechanisms for adolescents and young people (including girls and women) in school platforms to retain and promote treatment adherence.
- Holistic approaches to health for AGYW services, service integration beyond health (income generating programme).
- Stakeholders engagement on AGYW programmes, i.e. private sector, education etc.
- Accessibility of services that are available for AGYW with no stigma and discrimination.
- Scaling up innovations that are AGYW-friendly.
- Addressing the gendered digital divide as we now have a strong need to focus on diversifying access to information and referral services via digital platforms.
- Prioritizing stronger focus of social protection programmes on adolescent girls and women and especially girls and young women who are out of school, young mothers, and those who are highly vulnerable.
- Prevention need to be put high on the agenda and scale up combination prevention, i.e. PrEP integration into family planning.
- IEC and poor packaging for adolescent and young people services need to be revisited.
- Male engagement and involvement as part of agents of change for AGYW and their capacity build.
- Understanding the diversity of AGYW needs.
- Community-led intervention by AGYW and making sure AGYW are at the front and centre of programming and implementation.
- Empowerment and capacity of AGYW to access services and ensuring their voices in making stakeholders accountable.
- Working on violence in general: social and sexual, accelerate education including sexual education both among AGYW and teachers.
- Intensity of prevention packages by population and location.

To move from commitment to action we need

- Focus on intersectional approaches that prioritize holistic programming and integration, recognizing the multiplicity of ways in which AGYW experience their lives. Recognize that COVID-19 has brought to the fore the multiple and intersecting forms of violence, barriers and the need to respond to them.
- At this time, when violence against women and girls is being named as a shadow pandemic, we must recognize the ways in which gender unequal societies are exposing AGYW to harm across board beyond the various public health (COVID, SRHR, HIV etc.) fronts.
- Address the gaps in HIV knowledge/awareness and in prevention needs of adolescent girls and young women, as well as adolescent boys and young men and urge for its accelerated implementation. For instance: develop strategies to reduce stigma and discrimination, invest in knowledge transfer from people affected by HIV, offer comprehensive sexuality education from an early age on availability of effective biomedical prevention tools, such as male and female condoms, treatment as prevention and new, female-controlled tools (PrEP and vaginal ring).
- Reinforce the multisectoral approach in this regard, by e.g. promoting universal and long-term schooling for girls and reinforcing the effective fight against gender inequality and gender-based violence. Make sure that (youth-focused) harm reduction services are available to all, since they remain heavily dependent on external financial and technical support.
- Accelerate gains for adolescent girls and young women in the HIV response will require greater political commitment, smarter programming and attention to the root causes of vulnerability. Stronger investments in primary prevention programmes which especially focus on AGYW are needed. Focused efforts and innovative approaches are needed to incentivize nonhealth sectors to reduce the vulnerability of AGYW—including scale-up of cash transfers and other measures to keep young girls in school, substantially stronger investments in programming to change gender norms and prevent gender-based violence.
- AGYW should be empowered and supported to serve as change agents in their own communities. Key aspects of programmes evaluated in recent universal test-and-treat studies, which succeeded in sharply improving young people's HIV outcomes, should be broadly replicated and brought to scale.
- Further efforts are needed to increase the capacity of healthy systems and service delivery sites to effectively serve AGYW, and intensifies advocacy should word to roll back age-of consent laws and other policies that block young people's access to essential services
- AGYW remain the most vulnerable in our region of the world and we would like to echo some of the inputs by colleagues. The challenge has been applying a blanket approach. It is therefore important that the next Strategy address their special needs and vulnerabilities. Among others is using disaggregated data to tailor interventions comprehensively to address their specific needs. This includes sexual and reproductive health services, stigma and discrimination, and gender-based violence, which all drive the infection rates.
- Working with adolescents and young people through peer-led and -managed networks and community-based organizations.
- Adolescent mothers affected by HIV and their children are a vast and growing population being left behind by the HIV response.

What is needed to improve our capacity to measure and monitor to drive accountability in responses?

