

GLOBAL UPDATE ON THE HEALTH SECTOR RESPONSE TO HIV, 2014

JULY 2014

EXECUTIVE SUMMARY



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EXECUTIVE SUMMARY

The massive expansion globally of HIV interventions has transformed both the HIV epidemic and the broader public health landscape, demonstrating that the right to health can be realized even in the most trying of circumstances.

Substantial – and in some respects, remarkable – progress has been made in the past 3–4 years, especially in areas in which clear service delivery targets have been set, such as HIV treatment, preventing the mother-to-child transmission of HIV and preventing and treating tuberculosis (TB) and HIV coinfection. Nevertheless, this report also highlights

the current unevenness of the HIV response – across different countries, communities, populations and interventions – and the considerable opportunities that exist for extending and sustaining recent improvements with a view towards ending the AIDS epidemic by 2030. Lessons learned from HIV can also inform the broader effort to achieve universal health coverage, a key element of the post-2015 development agenda, affording to all people access to high-quality health services they need without subjecting them to financial hardship.

A review of recent progress

This review¹ is cast within the framework of the Global Health Sector Strategy on HIV/AIDS 2011–2015 (see box). Endorsed at the 2011 World Health Assembly, the Strategy was developed to guide the expansion of the global HIV response beyond the HIV-specific programmes of the past, by strategically positioning HIV within a rapidly changing health and development agenda.

While building on core HIV programmes, the Strategy is aimed at maximizing links and synergy with other vital public health areas in ways that improve health outcomes overall and strengthen health and community systems for sustainable action. It is also intended to influence other sectors to adopt policies that reflect public health priorities and that foster enabling environments, and to address the underlying social and structural determinants of HIV epidemics.

Global Health Sector Strategy on HIV/AIDS: four targets for 2015

The goals of the Strategy are zero new HIV infections, zero AIDS-related deaths and zero discrimination in a world in which people living with HIV are able to live long, healthy lives. Reaching these goals requires drastically expanding the coverage and improvement in the quality of HIV prevention, diagnosis, treatment and care interventions. Designed to help achieve those outcomes, the Strategy is structured along four strategic directions:

Strategic direction 1: Optimize HIV prevention, diagnosis, treatment and care outcomes;

Strategic direction 2: Leverage broader health outcomes through HIV responses;

Strategic direction 3: Build strong and sustainable systems; and

Strategic direction 4: Reduce vulnerability and remove structural barriers to accessing services.

HIV prevention gains need to be extended and focused better

The coverage and quality of prevention services have generally improved, and an expanding array of highly effective HIV interventions is available. In addition to the promotion of behavioural changes, several biomedical interventions are being deployed. They include initiating ART regardless of CD4 cell count for serodiscordant couples, pregnant and

breastfeeding women, and in some settings key populations, as well as voluntary medical male circumcision (in settings with a high prevalence of HIV infection in eastern and southern Africa) and the use of ARV drugs for both pre-exposure prophylaxis and post-exposure prophylaxis of HIV.

¹ The full report is available at www.who.int/hiv.

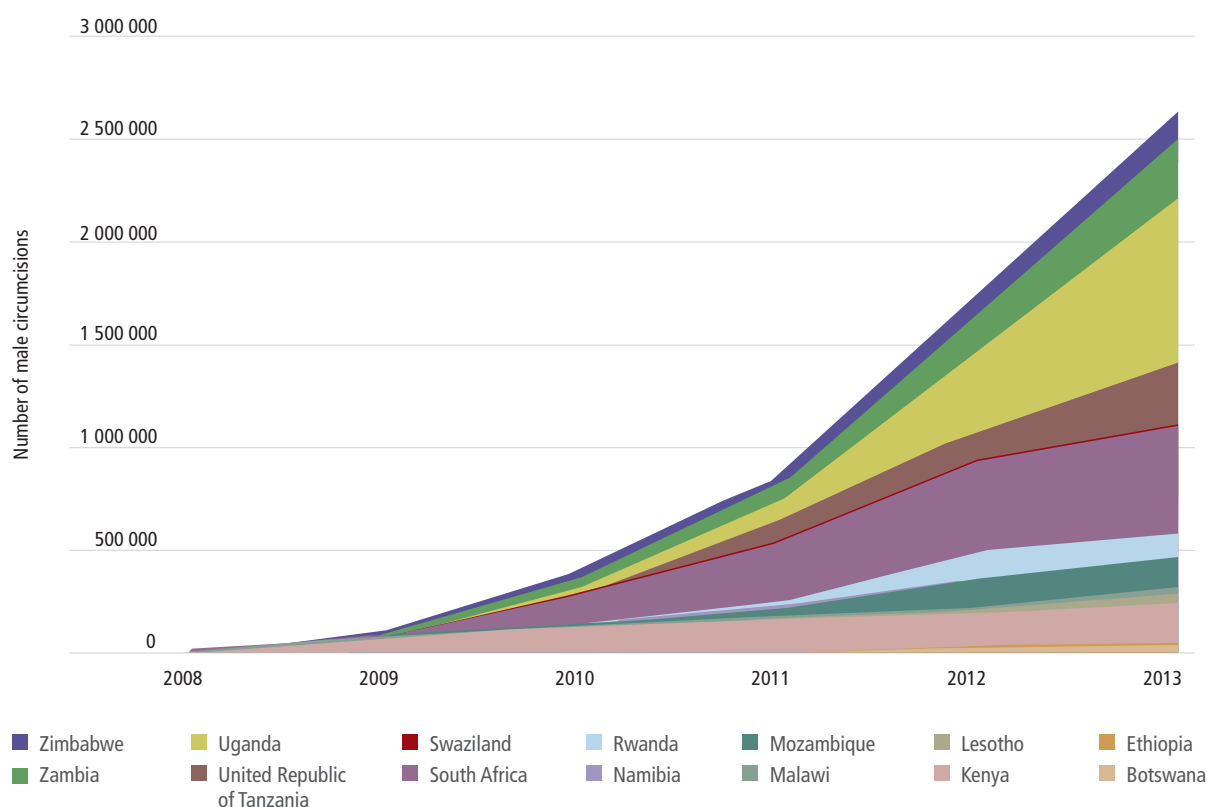
Together, these interventions have been contributing to significant reductions in the numbers of adults and children acquiring HIV infection, from 2.5 million [2.3 – 2.7 million] in 2009 to 2.1 million [1.9 – 2.4 million] in 2013. A priority now is to tailor these approaches and focus efforts more effectively on settings and populations in which HIV transmission is occurring.

