REPORT OF THE GLOBAL ALLIANCE TO END AIDS IN CHILDREN BY 2030 VIRTUAL MEETING

3-4 JUNE 2025

Contents

1. Background

In 2022, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), and World Health Organization (WHO), together with networks of people living with HIV, and technical and funding partners, including PEPFAR and the Global Fund, launched a strategic initiative, the Global Alliance to End AIDS in Children by 2030. Twelve national governments (Angola, Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe) joined the initiative. At the launch of the Global Alliance in Dar es Salam in February 2023, Ministers of Health from all 12 countries and partners signed the Dar es Salaam Declaration for Action to end AIDS in Children, committing to end pediatric AIDS by 2030, and to implement tailored, prioritized country action plans.

The country plans emphasize action through four pillars that focus on the priority actions for children as defined in the "Global AIDS Strategy 2021-2026."[1]

Pillar 1	Pillar 2	Pillar 3	Pillar 4
Early testing and optimized comprehensive, high quality treatment and care for infants, children, and adolescents living with and children exposed to HIV	*Closing the treatment gap for pregnant and breastfeeding women living with HIV and optimizing continuity of treatment towards the goal of elimination of vertical transmission*	*Preventing and detecting new HIV infections among pregnant and breastfeeding adolescents and women*	*Addressing rights, gender equality, social/structural barriers that hinder access to services*

Over the past two years, country teams, led by Ministries of Health, have met virtually in regional and global working groups to share updates and progress on country priorities, discuss common challenges, and develop new strategies by learning from each other through peer-to-peer exchanges.

2. Meeting objectives

In June 2025, the Global Alliance Steering Committee and Regional Hubs for Eastern and Southern Africa (ESA) and Western and Central Africa (WCA), along with global networks of people living with HIV, invited the 12 country teams, led by Ministry of Health representatives, as well as funding agencies and implementing partners to a two-day virtual technical consultation. The meeting was a chance for stakeholders to come together at a critical time for global health, reflect on what has been most successful in the past, identify sustainable solutions, and focus on the needs of children and families affected by HIV. Specific objectives were to:

- Provide a progress update by Global Alliance countries on activities, challenges, and lessons learned across the four pillars.
- Share country-level responses and strategies that national programmes are currently implementing in response to reduced funding and identify how strategies could be adapted along the four pillars in different contexts.

[1] https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026

- Identify short-, medium- and long-term interventions to be prioritized by national stakeholders and partners

Prior to the meeting, each Global Alliance country team submitted a written update. During the meeting, countries presented their updates, followed by breakout sessions that provided a brief opportunity for each country team to draft a list of priority actions for 2025-2026. The meeting agenda can be found in Annex 1.

Over 300 participants attended, including representatives from the 12 Alliance Country Teams. Also present were members of the various Alliance structures—such as the Steering Committee, Community Oversight Task Force, Regional Hubs, Monitoring and Evaluation Working Group, Communications and Advocacy Working Group, and the Pillar Working Groups. In addition, several countries outside the Alliance, including the Central African Republic, Chad, Ethiopia, Indonesia, Malawi, Mali, and Morocco, joined to learn from and engage with the Alliance's work.

3. Country Global Alliance Action Plans – Key Results, Challenges and Mitigation Strategies

"The progress made is a real testament to a partnership designed to achieve targets for our most vulnerable, our children and our grandchildren….and of course we know we still have work to do…As we break down the data, we can see exactly where the problem areas are." – Anne Shongwe , UNAIDS, RST Director ESA

An estimated 1,190,000 children (<15 years) living with HIV reside in sub-Saharan Africa, accounting for more than two-thirds (87%) of the children living with HIV worldwide. The ESA region, where most countries have a generalized epidemic, comprises 59% of all children living with HIV. In WCA, where overall HIV prevalence is lower, the number of children living with HIV accounts for 28% of the global total. Treatment coverage for children is only 61% in ESA while in WCA only one in three (37%) children living with HIV is on treatment. Adolescent girls and young women (15-24 years) comprise 28% of new HIV infections in ESA and 19% in WCA.[2]

The Alliance meeting provided an opportunity for a closer examination of programme data, revealing more nuanced insight into why children and adolescents continue to fall behind adults in HIV diagnosis, treatment, and viral suppression. The meeting also created space for colleagues to exchange ideas on how to sustain gains and drive further progress across the four pillars.