- The architecture of the adolescents and young people actions; who hosts them, which constituency do they belong to, who coordinates them and where do they holistically

report their interventions, including young mothers themselves. It highlights the urgent need for holistic, tailored support delivered in and by communities themselves. And it makes recommendations for how to achieve this.

- More granular data to ensure right programming, including mechanisms to report with clear targets.
- Investments on the architecture for AGYW programming and reporting.
- Age disaggregation, ensuring that intervention for 15–19 year-olds and 20–24 year-olds are intensified and well-thought through and transformative.

<u>**Community-led responses**</u>

What needs to be amplified that would be a game-changer to the response?

- With the adequate considerations, but we need to find a balance to guarantee also a leading role of community in health system. It is opportune to have a definition and to set separated targets for community, however we need to advocate for community-led response at the centre of the health system and Universal Health Care. Frequently community-led response is left out from the Universal Health Care and health discussion.
- It is pivotal to revise the WHO building blocks to ensure adequate integration and inclusion of communities. In general, all different systems, including the health framework, need to be adapted to make community-led response stronger, with evidence to support and inform the process. Innovative health system.
- Advocate to slowly move away/phase out from the World Bank classification (gross domestic product) toward an equity base parameter to define negotiations.
- Stigma needs to be better addressed to ensure people can really access to all services. Currently, stigma is captured, but we do not intervene concretely.
- We need to look beyond numbers: key populations groups may represent small numbers, but their need may be very high (e.g. children) and it is a matter of human right. Funding investments should be allocated not only by looking at numbers but also at the needs.
- Define a basic package of service (which goes beyond treatment) which are adequately funded, and where community is considered an essential actor for the success of the deliver and implementation of this package (e.g. to reach key populations).
- HIV/TB collaboration should be strengthened at community level. In general, advocate for a multisectoral response.
- Ensure an amplified community response role, which goes beyond programme implementation but also advocacy functions. Amplifying the voice of the community for different agendas.
- Social contracting needs to become normality and not an exception. Criminalization is a barrier for social contracting.
- Funding mechanisms need to be revised to be fit for purpose for communities. Social contracting needs to be realistic and therefore allow also key populations to play a key role and therefore empower them.
- A "game-changer" is to have long-term investment to allow communities to be at the centre of the response.

What will help us to move from commitments to action?

- Advocate to have a stand-alone pillar in the next Strategy, but at the same time ensure a community crosscutting approach. Community-led response should be considered across all the different responses, for example health system response.

- Advocate for tracking the real investments towards community-led response vis a vis commitment and therefore check discrepancies of investment between bigger nongovernment organizations and small community organizations.
- Need more investments for technical support for communities.Currently there is small investment for capacity building/organization development, which is normally stuck at national/central level and not reaching the grassroots level. Advocate for the use of technical assistance for the community members, to strengthen the capacity of small organizations (e.g. during COVID-19 technology was largely used by big organizations, but small ones were not able to access to it).
- Track investment (multilateral funding allocation) to check if investment is adequate to reach goals/targets and that it is flexible enough to enable communities to invest where they see the needs.
- Key question to raise is: “What needs to be done differently from what has been done so far?” We need to do more at policy level to include communities in health funding and also increase their recognition. In doing so, we need to collaborate with other actors/players, even non-HIV players
- Communities should play a key role within the health system, but across all the different sectors.
- Look beyond health system and instead refer to the person first. We need to advocate for community engagement in their own health for a sustainable response. We need to allow people-centred approach at community level.
- The action plan needs to be weighted in terms of community involvement (a kind of markers to be set): community-led response should be ensured across the different UN agencies response.

What is needed to improve our capacity to measure and monitor to drive accountability in responses?

