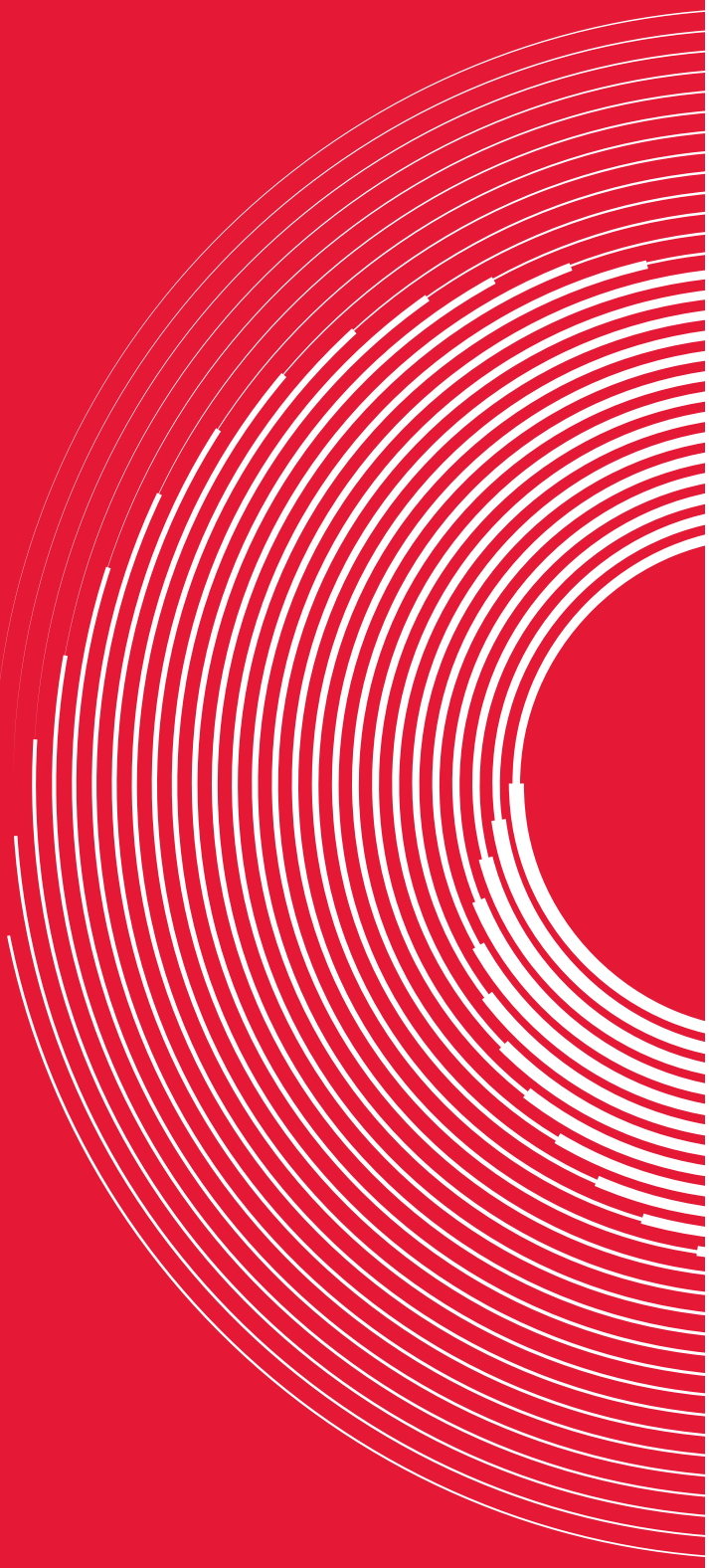
COUNTRY SNAPSHOTS

Fast-Track: Quickening the pace of action to end AIDS



UNAIDS | 2017

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Introduction

The Fast-Track approach to ending AIDS is saving lives

Governments, implementers, civil society, multilateral organizations and communities have committed to the shared agenda of ending AIDS by 2030. And there is progress: for the first time, 19.5 million people—more than half of all people living with HIV—are accessing life-saving treatment. The world has cut the number of people who die from AIDS by nearly half since 2005, further tipping the scales in our favour.

But the pace of progress is insufficient

At the very moment countries need to be scaling up delivery of HIV services, fiscal space and community space is shrinking. Globally, new HIV infections have come down 11% since 2010, but clearly, they are not falling fast enough. Political momentum is building but has not yet reached a critical mass. When the United Nations General Assembly adopted a Political Declaration on Ending AIDS in June 2016, Member States committed to achieve global and regional Fast-Track Targets by 2020. We cannot reach these ambitious but achievable targets without increased high-level political leadership and engagement. For example, in June 2017, President Yoweri Museveni launched the Presidential Fast-Track Initiative on Ending AIDS as a Public Health Threat in Uganda, referred to as "Kisanja Hakuna Mchezo" or "no time for playing games".

The high-level side event

In order to assess progress and accelerate momentum, **President Museveni**, will host a high-level side event on the sidelines of the 72nd United Nations General Assembly. Held in collaboration with UNAIDS, the event aims to:

- **Demonstrate that the Fast-Track approach is working** and show its impact on health systems and the Sustainable Development Goals in Africa and beyond.
- **Renew political leadership and commit to action and accountability to achieve the global and regional targets adopted in the 2016 Political Declaration on Ending AIDS.**
- **For sustainable development build momentum for shared responsibility and global solidarity**, to reinforce and add urgency toward ending AIDS.

This collection of country snapshots is intended to inform the high-level side event and show how a selection of countries are getting on the Fast-Track.

Côte d'Ivoire
On the Fast-Track

Snapshot of the epidemic

Côte d'Ivoire has made progress in its response to its HIV epidemic.

In 2016, HIV prevalence among adults aged 15 years and older in Côte d'Ivoire was 2.7%, compared to the 3.7% national prevalence figure published in the Demographic and Health Survey 2011–2012. However, much higher rates among female sex workers and men who have sex with men have been estimated by recent studies.

According to UNAIDS, there were 460 000 [390 000–520 000] people living with HIV in the country in 2016; 59% of adults living with HIV are women. There has been a decline in new HIV infections, from 25 000 [20 000–29 000] in 2010 to 20 000 [14 000–26 000] in 2016 (UNAIDS, 2017). There were approximately 3300 [2200–4600] new HIV infections among children (0–14 years old) and 25 000 [21 000–29 000] AIDS-related deaths in all ages in Côte d'Ivoire in 2016 (UNAIDS, 2017).

Country Fast-Track Targets

Fast-Track Targets in the National Strategic Plan 2016–2020

	2016	2018	2020
People living with HIV knowing their HIV status	58% [49–66%]	80%	90%
Antiretroviral therapy coverage, adults (>15 years)	47%	68%	90%
Antiretroviral therapy coverage, children (0–14 years)	35%	65%	90%
Viral load suppression	32 [27–36%]	82%	90%
Prevention of mother-to-child transmission of HIV coverage	87%	91%	95%

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Test and treat

According to UNAIDS, 58% [49–66%] of people living with HIV know their HIV status, 41% [35–46%] are on treatment and 32% [27–36%] have a suppressed viral load. Antiretroviral therapy coverage for children was 25% [20–30%] in 2016. According to government data, 32 000 people living with HIV were enrolled onto treatment in 2016. Côte d'Ivoire launched its test and start strategy in February 2017. The national catch-up plan to accelerate the implementation of the AIDS response aims to increase the number of people living with HIV on treatment to 288 000.

Significant progress has been made in the area of prevention of mother-to-child transmission of HIV and paediatric HIV. In 2016 nationally, 73% [55–87%] of HIV-positive pregnant and breastfeeding women had access to antiretroviral therapy, 78.5% of antenatal health centres had integrated prevention of mother-to-child transmission of HIV services and all prevention of mother-to-child transmission of HIV sites had switched to the Option B+ protocol.

More than 769 000 pregnant women (78%) were seen for a first antenatal care consultation and 11 000 women tested HIV-positive, of whom 9000 already knew their status, in 2016. Of these, 16 000 (83%) accessed antiretroviral therapy and 13 000 infants benefited from an early diagnosis.

According to the first preliminary Multiple Indicator Cluster Survey 2016 results, some key markers of the HIV response in the prevention of mother-to-child transmission of HIV have increased significantly. For example, the proportion of women 15–49 years old who received counselling on HIV during an antenatal visit increased from 37.6% in 2011 to 53.8% in 2016. The proportion of pregnant women who were offered and took an HIV test during prenatal visits and who know the results increased from 31.7% in 2011 to 62.4% in 2016.

According to the preliminary Multiple Indicator Cluster Survey 2016 results, 22.4% of young women and 11.7% of young men aged 15–24 years took an HIV test during the past 12 months and got their results. Comprehensive knowledge on HIV also increased significantly among young women aged 15–24 years, from 15.7% in 2011 to 24% in 2016.

Test and treat was adopted in February 2017. The adoption of differentiated care models for antiretroviral therapy is increasing uptake and adherence to treatment. Option B+ and task-shifting for nurses and midwifes will expand the capacities of the health sector and increase coverage of prevention of mother-to-child transmission of HIV services.

"We have made significant efforts at the domestic level by increasing the budget allocated to the response to AIDS. Global solidarity and shared responsibility must go hand in hand."

Alassane Ouattara,
President of Côte d'Ivoire

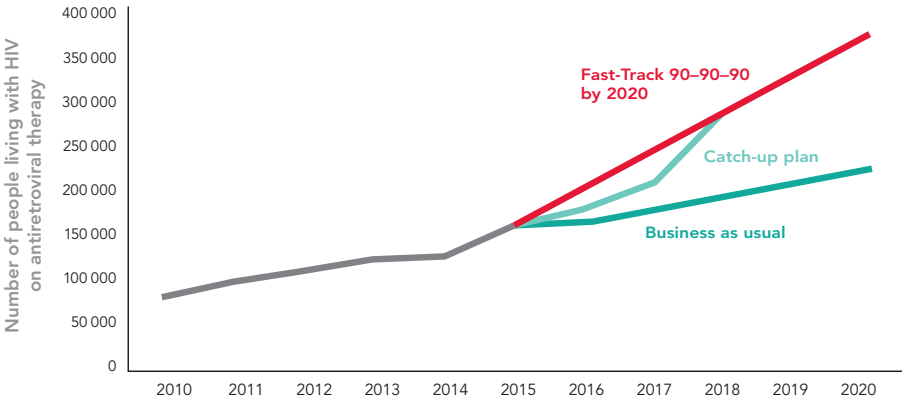
Political commitment and shared responsibility

The government has committed to increase the domestic financing of antiretroviral therapy and other strategic inputs and made a US$ 1 million contribution to UNAIDS in 2017.