Despite country-specific differences, commonality in key results could be found across the 12 countries:

National and sub-national government leadership, alongside multidisciplinary and multistakeholder collaboration continue to be key to achieving progress across the four pillars.

[2] https://www.unaids.org/en/UNAIDS-global-AIDS-update-2025

Countries are employing a range of facility and community-based approaches to **increase case finding of children living with HIV**, including early registration of HIV-exposed infants before six weeks, rigorous index testing, HIV risk assessment at outpatient settings, integrated outreach services, and family-centered outreach. Early infant diagnosis and point-of-care for early infant diagnosis continued to expand across most countries, with decentralization improving turn-around times for test results.

Systematic scale-up and national rollout of paediatric fixed-dose combinations have contributed to **expanded optimized treatment coverage** and **increased pediatric viral suppression**.

The quality and accessibility of service delivery has improved through ongoing training and mentorship of health care workers, integration of pediatric care into maternal-child health clinics, following mother-infant pairs for at least two years, flexible clinic hours for older children, and other client-centered approaches. Countries noted that **decentralizing HIV services** to primary health care centres has expanded coverage, alongside investments in training and quality improvement systems. **Triple elimination** efforts have increased as more countries have adopted dual HIV/syphilis test kits, combined with Hepatitis-B testing, in antenatal care.

Peer-led outreach strategies, such as those delivered by mentor mothers and expert clients, have significantly improved HIV outcomes. By leveraging shared experiences, these peers built trust and created meaningful connections that enhance HIV literacy, strengthened treatment adherence, and boosted viral load suppression among pregnant and breastfeeding women living with HIV. In addition, mentor mothers and expert clients played a critical role in early infant diagnosis, ensuring HIV-exposed infants were promptly linked to care and achieved timely viral load suppression. Their community-driven engagement not only bridged service delivery gaps but also fostered local ownership of HIV programmes.

Data quality and use have improved through multiple mechanisms, including improved facility-level data verification, expanded electronic medical records, and a multi-country data mentorship programme. One example of success is the **more precise data analysis** that has helped countries focus on appropriate interventions to improve treatment initiation and retention and prevent new HIV infections among women who are pregnant and breastfeeding. For example, in ESA new infections in children mostly occur among mothers acquiring HIV during pregnancy or breastfeeding, while in WCA new infections in children are primarily due to pregnant or breastfeeding women not having access to treatment. Interventions have included HIV testing for couples, HIV self-testing, repeat testing during the breastfeeding period, counselling, support, and referral to needed services, pre- exposure prophylaxis (PrEP) to women and/or their sexual partners, and condoms and other contraceptive methods during antenatal and postnatal care.

In addition to promoting routine HIV prevention to prevent new HIV infections in pregnant and breastfeeding women, such as condoms and behaviour change, countries have adopted **new prevention technologies**, including the Dapivirine vaginal ring and injectable PrEP. HIV self-testing has reached new clients, especially adolescents, young people and male partners.

Countries are addressing **systemic social and structural barriers** to HIV services and **social determinants and structural pathways** that increase risk of HIV transmission through legal processes, engaging community leadership in Global Alliance structures and community dialogue. As participants in

decentralized task forces, community members are also supporting **accountability and quality improvement** through data reviews, scorecards and service improvement planning.

"Today we must ensure that each clinic visit is genuinely valuable, especially for our paediatric and adolescent clients. For adolescents, that means coupling our interventions with topics that resonate, such as menstrual poverty, sexual violence, first sexual experiences, and growing up with HIV." Adjovi Husunukpe (Executive Director, REAJIR+, Togo)

Countries also reported a range of formidable challenges in their efforts to increase the number of children on treatment and prevent new HIV infections. Some were unexpected and deeply destabilising, such as the abrupt withdrawal of substantial U.S. government funding.