- The UNAIDS Strategy should use as reference the Rome Action for Paediatric Acceleration Road Map: an example of self-monitored framework. It is made public and each actor involved is made accountable to achieve the targets/goals for a specific portion of the action plan.
- It is important to keep an eye on enablers such as financing factors and systems laws and therefore advocate for an equal and adequate funding approach. Funding allocation for key populations is small if we consider the high levels of new infections among these groups. Finance/funding allocation should be based on scientific data and common sense. Targets should be set for system laws and funding allocation, and be adequately monitored/tracked to enable communities to work.
- Enabling system laws and have dedicated funding to address criminalization. Theory of change approach should be adopted as standard practice, to identify and fix those problems that undermine the community-led response. It is important to address these problems/aspects that undermine the work.

Others

- Before advocate and look at what is a community-led response, it is fundamental to have a clear definition of community (e.g., faith-based organization can be considered as communities?), as well as of key populations.
- Community is a principle that needs to be recognized by all actors and that can make the difference in terms of sustainability of treatment, prevention, support, etc. The role of community should go beyond the implementation of the response, but we need to consider also community-led monitoring as well as research, among others.

- Community should be included in the health system response, but also keep and maintain its independent "watch dog" role to allow the delivery of good services and programmes. Monitoring service accountable for the quality.

Eliminating stigma, discrimination, and punitive laws: towards enabling social and legal environments

What needs to be amplified that would be a game-changer to the response?

- Scale-up of resourcing and institutionalizing development, including social contracting mechanism. Importance of integrated multisectoral and multistakeholder approach, including into national development strategy and framework.
- Catalytic funding needed and progressively monitoring impact.
- Focus on removing legal barriers and decriminalization and include policies and legal framework to protect against violence and violation of human rights.
- Protection against discrimination, including right to privacy (health information)
- Concrete actions include: resourcing and training networks of lawyers; resourcing networks of key populations; ensuring access to sustainable funding.
- Create more space for civil society, amplify community voices to be heard at decision-making levels.
- Meaningful involvement of community in design, implementation and evaluation.

What will help us to move from commitments to action?

- Establish national multistakeholder framework and strategy on ending stigma and discrimination (including strategies for addressing self-stigma).
- Hold leaders accountable.
- Need regional- and national-specificity, with road maps tailored to different context.
- Build alliances beyond the AIDS movement to change broader social norms, engage other sectors in a multisectoral approach and tap into other movements and ensuring HIV is part of the national agenda.
- Education, comprehensive sexuality education and information (correct information) are key to reducing stigma and discrimination.
- Ensure strategies and interventions are effectively communicated to and understood by the general population

What is needed to improve our capacity to measure and monitor to drive accountability in responses?

- Need transparent and measurable poltical commitment to remove punitive laws and protect key populations and people living with HIV against stigma and discrimination .
- Establish comprehensive, real-time monitoring platform to track cases of violations, harrassment, stigma and discrimination (accessible by both government and nongovernment stakeholders).
- Enhance tools for monitoring and evaluating progress against stigma and discrimination (move beyond the Stigma Index and integrate into other national instruments).
- Support and resource community-led monitoring and include as evidence to course-correct programmes and interventions.
- Data protection (confidentiality and prevent misuse of data).
- Set ambitious goals: zero tolerance of stigma and discrimination.
- Acknowledge interlinkages between existence of punitive laws and occurance of stigma and discrimination.
- Use financial and political leverages to push concrete action by governments.

Regional specificity

What needs to be amplified that would be a ”game-changer” to the response?