In particular, HIV strategies need to draw adolescents and young people (especially girls and young women) into sharper focus, and the neglect of HIV services for key populations (including men who have sex with men, sex workers, transgender people and people who inject drugs) in many countries has to end. Young people (15–24 years old) accounted for about one third of the people estimated to be

newly infected with HIV globally. Key populations, meanwhile, account for most of the people newly infected with HIV outside the WHO African Region and a significant share of the people acquiring HIV infection in urban settings in Africa. The coverage and uptake of HIV and other essential health services for these populations need to improve substantially.

Although the full benefits of condom promotion have not yet been realized (in low- and middle-income countries, a median of about 41% of adults with multiple partners reported using a condom the last time they had sex), voluntary medical male circumcision has been scaled up considerably. In 2013, 2.7 million men in the 14 priority countries in eastern and southern Africa underwent this procedure, 1 million more than in 2012. This brought to about 5.8 million the number

Annual number of voluntary medical male circumcisions performed in 14 priority countries in the WHO African Region, 2008–2013



Note: The data shown for Ethiopia apply only to the Gambella Region.

Sources: Global AIDS Response Progress Reporting (WHO/UNICEF/UNAIDS), WHO and health ministries.

of males who had undergone voluntary medical male circumcision. The increased momentum towards reaching the nearly 20 million male circumcisions that are needed to achieve 80% coverage among adolescent and adult males in these priority countries reflects growing acceptability of and investment in these services.

Countries are increasingly adopting policies to seize new opportunities such as the use of ARV drugs to prevent HIV

transmission. By June 2014, 28 of the 58 WHO HIV focus countries² had policies for offering ART to the HIV-positive partner in a serodiscordant couple, regardless of the partners' clinical or immune status.

The use of other, more longstanding interventions has also expanded, including measures to eliminate HIV transmission during health care procedures. The absolute numbers of HIV and hepatitis C virus (HCV) infections

² The 2014–2015 WHO HIV focus countries are: Angola, Bolivia (Plurinational State of), Botswana, Brazil, Burundi, Cambodia, Cameroon, Central African Republic, Chad, China, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, El Salvador, Ethiopia, Ghana, Guatemala, Haiti, Honduras, India, Indonesia, Iran (Islamic Republic of), Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Libya, Malawi, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nigeria, Pakistan, Papua New Guinea, Paraguay, Philippines, Russian Federation, Rwanda, Somalia, South Africa, South Sudan, Sudan, Swaziland, Tajikistan, Thailand, Uganda, Ukraine, United Republic of Tanzania, Uzbekistan, Viet Nam, Yemen, Zambia and Zimbabwe.

transmitted through unsafe health care injections fell by 87% and 83%, respectively, during 2000–2010. Increasing numbers of countries have introduced or enhanced blood safety procedures, although about 24% of the blood

donations in low-income countries are still not screened for one or more of HIV, hepatitis B virus (HBV) and HCV using basic quality procedures.

Too many children are still being infected with HIV

International efforts to eliminate the mother-to-child transmission of HIV continue to intensify. The number of children newly infected with HIV in low- and middle-income countries declined by 40% to an estimated 240 000 [210 000–280 000] in 2013, down from the estimated 400 000 [370 000–450 000] who acquired HIV infection in 2009, the baseline year for the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

Several improvements have led to these achievements. The number of pregnant women with HIV has remained relatively stable since 2009, but the proportion receiving recommended ARV regimens for prevention of mother-to-child transmission (PMTCT) of HIV has increased steadily. In 2013, about two thirds (67%, range 62–73%) of all pregnant women living with HIV in low- and middle-income countries – close to one million women – received ARV drugs that prevent mother-to-child transmission. By June 2014, almost half of the 58 WHO HIV focus countries had adopted the WHO recommendation to provide lifelong ART to all pregnant women living with HIV (option B+), and all 21 Global Plan priority countries in the WHO African Region now have guidelines officially endorsing options B or B+.