Joint action from the Ministers of Health, Youth and Education will establish and step up the implementation of a targeted strategy for male engagement, taking into account young men aged from 19 years old.

The renewed commitment of the First Lady, who is a UNAIDS Special Ambassador, for the elimination of mother-to-child transmission of HIV and to promote paediatric treatment will expand advocacy for early infant diagnosis.

Scenarios to increase treatment coverage by 2020



Key challenges

Adopting test and treat is a key achievement. Yet, test and treat coverage rates remain low. Much remains to be done, despite the progress of 32 000 people living with HIV accessing antiretroviral therapy in 2016. About six in ten people living with HIV still do not have access to antiretroviral therapy and coverage is only 25% [20–30%] among children aged 0–14 years.

Testing rates among men are low, with a significant rate of refusal for HIV testing, and there are low coverage rates for men on treatment, significantly lower than for women. Expanding programmes for pregnant women, key populations, young women and prisoners remains a priority.

There is a need to scale up community programmes to reach the most vulnerable adolescents, as well as to reduce new HIV infections among adolescents (especially young girls) and children.

Way forward

Progress towards the 90–90–90 targets in Côte d'Ivoire demonstrates that although there has been significant progress, much remains to be done. To stay on track by 2018, Côte d'Ivoire needs to:

- Increase treatment coverage and retention, including implementing innovative strategies for male engagement, to close the gaps on HIV testing, prevention and treatment.
- Accelerate implementation and leave no one behind through scaling up task-shifting for nurses and midwives and increasing community mobilization to reduce stigma and encourage access to services.
- Reinvigorate the accelerated implementation of HIV prevention, treatment and care, with a focus on key populations, including sex workers and their partners and men who have sex with men.

"To all the people who are going through difficult times because of HIV, be reassured, you can live with the virus. As proof, I am here in front of you, standing on this podium, and everyone at their own level can do something that will prove useful."

Sidjé Léontine,
Chair of the Board, Network of Organizations of People Living with HIV, Côte d'Ivoire

Guinea
Scaling up its HIV response

Snapshot of the epidemic

In 2016, Guinea had a national HIV prevalence of 1.7% and 120 000 [100 000–150 000] people living with HIV (UNAIDS, 2017). Women and girls are disproportionately affected, with a prevalence of 2.1% in the 15–49 years age group (L'Enquête Démographique et de Santé et à Indicateurs Multiples, 2012). HIV prevalence is high among key populations (14.2% among sex workers, 11.4% among men who have sex with men and 8.5% among prisoners), and twice as high among mobile populations (miners, fishermen, truck drivers and uniformed men) than the general population (Enquête de Surveillance Comportementale et Biologique du VIH/SIDA en Guinée, 2015). Antiretroviral therapy coverage of people living with HIV increased from 18% [13–22%] in 2010 to 35% [25–43%] in 2016 (UNAIDS, 2017). Viral load suppression among all people living with HIV was estimated at 18% [15–21%] in 2015.

The renewed political commitment of the President of Guinea and partners has been instrumental to the progress made. The country responded to UNAIDS' call at the 2016 High-Level Meeting on Ending AIDS for an accelerated response in western and central Africa to triple treatment in three years and developed an 18-month HIV catch-up plan focused on accelerating treatment, focused on the eight cities with the highest population density of people living with HIV. Despite progress, many challenges remain, mainly: the weak multisectoral and integrated approach and private sector involvement; inadequate funding; the weakness of the management system, including supply and distribution chains; and high levels of stigma and discrimination against key populations.

Country Fast-Track Targets

	2010	2016	2020
Know their HIV status			90%
People living with HIV on antiretroviral therapy	18% [13–22%] 19 900 people	35% [25–45%] 43 700 people	81%
Viral load coverage			73%
Pregnant women antiretroviral therapy coverage	18% [14–23%]	43% [32–53%]	95%

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

A test and treat strategy was officially adopted by the Ministry of Health across Guinea in August 2017. Implementation of this strategy is supported by all partners and requires considerable strengthening in the delivery of health-care services and in generating demand. In addition, the supply chain management system will need to be strengthened for all services at the national level.

Men who have sex with men and sex workers and their clients continue to be disproportionately affected by the HIV epidemic. Programmes for key populations, including for men who have sex with men and in sex work settings, have limited coverage and impact, despite the increasing efforts of civil society. Resources have been prioritized to support scaled-up quality programmes for key populations. The implementation of prevention and sexual and reproductive health programmes among young people and key populations provides an opportunity to improve access to testing for these populations.

The national community health policy was validated in 2017 and its implementation plan is under preparation. It will be based on the setting up of a platform of partners (at the national and regional levels) and the strengthening of the health system by community health workers. Guinea increased its domestic public funding 2.7-fold between 2010 and 2017.

Political commitment and shared responsibility

The contribution of the national budget to health, while increasing gradually, remains very low, forcing Guinea to rely heavily on external funding.

Guinea increased its domestic public funding 2.7-fold between 2010 and 2017.

The resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) increased almost eightfold between 2010 and 2015.

With the support of UNAIDS, the President will establish a High Council for the National Response to AIDS, Tuberculosis, Malaria and Other Emerging Pathologies in the Republic of Guinea in order to improve governance for health and strengthen cross-sectoral dialogue, integration and stakeholder coordination.

Key challenges

The following are key challenges:

- Combined prevention efforts have not yet produced the expected results in terms of behaviour change, particularly among young people.
- Guinea is implementing a treat all programme. This will require building the capacity of the health system, which was heavily affected by the Ebola crisis, while prioritizing demand creation for HIV prevention, treatment and care. Strengthening the supply system, addressing stigma and discrimination and reaching key populations will be key to further progress.
- The ability to effectively implement the resources of the Global Fund, which account for the largest part of the HIV resources in the country, will be critical to achieving the ambitious goals.

Way forward

Key for the way forward is:

- Strengthening national commitment and investment with a new governance architecture for the health sector under the direct leadership of the President and guaranteeing the central role of the Ministry of Health and multisectoriality.
- Expanding HIV prevention and treatment programmes to reach the ambitious targets of the HIV catch-up plan. Implementing the national community health policy, innovatively and effectively, especially with respect to the 2 million community health workers initiative in Africa.
- Effective and efficient rapid implementation of the response, including the Global Fund grant.

Haiti
Towards a sustainable response in a challenging environment

Snapshot of the epidemic

Haiti is a low-income country, with an estimated 58.6% of the country's approximately 10.8 million people living on less than a dollar a day (United Nations Development Programme, 2014). Haiti's estimated 150 000 [140 000–170 000] people living with HIV—out of which 7200 [6200–8400] are children aged 0–14 years—constitutes the greatest burden of HIV infection in the western hemisphere, exacerbated by the high incidence of tuberculosis (TB)—194 cases per 100 000 people (World Health Organization Global Tuberculosis Report, 2016).

Haiti has a generalized HIV epidemic, with a prevalence stabilized at 2.1% [1.9–2.3%], although HIV prevalence is higher among women, young people, men who have sex with men (10–34%) and sex workers (4–15%). The number of new HIV infections declined to 7900 [6000–11 000] in 2016 (a 24% reduction compared to 2010) (UNAIDS, 2017). HIV and TB coinfection is high in prisons, and approximately 16% of all TB patients are coinfected with HIV, with TB the leading cause of death for people living with HIV (World Health Organization Global Tuberculosis Report, 2018).

Adopting the Fast-Track Targets is yielding results—test and start, adopted by the Ministry of Health in July 2016, has accelerated access to life-saving antiretroviral therapy, although paediatric treatment is lagging behind. Government data indicate that as of July 2017, 90 000 people were accessing antiretroviral therapy, including 3700 children, representing 60% of the estimated number of people living with HIV and more than 94% of people who know their HIV status (Haiti National AIDS Programme, 2017).

The government has made commitments to reach the virtual elimination of mother-to-child transmission of HIV by 2020. Overall, 71% of pregnant women living with HIV are on treatment (UNAIDS, 2017). The commitment to reducing the number of new HIV infections has resulted in prioritizing prevention and treatment for key populations and adolescents, young women and girls, while continuing to accelerate implementation of test and treat.

Country Fast-Track Targets

	2005	2010	2016	2020
Know their status			59% [54–65%] 90 200 people	90% 122 538 people
People living with HIV who are on treatment	3% [3–3%] 4100 people	21% [19–22%] 29 200 people	55% [50–61%] 84 500 people	91% 111 509 people
New HIV infections among children			<1000 [<500–<1000]	<1000

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Innovative technology and community-based services

Haiti is rolling out innovative models of care, including multiple-month prescriptions of up to six months and community-based delivery of medicines, with a mixture of facility- and community-based services. More than 5000 people living with HIV on antiretroviral therapy are accessing their medicines through community-based distribution. Innovative technology allows community health-care workers to know the locations of people living with HIV in order to facilitate linkage with care. Community health-care workers use text messages and home visits to maintain contact and facilitate links with facilities, identify individual barriers to access and propose alternative delivery models to address those barriers, for example home- or community-based distribution of medicines when distance and/or the cost of transport are causing appointments to be missed. When implemented in 70 sites, nearly 50% of people lost to follow-up have been brought back into care.

"The active participation and engagement of civil society are key factors for the success of the national AIDS response."

Fritz Moise, Executive Director, Fondation de la Sante de la Reproduction et l'Education Familiale

Retention in care and adherence—key determinants of treatment outcomes—are a major challenge in Haiti, where the majority of people lost to follow-up are people living with HIV enrolled on treatment for less than 12 months. These people-centred models of flexible delivery to meet the needs of people living with HIV are promising solutions in resource-constrained and fragmented health system marked by a severe shortage of health-care workers and a low retention of nurses and doctors.

Emerging data empowers policy-makers and implementers to invest for impact

Disaggregated data have informed the shift to clinical and community services and strategies that have demonstrated the most impact. HIV prevention for adolescents, young women and girls will focus on districts with high rates of gender-based violence and where women and girls under 24 years of age are being diagnosed with HIV at a higher percentage than the national HIV prevalence.

Programmes for key populations will be intensified in the more than 2300 key population hotspots mapped for the first time throughout all of Haiti's 10 departments. Key populations continue to face stigma. The first ever People Living with HIV Stigma Index survey in Haiti will take place in 2018 and data from the survey will shape programmes for key populations and policy actions to address these violations.