- UNAIDS should amplify its political role. It is a risk but UNAIDS needs to reboot where the Joint Programme is in the political space. We need to make it clear we don’t just focus on health crises. We should emphasize the need for all people to have dignified and quality health services and we need to fund these services in ways that means they won’t be taken away when the next crises hits.
- We need to sustain high-level political interest in ending AIDS from HOS to ministries of health and ministries of finance. Leadership changes and there are a lot of other pressing issues. We need today’s leaders to recommit to ending AIDS. We need to build a global network of champions in national governments.
- Regionalized reports can help drive this kind of high-level political engagement. The AIDS in Asia report is a good example of both the kind of report and the outcomes it drove. It is a good model for making the investment case for continued support for ending AIDS. We need to articulate the cost of inaction.
- Regional political leadership is key; let some countries lead others, by example.
- We need dedicated staff to keep advocacy efforts strong. Peer support/advocacy can help address stigma and encourage others to take HIV seriously.
- High- and middle-income countries need to be held more accountable; evidence from the global North (on progress against HIV) should be reflected.
- Our next Strategy should have targets disaggregated by regions. Granularity and disaggregated data are essential to measure progress as well as to identify barriers and obstacles. We need to customized/context-specific responses at the regional, country, and local levels.
- While we need bold global targets, it’s not reasonable/fair to expect all countries to achieve them equally (e.g. it may be harder in the Middle East and North Africa than in eastern and southern Africa).
- We need to focus on young people, especially AGYW, because not doing so will really drive rates of new infections up. World leaders need to be made aware that the bulk of new infections are among young people. Faith leaders and their support are critical to the response. We need a well-funded advocacy campaign to keep them engaged in the fight. We need to fund and institutionalize the engagement of young people.
- We can’t forget the issue of HIV and aging.
- Members of parliament and their networks are essential; we need national/regional/global strategies for ensuring strong support from members of parliament.
- Data is key. We need real-time, hyper-local data delivered from the ground-up/frontlines to drive the response/to engender political support (UNAIDS situation room is good example).

What will help us to move from commitment to action?

- We need to ensure there are links between global commitments and targets and regional, subregional and national efforts.
- The role of the African Union is critical. Senior African leadership needs to be reinvigorated/brought into the discussion. The political is as critical as the epidemiological. High-level leadership needs to be informed about barriers at the regional/country/local levels and pressure applied to encourage them to address those barriers.

- Political leadership shifts/changes so be realistic about what is possible. Regional targets must reflect the region's geopolitical reality.
- Reporting against regional targets is essential for HOS/MOH.
- It could be helpful to creative "constructive criticism" between countries, especially those linked regionally.
- Regional networks of countries can come together in collaborative initiatives/regional collaboration—such as the Malaria Alliance—to help and inspire each other to make progress.
- A regional focus should also support regional technical assistance efforts. We need to use different mechanisms in different regions to do this.
- Cultural context, language and social similarities in regions must be considered and reflected. Sometimes, a region that is large and diverse is represented by a small handful of people. We need transparency and appreciation for radically different dynamics in sub-regions of any given region. Regional delegates should be diverse and sufficient in number to accurately represent the full diversity of any given region.
- We need to fund advocacy at the regional level.
- Cultural barriers (in Middle East and North Africa e.g.) mean that sometimes the government isn't best-positioned to drive the response. This is where UNAIDS can play a more significant role, highlighting barriers/solutions when a government can't/won't. UNAIDS has the power/strength the governments in some regions don't.
- Some rich countries aren't giving money to their own HIV responses. This is where the Global Fund comes in, closes gaps. But now the Global Fund is pulling out of some countries and gaps need to be closed. We need to focus on antiretrovirals for kids, PrEP and ensuring access to medicines for people living with HIV whose treatment may be interrupted (including due to COVID-19).

What is needed to improve our capacity to measure and monitor to drive accountability in responses?

- Use existing regional mechanisms. Evaluate existing mechanisms (e.g. AESEAN Taskforce on AIDS, SARC etc.) to understand their ability to foster technical collaboration and impact on progress against HIV.
- There are too many multistakeholder meetings/consultations where people get together and express solidarity/pat each other on the back. We need to be honest about what works and what doesn't.
- We need regional accountability mechanisms like AIDS Watch Africa; mechanisms like these ensure civil society is at the table and can hold leaders accountable.
- These accountability mechanisms need to be funded/civil society needs to be funded. If civil society voices aren't brought actively into policy-making dialogues, policies won't reflect actual needs/barriers/solutions.
- Stop pretending all regional mechanisms are equal or equally effective.
- Recognize that governments can work very differently across any region.
- Communities at risk and affected need to engage in regional bodies.
- OAFLA can play a very important role in oversight.
- The quality of data must continue to improve.
- We need balanced, regionally focused scorecards to hold leaders to account.
- UN agencies working together better in concert will help the UN overall.