ART (triple drugs provided lifelong or during the MTCT risk period) is rapidly becoming the standard for pregnant women living with HIV, including in the 21 priority countries under the Global Plan in the WHO African Region.³

At current trends, the mother-to-child transmission of HIV may soon be virtually eliminated in some countries in which very low numbers of children are being newly infected with HIV.

Eliminating congenital syphilis and strengthening maternal, newborn and child health services form part of the efforts to prevent new HIV infections among children.

Greater efforts are needed to measure ARV coverage during the breastfeeding period and to ascertain the final outcomes of PMTCT interventions for mothers and children. The current failure to perform early infant diagnosis in even half of HIV-exposed infants is one of the major reasons for the low ART coverage among infants generally.

More people are being reached through diverse HIV testing approaches

The number of people who took an HIV test in 2013 in 77 reporting countries increased by 33% compared with 2009. The increased use of diverse testing approaches has been an important development. At the end of 2012, 95% of 102 reporting countries had explicit policies for provider-initiated testing and counselling in health facilities. Partner testing is also expanding rapidly, testing services are being moved closer to communities (85 of 119 countries were using community-based testing approaches in 2013) and self-testing is being used increasingly as an additional testing option.

Nevertheless, too many people remain unaware of their HIV infection: in most countries reporting data, less than half the people living with HIV have ever had an HIV test and received their test result. In countries with a high HIV prevalence, testing rates are generally lower for men than for women, and the use of HIV testing and counselling services remains especially low among adolescents and some key populations. Earlier diagnosis of people with HIV enables them to be linked to services, thus improving efforts to retain them in HIV care until they are eligible to initiate ART (in accordance with WHO guidelines).

³ The 21 priority countries in the WHO African Region are Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. India is the only priority country outside the African Region.

With almost 13 million people receiving ART, HIV treatment is being expanded more rapidly than ever

Provision of ART has accelerated even further, with about 12.9 million people receiving ART globally at the end of 2013, 11.7 million of them in low- and middle-income countries. The 11.7 million people on ART represent 36% [34–38%] of the 32.6 million [30.8 – 34.7 million] people living with HIV in low- and middle-income countries. The additional 2 million people who started ART in 2013 marked the largest-ever annual increase in ART provision. At current trends, the target of placing 15 million people on ART by 2015 in low- and middle-income countries will be exceeded.

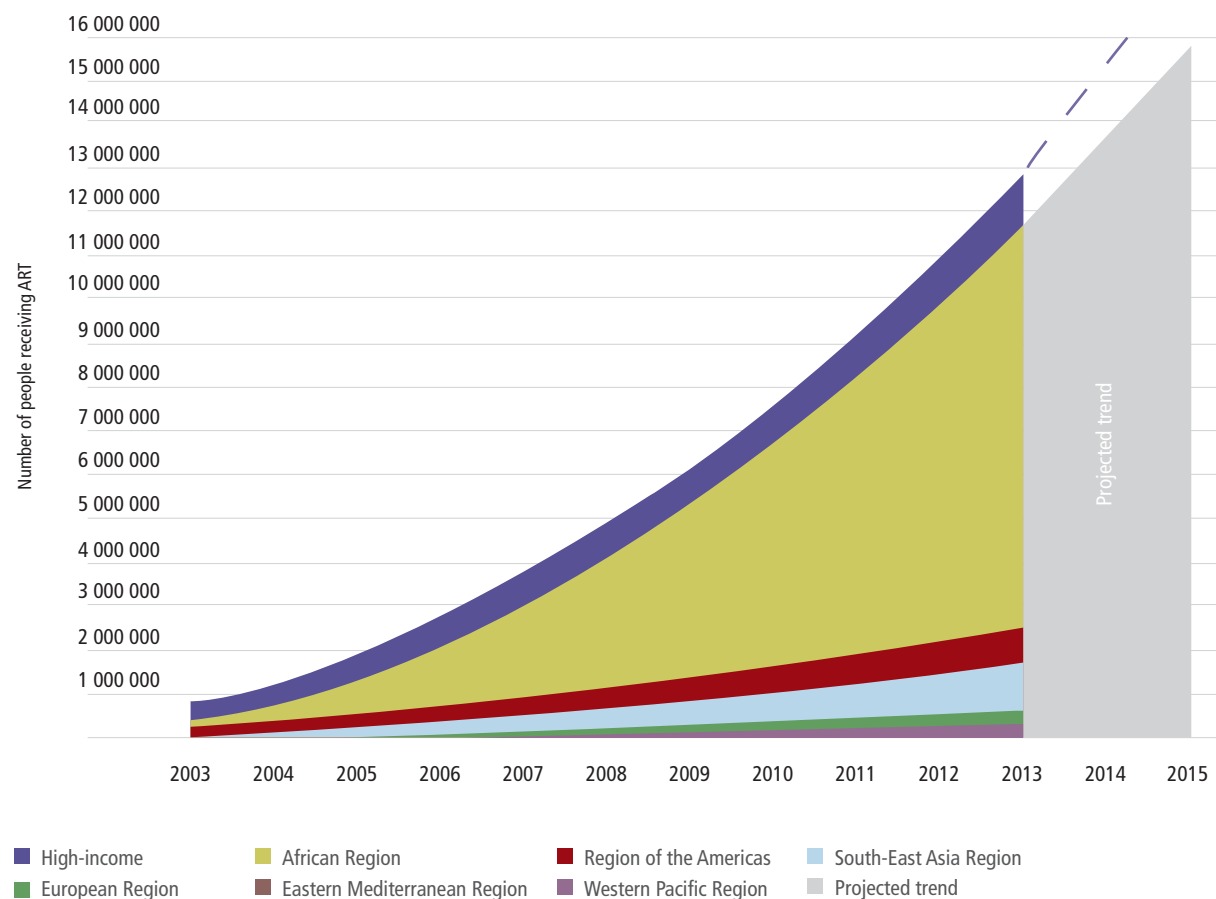
The annual number of people dying from HIV-related causes has decreased by 22% in recent years – from 2.0 million [1.8 – 2.1 million] in 2009 to 1.5 million [1.4 – 1.7 million] in 2013. Countries have reacted swiftly in adopting the new global WHO ARV drug guidelines that increase the number of people eligible for ART to about 85% of all people living with HIV, with close to half of the WHO HIV focus countries having increased the ART initiation threshold to ≤ 500 CD4 cells/mm³ by June 2014.