Dialogue with civil society about policy and programmatic barriers has informed the improvement of testing modalities and helped to reduce the gap for men and young people to take a test, seek their results and enrol on treatment and to decrease unnecessary facility-based tests. In addition to the various existing methods of testing, new targeted testing strategies will be implemented, including index case contact tracing in which counsellors and/or health-care workers will work together with people living with HIV to notify and test their partners.

"AIDS, tuberculosis and malaria are still lurking. I will recommend the appointment of a presidential commission in order to streamline the implementation of a multisectoral approach to better control these diseases."

Jack Guy Lafontant,
Prime Minister of Haiti

HIV in emergency preparedness and response

Ensuring that the needs of people living with HIV and their families are addressed in emergency situations is essential in Haiti, which has often faced humanitarian crisis owing to earthquakes and violent hurricanes. The government estimates that in October 2016, Hurricane Matthew affected service provision for more than 12 000 people living with HIV in five departments of Haiti. Community-level AIDS services were intensified to deliver community medicine distribution and active monitoring of loss to follow-up.

Political commitment and shared responsibility

HIV services are funded almost exclusively through international support, namely the United States President's Emergency Plan for AIDS Relief (~87%) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (~10%). The establishment of a specific HIV budget line two years ago is a step forward. The development of the health financing strategy is an important entry point to ensure domestic resources for HIV.

The adoption of community health-care services was instrumental to advance the response. The newly elected head of state, government and parliament have prioritized the HIV response among the government's priorities.

Key challenges

The fragmented health system, severe shortage of health workers, low retention of nurses and doctors and gaps in services across all levels of the health system hamper scaled-up implementation and the sustainability of the AIDS response. Health infrastructure has not kept pace with Haiti's population growth.

Human rights issues related to key populations and gender-based violence threaten the public health objective of leaving no one behind. Stigma in the health sector discourages people from seeking services and undermines trust and confidentiality in the system.

The limited investment of domestic financial resources is a threat to the sustainability of the AIDS response and the results achieved. However, in a country with such limited resources and competing social needs, public spending on health is likely to remain low and be mainly spent on health personnel.

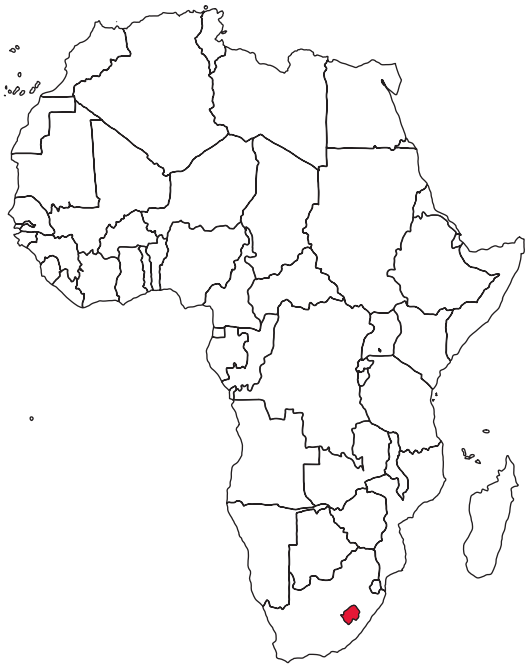
Way forward

An enabling policy environment to facilitate the scaling up of innovative community-level services, pre-exposure prophylaxis, paediatric care and HIV prevention services will strengthen the health system and accelerate the roll-out of HIV services.

Legal frameworks and policies in partnership with civil society that reduce stigma in communities and the health sector, guarantee rights and access to services by populations at risk and address the structural factors of gender-based violence will be reinforced.

Commitment to increase domestic investments, prioritize the implementation of the newly developed health and HIV financing strategy, active engagement with the private sector.

Lesotho
Test and treat



Snapshot of the epidemic

In 2016, Lesotho had a high HIV prevalence, at 25% [22.7–26.5%], and an incidence of 2.27% [1.97–2.58%] among adults (15–49 years old). The number of new HIV infections has slightly decreased from 22 000 [20 000–23 000] in 2010 to 21 000 [19 000–24 000] by the end of 2016 (UNAIDS, 2017). The number of AID-related deaths has declined from 15 000 [13 000–18 000] in 2005 to 9900 [8500–11 000] by the end of 2016 (UNAIDS, 2017). There are 330 000 [300 000–360 000] people living with HIV in Lesotho.

The National Strategic Plan 2011–2018 has set country targets that will advance the AIDS response to achieve the commitments in the 2016 United Nations Political Declaration on Ending AIDS. The goal of the national response is to reduce by 50% new HIV infections and AIDS-related deaths, while programme targets aim to reach 79% prevalence of voluntary male circumcision and 80% condom use at last high-risk sex and contribute to bringing AIDS out of isolation Lesotho (National Strategic Plan, 2011–2018).

Country Fast-Track Targets

65%
by 2018
People living with HIV who know their HIV status.

70%
by 2018
People living with HIV on antiretroviral therapy.

70%
by 2018
Accepting attitudes towards people living with HIV.

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Test and treat is yielding results

Launched in April 2016, test and treat resulted in a more than 175 000 people on antiretroviral therapy, compared to 130 000 in 2015. The 2016 Lesotho Population-Based HIV Impact Assessment national survey shows that Lesotho is making significant progress towards the 90–90–90 targets. Among adults living with HIV, 77% are aware of their status, 90% of those are on antiretroviral therapy and 88% of those on antiretroviral therapy are virally suppressed. Viral load suppression among all adults living with HIV was 67.6% (70.6 % among women and 63.4% among men).

Community same-day antiretroviral therapy initiation sites facilitate test and immediate start on treatment. Evidence suggests that when test and treat are available in the same facility, it increases the uptake of treatment. As a result, antiretroviral therapy initiation has increased significantly. Through partnership with the Employment Bureau of Africa, four sites for HIV testing, tuberculosis

and antiretroviral therapy services for migrant workers, especially men, have been established. Multiscripting of antiretroviral therapy has been introduced for migrant workers. These innovations need expansion in order to reach more men, as antiretroviral therapy coverage is still low, at 43% [40–47%], compared to 60% [55–65%] for women.

Preventing HIV infections among young women and girls

HIV disproportionately affects women: 7.6% [6.9–8.1%] of young women aged 15–19 years are living with HIV, reaching 20.4% [18.5–21.6%] by the time they are 20–24 years old. Among young men, prevalence increases from 3.3% [3.0–3.5%] to 9.3% [8.4–9.9%] in ages 15–19 and 20–24 years, respectively. Prevention programmes for adolescent girls and young women and their partners have been put in place, combined with comprehensive sexuality education. However, the scale and reach is limited and their impact is yet to be realized.

Political commitment and shared responsibility

The country's HIV response has a strong political leadership, with a parliamentary committee on AIDS and a cabinet subcommittee on HIV. However, leadership in HIV prevention is still weak, with more needed to strengthen the government institutions for strong HIV prevention programmes. Though the government's commitment, especially in antiretroviral medicine procurement, is commended, the same level of commitment is needed in HIV prevention, both in terms of resources and government leadership.

Key challenges

Treatment coverage remains low, in particular among men and young people. Low paediatric coverage at 43% [34–50%] in 2016 also remains a concern and diverse strategies will be pursued to address the gaps.

HIV prevention programmes and their scale are limited. This is particularly concerning given the high rates of new HIV infections, especially among young women. Stigma, gender inequalities and limited community engagement to implement a comprehensive approach that addresses the vulnerabilities of young women and girls are also challenges.

Challenges in health system delivery, coupled with the diverse capacities of civil society and community organizations, impede rapid acceleration of the response at the community level.

Way forward

Quality targeted testing and comprehensive treatment should be focused on the areas and populations with a low coverage. The elimination of mother-to-child transmission of HIV and increased coverage of paediatric care remains a priority.

HIV prevention should be reinvigorated, ensuring that high-quality combination prevention services are provided to young people. Comprehensive programmes that address gender inequalities and the vulnerability of young women, while increasing male engagement, will be established and expanded.

Innovative financing mechanisms from domestic sources should be identified to ensure increased accountability towards sustaining the results of the response. The continued support of partners is essential to the immediate scale-up of the AIDS response and bringing AIDS out of isolation.

Malawi
Getting to 90–90–90

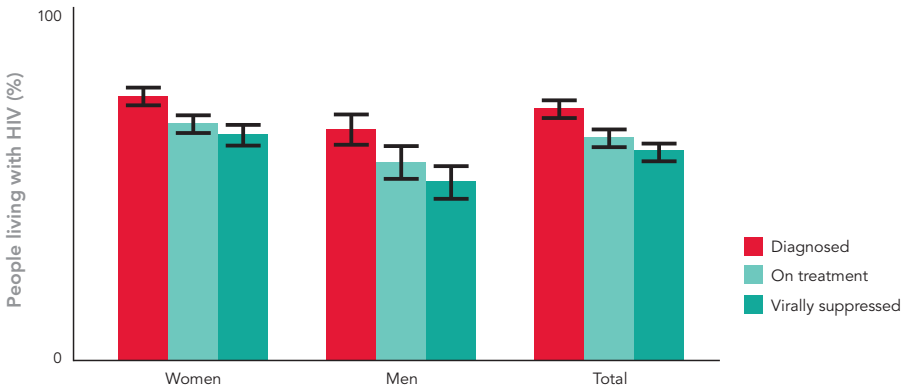
Snapshot of the epidemic

Malawi is a low-income, densely populated country with a population of more than 18 million people and has made great progress in reducing new HIV infections and AIDS-related deaths. HIV prevalence is estimated at 9.2% [8.6–9.7%], while the number of new HIV infections declined to 36 000 [31 000–45 000] at the end of 2016, compared to 59 000 [54 000–70 000] in 2010. AIDS-related deaths had almost halved by the end of 2016 (24 000 [20 000–31 000]) compared to 2010 (45 000 [39 000–51 000]).

Malawi's HIV epidemic is generalized and particularly affects women—in 2016, there were 8800 [8000–11 000] new HIV infections among 15–24-year-old women, compared with 3700 [1100–5300] among 15–24-year-old men. An estimated 1.0 million [970 000–1.1 million] people are living with HIV, including 110 000 [91 000–120 000] children.

Since the President committed to test and treat in 2015, Malawi's progress to 90–90–90 has rapidly advanced: 70% [66–74%] of people living with HIV know their status, 66% [62–70%] of people living with HIV are on treatment and 59% [56–63%] of people living with HIV are virally suppressed (UNAIDS special analyses, 2017). Adolescents, young women and girls and key populations are for the first time prioritized in the national strategic plan for reducing new HIV infections.