<u>HIV and Universal Health Coverage</u>

Within the context of HIV and UHC what needs to be amplified that would be a "game-changer" for the response?

- Integration. HIV Integration across the six building blocks of a health system. Life course approach, people do not seek HIV care in isolation. Community health important. Integrate HIV in maternal health where we are already stalling. Women in eastern and southern Africa women contracting HIV while pregnant and breastfeeding. Too much to expect people going to multiple appointments. Where do children go for immunizations, integrate HIV with this and with newborns screening. Integrating sexual and reproductive health rights for young people and involving them in design of services. Prevention, treatment and care into primary care integration. Strengthening community and primary health care, HIV embed into these. Integration is the main ”game-changer”.
- People-centered. Universal Health Coverage aims to ensure that all people can receive high quality and comprehensive services without experiencing financial difficulties and not leave anyone behind including key populations. Voice of the people must be heard. Next Strategy should be based on principle of no-one left behind. Enable people living with HIV to enjoy healthy lives, strengthen comprehensive health systems—not just for HIV, also for noncommunicable diseases etc. Integration of services to promote health and well-being of people living with HIV over the life course. SDG principles of putting those furthest behind first. Epidemic now among key populations but them first.

Health financing strengthened to ensure sustainable health care with domestic resources

- Further cooperation between health and finance ministries should be strengthened in next Strategy. COVID, Universal Health Coverage backbone to protect people from health crisis.
- While we have been strong on service delivery, we are weak on the financing and sustainability side. Need shifting from external to domestic financing.
- Understanding costs and technologies. Forecasting, commodities. Vision on long-term costing and new innovations and how they help beyond HIV. Early infant diagnosis, TB and HIV, but also COVID-19 technologies. Seen as expensive but look at its impact across several diseases, e.g. point-of-care diagnostics. Don't avoid the cost issue. Adaptability assessing costs, and how it is borne over diseases. Hopefully encourage adoption of technologies that are "game-changers" across health issues.
- Notion of integration and person-centered care laudable, but considerable variation and experience. Collecting, reporting and making data visible for decision-making. Moving from theory to practice. Looking at places where Universal Health Coverage exists, analyse factors that lead to, or are associated with certain outcomes. Addressing vertical transmission is easily understood, but then becomes more challenging. Health financing critical, what in a Universal Health Coverage package can we fund? HIV natural connections and intersections, data-driven high-impact step-wise pathway. For instance, giving practical guidance, e.g. start with eMTCT.

Moving from commitments to action

- Question about costs are the hardest part of the conversation but is necessary, not just a question of political will. Cost containment and financing questions can divert. Vertical transmission agree that you cannot have a testing approach, antenatal when breastfeeding, and during and after pregnancy. Test important to identify both positive and negatives, certain of aspects wise across the HIV field. Need tailored and differentiated approaches, not a cost containment, but more cost-effective and stop wasting to do repeat testing. Need to look holistically.
- Last HIV Strategy did not prioritize and what to do to get greatest impact.

- Use of resources and unequal resources across communities and countries. Need to leverage.
  Partnerships and exchanges of good practices of what can be done in a costs-effective manner, for example, technology and data: no one-size-fits-all, some mysteries out there … critical to analyse data and ensure interventions are cost-effective and targeted to those who need to the resources the most.
- Ensure health workers and health systems are inclusive and ensure that stigma and discrimination are addressed. These includes sensitizing health workers on issues such as sexual orientation and gender identity. Health systems reflect and reproduce inequalities and disparities in society. Paradigm of human rights SRHR, health workers, sharing, equal and respectful, difficulty gender stereotypes, advice on sexuality, gender identities and sexual orientation.
- Political will critical- context of Brazil, 1996 federal law, free of charge treatment for all people living with HIV, incorporate timely the best technologies, solidarity key element to strengthen our democracy, and social participation. Part of right to health constitutional guarantee. Health budget guaranteed by the constitution. Aligned HIV response with universal health coverage. With social participation and law that guaranteed treatment. Governance piece needs to be factored in strongly in Universal Health Coverage.