Earlier treatment will save more lives – but it also increases the challenge to achieve the goal of treatment for everyone who is eligible in accordance with WHO guidelines. The 11.7 million people receiving ART in low- and middle-income countries in 2013 represented a little over one in three people living with HIV in these countries.

Progress in scaling up ART is not uniformly evident across the globe. ART continues to expand dynamically in the WHO African Region, especially in eastern and southern Africa. At the end of 2013, an estimated 37% of all people living with HIV in the Africa Region were receiving ART. However, the proportions of people with HIV receiving ART in the eastern parts of the WHO European Region and in the WHO Eastern Mediterranean Region still lag significantly behind those in other regions, although both regions have seen significant improvements in 2013.

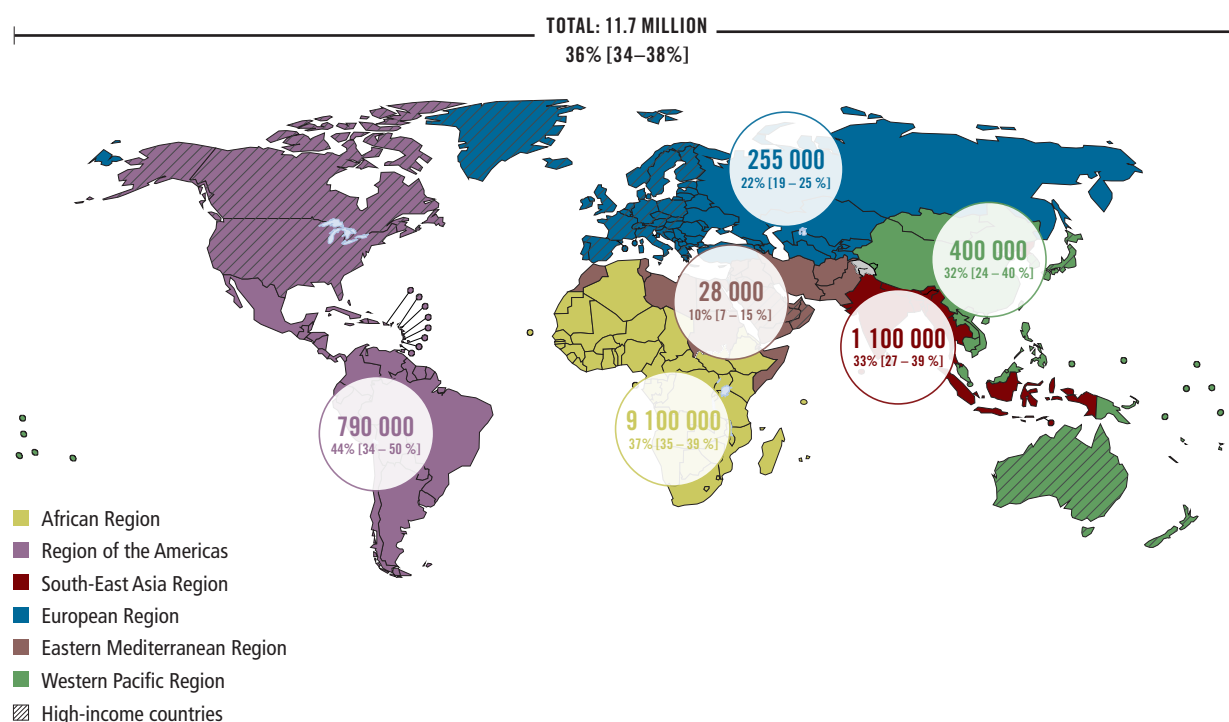
ART provision is not expanding as rapidly for children as for adults. Provisional estimates show that, at the end of 2013, less than one quarter (23%, range 21–25%) of children