The Malawi HIV care and treatment cascade



Source: Malawi Population-Based HIV Impact Assessment (MPHIA) 2016.

Country Fast-Track Targets

90%

exceed testing

Increasing coverage of HIV testing in order to minimize lost opportunities.

0.2%

by 2020

Reducing adult (15–49 years) HIV incidence from 0.49% in 2015.

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Test and treat to accelerate the response

Since July 2016, a test and start policy has been fully adopted and rolled out nationally at all antiretroviral therapy sites. All people who test HIV-positive are immediately started on antiretroviral therapy: 84% [72–95%] of pregnant women have access to antiretroviral therapy, compared to 23% [19–26%] in 2010.

Encouraging results are emerging rapidly. By the end of the first quarter of 2017, 690 000 people living with HIV (including 54 000 children) were on antiretroviral therapy. An estimated 67.6% were virally suppressed. Reaching the first 90 (testing), especially among men aged 15–40 years old, and young people less than 30 years old, represents the greatest challenge and is the key reason for low levels of viral suppression among men and young people.

Policy change to reach the first 90

The Ministry of Health introduced a new HIV testing guideline in 2016, which resulted in an increased uptake of HIV testing services. Implementing this new policy guideline resulted in 150 491 HIV cases newly diagnosed in 2016 (2016 Ministry of Health Programme Report). This was a major achievement, as getting 90% of people living with HIV knowing their HIV status remains a major challenge. Targeted HIV testing has also been intensified among key populations, particularly men who have sex with men and female sex workers. Door-to-door community HIV testing has also been intensified to complement provider-initiated testing and counselling. To scale up access

and uptake of HIV testing services, HIV self-testing and family referral systems have been piloted, with a particular focus on men aged 15–40 years old and young people less than 30 years old. These new approaches are expected to be integrated in the new HIV testing and counselling guidelines and scaled up across the country.

Prioritizing HIV prevention for adolescents, young women and girls

According to the Malawi Population-Based HIV Impact Assessment (2016), prevalence of viral load suppression is considerably lower among young adults. The assessment indicated that viral load suppression was 51.9% among women and 36.7% among men aged 15–24 years, compared to 86.5% among adults aged 55–64 years.

Currently, the roll-out of a comprehensive package of HIV prevention interventions is being implemented in five districts with support from the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Teen clubs have been established across the country to facilitate access to HIV prevention services for adolescent girls and young women and to create demand for HIV testing, treatment adherence and viral load testing.

A presidential task force has been established to spearhead a comprehensive national strategy for adolescent girls and young women. The strategy focuses on reducing HIV infections and addressing the sociocultural and structural factors that increase the vulnerability of adolescents and young women to HIV.

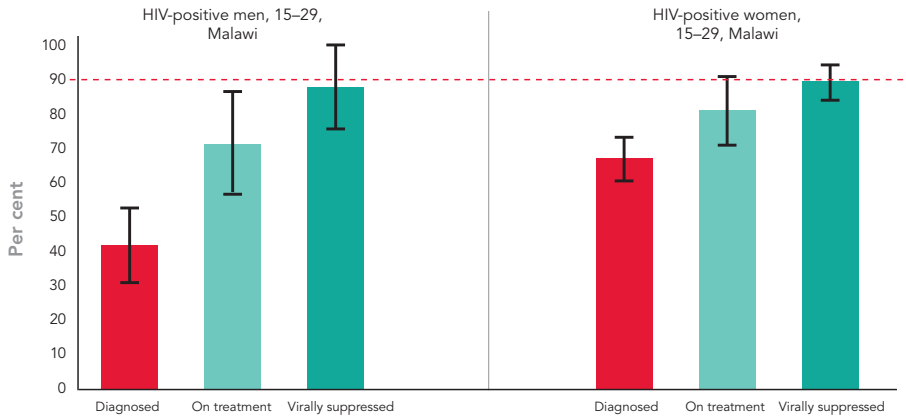
"I can look ahead with optimism and confidence because of all that we have achieved so far; together we can end the AIDS epidemic in Malawi."

Arthur Peter Mutharika,
President of Malawi

Political commitment and shared responsibility

Despite a low per capita gross national income of only US$ 250 per year, the Government of Malawi has demonstrated its commitment to funding the national AIDS response. The government's contribution to the national response increased from 1.8% in 2010/2011 to 14.1% in 2014/2015, but fell to 10% in 2016, owing to challenges in the economy (Global AIDS Response Progress Reporting, 2015, and Global AIDS Monitoring, 2016).

Progress to 90–90–90 among 15–29-year-olds by sex in Malawi



Source: Malawi Population-Based HIV Impact Assessment (MPHIA) 2016.

Political commitment to scale up HIV prevention and reduce stigma

The government is in the process of enacting its HIV and AIDS Prevention and Management Bill. The bill is expected to address issues of HIV-related stigma and discrimination and guarantee all Malawians access to HIV services.

Key challenges

Preventing HIV infections among adolescent girls and young women between the ages of 15 and 24 years old is lagging behind and HIV prevalence for adolescent girls and young women remains disproportionately high. The current limited human and financial resources may hinder the full-scale implementation of a comprehensive national strategy for adolescent girls and young women across the country.

Persistent coverage gaps for HIV testing, treatment and viral load suppression among men aged 15–40 years old and young people less than 30 years old. Severe shortage of health-care workers, leading to gaps in the coverage of services, and a low level of the use of funds.

Pre-exposure prophylaxis (PrEP) is in a pilot phase and has not been approved for use in the country. PrEP demonstration projects for key populations, in particular sex workers and men who have sex with men, are at the design or early implementation stage. These demonstration projects will collect evidence for the effective roll-out of PrEP in Malawi.

Way forward

Implementation must be accelerated to close the gaps. Policy changes, diverse methods of service delivery and sufficient human resources shall be established to fully implement the strategy on prevention for adolescent girls and young women, along with an increased engagement of men.

Ensure sustainable and predictable financing of the national AIDS response. Malawi's response to HIV is heavily donor-dependent, but the government has continued to demonstrate its commitment to increasing domestic financing of the AIDS response. Improving the implementation and efficiency of HIV services will be central to reducing the funding gap. Maintaining international commitment to reliable and predictable long-term investment is critical to enhancing and sustaining the gains of the national AIDS response.

"UNAIDS should remain the voice for the voiceless and not remove the foot off the pedal until the very last person can access treatment and together we end AIDS in Malawi."

Abigail Dzimadzi, Executive Director, Malawi Network of AIDS Service Organizations

Namibia
On track to an AIDS-free generation

Snapshot of the epidemic

The HIV epidemic has been a major factor for health and development in Namibia over the past three decades. Political commitment and the advocacy of civil society and people living with HIV, combined with the joint efforts of governments and international partners, have been essential to advance the response. Mother-to-child transmission of HIV is close to elimination and the number of children living with HIV is falling, while domestic financing of the HIV response is increasing. The Start Free, Stay Free, AIDS Free initiative has been rolled out in six regions under the leadership of the First Lady of Namibia.

In 2016, there were 9600 [8000–11 000] new HIV infections (compared to 13 000 [12 000–15 000] in 2005) and 4300 [3300–5500] AIDS-related deaths (compared to 11 000 [9400–13 000] in 2005). Access to treatment since 2005 has contributed to a strong rebound in life expectancy, from 56 years in 2005 to 65 years in 2015.

Challenges remain, however, with AIDS-related illnesses still the leading cause of death in Namibia. In 2016, 64% [51–74%] of the estimated 230 000 people living with HIV in Namibia were on antiretroviral therapy and collective action is required to accelerate increased coverage. Infant HIV case identification through early infant diagnosis (EID)—which includes retesting during the first 18 months of life—is a Namibian policy, but its execution remains challenging. EID coverage in 2016 was 65% for infants at age two months and 78% for infants at age 12 months.

HIV prevention programmes are lagging behind in scope and coverage. The male circumcision programme has a low coverage, at 26% in 2016 (UNAIDS, 2017). Since the government adopted the Fast-Track Targets for HIV prevention, treatment and stigma in its Namibia Investment Case on HIV, and endorsed the 2016 United Nations Political Declaration on Ending AIDS, good results have emerged, with more to follow.

Country Fast-Track Targets

	2005	2010	2016	2020
Know their HIV status			77% [70–84%]	90%
People living with HIV who are on treatment	7% [6–8%]	43% [51–74%]	64% [58–70%]	95%
Number of new infections among young people (15–24)	4300 [2500–5400]	4200 [2500–5000]	3500 [2000–4500]	1000
Domestic contribution to the AIDS response		60% (2010/2011)		80%

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Test and treat is yielding results

A treat all policy was adopted in July 2016 that was initially rolled out in the Khomas, Zambezi and Ohangwena regions, which are the high-burden regions of Namibia. By February 2017, the policy had been rolled out in all of the remaining regions, with promises to enrol a record number of patients through same-day initiation. Since antiretroviral therapy was introduced in 2003, the number of people living with HIV on antiretroviral therapy has increased annually, rising from 86 000 in 2010 to 151 000 in 2016 and 158 500 in June 2017. Viral load testing coverage—the estimated percentage of people on antiretroviral therapy who are eligible for viral load testing and who actually took the test—stands at 90% overall and 88% among children. However, coverage, coverage remains as low as 49% in some districts.

Innovative testing modalities to reach the people left behind

Namibia has piloted index partner tracing and testing services for people who have been newly diagnosed with HIV or have been enrolled on HIV treatment services. Preliminary data suggest that effective identification of people living with HIV and their immediate linkage to treatment are key strategies for the groups with the largest gaps in treatment coverage—young adults aged 20–24 years old (who have a treatment coverage of 22% for men and 38% for women) and men aged more than 30 years old (who have a treatment coverage of 55%).

Expanding the number of health-care workers

The antiretroviral therapy programme in Namibia is predominantly facility-based and driven by health-care workers, owing to the large area of the country and the population being dispersed in rural areas. The Ministry of Health and Social Security Health Care Extension Workers programme, which started with donor support in 2012, has taken on 700 community health workers, strengthening the health-care system in a country that faces an acute shortage in its health-care workforce.

The intention is to double the number of community health workers to 1500 and to build on HIV and antiretroviral therapy service provision as a platform for providing services to mothers, children and families. The strategic shift—to repurposed community-based care and support partners, in order to improve links to treatment, adherence to antiretroviral therapy and retention strategies—complements the facility-based services, transforming the system into one for the health of people in need.