What is needed to improve our capacity to monitor and measure?

- Wise to break down into the building blocks of the health system around measurable targets. Last Strategy did not have clear enough targets.
- Integrating HIV into national health strategies is important to get everything under one roof.
- Make HIV programmes not damaging of health system but rather promote health systems strengthening and ensure more resilient systems for health.
- Challenge is that very few HIV specific indicators in measuring Universal Health Coverage. Beyond the Treatment coverage indicator, could Universal Health Coverage be more embracing of HIV? Targets for prevention need to be integrated into Universal Health Coverage. What proportion of AGYW are attending integrated services? Quality must be measured. Bigger barrier than accessibility. Life course approach. What coverage and what quality?
- Paediatric treatment coverage not great, but viral suppression even worse. Quality of care is critical.
- Data for evidence and monitoring but not so much for decision-makers. Coverage is not a useful data for decision-making. Must move from monitoring to decision-making data.
- Basic costing tools, budget discussion, complicated budget tools, need more simplified versions. Universal Health Coverage is about cost as much as it is about access. Have civil society organizations in costing dialogues and not just in-service delivery dialogues.
- Need to expand sectors and stakeholders involved in the monitoring and measuring. Capacity needs to be built among those involved including among civil society organizations.
- Universal Health Coverage SDG indicator includes financial risk protection. Anything from social protection for HIV and insurance.
- Global Action Plan for healthy lives and wellbeing launch, principles reflected in HIV efforts to be more efficient in using resources.
- Improving capacity to monitor, only matters if targets are about impact. Universal Health Coverage needs to lead to lowered HIV incidence, morbidity and mortality. Yet now, effect and duration and cost and effect are not known. Targets are important, also precision within targets. Service package within Universal Health Coverage and morbidity and mortality in gender. Intersection with other health outcomes, understand

the impact, the effect, the proportion of would be that would be reached. Support targets that move the needle on interventions. Monitor and evaluate the things that matter.
- Budgets and political will are critical, in Universal Health Coverage Brazil, nationwide database with unique identifiers for people living with HIV allowing to monitor epidemiology and clinical indicators. Still missing indicators for prevention among key populations. Nationwide studies for key populations. Question of political will and budget. Mathematically modeling requires good data inputs.
- Efficiencies and cost-effectiveness that can be done through integrated health services. Reframing the discussion about what efficiencies can be made through integrated health services.

Multisectorality

What needs to be amplified that would be a "game-changer" in the response?

- Consultation with affected communities and meaningful integration between HIV and TB. TB preventive therapy must be accessible for all people living with HIV and there should be key targets to measure this. Prioritize TB preventive therapy coverage.
- Multisectoral response must involve civil society public and private sector. Need clear indicators for multisectoral activities. We deal a lot with structural issues such as human rights, gender and community-led responses. These issues often do not have clear indicators or clear timelines, which makes it difficult to track implementation.
- When people hear the word multisectorality they often do not appreciate it. Multisectorality must emphasize the people-centered approach. For example, by looking at the experience of a young woman and in order to meet her HIV prevention needs it requires involvement of all sectors (labour, education, health, etc.).
- Acknowledgement by these sectors of their role in impacting HIV. Both sides must look at it from the people's perspective and ensure mutual recognition of the role of both sectors, in terms of accountability, responsibility and engagement.

Summary: (1) Underscore the people-centred nature of multisectorality and the mutual responsibility of all sectors; (2) Need for clear indicators and timelines to track progress against work in multisectoral areas (e.g. human rights and gender); (3) Address the linkages between multisectorality and integration, for example around TB preventive therapy coverage.

What will help us move from commitments to action?