Preliminary data indicate that reduced funding has negatively impacted both the accessibility and availability of HIV services, leading to cuts in health workforce capacity and supervision. In response, several countries have prioritised a minimum package of services to maintain HIV care in a sustainable way. Guidelines are also evolving to integrate HIV and tuberculosis services into chronic and general healthcare across all levels. Additionally, countries are providing virtual mentorship and on-the-job training to support health care workers in delivering HIV services.

Resources essential for diagnosing and monitoring HIV in children have been severely reduced, affecting laboratory staff, the transport of samples and results, maintenance of equipment, and other critical elements of the HIV testing and care continuum. In some countries, this has also delayed the roll-out of more effective paediatric treatment regimens. To mitigate the impact of these funding cuts, some countries have integrated sample transportation systems and set up task forces to strengthen forecasting, redistribute existing commodities, and tap into emergency stocks.

HIV strategic information systems, the backbone of any effective HIV response, have been severely disrupted and, in some cases, rendered inaccessible. The existence of parallel and proprietary electronic medical records, combined with the retrenchment of data clerks, has left many countries without reliable access to routine data on HIV service delivery, laboratory operations, commodities, and other critical areas essential for managing the response. Although these systems are expected to transition to full government ownership over time, immediate data gaps are hindering effective planning and implementation. Even so, some countries are leveraging real-time programme data to identify service gaps and better direct resources.

Country teams reported that many low-cost, high-impact programmes, especially those led by community health workers, peer experts, and mentor mothers, have been among the hardest hit by funding cuts. While governments may eventually integrate some of these programmes into national health budgets, in the immediate term countries are urgently seeking ways to sustain community-based and peer-led interventions to prevent losing critical ground.

Other challenges presented, such as generating demand for PrEP, are complex programmatic hurdles, often fueled by persistent stigma, discrimination, and gender inequality. These are not merely routine concerns; they are deeply entrenched barriers that continue to obstruct access to prevention and treatment services, with stigma toward people living with HIV remaining particularly pervasive. Such challenges undermine efforts to expand PrEP and other critical interventions and impede the strengthening of health systems needed to deliver comprehensive care, whether through outreach

centres, trained health personnel, or reliable supplies. Addressing these profound, interconnected issues requires urgent, coordinated, and sustained action.

Country Highlights

"Countries have continued to make remarkable progress across the four pillars. In doing so, countries have demonstrated resilience and innovation despite unprecedented funding challenges. The achievements reported by countries show the continued commitment, but also the effectiveness of the approaches." Dr. Akudo Ikpeazu, Medical Officer, WHO

Each country presentation contained a wealth of detailed data and helpful insights. Below are highlighted a selective sample of country experiences, highlighting progress and challenges in policy, service delivery and uptake, data management, community engagement, and multi-sectoral linkages.

Angola has expanded HIV services along its southern border with Namibia to improve access to care for mobile and border populations and recently launched cross-border services with the Democratic Republic of the Congo. Negotiations are underway to establish additional cross-border HIV services.

Cameroon highlighted efforts to improve paediatric HIV diagnosis and treatment coverage through decentralized care and community-based strategies. Index testing increased the identification of undiagnosed children living with HIV. However, these efforts are now impeded by funding gaps and disruptions in training, mentorship and community follow-up.

Cote d'Ivoire significantly improved viral suppression rates among adolescents living with HIV across several districts by tailoring programmes to their needs and including parents and guardians. The programme focused on parents saw viral suppression increase from 54% to 92% among adolescents, while the peer-led programme resulted in improved viral suppression from 79% to 86% in just over six months.

Democratic Republic of the Congo decentralized the National Alliance Plan into provincial plans that guided local efforts and community-led monitoring extended programme reach and accountability. Domestic allocation of resources increased, with national funds used to purchase commodities that were formerly procured by external donors.