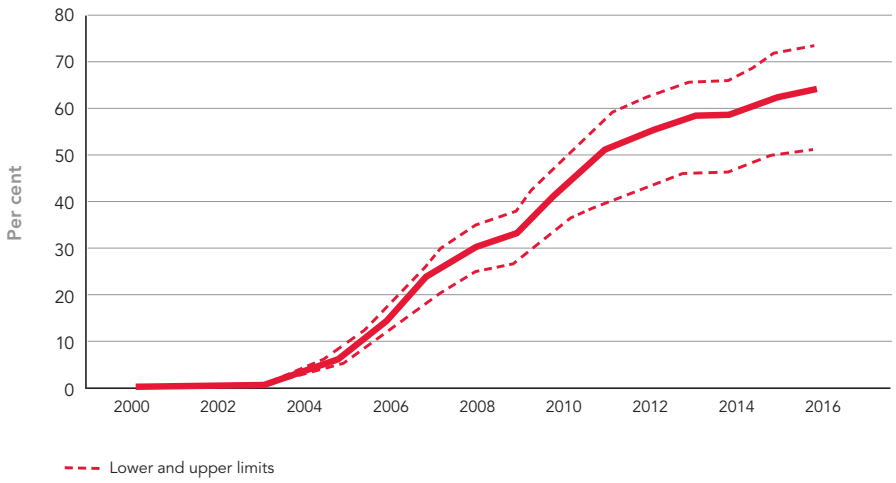
"My government adopted an integrated approach for ending AIDS with an eradication of poverty and leaving no one behind strategy."

Hage G. Geingob,
President of Namibia

HIV services in informal settlements

The Fast-Track cities approach has brought a comprehensive response to HIV to the informal settlements, providing health and social services to people who had been marginalized and without access to basic health services. Mobile outreach testing has been made available for key populations, with community involvement from the Namibia women's health network, which has provided counselling and connected people to treatment, particularly pregnant women living with HIV. The success of the programme has resulted in a mobilization of funds from the Global Fund to provide for an additional seven mobile clinics. The Namibia Planned Parenthood Association is also providing sexual and reproductive health and HIV services to young people.

Percentage of people living with HIV on antiretroviral therapy



Comprehensive HIV prevention a priority for action

Namibia's combination HIV prevention strategy focuses on reducing new HIV infections by targeting essential, evidence-informed programmes—such as HIV testing services, prevention of mother-to-child transmission of HIV services, antiretroviral therapy, voluntary medical male circumcision and pre-exposure prophylaxis (PrEP)—to the people who need them and by providing condoms to people at higher risk.

In the areas of the country with the highest levels of HIV prevalence, gender-based violence and teenage pregnancy (Demographic Health Survey, 2013)—Katima Mulilo, Omuthiya, Onandjokwe and Tsumeb—programmes for 10–24-year-old girls and young women will focus on HIV and gender-based violence prevention, with support from the United States President's Emergency Plan for AIDS Relief. Innovative approaches have been adopted to attract young people to prevention services by making selected public health facilities and Namibia Planned Parenthood Association facilities adolescent-friendly, including by providing free Wi-Fi and encouraging young people to become ambassadors of change.

Political commitment and shared responsibility

Namibia has consistently increased its domestic contribution to the AIDS response. The total domestic spending increased from US$ 111 million in 2012/2013 to US$ 136 million in 2013/2014, representing an increase of 23% (National AIDS Spending Assessment, 2012/2014), reaching 64%, and contributes to the Global Fund. Despite the current national economic constraints, the government is committed to maintaining the momentum and reaching a domestic resource contribution of 80% by 2022. The government is working on efficiencies to reduce costs, based on the 2016–2030 Namibia HIV Investment Framework findings.

Namibia is to allocate 30% of its HIV budget to combination prevention during the implementation of its 2017–2022 National Strategic Framework, compared with 17% in the previous HIV strategy. Under the National Strategic Framework, the resource allocation for adolescents, young women and girls increased from 1.4% to 9.6%, while programmes for key populations will increase from 0.9% to 8%. PrEP will be introduced and there will be allocations for voluntary medical male circumcision and condoms.

"To end AIDS by 2030, it is my appeal to global partners and governments to put the money where their mouth is by frontloading investments now to reap the dividends in the immediate future."

Sandie Tjaronda, Executive Director, Namibia Networks of AIDS Service Organizations

Key challenges

Insufficient acceleration of treatment coverage with significant gaps in testing, treatment and viral load suppression services for men and women aged 20–24 years old, key populations and men aged older than 30 years, and paediatric care.

With 34% of new HIV infections occurring among young people aged 15–24 years, focusing on young women and girls, especially reducing teenage pregnancies, addressing gender equality and providing comprehensive sex education, is vital.

The policies and regulatory framework to reinforce the expansion of the number of health-care workers and community-level delivery modalities, including through mechanisms of contractual agreements between the government and civil society, have yet to be developed and remain essential in the context of inadequate human resources for health, both in absolute numbers and as a consequence of their geographical distribution.

In response to declining international resources, the government has prioritized increasing efficiencies and the effectiveness of the AIDS response and improving the current low absorption rate of Global Fund resources. The reduced funding for community organizations, decline of the Global Fund resources and domestic fiscal consolidation, threaten the further scale-up of the AIDS response and reaching the people being left behind.

Way forward

Advocacy for legal reform, building on the government's commitment to leave no one behind in the eradication of poverty, to create an environment for increasing access to services for key populations, reducing stigma and addressing the vulnerability of young women.

Accelerating quality implementation of a comprehensive HIV response to close the gaps, including changing policies and frameworks to strengthen system delivery by combining the community health worker programme with community-based service delivery, is important.

Maintaining both a political and a financial commitment to reach the Fast-Track Targets and embarking on developing a sustainable approach to ensuring shared responsibility and to affirming global solidarity is vital to ending the AIDS epidemic in Namibia.

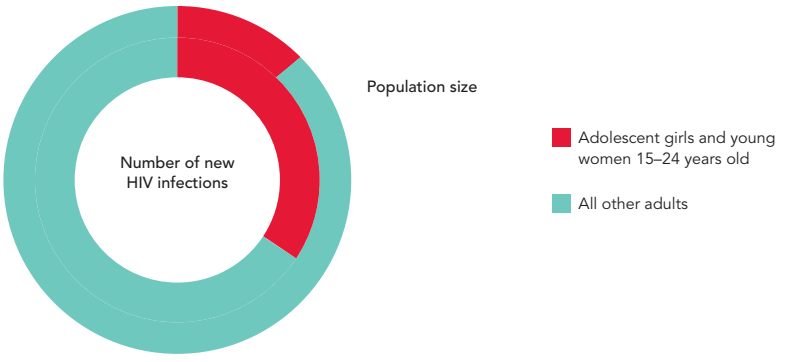
South Africa
Fast-Track to quality

Snapshot of the epidemic

There are an estimated 7 million people living with HIV in South Africa. By the end of 2016, 3.9 million people living with HIV (56%) were on antiretroviral therapy, and 45% of people living with HIV were virally suppressed, making it the world's largest publicly funded antiretroviral programme. While on track to achieve the first two of the 90–90–90 targets by 2020, national coverage is not equitably shared by all age, sex and key population groups. Almost 90% of women living with HIV had been tested and knew their status, compared to only 82% of men, and 65% of women were accessing antiretroviral therapy, compared to only 54% of men.

Men are not being reached with testing and treatment services, placing themselves and their partners at increased risk of HIV infection. Combined with systemic gender inequality and a high level of gender-based violence, this perpetuates the unacceptably high rates of new HIV infections among adolescent girls and young women. To be on the Fast-Track to ending AIDS by 2030, South Africa has to achieve the targets of the 2016 United Nations Political Declaration on Ending AIDS by 2020. The UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria and other key partners, works closely with national partners and civil society to support the response.

The burden of new HIV infections among adolescent girls and young women aged 15–24 years in South Africa compared with their population in 2016



Source: Thembisa 3.2

Country Fast-Track Targets

South Africa has adopted the 90–90–90 targets at the national, provincial and district levels, with a particular emphasis on 27 high-burden districts of 52 districts.

The target for new HIV infections is less than 100 000 new infections by 2022 (set in the National Strategic Plan 2017–2022). The 2022 target for new infections among children is zero.

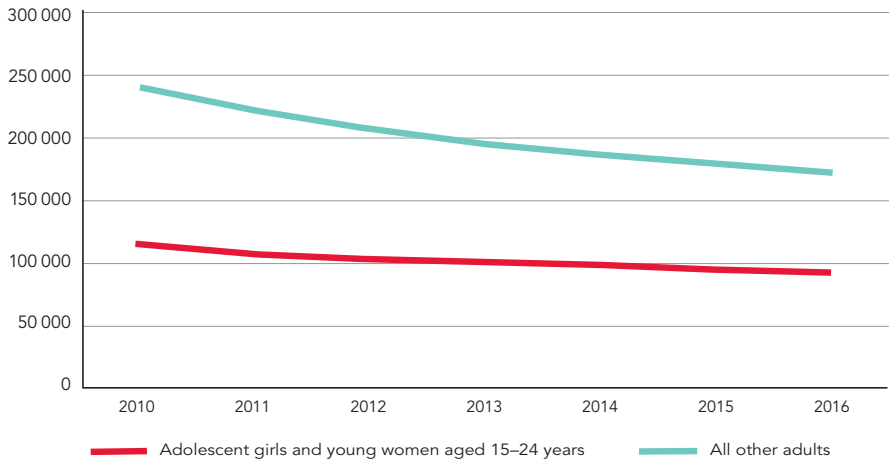
International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

To achieve the ambitious goals will require a prevention revolution that addresses the sociocultural and structural factors driving new HIV infections among adolescent girls and young women.