- Incentives to move from commitment to action.
- Is there an opportunity to leverage political will around COVID response to strengthen health systems? "Leverage political will around COVID for TB-HIV responses".
- There needs to be greater emphasis on service delivery frameworks that are country specific, population specific, etc. needs to be more of an emphasis on the "how." Are the "game-changing" strategies defined? Need to provide clearer frameworks that have options that can be flexible and responsive in different contexts.
- Moving from commitment to action depends on capacity. Need to look at what resources are available.
- When we consider Joint Programme governance, it often seems that the health sector is predominantly represented by the Member States on the PCB. One idea is to encourage Member States to send representatives from other sectors in order to engage them. Increase participation of nonhealth sectors in Joint Programme consultations and events, including the PCB and also at country level.

Summary: (1) Leverage political will around COVID for HIV-TB responses; (2) Increase participation of nonhealth sectors in Joint Programme consultations and events, including the PCB and also at country level; (3) Provide clear frameworks with options that can be flexible and responsive in different contexts.

What is needed to improve our capacity to measure and monitor responses?

- The UBRAF, when done properly, will automatically reflect principles and approaches of the UNAIDS Strategy anyway. As long as multisectoral approach is reflected in Strategy, the UBRAF should convey and measure this.
- Need to know how most vulnerable communities are benefitting or not from interaction with different sectors, and where their needs are met.
- PEPFAR has recognized that to make an impact, you need to bring your entire constituency of government, civil society and the private sector to this fight. One key aspect is that when the client is your centre of focus, it helps you to prioritize and remove some of the noise.
- Educational aspect is important. When we go to communities and nongovernmental organizations to provide services for key populations, must give knowledge not just on HIV but also on other sexually transmitted infections and areas. Build knowledge among nongovernmental organizations and those who work in the field, not just for HIV.

Summary: (1) To be “CLIENT-CENTERED” we must be MULTISECTORAL and put them at the centre of our thinking; (2) Education is key, must build HIV knowledge across sectors and not just in the HIV specific world; (3) Track and pool resources across sectors to enhance capacity for action.

<u>Inequalities</u>

Key issues and recommendations emerging from discussion

Data collection and analysis

- We need more detailed disaggregation of data. Must collect data on race, gender and gender identity (not just binary), sexual orientation.
- Demand better data disaggregation. COVID-19 is impacting different ethnic groups differently. This has made many people wake up to the need to disaggregate data to understand different impacts.
- Communities to have a key role in data collection since they often have access to information that others do not. But this data must be seen as relevant and credible. The “hierarchy” of data must be addressed. Communities must also be supported in data collection because it is often difficult for criminalized and/or marginalized communities to collect data.
- Need to look also at indicators to measure inequalities.
- Intersectionalities of inequalities must also be captured in modelling and financial projections.
- We also need political economy analysis.

Examine and tackle intersections of inequality

- Need to look at intersections of race, gender, sexual orientation, etc. to understand the experiences of key populations and identify the barriers to prevention, support and care.
- Assess how inequalities, racism, transphobia, homophobia, violence against women, etc. impact on determinants of health.

- UNAIDS needs to tap into data collected by others on inequalities, including employment data, education data, civil engagement, etc. Connecting HIV data with data from other sources and using HIV response as a catalyst will support robust action on inequalities.
- Policies and programmes on stigma and discrimination must be developed from an intersectional perspective, not only cover HIV status.

Scale up interventions to address inequalities

- We have many interventions that have proven to work on addressing gender inequalities and harmful gender norms, for example, but they have not been scaled up (e.g. work with men and women in communities, engaging men on positive masculinities).

Act even in the absence of data

- Some of the lack of data is due to political decisions not to collect it. There is a need to act, nonetheless.
- Community-led responses are key. People on the ground understand the situations impacting their communities.
- There is a need for investment in building trust and partnerships. When you build trust, you feel accountable to each other.
- Tackling inequalities starts early. “Empower feminist moms!” and support from primary caregivers to change social norms is important.

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