Actual and projected numbers of people receiving antiretroviral therapy in low- and middle-income countries by WHO region and in high-income countries across WHO regions, 2003–2015^a



^aCountry income classification by the World Bank at the time of the 2011 Political Declaration on HIV and AIDS.

Number of people receiving ART and percentage of all people living with HIV receiving ART in low- and middle-income countries overall and by WHO region, 2013^a



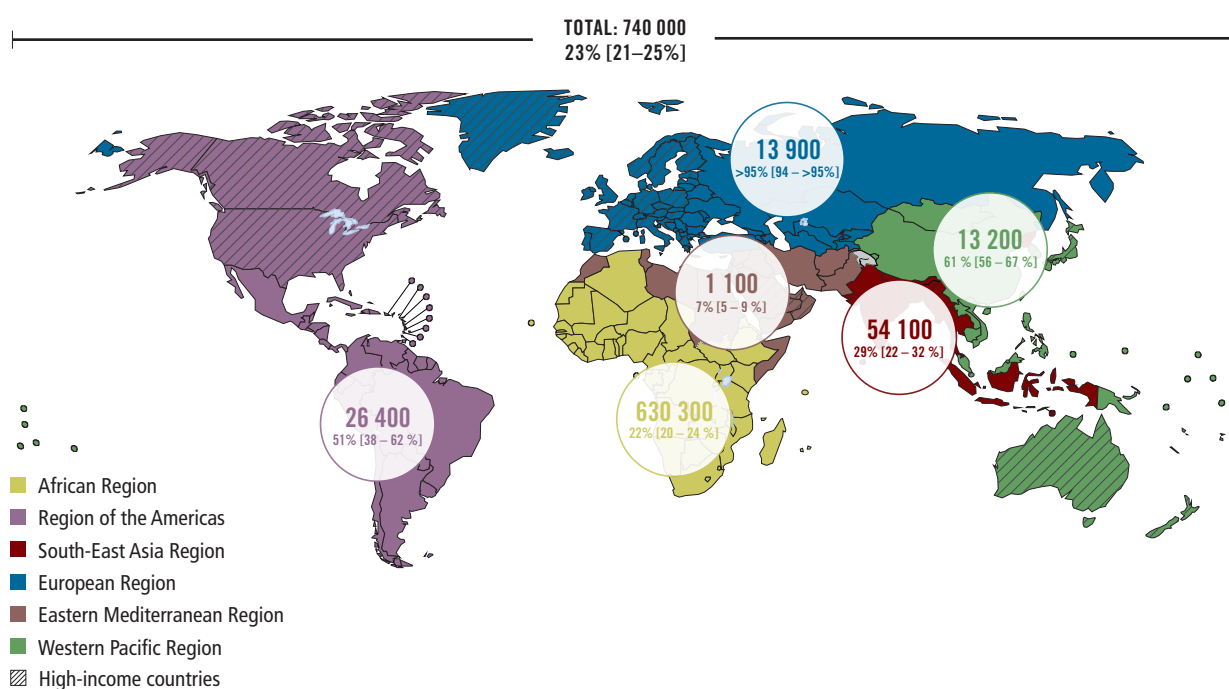
^aCountry income classification by the World Bank at the time of the 2011 Political Declaration on HIV and AIDS.

Source: Global AIDS Response Progress Reporting (WHO/UNICEF/UNAIDS).

(0–14 years) living with HIV in low- and middle-income countries were receiving ART in 2013, compared with more than one third (37%, range 35–39%) of adults living with

HIV. Worryingly, the increase in access to ART for children was slower than for adults in 2013, and the ART coverage gap is widening.

Number of children receiving ART and percentage of all children living with HIV receiving ART in low- and middle-income countries overall and by WHO region, 2013^a



^aCountry income classification by the World Bank at the time of the 2011 Political Declaration on HIV and AIDS.

Source: Global AIDS Response Progress Reporting (WHO/UNICEF/UNAIDS).

Early diagnosis of HIV infection among infants and treatments for children need to improve, and high-quality treatment and care services must reach more adolescents, especially as they transition from child to adult services. HIV has emerged as the second largest cause of death among adolescents globally. Available data suggest that key populations with HIV continue to be underrepresented among people receiving ART even though their treatment access has improved.