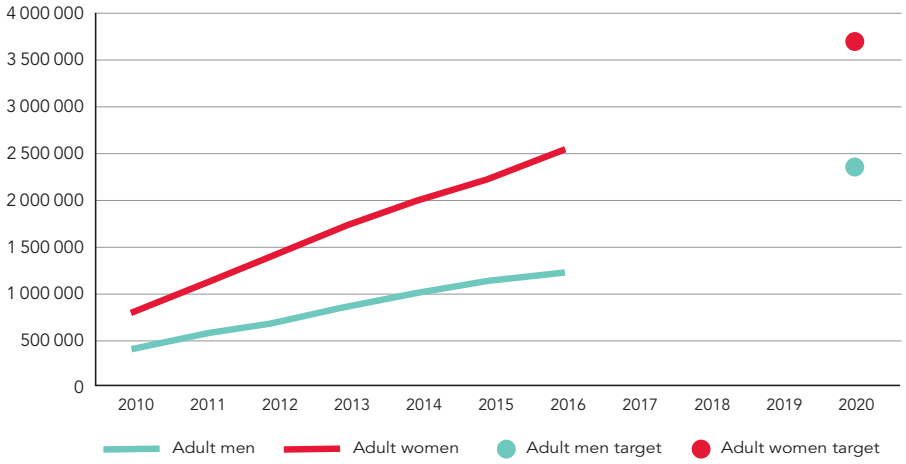
Although new HIV infections have declined by 29% from 2010, to 270 000 in 2016, young women continue to bear a disproportionately high burden of new infections. Young people (15–24 years old) make up 24% of the population and 10% of all people living with HIV, but account for 41% of new HIV infections, of which more than 70% were among adolescent girls and young women.

Trend of new HIV infections among adolescent girls and young women aged 15–24 years and other adults in South Africa, 2010–2016



Source: Thembisa 3.2

Number of adult men and women living with HIV who access antiretroviral therapy



Source: Thembisa 3.2

South Africa's success in progressing towards the elimination of mother-to-child transmission of HIV (new HIV infections among children aged 0–14 years more than halved between 2010 and 2016 to only 12 000) needs to be expanded to broader prevention efforts. A prevention revolution has begun that targets the structural and societal factors that perpetuate gender inequalities. It starts by building stronger families and communities, with parenting classes to change gender norms and promote gender equality.

A national campaign to empower young women, She Conquers, is gaining momentum. The Department of Basic Education is revitalizing the school health programme, with a strong emphasis on comprehensive sexuality education, access to sexual and reproductive health services and HIV prevention information and methods, combined with efforts to keep young women in school, which continues into tertiary education.

Although AIDS-related deaths have declined by almost half since 2010, there were still 110 000 AIDS-related deaths in 2016. Tuberculosis (TB) is among the leading causes of death among all South Africans, despite being preventable and curable. The national response to TB and HIV is being threatened by drug resistance and challenges to HIV and TB treatment adherence. The health system is struggling to adequately support the massive scale-up in HIV and TB treatment.

The recent death of leading HIV activist Prudence Mabele highlighted the inadequacy of services to support lifelong treatment and prevent adherence fatigue. Urgent investment in community service delivery is essential, with an expansion of the community health worker programme and differentiated care models. Affected communities need to be engaged in the planning, monitoring and delivery of services to ensure sustainable, person-centred care for everyone.

"Government is playing its part in fighting crimes against women. South Africa must be safe for women and children in every corner."

Jacob Zuma,
President of South Africa

"We cannot allow our achievements to lull us into complacency. We need the whole of the country to re-unite behind the response, as led by the 2017–2022 National Strategic Plan."

Mmapaseka "Steve" Letsike, South African National AIDS Council Civil Society Forum Chairperson and Deputy Chairperson

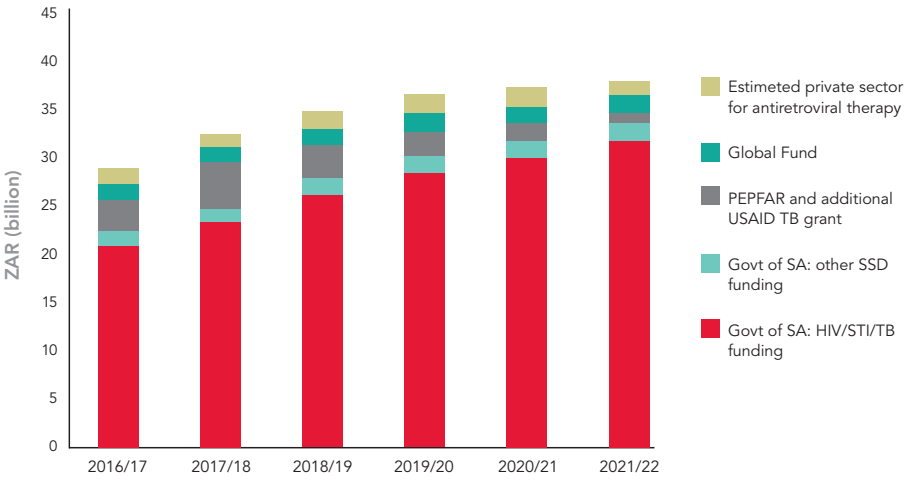
There is a need to sustain an effective and efficient response. Strong, consistent political leadership on HIV has ensured that the majority of AIDS funding comes from the National Treasury. Smart investments in technology, such as the GeneXpert multidisease diagnostic platform, enables rapid, cost-effective and more accurate diagnosis of HIV, TB, drug resistance, hepatitis and human papillomavirus infection.

Key challenges

Preventing new infections among adolescent girls and young women is essential for South Africa to reach its target of reducing new HIV infections to 100 000 by 2022. Adolescent girls and young women aged 15–24 constitute 13% of the total adult population in South Africa, but had 34% of the new HIV infections in 2016. The rate of decline in new infections among adolescent girls and young women is much lower (20% since 2010) than the rest of the adult population (28%).

Reaching men with HIV testing and treatment services is another important challenge. It is estimated that 3 million men will be living with HIV in South Africa by 2020. However, only an estimated 2.3 million men living with HIV knew their status in 2016. Thus 400 000 additional men should know their status by 2020 in order to reach the first 90 among men. An additional 350 000 women will need to know their HIV-positive status, but this would be easier to reach in view of the current trend. The treatment gap is also much wider among men, with coverage among adult men living with HIV

Current and anticipated HIV, tuberculosis (TB) and sexually transmitted infection (STI) funding from all sources



Source: South Africa's National Strategic Plan for HIV, TB and STIs 2017–2022.

at 47%, compared to 60% among women. Among people who have been tested and know they are HIV-positive, treatment coverage among men is 54%, compared to more than 90% among women. Adult men living with HIV subsequently have a much higher death rate compared to women (a more than 50% higher annual death rate in 2016). If incidence remains at the 2016 rate, almost a quarter of boys at the age of 15 today will acquire HIV before they turn 60.

The National Strategic Plan on HIV, TB and STIs (2017–2022) recognizes the key role of structural drivers, especially that there is an acute need to reduce new HIV infections. These drivers include: a high rate of unemployment, especially among young black South Africans; high poverty rates and high levels of inequality; and major challenges with gender-based violence and other gender inequalities. The government is working with civil society to respond to these issues despite budget constraints, with projected annual economic growth at less than 1%.

Way forward

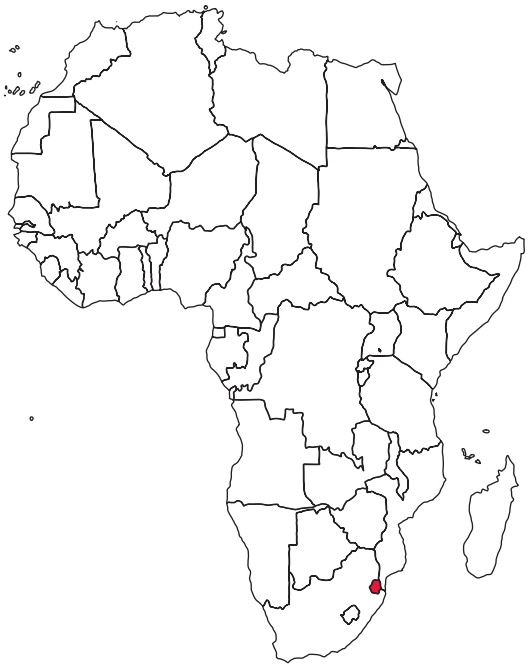
Reaching the populations being left behind

The current models of health service delivery do not meet the needs of working age men, who are "missing in action", and people from key populations. Innovative approaches designed by the South African National AIDS Council men's dialogue aim to reach working age men through extended clinic opening hours, men's health clinics and the promotion of partner testing through distribution of self-test kits to couples and in workplaces. The national sex worker HIV strategy is a multifaceted approach to empowering sex workers to take control of their health and protect themselves and their clients from HIV, sexually transmitted infections and violence.

Sustaining a quality response

An aggressive approach to HIV prevention will ultimately reduce the national HIV treatment burden, but in the short term South Africa still has to significantly increase the number of people on HIV treatment, which demands innovative financing and service delivered through strategic partnerships. The new National Health Insurance scheme aims to expand access through the capacity available in the private health sector in addition to strengthened community systems in health. Political commitment at the national and provincial levels, resources and innovations are required to address the emerging challenge in sustaining a quality response that is accessible to everyone in need.

Swaziland
On track to control its HIV epidemic



Snapshot of the epidemic

Progress towards the 90–90–90 targets demonstrates that Swaziland has achieved great advances in its response to its HIV epidemic. In 2016, HIV prevalence among adults aged 15–49 years old in Swaziland was 27.2% [24.9–29.1%], at the same level as in 2010. There were 220 000 [200 000–230 000] people living with HIV in the country in 2016.

The reduction of new infections from 13 000 [12 000–14 000] in 2010 to 8800 [7300–11 000] in 2016 (UNAIDS, 2017) is a testament to political commitment, leadership across all sectors of the AIDS response and a strong partnership with communities and international partners. Yet, the country faces a dual epidemic of HIV and tuberculosis (TB) and AIDS-related illnesses remain the leading cause of death in Swaziland. Male circumcision programmes have achieved low results, and HIV prevention programmes are of limited scale.

HIV particularly affects women in the country, with HIV prevalence standing at 32.5% for women aged 15 years and older, compared to 20.4% for men (Swaziland HIV Incidence Measurement Survey, 2017).

Country Fast-Track Targets

	2005	2010	2016	2020
Know their HIV status				90%
Adults on antiretroviral therapy	6% [5–7%]	33% [26–37%]	79% [63–89%]	81%
Children on antiretroviral therapy	9% [7–10%]	30% [24–36%]	64% [50–76%]	
Viral load suppression coverage			68% [62–73%]	73%
Combination prevention (general and key populations) coverage				90%
Reduce stigma				By at least 50%
Domestic funding				At least 53% of antiretroviral medicine national need

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Treat all

Swaziland launched its test and start strategy in October 2016. At the end of 2016, antiretroviral therapy coverage for adults living with HIV was 80% [64–90%] , and for children was 64% [50–74%], with women having a higher coverage than men, at 85% [68–>95%] and 72% [66–78%], respectively. Prevention of mother-to-child transmission of HIV services reach 95% [81–>95%] of pregnant women, compared to 77% [67–88%] in 2010 (UNAIDS, 2017).