Kenya's 2023 Rapid Result Initiative and National Global Alliance Plan catalyzed significant gains in identifying and diagnosing children with HIV and linking them to treatment. In 2024, Kenya decentralized the national plan, formed triple elimination task forces at county level, and implemented sub-national workplans, creating synergies between sub-national and national efforts. In addition to increased paediatric case finding and treatment coverage, retention among pregnant and breastfeeding women living with HIV has increased.

Mozambique has been implementing a "One Stop Shop" model in mother and child health care, integrating maternal and child health, HIV prevention, care, treatment, and psychosocial support into a single service delivery point. This centralized, person-centered approach enabled mother-baby pairs to receive a comprehensive package of care from a single provider, improving service uptake, continuity of care, and health outcomes.

Nigeria has sharply increased the number of HIV testing delivery service points, expanding from 6,000 to over 38,000, including public, faith-based, and traditional birth settings. The increase of available services has contributed to increased HIV testing for pregnant women tested for HIV, from 27% in 2022 to 68% in 2024, as well as increased treatment coverage for children living with HIV, from 29% in 2023 to 74%.

South Africa is tracking progress and identifying gaps in paediatric service delivery through a dedicated dashboard, hosted by the Department of Health Nerve Center, that synthesizes clinical data from various health information systems and allows data analysts to produce quarterly updates and clinicians to support linkages between services. With plans to expand the dashboard to provincial level, communities will be able to better engage in data reviews and joint problem-solving. South Africa has achieved near-universal HIV testing in children (97% of children living with HIV know their status), but only 81% of those are linked to treatment. To address this gap, the government has launched a national "Know Your Child's Health Status" campaign that pairs HIV with comprehensive service delivery, supported by community outreach teams.

Tanzania's Community Health Workers have played a pivotal role in identifying pregnant women, linking them to antenatal care, and promoting facility-based delivery. They have conducted home visits, community sensitization and tracked mother-infant pairs using the Unified Community System (UCS) platform. The UCS is an open-source data tool that has helped enhance referrals and linkages from community-based services to formal health care delivery, including HIV, family planning, tuberculosis, sexual and reproductive health, maternal-newborn-child-adolescent health, and gender-based violence. To date, over 264,000 clients have been registered and linked to services at 822 health facilities.

Uganda demonstrated the importance of a group-based approach to support HIV prevention and treatment among pregnant and breastfeeding adolescent girls and young women. An evaluation found that health facilities implementing the group model had significantly higher rates of re-testing for HIV, use of antenatal care services, more than four antenatal care visits, health facility delivery, uptake of modern contraceptive methods, postnatal care attendance, and immunization at 6 weeks. Most importantly, there was a significant increase in the percentage of live births among mothers who participated in the group model.

Zambia has adopted a multi-pronged approach to improve paediatric diagnosis and care, including point-of-care early infant diagnosis using GeneXpert platforms, a national "Know Your Child's HIV Status Plus" campaign, caregiver-assisted HIV self-testing, provider-initiated testing in inpatient and outpatient clinics, roll-out of pALD, and enhanced viral load testing using both point-of-care and conventional platforms.

Zimbabwe's community-based peer support, including male mobilizers, Young Mentor Mothers (YMM) and Community Adolescent Treatment Supporters have served as a model for the region and have been replicated in several other countries in ESA and WCA. Using both in-person and digital approaches, the YMMs continued to provide counselling, referrals and linkage to care and peer support. Referrals for mental health and intimate-partner violence prevention and response services were also integrated into peer support interventions. The result has been increased adherence and retention in treatment, viral suppression, and disclosure to and uptake of HIV services by partners.

Way forward

"Children and adolescents are depending on us to work for them and with them." Laurie Gulaid, Regional HIV Advisor, UNICEF ESA

A clear message throughout the meeting was that ending AIDS in children will rely on leveraging other platforms and cadres and providing layered services. This approach includes using national and sub-national data systems to tailor the HIV response; for example, some countries need to focus on identifying older children living with HIV (> 5 years), while others need to strengthen early infant diagnosis and HIV testing for children 0-2 years.