The overall goal of HIV treatment is to achieve long-term viral suppression and dramatically improve the survival

rates of as many people living with HIV as possible. Identifying greater numbers of people living with HIV and then enabling them to start ART are therefore vital. No less important is the need to identify people living with HIV early and then to link them with and retain them in care so that they can gain the full benefits of ARV drugs. Countries need to consolidate the improvements made in these areas by strengthening referral and recordkeeping systems and through wider use of treatment support groups, point-of-care CD4 testing and viral load monitoring.

Linking services for HIV and comorbidities is saving lives

The expansion of co-managed HIV and TB services is significantly reducing mortality and morbidity.

In 2013, 48% of people with TB had an HIV test, and the number of people living with HIV reported to have been screened for TB has more than tripled since 2009. ART provision for people coinfected with notified TB and HIV rose from about 40% in 2009 to 70% in 2013, and the number of people dying from HIV-associated TB dropped by a third from 2004 to 2013.

Nevertheless, ART coverage among people with both TB and HIV was still low in some countries with very large burdens of HIV and TB coinfection, and services need to expand considerably. TB remains a leading cause of death among people living with HIV. Further improvements require that TB and HIV services expand and that all opportunities be taken to screen people with TB for HIV and start ART, especially in countries with very large burdens of HIV and TB coinfection, mostly in the WHO African Region.

Many other coinfections and comorbidities tend to be more severe for people living with HIV – including viral hepatitis and various noncommunicable diseases. Viral hepatitis is a growing cause of mortality among people living with HIV, and the burden of HIV and viral hepatitis in different regions needs to be estimated better. Hepatitis screening, prevention and treatment are getting more global attention, and promising new treatments for chronic HCV infection hold great potential if they can be implemented at scale.

Women living with HIV have a high risk of cervical cancer, which is preventable and curable. But in some places, including in the countries of eastern and southern Africa with a high burden of HIV infection, coordinated national efforts to prevent, screen for and manage cervical cancer are scarce.

Chronic HIV care is a great opportunity to screen for, monitor and manage chronic noncommunicable diseases and mental health disorders. This is especially important for people 50 years and older who are living with HIV. In low- and middle-income countries they comprise about 10% of all adults with HIV, yet few HIV programmes currently respond to their needs.

Key populations are largely missing out on recent progress

Despite some improvements, HIV services are not reaching enough key populations, and the HIV prevalence among them remains very high in all regions. Studies show that men who have sex with men are 19 times and transgender women almost 50 times more likely to have HIV than the general adult population, and female sex workers are 14 times more likely to have HIV than other women.

Punitive laws and practices and a lack of political will remain major barriers blocking access to HIV prevention and treatment services. In some countries, a hostile context makes it difficult and even dangerous for nongovernmental organizations to provide services for certain key populations, including for men who have sex with men.

About two in three men who have sex with men were

reportedly reached with HIV prevention programmes in the 109 countries providing these data during 2011–2013. But coverage varies considerably, and adequate government-sponsored HIV services for men who have sex with men remain rare in the WHO African Region and Eastern Mediterranean Region. A rising incidence of HIV infection in this key population is being reported in several places. The HIV needs of transgender people continue to be neglected or ignored, despite the high burden of HIV among them.

Although accurately estimating the coverage of HIV prevention services for female sex workers is still difficult, available data indicate that between two thirds and three quarters of sex workers were being reached with HIV prevention programmes in the 114 countries

that reported these data during 2011–2013. Condom use during sex work appears to be relatively common in many countries and could be increasing. Service provision and access varies considerably between regions and countries, however, and tends to be insufficient in much of the WHO African Region.

In too many places, lack of political will still blocks comprehensive services for people who inject drugs. Even though needle and syringe provision has expanded in some countries, current service coverage is not sufficient to stabilize or reverse HIV epidemics in this population.

Worldwide, 79 countries reported offering opioid substitution therapy in 2013, but two thirds of them were providing it to 40% or less of the opioid-dependent people who inject drugs.

HIV services are mostly lacking in prisons and other closed settings. Needle and syringe programmes were available in prisons in only eight countries, and opioid substitution therapy was available in prisons in about 40 countries, mostly in Europe and the Americas. Very few countries provide ART in prisons.

The HIV response is strengthening public health systems

Wide-ranging improvements are being seen in the coverage and quality of health provision as HIV services are adapted and integrated with other health programmes and services. The benefits include expanding human resource capacity through task-shifting and task-sharing, stronger health service management to provide chronic care, innovations that link patients more reliably to care, approaches to support adherence and retention in long-term care and fortifying community systems.

HIV programmes have played a key role in advocating for, funding and implementing harm-reduction programmes for people who use drugs in many countries, with new interventions to prevent opioid overdose as well as to prevent and manage hepatitis B and C infection being included.

Collaboration between HIV and TB programmes is fostering model programmes for integrating HIV and TB service

delivery. More than half of 105 countries reported that they had either fully integrated or strengthened the joint provision of HIV and TB services, and more than half the WHO focus countries said they had integrated their TB and ART services, with ART being provided in TB clinics in almost half of them.