According to government data, more than 14 900 people were enrolled on antiretroviral therapy between October 2016 and March 2017 (UNAIDS country office, Swaziland National AIDS Programme, 2017), a significantly higher rate than previous enrolments. Same-day HIV testing and initiation on antiretroviral therapy has been proven to improve retention and health outcomes. In Swaziland, a general increase in same-day antiretroviral therapy initiation, ranging from 45% to 57% of people newly diagnosed as living with HIV, was noted across all age groups within the first six months following the shift to test and treat (UNAIDS country office, Swaziland National AIDS Programme, 2017).

The findings of the recent Swaziland HIV Incidence Measurement Survey 2 are broadly similar to UNAIDS 2016 estimates for antiretroviral therapy coverage and viral suppression and show the remarkable progress the country is making towards the 90–90–90 targets. Among all people living with HIV aged 15 years and older, 84.7% report knowing their HIV status. Among people living with HIV who know their HIV status, 87.4% self-report current use of antiretroviral therapy, and among people living with HIV who self-report current use of antiretroviral therapy, 91.9% are virally suppressed. However, these results mask gaps. Viral load suppression is lowest among younger adults: 55.5% among 15–24-year-old women living with HIV and 32.9% among men of the same age living with HIV.

HIV prevention

Despite the decline of HIV incidence, the Fast-Track approach demonstrates the need to intensify comprehensive prevention services for people at higher risk. Adolescent girls and young women face HIV prevalence three times higher than boys and young men. Prevention programmes for adolescent girls and young women implement a comprehensive package that increases access to HIV prevention as well as adolescent- and youth-friendly HIV and sexual and reproductive health services, aiming to reduce HIV transmission as well as teenage pregnancies.

Sexual and reproductive health services are essential, since 16.7% of women aged 20–24 years old have at least one live birth before the age of 18, and 4% are pregnant with their first child at 15. In Swaziland, one in every three deliveries is from an adolescent girl (Multiple Indicator Cluster Surveys, Demographic Health Survey). For the first time, programmes for sex workers and their clients and men who have sex with men have been prioritized in the national HIV strategy, in the light of the 60.5% HIV prevalence among sex workers (USAID, Research 2 Prevention Report, 2013). A national pre-exposure prophylaxis (PrEP) framework has been developed and endorsed by the Ministry of Health, but voluntary male circumcision has progressed at a slow pace.

There is an increased focus on identifying the most vulnerable populations by age and sex (e.g. out-of-school rural adolescent girls, remote poor people and wealthier men) and a particular focus on mother and baby pairs.

Innovative models to leave no one behind

Test and treat has transformed approaches to service delivery by bringing services closer to the people. There is rapid enrolment on treatment as a result of models of care tailored to the different population groups and decentralization of the distribution of antiretroviral therapy to lower-level clinics. Mobile test and start and community antiretroviral therapy refills are promising methods of reaching people in remote areas.

Self-testing and index testing will be rolled out to reach men, young people and key populations in different locations. A Médecins Sans Frontières pilot self-testing project saw men accounting for 45% of self-testers and 15–24-year-olds accounting for 24%, compared to standard HIV testing, where only 35% of those tested were men and only 8% were 15–24-year-olds (Médecins Sans Frontières, Swaziland, 2017). Community delivery models that engage at every step of the test and treatment cascade have proven effective to improve test and start and improve linkages and retention to care. Models where the client is accompanied in all steps, encouraged to start treatment if found HIV-positive, receive regular follow-up and have transport facilitated if lack of transport is an obstacle to adherence have significantly increased retention. Health-care workers have been trained to work with community-based organizations in order to increase their reach and efficiency.

Shared responsibility and global solidarity

The government, through Umgubudla (the investment case on HIV), has committed to ending AIDS by 2022 and to Fast-Track the vision of the King and his commitment to achieving the targets in the 2016 United Nations Political Declaration on Ending AIDS. The absorption rate of HIV response funds has improved, reflecting accelerated implementation.

Key challenges

Limited scale, coverage, intensity and funding of HIV prevention programmes and linkages with test and treat services. Early sexual debut and transactional sex, compounded by stigma and limited access to sexuality education and services, remain significant barriers. Cultural barriers to male circumcision are pervasive and PrEP distribution is only in a pilot phase.

Men and younger adults are not being reached with HIV prevention, testing and treatment, placing themselves and partners at risk of infection. Viral load suppression is lowest among younger adults and only 77.5% of men living with HIV know their HIV status, compared to 88.6% of women living with HIV (Swaziland HIV Incidence Measurement Survey II). The 26.7% prevalence of voluntary medical male circumcision among men aged 15 years and older is low (Swaziland HIV Incidence Measurement Survey II).

There is unpredictable donor commitment towards the HIV and TB response, in particular in view of the recent decline of Global Fund resources, which threatens the sustainability of the AIDS response and the results achieved. As more people are enrolled on treatment, increased domestic resources and efficiencies will not suffice to increase the resources required to maintain life-long treatment and to rapidly expand the response to close the gaps and leave no one behind.

Way forward

Progress toward the 90–90–90 targets in Swaziland demonstrates that the national HIV response has achieved great advances. To achieve the targets, there is a need to:

- Rapidly expand policies and comprehensive programmes that combine facility-based and community-level services to reach the people left behind, with a focus on paediatric care and young women and on engaging men.
- Maintain and voice leadership on reducing stigma and addressing cultural practices that contribute to the vulnerability to HIV infection of adolescent girls and young women.
- Increase the accountability of the government, partners and donors to ensure a fully funded HIV and TB response to reach the end of AIDS as public health threat and fulfil the commitments of the 2016 Political Declaration.

Uganda
President in the driver's seat

Snapshot of the epidemic

In June 2017, the President of Uganda, Yoweri Kaguta Museveni, become the first head of state in Africa to launch a presidential Fast-Track initiative on ending AIDS as a public health threat, referred to as "Kisanja Hakuna Mchezo" or "no time for playing games".

Uganda continues to make progress in its response to HIV. Between 2010 and 2016, new HIV infections declined by 48% and AIDS-related deaths declined by 55%. A total of 1.4 million [1.3 million–1.5 million] people were living with HIV in Uganda in 2016 (UNAIDS, 2017). HIV prevalence among adults aged 15–49 years stands at 6.5%.

Uganda has also rolled out a test and start policy. Already, 74% [69–80%] of Ugandans living with HIV know their HIV status, 67% [63–72%] of all people living with HIV are receiving effective antiretroviral therapy. This places Uganda on a firm path towards meeting the 90–90–90 targets by 2020. There is also a need to enhance treatment, particularly among specific populations: young people, men and children.

There were 52 000 [42 000–64 000] new HIV infections in the country in 2016, and the high new HIV infection rate among populations at risk poses a major concern. Young women aged 15–24 years old and men under 35 years of age who are living with HIV have viral suppression rates of under 50%, compared to 60% among all adults, indicating gaps in linking testing and treatment to young people (Uganda Population HIV Impact Assessment, 2017).

Stigma and discrimination remains a major barrier in Uganda. This is manifested in violations of the rights of people living with HIV, cases of HIV-related termination from employment, fear of breach of confidentiality and marginalization of sexual minorities.

While challenges are present, Uganda also provides an opportunity for innovation and experimentation, and quickly adopts best practices.

Country Fast-Track Targets

70%

by 2020

Reducing the number of new HIV infections.

90%

by 2020

Reaching adherence and viral load suppression among people living with HIV on treatment.

80%

by 2020

Increasing the percentage of HIV testing and counselling of women and men (15–49 years) who tested in the past 12 months and know their results.

5%

by 2020

Reducing the proportion of people with discriminatory attitudes.

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

As part of his Fast-Track initiative to end AIDS in Uganda by 2030, the President has challenged men to demonstrate leadership in their families by finding out their HIV status and taking appropriate action. Of the 23 000 [17 000–32 000] AIDS-related deaths among adults in 2016, 15 000 [11 000–21 000] were among men, compared to 7700 [5700–11 000] among women, even though HIV prevalence is higher among women than men (7.6% versus 5.4%). Viral suppression among adult men is 53.6%, compared to 62.9% among women (Uganda Population HIV Impact Assessment, 2017).

Training of health-care providers is currently under way nationwide, in order to disseminate the treatment guidelines and to ensure quality control. Uganda is presently examining approaches such as self-testing, use of pre-exposure prophylaxis, differentiated service models and refinement of monitoring and evaluation tools in order to optimize data for decision-making.

Uganda met the global milestone for the elimination of mother-to-child transmission in 2015, achieving treatment coverage of more than 95% for pregnant and breastfeeding women, and a mother-to-child HIV transmission rate of less than 5%. Uganda was one of the first countries to scale up the Option B+ for pregnant and breastfeeding women and rolled out a national strategy for accelerating implementation. HIV prevalence among children 0–14 years old is 0.5%, and new infections in this age group declined by 83% between 2010 and 2016. This was the fastest reduction among the high-burden countries. Yet, there is need to improve paediatric treatment: of the country's 130 000 [120 000–150 000] children under 15 years of age living with HIV, only 47% [42-55%] are receiving treatment, compared to 69% [64-75%] among adults (Uganda Population HIV Impact Assessment, 2017).

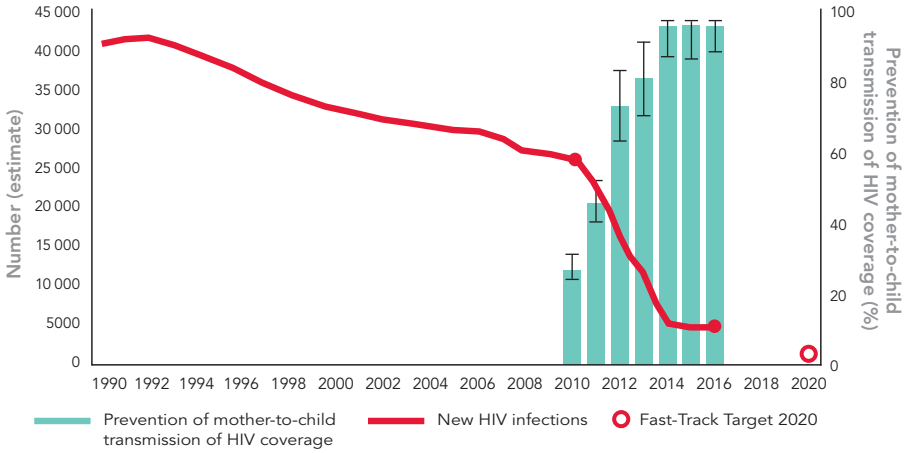
Male circumcision is one of the prevention strategies that has demonstrated results in Uganda. The proportion of men aged 15–49 who are circumcised increased from 26% in 2011 to 43% in 2016. Programmes for young women and girls and populations at risk are of limited scope and scale.