In small groups, Country Teams identified what will propel them towards success. Some of the most common priorities and interventions are the following:

Pillar 1: Increase testing uptake among children and linkage to care and treatment

- Strengthen the integration of HIV risk assessment tools and testing services and skills of health workers at all facility and community-based paediatric entry points and within maternal and child health services. Systematically review clinical files to follow up with clients on treatment. Ensure strong linkages to paediatric treatment and follow up services for children who test positive.
- Advocate for legislation making paediatric HIV testing services more accessible, such as when a child is changing caregivers.
- Expand national campaigns from "know your child's HIV status" to a "know your child's health status" and leverage the reach of different cadres, including community health workers and mentor mothers.
- Promote "self-care" among families and improve adherence of children to treatment through support to caregivers, including treatment literacy.

Pillar 2: Increase treatment coverage for pregnant and breastfeeding women and improve maternal viral load

- Standardize peer-led programmes, such as mentor mothers, including training packages, standard operating procedures and tools for sustainable implementation and scale up.
- Institutionalize routine screening, testing and treatment of HIV, syphilis, and hepatitis B within antenatal care, maternity, and postnatal services to ensure a comprehensive and sustainable approach.

Pillar 3: Prevent new infections among pregnant and breastfeeding girls and women

- Enhance targeting for PrEP demand creation and services using Spectrum data and other data tools and integrate PrEP within comprehensive HIV and sexual and reproductive health services, as well as antenatal and postnatal care.
- Scale up repeat testing for pregnant and breastfeeding women, including engaging peer supporters and promoting risk assessment.
- Strengthen the engagement of young people in designing, delivering and monitoring youth-responsive services.

Pillar 4: Increase access to services by removing social and structural barriers

- Advocate for national health insurance schemes to include HIV services.
- Institutionalise stigma-reduction in pre-service and in-service training for all health care workers, ensuring that respectful service delivery becomes a standard of care across the health system.
- Support implementors to address the intersectionality of HIV, violence against women, substance abuse and mental health in their programmes.
- Increase community engagement and accountability through score cards to assess gaps and barriers.

Collaboration, learning and support

The Global Alliance Steering Committee and ESA and WCA Regional Hubs noted requests for on-going learning and collaboration and will continue to use the pillar working groups and regional hub virtual meetings for more in-depth discussion, evidence sharing, and country-specific data review and technical support. Some of the suggested issues to be taken forward include:

- Sustainable transition planning, including workforce and supply chain strategies
- Developing innovative funding mechanisms, broadening health insurance schemes, and operationalizing domestic HIV financing
- Using data to implement effective national and sub-national campaigns to identify children living with HIV and link them to care
- Delivering virtual mentorship tailored to country needs
- Building a digital health infrastructure
- Improving sub-national data management and use
- Fostering cross-border cooperation for service delivery
- Integrating and scaling up standardized community-based and peer-led programmes
- Successful examples of social protection and wrap-around services for children and their families affected by HIV
- Exploring opportunities for multi-country public-private partnerships, especially in supply chain management
- Providing updates on policies, guidance, implementation tools

Conclusion

"This consultation represents a pivotal moment to align global ambition with national realities. It offers a powerful opportunity to reimagine the future of the HIV response in Africa—particularly paediatric HIV—through an integrated, equity-driven, and country-led health agenda." Dr. Landry Tsague Dongmo Director, Centre for Primary Health Care, Africa CDC

A Call to Action

No one wants children to be born with HIV or, if the child has HIV, to not have access to the services that help them thrive. Remember:

- Children are not lost; their caregivers and mothers know where these children are.
- Children are not left behind, but their caregivers and mothers may be unable to engage in services.
- Children have no voice of their own and are not in the discussions where decisions that affect them are being made, including what gets prioritized and funded. We are their voice and need to ensure that their concerns are heard and addressed.