HIV testing is being linked to a varying extent with child immunization services and is being offered in paediatric inpatient wards, nutrition support programmes, community childcare services and other child health services. Links with other programmes were also consolidated, including with antenatal care services and sexual and reproductive health services. The unmet need for family planning, however, remains high among women living with HIV. The progress seen in integrating and linking programmes now needs to be supplemented with reliable methods for measuring the impact of integrated or linked services and for determining how best to organize such services.

Fresh approaches are generating broader benefits

HIV programmes are pioneering approaches that are paving paths toward achieving universal health coverage. Despite concerns that the pressures of HIV programmes might overwhelm health systems, in many countries, health services – including primary health care, outreach services and laboratory systems – are now generally stronger and more versatile.

The use of task shifting and decentralization is helping stressed health care systems to expand services without comprising quality – especially ART and services for preventing the mother-to-child transmission of HIV in the WHO African Region.

In mid-2013, 27 of 65 reporting countries, mostly in the WHO African Region, had policies that allow nurses to initiate ART for some groups of people. And more than 50% of the countries surveyed in the WHO African Region and 15–30% of countries in other regions now use community health workers

to support ART provision. These adaptations are boosting the reach of HIV and other health services.

Reliance on volunteers and community vitality, however, cannot compensate for inadequate public-sector infrastructure and services. The fundamental duty of ensuring universal health coverage still rests with government leadership, including investing in strengthening community systems, which are critical for delivering sustainable and acceptable services. Fulfilling this duty presupposes having long-term human resource planning for health services – both public and private – and using quality-assurance measures, capacity-building and arrangements for integrating community-based support solidly into formal health systems.

HIV responses continue to deploy methods that can protect people against the financial risks associated with health problems. Direct, out-of-pocket payments for health services are declining and increasingly being replaced with various

pooling and prepayment arrangements as well as with conditional cash transfer and voucher systems. This forms part of a wider shift towards structuring domestic spending on health in ways that can enable everybody to use the full-range of health services they need.

Domestic expenditure is now the single largest source of funding for ART programmes in some countries, and countries are experimenting with new funding methods. Nevertheless, many countries, specifically low-income countries, cannot realistically fund adequate services all on their own. In 2012, 51 countries relied on international sources for more than 75% of their HIV-related spending (especially for ART programmes and services for key populations). External funding remains vitally important.

Other improvements include the continuing drop in the

prices of ARV drugs, because of greater predictability of demand, economies of scale, increased competition among manufacturers and voluntary licensing. In 2013, generic manufacturers supplied 98% of all ARV drugs in low- and middle-income countries, at competitive prices. WHO-recommended first-line regimens containing tenofovir can now be administered for a median price of about US\$ 115 per person per year in low- and middle-income countries.

Although still high, the prices of second-line ARV regimens have also fallen significantly, with most low- and middle-income countries able to access second-line treatment at about US\$ 330 per person per year. However, price reductions remain highly uneven, and many upper-middle-income countries continue to pay higher prices than they can afford, while options beyond second-line therapy remain extremely costly.

Equity and rights are on the agenda, but action needs to intensify

HIV advocacy has sharpened awareness of the importance of health equity, gender equality and human rights – in their own right and for public health. These dimensions are improving but too slowly. Although effective interventions exist and political commitment appears to be increasing, suitable action is still irresolute and isolated in most countries. Stronger public health advocacy and political momentum need to be mobilized to promote policies and programmes that reflect the centrality of human rights for good public health practice.

Gender inequalities and gender violence are major unmet challenges that continue to contribute to the disproportionately high incidence of HIV infection among women and girls in generalized HIV epidemics. In eastern and southern Africa, young women are more than twice as likely to have acquired HIV than their male counterparts.

Those disparities are also partly shaped by gender-based violence, which remains a problem of epidemic proportions worldwide and is a great risk factor for HIV infection. Women who experience intimate partner violence are about 1.5 times more likely to be living with HIV than women who are spared such violence.

Promising recent findings include evidence that empowering women economically can cut their risk of acquiring HIV infection and that the HIV risk for women and girls tends to diminish significantly the further they progress in secondary school. More countries are experimenting with such interventions, which need to be translated into systemic improvements.

Meanwhile, the legal environments in many countries still

block or diminish the impact of HIV services, although some improvements are occurring.

Most countries retain laws that either criminalize or sanction the persecution of people who are at higher risk of HIV infection. Many also have laws or policies that restrict the provision of certain health services that are particularly relevant to key populations, especially people who inject drugs. Indeed, more than 40% of national governments in 2013 reported having laws, regulations or policies that can hinder effective HIV services for key populations.

Homophobic laws and practices have serious public health consequences, yet more than 70 countries criminalized same-sex relations in 2013, and several countries have passed new laws that further criminalize lesbian, gay, bisexual and transgender people. A more encouraging development is the shift, mostly in some high-income countries at the moment, to give priority to public health approaches as alternatives to criminalizing the behaviour of certain key populations – notably sex workers and men who have sex with men.