To address the HIV response sustainability, Uganda has made bold steps and has set in motion steps towards an AIDS Trust Fund, has launched the One Dollar Initiative private sector partnership and is working towards a budgetary increase. Uganda has also developed a strong monitoring and evaluation database, which provides a robust platform on which programme assessments can be made.

"AIDS is a simple disease. Its transmission is through a few ways. It can be treated, even if it cannot be cured. And now that more controls have been added on, let us target an AIDS-free Uganda by 2030."

Yoweri Museveni,
President of Uganda

Will Uganda meet the 2020 Fast-Track Target for new HIV infections among children? It can!



Source: UNAIDS Estimates, 2017.

"Investing in communities keeps people at the centre of the response and contributes to responding to HIV in an effective and sustainable manner. However, this is the sector we least invest in."

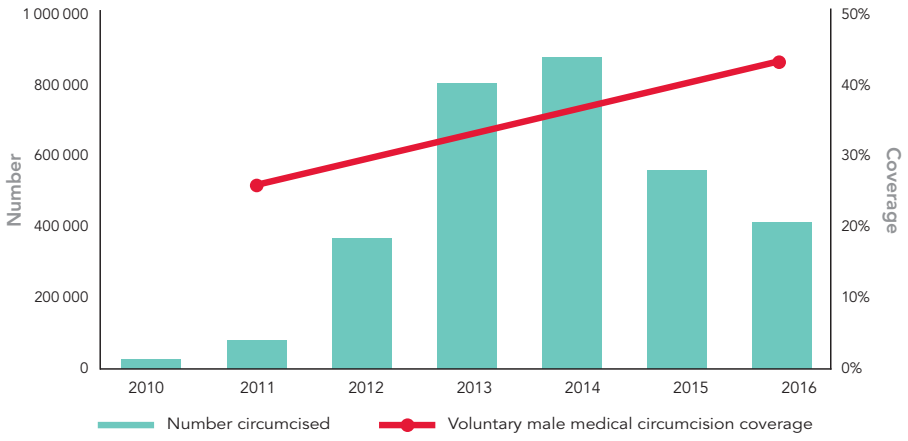
Jacquelyne Alesi, Uganda Network of Young Positives Association

Key challenges

The following are key challenges:

- Limited HIV prevention programmes coupled with pervasive stigma, discrimination and violations of rights remains a priority challenge to having an impact on the HIV epidemic trajectory in Uganda.
- Overreliance on donor funding. Nearly 90% of the HIV response is funded by donors, leaving the country's AIDS response vulnerable. The health budget has declined over the past five years. External resources were reduced by 10% in 2015 from the peak in 2013. The reduction in external resources and, in the future, maintaining the level of external resources could also be a bigger challenge.
- Accelerating implementation and accounting for the deficiencies in the health system, including the shortage of health personnel, poor health infrastructure, weak supply systems and poor accountability.
- General poverty in the country and competing priorities in the community's agenda. This has a particular impact on children living with HIV, who already are less likely than adults to access treatment.
- The war in South Sudan has triggered a refugee crisis and by, July 2017, more than a million refugees had arrived in northern Uganda. With no end to the civil war in South Sudan in sight, UNAIDS is joining partners to determine the best way to ensure continuity of services for the refugees.

Annual number of men circumcised, and voluntary male medical circumcision coverage in Uganda, 2010–2016



Source: WHO, 2017. WHO Progress Brief. Voluntary Medical Male Circumcision for HIV prevention in 14 priority countries in East and Southern Africa: July 2017; GAM 2017, UAIS 2011, and UPHIA 2016.

Way forward

The presidential Fast-Track initiative will:

- Revitalize HIV prevention and stop new infections, particularly among girls and young women.
- Engage men in HIV prevention and stop new infections, particularly among adolescent girls and young women.
- Consolidate progress on eliminating mother-to-child transmission of HIV.
- Accelerate implementation of test and treat and attaining the 90–90–90 targets, particularly among men and young people.
- Scale up financing sustainability for the AIDS response.
- Improve institutional effectiveness for a multisectoral response.

Zambia
Test and treat: towards ending AIDS

Snapshot of the epidemic

There are 1.2 million people (UNAIDS, 2017) living with HIV in Zambia; HIV prevalence among 20–24-year-olds is four times as high among women (8.6%) than among men (2.1%) (Zambia Population-Based HIV Impact Assessment, 2016). The estimated number of new HIV infections among adults dropped from 69 000 [62 000–79 000] in 2005 to 59 000 [52 000–69 000] in 2016 (UNAIDS, 2017), and annual AIDS-related deaths have seen similar decreases, from 64 000 [56 000–74 000] to 21 000 [17 000–28 000] (UNAIDS, 2017). Zambia has integrated refugees into local communities, where refugees have unrestricted access to health and HIV services.

In 2016, 66% [63–70%] of people living with HIV new their HIV status, treatment coverage reached 65% [62–69%] and 58% [55–62%] of people living with HIV were virally suppressed (UNAIDS, 2017). Recognizing the need to accelerate the response, Zambia published the Fast-Track National AIDS Strategic Framework 2017–2021, which commits to accelerating an efficient and effective AIDS response and prioritizes key populations, including men who have sex with men, for the first time. Following this, the President launched HIV test and treat to promote 90% of people living with HIV knowing their status and linked to treatment.

Country Fast-Track Targets

Zambia has set prevention and treatment Fast-Track Targets in line with the 2016 United Nations Political Declaration on Ending AIDS. The National AIDS Strategic Framework 2017 is fully aligned with the Political Declaration and set ambitious targets for priority populations.

	2005	2010	2016	2021
New HIV infections	69 000 [62 000–79 000]	67 000 [59 000–77 000]	59 000 [52 000–69 000]	18 000
Knowledge of HIV status			810 000 66% [63–70%]	90%
People living with HIV who are on treatment	57 200 6% [6–7%]	349 000 34% [33–36%]	798 000 65% [62–69%]	83%
People living with HIV who are virally suppressed			709 900 58% [55–62%]	90% of people living with HIV on treatment
Stigma and discrimination				0
Domestic financing				30%

International partners, including the UNAIDS family, along with the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other key partners, work closely with national partners and civil society to support the response and achieve the Fast-Track Targets.

Progress in Fast-Track

Test and treat

Just under 800 000 people living with HIV are on antiretroviral therapy (65% [62–69%]). Paediatric treatment has improved and reached 52% [47–58%] (UNAIDS 2017 estimates). Recognizing that the coverage needs to be accelerated, the government has launched test and treat to ensure that the 90–90–90 targets are met by 2020. HIV self-testing has been included as one of the testing strategies to identify hard-to-reach populations. Policies to facilitate community service delivery and reach the people left behind are in place. Innovative measures to involve communities and faith-based organizations are being considered to increase treatment adherence, in particular for adolescents and young people. The elimination of mother-to-child transmission of HIV by 2020 should be further reinvigorated.

Expanding comprehensive HIV prevention

Prevention programmes targeting adolescent girls and young women are being scaled up. Condom programming is still functioning mainly for family planning, with age restriction (16 years) for accessing sexual and reproductive health services, including condoms, from health facilities. The voluntary medical male circumcision programme has been a successful intervention implemented progressively. Pre-exposure prophylaxis has been introduced, targeting serodiscordant couples and key populations at higher risk of infection, with the overall goal of rapidly expanding implementation. The new National AIDS Strategic Framework has recognized and embraced key populations, but a prevention package and scale-up plan is yet to be defined. Barriers include a limiting legal framework and the lack of size estimations of key populations. The involvement of boys and men needs to be strengthened.

Scaling up community services

The Ministry of Health has finalized a community health strategy to strengthen community systems as part of the primary health-care approach. Innovative models of community involvement in demand creation and treatment adherence, as well as viral load literacy and advocacy, are expanding. Viral load score cards will be produced to facilitate the retention and adherence of people living with HIV. The Ministry of Health has extended the opening hours of clinics and pharmacies to facilitate ease of access by clients during off-hours and holidays.

"Let's not wait for people to fall sick before they can start life-saving treatment. Let's take integrated health services, including HIV testing and treatment, to the communities."

Edgar Lungu,
President of Zambia

The model introduced by HPTN 071 (PopART), where community care providers conduct annual rounds of a combination HIV prevention package to communities, yielded impressive gains on knowledge of HIV status, which increased from 52% to 78% among men living with HIV, from 24% to 73% among people aged 20–24 living with HIV, and shed light on delays in initiation of HIV treatment after HIV diagnosis. The package included interventions that included home-based HIV testing and counselling, condoms, promoting voluntary male circumcision for HIV-negative men and linkages with care and treatment retention. The effective implementation of a decentralized policy and creating a clear linkage between health and local government is crucial to taking services close to the people.

Political commitment and shared responsibility

The Ministry of Health has developed the Social Health Insurance Bill, which has been presented to Parliament for review and passing. This is expected to provide additional domestic resources for HIV funding.

The National AIDS Council, in collaboration with Economic Association of Zambia, initiated dialogue around shared responsibility and sustainable financing of the AIDS response for better impact.

HIV test and treat was launched in August 2017, demonstrating the government's commitment to ending AIDS.

Key challenges

The age of consent to access HIV services remains an impediment to reaching young people with services, as the current legal age of consent to testing denies sexually active young people access to HIV testing.

Gender inequalities, social and cultural inequalities between men and women and high levels of gender-based violence often make it difficult for women, especially young women, to access HIV and sexual and reproductive health services.

Stigma and discrimination remains pervasive and holds people back from testing. The law criminalizes homosexuality and key populations do not have an enabling environment to demand access to services.

Way forward

Decentralization of the AIDS response through the cities initiative and to high-burden locations combined with expanding the mix of facility-based and community services to accelerate quality implementation.

The sustainability of the AIDS response will require joint commitment and accountability from the government and international partners, to ensure that the government's investments in the HIV response and the health sector increase and reaffirm global solidarity and resources.

"We want to see increased access to viral load services by people living with HIV in Zambia."

Felix Mwanza, Treatment Advocacy and Literacy Campaign