Lilian Mworeko, Executive Director, International Community of Women Living with HIV

New HIV infections and HIV-related mortality in children are reported as the lowest they have ever been since the beginning of the HIV epidemic. However, these gains are at serious risk of reversal as countries cope with sudden and drastic funding cuts. Participation of 12 Global Alliance countries and more than 300 participants over the two-days was a clear demonstration of the urgency of the moment as well as the opportunities for increased collaboration. Countries are moving forward to strengthen overall health systems by building on HIV programmes, while continuing to ensure children's needs are met. This two-day meeting of the Global Alliance was a resounding affirmation that, despite the challenges, the goal of eliminating AIDS in children by 2030 is still within our reach.

Annex 1: Meeting Agenda

The Global Alliance to End AIDS in Children by 2030
Technical Virtual Call for Alliance Countries - 2025

Key objective: Convene Global Alliance country teams and invited partners to participate in a discussion on the current situation and strategies to maintain essential maternal-child health and pediatric HIV prevention and treatment services in the context of funding cuts.

Specific objectives:

1. Progress update by GA countries since the last report/Virtual call June 2024.

2. Share, learn, and document country-level emergency responses and strategies that national programs are currently implementing and identify how strategies could be adapted for different contexts.

3. Identify short, medium and long interventions to be prioritized by national stakeholders and partners based on completed country templates describing successful Global Alliance activities, challenges encountered, and lessons learned.

Agenda Day 1

Time (SAT/CET)	Topic	Speaker/Moderators/Chairs
11:00-11:05	Welcoming remarks	Anne Shongwe UNAIDS RST Director ESA
11:05-11:10	Review of the agenda	Tim Rwabuhemba Musinguzi, UNAIDS
11:10-11:20	Progress update: overview of the HIV epidemic in infants, children, adolescents and women	Anna Yakusik, UNAIDS Data for Impact
11:20-11:25	Discussion	Tim Rwabuhemba Musinguzi, UNAIDS
11:25-12:15	**Plenary** Countries' response and mitigation measures to current situation: Angola, Cameroon, Kenya, Mozambique, Nigeria	Angela Mushavi (Chair)
12:15-12:20	Introduction to group work	Dorothy Mbori-Ngacha
12:20-12:50	Group work on recommendations (short- and medium-term interventions) - 5 break-out rooms by presenter countries (and other countries as participants) Discussion to cover each pillar of the Global Alliance (30 min)	Group moderators
12:50-13:15	Presentation by groups - 5 min each	Group Rapporteurs
13:15-13:25	Discussion	Dorothy Mbori-Ngacha
13:25-13:30	Concluding remarks Day One	Angela Mushavi (Chair)

Agenda Day 2

Time (SAT/CET)	Topic	Speaker/Moderators
11:00-11:05	Welcoming remarks Day 2	Laurie Gulaid, UNICEF ESARO Landry Tsague Dongmo, Africa Centres for Disease Control and Prevention
11:05-11:15	Recap of Day One and Agenda of Day 2	Nandita Sugandhi, WHO
11:15-12:25	**Plenary** Countries' response and mitigation measures to current situation: Cote d'Ivoire, South Africa, Tanzania, DRC, Uganda, Zambia, Zimbabwe	Joseph Fokam (Chair)
12:25-12:30	Introduction to group work	Dorothy Mbori-Ngacha
12:30-13:00	Group work on recommendations (short- and medium-term interventions) - 7 break-out rooms by presenter countries (and other countries as participants) Discussion to cover Pillar 3 & 4 of the Global Alliance (30 min)	Moderators
12:00-13:35	Presentation by groups	Group Rapporteurs
13:35-13:45	Discussion / Wrap Up	Dorothy Mbori-Ngacha
13:45-13:55	Call for Action: Representatives of People living with HIV	Adjovi Husunukpe, REAJIR+, Togo Lilian Mworeko, International Community of Women living with HIV
13:55-14:05	Closure and Concluding remarks	Akudo Ikpeazu, WHO AFRO