Stigma and discrimination against people living with HIV and key populations in health care settings continue to undermine HIV responses. But countries are increasingly documenting, publicizing and acting to reduce the harmful impact of stigma and discrimination. And although some countries retain laws that potentially sanction discrimination against people living with HIV, about 60% of countries around the world reported having anti-discrimination laws that protect people living with HIV.

Conclusion

The global HIV response is now operating more firmly as part of a broader health and development agenda. The growing momentum of the HIV response has the potential to significantly benefit wider public health even more profoundly in years to come. This fits with the increasing prominence of the concept of universal health coverage, which affords all people access to health services of sufficient quality without subjecting them to financial hardship.












The goal of ending the AIDS epidemic is emerging as a possible key element of a post-2015 sustainable

development framework. The achievements described in this report confirm that the AIDS epidemic can be ended. But it is also clear that much more needs to be done, particularly in improving the quality of services, reaching the key populations and others being left behind, promoting health equity in which all health needs are addressed and ensuring social and financial security so that programmes are sustainable. A robust HIV response will contribute significantly to broader health and development goals as the world advances into the post-2015 era.

A snapshot of progress in implementing the Global Health Sector Strategy on HIV/AIDS 2011-2015






Strategic Direction 1

OPTIMIZE HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE OUTCOMES

Increasing condom use		Reduced external investment in condom procurement and mixed trends in condom use
Reducing and managing sexually transmitted infections		Some progress, but the pace needs to quicken
Expanding voluntary medical male circumcision		Significant progress in some countries; new male circumcision devices provide opportunities for scaling up, but coverage is still much too low overall
Reaching key populations with HIV services		Effective interventions exist, but they are not being implemented at sufficient scale
Using ARV medicines to prevent HIV infection		More countries are expanding ART eligibility to leverage prevention efforts
Expanding coverage of services to prevent the mother-to-child transmission of HIV		Major advances in some countries, increasing commitment tied to the Global Plan, but insufficient coverage overall
Expanding and improving treatment of children		Progress in some regions, but coverage lags behind that of adults
Expanding and optimizing ART		Strong progress and on track to reach targets
Expanding HIV testing and counselling		Progress in diversifying testing and counselling models and use of new diagnostics, but inadequate coverage
Strengthening retention in care and adherence to treatment		Attrition remains a major problem, but improving regimens and adherence support offer opportunities for progress
Monitoring and managing resistance and toxicity		Drug resistance is still limited; toxicity monitoring systems are being developed







Strategic Direction 2

ENHANCE BROADER HEALTH OUTCOMES

Integrating TB and HIV services		Strong model programmes and collaborative policy frameworks, but implementation can broaden
Integrating and linking HIV with maternal, newborn and child health services and sexual and reproductive health services		Good models of integrated services (especially for preventing mother-to-child transmission), but coverage can widen
Linking and integrating HIV and harm-reduction programmes		Good models of integrated prevention and care, but coverage is inadequate and major legal and political constraints persist
Linking and integrating HIV and noncommunicable disease programmes		Growing awareness needs to be translated into actual services
Linking and integrating HIV and viral hepatitis treatment services		Increasing investment and interest, and new treatments offer hope



Strategic Direction 3

BUILD STRONG AND SUSTAINABLE HEALTH SYSTEMS

Enhancing service delivery methods		New models of service delivery, but infrastructure and basic resources remain inadequate in many countries
Strengthening community systems		Good models for community systems strengthening, but greater funding and capacity-building are required
Enhancing strategic information		New systems and methods being introduced, but data quality needs to improve
Making health system funding sustainable		Increasing domestic funding and innovative funding channels, but challenges remain, especially for low-income countries
Building human resources for health		New approaches to task-shifting and community systems strengthening are improving service delivery, but basic capacity constraints remain a concern
Improving access to medicines and diagnostics		Major reductions in prices and innovations in ARV regimens and point-of-care diagnostics

Strategic Direction 4

REDUCE VULNERABILITIES AND REMOVE STRUCTURAL BARRIERS

Advancing gender equality and removing harmful gender norms		Increasing awareness and promising approaches, but too little decisive and systematic action to enhance gender equality
Safeguarding human rights and enhancing health equity		Continued stigma and discrimination, disparities in access to essential services and criminalization of key populations. Progress in a few countries, but a worsening situation in others

Note: In this publication, a “traffic light” graphic is used to summarize progress made under each of the main areas of the HIV response. The grading used is subjective in nature but aims to visually highlight areas of concern and achievement. The graphics also aim to reflect the varied responses across countries and settings. For each major area, a traffic light grading is provided, with a brief rationale for the grading.

Green: On track to meet agreed targets; good programme coverage; evidence of successful implementation of interventions; examples of good practice exist.
 Yellow: Progress is lagging; targets could still be achieved with intensified and accelerated action; the coverage and quality of programmes need to improve.
 Red: Targets are unlikely to be met; substantial overhaul of the response may be required.
 Cross-hatched “traffic lights” indicate significant variation in the response, including in quality and equitable coverage and across countries and regions.



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